**STATE OF MINNESOTA**

# Journal of the Senate

EIGHTY-SECOND LEGISLATURE

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FIFTY-FOURTH DAY

St. Paul, Minnesota, Tuesday, May 15, 2001

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

## CALL OF THE SENATE

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

Prayer was offered by Senator Dean E. Johnson.

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

| | | | | |
|---|---|---|---|---|
| Anderson | Higgins | Langseth | Ourada | Scheevel |
| Bachmann | Hottinger | Larson | Pappas | Scheid |
| Belanger | Johnson, Dave | Lesewski | Pariseau | Schwab |
| Berg | Johnson, Dean | Lessard | Pogemiller | Stevens |
| Berglin | Johnson, Debbie | Limmer | Price | Stumpf |
| Betzold | Johnson, Doug | Lourey | Ranum | Terwilliger |
| Chaudhary | Kelley, S.P. | Marty | Reiter | Tomassoni |
| Cohen | Kelly, R.C. | Metzen | Rest | Vickerman |
| Day | Kierlin | Moe, R.D. | Ring | Wiener |
| Dille | Kinkel | Murphy | Robertson | Wiger |
| Fischbach | Kiscaden | Neuville | Robling | |
| Foley | Kleis | Oliver | Sabo | |
| Fowler | Knutson | Olson | Sams | |
| Frederickson | Krentz | Orfield | Samuelson | |

The President declared a quorum present.

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

## MEMBERS EXCUSED

Senator Solon was excused from the Session of today.

## EXECUTIVE AND OFFICIAL COMMUNICATIONS

The following communications were received.

May 14, 2001

The Honorable Don Samuelson
President of the Senate

Dear President Samuelson:

It is my honor to inform you that I have received, approved, signed and deposited in the Office of the Secretary of State, S.F. Nos. 1008, 1441, 1404, 1835 and 986.

Sincerely,
Jesse Ventura, Governor

May 14, 2001

The Honorable Steve Sviggum
Speaker of the House of Representatives

The Honorable Don Samuelson
President of the Senate

I have the honor to inform you that the following enrolled Acts of the 2001 Session of the State Legislature have been received from the Office of the Governor and are deposited in the Office of the Secretary of State for preservation, pursuant to the State Constitution, Article IV, Section 23:

| S.F. No. | H.F. No. | Session Laws Chapter No. | Time and Date Approved 2001 | Date Filed 2001 |
|---|---|---|---|---|
| 1008 | | 92 | 2:57 p.m. May 14 | May 14 |
| 1441 | | 93 | 2:56 p.m. May 14 | May 14 |
| 1404 | | 94 | 2:58 p.m. May 14 | May 14 |
| 1835 | | 95 | 2:59 p.m. May 14 | May 14 |
| 986 | | 96 | 3:01 p.m. May 14 | May 14 |

Sincerely,
Mary Kiffmeyer
Secretary of State

## MESSAGES FROM THE HOUSE

Mr. President:

I have the honor to announce the passage by the House of the following Senate Files, herewith returned: S.F. Nos. 1222, 1264, 1821, 2046 and 2031.

Edward A. Burdick, Chief Clerk, House of Representatives

Returned May 14, 2001

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. 491:** A bill for an act relating to health; providing patient protections; amending Minnesota Statutes 2000, sections 45.027, subdivision 6; 62D.17, subdivision 1; 62J.38; 62M.02, subdivision 21; 62Q.56; and 62Q.58; proposing coding for new law in Minnesota Statutes, chapter 62D.

Senate File No. 491 is herewith returned to the Senate.

Edward A. Burdick, Chief Clerk, House of Representatives

Returned May 14, 2001

Senator Berglin moved that the Senate do not concur in the amendments by the House to S.F. No. 491, and that a Conference Committee of 3 members be appointed by the Subcommittee on

Committees on the part of the Senate, to act with a like Conference Committee to be appointed on the part of the House. The motion prevailed.

Mr. President:

I have the honor to announce that the House refuses to concur in the Senate amendments to House File No. 1507:

**H.F. No. 1507:** A bill for an act relating to municipal planning; zoning; clarifying the treatment of legal nonconforming uses; amending Minnesota Statutes 2000, section 462.357, by adding a subdivision.

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

Bishop, Dempsey and Milbert have been appointed as such committee on the part of the House.

House File No. 1507 is herewith transmitted to the Senate with the request that the Senate appoint a like committee.

Edward A. Burdick, Chief Clerk, House of Representatives

Transmitted May 14, 2001

Senator Langseth moved that the Senate accede to the request of the House for a Conference Committee on H.F. No. 1507, and that a Conference Committee of 3 members be appointed by the Subcommittee on 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 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. 722:** A bill for an act relating to energy; providing for comprehensive energy conservation, production, and regulatory changes; amending Minnesota Statutes 2000, sections 16B.32, subdivision 2; 116C.52, subdivisions 4, 10; 116C.53, subdivisions 2, 3; 116C.57, subdivisions 1, 2, 4, by adding subdivisions; 116C.58; 116C.59, subdivisions 1, 4; 116C.60; 116C.61, subdivisions 1, 3; 116C.62; 116C.63, subdivision 2; 116C.645; 116C.65; 116C.66; 116C.69; 216B.095; 216B.097, subdivision 1; 216B.16, subdivision 15; 216B.241, subdivisions 1, 1a, 1b, 1c, 2; 216B.2421, subdivision 2; 216B.243, subdivisions 3, 4, 8; 216B.62, subdivision 5; 216C.41; proposing coding for new law in Minnesota Statutes, chapters 16B; 116C; 216B; 452; repealing Minnesota Statutes 2000, sections 116C.55, subdivisions 2, 3; 116C.57, subdivisions 3, 5, 5a; 116C.67; 216B.2421, subdivision 3.

Senate File No. 722 is herewith returned to the Senate.

Edward A. Burdick, Chief Clerk, House of Representatives

Returned May 14, 2001

Senator Metzen moved that the Senate do not concur in the amendments by the House to S.F. No. 722, and that a Conference Committee of 5 members be appointed by the Subcommittee on Committees on the part of the Senate, to act with a like Conference Committee to be appointed on the part of the House. The motion prevailed.

Mr. President:

I have the honor to announce that the House refuses to concur in the Senate amendments to House File No. 707:

**H.F. No. 707:** A bill for an act relating to crime prevention; classifying Carisoprodol as a controlled substance upon the effective date of a final rule adding Carisoprodol to the federal

schedules of controlled substances; amending Laws 1997, chapter 239, article 4, section 15, as amended.

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

Skoglund, Mulder and Clark, J. have been appointed as such committee on the part of the House.

House File No. 707 is herewith transmitted to the Senate with the request that the Senate appoint a like committee.

Edward A. Burdick, Chief Clerk, House of Representatives

Transmitted May 14, 2001

Senator Kelly, R.C. moved that the Senate accede to the request of the House for a Conference Committee on H.F. No. 707, and that a Conference Committee of 3 members be appointed by the Subcommittee on 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 refuses to concur in the Senate amendments to House File No. 1155:

**H.F. No. 1155:** A bill for an act relating to insurance; regulating action plans of certain health plan companies; requiring an affirmative provider consent to participate in a network under a category of coverage; requiring disclosure of changes in a provider's contract; imposing a moratorium on managed care auto insurance plans; amending Minnesota Statutes 2000, sections 62Q.07; 62Q.74, subdivisions 2, 3, and 4; proposing coding for new law in Minnesota Statutes, chapter 62Q.

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

Abeler, Davids and Lieder have been appointed as such committee on the part of the House.

House File No. 1155 is herewith transmitted to the Senate with the request that the Senate appoint a like committee.

Edward A. Burdick, Chief Clerk, House of Representatives

Transmitted May 14, 2001

Senator Sams moved that the Senate accede to the request of the House for a Conference Committee on H.F. No. 1155, and that a Conference Committee of 3 members be appointed by the Subcommittee on 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 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. 970:** A bill for an act relating to trade regulations; prohibiting gasoline sales below cost; providing enforcement authority; amending Minnesota Statutes 2000, section 325D.01, subdivision 5, and by adding subdivisions; proposing coding for new law in Minnesota Statutes, chapter 325D.

Senate File No. 970 is herewith returned to the Senate.

Edward A. Burdick, Chief Clerk, House of Representatives

Returned May 14, 2001

## CONCURRENCE AND REPASSAGE

Senator Murphy moved that the Senate concur in the amendments by the House to S.F. No. 970 and that the bill be placed on its repassage as amended. The motion prevailed.

S.F. No. 970 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 11, as follows:

Those who voted in the affirmative were:

| | | | | |
|---|---|---|---|---|
| Anderson | Frederickson | Langseth | Pappas | Scheevel |
| Bachmann | Higgins | Lesewski | Pogemiller | Schwab |
| Belanger | Hottinger | Lessard | Price | Stevens |
| Berg | Johnson, Dave | Lourey | Ranum | Stumpf |
| Berglin | Johnson, Dean | Metzen | Rest | Tomassoni |
| Betzold | Johnson, Doug | Murphy | Ring | Vickerman |
| Chaudhary | Kelley, S.P. | Neuville | Robertson | Wiener |
| Dille | Kelly, R.C. | Olson | Sabo | Wiger |
| Fischbach | Kinkel | Orfield | Sams | |
| Fowler | Kiscaden | Ourada | Samuelson | |

Those who voted in the negative were:

| | | | | |
|---|---|---|---|---|
| Day | Kleis | Krentz | Limmer | Reiter |
| Foley | Knutson | Larson | Pariseau | Robling |
| Johnson, Debbie | | | | |

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 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. 694:** A bill for an act relating to public safety; providing for creation of a propane education and research council.

Senate File No. 694 is herewith returned to the Senate.

Edward A. Burdick, Chief Clerk, House of Representatives

Returned May 14, 2001

## CONCURRENCE AND REPASSAGE

Senator Murphy moved that the Senate concur in the amendments by the House to S.F. No. 694 and that the bill be placed on its repassage as amended. The motion prevailed.

S.F. No. 694 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 53 and nays 8, as follows:

Those who voted in the affirmative were:

| | | | | |
|---|---|---|---|---|
| Anderson | Foley | Kinkel | Neuville | Sabo |
| Bachmann | Fowler | Kleis | Oliver | Sams |
| Belanger | Frederickson | Krentz | Orfield | Samuelson |
| Berg | Higgins | Langseth | Ourada | Scheid |
| Berglin | Hottinger | Larson | Pappas | Stevens |
| Betzold | Johnson, Dave | Lesewski | Pogemiller | Stumpf |
| Chaudhary | Johnson, Dean | Lessard | Price | Vickerman |
| Cohen | Johnson, Doug | Lourey | Ranum | Wiener |
| Day | Kelley, S.P. | Metzen | Rest | Wiger |
| Dille | Kelly, R.C. | Moe, R.D. | Ring | |
| Fischbach | Kierlin | Murphy | Robling | |

Those who voted in the negative were:

| | | | | |
|---|---|---|---|---|
| Johnson, Debbie | Knutson | Olson | Reiter | Robertson |
| Kiscaden | Limmer | Pariseau | | |

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 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. 1610:** A bill for an act relating to insurance; regulating liquidations and investments of insurers; amending Minnesota Statutes 2000, sections 60A.11, subdivision 10, by adding a subdivision; 60B.44, subdivision 4; 60L.01, subdivision 14, by adding a subdivision; 60L.08, by adding a subdivision; 60L.10, subdivision 1; 61A.276, subdivision 2; 61A.28, subdivision 6, by adding a subdivision; 61A.29, subdivision 2.

Senate File No. 1610 is herewith returned to the Senate.

Edward A. Burdick, Chief Clerk, House of Representatives

Returned May 14, 2001

## CONCURRENCE AND REPASSAGE

Senator Rest moved that the Senate concur in the amendments by the House to S.F. No. 1610 and that the bill be placed on its repassage as amended. The motion prevailed.

**S.F. No. 1610:** A bill for an act relating to insurance; regulating liquidations and investments of insurers; regulating consolidated or combined financial statements and annuities purchased to finance structured settlement agreements; authorizing domestic mutual life companies to be formed with or establish guaranty funds; regulating certain workers compensation rates and rating plans; amending Minnesota Statutes 2000, sections 60A.11, subdivision 10, by adding a subdivision; 60A.129, subdivision 5; 60B.44, subdivision 4; 60L.01, subdivision 14, by adding a subdivision; 60L.08, by adding a subdivision; 60L.10, subdivision 1; 61A.276, subdivision 2; 61A.28, subdivision 6, by adding a subdivision; 61A.29, subdivision 2; 79.56, subdivision 3; proposing coding for new law in Minnesota Statutes, chapters 60A; 61A.

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 0, as follows:

Those who voted in the affirmative were:

| | | | | |
|---|---|---|---|---|
| Anderson | Frederickson | Knutson | Olson | Sabo |
| Bachmann | Higgins | Krentz | Orfield | Sams |
| Belanger | Hottinger | Langseth | Ourada | Samuelson |
| Berg | Johnson, Dave | Larson | Pappas | Scheid |
| Berglin | Johnson, Dean | Lesewski | Pariseau | Stevens |
| Betzold | Johnson, Debbie | Lessard | Pogemiller | Stumpf |
| Chaudhary | Johnson, Doug | Limmer | Price | Vickerman |
| Cohen | Kelley, S.P. | Lourey | Ranum | Wiener |
| Day | Kelly, R.C. | Marty | Reiter | Wiger |
| Dille | Kierlin | Metzen | Rest | |
| Fischbach | Kinkel | Moe, R.D. | Ring | |
| Foley | Kiscaden | Neuville | Robertson | |
| Fowler | Kleis | Oliver | Robling | |

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 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. 1154:** A bill for an act relating to the metropolitan radio board; extending the expiration date for the board to 2005; amending Laws 1995, chapter 195, article 1, section 18, as amended.

Senate File No. 1154 is herewith returned to the Senate.

Edward A. Burdick, Chief Clerk, House of Representatives

Returned May 11, 2001

Senator Kelley, S.P. moved that the Senate do not concur in the amendments by the House to S.F. No. 1154, and that a Conference Committee of 3 members be appointed by the Subcommittee on Committees on the part of the Senate, to act with a like Conference Committee to be appointed on the part of the House. 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. 1215:** A bill for an act relating to human rights; changing provisions pertaining to business discrimination and inquiry into a charge; permitting discretionary disclosure during investigation; amending Minnesota Statutes 2000, sections 363.01, subdivision 41; 363.03, subdivision 8a; 363.06, subdivision 4; 363.061, subdivision 2.

Senate File No. 1215 is herewith returned to the Senate.

Edward A. Burdick, Chief Clerk, House of Representatives

Returned May 14, 2001

Senator Cohen moved that the Senate do not concur in the amendments by the House to S.F. No. 1215, and that a Conference Committee of 3 members be appointed by the Subcommittee on Committees on the part of the Senate, to act with a like Conference Committee to be 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 3 members of the House, on the amendments adopted by the House to the following Senate File:

**S.F. No. 229:** A bill for an act relating to criminal records; requiring that crime victims be notified of expungement proceedings and allowed to submit a statement; amending Minnesota Statutes 2000, section 609A.03, subdivisions 2, 3, and 4.

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

McGuire, Tuma and Walz.

Senate File No. 229 is herewith returned to the Senate.

Edward A. Burdick, Chief Clerk, House of Representatives

Returned May 14, 2001

Mr. President:

I have the honor to announce that the House refuses to concur in the Senate amendments to House File No. 1153:

**H.F. No. 1153:** A bill for an act relating to local government; exempting certain building projects from the requirement to employ an architect; amending Minnesota Statutes 2000, section 326.03, by adding a subdivision.

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

Mulder, Fuller and Wenzel have been appointed as such committee on the part of the House.

House File No. 1153 is herewith transmitted to the Senate with the request that the Senate appoint a like committee.

Edward A. Burdick, Chief Clerk, House of Representatives

Transmitted May 14, 2001

Senator Lesewski moved that the Senate accede to the request of the House for a Conference Committee on H.F. No. 1153, and that a Conference Committee of 3 members be appointed by the Subcommittee on 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 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. 974:** A bill for an act relating to local government; adding exceptions to the local public officer's conflict of interest law; amending Minnesota Statutes 2000, section 471.88, by adding subdivisions.

Senate File No. 974 is herewith returned to the Senate.

Edward A. Burdick, Chief Clerk, House of Representatives

Returned May 14, 2001

## CONCURRENCE AND REPASSAGE

Senator Lessard moved that the Senate concur in the amendments by the House to S.F. No. 974 and that the bill be placed on its repassage as amended. The motion prevailed.

S.F. No. 974 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 59 and nays 5, as follows:

Those who voted in the affirmative were:

| | | | | |
|---|---|---|---|---|
| Anderson | Hottinger | Larson | Ourada | Samuelson |
| Bachmann | Johnson, Dave | Lesewski | Pappas | Scheevel |
| Belanger | Johnson, Dean | Lessard | Pariseau | Scheid |
| Berg | Johnson, Debbie | Lourey | Pogemiller | Schwab |
| Chaudhary | Kelley, S.P. | Marty | Price | Stevens |
| Cohen | Kelly, R.C. | Metzen | Ranum | Stumpf |
| Day | Kierlin | Moe, R.D. | Reiter | Terwilliger |
| Dille | Kinkel | Murphy | Rest | Tomassoni |
| Fischbach | Kiscaden | Neuville | Ring | Vickerman |
| Foley | Knutson | Oliver | Robertson | Wiener |
| Fowler | Krentz | Olson | Robling | Wiger |
| Higgins | Langseth | Orfield | Sams | |

Those who voted in the negative were:

| | | | | |
|---|---|---|---|---|
| Berglin | Betzold | Kleis | Limmer | Sabo |

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 refuses to concur in the Senate amendments to House File No. 1487:

**H.F. No. 1487:** A bill for an act relating to natural resources; modifying provisions rendered obsolete by the electronic licensing system; modifying the disposition of certain taxes and proceeds; clarifying certain licensing and training requirements; providing for removal of submerged vehicles; modifying watercraft license and title provisions; clarifying sale of live animals and animal portions; modifying rulemaking authority; modifying certain license revocation provisions; clarifying taxidermy and bow fishing provisions; modifying fish house requirements; repealing certain fleeing provisions; amending Minnesota Statutes 2000, sections 6.48; 84.788, subdivisions 3 and 4; 84.796; 84.798, subdivisions 3 and 5; 84.82, subdivision 2; 84.83, subdivisions 3 and 5; 84.862, subdivisions 1 and 2; 84.872, subdivision 1; 84.922, subdivisions 2 and 3; 86B.401, subdivisions 1, 3, and 4; 86B.705, subdivision 2; 86B.820, subdivision 13; 86B.825, subdivision 1; 86B.830, subdivision 1; 97A.065, subdivision 2; 97A.105, subdivisions 4 and 9; 97A.421, subdivision 1; 97A.425, subdivision 1; 97A.441, subdivision 1; 97A.512; 97B.055, subdivision 2; 97C.355, subdivision 1, and by adding a subdivision; and 297A.94; proposing coding for new law in Minnesota Statutes, chapter 86B; repealing Minnesota Statutes 2000, sections 84.792; and 84.801.

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

Haas, Finseth and Bakk have been appointed as such committee on the part of the House.

House File No. 1487 is herewith transmitted to the Senate with the request that the Senate appoint a like committee.

Edward A. Burdick, Chief Clerk, House of Representatives

Transmitted May 14, 2001

Senator Lessard moved that the Senate accede to the request of the House for a Conference Committee on H.F. No. 1487, and that a Conference Committee of 3 members be appointed by the

Subcommittee on 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 the passage by the House of the following House Files, herewith transmitted: H.F. Nos. 156 and 1541.

Edward A. Burdick, Chief Clerk, House of Representatives

Transmitted May 14, 2001

## FIRST READING OF HOUSE BILLS

The following bills were read the first time and referred to the committees indicated.

**H.F. No. 156:** A bill for an act relating to occupations; regulating registration renewal fees for certain multiple barber shops operated by a single barber; amending Minnesota Statutes 2000, section 154.15, subdivision 1.

Referred to the Committee on Commerce.

**H.F. No. 1541:** A bill for an act relating to landlords and tenants; requiring a study of rental application fees.

Referred to the Committee on Rules and Administration for comparison with S.F. No. 882, now on General Orders.

## REPORTS OF COMMITTEES

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

**Senator Moe, R.D. from the Committee on Rules and Administration, to which was referred**

**H.F. No. 1182** 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. |
| 1182 | 831 | | | | |

Pursuant to Rule 45, the Committee on Rules and Administration recommends that H.F. No. 1182 be amended as follows:

Delete all the language after the enacting clause of H.F. No. 1182 and insert the language after the enacting clause of S.F. No. 831; further, delete the title of H.F. No. 1182 and insert the title of S.F. No. 831.

And when so amended H.F. No. 1182 will be identical to S.F. No. 831, and further recommends that H.F. No. 1182 be given its second reading and substituted for S.F. No. 831, 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 Moe, R.D. from the Committee on Rules and Administration, to which was referred**

**H.F. No. 1828** 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. |
| 1828 | 1486 | | | | |

Pursuant to Rule 45, the Committee on Rules and Administration recommends that H.F. No. 1828 be amended as follows:

Delete all the language after the enacting clause of H.F. No. 1828 and insert the language after the enacting clause of S.F. No. 1486, the second engrossment; further, delete the title of H.F. No. 1828 and insert the title of S.F. No. 1486, the second engrossment.

And when so amended H.F. No. 1828 will be identical to S.F. No. 1486, and further recommends that H.F. No. 1828 be given its second reading and substituted for S.F. No. 1486, 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 Moe, R.D. from the Committee on Rules and Administration, to which was referred**

**H.F. No. 1310** 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. |
| 1310 | 1205 | | | | |

Pursuant to Rule 45, the Committee on Rules and Administration recommends that H.F. No. 1310 be amended as follows:

Delete all the language after the enacting clause of H.F. No. 1310 and insert the language after the enacting clause of S.F. No. 1205, the second engrossment; further, delete the title of H.F. No. 1310 and insert the title of S.F. No. 1205, the second engrossment.

And when so amended H.F. No. 1310 will be identical to S.F. No. 1205, and further recommends that H.F. No. 1310 be given its second reading and substituted for S.F. No. 1205, 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. 1182, 1828 and 1310 were read the second time.

## MOTIONS AND RESOLUTIONS

Senator Krentz moved that S.F. No. 222, No. 35 on General Orders, be stricken and re-referred to the Committee on Environment and Natural Resources. The motion prevailed.

Pursuant to Rule 26, Senator Moe, R.D., Chair of the Committee on Rules and Administration, designated H.F. No. 1947 a Special Order to be heard immediately.

## SPECIAL ORDER

**H.F. No. 1947:** A bill for an act relating to health; modifying the Vital Statistics Act; modifying access to adoption records; amending Minnesota Statutes 2000, sections 144.212, subdivisions 2a, 3, 5, 7, 8, 9, 11; 144.214, subdivisions 1, 3, 4; 144.215, subdivisions 1, 3, 4, 6, 7; 144.217; 144.218; 144.221, subdivisions 1, 3; 144.222, subdivision 2; 144.223; 144.225, subdivisions 1, 2, 3, 4, 7; 144.226, subdivisions 1, 3; 144.227; 260C.317, subdivision 4; proposing coding for new law in Minnesota Statutes, chapter 144; repealing Minnesota Statutes 2000, sections 144.1761; 144.217, subdivision 4; 144.219.

Senator Berglin moved to amend H.F. No. 1947, as amended pursuant to Rule 45, adopted by the Senate May 11, 2001, as follows:

(The text of the amended House File is identical to S.F. No. 1345.)

Page 1, after line 14, insert:

"ARTICLE 1

DEPARTMENT OF HEALTH

Section 1. Minnesota Statutes 2000, section 62J.152, subdivision 8, is amended to read:

Subd. 8. [REPEALER.] This section and sections 62J.15 and 62J.156 are repealed effective July 1, ~~2001~~ 2005.

Sec. 2. Minnesota Statutes 2000, section 62J.451, subdivision 5, is amended to read:

Subd. 5. [HEALTH CARE ELECTRONIC DATA INTERCHANGE SYSTEM.] ~~(a)~~ The health data institute shall establish an electronic data interchange system that electronically transmits, collects, archives, and provides users of data with the data necessary for their specific interests, in order to promote a high quality, cost-effective, consumer-responsive health care system. This public-private information system shall be developed to make health care claims processing and financial settlement transactions more efficient and to provide an efficient, unobtrusive method for meeting the shared electronic data interchange needs of consumers, group purchasers, providers, and the state.

~~(b) The health data institute shall operate the Minnesota center for health care electronic data interchange established in section 62J.57, and shall integrate the goals, objectives, and activities of the center with those of the health data institute's electronic data interchange system.~~

Sec. 3. Minnesota Statutes 2000, section 103I.101, subdivision 6, is amended to read:

Subd. 6. [FEES FOR VARIANCES.] The commissioner shall charge a nonrefundable application fee of ~~$120~~ $150 to cover the administrative cost of processing a request for a variance or modification of rules adopted by the commissioner under this chapter.

**[EFFECTIVE DATE.]** This section is effective July 1, 2002.

Sec. 4. Minnesota Statutes 2000, section 103I.112, is amended to read:

103I.112 [FEE EXEMPTIONS FOR STATE AND LOCAL GOVERNMENT.]

(a) The commissioner of health may not charge fees required under this chapter to a federal agency, state agency, or a local unit of government or to a subcontractor performing work for the state agency or local unit of government.

(b) "Local unit of government" means a statutory or home rule charter city, town, county, or soil and water conservation district, watershed district, an organization formed for the joint exercise of powers under section 471.59, a board of health or community health board, or other special purpose district or authority with local jurisdiction in water and related land resources management.

**[EFFECTIVE DATE.]** This section is effective July 1, 2002.

Sec. 5. Minnesota Statutes 2000, section 103I.208, subdivision 1, is amended to read:

Subdivision 1. [WELL NOTIFICATION FEE.] The well notification fee to be paid by a property owner is:

(1) for a new well, ~~$120~~ $150, which includes the state core function fee;

(2) for a well sealing, ~~$20~~ $30 for each well, which includes the state core function fee, except that for monitoring wells constructed on a single property, having depths within a 25 foot range, and sealed within 48 hours of start of construction, a single fee of ~~$20~~ $30; and

(3) for construction of a dewatering well, ~~$120~~ $150, which includes the state core function fee, for each well except a dewatering project comprising five or more wells shall be assessed a single fee of ~~$600~~ $750 for the wells recorded on the notification.

**[EFFECTIVE DATE.]** This section is effective July 1, 2002.

Sec. 6. Minnesota Statutes 2000, section 103I.208, subdivision 2, is amended to read:

Subd. 2. [PERMIT FEE.] The permit fee to be paid by a property owner is:

(1) for a well that is not in use under a maintenance permit, ~~$100~~ $125 annually;

(2) for construction of a monitoring well, ~~$120~~ $150, which includes the state core function fee;

(3) for a monitoring well that is unsealed under a maintenance permit, ~~$100~~ $125 annually;

(4) for monitoring wells used as a leak detection device at a single motor fuel retail outlet, a single petroleum bulk storage site excluding tank farms, or a single agricultural chemical facility site, the construction permit fee is ~~$120~~ $150, which includes the state core function fee, per site regardless of the number of wells constructed on the site, and the annual fee for a maintenance permit for unsealed monitoring wells is ~~$100~~ $125 per site regardless of the number of monitoring wells located on site;

(5) for a groundwater thermal exchange device, in addition to the notification fee for wells, ~~$120~~ $150, which includes the state core function fee;

(6) for a vertical heat exchanger, ~~$120~~ $150;

(7) for a dewatering well that is unsealed under a maintenance permit, ~~$100~~ $125 annually for each well, except a dewatering project comprising more than five wells shall be issued a single permit for ~~$500~~ $625 annually for wells recorded on the permit; and

(8) for excavating holes for the purpose of installing elevator shafts, ~~$120~~ $150 for each hole.

**[EFFECTIVE DATE.]** This section is effective July 1, 2002.

Sec. 7. Minnesota Statutes 2000, section 103I.235, subdivision 1, is amended to read:

Subdivision 1. [DISCLOSURE OF WELLS TO BUYER.] (a) Before signing an agreement to sell or transfer real property, the seller must disclose in writing to the buyer information about the status and location of all known wells on the property, by delivering to the buyer either a statement by the seller that the seller does not know of any wells on the property, or a disclosure statement indicating the legal description and county, and a map drawn from available information showing the location of each well to the extent practicable. In the disclosure statement, the seller must indicate, for each well, whether the well is in use, not in use, or sealed.

(b) At the time of closing of the sale, the disclosure statement information, name and mailing address of the buyer, and the quartile, section, township, and range in which each well is located must be provided on a well disclosure certificate signed by the seller or a person authorized to act on behalf of the seller.

(c) A well disclosure certificate need not be provided if the seller does not know of any wells on the property and the deed or other instrument of conveyance contains the statement: "The Seller certifies that the Seller does not know of any wells on the described real property."

(d) If a deed is given pursuant to a contract for deed, the well disclosure certificate required by this subdivision shall be signed by the buyer or a person authorized to act on behalf of the buyer. If the buyer knows of no wells on the property, a well disclosure certificate is not required if the following statement appears on the deed followed by the signature of the grantee or, if there is more than one grantee, the signature of at least one of the grantees: "The Grantee certifies that the Grantee does not know of any wells on the described real property." The statement and signature of the grantee may be on the front or back of the deed or on an attached sheet and an acknowledgment of the statement by the grantee is not required for the deed to be recordable.

(e) This subdivision does not apply to the sale, exchange, or transfer of real property:

(1) that consists solely of a sale or transfer of severed mineral interests; or

(2) that consists of an individual condominium unit as described in chapters 515 and 515B.

(f) For an area owned in common under chapter 515 or 515B the association or other responsible person must report to the commissioner by July 1, 1992, the location and status of all wells in the common area. The association or other responsible person must notify the commissioner within 30 days of any change in the reported status of wells.

(g) For real property sold by the state under section 92.67, the lessee at the time of the sale is responsible for compliance with this subdivision.

(h) If the seller fails to provide a required well disclosure certificate, the buyer, or a person authorized to act on behalf of the buyer, may sign a well disclosure certificate based on the information provided on the disclosure statement required by this section or based on other available information.

(i) A county recorder or registrar of titles may not record a deed or other instrument of conveyance dated after October 31, 1990, for which a certificate of value is required under section 272.115, or any deed or other instrument of conveyance dated after October 31, 1990, from a governmental body exempt from the payment of state deed tax, unless the deed or other instrument of conveyance contains the statement made in accordance with paragraph (c) or (d) or is accompanied by the well disclosure certificate containing all the information required by paragraph (b) or (d). The county recorder or registrar of titles must not accept a certificate unless it contains all the required information. The county recorder or registrar of titles shall note on each deed or other instrument of conveyance accompanied by a well disclosure certificate that the well disclosure certificate was received. The notation must include the statement "No wells on property" if the disclosure certificate states there are no wells on the property. The well disclosure certificate shall not be filed or recorded in the records maintained by the county recorder or registrar of titles. After noting "No wells on property" on the deed or other instrument of conveyance, the county recorder or registrar of titles shall destroy or return to the buyer the well disclosure certificate. The county recorder or registrar of titles shall collect from the buyer or the person seeking to record a deed or other instrument of conveyance, a fee of ~~$20~~ $30 for receipt of a completed well disclosure certificate. By the tenth day of each month, the county recorder or registrar of titles shall transmit the well disclosure certificates to the commissioner of health. By the tenth day after the end of each calendar quarter, the county recorder or registrar of titles shall transmit to the commissioner of health ~~$17.50~~ $27.50 of the fee for each well disclosure certificate received during the quarter. The commissioner shall maintain the well disclosure certificate for at least six years. The commissioner may store the certificate as an electronic image. A copy of that image shall be as valid as the original.

(j) No new well disclosure certificate is required under this subdivision if the buyer or seller, or a person authorized to act on behalf of the buyer or seller, certifies on the deed or other instrument of conveyance that the status and number of wells on the property have not changed since the last previously filed well disclosure certificate. The following statement, if followed by the signature

of the person making the statement, is sufficient to comply with the certification requirement of this paragraph: "I am familiar with the property described in this instrument and I certify that the status and number of wells on the described real property have not changed since the last previously filed well disclosure certificate." The certification and signature may be on the front or back of the deed or on an attached sheet and an acknowledgment of the statement is not required for the deed or other instrument of conveyance to be recordable.

(k) The commissioner in consultation with county recorders shall prescribe the form for a well disclosure certificate and provide well disclosure certificate forms to county recorders and registrars of titles and other interested persons.

(l) Failure to comply with a requirement of this subdivision does not impair:

(1) the validity of a deed or other instrument of conveyance as between the parties to the deed or instrument or as to any other person who otherwise would be bound by the deed or instrument; or

(2) the record, as notice, of any deed or other instrument of conveyance accepted for filing or recording contrary to the provisions of this subdivision.

**[EFFECTIVE DATE.]** This section is effective July 1, 2002.

Sec. 8. Minnesota Statutes 2000, section 103I.525, subdivision 2, is amended to read:

Subd. 2. [APPLICATION FEE.] The application fee for a well contractor's license is ~~$50~~ $75. The commissioner may not act on an application until the application fee is paid.

**[EFFECTIVE DATE.]** This section is effective July 1, 2002.

Sec. 9. Minnesota Statutes 2000, section 103I.525, subdivision 6, is amended to read:

Subd. 6. [LICENSE FEE.] The fee for a well contractor's license is $250, except the fee for an individual well contractor's license is ~~$50~~ $75.

**[EFFECTIVE DATE.]** This section is effective July 1, 2002.

Sec. 10. Minnesota Statutes 2000, section 103I.525, subdivision 8, is amended to read:

Subd. 8. [RENEWAL.] (a) A licensee must file an application and a renewal application fee to renew the license by the date stated in the license.

(b) The renewal application fee ~~shall be set by the commissioner under section 16A.1285~~ for a well contractor's license is $250.

(c) The renewal application must include information that the applicant has met continuing education requirements established by the commissioner by rule.

(d) At the time of the renewal, the commissioner must have on file all properly completed well reports, well sealing reports, reports of excavations to construct elevator shafts, well permits, and well notifications for work conducted by the licensee since the last license renewal.

**[EFFECTIVE DATE.]** This section is effective July 1, 2002.

Sec. 11. Minnesota Statutes 2000, section 103I.525, subdivision 9, is amended to read:

Subd. 9. [INCOMPLETE OR LATE RENEWAL.] If a licensee fails to submit all information required for renewal in subdivision 8 or submits the application and information after the required renewal date:

(1) the licensee must include ~~an additional~~ a late fee ~~set by the commissioner~~ of $75; and

(2) the licensee may not conduct activities authorized by the well contractor's license until the renewal application, renewal application fee, late fee, and all other information required in subdivision 8 are submitted.

**[EFFECTIVE DATE.]** This section is effective July 1, 2002.

Sec. 12. Minnesota Statutes 2000, section 103I.531, subdivision 2, is amended to read:

Subd. 2. [APPLICATION FEE.] The application fee for a limited well/boring contractor's license is ~~$50~~ $75. The commissioner may not act on an application until the application fee is paid.

**[EFFECTIVE DATE.]** This section is effective July 1, 2002.

Sec. 13. Minnesota Statutes 2000, section 103I.531, subdivision 6, is amended to read:

Subd. 6. [LICENSE FEE.] The fee for a limited well/boring contractor's license is ~~$50~~ $75.

**[EFFECTIVE DATE.]** This section is effective July 1, 2002.

Sec. 14. Minnesota Statutes 2000, section 103I.531, subdivision 8, is amended to read:

Subd. 8. [RENEWAL.] (a) A person must file an application and a renewal application fee to renew the limited well/boring contractor's license by the date stated in the license.

(b) The renewal application fee ~~shall be set by the commissioner under section 16A.1285~~ for a limited well/boring contractor's license is $75.

(c) The renewal application must include information that the applicant has met continuing education requirements established by the commissioner by rule.

(d) At the time of the renewal, the commissioner must have on file all properly completed well sealing reports, well permits, vertical heat exchanger permits, and well notifications for work conducted by the licensee since the last license renewal.

**[EFFECTIVE DATE.]** This section is effective July 1, 2002.

Sec. 15. Minnesota Statutes 2000, section 103I.531, subdivision 9, is amended to read:

Subd. 9. [INCOMPLETE OR LATE RENEWAL.] If a licensee fails to submit all information required for renewal in subdivision 8 or submits the application and information after the required renewal date:

(1) the licensee must include ~~an additional~~ a late fee ~~set by the commissioner~~ of $75; and

(2) the licensee may not conduct activities authorized by the limited well/boring contractor's license until the renewal application, renewal application fee, and late fee, and all other information required in subdivision 8 are submitted.

**[EFFECTIVE DATE.]** This section is effective July 1, 2002.

Sec. 16. Minnesota Statutes 2000, section 103I.535, subdivision 2, is amended to read:

Subd. 2. [APPLICATION FEE.] The application fee for an elevator shaft contractor's license is ~~$50~~ $75. The commissioner may not act on an application until the application fee is paid.

**[EFFECTIVE DATE.]** This section is effective July 1, 2002.

Sec. 17. Minnesota Statutes 2000, section 103I.535, subdivision 6, is amended to read:

Subd. 6. [LICENSE FEE.] The fee for an elevator shaft contractor's license is ~~$50~~ $75.

**[EFFECTIVE DATE.]** This section is effective July 1, 2002.

Sec. 18. Minnesota Statutes 2000, section 103I.535, subdivision 8, is amended to read:

Subd. 8. [RENEWAL.] (a) A person must file an application and a renewal application fee to renew the license by the date stated in the license.

(b) The renewal application fee ~~shall be set by the commissioner under section 16A.1285~~ for an elevator shaft contractor's license is $75.

(c) The renewal application must include information that the applicant has met continuing education requirements established by the commissioner by rule.

(d) At the time of renewal, the commissioner must have on file all reports and permits for elevator shaft work conducted by the licensee since the last license renewal.

**[EFFECTIVE DATE.]** This section is effective July 1, 2002.

Sec. 19. Minnesota Statutes 2000, section 103I.535, subdivision 9, is amended to read:

Subd. 9. [INCOMPLETE OR LATE RENEWAL.] If a licensee fails to submit all information required for renewal in subdivision 8 or submits the application and information after the required renewal date:

(1) the licensee must include ~~an additional~~ a late fee ~~set by the commissioner~~ of $75; and

(2) the licensee may not conduct activities authorized by the elevator shaft contractor's license until the renewal application, renewal application fee, and late fee, and all other information required in subdivision 8 are submitted.

**[EFFECTIVE DATE.]** This section is effective July 1, 2002.

Sec. 20. Minnesota Statutes 2000, section 103I.541, subdivision 2b, is amended to read:

Subd. 2b. [APPLICATION FEE.] The application fee for a monitoring well contractor registration is ~~$50~~ $75. The commissioner may not act on an application until the application fee is paid.

**[EFFECTIVE DATE.]** This section is effective July 1, 2002.

Sec. 21. Minnesota Statutes 2000, section 103I.541, subdivision 4, is amended to read:

Subd. 4. [RENEWAL.] (a) A person must file an application and a renewal application fee to renew the registration by the date stated in the registration.

(b) The renewal application fee ~~shall be set by the commissioner under section 16A.1285~~ for a monitoring well contractor's registration is $75.

(c) The renewal application must include information that the applicant has met continuing education requirements established by the commissioner by rule.

(d) At the time of the renewal, the commissioner must have on file all well reports, well sealing reports, well permits, and notifications for work conducted by the registered person since the last registration renewal.

**[EFFECTIVE DATE.]** This section is effective July 1, 2002.

Sec. 22. Minnesota Statutes 2000, section 103I.541, subdivision 5, is amended to read:

Subd. 5. [INCOMPLETE OR LATE RENEWAL.] If a registered person submits a renewal application after the required renewal date:

(1) the registered person must include ~~an additional~~ a late fee ~~set by the commissioner~~ of $75; and

(2) the registered person may not conduct activities authorized by the monitoring well contractor's registration until the renewal application, renewal application fee, late fee, and all other information required in subdivision 4 are submitted.

**[EFFECTIVE DATE.]** This section is effective July 1, 2002.

Sec. 23. Minnesota Statutes 2000, section 103I.545, is amended to read:

103I.545 [REGISTRATION OF DRILLING MACHINES REQUIRED.]

Subdivision 1. [DRILLING MACHINE.] (a) A person may not use a drilling machine such as a cable tool, rotary tool, hollow rod tool, or auger for a drilling activity requiring a license or registration under this chapter unless the drilling machine is registered with the commissioner.

(b) A person must apply for the registration on forms prescribed by the commissioner and submit a ~~$50~~ $75 registration fee.

(c) A registration is valid for one year.

Subd. 2. [PUMP HOIST.] (a) A person may not use a machine such as a pump hoist for an activity requiring a license or registration under this chapter to repair wells or borings, seal wells or borings, or install pumps unless the machine is registered with the commissioner.

(b) A person must apply for the registration on forms prescribed by the commissioner and submit a ~~$50~~ $75 registration fee.

(c) A registration is valid for one year.

**[EFFECTIVE DATE.]** This section is effective July 1, 2002.

Sec. 24. Minnesota Statutes 2000, section 144.1202, subdivision 4, is amended to read:

Subd. 4. [AGREEMENT; CONDITIONS OF IMPLEMENTATION.] (a) An agreement entered into before August 2, ~~2002~~ 2003, must remain in effect until terminated under the Atomic Energy Act of 1954, United States Code, title 42, section 2021, paragraph (j). The governor may not enter into an initial agreement with the Nuclear Regulatory Commission after August 1, ~~2002~~ 2003. If an agreement is not entered into by August 1, ~~2002~~ 2003, any rules adopted under this section are repealed effective August 1, ~~2002~~ 2003.

(b) An agreement authorized under subdivision 1 must be approved by law before it may be implemented.

Sec. 25. [144.1205] [RADIOACTIVE MATERIAL; SOURCE AND SPECIAL NUCLEAR MATERIAL; FEES; INSPECTION.]

Subdivision 1. [APPLICATION AND LICENSE RENEWAL FEE.] When a license is required for radioactive material or source or special nuclear material by a rule adopted under section 144.1202, subdivision 2, an application fee according to subdivision 4 must be paid upon initial application for a license. The licensee must renew the license 60 days before the expiration date of the license by paying a license renewal fee equal to the application fee under subdivision 4. The expiration date of a license is the date set by the United States Nuclear Regulatory Commission before transfer of the licensing program under section 144.1202 and thereafter as specified by rule of the commissioner of health.

Subd. 2. [ANNUAL FEE.] A licensee must pay an annual fee at least 60 days before the anniversary date of the issuance of the license. The annual fee is an amount equal to 80 percent of the application fee under subdivision 4, rounded to the nearest whole dollar.

Subd. 3. [FEE CATEGORIES; INCORPORATION OF FEDERAL LICENSING CATEGORIES.] (a) Fee categories under this section are equivalent to the licensing categories used by the United States Nuclear Regulatory Commission under Code of Federal Regulations, title 10, parts 30 to 36, 39, 40, 70, 71, and 150, except as provided in paragraph (b).

(b) The category of "Academic, small" is the type of license required for the use of radioactive materials in a teaching institution. Radioactive materials are limited to ten radionuclides not to exceed a total activity amount of one curie.

Subd. 4. [APPLICATION FEE.] A licensee must pay an application fee as follows:

| Radioactive material, source and special material | Application fee | U.S. Nuclear Regulatory Commission licensing category as reference |
|---|---|---|
| Type A broadscope | $20,000 | Medical institution type A |
| Type B broadscope | $15,000 | Research and development type B |
| Type C broadscope | $10,000 | Academic type C |
| Medical use | $4,000 | Medical<br>Medical institution<br>Medical private practice |
| Mobile nuclear medical laboratory | $4,000 | Mobile medical laboratory |
| Medical special use sealed sources | $6,000 | Teletherapy<br>High dose rate remote afterloaders<br>Stereotactic radiosurgery devices |
| In vitro testing | $2,300 | In vitro testing laboratories |
| Measuring gauge, sealed sources | $2,000 | Fixed gauges<br>Portable gauges<br>Analytical instruments<br>Measuring systems - other |
| Gas chromatographs | $1,200 | Gas chromatographs |
| Manufacturing and distribution | $14,700 | Manufacturing and distribution - other |
| Distribution only | $8,800 | Distribution of radioactive material for commercial use only |
| Other services | $1,500 | Other services |
| Nuclear medicine pharmacy | $4,100 | Nuclear pharmacy |
| Waste disposal | $9,400 | Waste disposal service prepackage<br>Waste disposal service processing/repackage |
| Waste storage only | $7,000 | To receive and store radioactive material waste |
| Industrial radiography | $8,400 | Industrial radiography fixed location<br>Industrial radiography portable/temporary sites |
| Irradiator - self-shielded | $4,100 | Irradiators self-shielded less than 10,000 curies |
| Irradiator - less than 10,000 Ci | $7,500 | Irradiators less than 10,000 curies |
| Irradiator - more than 10,000 Ci | $11,500 | Irradiators greater than |

| | | |
|---|---|---|
| | | 10,000 curies |
| Research and development, no distribution | $4,100 | Research and development |
| Radioactive material possession only | $1,000 | Byproduct possession only |
| Source material | $1,000 | Source material shielding |
| Special nuclear material, less than 200 grams | $1,000 | Special nuclear material plutonium-neutron sources less than 200 grams |
| Pacemaker manufacturing | $1,000 | Pacemaker byproduct and/or special nuclear material - medical institution |
| General license distribution | $2,100 | General license distribution |
| General license distribution, exempt | $1,500 | General license distribution - certain exempt items |
| Academic, small | $1,000 | Possession limit of ten radionuclides, not to exceed a total of one curie of activity |
| Veterinary | $2,000 | Veterinary use |
| Well logging | $5,000 | Well logging |

Subd. 5. [PENALTY FOR LATE PAYMENT.] An annual fee or a license renewal fee submitted to the commissioner after the due date specified by rule must be accompanied by an additional amount equal to 25 percent of the fee due.

Subd. 6. [INSPECTIONS.] The commissioner of health shall make periodic safety inspections of the radioactive material and source and special nuclear material of a licensee. The commissioner shall prescribe the frequency of safety inspections by rule.

Subd. 7. [RECOVERY OF REINSPECTION COST.] If the commissioner finds serious violations of public health standards during an inspection under subdivision 6, the licensee must pay all costs associated with subsequent reinspection of the source. The costs shall be the actual costs incurred by the commissioner and include, but are not limited to, labor, transportation, per diem, materials, legal fees, testing, and monitoring costs.

Subd. 8. [RECIPROCITY FEE.] A licensee submitting an application for reciprocal recognition of a materials license issued by another agreement state or the United States Nuclear Regulatory Commission for a period of 180 days or less during a calendar year must pay one-half of the application fee specified under subdivision 4. For a period of 181 days or more, the licensee must pay the entire application fee under subdivision 4.

Subd. 9. [FEES FOR LICENSE AMENDMENTS.] A licensee must pay a fee to amend a license as follows:

(1) to amend a license requiring no license review including, but not limited to, facility name change or removal of a previously authorized user, no fee;

(2) to amend a license requiring review including, but not limited to, addition of isotopes, procedure changes, new authorized users, or a new radiation safety officer, $200; and

(3) to amend a license requiring review and a site visit including, but not limited to, facility move or addition of processes, $400.

**[EFFECTIVE DATE.]** This section is effective July 1, 2002.

Sec. 26. Minnesota Statutes 2000, section 144.122, is amended to read:

144.122 [LICENSE, PERMIT, AND SURVEY FEES.]

(a) The state commissioner of health, by rule, may prescribe reasonable procedures and fees for filing with the commissioner as prescribed by statute and for the issuance of original and renewal permits, licenses, registrations, and certifications issued under authority of the commissioner. The expiration dates of the various licenses, permits, registrations, and certifications as prescribed by the rules shall be plainly marked thereon. Fees may include application and examination fees and a penalty fee for renewal applications submitted after the expiration date of the previously issued permit, license, registration, and certification. The commissioner may also prescribe, by rule, reduced fees for permits, licenses, registrations, and certifications when the application therefor is submitted during the last three months of the permit, license, registration, or certification period. Fees proposed to be prescribed in the rules shall be first approved by the department of finance. All fees proposed to be prescribed in rules shall be reasonable. The fees shall be in an amount so that the total fees collected by the commissioner will, where practical, approximate the cost to the commissioner in administering the program. All fees collected shall be deposited in the state treasury and credited to the state government special revenue fund unless otherwise specifically appropriated by law for specific purposes.

(b) The commissioner may charge a fee for voluntary certification of medical laboratories and environmental laboratories, and for environmental and medical laboratory services provided by the department, without complying with paragraph (a) or chapter 14. Fees charged for environment and medical laboratory services provided by the department must be approximately equal to the costs of providing the services.

(c) The commissioner may develop a schedule of fees for diagnostic evaluations conducted at clinics held by the services for children with handicaps program. All receipts generated by the program are annually appropriated to the commissioner for use in the maternal and child health program.

(d) The commissioner, for fiscal years 1996 and beyond, shall set license fees for hospitals and nursing homes that are not boarding care homes at the following levels:

| | |
|---|---|
| Joint Commission on Accreditation of Healthcare Organizations (JCAHO hospitals) | ~~$1,017~~ $7,055 |
| Non-JCAHO hospitals | ~~$762 plus $34 per bed~~ $4,680 plus $234 per bed |
| Nursing home | $78 plus $19 per bed |

For fiscal years 1996 and beyond, the commissioner shall set license fees for outpatient surgical centers, boarding care homes, and supervised living facilities at the following levels:

| | |
|---|---|
| Outpatient surgical centers | ~~$517~~ $1,512 |
| Boarding care homes | ~~$78 plus $19 per bed~~ $183 plus $91 per bed |
| Supervised living facilities | ~~$78 plus $19 per bed~~ $183 plus $91 per bed. |

(e) Unless prohibited by federal law, the commissioner of health shall charge applicants the following fees to cover the cost of any initial certification surveys required to determine a provider's eligibility to participate in the Medicare or Medicaid program:

| | |
|---|---|
| Prospective payment surveys for hospitals | $ 900 |
| Swing bed surveys for nursing homes | $1,200 |
| Psychiatric hospitals | $1,400 |
| Rural health facilities | $1,100 |
| Portable X-ray providers | $ 500 |
| Home health agencies | $1,800 |
| Outpatient therapy agencies | $ 800 |
| End stage renal dialysis providers | $2,100 |
| Independent therapists | $ 800 |
| Comprehensive rehabilitation outpatient facilities | $1,200 |
| Hospice providers | $1,700 |
| Ambulatory surgical providers | $1,800 |
| Hospitals | $4,200 |
| Other provider categories or additional resurveys required to complete initial certification | Actual surveyor costs: average surveyor cost x number of hours for the survey process. |

These fees shall be submitted at the time of the application for federal certification and shall not be refunded. All fees collected after the date that the imposition of fees is not prohibited by federal law shall be deposited in the state treasury and credited to the state government special revenue fund.

Sec. 27. Minnesota Statutes 2000, section 144.1464, is amended to read:

144.1464 [SUMMER HEALTH CARE INTERNS.]

Subdivision 1. [SUMMER INTERNSHIPS.] The commissioner of health, through a contract with a nonprofit organization as required by subdivision 4, shall award grants to hospitals ~~and~~, clinics, nursing facilities, and home care providers to establish a secondary and post-secondary summer health care intern program. The purpose of the program is to expose interested secondary and post-secondary pupils to various careers within the health care profession.

Subd. 2. [CRITERIA.] (a) The commissioner, through the organization under contract, shall award grants to hospitals ~~and~~, clinics, nursing facilities, and home care providers that agree to:

(1) provide secondary and post-secondary summer health care interns with formal exposure to the health care profession;

(2) provide an orientation for the secondary and post-secondary summer health care interns;

(3) pay one-half the costs of employing the secondary and post-secondary summer health care intern~~, based on an overall hourly wage that is at least the minimum wage but does not exceed $6 an hour~~;

(4) interview and hire secondary and post-secondary pupils for a minimum of six weeks and a maximum of 12 weeks; and

(5) employ at least one secondary student for each post-secondary student employed, to the extent that there are sufficient qualifying secondary student applicants.

(b) In order to be eligible to be hired as a secondary summer health intern by a hospital ~~or~~, clinic, nursing facility, or home care provider, a pupil must:

(1) intend to complete high school graduation requirements and be between the junior and senior year of high school; and

(2) be from a school district in proximity to the facility~~; and~~

~~(3) provide the facility with a letter of recommendation from a health occupations or science educator~~.

(c) In order to be eligible to be hired as a post-secondary summer health care intern by a hospital or clinic, a pupil must:

(1) intend to complete a health care training program or a two-year or four-year degree program and be planning on enrolling in or be enrolled in that training program or degree program; and

(2) be enrolled in a Minnesota educational institution or be a resident of the state of Minnesota; priority must be given to applicants from a school district or an educational institution in proximity to the facility~~; and~~

~~(3) provide the facility with a letter of recommendation from a health occupations or science educator~~.

(d) Hospitals ~~and~~, clinics, nursing facilities, and home care providers awarded grants may employ pupils as secondary and post-secondary summer health care interns beginning on or after June 15, 1993, if they agree to pay the intern, during the period before disbursement of state grant money, with money designated as the facility's 50 percent contribution towards internship costs.

Subd. 3. [GRANTS.] The commissioner, through the organization under contract, shall award separate grants to hospitals ~~and~~, clinics, nursing facilities, and home care providers meeting the requirements of subdivision 2. The grants must be used to pay one-half of the costs of employing secondary and post-secondary pupils in a hospital ~~or~~, clinic, nursing facility, or home care setting during the course of the program. No more than 50 percent of the participants may be post-secondary students, unless the program does not receive enough qualified secondary applicants per fiscal year. No more than five pupils may be selected from any secondary or post-secondary institution to participate in the program and no more than one-half of the number of pupils selected may be from the seven-county metropolitan area.

Subd. 4. [CONTRACT.] The commissioner shall contract with a statewide, nonprofit organization representing facilities at which secondary and post-secondary summer health care interns will serve, to administer the grant program established by this section. Grant funds that are not used in one fiscal year may be carried over to the next fiscal year. The organization awarded the grant shall provide the commissioner with any information needed by the commissioner to evaluate the program, in the form and at the times specified by the commissioner.

Sec. 28. Minnesota Statutes 2000, section 144.148, subdivision 2, is amended to read:

Subd. 2. [PROGRAM.] The commissioner of health shall award rural hospital capital improvement grants to eligible rural hospitals. A grant shall not exceed ~~$300,000~~ $1,000,000 per hospital. Prior to the receipt of any grant, the hospital must certify to the commissioner that at least one-quarter of the grant amount, which may include in-kind services, is available for the same purposes from nonstate resources.

Sec. 29. Minnesota Statutes 2000, section 144.1494, subdivision 1, is amended to read:

Subdivision 1. [CREATION OF ACCOUNT.] ~~A rural physician~~ Education ~~account is~~ accounts are established in the health care access fund and the general fund. The commissioner shall use money from the account to establish a loan forgiveness program for medical residents agreeing to practice in designated rural areas, as defined by the commissioner. Appropriations made to ~~this account~~ these accounts do not cancel and are available until expended, except that at the end of each biennium the commissioner shall cancel to the health care access fund or general fund, as applicable, any remaining unobligated balance ~~in this accounts~~.

Sec. 30. Minnesota Statutes 2000, section 144.1494, subdivision 3, is amended to read:

Subd. 3. [LOAN FORGIVENESS.] ~~For each fiscal year after 1995,~~ The commissioner may accept up to ~~12~~ 22 applicants a year who are medical residents for participation in the loan forgiveness program with payment for the first 12 applicants accepted to be made out of the health care access fund education account and payment for the remaining applicants accepted to be made out of the general fund education account. The ~~12 resident~~ applicants may be in any year of residency training; however, priority must be given to the following categories of residents in descending order: third year residents, second year residents, and first year residents. Applicants are responsible for securing their own loans. Applicants chosen to participate in the loan forgiveness program may designate for each year of medical school, up to a maximum of four years, an agreed amount, not to exceed $10,000, as a qualified loan. For each year that a participant serves as a physician in a designated rural area, up to a maximum of four years, the commissioner shall annually pay an amount equal to one year of qualified loans. Participants who move their practice from one designated rural area to another remain eligible for loan repayment. In addition, in any year that a resident participating in the loan forgiveness program serves at least four weeks during a year of residency substituting for a rural physician to temporarily relieve the rural physician of rural practice commitments to enable the rural physician to take a vacation, engage in activities outside the practice area, or otherwise be relieved of rural practice commitments, the participating resident may designate up to an additional $2,000, above the $10,000 yearly maximum.

Sec. 31. Minnesota Statutes 2000, section 144.1494, subdivision 4, is amended to read:

Subd. 4. [PENALTY FOR NONFULFILLMENT.] If a participant does not fulfill the required three-year minimum commitment of service in a designated rural area, the commissioner shall collect from the participant the amount paid under the loan forgiveness program. The commissioner shall deposit the ~~money collected in the rural physician education account~~ collections in the health care access fund or the general fund, as applicable, to be credited to the accounts established in subdivision 1. The commissioner shall allow waivers of all or part of the money owed the commissioner if emergency circumstances prevented fulfillment of the three-year service commitment.

Sec. 32. Minnesota Statutes 2000, section 144.1496, is amended to read:

144.1496 [NURSES IN NURSING HOMES ~~OR~~, ICFMRS, OR HOME HEALTH CARE AGENCIES.]

Subdivision 1. [CREATION OF THE ACCOUNT.] ~~An~~ Education ~~account~~ accounts in the health care access fund ~~is~~ and the general fund are established for a loan forgiveness program for nurses who agree to practice nursing in a nursing home ~~or~~, intermediate care facility for persons with mental retardation or related conditions, or home health care agency. The ~~account consists~~ accounts consist of money appropriated by the legislature and repayments and penalties collected under subdivision 4. Money from the ~~account~~ accounts must be used for a loan forgiveness program.

Subd. 2. [ELIGIBILITY.] To be eligible to participate in the loan forgiveness program, a person enrolled in a program of study designed to prepare the person to become a registered nurse or licensed practical nurse must submit an application to the commissioner before completion of a nursing education program. A nurse who is selected to participate must sign a contract to agree to serve a minimum one-year service obligation providing nursing services in a licensed nursing home ~~or~~, intermediate care facility for persons with mental retardation or related conditions, or home health care agency, which shall begin no later than March following completion of a nursing program or loan forgiveness program selection.

Subd. 3. [LOAN FORGIVENESS.] The commissioner may accept up to ~~ten~~ 177 applicants a year with payment for the first ten applicants accepted to be made out of the health care access fund education account and payment for the remaining applicants accepted to be made out of the general fund education account. Applicants are responsible for securing their own loans. For each year of nursing education, for up to two years, applicants accepted into the loan forgiveness

program may designate an agreed amount, not to exceed $3,000, as a qualified loan. For each year that a participant practices nursing in a nursing home ~~or~~, intermediate care facility for persons with mental retardation or related conditions, or home health care agency, up to a maximum of two years, the commissioner shall annually repay an amount equal to one year of qualified loans. Participants who move from one nursing home ~~or~~, intermediate care facility for persons with mental retardation or related conditions, or home health care agency to another remain eligible for loan repayment.

Subd. 4. [PENALTY FOR NONFULFILLMENT.] If a participant does not fulfill the service commitment required under subdivision 3 for full repayment of all qualified loans, the commissioner shall collect from the participant 100 percent of any payments made for qualified loans and interest at a rate established according to section 270.75. The commissioner shall deposit the collections in the health care access fund or the general fund, as applicable, to be credited to the ~~account~~ accounts established in subdivision 1. The commissioner may grant a waiver of all or part of the money owed as a result of a nonfulfillment penalty if emergency circumstances prevented fulfillment of the required service commitment.

Subd. 5. [RULES.] The commissioner may adopt rules to implement this section.

Sec. 33. [144.1499] [PROMOTION OF HEALTH CARE AND LONG-TERM CARE CAREERS.]

The commissioner of health, in consultation with an organization representing health care employers, long-term care employers, and educational institutions, may make grants to qualifying consortia as defined in section 116L.11, subdivision 4, for intergenerational programs to encourage middle and high school students to work and volunteer in health care and long-term care settings. To qualify for a grant under this section, a consortium shall:

(1) develop a health and long-term care careers curriculum that provides career exploration and training in national skill standards for health care and long-term care and that is consistent with Minnesota graduation standards and other related requirements;

(2) offer programs for high school students that provide training in health and long-term care careers with credits that articulate into post-secondary programs; and

(3) provide technical support to the participating health care and long-term care employer to enable the use of the employer's facilities and programs for kindergarten to grade 12 health and long-term care careers education.

Sec. 34. [144.1501] [RURAL PHARMACISTS LOAN FORGIVENESS.]

Subdivision 1. [DEFINITIONS.] (a) For purposes of this section, the terms defined in this subdivision have the meanings given them.

(b) "Designated rural area" means:

(1) an area in Minnesota outside the counties of Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington, excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud; or

(2) a municipal corporation, as defined under section 471.634, that is physically located, in whole or in part, in an area defined as a designated rural area under clause (1).

Designated rural areas may be further defined by the commissioner of health to reflect a shortage of pharmacists as indicated by the ratio of pharmacists to population and the distance to the next nearest pharmacy.

(c) "Qualifying educational loans" means government, commercial, and foundation loans for actual costs paid for tuition, reasonable education expenses, and reasonable living expenses related to the graduate or undergraduate education of a pharmacist.

Subd. 2. [CREATION OF ACCOUNT; LOAN FORGIVENESS PROGRAM.] A rural pharmacist education account is established in the general fund. The commissioner of health shall use money from the account to establish a loan forgiveness program for pharmacists who agree to practice in designated rural areas. The commissioner may seek advice in establishing the program from the pharmacists association, the University of Minnesota, and other interested parties.

Subd. 3. [ELIGIBILITY.] To be eligible to participate in the loan forgiveness program, a pharmacy student must submit an application to the commissioner of health while attending a program of study designed to prepare the individual to become a licensed pharmacist. For fiscal year 2002, applicants may have graduated from a pharmacy program in calendar year 2001. A pharmacy student who is accepted into the loan forgiveness program must sign a contract to agree to serve a minimum three-year service obligation within a designated rural area, which shall begin no later than March 31 of the first year following completion of a pharmacy program or residency. If fewer applications are submitted by pharmacy students than there are participant slots available, the commissioner may consider applications submitted by pharmacy program graduates who are licensed pharmacists. Pharmacists selected for loan forgiveness must comply with all terms and conditions of this section.

Subd. 4. [LOAN FORGIVENESS.] The commissioner of health may accept up to 14 applicants per year for participation in the loan forgiveness program. Applicants are responsible for securing their own loans. The commissioner shall select participants based on their suitability for rural practice, as indicated by rural experience or training. The commissioner shall give preference to applicants closest to completing their training. For each year that a participant serves as a pharmacist in a designated rural area as required under subdivision 3, up to a maximum of four years, the commissioner shall make annual disbursements directly to the participant equivalent to $5,000 per year of service, not to exceed $20,000 or the balance of the qualifying educational loans, whichever is less. Before receiving loan repayment disbursements and as requested, the participant must complete and return to the commissioner an affidavit of practice form provided by the commissioner verifying that the participant is practicing as required in an eligible area. The participant must provide the commissioner with verification that the full amount of loan repayment disbursement received by the participant has been applied toward the qualifying educational loans. After each disbursement, verification must be received by the commissioner and approved before the next loan repayment disbursement is made. Participants who move their practice from one designated rural area to another remain eligible for loan repayment.

Subd. 5. [PENALTY FOR NONFULFILLMENT.] If a participant does not fulfill the service commitment under subdivision 3, the commissioner of health shall collect from the participant 100 percent of any payments made for qualified educational loans and interest at a rate established according to section 270.75. The commissioner shall deposit the money collected in the rural pharmacist education account established under subdivision 2.

Subd. 6. [SUSPENSION OR WAIVER OF OBLIGATION.] Payment or service obligations cancel in the event of a participant's death. The commissioner of health may waive or suspend payment or service obligations in cases of total and permanent disability or long-term temporary disability lasting for more than two years. The commissioner shall evaluate all other requests for suspension or waivers on a case-by-case basis and may grant a waiver of all or part of the money owed as a result of a nonfulfillment penalty if emergency circumstances prevented fulfillment of the required service commitment.

Sec. 35. [144.1502] [DENTISTS LOAN FORGIVENESS.]

Subdivision 1. [DEFINITION.] For purposes of this section, "qualifying educational loans" means government, commercial, and foundation loans for actual costs paid for tuition, reasonable education expenses, and reasonable living expenses related to the graduate or undergraduate education of a dentist.

Subd. 2. [CREATION OF ACCOUNT; LOAN FORGIVENESS PROGRAM.] A dentist education account is established in the general fund. The commissioner of health shall use money from the account to establish a loan forgiveness program for dentists who agree to care for substantial numbers of state public program participants and other low- to moderate-income uninsured patients.

Subd. 3. [ELIGIBILITY.] To be eligible to participate in the loan forgiveness program, a dental student must submit an application to the commissioner of health while attending a program of study designed to prepare the individual to become a licensed dentist. For fiscal year 2002, applicants may have graduated from a dentistry program in calendar year 2001. A dental student who is accepted into the loan forgiveness program must sign a contract to agree to serve a minimum three-year service obligation during which at least 25 percent of the dentist's yearly patient encounters are delivered to state public program enrollees or patients receiving sliding fee schedule discounts through a formal sliding fee schedule meeting the standards established by the United States Department of Health and Human Services under Code of Federal Regulations, title 42, section 51, chapter 303. The service obligation shall begin no later than March 31 of the first year following completion of training. If fewer applications are submitted by dental students than there are participant slots available, the commissioner may consider applications submitted by dental program graduates who are licensed dentists. Dentists selected for loan forgiveness must comply with all terms and conditions of this section.

Subd. 4. [LOAN FORGIVENESS.] The commissioner of health may accept up to 14 applicants per year for participation in the loan forgiveness program. Applicants are responsible for securing their own loans. The commissioner shall select participants based on their suitability for practice serving public program patients, as indicated by experience or training. The commissioner shall give preference to applicants who have attended a Minnesota dentistry educational institution and to applicants closest to completing their training. For each year that a participant meets the service obligation required under subdivision 3, up to a maximum of four years, the commissioner shall make annual disbursements directly to the participant equivalent to $10,000 per year of service, not to exceed $40,000 or the balance of the qualifying educational loans, whichever is less. Before receiving loan repayment disbursements and as requested, the participant must complete and return to the commissioner an affidavit of practice form provided by the commissioner verifying that the participant is practicing as required under subdivision 3. The participant must provide the commissioner with verification that the full amount of loan repayment disbursement received by the participant has been applied toward the designated loans. After each disbursement, verification must be received by the commissioner and approved before the next loan repayment disbursement is made. Participants who move their practice remain eligible for loan repayment as long as they practice as required under subdivision 3.

Subd. 5. [PENALTY FOR NONFULFILLMENT.] If a participant does not fulfill the service commitment under subdivision 3, the commissioner of health shall collect from the participant 100 percent of any payments made for qualified educational loans and interest at a rate established according to section 270.75. The commissioner shall deposit the money collected in the dentist education account established under subdivision 2.

Subd. 6. [SUSPENSION OR WAIVER OF OBLIGATION.] Payment or service obligations cancel in the event of a participant's death. The commissioner of health may waive or suspend payment or service obligations in cases of total and permanent disability or long-term temporary disability lasting for more than two years. The commissioner shall evaluate all other requests for suspension or waivers on a case-by-case basis and may grant a waiver of all or part of the money owed as a result of a nonfulfillment penalty if emergency circumstances prevented fulfillment of the required service commitment.

Sec. 36. [144.1503] [RURAL MENTAL HEALTH PROFESSIONAL LOAN FORGIVENESS.]

Subdivision 1. [DEFINITIONS.] (a) For purposes of this section, the terms defined in this subdivision have the meanings given them.

(b) "Designated rural area" means:

(1) an area in Minnesota outside the counties of Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington, excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud; or

(2) a municipal corporation, as defined under section 471.634, that is physically located, in whole or in part, in an area defined as a designated rural area under clause (1).

(c) "Mental health professional" means a psychologist, clinical social worker, marriage and family therapist, or psychiatric nurse.

(d) "Qualifying educational loans" means government, commercial, and foundation loans for actual costs paid for tuition, reasonable education expenses, and reasonable living expenses related to the graduate or undergraduate education of a mental health professional.

Subd. 2. [CREATION OF ACCOUNT; LOAN FORGIVENESS PROGRAM.] A rural mental health professional education account is established in the general fund. The commissioner of health shall use money from the account to establish a loan forgiveness program for mental health professionals who agree to practice in designated rural areas.

Subd. 3. [ELIGIBILITY.] To be eligible to participate in the loan forgiveness program, a mental health professional student must submit an application to the commissioner of health while attending a program of study designed to prepare the individual to become a mental health professional. For fiscal year 2002, applicants may have graduated from a mental health professional educational program in calendar year 2001. A mental health professional student who is accepted into the loan forgiveness program must sign a contract to agree to serve a minimum three-year service obligation within a designated rural area, which shall begin no later than March 31 of the first year following completion of a mental health professional educational program.

Subd. 4. [LOAN FORGIVENESS.] The commissioner of health may accept up to 12 applicants per year for participation in the loan forgiveness program. Applicants are responsible for securing their own loans. The commissioner shall select participants based on their suitability for rural practice, as indicated by rural experience or training. The commissioner shall give preference to applicants who have attended a Minnesota mental health professional educational institution and to applicants closest to completing their training. For each year that a participant serves as a mental health professional in a designated rural area as required under subdivision 3, up to a maximum of four years, the commissioner shall make annual disbursements directly to the participant equivalent to $4,000 per year of service, not to exceed $16,000 or the balance of the qualifying educational loans, whichever is less. Before receiving loan repayment disbursements and as requested, the participant must complete and return to the commissioner an affidavit of practice form provided by the commissioner verifying that the participant is practicing as required in an eligible area. The participant must provide the commissioner with verification that the full amount of loan repayment disbursement received by the participant has been applied toward the qualifying educational loans. After each disbursement, verification must be received by the commissioner and approved before the next loan repayment disbursement is made. Participants who move their practice from one designated rural area to another remain eligible for loan repayment.

Subd. 5. [PENALTY FOR NONFULFILLMENT.] If a participant does not fulfill the service commitment under subdivision 3, the commissioner of health shall collect from the participant 100 percent of any payments made for qualified educational loans and interest at a rate established according to section 270.75. The commissioner shall deposit the money collected in the rural mental health professional education account established under subdivision 2.

Subd. 6. [SUSPENSION OR WAIVER OF OBLIGATION.] Payment or service obligations cancel in the event of a participant's death. The commissioner of health may waive or suspend payment or service obligations in cases of total and permanent disability or long-term temporary disability lasting for more than two years. The commissioner shall evaluate all other requests for suspension or waivers on a case-by-case basis and may grant a waiver of all or part of the money owed as a result of a nonfulfillment penalty if emergency circumstances prevented fulfillment of the required service commitment.

Sec. 37. [144.1504] [RURAL HEALTH CARE TECHNICIANS LOAN FORGIVENESS.]

Subdivision 1. [DEFINITIONS.] (a) For purposes of this section, the terms defined in this subdivision have the meanings given them.

(b) "Clinical laboratory scientist" means a person who performs and interprets results of

medical tests that require the exercise of independent judgment and responsibility, with minimal supervision by the director or supervisor, in only those specialties or subspecialties in which the person is qualified by education, training, and experience and has demonstrated ongoing competency by certification or other means. A clinical laboratory scientist may also be called a medical technologist.

(c) "Clinical laboratory technician" means any person other than a medical laboratory director, clinical laboratory scientist, or trainee who functions under the supervision of a medical laboratory director or clinical laboratory scientist and performs diagnostic and analytical laboratory tests in only those specialties or subspecialties in which the person is qualified by education, training, and experience and has demonstrated ongoing competency by certification or other means. A clinical laboratory technician may also be called a medical technician.

(d) "Designated rural area" means:

(1) an area in Minnesota outside the counties of Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington, excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud; or

(2) a municipal corporation, as defined under section 471.634, that is physically located, in whole or in part, in an area defined as a designated rural area under clause (1).

(e) "Health care technician" means a clinical laboratory scientist, clinical laboratory technician, radiologic technologist, dental hygienist, dental assistant, or paramedic.

(f) "Paramedic" means a person certified under chapter 144E by the emergency medical services regulatory board as an emergency medical technician-paramedic.

(g) "Qualifying educational loans" means government, commercial, and foundation loans for actual costs paid for tuition, reasonable education expenses, and reasonable living expenses related to the graduate or undergraduate education of a health care technician.

(h) "Radiologic technologist" means a person, other than a licensed physician, who has demonstrated competency by certification, registration, or other means for administering medical imaging or radiation therapy procedures to other persons for medical purposes. Radiologic technologist includes, but is not limited to, radiographers, radiation therapists, and nuclear medicine technologists.

Subd. 2. [CREATION OF ACCOUNT; LOAN FORGIVENESS PROGRAM.] A rural health care technician education account is established in the general fund. The commissioner of health shall use money from the account to establish a loan forgiveness program for health care technicians who agree to practice in designated rural areas.

Subd. 3. [ELIGIBILITY.] To be eligible to participate in the loan forgiveness program, a health care technician student must submit an application to the commissioner of health while attending a program of study designed to prepare the individual to become a health care technician. For fiscal year 2002, applicants may have graduated from a health care technician program in calendar year 2001. A health care technician student who is accepted into the loan forgiveness program must sign a contract to agree to serve a minimum one-year service obligation within a designated rural area, which shall begin no later than March 31 of the first year following completion of a health care technician program.

Subd. 4. [LOAN FORGIVENESS.] The commissioner of health may accept up to 30 applicants per year for participation in the loan forgiveness program. Applicants are responsible for securing their own loans. The commissioner shall select participants based on their suitability for rural practice, as indicated by rural experience or training. The commissioner shall give preference to applicants who have attended a Minnesota health care technician educational institution and to applicants closest to completing their training. For each year that a participant serves as a health care technician in a designated rural area as required under subdivision 3, up to a maximum of two years, the commissioner shall make annual disbursements directly to the participant equivalent to $2,500 per year of service, not to exceed $5,000 or the balance of the qualifying educational loans,

whichever is less. Before receiving loan repayment disbursements and as requested, the participant must complete and return to the commissioner an affidavit of practice form provided by the commissioner verifying that the participant is practicing as required in an eligible area. The participant must provide the commissioner with verification that the full amount of loan repayment disbursement received by the participant has been applied toward the qualifying educational loans. After each disbursement, verification must be received by the commissioner and approved before the next loan repayment disbursement is made. Participants who move their practice from one designated rural area to another remain eligible for loan repayment.

Subd. 5. [PENALTY FOR NONFULFILLMENT.] If a participant does not fulfill the service commitment under subdivision 3, the commissioner of health shall collect from the participant 100 percent of any payments made for qualified educational loans and interest at a rate established according to section 270.75. The commissioner shall deposit the money collected in the rural health care technician education account established under subdivision 2.

Subd. 6. [SUSPENSION OR WAIVER OF OBLIGATION.] Payment or service obligations cancel in the event of a participant's death. The commissioner of health may waive or suspend payment or service obligations in cases of total and permanent disability or long-term temporary disability lasting for more than two years. The commissioner shall evaluate all other requests for suspension or waivers on a case-by-case basis and may grant a waiver of all or part of the money owed as a result of a nonfulfillment penalty if emergency circumstances prevented fulfillment of the required service commitment.

Sec. 38. Minnesota Statutes 2000, section 144.226, subdivision 4, is amended to read:

Subd. 4. [VITAL RECORDS SURCHARGE.] In addition to any fee prescribed under subdivision 1, there is a nonrefundable surcharge of ~~$3~~ $2 for each certified and noncertified birth or death record, and for a certification that the record cannot be found. The local or state registrar shall forward this amount to the state treasurer to be deposited into the state government special revenue fund. This surcharge shall not be charged under those circumstances in which no fee for a birth or death record is permitted under subdivision 1, paragraph (a). ~~This surcharge requirement expires June 30, 2002.~~

Sec. 39. [144.3805] [HEALTH STANDARDS.]

Subdivision 1. [CRITERIA.] When establishing or revising safe drinking water standards, the commissioner of health shall adopt standards that adequately protect children and adults with a margin of safety that provides a reasonable certainty of no harm to child and adult health, by taking into account the risk of cancer and effects on each of the following health outcomes:

(1) general infant and child development;

(2) development of the brain and nervous system;

(3) respiratory function;

(4) immunologic suppression or hypersensitization;

(5) endocrine (hormonal) function; and

(6) any other important health outcomes identified by the commissioner.

Subd. 2. [MARGIN OF SAFETY.] If there is insufficient information to establish with reasonable certainty, for cancer or any health outcome under subdivision 1, that child health will not be harmed, the commissioner shall adopt a specific margin of safety for that health outcome or risk that shall be included in the overall margin of safety to protect human health.

Sec. 40. Minnesota Statutes 2000, section 144.396, subdivision 7, is amended to read:

Subd. 7. [LOCAL PUBLIC HEALTH PROMOTION AND PROTECTION.] The commissioner shall distribute the funds available under section 144.395, subdivision 2, paragraph (c), clause (3) for the following:

(1) to community health boards for local health promotion and protection activities for local health initiatives other than tobacco prevention aimed at high risk health behaviors among youth. The commissioner shall distribute these funds to the community health boards based on demographics and other need-based factors relating to health;

(2) for activities that improve the health and learning environment of school-aged children; and

(3) for competitive grants to public-private partnerships focusing on the state school health issues identified by the commissioner.

Sec. 41. Minnesota Statutes 2000, section 144.98, subdivision 3, is amended to read:

Subd. 3. [FEES.] (a) An application for certification under subdivision 1 must be accompanied by the biennial fee specified in this subdivision. The fees are for:

(1) nonrefundable base certification fee, ~~$500~~ $1,200; and

(2) test category certification fees:

| Test Category | Certification Fee |
|---|---|
| Clean water program bacteriology | ~~$200~~ $600 |
| Safe drinking water program bacteriology | $600 |
| Clean water program inorganic chemistry~~,~~ | |
| ~~fewer than four constituents~~ | ~~$100~~ $600 |
| Safe drinking water program inorganic chemistry~~,~~ | |
| ~~four or more constituents~~ | ~~$300~~ $600 |
| Clean water program chemistry metals~~,~~ | |
| ~~fewer than four constituents~~ | ~~$200~~ $800 |
| Safe drinking water program chemistry metals~~,~~ | |
| ~~four or more constituents~~ | ~~$500~~ $800 |
| Resource conservation and recovery program | |
| chemistry metals | $800 |
| Clean water program volatile organic compounds | ~~$600~~ $1,200 |
| Safe drinking water program | |
| volatile organic compounds | $1,200 |
| Resource conservation and recovery program | |
| volatile organic compounds | $1,200 |
| Underground storage tank program | |
| volatile organic compounds | $1,200 |
| Clean water program other organic compounds | ~~$600~~ $1,200 |
| Safe drinking water program other organic compounds | $1,200 |
| Resource conservation and recovery program | |
| other organic compounds | $1,200 |

(b) The total biennial certification fee is the base fee plus the applicable test category fees. ~~The biennial certification fee for a contract laboratory is 1.5 times the total certification fee.~~

(c) Laboratories located outside of this state that require an on-site survey will be assessed an additional ~~$1,200~~ $2,500 fee.

(d) Fees must be set so that the total fees support the laboratory certification program. Direct costs of the certification service include program administration, inspections, the agency's general support costs, and attorney general costs attributable to the fee function.

(e) A change fee shall be assessed if a laboratory requests additional analytes or methods at any time other than when applying for or renewing its certification. The change fee is equal to the test category certification fee for the analyte.

(f) A variance fee shall be assessed if a laboratory requests and is granted a variance from a rule adopted under this section. The variance fee is $500 per variance.

(g) Refunds or credits shall not be made for analytes or methods requested but not approved.

(h) Certification of a laboratory shall not be awarded until all fees are paid.

Sec. 42. [145.56] [SUICIDE PREVENTION.]

Subdivision 1. [SUICIDE PREVENTION PLAN.] The commissioner of health shall refine, coordinate, and implement the state's suicide prevention plan using an evidence-based, public health approach focused on prevention, in collaboration with the commissioner of human services; the commissioner of public safety; the commissioner of children, families, and learning; and appropriate agencies, organizations, and institutions in the community.

Subd. 2. [COMMUNITY-BASED PROGRAMS.] (a) The commissioner shall establish a grant program to fund:

(1) community-based programs to provide education, outreach, and advocacy services to populations who may be at risk for suicide;

(2) community-based programs that educate community helpers and gatekeepers, such as family members, spiritual leaders, coaches, and business owners, employers, and coworkers on how to prevent suicide by encouraging help-seeking behaviors;

(3) community-based programs that educate populations at risk for suicide and community helpers and gatekeepers that must include information on the symptoms of depression and other psychiatric illnesses, the warning signs of suicide, skills for preventing suicides, and making or seeking effective referrals to intervention and community resources; and

(4) community-based programs to provide evidence-based suicide prevention and intervention education to school staff, parents, and students in grades kindergarten through 12.

Subd. 3. [WORKPLACE AND PROFESSIONAL EDUCATION.] (a) The commissioner shall promote the use of employee assistance and workplace programs to support employees with depression and other psychiatric illnesses and substance abuse disorders, and refer them to services. The commissioner shall collaborate with employer and professional associations, unions, and safety councils.

(b) The commissioner shall provide training and technical assistance to local public health and other community-based professionals to provide for integrated implementation of best practices for preventing suicide.

Subd. 4. [COLLECTION AND REPORTING SUICIDE DATA.] The commissioner shall coordinate with federal, regional, local, and other state agencies to collect, analyze, and annually issue a public report on Minnesota-specific data on suicide and suicidal behaviors.

Subd. 5. [PERIODIC EVALUATIONS; BIENNIAL REPORTS.] The commissioner shall conduct periodic evaluations of the impact of and outcomes from implementation of the state's suicide prevention plan and each of the activities specified in this section. Beginning July 1, 2004, and July 1 of each even-numbered year thereafter, the commissioner shall report the results of these evaluations to the chairs of the policy and finance committees in the house and senate with jurisdiction over health and human services issues.

Sec. 43. Minnesota Statutes 2000, section 145.881, subdivision 2, is amended to read:

Subd. 2. [DUTIES.] The advisory task force shall meet on a regular basis to perform the following duties:

(a) review and report on the health care needs of mothers and children throughout the state of Minnesota;

(b) review and report on the type, frequency and impact of maternal and child health care services provided to mothers and children under existing maternal and child health care programs, including programs administered by the commissioner of health;

(c) establish, review, and report to the commissioner a list of program guidelines and criteria which the advisory task force considers essential to providing an effective maternal and child health care program to low income populations and high risk persons and fulfilling the purposes defined in section 145.88;

(d) review staff recommendations of the department of health regarding maternal and child health grant awards before the awards are made;

(e) make recommendations to the commissioner for the use of other federal and state funds available to meet maternal and child health needs;

(f) make recommendations to the commissioner of health on priorities for funding the following maternal and child health services: (1) prenatal, delivery and postpartum care, (2) comprehensive health care for children, especially from birth through five years of age, (3) adolescent health services, (4) family planning services, (5) preventive dental care, (6) special services for chronically ill and handicapped children and (7) any other services which promote the health of mothers and children; ~~and~~

(g) make recommendations to the commissioner of health on the process to distribute, award and administer the maternal and child health block grant funds; and

(h) review the measures that are used to define the variables of the funding distribution formula in section 145.882, subdivision 4a, every two years and make recommendations to the commissioner of health for changes based upon principles established by the advisory task force for this purpose.

Sec. 44. Minnesota Statutes 2000, section 145.882, is amended by adding a subdivision to read:

Subd. 4a. [ALLOCATION TO COMMUNITY HEALTH BOARDS.] (a) Federal maternal and child health block grant money remaining after distributions made under subdivision 2 and money appropriated for allocation to community health boards must be allocated according to paragraphs (b) to (d) to community health boards as defined in section 145A.02, subdivision 5.

(b) All community health boards must receive 95 percent of the funding awarded to them for the 1998-1999 funding cycle. If the amount of state and federal funding available is less than 95 percent of the amount awarded to community health boards for the 1998-1999 funding cycle, the available funding must be apportioned to reflect a proportional decrease for each recipient.

(c) The federal and state funding remaining after distributions made under paragraph (b) must be allocated to each community health board based on the following three variables:

(1) 25 percent based on the maternal and child population in the area served by the community health board;

(2) 50 percent based on the following factors as determined by averaging the data available for the three most current years:

(i) the proportion of infants in the area served by the community health board whose weight at birth is less than 2,500 grams;

(ii) the proportion of mothers in the area served by the community health board who received inadequate or no prenatal care;

(iii) the proportion of births in the area served by the community health board to women under age 19; and

(iv) the proportion of births in the area served by the community health board to American Indians and women of color; and

(3) 25 percent based on the income of the maternal and child population in the area served by the community health board.

(d) Each variable must be expressed as a city or county score consisting of the city or county frequency of each variable divided by the statewide frequency of the variable. A total score for each city or county jurisdiction must be computed by totaling the scores of the three variables. Each community health board must be allocated an amount equal to the total score obtained for the city, county, or counties in its area multiplied by the amount of money available.

Sec. 45. Minnesota Statutes 2000, section 145.882, subdivision 7, is amended to read:

Subd. 7. [USE OF BLOCK GRANT MONEY.] (a) Maternal and child health block grant money allocated to a community health board or community health services area under this section must be used for qualified programs for high risk and low-income individuals. Block grant money must be used for programs that:

(1) specifically address the highest risk populations, particularly low-income and minority groups with a high rate of infant mortality and children with low birth weight, by providing services, including prepregnancy family planning services, calculated to produce measurable decreases in infant mortality rates, instances of children with low birth weight, and medical complications associated with pregnancy and childbirth, including infant mortality, low birth rates, and medical complications arising from chemical abuse by a mother during pregnancy;

(2) specifically target pregnant women whose age, medical condition, maternal history, or chemical abuse substantially increases the likelihood of complications associated with pregnancy and childbirth or the birth of a child with an illness, disability, or special medical needs;

(3) specifically address the health needs of young children who have or are likely to have a chronic disease or disability or special medical needs, including physical, neurological, emotional, and developmental problems that arise from chemical abuse by a mother during pregnancy;

(4) provide family planning and preventive medical care for specifically identified target populations, such as minority and low-income teenagers, in a manner calculated to decrease the occurrence of inappropriate pregnancy and minimize the risk of complications associated with pregnancy and childbirth; or

(5) specifically address the frequency and severity of childhood injuries and other child and adolescent health problems in high risk target populations by providing services calculated to produce measurable decreases in mortality and morbidity. ~~However, money may be used for this purpose only if the community health board's application includes program components for the purposes in clauses (1) to (4) in the proposed geographic service area and the total expenditure for injury-related programs under this clause does not exceed ten percent of the total allocation under subdivision 3.~~

~~(b) Maternal and child health block grant money may be used for purposes other than the purposes listed in this subdivision only under the following conditions:~~

~~(1) the community health board or community health services area can demonstrate that existing programs fully address the needs of the highest risk target populations described in this subdivision; or~~

~~(2) the money is used to continue projects that received funding before creation of the maternal and child health block grant in 1981.~~

~~(c)~~ (b) Projects that received funding before creation of the maternal and child health block grant in 1981~~, must be allocated at least the amount of maternal and child health special project grant funds received in 1989, unless (1) the local board of health provides equivalent alternative funding for the project from another source; or (2) the local board of health demonstrates that the need for the specific services provided by the project has significantly decreased as a result of changes in the demographic characteristics of the population, or other factors that have a major impact on the demand for services. If the amount of federal funding to the state for the maternal and child health block grant is decreased, these projects must receive a proportional decrease as required in subdivision 1. Increases in allocation amounts to local boards of health under subdivision 4 may be used to increase funding levels for these projects~~ may be continued at the discretion of the community health board.

Sec. 46. Minnesota Statutes 2000, section 145.885, subdivision 2, is amended to read:

Subd. 2. [ADDITIONAL REQUIREMENTS FOR COMMUNITY BOARDS OF HEALTH.] Applications by community health boards as defined in section 145A.02, subdivision 5, under section 145.882, subdivision ~~3~~ 4a, must also contain a summary of the process used to develop the local program, including evidence that the community health board notified local public and private providers of the availability of funding through the community health board for maternal and child health services; a list of all public and private agency requests for grants submitted to the community health board indicating which requests were included in the grant application; and an explanation of how priorities were established for selecting the requests to be included in the grant application. The community health board shall include, with the grant application, a written statement of the criteria to be applied to public and private agency requests for funding.

Sec. 47. Minnesota Statutes 2000, section 145.925, subdivision 1, is amended to read:

Subdivision 1. [ELIGIBLE ORGANIZATIONS; PURPOSE.] The commissioner of health may make special grants to cities, counties, groups of cities or counties, or nonprofit corporations to provide prepregnancy family planning services. No funds received under this section shall be used to provide abortion services.

Sec. 48. [145.9263] [PROMOTING HEALTHY LIFESTYLES AMONG YOUTH.]

Subdivision 1. [ESTABLISHMENT.] The commissioner shall establish a grant program to promote healthy behavior among youth.

Subd. 2. [LOCAL GRANTS.] The commissioner shall award competitive grants to eligible applicants for projects and initiatives directed at promoting healthy lifestyles such as proper nutrition, the need for physical exercise, and the avoidance of other unhealthy behaviors. The project areas for grants include;

(1) after-school programs that focus on leadership, youth mentoring and peer counseling, academic support, and after-school enrichment;

(2) programs that provide education and support for youth and parents that support healthy behaviors and self-sufficiency;

(3) youth development programs; or

(4) programs that focus on ethnic or cultural enrichment.

Subd. 3. [HIGH-RISK COMMUNITY YOUTH GRANTS.] (a) the commissioner shall award grants to communities that have significant risk factors for unhealthy youth behaviors and that currently have in place youth development programs.

(b) To be eligible for a grant under this subdivision, an applicant must be a tribal government or a community health board as defined in section 145A.02. Applicants must submit proposals to the commissioner. A proposal must specify the strategies to be implemented. Strategies may include youth mentoring programs, academic support programs, and parent support and education programs. Applicants must demonstrate that a proposed project:

(1) is research-based or based on proven effective strategies;

(2) is designed to coordinate with related youth risk behavior reduction activities;

(3) involves youth and parents in the project's development and implementation;

(4) reflects racially and ethnically appropriate approaches; and

(5) will be implemented through or with persons or community-based organizations that reflect the race or ethnicity of the population to be reached.

Subd. 4. [PUBLIC AWARENESS.] The commissioner shall coordinate a public/private partnership to provide a statewide outreach campaign directed at youth on the importance of a healthy lifestyle and the health consequences of poor nutrition and the lack of physical exercise in terms of obesity and other health problems. The campaign shall include culturally specific and community-based messages.

Subd. 5. [PROCESS.] (a) The commissioner, in consultation with community partners, shall develop the criteria and procedures to allocate the grants under this section. In developing the criteria, the commissioner shall establish an administrative cost limit for grant recipients. The outcomes established under subdivision 6 must be specified to the grant recipients receiving grants under this section at the time the grant is awarded. The commissioner may require an applicant to enter into a collaborative agreement with the local public health entity.

(b) Eligible applicants may include, but are not limited to, nonprofit organizations, community clinics, and social service organizations. Applicants must submit proposals to the commissioner. The proposals must specify the strategies to be implemented and must take into account the need for a coordinated local effort.

(c) The commissioner shall give priority to programs that:

(1) are designed to coordinate with related youth risk behavior reduction activities;

(2) involve youth and parents in the development and implementation;

(3) are implemented through or with community-based organizations reflecting the race and ethnicity of the population to be needed; and

(4) reflect racial and ethnic appropriate approaches.

Subd. 6. [MEASURABLE OUTCOMES.] The commissioner, in consultation with other public and private nonprofit organizations interested in youth development efforts, shall establish measurable outcomes to determine the effectiveness of the grants receiving funds under this section.

Subd. 7. [COORDINATION.] The commissioner shall coordinate the projects and initiatives funded under this section with other efforts at the local, state, and national level to avoid duplication and promote complimentary efforts.

Subd. 8. [EVALUATION.] (a) Using the outcome measures established in subdivision 6, the commissioner shall conduct a biennial evaluation of the efforts funded under this section.

(b) Grant recipients shall cooperate with the commissioner of health in the evaluation and provide the commissioner with the information necessary to conduct the evaluation.

Subd. 9. [REPORT.] The commissioner shall submit biennial reports to the legislature on the activities of the projects funded under this section and the results of the biennial evaluation. These reports are due by January 15 of every other year, beginning in the year 2004.

Sec. 49. [145.9268] [COMMUNITY CLINIC GRANTS.]

Subdivision 1. [DEFINITION.] For purposes of this section, "eligible community clinic" means:

(1) a clinic that provides services under conditions as defined in Minnesota Rules, part 9505.0255, and utilizes a sliding fee scale to determine eligibility for charity care;

(2) an Indian tribal government or Indian health service unit; or

(3) a consortium of clinics comprised of entities under clause (1) or (2).

Subd. 2. [GRANTS AUTHORIZED.] The commissioner of health shall award grants to eligible community clinics to improve the ongoing viability of Minnesota's clinic-based safety net providers. Grants shall be awarded to support the capacity of eligible community clinics to serve low-income populations, reduce current or future uncompensated care burdens, or provide for improved care delivery infrastructure.

Subd. 3. [ALLOCATION OF GRANTS.] (a) To receive a grant under this section, an eligible community clinic must submit an application to the commissioner of health by the deadline established by the commissioner. A grant may be awarded upon the signing of a grant contract.

(b) An application must be on a form and contain information as specified by the commissioner but at a minimum must contain:

(1) a description of the project for which grant funds will be used;

(2) a description of the problem the proposed project will address; and

(3) a description of achievable objectives, a workplan, and a timeline for project completion.

(c) The commissioner shall review each application to determine whether the application is complete and whether the applicant and the project are eligible for a grant. In evaluating applications according to paragraph (e), the commissioner shall establish criteria including, but not limited to: the priority level of the project; the applicant's thoroughness and clarity in describing the problem; a description of the applicant's proposed project; the manner in which the applicant will demonstrate the effectiveness of the project; and evidence of efficiencies and effectiveness gained through collaborative efforts. The commissioner may also take into account other relevant factors, including, but not limited to, the percentage for which uninsured patients represent the applicant's patient base. During application review, the commissioner may request additional information about a proposed project, including information on project cost. Failure to provide the information requested disqualifies an applicant. The commissioner has discretion over the number of grants awarded.

(d) In determining which eligible community clinics will receive grants under this section, the commissioner shall give preference to those grant applications that show evidence of collaboration with other eligible community clinics, hospitals, health care providers, or community organizations. In addition, the commissioner shall give priority, in declining order, to grant applications for projects that:

(1) establish, update, or improve information, data collection, or billing systems;

(2) procure, modernize, remodel, or replace equipment used an the delivery of direct patient care at a clinic;

(3) provide improvements for care delivery, such as increased translation and interpretation services;

(4) provide a direct offset to expenses incurred for charity care services; or

(5) other projects determined by the commissioner to improve the ability of applicants to provide care to the vulnerable populations they serve.

Subd. 4. [EVALUATION.] The commissioner of health shall evaluate the overall effectiveness of the grant program. The commissioner shall collect progress reports to evaluate the grant program from the eligible community clinics receiving grants.

Sec. 50. [145.9269] [ELIMINATING HEALTH DISPARITIES.]

Subdivision 1. [STATE-COMMUNITY PARTNERSHIPS.] The commissioner, in partnership with culturally based community organizations; the Indian affairs council as defined in section 3.922; the council on affairs of Chicano/Latino people as defined in section 3.9223; the council on Black Minnesotans as defined in section 3.9225; the council on Asian-Pacific Minnesotans as defined in section 3.9226; community health boards; and tribal governments, shall develop and implement a comprehensive coordinated plan to reduce health disparities experienced by American Indians and communities of color in infant mortality, breast and cervical cancer screening, HIV/AIDS/STDs, immunizations, cardiovascular disease, diabetes, injury, and violence.

Subd. 2. [MEASURABLE OUTCOMES.] The commissioner, in consultation with community partners, shall establish measurable outcomes to determine the effectiveness of the grants and other activities receiving funds under this section in reducing health disparities. The goal of the grants shall be to decrease by one-half the ratio of American Indians and communities of color specific health condition rates to white rates in the areas identified in subdivision 1.

Subd. 3. [STATEWIDE ASSESSMENT.] The commissioner shall enhance current data tools to assure a statewide assessment of the risk behaviors associated with the areas identified in subdivision 1. This statewide assessment must be used to establish a baseline to measure the effect of activities funded under this section. To the extent feasible, the commissioner of health must conduct the assessment so that the results may be compared to nationwide data. Data collected and used for assessment must not identify an individual according to section 13.05, subdivision 7.

Subd. 4. [TECHNICAL ASSISTANCE.] The commissioner shall provide the necessary expertise to community organizations to ensure that submitted proposals are likely to be successful in reducing health disparities. The commissioner shall provide grant recipients with guidance and training on strategies related to reducing the health disparities identified in this section. The commissioner shall also provide grant recipients with assistance in the development of evaluation of local community activities.

Subd. 5. [PROCESS.] (a) The commissioner shall, in consultation with community partners, develop the criteria and procedures to allocate the grants under this section. In developing the criteria, the commissioner shall establish an administrative cost limit for grant recipients. The outcomes established under subdivision 2 must be specified to the grant recipients receiving grants under this section at the time the grant is awarded.

(b) A grant recipient must coordinate the activities related to reducing health disparities with other grant recipients receiving funding under this section within the recipient's service area.

Subd. 6. [COMMUNITY GRANT PROGRAM.] (a) The commissioner shall award grants to eligible applicants for local or regional projects and initiatives directed at reducing health disparities. Grant proposals must address one or more of the following priority areas:

(1) decreasing racial and ethnic disparities in infant mortality rates;

(2) decreasing racial and ethnic disparities in morbidity and mortality rates relating to breast and cervical cancer;

(3) decreasing racial and ethnic disparities in morbidity and mortality rates relating to HIV/AIDS/STDs;

(4) increasing adult and child immunization rates in racial and ethnic populations;

(5) decreasing racial and ethnic disparities in morbidity and mortality rates relating to cardiovascular disease;

(6) decreasing racial and ethnic disparities in morbidity and mortality rates relating to diabetes; and

(7) decreasing racial and ethnic disparities in morbidity and mortality rates relating to injury or violence.

(b) The commissioner may award up to 20 percent of the funds available as planning grants. Planning grant proposals must be used to address such areas as community assessment, determining community priority areas, coordination activities, and development of community-supported strategies.

(c) Eligible applicants may include, but are not limited to, faith-based organizations, social service organizations, community nonprofit organizations, and community clinics. Applicants must submit proposals to the commissioner and must demonstrate partnerships with local public health. The proposals must specify the strategies to be implemented to reduce one or more of the project areas listed under subdivision 6, paragraph (a), and must be targeted to achieve the outcomes established in subdivision 2.

(d) The commissioner must give priority to applicants who demonstrate that the proposed project or initiative:

(1) is supported by the community the applicant will be serving;

(2) is research based or based on promising strategies;

(3) is designed to compliment other related community activities;

(4) utilizes strategies that positively impacts more than one priority area; and

(5) is implemented through or with community-based organizations that reflect the race or ethnicity of the population to be reached.

Subd. 7. [LOCAL PUBLIC HEALTH.] The commissioner shall award grants to community health boards for local health promotion and protection activities aimed at reducing maternal and child health disparities between whites and American Indians and populations of color. Local public health must submit proposals to the commissioner and must demonstrate partnerships with culturally based community organizations or with tribal governments. The commissioner shall distribute these funds to community health boards according to the formula in section 145.882, subdivision 4.

Subd. 8. [TRIBAL GOVERNMENTS.] The commissioner shall award grants to American Indian tribal governments for implementation of community interventions to reduce health disparities for the project areas listed under subdivision 6, paragraph (a), and must be targeted to achieve the outcomes established in subdivision 2. Tribal governments must submit proposals to the commissioner and must demonstrate partnerships with local public health. The distribution formula shall be determined by the commissioner, in consultation with the tribal governments.

Subd. 9. [REFUGEE AND IMMIGRANT HEALTH.] The commissioner shall distribute funds to community health boards for health screening and follow-up services for foreign-born persons. Distribution shall be based on the following criteria:

(1) cases of pulmonary tuberculosis;

(2) cases of extrapulmonary tuberculosis;

(3) the number of months providing directly observed therapy to cases of uninsured tuberculosis or extrapulmonary tuberculosis; and

(4) the number of new refugees in the service area within the fiscal year.

The commissioner, in cooperation with the affected local public health departments, shall determine reimbursement rates within the given appropriations.

Subd. 10. [COORDINATION.] The commissioner shall coordinate the projects and initiatives funded under this section with other efforts at the local, state, or national level to avoid duplication of effort and promote complimentary efforts.

Subd. 11. [EVALUATION.] Using the outcome measures established in subdivision 2, the commissioner shall conduct a biennial evaluation of the community grants program, community health board activities, and tribal government activities funded under this section. Grant recipients, tribal governments, and community health boards shall cooperate with the commissioner in the evaluation and provide the commissioner with the information necessary to conduct the evaluation.

Subd. 12. [REPORT.] The commissioner shall submit a biennial report to the legislature on the local community projects, tribal government, and community health board prevention activities 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. These reports are due by January 15 of every other year, beginning in the year 2004.

Sec. 51. Minnesota Statutes 2000, section 157.16, subdivision 3, is amended to read:

Subd. 3. [ESTABLISHMENT FEES; DEFINITIONS.] (a) The following fees are required for food and beverage service establishments, hotels, motels, lodging establishments, and resorts licensed under this chapter. Food and beverage service establishments must pay the highest applicable fee under paragraph (e), clause (1), (2), (3), or (4), and establishments serving alcohol must pay the highest applicable fee under paragraph (e), clause (6) or (7). The license fee for new operators previously licensed under this chapter for the same calendar year is one-half of the appropriate annual license fee, plus any penalty that may be required. The license fee for operators opening on or after October 1 is one-half of the appropriate annual license fee, plus any penalty that may be required.

(b) All food and beverage service establishments, except special event food stands, and all hotels, motels, lodging establishments, and resorts shall pay an annual base fee of ~~$100~~ $145.

(c) A special event food stand shall pay a flat fee of ~~$30~~ $35 annually. "Special event food stand" means a fee category where food is prepared or served in conjunction with celebrations, county fairs, or special events from a special event food stand as defined in section 157.15.

(d) In addition to the base fee in paragraph (b), each food and beverage service establishment, other than a special event food stand, and each hotel, motel, lodging establishment, and resort shall pay an additional annual fee for each fee category as specified in this paragraph:

(1) Limited food menu selection, ~~$30~~ $40. "Limited food menu selection" means a fee category that provides one or more of the following:

(i) prepackaged food that receives heat treatment and is served in the package;

(ii) frozen pizza that is heated and served;

(iii) a continental breakfast such as rolls, coffee, juice, milk, and cold cereal;

(iv) soft drinks, coffee, or nonalcoholic beverages; or

(v) cleaning for eating, drinking, or cooking utensils, when the only food served is prepared off site.

(2) Small establishment, including boarding establishments, ~~$55~~ $75. "Small establishment" means a fee category that has no salad bar and meets one or more of the following:

(i) possesses food service equipment that consists of no more than a deep fat fryer, a grill, two hot holding containers, and one or more microwave ovens;

(ii) serves dipped ice cream or soft serve frozen desserts;

(iii) serves breakfast in an owner-occupied bed and breakfast establishment;

(iv) is a boarding establishment; or

(v) meets the equipment criteria in clause (3), item (i) or (ii), and has a maximum patron seating capacity of not more than 50.

(3) Medium establishment, ~~$150~~ $210. "Medium establishment" means a fee category that meets one or more of the following:

(i) possesses food service equipment that includes a range, oven, steam table, salad bar, or salad preparation area;

(ii) possesses food service equipment that includes more than one deep fat fryer, one grill, or two hot holding containers; or

(iii) is an establishment where food is prepared at one location and served at one or more separate locations.

Establishments meeting criteria in clause (2), item (v), are not included in this fee category.

(4) Large establishment, ~~$250~~ $350. "Large establishment" means either:

(i) a fee category that (A) meets the criteria in clause (3), items (i) or (ii), for a medium establishment, (B) seats more than 175 people, and (C) offers the full menu selection an average of five or more days a week during the weeks of operation; or

(ii) a fee category that (A) meets the criteria in clause (3), item (iii), for a medium establishment, and (B) prepares and serves 500 or more meals per day.

(5) Other food and beverage service, including food carts, mobile food units, seasonal temporary food stands, and seasonal permanent food stands, ~~$30~~ $40.

(6) Beer or wine table service, ~~$30~~ $40. "Beer or wine table service" means a fee category where the only alcoholic beverage service is beer or wine, served to customers seated at tables.

(7) Alcoholic beverage service, other than beer or wine table service, ~~$75~~ $105.

"Alcohol beverage service, other than beer or wine table service" means a fee category where alcoholic mixed drinks are served or where beer or wine are served from a bar.

(8) Lodging per sleeping accommodation unit, ~~$4~~ $6, including hotels, motels, lodging establishments, and resorts, up to a maximum of ~~$400~~ $600. "Lodging per sleeping accommodation unit" means a fee category including the number of guest rooms, cottages, or other rental units of a hotel, motel, lodging establishment, or resort; or the number of beds in a dormitory.

(9) First public swimming pool, ~~$100~~ $140; each additional public swimming pool, ~~$50~~ $80. "Public swimming pool" means a fee category that has the meaning given in Minnesota Rules, part 4717.0250, subpart 8.

(10) First spa, ~~$50~~ $80; each additional spa, ~~$25~~ $40. "Spa pool" means a fee category that has the meaning given in Minnesota Rules, part 4717.0250, subpart 9.

(11) Private sewer or water, ~~$30~~ $40. "Individual private water" means a fee category with a water supply other than a community public water supply as defined in Minnesota Rules, chapter 4720. "Individual private sewer" means a fee category with an individual sewage treatment system which uses subsurface treatment and disposal.

(e) ~~A fee is not required for a food and beverage service establishment operated by a school as defined in sections 120A.05, subdivisions 9, 11, 13, and 17 and 120A.22.~~

~~(f)~~ A fee of $150 for review of the construction plans must accompany the initial license application for food and beverage service establishments, hotels, motels, lodging establishments, or resorts.

~~(g)~~ (f) When existing food and beverage service establishments, hotels, motels, lodging establishments, or resorts are extensively remodeled, a fee of $150 must be submitted with the remodeling plans.

~~(h)~~ (g) Seasonal temporary food stands and special event food stands are not required to submit construction or remodeling plans for review.

Sec. 52. Minnesota Statutes 2000, section 157.22, is amended to read:

157.22 [EXEMPTIONS.]

This chapter shall not be construed to apply to:

(1) interstate carriers under the supervision of the United States Department of Health and Human Services;

(2) any building constructed and primarily used for religious worship;

(3) any building owned, operated, and used by a college or university in accordance with health regulations promulgated by the college or university under chapter 14;

(4) any person, firm, or corporation whose principal mode of business is licensed under sections 28A.04 and 28A.05, is exempt at that premises from licensure as a food or beverage establishment; provided that the holding of any license pursuant to sections 28A.04 and 28A.05 shall not exempt any person, firm, or corporation from the applicable provisions of this chapter or the rules of the state commissioner of health relating to food and beverage service establishments;

(5) family day care homes and group family day care homes governed by sections 245A.01 to 245A.16;

(6) nonprofit senior citizen centers for the sale of home-baked goods; ~~and~~

(7) food not prepared at an establishment and brought in by individuals attending a potluck event for consumption at the potluck event. An organization sponsoring a potluck event under this clause may advertise the potluck event to the public through any means. Individuals who are not members of an organization sponsoring a potluck event under this clause may attend the potluck event and consume the food at the event. Licensed food establishments cannot be sponsors of potluck events. Potluck event food shall not be brought into a licensed food establishment kitchen; and

(8) a home school in which a child is provided instruction at home.

Sec. 53. Minnesota Statutes 2000, section 326.38, is amended to read:

326.38 [LOCAL REGULATIONS.]

Any city having a system of waterworks or sewerage, or any town in which reside over 5,000 people exclusive of any statutory cities located therein, or the metropolitan airports commission, may, by ordinance, adopt local regulations providing for plumbing permits, bonds, approval of plans, and inspections of plumbing, which regulations are not in conflict with the plumbing standards on the same subject prescribed by the state commissioner of health. No city or such town shall prohibit plumbers licensed by the state commissioner of health from engaging in or working at the business, except cities and statutory cities which, prior to April 21, 1933, by ordinance required the licensing of plumbers. Any city by ordinance may prescribe regulations, reasonable standards, and inspections and grant permits to any person, firm, or corporation engaged in the business of installing water softeners, who is not licensed as a master plumber or journeyman plumber by the state commissioner of health, to connect water softening and water filtering equipment to private residence water distribution systems, where provision has been previously made therefor and openings left for that purpose or by use of cold water connections to a domestic water heater; where it is not necessary to rearrange, make any extension or alteration of, or addition to any pipe, fixture or plumbing connected with the water system except to connect

the water softener, and provided the connections so made comply with minimum standards prescribed by the state commissioner of health.

Sec. 54. [MEDICATIONS DISPENSED IN SCHOOLS STUDY.]

(a) The commissioner of health, in consultation with the board of nursing, shall study the relationship between the Nurse Practice Act, Minnesota Statutes, sections 148.171 to 148.285; and 121A.22, which specifies the administration of medications in schools and the activities authorized under these sections, including the administration of prescription and nonprescription medications and medications needed by students to manage a chronic illness. The commissioner shall also make recommendations on necessary statutory changes needed to promote student health and safety in relation to administering medications in schools and addressing the changing health needs of students.

(b) The commissioner shall convene a work group to assist in the study and recommendations. The work group shall consist of representatives of the commissioner of human services; the commissioner of children, families, and learning; the board of nursing; the board of teaching; school nurses; parents; school administrators; school board associations; the American Academy of Pediatrics; and the Minnesota Nurse's Association.

(c) The commissioner shall submit these recommendations and any recommended statutory changes to the legislature by January 15, 2002.

Sec. 55. [REPEALER.]

Minnesota Statutes 2000, sections 144.148, subdivision 8; 145.882, subdivisions 3 and 4; and 145.927, are repealed.

ARTICLE 2

HEALTH CARE

Section 1. Minnesota Statutes 2000, section 16A.87, is amended to read:

16A.87 [TOBACCO SETTLEMENT FUND.]

Subdivision 1. [ESTABLISHMENT; PURPOSE.] The tobacco settlement fund is established as a clearing account in the state treasury.

Subd. 2. [DEPOSIT OF MONEY.] The commissioner shall credit to the tobacco settlement fund the tobacco settlement payments received by the state on September 5, 1998, January 4, 1999, January 3, 2000, ~~and~~ January 2, 2001, January 2, 2002, and January 2, 2003, as a result of the settlement of the lawsuit styled as State v. Philip Morris Inc., No. C1-94-8565 (Minnesota District Court, Second Judicial District).

Subd. 3. [APPROPRIATION.] (a) Of the amounts credited to the fund prior to June 30, 2001, 61 percent is appropriated for transfer to the tobacco use prevention and local public health endowment fund created in section 144.395 and 39 percent is appropriated for transfer to the medical education endowment fund created in section 62J.694.

(b) The entire amount credited to the fund from the payments made on January 2, 2002, and on January 2, 2003, are appropriated for transfer to the children's health care endowment fund created in section 256.952.

Subd. 4. [SUNSET.] The tobacco settlement fund expires June 30, 2015.

Sec. 2. Minnesota Statutes 2000, section 62A.095, subdivision 1, is amended to read:

Subdivision 1. [APPLICABILITY.] (a) No health plan shall be offered, sold, or issued to a resident of this state, or to cover a resident of this state, unless the health plan complies with subdivision 2.

(b) Health plans providing benefits under health care programs administered by the

commissioner of human services are not subject to the limits described in subdivision 2 but are subject to the right of subrogation provisions under section 256B.37 and the lien provisions under section 256.015; 256B.042; 256D.03, subdivision 8; or 256L.03, subdivision 6.

Sec. 3. Minnesota Statutes 2000, section 62J.692, subdivision 7, is amended to read:

Subd. 7. [TRANSFERS FROM THE COMMISSIONER OF HUMAN SERVICES.] (a) The amount transferred according to section 256B.69, subdivision 5c, paragraph (a), clause (3), shall be distributed to the University of Minnesota academic health center.

(b) The amount transferred according to section 256B.69, subdivision 5c, paragraph (a), clause (4), shall be distributed to the Hennepin county medical center.

(c) The amount transferred according to section 256B.69, subdivision 5c, paragraph (a), clause (2), shall be distributed by the commissioner to clinical medical education programs that meet the qualifications of subdivision 3 based on a distribution formula that reflects a summation of two factors:

(1) an education factor, which is determined by the total number of eligible trainee FTEs and the total statewide average costs per trainee, by type of trainee, in each clinical medical education program; and

(2) a public program volume factor, which is determined by the total volume of public program revenue received by each training site as a percentage of all public program revenue received by all training sites in the fund pool created under this subdivision.

In this formula, the education factor shall be weighted at 50 percent and the public program volume factor shall be weighted at 50 percent.

~~(b)~~ (d) Public program revenue for the formula in paragraph ~~(a)~~ (c) shall include revenue from medical assistance, prepaid medical assistance, general assistance medical care, and prepaid general assistance medical care.

~~(c)~~ Training sites that receive no public program revenue shall be ineligible for funds available under ~~this subdivision~~ paragraph (c).

Sec. 4. Minnesota Statutes 2000, section 62J.694, subdivision 2, is amended to read:

Subd. 2. [EXPENDITURES.] (a) Up to five percent of the fair market value of the fund is appropriated for medical education activities in the state of Minnesota. The appropriations are to be transferred quarterly for the purposes identified in the following paragraphs.

(b) For fiscal year 2000, 70 percent of the appropriation in paragraph (a) is for transfer to the board of regents for the instructional costs of health professional programs at the academic health center and affiliated teaching institutions, and 30 percent of the appropriation is for transfer to the commissioner of health to be distributed for medical education under section 62J.692.

(c) For fiscal year 2001, 49 percent of the appropriation in paragraph (a) is for transfer to the board of regents for the instructional costs of health professional programs at the academic health center and affiliated teaching institutions, and 51 percent is for transfer to the commissioner of health to be distributed for medical education under section 62J.692.

(d) For fiscal year 2002, and each year thereafter, 42 percent of the appropriation in paragraph (a) ~~may be appropriated by another law for the instructional costs of health professional programs at publicly funded academic health centers and affiliated teaching institutions~~ is for transfer to the commissioner of human services to be used to increase the capitation payments under section 256B.69, and 58 percent is for transfer to the commissioner of health to be distributed for medical education under section 62J.692.

(e) A maximum of $150,000 of each annual appropriation to the commissioner of health in paragraph (d) may be used by the commissioner for administrative expenses associated with implementing section 62J.692.

Sec. 5. Minnesota Statutes 2000, section 62Q.19, subdivision 2, is amended to read:

Subd. 2. [APPLICATION.] (a) Any provider may apply to the commissioner for designation as an essential community provider by submitting an application form developed by the commissioner. Except as provided in paragraph (d), applications must be accepted within two years after the effective date of the rules adopted by the commissioner to implement this section.

(b) Each application submitted must be accompanied by an application fee in an amount determined by the commissioner. The fee shall be no more than what is needed to cover the administrative costs of processing the application.

(c) The name, address, contact person, and the date by which the commissioner's decision is expected to be made shall be classified as public data under section 13.41. All other information contained in the application form shall be classified as private data under section 13.41 until the application has been approved, approved as modified, or denied by the commissioner. Once the decision has been made, all information shall be classified as public data unless the applicant designates and the commissioner determines that the information contains trade secret information.

(d) The commissioner shall accept an application for designation as an essential community provider until June 30, 2001, from:

(1) one applicant that is a nonprofit community health care facility, certified as a medical assistance provider effective April 1, 1998, that provides culturally competent health care to an underserved Southeast Asian immigrant and refugee population residing in the immediate neighborhood of the facility;

(2) one applicant that is a nonprofit home health care provider, certified as a Medicare and a medical assistance provider that provides culturally competent home health care services to a low-income culturally diverse population;

(3) up to five applicants that are nonprofit community mental health centers certified as medical assistance providers that provide mental health services to children with serious emotional disturbance and their families or to adults with serious and persistent mental illness; and

(4) one applicant that is a nonprofit provider certified as a medical assistance provider that provides mental health, child development, and family services to children with physical and mental health disorders and their families.

(e) The commissioner shall accept applications for designation as an essential community provider until June 30, 2002, from an alternative school authorized under sections 123A.05 to 123A.08 or under section 124D.68 and a charter school authorized under section 124D.10. For these schools, the essential community provider designation applies for mental health services delivered by a licensed health care or social services practitioner to a child currently enrolled in the school.

Sec. 6. [145.495] [HEALTH CARE SAFETY NET ENDOWMENT FUND.]

Subdivision 1. [CREATION.] The health care safety net endowment fund is created in the state treasury. The state board of investment shall invest the fund under section 11A.24. All earnings of the fund must be credited to the fund. The principal of the fund must be maintained inviolate, except that the principal may be used to make expenditures from the fund for the purposes specified in this section.

Subd. 2. [EXPENDITURES.] (a) For fiscal year 2003, and each year thereafter, up to five percent of the average of the fair market values of the fund for the preceding 12 months is appropriated for the purposes identified in clauses (1) to (4):

(1) 26.7 percent is appropriated to the commissioner of health to distributed as grants to community clinics in accordance in section 145.928;

(2) 26.7 percent is appropriated to the commissioner of commerce to be paid to the Minnesota comprehensive health association for the exclusive purpose of reducing the association's operating deficit assessment for the year;

(3) 33.3 percent is appropriated to the commissioner of health to be distributed as rural hospital capital improvement grants in accordance with section 144.148; and

(4) 13.3 percent is appropriated to the commissioner of human services to be distributed as dental access grants in accordance with section 256B.53. If the amount appropriated is not used within that fiscal year for dental access grants, the commissioner of finance shall transfer the remaining amount to the commissioner of health to be added to the amount to be distributed as rural hospital capital improvement grants for the next fiscal year.

Subd. 3. [ENDOWMENT FUND NOT TO SUPPLANT EXISTING FUNDS.] Appropriations from the fund must not be used as a substitute for traditional sources of funding for health care programs. Any local political subdivision of the state receiving money under this section must ensure that existing local financial efforts remain in place.

Subd. 4. [HEALTH CARE SAFETY NET ENDOWMENT FUND.]

If the health care safety net endowment fund created under subdivision 1 is repealed, the commissioner of finance shall transfer the principal and any remaining interest to the health care access fund.

Sec. 7. Minnesota Statutes 2000, section 150A.10, is amended by adding a subdivision to read:

Subd. 1a. [LIMITED AUTHORIZATION FOR DENTAL HYGIENISTS.] (a) Notwithstanding subdivision 1, a dental hygienist licensed under this chapter may be employed or retained by a health care facility to perform dental hygiene services described under paragraph (b) without the patient first being examined by a licensed dentist if the dental hygienist:

(1) has two years practical clinical experience with a licensed dentist within the preceding five years; and

(2) has entered into a collaborative agreement with a licensed dentist that designates authorization for the services provided by the dental hygienist.

(b) The dental hygiene services authorized to be performed by a dental hygienist under this subdivision are limited to removal of deposits and stains from the surfaces of the teeth, application of topical preventive or prophylactic agents, polishing and smoothing restorations, and performance of root planing and soft-tissue curettage. The dental hygienist shall not place pit and fissure sealants, unless the patient has been recently examined and the treatment planned by a licensed dentist. The dental hygienist shall not perform injections of anesthetic agents or the administration of nitrous oxide unless under the indirect supervision of a licensed dentist. The performance of dental hygiene services in a health care facility is limited to patients, students, and residents of the facility. A dental hygienist must refer patients to a licensed dentist for dental diagnosis, treatment planning, and dental treatment.

(c) A collaborating dentist must be licensed under this chapter and may enter into a collaborative agreement with more than one dental hygienist. The collaborative agreement must be maintained by the dentist and the dental hygienist and must be made available to the board upon request.

(d) For the purposes of this subdivision, a "health care facility" is limited to a hospital; nursing home; home health agency; group home serving the elderly, disabled, or juveniles; state-operated facility licensed by the commissioner of human services or the commissioner of corrections; and federal, state, or local public health facility, community clinic, or tribal clinic.

(e) For purposes of this subdivision, "a collaborative agreement" means an agreement with a licensed dentist who authorizes and accepts responsibility for the services performed by the dental hygienist. The services authorized under this subdivision and the collaborative agreement may be

performed without the presence of a licensed dentist and may be performed at a location other than the usual place of practice of the dentist or dental hygienist and without a dentist's diagnosis and treatment plan.

Sec. 8. Minnesota Statutes 2000, section 256.01, subdivision 2, is amended to read:

Subd. 2. [SPECIFIC POWERS.] Subject to the provisions of section 241.021, subdivision 2, the commissioner of human services shall:

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

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

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

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

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

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

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

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

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

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

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

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

(6) Act as the agent of and cooperate with the federal government in matters of mutual concern relative to and in conformity with the provisions of Laws 1939, chapter 431, including the administration of any federal funds granted to the state to aid in the performance of any functions of the commissioner as specified in Laws 1939, chapter 431, and including the promulgation of rules making uniformly available medical care benefits to all recipients of public assistance, at such times as the federal government increases its participation in assistance expenditures for medical care to recipients of public assistance, the cost thereof to be borne in the same proportion as are grants of aid to said recipients.

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

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

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

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

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

(12) Have the authority to conduct and administer experimental projects to test methods and procedures of administering assistance and services to recipients or potential recipients of public welfare. To carry out such experimental projects, it is further provided that the commissioner of human services is authorized to waive the enforcement of existing specific statutory program requirements, rules, and standards in one or more counties. The order establishing the waiver shall provide alternative methods and procedures of administration, shall not be in conflict with the basic purposes, coverage, or benefits provided by law, and in no event shall the duration of a project exceed four years. It is further provided that no order establishing an experimental project as authorized by the provisions of this section shall become effective until the following conditions have been met:

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

(b) A comprehensive plan, including estimated project costs, shall be approved by the legislative advisory commission and filed with the commissioner of administration.

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

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

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

(b) Notwithstanding the provisions of paragraph (a), if the disallowance results from knowing noncompliance by one or more counties with a specific program instruction, and that knowing noncompliance is a matter of official county board record, the commissioner may require payment or recover from the county or counties, in the manner prescribed in paragraph (a), an amount equal to the portion of the total disallowance which resulted from the noncompliance, and may distribute the balance of the disallowance according to paragraph (a).

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

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

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

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

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

(c) If the required reports are not received by the deadlines established in clause (b), the commissioner may delay payments and withhold funds from the county board until the next reporting period. When the report is needed to account for the use of federal funds and the late report results in a reduction in federal funding, the commissioner shall withhold from the county boards with late reports an amount equal to the reduction in federal funding until full federal funding is received.

(d) A county board that submits reports that are late, illegible, incomplete, or not in the required

format for two out of three consecutive reporting periods is considered noncompliant. When a county board is found to be noncompliant, the commissioner shall notify the county board of the reason the county board is considered noncompliant and request that the county board develop a corrective action plan stating how the county board plans to correct the problem. The corrective action plan must be submitted to the commissioner within 45 days after the date the county board received notice of noncompliance.

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

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

(g) Counties subject to withholding of funds under paragraph (c) or forfeiture or repayment of funds under paragraph (e) shall not reduce or withhold benefits or services to clients to cover costs incurred due to actions taken by the commissioner under paragraph (c) or (e).

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

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

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

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

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

(~~22~~) (23) Operate the department's communication systems account established in Laws 1993,

First Special Session chapter 1, article 1, section 2, subdivision 2, to manage shared communication costs necessary for the operation of the programs the commissioner supervises. A communications account may also be established for each regional treatment center which operates communications systems. Each account must be used to manage shared communication costs necessary for the operations of the programs the commissioner supervises. The commissioner may distribute the costs of operating and maintaining communication systems to participants in a manner that reflects actual usage. Costs may include acquisition, licensing, insurance, maintenance, repair, staff time and other costs as determined by the commissioner. Nonprofit organizations and state, county, and local government agencies involved in the operation of programs the commissioner supervises may participate in the use of the department's communications technology and share in the cost of operation. The commissioner may accept on behalf of the state any gift, bequest, devise or personal property of any kind, or money tendered to the state for any lawful purpose pertaining to the communication activities of the department. Any money received for this purpose must be deposited in the department's communication systems accounts. Money collected by the commissioner for the use of communication systems must be deposited in the state communication systems account and is appropriated to the commissioner for purposes of this section.

~~(23)~~ (24) Receive any federal matching money that is made available through the medical assistance program for the consumer satisfaction survey. Any federal money received for the survey is appropriated to the commissioner for this purpose. The commissioner may expend the federal money received for the consumer satisfaction survey in either year of the biennium.

~~(24)~~ (25) Incorporate cost reimbursement claims from First Call Minnesota and Greater Twin Cities United Way into the federal cost reimbursement claiming processes of the department according to federal law, rule, and regulations. Any reimbursement received is appropriated to the commissioner and shall be disbursed to First Call Minnesota and Greater Twin Cities United Way according to normal department payment schedules.

~~(25)~~ (26) Develop recommended standards for foster care homes that address the components of specialized therapeutic services to be provided by foster care homes with those services.

Sec. 9. [256.952] [CHILDREN'S HEALTH CARE ENDOWMENT FUND.]

Subdivision 1. [CREATION.] The children's health care endowment fund is created in the state treasury. The state board of investment shall invest the fund under section 11A.24. All earnings of the fund must be credited to the fund. The principal of the fund must be maintained inviolate, except that the principal may be used to make expenditures from the fund for the purposes specified in this section.

Subd. 2. [EXPENDITURES.] (a) For fiscal year 2003, up to five percent of the average of the fair market values of the fund for the preceding six months is appropriated to the commissioner of human services to provide coverage for low-income children in the MinnesotaCare program.

(b) For fiscal year 2004 and each year thereafter, up to five percent of the average of the fair market values of the fund for the preceding 12 months is appropriated to the commissioner of human services to provide coverage for low-income children in the MinnesotaCare program.

Sec. 10. Minnesota Statutes 2000, section 256.955, subdivision 2, is amended to read:

Subd. 2. [DEFINITIONS.] (a) For purposes of this section, the following definitions apply.

(b) "Health plan" has the meaning provided in section 62Q.01, subdivision 3.

(c) "Health plan company" has the meaning provided in section 62Q.01, subdivision 4.

(d) "Qualified individual" means an individual who meets the requirements described in subdivision 2a ~~or 2b~~, and:

(1) who is not determined eligible for medical assistance according to section 256B.0575, who is not determined eligible for medical assistance or general assistance medical care without a spenddown, or who is not enrolled in MinnesotaCare;

(2) is not enrolled in prescription drug coverage under a health plan;

(3) is not enrolled in prescription drug coverage under a Medicare supplement plan, as defined in sections 62A.31 to 62A.44, or policies, contracts, or certificates that supplement Medicare issued by health maintenance organizations or those policies, contracts, or certificates governed by section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395, et seq., as amended;

(4) has not had coverage described in clauses (2) and (3) for at least four months prior to application for the program; and

(5) is a permanent resident of Minnesota as defined in section 256L.09.

(e) For purposes of clauses (2) and (3), prescription drug coverage does not include:

(1) a Medicare risk product that provides prescription drug coverage of less than $450 per year; or

(2) a Medicare cost product that provides prescription drug coverage that provides a maximum benefit on brand name drugs of nor more than $500 per year.

**[EFFECTIVE DATE.]** This section is effective January 1, 2002.

Sec. 11. Minnesota Statutes 2000, section 256.955, subdivision 2a, is amended to read:

Subd. 2a. [ELIGIBILITY.] An individual satisfying the following requirements and the requirements described in subdivision 2, paragraph (d), is eligible for the prescription drug program:

(1) is ~~at least 65 years of age or older; and~~

~~(2) is eligible as~~ a ~~qualified~~ Medicare ~~beneficiary according to section 256B.057, subdivision 3 or 3a, or is eligible under section 256B.057, subdivision 3 or 3a, and is also eligible for medical assistance or general assistance medical care with a spenddown as defined in section 256B.056, subdivision 5~~ enrollee whose assets are no more than $10,000 for a single individual and $18,000 for a married couple or family of two or more, using the asset methodology for aged, blind, or disabled individuals specified in section 256B.056, subdivision 1a; and

(2) has a household income that does not exceed 150 percent of the federal poverty guidelines, using the income methodology for aged, blind, or disabled individuals specified in section 256B.056, subdivision 1a.

**[EFFECTIVE DATE.]** This section is effective January 1, 2002.

Sec. 12. Minnesota Statutes 2000, section 256.955, subdivision 7, is amended to read:

Subd. 7. [COST SHARING.] Program enrollees must satisfy a ~~$420 annual~~ monthly deductible, based upon expenditures for prescription drugs~~, to be paid in $35 monthly increments~~. The monthly deductible must be calculated by the commissioner based upon the household income of the enrollee expressed as a percentage of the federal poverty guidelines, using the following sliding scale:

| Household Income of Enrollee | Monthly Deductible |
|---|---|
| not more than 120 percent | $35 |
| more than 120 percent but not more than 125 percent | $43 |
| more than 125 percent but not more than 130 percent | $52 |
| more than 130 percent but not more than 135 percent | $60 |

| | |
|---|---|
| more than 135 percent but not more than 140 percent | $68 |
| more than 140 percent but not more than 145 percent | $77 |
| more than 145 percent but not more than 150 percent | $85 |

**[EFFECTIVE DATE.]** This section is effective January 1, 2002.

Sec. 13. Minnesota Statutes 2000, section 256.955, is amended by adding a subdivision to read:

Subd. 10. [DEDICATED ACCOUNT.] (a) The Minnesota prescription drug dedicated account is established in the state treasury. The commissioner of finance shall credit to the account all rebates paid under section 256.01, subdivision 1, clause (21), any appropriations designated for the prescription drug program and any federal funds received by the state to implement a senior prescription drug program. The commissioner of finance shall ensure that account money is invested under section 11A.25. All money earned by the account must be credited to the account.

(b) Money in the account is appropriated to the commissioner of human services for the prescription drug program.

**[EFFECTIVE DATE.]** This section is effective July 1, 2001.

Sec. 14. [256.956] [PURCHASING ALLIANCE STOP-LOSS FUND.]

Subdivision 1. [DEFINITIONS.] For purposes of this section, the following definitions apply:

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

(b) "Health plan" means a policy, contract, or certificate issued by a health plan company to a qualifying purchasing alliance. Any health plan issued to the members of a qualifying purchasing alliance must meet the requirements of chapter 62L.

(c) "Health plan company" means:

(1) a health carrier as defined under section 62A.011, subdivision 2;

(2) a community integrated service network operating under chapter 62N; or

(3) an accountable provider network operating under chapter 62T.

(d) "Qualifying employer" means an employer who:

(1) is a member of a qualifying purchasing alliance;

(2) has at least one employee but no more than ten employees or is a sole proprietor or farmer;

(3) did not offer employer-subsidized health care coverage to its employees for at least 12 months prior to joining the purchasing alliance; and

(4) is offering health coverage through the purchasing alliance to all employees who work at least 20 hours per week unless the employee is eligible for Medicare.

For purposes of this subdivision, "employer-subsidized health coverage" means health coverage for which the employer pays at least 50 percent of the cost of coverage for the employee.

(e) "Qualifying enrollee" means an employee of a qualifying employer or the employee's dependent covered by a health plan.

(f) "Qualifying purchasing alliance" means a purchasing alliance as defined in section 62T.01, subdivision 2, that:

(1) meets the requirements of chapter 62T;

(2) services a geographic area located in outstate Minnesota, excluding the city of Duluth; and

(3) is organized and operating before May 1, 2001.

The criteria used by the qualifying purchasing alliance for membership must be approved by the commissioner of health. A qualifying purchasing alliance may begin enrolling qualifying employers after July 1, 2001, with enrollment ending by December 31, 2003.

Subd. 2. [CREATION OF ACCOUNT.] A purchasing alliance stop-loss fund account is established in the general fund. The commissioner shall use the money to establish a stop-loss fund from which a health plan company may receive reimbursement for claims paid for qualifying enrollees. The account consists of money appropriated by the legislature. Money from the account must be used for the stop-loss fund.

Subd. 3. [REIMBURSEMENT.] (a) A health plan company may receive reimbursement from the fund for 90 percent of the portion of the claim that exceeds $30,000 but not of the portion that exceeds $100,000 in a calendar year for a qualifying enrollee.

(b) Claims shall be reported and funds shall be distributed on a calendar-year basis. Claims shall be eligible for reimbursement only for the calendar year in which the claims were paid.

(c) Once claims paid on behalf of a qualifying enrollee reach $100,000 in a given calendar year, no further claims may be submitted for reimbursement on behalf of that enrollee in that calendar year.

Subd. 4. [REQUEST PROCESS.] (a) Each health plan company must submit a request for reimbursement from the fund on a form prescribed by the commissioner. Requests for payment must be submitted no later than April 1 following the end of the calendar year for which the reimbursement request is being made, beginning April 1, 2002.

(b) The commissioner may require a health plan company to submit claims data as needed in connection with the reimbursement request.

Subd. 5. [DISTRIBUTION.] (a) The commissioner shall calculate the total claims reimbursement amount for all qualifying health plan companies for the calendar year for which claims are being reported and shall distribute the stop-loss funds on an annual basis.

(b) In the event that the total amount requested for reimbursement by the health plan companies for a calendar year exceeds the funds available for distribution for claims paid by all health plan companies during the same calendar year, the commissioner shall provide for the pro rata distribution of the available funds. Each health plan company shall be eligible to receive only a proportionate amount of the available funds as the health plan company's total eligible claims paid compares to the total eligible claims paid by all health plan companies.

(c) In the event that funds available for distribution for claims paid by all health plan companies during a calendar year exceed the total amount requested for reimbursement by all health plan companies during the same calendar year, any excess funds shall be reallocated for distribution in the next calendar year.

Subd. 6. [DATA.] Upon the request of the commissioner, each health plan company shall furnish such data as the commissioner deems necessary to administer the fund. The commissioner may require that such data be submitted on a per enrollee, aggregate, or categorical basis. Any data submitted under this section shall be classified as private data or nonpublic data as defined in section 13.02.

Subd. 7. [DELEGATION.] The commissioner may delegate any or all of the commissioner's administrative duties to another state agency or to a private contractor.

Subd. 8. [REPORT.] The commissioner of commerce, in consultation with the office of rural health and the qualifying purchasing alliances, shall evaluate the extent to which the purchasing alliance stop-loss fund increases the availability of employer-subsidized health care coverage for

residents residing in the geographic areas served by the qualifying purchasing alliances. A preliminary report must be submitted to the legislature by February 15, 2003, and a final report must be submitted by February 15, 2004.

Subd. 9. [SUNSET.] This section shall expire January 1, 2005.

Sec. 15. [256.958] [RETIRED DENTIST PROGRAM.]

Subdivision 1. [PROGRAM.] The commissioner of human services shall establish a program to reimburse a retired dentist for the dentist's license fee and for the reasonable cost of malpractice insurance compared to other dentists in the community in exchange for the dentist providing 100 hours of dental services on a volunteer basis within a 12-month period at a community dental clinic or a dental training clinic located at a Minnesota state college or university.

Subd. 2. [DOCUMENTATION.] Upon completion of the required hours, the retired dentist shall submit to the commissioner the following:

(1) documentation of the service provided;

(2) the cost of malpractice insurance for the 12-month period; and

(3) the cost of the license.

Subd. 3. [REIMBURSEMENT.] Upon receipt of the information described in subdivision 2, the commissioner shall provide reimbursement to the retired dentist for the cost of malpractice insurance for the previous 12-month period and the cost of the license.

Sec. 16. [256.959] [DENTAL PRACTICE DONATION PROGRAM.]

Subdivision 1. [ESTABLISHMENT.] The commissioner of human services shall establish a dental practice donation program that coordinates the donation of a qualifying dental practice to a qualified charitable organization and assists in locating a dentist licensed under chapter 150A who wishes to maintain the dental practice.

Subd. 2. [QUALIFYING DENTAL PRACTICE.] To qualify for the dental practice donation program, a dental practice must meet the following requirements:

(1) the dental practice must be owned by the donating dentist;

(2) the dental practice must be located in a designated underserved area of the state as defined by the commissioner; and

(3) the practice must be equipped with the basic dental equipment necessary to maintain a dental practice as determined by the commissioner.

Subd. 3. [COORDINATION.] The commissioner shall establish a procedure for dentists to donate their dental practices to a qualified charitable organization. The commissioner shall authorize a practice for donation only if it meets the requirements of subdivision 2 and there is a licensed dentist who is interested in entering into an agreement as described in subdivision 4. Upon donation of the practice, the commissioner shall provide the donating dentist with a statement verifying that a donation of the practice was made to a qualifying charitable organization for purposes of state and federal income tax returns.

Subd. 4. [DONATED DENTAL PRACTICE AGREEMENT.] (a) A dentist accepting the donated practice must enter into an agreement with the qualified charitable organization to maintain the dental practice for a minimum of five years at the donated practice site and to provide services to underserved populations up to a preagreed percentage of patients served.

(b) The agreement must include the terms for the recovery of the donated dental practice if the dentist accepting the practice does not fulfill the service commitment required under this subdivision.

(c) Any costs associated with operating the dental practice during the service commitment time period are the financial responsibility of the dentist accepting the practice.

Sec. 17. Minnesota Statutes 2000, section 256.9657, subdivision 2, is amended to read:

Subd. 2. [HOSPITAL SURCHARGE.] (a) Effective October 1, 1992, each Minnesota hospital except facilities of the federal Indian Health Service and regional treatment centers shall pay to the medical assistance account a surcharge equal to 1.4 percent of net patient revenues excluding net Medicare revenues reported by that provider to the health care cost information system according to the schedule in subdivision 4.

(b) Effective July 1, 1994, the surcharge under paragraph (a) is increased to 1.56 percent.

(c) Notwithstanding the Medicare cost finding and allowable cost principles, the hospital surcharge is not an allowable cost for purposes of rate setting under sections 256.9685 to 256.9695.

Sec. 18. Minnesota Statutes 2000, section 256.969, is amended by adding a subdivision to read:

Subd. 26. [GREATER MINNESOTA PAYMENT ADJUSTMENT AFTER JUNE 30, 2001.] (a) For admissions occurring after June 30, 2001, the commissioner shall pay fee-for-service inpatient admissions for the diagnosis-related groups specified in paragraph (b) at hospitals located outside of the seven-county metropolitan area at the higher of:

(1) the hospital's current payment rate for the diagnostic category to which the diagnosis-related group belongs, exclusive of disproportionate population adjustments received under subdivision 9 and hospital payment adjustments received under subdivision 23; or

(2) 90 percent of the average payment rate for that diagnostic category for hospitals located within the seven-county metropolitan area, exclusive of disproportionate population adjustments received under subdivision 9 and hospital payment adjustments received under subdivisions 20 and 23.

(b) The payment increases provided in paragraph (a) apply to the following diagnosis-related groups, as they fall within the diagnostic categories:

(1) 370 cesarean section with complicating diagnosis;

(2) 371 cesarean section without complicating diagnosis;

(3) 372 vaginal delivery with complicating diagnosis;

(4) 373 vaginal delivery without complicating diagnosis;

(5) 386 extreme immaturity and respiratory distress syndrome, neonate;

(6) 388 full-term neonates with other problems;

(7) 390 prematurity without major problems;

(8) 391 normal newborn;

(9) 385 neonate, died or transferred to another acute care facility;

(10) 425 acute adjustment reaction and psychosocial dysfunction;

(11) 430 psychoses;

(12) 431 childhood mental disorders; and

(13) 164-167 appendectomy.

Sec. 19. Minnesota Statutes 2000, section 256B.02, subdivision 7, is amended to read:

Subd. 7. "Vendor of medical care" means any person or persons furnishing, within the scope of the vendor's respective license, any or all of the following goods or services: medical, surgical, hospital, optical, visual, dental and nursing services; drugs and medical supplies; appliances; laboratory, diagnostic, and therapeutic services; nursing home and convalescent care; screening and health assessment services provided by public health nurses as defined in section 145A.02, subdivision 18; health care services provided at the residence of the patient if the services are performed by a public health nurse and the nurse indicates in a statement submitted under oath that the services were actually provided; oral language interpreter services for persons of limited English proficiency when necessary to access health care; and such other medical services or supplies provided or prescribed by persons authorized by state law to give such services and supplies. The term includes, but is not limited to, directors and officers of corporations or members of partnerships who, either individually or jointly with another or others, have the legal control, supervision, or responsibility of submitting claims for reimbursement to the medical assistance program. The term only includes directors and officers of corporations who personally receive a portion of the distributed assets upon liquidation or dissolution, and their liability is limited to the portion of the claim that bears the same proportion to the total claim as their share of the distributed assets bears to the total distributed assets.

Sec. 20. Minnesota Statutes 2000, section 256B.04, is amended by adding a subdivision to read:

Subd. 1b. [ADMINISTRATIVE SERVICES.] Notwithstanding subdivision 1, the commissioner may contract with federally recognized Indian tribes with a reservation in Minnesota for the provision of early and periodic screening, diagnosis, and treatment administrative services for American Indian children, in accordance with the Code of Federal Regulations, title 42, section 441, subpart B, and Minnesota Rules, part 9505.1693, when the tribe chooses to provide such services. For purposes of this subdivision, "American Indian" has the meaning given to persons to whom services will be provided in the Code of Federal Regulations, title 42, section 36.12. Notwithstanding Minnesota Rules, part 9505.1748, subpart 1, the commissioner, the local agency, and the tribe may contract with any entity for the provision of early and periodic screening, diagnosis, and treatment administrative services.

Sec. 21. Minnesota Statutes 2000, section 256B.055, subdivision 3a, is amended to read:

Subd. 3a. [~~MFIP-S FAMILIES;~~ FAMILIES ELIGIBLE UNDER PRIOR AFDC RULES.] (a) ~~Beginning January 1, 1998, or on the date that MFIP-S is implemented in counties, medical assistance may be paid for a person receiving public assistance under the MFIP-S program.~~ Beginning July 1, 2002, medical assistance may be paid for a person who would have been eligible, but for excess income or assets, under the state's AFDC plan in effect as of July 16, 1996, with the base AFDC standard increased according to section 256B.056, subdivision 4.

(b) Beginning ~~January 1, 1998,~~ July 1, 2002, medical assistance may be paid for a person who would have been eligible for public assistance under the income and ~~resource~~ assets standards~~, or who would have been eligible but for excess income or assets,~~ under the state's AFDC plan in effect as of July 16, 1996, ~~as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law Number 104-193~~ with the base AFDC rate increased according to section 256B.056, subdivision 4.

**[EFFECTIVE DATE.]** This section is effective July 1, 2002.

Sec. 22. Minnesota Statutes 2000, section 256B.056, subdivision 1a, is amended to read:

Subd. 1a. [INCOME AND ASSETS GENERALLY.] Unless specifically required by state law or rule or federal law or regulation, the methodologies used in counting income and assets to determine eligibility for medical assistance for persons whose eligibility category is based on blindness, disability, or age of 65 or more years, the methodologies for the supplemental security income program shall be used. For children eligible for home and community-based waiver services whose eligibility for medical assistance is determined without regard to parental income, or for children eligible under section 256B.055, subdivision 12, child support payments, including any payments made by an obligor in satisfaction of or in addition to a temporary or permanent order for child support, and social security payments, are not counted as income. For families and

children, which includes all other eligibility categories, the methodologies under the state's AFDC plan in effect as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law Number 104-193, shall be used. Effective upon federal approval, in-kind contributions to, and payments made on behalf of, a recipient, by an obligor, in satisfaction of or in addition to a temporary or permanent order for child support or maintenance, shall be considered income to the recipient. For these purposes, a "methodology" does not include an asset or income standard, or accounting method, or method of determining effective dates.

**[EFFECTIVE DATE.]** This section is effective July 1, 2001, or the date upon which federal rules published in the Federal Register at 66FR2316 become effective, whichever is later.

Sec. 23. Minnesota Statutes 2000, section 256B.056, subdivision 4, is amended to read:

Subd. 4. [INCOME.] To be eligible for medical assistance, a person eligible under section 256B.055, subdivision 7, not receiving supplemental security income program payments, and families and children may have an income up to 133-1/3 percent of the AFDC income standard in effect under the July 16, 1996, AFDC state plan. Effective July 1, 2000, the base AFDC standard in effect on July 16, 1996, shall be increased by three percent. Effective July 1, 2001, or the date upon which federal rules published in the Federal Register at 66FR2316 become effective, whichever is later, the income limit for a person eligible under this subdivision shall be increased by 3.2 percent. Effective January 1, 2000, and each successive January, recipients of supplemental security income may have an income up to the supplemental security income standard in effect on that date. In computing income to determine eligibility of persons who are not residents of long-term care facilities, the commissioner shall disregard increases in income as required by Public Law Numbers 94-566, section 503; 99-272; and 99-509. Veterans aid and attendance benefits and Veterans Administration unusual medical expense payments are considered income to the recipient.

Sec. 24. Minnesota Statutes 2000, section 256B.056, subdivision 4b, is amended to read:

Subd. 4b. [INCOME VERIFICATION.] The local agency shall not require a monthly income verification form for a recipient who is a resident of a long-term care facility and who has monthly earned income of $80 or less. The commissioner or county agency shall use electronic verification as the primary method of income verification. If there is a discrepancy in the electronic verification, an individual may be required to submit additional verification.

Sec. 25. Minnesota Statutes 2000, section 256B.057, subdivision 2, is amended to read:

Subd. 2. [CHILDREN.] A child ~~one~~ two through ~~five~~ 18 years of age in a family whose countable income is ~~less~~ no greater than ~~133~~ 185 percent of the federal poverty guidelines for the same family size, is eligible for medical assistance. ~~A child six through 18 years of age, who was born after September 30, 1983, in a family whose countable income is less than 100 percent of the federal poverty guidelines for the same family size is eligible for medical assistance.~~ Countable income means gross income minus child support paid according to a court order and dependent care costs deducted from income under the state's AFDC plan in effect as of July 16, 1996.

**[EFFECTIVE DATE.]** This section is effective July 1, 2002.

Sec. 26. Minnesota Statutes 2000, section 256B.057, subdivision 9, is amended to read:

Subd. 9. [EMPLOYED PERSONS WITH DISABILITIES.] (a) Medical assistance may be paid for a person who is employed and who:

(1) meets the definition of disabled under the supplemental security income program;

(2) is at least 16 but less than 65 years of age;

(3) meets the asset limits in paragraph (b); and

(4) pays a premium, if required, under paragraph (c).

Any spousal income or assets shall be disregarded for purposes of eligibility and premium determinations.

After the month of enrollment, a person enrolled in medical assistance under this subdivision who is temporarily unable to work and without receipt of earned income due to a medical condition, as verified by a physician, or who has involuntarily left employment may retain eligibility for up to four calendar months.

(b) For purposes of determining eligibility under this subdivision, a person's assets must not exceed $20,000, excluding:

(1) all assets excluded under section 256B.056;

(2) retirement accounts, including individual accounts, 401(k) plans, 403(b) plans, Keogh plans, and pension plans; and

(3) medical expense accounts set up through the person's employer.

(c) A person whose earned and unearned income is equal to or greater ~~than 200~~ than 100 percent of federal poverty guidelines for the applicable family size must pay a premium to be eligible for medical assistance under this subdivision. The premium shall be ~~equal to ten percent of the person's gross earned and unearned income above 200 percent of federal poverty guidelines for the applicable family size up to the cost of coverage~~ based on the person's gross earned and unearned income and the applicable family size using a sliding fee scale established by the commissioner, which begins at one percent of income at 100 percent of the federal poverty guidelines and increases to 7.5 percent of income for those with incomes at or above 300 percent of the federal poverty guidelines. Annual adjustments in the premium schedule based upon changes in the federal poverty guidelines shall be effective for premiums due in June of each year.

(d) A person's eligibility and premium shall be determined by the local county agency. Premiums must be paid to the commissioner. All premiums are dedicated to the commissioner.

(e) Any required premium shall be determined at application and redetermined annually at recertification or when a change in income or family size occurs.

(f) Premium payment is due upon notification from the commissioner of the premium amount required. Premiums may be paid in installments at the discretion of the commissioner.

(g) Nonpayment of the premium shall result in denial or termination of medical assistance unless the person demonstrates good cause for nonpayment. Good cause exists if the requirements specified in Minnesota Rules, part 9506.0040, subpart 7, items B to D, are met. Nonpayment shall include payment with a returned, refused, or dishonored instrument. The commissioner may require a guaranteed form of payment as the only means to replace a returned, refused, or dishonored instrument.

**[EFFECTIVE DATE.]** This section is effective September 1, 2001.

Sec. 27. Minnesota Statutes 2000, section 256B.057, is amended by adding a subdivision to read:

Subd. 10. [CERTAIN PERSONS NEEDING TREATMENT FOR BREAST OR CERVICAL CANCER.] (a) Medical assistance may be paid for a person who:

(1) has been screened for breast or cervical cancer under the centers for disease control and prevention's national breast and cervical cancer early detection program established under United States Code, title 42, sections 300k et seq.;

(2) according to the person's treating health professional, needs treatment, including diagnostic services necessary to determine the extent and proper course of treatment, for breast or cervical cancer, including precancerous conditions and early stage cancer;

(3) is under age 65;

(4) is not otherwise eligible for medical assistance under United States Code, title 42, section 1396(a)(10)(A)(i); and

(5) is not otherwise covered under creditable coverage, as defined under United States Code, title 42, section 300gg(c).

(b) Medical assistance provided for an eligible person under this subdivision shall be limited to services provided during the period that the person receives treatment for breast or cervical cancer.

(c) A person meeting the criteria in paragraph (a) is eligible for medical assistance without meeting the eligibility criteria relating to income and assets in section 256B.056, subdivisions 1a to 5b.

Sec. 28. Minnesota Statutes 2000, section 256B.057, is amended by adding a subdivision to read:

Subd. 11. [AGED, BLIND, OR DISABLED.] (a) To be eligible for medical assistance, a person eligible under section 256B.055, subdivision 7, 7a, or 12, may have an income up to 100 percent of the federal poverty guidelines.

(b)

In computing income to determine eligibility of persons who are not residents of long-term care facilities, the commissioner shall disregard increases in income as required by Public Law Numbers 94-566, section 503; 99-272; and 99-509. Veterans aid and attendance benefits and Veterans Administration unusual medical expense payments are considered income to the recipient.

Sec. 29. Minnesota Statutes 2000, section 256B.061, is amended to read:

256B.061 [ELIGIBILITY; RETROACTIVE EFFECT; RESTRICTIONS.]

(a) If any individual has been determined to be eligible for medical assistance, it will be made available for care and services included under the plan and furnished in or after the third month before the month in which the individual made application for such assistance, if such individual was, or upon application would have been, eligible for medical assistance at the time the care and services were furnished. The commissioner may limit, restrict, or suspend the eligibility of an individual for up to one year upon that individual's conviction of a criminal offense related to application for or receipt of medical assistance benefits.

(b) On the basis of information provided on the completed application, an applicant who meets the following criteria shall be determined eligible beginning in the month of application:

(1) ~~whose gross income is less than 90 percent of the applicable income standard;~~

~~(2)~~ whose total liquid assets are less than 90 percent of the asset limit;

~~(3)~~ (2) does not reside in a long-term care facility; and

~~(4)~~ (3) meets all other eligibility requirements.

The applicant must provide all required verifications within 30 days' notice of the eligibility determination or eligibility shall be terminated.

(c) Under this chapter and chapter 256D within the limits of the appropriation made available for this purpose, the commissioner shall develop and implement a pilot project establishing presumptive eligibility for children under age 19 with family income at or below the medical assistance guidelines. The commissioner shall select locations such as provider offices, hospitals, clinics, and schools where presumptive eligibility for medical assistance shall be determined on site by a trained staff person. The commissioner shall expand presumptive eligibility effective July 1, 2002, by selecting additional locations. The entity determining presumptive eligibility for a child must notify the parent or caretaker at the time of the determination and provide the parent or

caretaker with an application form, and within five working days after the date of the presumptive eligibility determination must notify the commissioner. The presumptive eligibility period ends on the earlier of the date a child is found to be eligible for medical assistance, or the last day of the month after the month of the presumptive eligibility determination if no application for medical assistance has been filed for that child.

Sec. 30. Minnesota Statutes 2000, section 256B.0625, is amended by adding a subdivision to read:

Subd. 5a. [AUTISM BEHAVIOR THERAPY CLINICAL SUPERVISION SERVICES.] (a) Medical assistance covers autism behavior therapy clinical supervision services. Autism behavior therapy clinical supervision services shall be reimbursed at the same rate as services provided by a mental health professional.

(b) Providers enrolled in medical assistance to provide this service or related autism behavior therapy services are not required to hold a contract with a county board, as specified in Minnesota Rules, part 9505.0324, subpart 2.

**[EFFECTIVE DATE.]** This section is effective January 1, 2003.

Sec. 31. Minnesota Statutes 2000, section 256B.0625, subdivision 13, is amended to read:

Subd. 13. [DRUGS.] (a) Medical assistance covers drugs, except for fertility drugs when specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed by a licensed pharmacist, by a physician enrolled in the medical assistance program as a dispensing physician, or by a physician or a nurse practitioner employed by or under contract with a community health board as defined in section 145A.02, subdivision 5, for the purposes of communicable disease control. The commissioner, after receiving recommendations from professional medical associations and professional pharmacist associations, shall designate a formulary committee to advise the commissioner on the names of drugs for which payment is made, recommend a system for reimbursing providers on a set fee or charge basis rather than the present system, and develop methods encouraging use of generic drugs when they are less expensive and equally effective as trademark drugs. The formulary committee shall consist of nine members, four of whom shall be physicians who are not employed by the department of human services, and a majority of whose practice is for persons paying privately or through health insurance, three of whom shall be pharmacists who are not employed by the department of human services, and a majority of whose practice is for persons paying privately or through health insurance, a consumer representative, and a nursing home representative. Committee members shall serve three-year terms and shall serve without compensation. Members may be reappointed once.

(b) The commissioner shall establish a drug formulary. Its establishment and publication shall not be subject to the requirements of the Administrative Procedure Act, but the formulary committee shall review and comment on the formulary contents. The formulary committee shall review and recommend drugs which require prior authorization. The formulary committee may recommend drugs for prior authorization directly to the commissioner, as long as opportunity for public input is provided. Prior authorization may be requested by the commissioner based on medical and clinical criteria before certain drugs are eligible for payment. Before a drug may be considered for prior authorization at the request of the commissioner:

(1) the drug formulary committee must develop criteria to be used for identifying drugs; the development of these criteria is not subject to the requirements of chapter 14, but the formulary committee shall provide opportunity for public input in developing criteria;

(2) the drug formulary committee must hold a public forum and receive public comment for an additional 15 days; and

(3) the commissioner must provide information to the formulary committee on the impact that placing the drug on prior authorization will have on the quality of patient care and information regarding whether the drug is subject to clinical abuse or misuse. Prior authorization may be

required by the commissioner before certain formulary drugs are eligible for payment. The formulary shall not include:

(i) drugs or products for which there is no federal funding;

(ii) over-the-counter drugs, except for antacids, acetaminophen, family planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults with documented vitamin deficiencies, vitamins for children under the age of seven and pregnant or nursing women, and any other over-the-counter drug identified by the commissioner, in consultation with the drug formulary committee, as necessary, appropriate, and cost-effective for the treatment of certain specified chronic diseases, conditions or disorders, and this determination shall not be subject to the requirements of chapter 14;

(iii) anorectics, except that medically necessary anorectics shall be covered for a recipient previously diagnosed as having pickwickian syndrome and currently diagnosed as having diabetes and being morbidly obese;

(iv) drugs for which medical value has not been established; and

(v) drugs from manufacturers who have not signed a rebate agreement with the Department of Health and Human Services pursuant to section 1927 of title XIX of the Social Security Act.

The commissioner shall publish conditions for prohibiting payment for specific drugs after considering the formulary committee's recommendations. An honorarium of $100 per meeting and reimbursement for mileage shall be paid to each committee member in attendance.

(c) The basis for determining the amount of payment shall be the lower of the actual acquisition costs of the drugs plus a fixed dispensing fee; the maximum allowable cost set by the federal government or by the commissioner plus the fixed dispensing fee; or the usual and customary price charged to the public. The pharmacy dispensing fee shall be $3.65, except that the dispensing fee for intravenous solutions which must be compounded by the pharmacist shall be $8 per bag, $14 per bag for cancer chemotherapy products, and $30 per bag for total parenteral nutritional products dispensed in one liter quantities, or $44 per bag for total parenteral nutritional products dispensed in quantities greater than one liter. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. The actual acquisition cost of a drug shall be estimated by the commissioner, at average wholesale price minus nine percent, except that where a drug has had its wholesale price reduced as a result of the actions of the National Association of Medicaid Fraud Control Units, the estimated actual acquisition cost shall be the reduced average wholesale price, without the nine percent deduction. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to, but no higher than, the maximum amount paid by other third-party payors in this state who have maximum allowable cost programs. The commissioner shall set maximum allowable costs for multisource drugs that are not on the federal upper limit list as described in United States Code, title 42, chapter 7, section 1396r-8(e), the Social Security Act, and Code of Federal Regulations, title 42, part 447, section 447.332. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act. An additional dispensing fee of $.30 may be added to the dispensing fee paid to pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities when a unit dose blister card system, approved by the department, is used. Under this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister card must be identified on the claim to the department. The unit dose blister card containing the drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider will be required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse. Over-the-counter medications must be dispensed in the manufacturer's unopened package. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply. Whenever a generically equivalent product is available, payment shall be on the basis of the actual acquisition cost of the generic drug, unless the prescriber specifically indicates "dispense as written - brand necessary" on the prescription as required by section 151.21, subdivision 2.

(d) For purposes of this subdivision, "multisource drugs" means covered outpatient drugs, excluding innovator multisource drugs for which there are two or more drug products, which:

(1) are related as therapeutically equivalent under the Food and Drug Administration's most recent publication of "Approved Drug Products with Therapeutic Equivalence Evaluations";

(2) are pharmaceutically equivalent and bioequivalent as determined by the Food and Drug Administration; and

(3) are sold or marketed in Minnesota.

"Innovator multisource drug" means a multisource drug that was originally marketed under an original new drug application approved by the Food and Drug Administration.

(e) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider; the average wholesale price minus five percent; or the maximum allowable cost set by the federal government under United States Code, title 42, chapter 7, section 1396r-8(e) and Code of Federal Regulations, title 42, section 447.332, or by the commissioner under paragraph (c).

Sec. 32. Minnesota Statutes 2000, section 256B.0625, subdivision 13a, is amended to read:

Subd. 13a. [DRUG UTILIZATION REVIEW BOARD.] A nine-member drug utilization review board is established. The board is comprised of at least three but no more than four licensed physicians actively engaged in the practice of medicine in Minnesota; at least three licensed pharmacists actively engaged in the practice of pharmacy in Minnesota; and one consumer representative; the remainder to be made up of health care professionals who are licensed in their field and have recognized knowledge in the clinically appropriate prescribing, dispensing, and monitoring of covered outpatient drugs. The board shall be staffed by an employee of the department who shall serve as an ex officio nonvoting member of the board. The members of the board shall be appointed by the commissioner and shall serve three-year terms. The members shall be selected from lists submitted by professional associations. The commissioner shall appoint the initial members of the board for terms expiring as follows: three members for terms expiring June 30, 1996; three members for terms expiring June 30, 1997; and three members for terms expiring June 30, 1998. Members may be reappointed once. The board shall annually elect a chair from among the members.

The commissioner shall, with the advice of the board:

(1) implement a medical assistance retrospective and prospective drug utilization review program as required by United States Code, title 42, section 1396r-8(g)(3);

(2) develop and implement the predetermined criteria and practice parameters for appropriate prescribing to be used in retrospective and prospective drug utilization review;

(3) develop, select, implement, and assess interventions for physicians, pharmacists, and patients that are educational and not punitive in nature;

(4) establish a grievance and appeals process for physicians and pharmacists under this section;

(5) publish and disseminate educational information to physicians and pharmacists regarding the board and the review program;

(6) adopt and implement procedures designed to ensure the confidentiality of any information collected, stored, retrieved, assessed, or analyzed by the board, staff to the board, or contractors to the review program that identifies individual physicians, pharmacists, or recipients;

(7) establish and implement an ongoing process to (i) receive public comment regarding drug utilization review criteria and standards, and (ii) consider the comments along with other scientific and clinical information in order to revise criteria and standards on a timely basis; and

(8) adopt any rules necessary to carry out this section.

The board may establish advisory committees. The commissioner may contract with appropriate organizations to assist the board in carrying out the board's duties. The commissioner may enter into contracts for services to develop and implement a retrospective and prospective review program.

The board shall report to the commissioner annually on the date the Drug Utilization Review Annual Report is due to the Health Care Financing Administration. This report is to cover the preceding federal fiscal year. The commissioner shall make the report available to the public upon request. The report must include information on the activities of the board and the program; the effectiveness of implemented interventions; administrative costs; and any fiscal impact resulting from the program. An honorarium of ~~$50~~ $100 per meeting and reimbursement for mileage shall be paid to each board member in attendance.

Sec. 33. Minnesota Statutes 2000, section 256B.0625, subdivision 17, is amended to read:

Subd. 17. [TRANSPORTATION COSTS.] (a) Medical assistance covers transportation costs incurred solely for obtaining emergency medical care or transportation costs incurred by nonambulatory persons in obtaining emergency or nonemergency medical care when paid directly to an ambulance company, common carrier, or other recognized providers of transportation services. For the purpose of this subdivision, a person who is incapable of transport by taxicab or bus shall be considered to be nonambulatory.

(b) Medical assistance covers special transportation, as defined in Minnesota Rules, part 9505.0315, subpart 1, item F, if the provider receives and maintains a current physician's order by the recipient's attending physician certifying that the recipient has a physical or mental impairment that would prohibit the recipient from safely accessing and using a bus, taxi, other commercial transportation, or private automobile. Special transportation includes driver-assisted service to eligible individuals. Driver-assisted service includes passenger pickup at and return to the individual's residence or place of business, assistance with admittance of the individual to the medical facility, and assistance in passenger securement or in securing of wheelchairs or stretchers in the vehicle. The commissioner shall establish maximum medical assistance reimbursement rates for special transportation services for persons who need a wheelchair ~~lift~~ accessible van or ~~stretcher-equipped~~ stretcher-accessible vehicle and for those who do not need a wheelchair ~~lift~~ accessible van or ~~stretcher-equipped~~ stretcher-accessible vehicle. The average of these two rates per trip must not exceed $15 for the base rate and ~~$1.20~~ $1.30 per mile. Special transportation provided to nonambulatory persons who do not need a wheelchair ~~lift~~ accessible van or ~~stretcher-equipped~~ stretcher-accessible vehicle, may be reimbursed at a lower rate than special transportation provided to persons who need a wheelchair ~~lift~~ accessible van or ~~stretcher-equipped~~ stretcher-accessible vehicle.

**[EFFECTIVE DATE.]** This section is effective July 1, 2001.

Sec. 34. Minnesota Statutes 2000, section 256B.0625, subdivision 17a, is amended to read:

Subd. 17a. [PAYMENT FOR AMBULANCE SERVICES.] Effective for services rendered on or after July 1, ~~1999~~ 2001, medical assistance payments for ambulance services shall be ~~increased by five percent~~ paid at the Medicare reimbursement rate or at the medical assistance payment rate in effect on July 1, 2000, whichever is greater.

Sec. 35. Minnesota Statutes 2000, section 256B.0625, subdivision 18a, is amended to read:

Subd. 18a. [~~PAYMENT FOR MEALS AND LODGING~~ ACCESS TO MEDICAL SERVICES.] (a) Medical assistance reimbursement for meals for persons traveling to receive medical care may not exceed $5.50 for breakfast, $6.50 for lunch, or $8 for dinner.

(b) Medical assistance reimbursement for lodging for persons traveling to receive medical care may not exceed $50 per day unless prior authorized by the local agency.

(c) Medical assistance direct mileage reimbursement to the eligible person or the eligible person's driver may not exceed 20 cents per mile.

(d) Medical assistance covers oral language interpreter services when provided by an enrolled health care provider during the course of providing a direct, person-to-person covered health care service to an enrolled recipient with limited English proficiency.

Sec. 36. Minnesota Statutes 2000, section 256B.0625, subdivision 30, is amended to read:

Subd. 30. [OTHER CLINIC SERVICES.] (a) Medical assistance covers rural health clinic services, federally qualified health center services, nonprofit community health clinic services, public health clinic services, and the services of a clinic meeting the criteria established in rule by the commissioner. Rural health clinic services and federally qualified health center services mean services defined in United States Code, title 42, section 1396d(a)(2)(B) and (C). Payment for rural health clinic and federally qualified health center services shall be made according to applicable federal law and regulation.

(b) A federally qualified health center that is beginning initial operation shall submit an estimate of budgeted costs and visits for the initial reporting period in the form and detail required by the commissioner. A federally qualified health center that is already in operation shall submit an initial report using actual costs and visits for the initial reporting period. Within 90 days of the end of its reporting period, a federally qualified health center shall submit, in the form and detail required by the commissioner, a report of its operations, including allowable costs actually incurred for the period and the actual number of visits for services furnished during the period, and other information required by the commissioner. Federally qualified health centers that file Medicare cost reports shall provide the commissioner with a copy of the most recent Medicare cost report filed with the Medicare program intermediary for the reporting year which support the costs claimed on their cost report to the state.

(c) In order to continue cost-based payment under the medical assistance program according to paragraphs (a) and (b), a federally qualified health center or rural health clinic must apply for designation as an essential community provider within six months of final adoption of rules by the department of health according to section 62Q.19, subdivision 7. For those federally qualified health centers and rural health clinics that have applied for essential community provider status within the six-month time prescribed, medical assistance payments will continue to be made according to paragraphs (a) and (b) for the first three years after application. For federally qualified health centers and rural health clinics that either do not apply within the time specified above or who have had essential community provider status for three years, medical assistance payments for health services provided by these entities shall be according to the same rates and conditions applicable to the same service provided by health care providers that are not federally qualified health centers or rural health clinics.

(d) Effective July 1, 1999, the provisions of paragraph (c) requiring a federally qualified health center or a rural health clinic to make application for an essential community provider designation in order to have cost-based payments made according to paragraphs (a) and (b) no longer apply.

(e) Effective January 1, 2000, payments made according to paragraphs (a) and (b) shall be limited to the cost phase-out schedule of the Balanced Budget Act of 1997.

(f) Effective January 1, 2001, each federally qualified health center and rural health clinic may elect to be paid either under the prospective payment system established in United States Code, title 42, section 1396a, (a) or under an alternative payment methodology consistent with the requirements of United States Code, title 42, section 1392a, (a) and approved by the Health Care Financing Administration. The alternative payment methodology shall be 100 percent of cost as determined according to Medicare cost principles.

Sec. 37. Minnesota Statutes 2000, section 256B.0625, subdivision 34, is amended to read:

Subd. 34. [INDIAN HEALTH SERVICES FACILITIES.] Medical assistance payments to facilities of the Indian health service and facilities operated by a tribe or tribal organization under funding authorized by United States Code, title 25, sections 450f to 450n, or title III of the Indian Self-Determination and Education Assistance Act, Public Law Number 93-638, for enrollees who are eligible for federal financial participation, shall be at the option of the facility in accordance

with the rate published by the United States Assistant Secretary for Health under the authority of United States Code, title 42, sections 248(a) and 249(b). General assistance medical care payments to facilities of the Indian health services and facilities operated by a tribe or tribal organization for the provision of outpatient medical care services billed after June 30, 1990, must be in accordance with the general assistance medical care rates paid for the same services when provided in a facility other than a facility of the Indian health service or a facility operated by a tribe or tribal organization. MinnesotaCare payments for enrollees who are not eligible for federal financial participation at facilities of the Indian health service and facilities operated by a tribe or tribal organization for the provision of outpatient medical services must be in accordance with the medical assistance rates paid for the same services when provided in a facility other than a facility of the Indian health service or a facility operated by a tribe or tribal organization.

**[EFFECTIVE DATE.]** This section shall be effective the day following final enactment.

Sec. 38. Minnesota Statutes 2000, section 256B.0625, is amended by adding a subdivision to read:

Subd. 43. [TARGETED CASE MANAGEMENT SERVICES.] Medical assistance covers case management services for vulnerable adults and persons with developmental disabilities not receiving home and community-based waiver services.

Sec. 39. Minnesota Statutes 2000, section 256B.0625, is amended by adding a subdivision to read:

Subd. 44. [TARGETED CASE MANAGEMENT SERVICE FOR CHILDREN UNDER THE AGE OF 19.] Medical assistance, subject to federal approval, covers targeted case management services in accordance with section 256B.0948 for children under the age of 19 who have had at least one previous birth.

Sec. 40. Minnesota Statutes 2000, section 256B.0635, subdivision 1, is amended to read:

Subdivision 1. [INCREASED EMPLOYMENT.] ~~Beginning January 1, 1998~~ (a) Until June 30, 2002, medical assistance may be paid for persons who received MFIP-S or medical assistance for families and children in at least three of six months preceding the month in which the person became ineligible for MFIP-S or medical assistance, if the ineligibility was due to an increase in hours of employment or employment income or due to the loss of an earned income disregard. In addition, to receive continued assistance under this section, persons who received medical assistance for families and children but did not receive MFIP-S must have had income less than or equal to the assistance standard for their family size under the state's AFDC plan in effect as of July 16, 1996, ~~as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law Number 104-193,~~ increased according to section 256B.056, subdivision 4, at the time medical assistance eligibility began. A person who is eligible for extended medical assistance is entitled to ~~six~~ 12 months of assistance without reapplication, unless the assistance unit ceases to include a dependent child~~. For a person under 21 years of age~~, except medical assistance may not be discontinued for that dependent child under 21 years of age within the ~~six-month~~ 12-month period of extended eligibility until it has been determined that the person is not otherwise eligible for medical assistance. ~~Medical assistance may be continued for an additional six months if the person meets all requirements for the additional six months, according to title XIX of the Social Security Act, as amended by section 303 of the Family Support Act of 1988, Public Law Number 100-485.~~

(b) Beginning July 1, 2002, medical assistance for families and children may be paid for persons who were eligible under section 256B.055, subdivision 3a, paragraph (b), in at least three of six months preceding the month in which the person became ineligible under that section if the ineligibility was due to an increase in hours of employment or employment income or due to the loss of an earned income disregard. A person who is eligible for extended medical assistance is entitled to 12 months of assistance without reapplication, unless the assistance unit ceases to include a dependent child, except medical assistance may not be discontinued for that dependent child under 21 years of age within the 12-month period of extended eligibility until it has been determined that the person is not otherwise eligible for medical assistance.

**[EFFECTIVE DATE.]** This section is effective July 1, 2001.

Sec. 41. Minnesota Statutes 2000, section 256B.0635, subdivision 2, is amended to read:

Subd. 2. [INCREASED CHILD OR SPOUSAL SUPPORT.] ~~Beginning January 1, 1998~~ (a) Until June 30, 2002, medical assistance may be paid for persons who received MFIP-S or medical assistance for families and children in at least three of the six months preceding the month in which the person became ineligible for MFIP-S or medical assistance, if the ineligibility was the result of the collection of child or spousal support under part D of title IV of the Social Security Act. In addition, to receive continued assistance under this section, persons who received medical assistance for families and children but did not receive MFIP-S must have had income less than or equal to the assistance standard for their family size under the state's AFDC plan in effect as of July 16, 1996, ~~as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law Number 104-193~~ increased according to section 256B.056, subdivision 4, at the time medical assistance eligibility began. A person who is eligible for extended medical assistance under this subdivision is entitled to four months of assistance without reapplication, unless the assistance unit ceases to include a dependent child~~. For a person under 21 years of age~~, except medical assistance may not be discontinued for that dependent child under 21 years of age within the four-month period of extended eligibility until it has been determined that the person is not otherwise eligible for medical assistance.

(b) Beginning July 1, 2002, medical assistance for families and children may be paid for persons who were eligible under section 256B.055, subdivision 3a, paragraph (b), in at least three of the six months preceding the month in which the person became ineligible under that section if the ineligibility was the result of the collection of child or spousal support under part D of title IV of the Social Security Act. A person who is eligible for extended medical assistance under this subdivision is entitled to four months of assistance without reapplication, unless the assistance unit ceases to include a dependent child, except medical assistance may not be discontinued for that dependent child under 21 years of age within the four-month period of extended eligibility until it has been determined that the person is not otherwise eligible for medical assistance.

**[EFFECTIVE DATE.]** This section is effective July 1, 2001.

Sec. 42. [256B.0637] [PRESUMPTIVE ELIGIBILITY FOR CERTAIN PERSONS NEEDING TREATMENT FOR BREAST OR CERVICAL CANCER.]

Medical assistance is available during a presumptive eligibility period for persons who meet the criteria in section 256B.057, subdivision 10. For purposes of this section, the presumptive eligibility period begins on the date on which an entity designated by the commissioner determines based on preliminary information that the person meets the criteria in section 256B.057, subdivision 10. The presumptive eligibility period ends on the day on which a determination is made as to the person's eligibility, except that if an application is not submitted by the last day of the month following the month during which the determination based on preliminary information is made, the presumptive eligibility period ends on that last day of the month.

Sec. 43. Minnesota Statutes 2000, section 256B.0644, is amended to read:

256B.0644 [PARTICIPATION REQUIRED FOR REIMBURSEMENT UNDER OTHER STATE HEALTH CARE PROGRAMS.]

A vendor of medical care, as defined in section 256B.02, subdivision 7, and a health maintenance organization, as defined in chapter 62D, must participate as a provider or contractor in the medical assistance program, general assistance medical care program, and MinnesotaCare as a condition of participating as a provider in health insurance plans and programs or contractor for state employees established under section 43A.18, the public employees insurance program under section 43A.316, for health insurance plans offered to local statutory or home rule charter city, county, and school district employees, the workers' compensation system under section 176.135, and insurance plans provided through the Minnesota comprehensive health association under sections 62E.01 to 62E.19. The limitations on insurance plans offered to local government employees shall not be applicable in geographic areas where provider participation is limited by

managed care contracts with the department of human services. For providers other than health maintenance organizations, participation in the medical assistance program means that (1) the provider accepts new medical assistance, general assistance medical care, and MinnesotaCare patients or (2) at least 20 percent of the provider's patients are covered by medical assistance, general assistance medical care, and MinnesotaCare as their primary source of coverage. Patients seen on a volunteer basis by the provider at a location other than the provider's usual place of practice may be considered in meeting this participation requirement. The commissioner shall establish participation requirements for health maintenance organizations. The commissioner shall provide lists of participating medical assistance providers on a quarterly basis to the commissioner of employee relations, the commissioner of labor and industry, and the commissioner of commerce. Each of the commissioners shall develop and implement procedures to exclude as participating providers in the program or programs under their jurisdiction those providers who do not participate in the medical assistance program. The commissioner of employee relations shall implement this section through contracts with participating health and dental carriers.

Sec. 44. Minnesota Statutes 2000, section 256B.0913, subdivision 12, is amended to read:

Subd. 12. [CLIENT PREMIUMS.] (a) A premium is required for all 180-day eligible clients to help pay for the cost of participating in the program. The amount of the premium for the alternative care client shall be determined as follows:

(1) when the alternative care client's income less recurring and predictable medical expenses is greater than the medical assistance income standard but less than 150 percent of the federal poverty guideline, and total assets are less than $10,000, the fee is zero;

(2) when the alternative care client's income less recurring and predictable medical expenses is greater than 150 percent of the federal poverty guideline, and total assets are less than $10,000, the fee is 25 percent of the cost of alternative care services or the difference between 150 percent of the federal poverty guideline and the client's income less recurring and predictable medical expenses, whichever is less; and

(3) when the alternative care client's total assets are greater than $10,000, the fee is 25 percent of the cost of alternative care services.

For married persons, total assets are defined as the total marital assets less the estimated community spouse asset allowance, under section 256B.059, if applicable. For married persons, total income is defined as the client's income less the monthly spousal allotment, under section 256B.058.

All alternative care services except case management shall be included in the estimated costs for the purpose of determining 25 percent of the costs.

The monthly premium shall be calculated based on the cost of the first full month of alternative care services and shall continue unaltered until the next reassessment is completed or at the end of 12 months, whichever comes first. Premiums are due and payable each month alternative care services are received unless the actual cost of the services is less than the premium.

(b) The fee shall be waived by the commissioner when:

(1) a person who is residing in a nursing facility is receiving case management only;

(2) a person is applying for medical assistance;

(3) a married couple is requesting an asset assessment under the spousal impoverishment provisions;

(4) a person is a medical assistance recipient, but has been approved for alternative care-funded assisted living services;

(5) a person is found eligible for alternative care, but is not yet receiving alternative care services; or

(6) a person's fee under paragraph (a) is less than $25.

(c) The county agency must record in the state's receivable system the client's assessed premium amount or the reason the premium has been waived. The commissioner will bill and collect the premium from the client ~~and forward the amounts collected to the commissioner in the manner and at the times prescribed by the commissioner~~. Money collected must be deposited in the general fund and is appropriated to the commissioner for the alternative care program. The client must supply the county with the client's social security number at the time of application. ~~If a client fails or refuses to pay the premium due,~~ The county shall supply the commissioner with the client's social security number and other information the commissioner requires to collect the premium from the client. The commissioner shall collect unpaid premiums using the Revenue Recapture Act in chapter 270A and other methods available to the commissioner. The commissioner may require counties to inform clients of the collection procedures that may be used by the state if a premium is not paid. This paragraph does not apply to alternative care pilot projects authorized in Laws 1993, First Special Session chapter 1, article 5, section 133, if a county operating under the pilot project reports the following dollar amounts to the commissioner quarterly:

(1) total premiums billed to clients;

(2) total collections of premiums billed; and

(3) balance of premiums owed by clients.

If a county does not adhere to these reporting requirements, the commissioner may terminate the billing, collecting, and remitting portions of the pilot project and require the county involved to operate under the procedures set forth in this paragraph.

(d) The commissioner shall begin to adopt emergency or permanent rules governing client premiums within 30 days after July 1, 1991, including criteria for determining when services to a client must be terminated due to failure to pay a premium.

Sec. 45. Minnesota Statutes 2000, section 256B.0913, subdivision 14, is amended to read:

Subd. 14. [REIMBURSEMENT AND RATE ADJUSTMENTS.] (a) Reimbursement for expenditures for the alternative care services as approved by the client's case manager shall be through the invoice processing procedures of the department's Medicaid Management Information System (MMIS). To receive reimbursement, the county or vendor must submit invoices within 12 months following the date of service. The county agency and its vendors under contract shall not be reimbursed for services which exceed the county allocation.

(b) ~~If a county collects less than 50 percent of the client premiums due under subdivision 12, the commissioner may withhold up to three percent of the county's final alternative care program allocation determined under subdivisions 10 and 11.~~

~~(c)~~ The county shall negotiate individual rates with vendors and may be reimbursed for actual costs up to the greater of the county's current approved rate or 60 percent of the maximum rate in fiscal year 1994 and 65 percent of the maximum rate in fiscal year 1995 for each alternative care service. Notwithstanding any other rule or statutory provision to the contrary, the commissioner shall not be authorized to increase rates by an annual inflation factor, unless so authorized by the legislature.

~~(d)~~ (c) On July 1, 1993, the commissioner shall increase the maximum rate for home delivered meals to $4.50 per meal.

Sec. 46. [256B.0924] [TARGETED CASE MANAGEMENT SERVICES FOR VULNERABLE ADULTS AND PERSONS WITH DEVELOPMENTAL DISABILITIES.]

Subdivision 1. [PURPOSE.] The state recognizes that targeted case management services can decrease the need for more costly services such as multiple emergency room visits or hospitalizations by linking eligible individuals with less costly services available in the community.

Subd. 2. [DEFINITIONS.] For purposes of this section, the following terms have the meanings given:

(a) "Targeted case management" means services which will assist medical assistance eligible persons to gain access to needed medical, social, educational, and other services. Targeted case management does not include therapy, treatment, legal, or outreach services.

(b) "Targeted case management for adults" means activities that coordinate and link social and other services designed to help eligible persons gain access to needed protective services, social, health care, mental health, habilitative, educational, vocational, recreational, advocacy, legal, chemical, health, and other related services.

Subd. 3. [ELIGIBILITY.] Persons are eligible to receive targeted case management services under this section if the requirements in paragraphs (a) and (b) are met.

(a) The person must be assessed and determined by the local county agency to:

(1) be age 18 or older;

(2) be receiving medical assistance;

(3) have significant functional limitations; and

(4) be in need of service coordination to attain or maintain living in an integrated community setting.

(b) The person must be a vulnerable adult in need of adult protection as defined in section 626.5572, or is an adult with mental retardation as defined in section 252A.02, subdivision 2, or a related condition as defined in section 252.27, subdivision 1a, and is not receiving home and community-based waiver services.

Subd. 4. [TARGETED CASE MANAGEMENT SERVICE ACTIVITIES.] (a) For persons with mental retardation or a related condition, targeted case management services must meet the provisions of section 256B.092.

(b) For persons not eligible as a person with mental retardation or a related condition, targeted case management service activities include:

(1) an assessment of the person’s need for targeted case management services;

(2) the development of a written personal service plan;

(3) a regular review and revision of the written personal service plan with the recipient and the recipient’s legal representative, and others as identified by the recipient, to ensure access to necessary services and supports identified in the plan;

(4) effective communication with the recipient and the recipient’s legal representative and others identified by the recipient;

(5) coordination of referrals for needed services with qualified providers;

(6) coordination and monitoring of the overall service delivery to ensure the quality and effectiveness of services;

(7) assistance to the recipient and the recipient’s legal representative to help make an informed choice of services;

(8) advocating on behalf of the recipient when service barriers are encountered or referring the recipient and the recipient’s legal representative to an independent advocate;

(9) monitoring and evaluating services identified in the personal service plan to ensure personal outcomes are met and to ensure satisfaction with services and service delivery;

(10) conducting face-to-face monitoring with the recipient at least twice a year;

(11) completing and maintain necessary documentation that supports verifies the activities in this section;

(12) coordinating with the medical assistance facility discharge planner in the 180-day period prior to the recipient's discharge into the community; and

(13) a personal service plan developed and reviewed at least annually with the recipient and the recipient's legal representative. The personal service plan must be revised when there is a change in the recipient's status. The personal service plan must identify:

(i) the desired personal short and long-term outcomes;

(ii) the recipient's preferences for services and supports, including development of a person-centered plan if requested; and

(iii) formal and informal services and supports based on areas of assessment, such as: social, health, mental health, residence, family, educational and vocational, safety, legal, self-determination, financial, and chemical health as determined by the recipient and the recipient's legal representative and the recipient's support network.

Subd. 5. [PROVIDER STANDARDS.] County boards or providers who contract with the county are eligible to receive medical assistance reimbursement for adult targeted case management services. To qualify as a provider of targeted case management services the vendor must:

(1) have demonstrated the capacity and experience to provide the activities of case management services defined in subdivision 4;

(2) be able to coordinate and link community resources needed by the recipient;

(3) have the administrative capacity and experience to serve the eligible population in providing services and to ensure quality of services under state and federal requirements;

(4) have a financial management system that provides accurate documentation of services and costs under state and federal requirements;

(5) have the capacity to document and maintain individual case records complying with state and federal requirements;

(6) coordinate with county social service agencies responsible for planning for community social services under chapters 256E and 256F; conducting adult protective investigations under section 626.557, and conducting prepetition screenings for commitments under section 253B.07;

(7) coordinate with health care providers to ensure access to necessary health care services;

(8) have a procedure in place that notifies the recipient and the recipient's legal representative of any conflict of interest if the contracted targeted case management service provider also provides the recipient's services and supports and provides information on all potential conflicts of interest and obtains the recipient's informed consent and provides the recipient with alternatives; and

(9) have demonstrated the capacity to achieve the following performance outcomes: access, quality, and consumer satisfaction.

Subd. 6. [PAYMENT FOR TARGETED CASE MANAGEMENT.] (a) Medical assistance and MinnesotaCare payment for targeted case management shall be made on a monthly basis. In order to receive payment for an eligible adult, the provider must document at least one contact per month and not more than two consecutive months without a face-to-face contact with the adult or the adult's legal representative.

(b) Payment for targeted case management provided by county staff under this subdivision shall be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph (b), calculated as one combined average rate together with adult mental health case management under section 256B.0625, subdivision 20. Billing and payment must identify the recipient's primary population group to allow tracking of revenues.

(c) Payment for targeted case management provided by county-contracted vendors shall be based on a monthly rate negotiated by the host county. The negotiated rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the county may negotiate a team rate with a vendor who is a member of the team. The team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county, except to reimburse the county for advance funding provided by the county to the vendor.

(d) If the service is provided by a team that includes contracted vendors and county staff, the costs for county staff participation on the team shall be included in the rate for county-provided services. In this case, the contracted vendor and the county may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services, the county must document, in the recipient's file, the need for team targeted case management and a description of the different roles of the team members.

(e) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for targeted case management shall be provided by the recipient's county of responsibility, as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds used to match other federal funds.

(f) The commissioner may suspend, reduce, or terminate reimbursement to a provider that does not meet the reporting or other requirements of this section. The county of responsibility, as defined in sections 256G.01 to 256G.12, is responsible for any federal disallowances. The county may share this responsibility with its contracted vendors.

(g) The commissioner shall set aside five percent of the federal funds received under this section for use in reimbursing the state for costs of developing and implementing this section.

(h) Notwithstanding section 256.025, subdivision 2, payments to counties for targeted case management expenditures under this section shall only be made from federal earnings from services provided under this section. Payments to contracted vendors shall include both the federal earnings and the county share.

(i) Notwithstanding section 256B.041, county payments for the cost of case management services provided by county staff shall not be made to the state treasurer. For the purposes of targeted case management services provided by county staff under this section, the centralized disbursement of payments to counties under section 256B.041 consists only of federal earnings from services provided under this section.

(j) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital, and the recipient's institutional care is paid by medical assistance, payment for targeted case management services under this subdivision is limited to the last 180 days of the recipient's residency in that facility and may not exceed more than six months in a calendar year.

(k) Payment for targeted case management services under this subdivision shall not duplicate payments made under other program authorities for the same purpose.

(l) Any growth in targeted case management services and cost increases under this section shall be the responsibility of the counties.

Subd. 7. [IMPLEMENTATION AND EVALUATION.] The commissioner of human services in consultation with county boards shall establish a program to accomplish the provisions of subdivisions 1 to 6. The commissioner in consultation with county boards shall establish performance measures to evaluate the effectiveness of the targeted case management services. If a county fails to meet agreed upon performance measures, the commissioner may authorize

contracted providers other than the county. Providers contracted by the commissioner shall also be subject to the standards in subdivision 6.

Sec. 47. [256B.0948] [TARGETED CASE MANAGEMENT SERVICES FOR CHILDREN UNDER THE AGE OF 19.]

Subdivision 1. [ELIGIBILITY.] An eligible recipient must:

(1) be under the age of 19;

(2) be enrolled in medical assistance or MinnesotaCare;

(3) have had at least one previous birth; and

(4) not receiving any other form of targeted case management or case management through home and community-based waiver services.

Subd. 2. [SCOPE.] "Targeted case management services" means the coordination or implementation of social, health, educational, counseling, or other services designed to ensure continued social support to the recipient to prevent or delay a subsequent pregnancy.

Subd. 3. [ELIGIBLE SERVICES.] (a) Case management services include:

(1) assessing the recipient's need for medical, social, educational, and other related services;

(2) coordinating health, social, educational, and vocational needs with community-based services and programs;

(3) providing counseling services, including mentoring, academic support, after-school enrichment, and healthy lifestyle practices;

(4) monitoring the needs of the recipient on a regular basis to ensure continued support; and

(5) promoting positive parenting.

(b) These services shall be provided to the recipient on a one-to-one basis, in the recipient's home, community setting, or in groups.

(c) Payment shall be made on a monthly basis. In order to receive payment, a provider must document at least a face-to-face contact with the recipient.

Subd. 4. [INDIVIDUAL SUPPORT PLAN.] Providers must develop and implement an individual support plan for each recipient. The plan must include concrete, measurable goals to be achieved and specific objectives directed toward the achievement of each goal. The plan must indicate how collaboration with other services will occur.

Subd. 5. [TARGET POPULATION.] The commissioner shall contract with qualified case managers to provide targeted case management services. The contract will further define the target population, covered case management services, payment rates, and provider qualifications to ensure that annual spending, including related administrative costs for the nonfederal share of the cost is within the amount appropriated for this purpose.

**[EFFECTIVE DATE.]** This section is effective on January 1, 2002, or upon federal approval, whichever is later.

Sec. 48. [256B.195] [ADDITIONAL INTERGOVERNMENTAL TRANSFERS; HOSPITAL PAYMENTS.]

Subdivision 1. [FEDERAL APPROVAL REQUIRED.] Section 256.969, subdivision 26, and this section are contingent on federal approval of the intergovernmental transfers and payments to safety net hospitals authorized under this section.

Subd. 2. [PAYMENTS FROM GOVERNMENTAL HOSPITALS.] In addition to any payment

required under section 256B.19, effective July 15, 2001, the following government entities shall make the payments indicated before noon on the 15th of each month:

(1) Hennepin county, $1,883,000; and

(2) Ramsey county, $696,450.

These sums shall be part of the designated governmental unit's portion of the nonfederal share of medical assistance costs.

Subd. 3. [PAYMENTS TO CERTAIN SAFETY NET HOSPITALS.] (a) Effective July 15, 2001, the commissioner shall make the following payments to the hospitals indicated after noon on the 15th of each month:

(1) to Hennepin county medical center, $3,218,000, of which $1,883,000 is to offset the amount of the transfer under subdivision 2 and $1,335,000 is to increase payments for medical assistance admissions; and

(2) to Regions hospital, $1,190,250, of which $696,450 is to offset the amount of the transfer under subdivision 2 and $493,800 is to increase payments for medical assistance admissions.

(b) This section and section 256.969, subdivision 26, shall apply to fee-for-service payments only and shall not increase capitation payments or payments made based on average rates.

(c) Medical assistance rate or payment changes required to obtain federal financial participation under section 62J.692, subdivision 8, shall precede the determination of intergovernmental transfer amounts determined in this subdivision. Participation in the intergovernmental transfer program shall not result in the offset of any health care provider's receipt of medical assistance payment increases other than limits on rates and payments.

Subd. 4. [ADJUSTMENTS PERMITTED.] (a) The commissioner may adjust the intergovernmental transfers under subdivision 2 and the hospital payments under subdivision 3, after consultation with the nonstate government entities named in this section, based on the commissioner's determination of Medicare upper payment limits and hospital-specific limitations on disproportionate share payments.

(b) The ratio of medical assistance payments specified in subdivision 3 to the intergovernmental transfers specified in subdivision 2 shall not be reduced below 170 percent unless a further reduction is required to preserve state budget neutrality.

(c) If the federal rules regarding the establishment of the 150 percent upper payment limit for certain nonstate public hospitals are rescinded, or if the upper payment limit is otherwise reduced to 100 percent, the ratio of intergovernmental transfers and medical assistance payments among the participating entities named in this section shall be adjusted based on the proportion of medical assistance inpatient hospital admissions from the third previous rate year provided by each participating hospital, and paragraph (b) shall not apply.

Subd. 5. [INCLUSION OF FAIRVIEW UNIVERSITY MEDICAL CENTER.] Upon federal approval of the inclusion of Fairview university medical center in the nonstate government category, the commissioner shall establish an intergovernmental transfer with the University of Minnesota in an amount determined by the commissioner based on the increase in the Medicare upper payment limit due solely to the inclusion of Fairview university medical center as a nonstate government hospital and the amount available under the hospital specific disproportionate share limit. All of the proceeds of the transfer shall be used to increase payments to Fairview university medical center for medical assistance admissions. From this payment, Fairview university medical center shall pay to the University of Minnesota the cost of the transfer on the same day the payment is received.

Sec. 49. [256B.53] [DENTAL ACCESS GRANTS.]

(a) The commissioner shall award grants to community clinics or other nonprofit community

organizations, political subdivisions, professional associations, or other organizations that demonstrate the ability to provide dental services effectively to public program recipients. Grants may be used to fund the costs related to coordinating access for recipients, developing and implementing patient care criteria, upgrading or establishing new facilities, acquiring furnishings or equipment, recruiting new providers, or other development costs that will improve access to dental care in a region.

(b) In awarding grants, the commissioner shall give priority to applicants that plan to serve areas of the state in which the number of dental providers is not currently sufficient to meet the needs of recipients of public programs or uninsured individuals. The commissioner shall consider the following in awarding the grants:

(1) potential to successfully increase access to an underserved population;

(2) the long-term viability of the project to improve access beyond the period of initial funding;

(3) the efficiency in the use of the funding; and

(4) the experience of the applicants in providing services to the target population.

(c) The commissioner shall consider grants for the following:

(1) implementation of new programs or continued expansion of current access programs that have demonstrated success in providing dental services in underserved areas;

(2) a program for mobile or other types of outreach dental clinics in underserved geographic areas;

(3) a program for school-based dental clinics in schools with high numbers of children receiving medical assistance;

(4) a program testing new models of care that are sensitive to the cultural needs of the recipients;

(5) a program creating new educational campaigns that inform individuals of the importance of good oral health and the link between dental disease and overall health status;

(6) a program that organizes a network of volunteer dentists to provide dental services to public program recipients or uninsured individuals; and

(7) a program that tests new delivery models by creating partnerships between local providers and county public health agencies.

(d) The commissioner shall evaluate the effects of the dental access initiatives funded through the dental access grants and submit a report to the legislature by January 15, 2003.

Sec. 50. [256B.55] [DENTAL ACCESS ADVISORY COMMITTEE.]

Subdivision 1. [ESTABLISHMENT.] The commissioner shall establish a dental access advisory committee to monitor the purchasing, administration, and coverage of dental care services for the public health care programs to ensure dental care access and quality for public program recipients.

Subd. 2. [MEMBERSHIP.] (a) The membership of the advisory committee shall include, but is not limited to, representatives of dentists, including a dentist practicing in the seven-county metropolitan area and a dentist practicing outside the seven-county metropolitan area; oral surgeons; pediatric dentists; dental hygienists; community clinics; client advocacy groups; public health; health service plans; the University of Minnesota school of dentistry and the department of pediatrics; and the commissioner of health.

(b) The advisory committee is governed by section 15.059 for membership terms and removal of members.

Subd. 3. [DUTIES.] The advisory committee shall provide recommendations on the following:

(1) how to reduce the administrative burden governing dental care coverage policies in order to promote administrative simplification, including prior authorization, coverage limits, and co-payment collections;

(2) developing and implementing an action plan to improve the oral health of children and persons with special needs in the state;

(3) exploring alternative ways of purchasing and improving access to dental services;

(4) developing ways to foster greater responsibility among health care program recipients in seeking and obtaining dental care, including initiatives to keep dental appointments and comply with dental care plans;

(5) exploring innovative ways for dental providers to schedule public program patients in order to reduce or minimize the effect of appointment no shows;

(6) exploring ways to meet the barriers that may be present in providing dental services to health care program recipients such as language, culture, disability, and lack of transportation; and

(7) exploring the possibility of pediatricians, family physicians, and nurse practitioners providing basic oral health screenings and basic preventive dental services.

Subd. 4. [REPORT.] The commissioner shall submit a report by February 1, 2002, and by February 1, 2003, summarizing the activities and recommendations of the advisory committee.

Subd. 5. [SUNSET.] Notwithstanding section 15.059, subdivision 5, this section expires June 30, 2003.

Sec. 51. Minnesota Statutes 2000, section 256B.69, subdivision 4, is amended to read:

Subd. 4. [LIMITATION OF CHOICE.] (a) The commissioner shall develop criteria to determine when limitation of choice may be implemented in the experimental counties. The criteria shall ensure that all eligible individuals in the county have continuing access to the full range of medical assistance services as specified in subdivision 6.

(b) The commissioner shall exempt the following persons from participation in the project, in addition to those who do not meet the criteria for limitation of choice:

(1) persons eligible for medical assistance according to section 256B.055, subdivision 1;

(2) persons eligible for medical assistance due to blindness or disability as determined by the social security administration or the state medical review team, unless:

(i) they are 65 years of age or older~~,~~; or

(ii) they reside in Itasca county or they reside in a county in which the commissioner conducts a pilot project under a waiver granted pursuant to section 1115 of the Social Security Act;

(3) recipients who currently have private coverage through a health maintenance organization;

(4) recipients who are eligible for medical assistance by spending down excess income for medical expenses other than the nursing facility per diem expense;

(5) recipients who receive benefits under the Refugee Assistance Program, established under United States Code, title 8, section 1522(e);

(6) children who are both determined to be severely emotionally disturbed and receiving case management services according to section 256B.0625, subdivision 20; ~~and~~

(7) adults who are both determined to be seriously and persistently mentally ill and received case management services according to section 256B.0625, subdivision 20; and

(8) persons eligible for medical assistance according to section 256B.057, subdivision 10. Children under age 21 who are in foster placement may enroll in the project on an elective basis. Individuals excluded under clauses (6) and (7) may choose to enroll on an elective basis.

(c) When a child enrolled with a demonstration provider has been identified as receiving mental health services in an alternative school, the alternative school shall notify the commissioner and the child's county of financial responsibility. The commissioner, in coordination with the county, shall determine whether the child qualifies under paragraph (b) for exclusion from participation in the demonstration project. If the child qualifies, the county shall contact the child's parent or guardian and offer the option for the child to be excluded from the demonstration project.

(d) The commissioner may allow persons with a one-month spenddown who are otherwise eligible to enroll to voluntarily enroll or remain enrolled, if they elect to prepay their monthly spenddown to the state.

(e) ~~Beginning on or after July 1, 1997,~~ The commissioner may require those individuals to enroll in the prepaid medical assistance program who otherwise would have been excluded under paragraph (b), clauses (1) ~~and~~, (3), and (8), and under Minnesota Rules, part 9500.1452, subpart 2, items H, K, and L.

(f) Before limitation of choice is implemented, eligible individuals shall be notified and after notification, shall be allowed to choose only among demonstration providers. The commissioner may assign an individual with private coverage through a health maintenance organization, to the same health maintenance organization for medical assistance coverage, if the health maintenance organization is under contract for medical assistance in the individual's county of residence. After initially choosing a provider, the recipient is allowed to change that choice only at specified times as allowed by the commissioner. If a demonstration provider ends participation in the project for any reason, a recipient enrolled with that provider must select a new provider but may change providers without cause once more within the first 60 days after enrollment with the second provider.

**[EFFECTIVE DATE.]** Paragraph (c) of this section is effective the day following final enactment.

Sec. 52. Minnesota Statutes 2000, section 256B.69, subdivision 5c, is amended to read:

Subd. 5c. [MEDICAL EDUCATION AND RESEARCH FUND.] (a) Beginning in January 1999 and each year thereafter:

(1) the commissioner of human services shall transfer an amount equal to the reduction in the prepaid medical assistance and prepaid general assistance medical care payments resulting from clause (2), excluding nursing facility and elderly waiver payments and demonstration projects operating under subdivision 23, and an amount totaling the amount identified in clauses (3) and (4) to the medical education and research fund established under section 62J.692;

(2) until January 1, 2002, the county medical assistance and general assistance medical care capitation base rate prior to plan specific adjustments and after the regional rate adjustments under section 256B.69, subdivision 5b, shall be reduced 6.3 percent for Hennepin county, two percent for the remaining metropolitan counties, and no reduction for nonmetropolitan Minnesota counties; and after January 1, 2002, the county medical assistance and general assistance medical care capitation base rate prior to plan specific adjustments shall be reduced 6.3 percent for Hennepin county, two percent for the remaining metropolitan counties, and 1.6 percent for nonmetropolitan Minnesota counties; ~~and~~

(3) effective July 1, 2001, the amount transferred under section 62J.694, subdivision 2, paragraph (d), to increase the capitation rates plus any federal matching funds;

(4) effective July 1, 2001, $600,000 from the capitation rates paid under this section plus any federal matching funds on this amount; and

(5) the amount calculated under clause (1) shall not be adjusted for subsequent changes to the capitation payments for periods already paid.

(b) This subdivision shall be effective upon approval of a federal waiver which allows federal financial participation in the medical education and research fund.

Sec. 53. Minnesota Statutes 2000, section 256B.69, is amended by adding a subdivision to read:

Subd. 6c. [DENTAL SERVICES DEMONSTRATION PROJECT.] The commissioner shall establish a dental services demonstration project in Crow Wing, Todd, Morrison, Wadena, and Cass counties for provision of dental services to medical assistance, general assistance medical care, and MinnesotaCare recipients. The commissioner may contract on a prospective per capita payment basis for these dental services with an organization licensed under chapter 62C, 62D, or 62N in accordance with section 256B.037 or may establish and administer a fee-for-service system for the reimbursement of dental services.

Sec. 54. Minnesota Statutes 2000, section 256B.69, subdivision 23, is amended to read:

Subd. 23. [ALTERNATIVE INTEGRATED LONG-TERM CARE SERVICES; ELDERLY AND DISABLED PERSONS.] (a) The commissioner may implement demonstration projects to create alternative integrated delivery systems for acute and long-term care services to elderly persons and persons with disabilities as defined in section 256B.77, subdivision 7a, that provide increased coordination, improve access to quality services, and mitigate future cost increases. The commissioner may seek federal authority to combine Medicare and Medicaid capitation payments for the purpose of such demonstrations. Medicare funds and services shall be administered according to the terms and conditions of the federal waiver and demonstration provisions. For the purpose of administering medical assistance funds, demonstrations under this subdivision are subject to subdivisions 1 to 22. The provisions of Minnesota Rules, parts 9500.1450 to 9500.1464, apply to these demonstrations, with the exceptions of parts 9500.1452, subpart 2, item B; and 9500.1457, subpart 1, items B and C, which do not apply to persons enrolling in demonstrations under this section. An initial open enrollment period may be provided. Persons who disenroll from demonstrations under this subdivision remain subject to Minnesota Rules, parts 9500.1450 to 9500.1464. When a person is enrolled in a health plan under these demonstrations and the health plan's participation is subsequently terminated for any reason, the person shall be provided an opportunity to select a new health plan and shall have the right to change health plans within the first 60 days of enrollment in the second health plan. Persons required to participate in health plans under this section who fail to make a choice of health plan shall not be randomly assigned to health plans under these demonstrations. Notwithstanding section 256L.12, subdivision 5, and Minnesota Rules, part 9505.5220, subpart 1, item A, if adopted, for the purpose of demonstrations under this subdivision, the commissioner may contract with managed care organizations, including counties, to serve only elderly persons eligible for medical assistance, elderly and disabled persons, or disabled persons only. For persons with primary diagnoses of mental retardation or a related condition, serious and persistent mental illness, or serious emotional disturbance, the commissioner must ensure that the county authority has approved the demonstration and contracting design. Enrollment in these projects for persons with disabilities shall be voluntary ~~until July 1, 2001~~. The commissioner shall not implement any demonstration project under this subdivision for persons with primary diagnoses of mental retardation or a related condition, serious and persistent mental illness, or serious emotional disturbance, without approval of the county board of the county in which the demonstration is being implemented.

Before implementation of a demonstration project for disabled persons, the commissioner must provide information to appropriate committees of the house of representatives and senate and must involve representatives of affected disability groups in the design of the demonstration projects.

(b) A nursing facility reimbursed under the alternative reimbursement methodology in section 256B.434 may, in collaboration with a hospital, clinic, or other health care entity provide services under paragraph (a). The commissioner shall amend the state plan and seek any federal waivers necessary to implement this paragraph.

Sec. 55. Minnesota Statutes 2000, section 256B.75, is amended to read:

256B.75 [HOSPITAL OUTPATIENT REIMBURSEMENT.]

(a) For outpatient hospital facility fee payments for services rendered on or after October 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge, or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for which there is a federal maximum allowable payment. Effective for services rendered on or after January 1, 2000, payment rates for nonsurgical outpatient hospital facility fees and emergency room facility fees shall be increased by eight percent over the rates in effect on December 31, 1999, except for those services for which there is a federal maximum allowable payment. Services for which there is a federal maximum allowable payment shall be paid at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare upper limit. If it is determined that a provision of this section conflicts with existing or future requirements of the United States government with respect to federal financial participation in medical assistance, the federal requirements prevail. The commissioner may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial participation resulting from rates that are in excess of the Medicare upper limitations.

(b) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory surgery hospital facility fee services for critical access hospitals designated under section 144.1483, clause (11), shall be paid on a cost-based payment system that is based on the cost-finding methods and allowable costs of the Medicare program.

(c) Effective for services provided on or after July 1, 2002, rates that are based on the Medicare outpatient prospective payment system shall be replaced by a budget neutral prospective payment system that is derived using medical assistance data. The commissioner shall provide a proposal to the 2002 legislature to define and implement this provision.

Sec. 56. Minnesota Statutes 2000, section 256B.76, is amended to read:

256B.76 [PHYSICIAN AND DENTAL REIMBURSEMENT.]

(a) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for physician services as follows:

(1) payment for level one Health Care Finance Administration's common procedural coding system (HCPCS) codes titled "office and other outpatient services," "preventive medicine new and established patient," "delivery, antepartum, and postpartum care," "critical care," ~~Caesarean~~ cesarean delivery and pharmacologic management provided to psychiatric patients, and HCPCS level three codes for enhanced services for prenatal high risk, shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992. If the rate on any procedure code within these categories is different than the rate that would have been paid under the methodology in section 256B.74, subdivision 2, then the larger rate shall be paid;

(2) payments for all other services shall be paid at the lower of (i) submitted charges, or (ii) 15.4 percent above the rate in effect on June 30, 1992;

(3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases except that payment rates for home health agency services shall be the rates in effect on September 30, 1992;

(4) effective for services rendered on or after January 1, 2000, payment rates for physician and professional services shall be increased by three percent over the rates in effect on December 31, 1999, except for home health agency and family planning agency services; and

(5) the increases in clause (4) shall be implemented January 1, 2000, for managed care.

(b) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for dental services as follows:

(1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992;

(2) dental rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases;

(3) effective for services rendered on or after January 1, 2000, payment rates for dental services shall be increased by three percent over the rates in effect on December 31, 1999;

(4) ~~the commissioner shall award grants to community clinics or other nonprofit community organizations, political subdivisions, professional associations, or other organizations that demonstrate the ability to provide dental services effectively to public program recipients. Grants may be used to fund the costs related to coordinating access for recipients, developing and implementing patient care criteria, upgrading or establishing new facilities, acquiring furnishings or equipment, recruiting new providers, or other development costs that will improve access to dental care in a region. In awarding grants, the commissioner shall give priority to applicants that plan to serve areas of the state in which the number of dental providers is not currently sufficient to meet the needs of recipients of public programs or uninsured individuals. The commissioner shall consider the following in awarding the grants: (i) potential to successfully increase access to an underserved population; (ii) the ability to raise matching funds; (iii) the long-term viability of the project to improve access beyond the period of initial funding; (iv) the efficiency in the use of the funding; and (v) the experience of the proposers in providing services to the target population.~~

~~The commissioner shall monitor the grants and may terminate a grant if the grantee does not increase dental access for public program recipients. The commissioner shall consider grants for the following:~~

~~(i) implementation of new programs or continued expansion of current access programs that have demonstrated success in providing dental services in underserved areas;~~

~~(ii) a pilot program for utilizing hygienists outside of a traditional dental office to provide dental hygiene services; and~~

~~(iii) a program that organizes a network of volunteer dentists, establishes a system to refer eligible individuals to volunteer dentists, and through that network provides donated dental care services to public program recipients or uninsured individuals.~~

~~(5)~~ beginning October 1, 1999, the payment for tooth sealants and fluoride treatments shall be the lower of (i) submitted charge, or (ii) 80 percent of median 1997 charges; ~~and~~

~~(6)~~ (5) the increases listed in clauses (3) and ~~(5)~~ (4) shall be implemented January 1, 2000, for managed care;

(6) effective for services provided on or after January 1, 2002, payment for diagnostic examinations and dental x-rays provided to children under age 21 shall be the lower of:

(i) the submitted charge; or

(ii) 70 percent of median 1999 charges; and

(7) a dental provider shall be reimbursed for the dental services actually provided to a patient when the dental work scheduled requires more than one appointment and the patient fails to keep the subsequent appointment or appointments.

(c) Effective for dental services provided on or after January 1, 2002, the commissioner may increase reimbursement to dentists or dental clinics designated by the commissioner as critical access providers. The commissioner may increase reimbursement to a critical access provider by up to 30 percent more than would otherwise be paid to that provider. In determining critical access provider status, the commissioner shall review:

(1) the utilization rate for dental services by Minnesota health care program patients in the service area;

(2) the level of service provided to Minnesota health care program patients by the dentist or dental clinic; and

(3) whether the level of services provided by the dentist or clinic is critical to maintaining an adequate level of access for patients in the service area.

If no provider in a service area is designated a critical access provider upon review, the commissioner may designate a dentist or dental clinic as a critical access provider if the dentist or clinic is willing to provide care to Minnesota health care program patients at a level that significantly increases access to dental care within the service area. The commissioner shall adjust payments to prepaid health plans to reflect increased reimbursement to critical access providers under this paragraph effective January 1, 2002.

(d) An entity that operates both a Medicare certified comprehensive outpatient rehabilitation facility and a facility which was certified prior to January 1, 1993, that is licensed under Minnesota Rules, parts 9570.2000 to 9570.3600, and for whom at least 33 percent of the clients receiving rehabilitation services and mental health services in the most recent calendar year are medical assistance recipients, shall be reimbursed by the commissioner for rehabilitation services and mental health services at rates that are 38 percent greater than the maximum reimbursement rate allowed under paragraph (a), clause (2), when those services are (1) provided within the comprehensive outpatient rehabilitation facility and (2) provided to residents of nursing facilities owned by the entity.

Sec. 57. [256B.78] [MEDICAL ASSISTANCE DEMONSTRATION PROJECT FOR FAMILY PLANNING SERVICES.]

(a) The commissioner of human services shall establish a medical assistance demonstration project to determine whether improved access to coverage of prepregnancy family planning services reduces medical assistance and MFIP costs.

(b) This section is effective upon federal approval of the demonstration project.

Sec. 58. [256B.79] [HEALTH CARE PREVENTIVE SERVICES POOL.]

The commissioner of human services shall create an uncompensated care pool to reimburse community clinics and other health care providers that provide initial health care screenings and preventive care services to children who are uninsured. The commissioner shall establish a process for clinics to apply for reimbursement. As a condition of receiving payment from this pool, the clinic or provider must offer services ranging from providing information up to on-site enrollment.

Sec. 59. Minnesota Statutes 2000, section 256J.31, subdivision 12, is amended to read:

Subd. 12. [RIGHT TO DISCONTINUE CASH ASSISTANCE.] A participant who is not in vendor payment status may discontinue receipt of the cash assistance portion of the MFIP assistance grant and retain eligibility for child care assistance under section 119B.05 ~~and for medical assistance under sections 256B.055, subdivision 3a, and 256B.0635~~. For the months a participant chooses to discontinue the receipt of the cash portion of the MFIP grant, the assistance unit accrues months of eligibility to be applied toward eligibility for child care under section 119B.05 ~~and for medical assistance under sections 256B.055, subdivision 3a, and 256B.0635~~.

**[EFFECTIVE DATE.]** This section is effective July 1, 2002.

Sec. 60. Minnesota Statutes 2000, section 256K.03, subdivision 1, is amended to read:

Subdivision 1. [NOTIFICATION OF PROGRAM.] Except for the provisions in this section, the provisions for the MFIP application process shall be followed. Within two days after receipt of a completed combined application form, the county agency must refer to the provider the applicant who meets the conditions under section 256K.02, and notify the applicant in writing of the program including the following provisions:

(1) notification that, as part of the application process, applicants are required to attend orientation, to be followed immediately by a job search;

(2) the program provider, the date, time, and location of the scheduled program orientation;

(3) the procedures for qualifying for and receiving benefits under the program;

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

(5) the rights, responsibilities, and obligations of participants in the program, including, but not limited to, the grounds for exemptions and deferrals, the consequences for refusing or failing to participate fully, and the appeal process.

**[EFFECTIVE DATE.]** This section is effective July 1, 2002.

Sec. 61. Minnesota Statutes 2000, section 256K.07, is amended to read:

256K.07 [ELIGIBILITY FOR FOOD STAMPS~~, MEDICAL ASSISTANCE,~~ AND CHILD CARE.]

The participant shall be treated as an MFIP recipient for food stamps~~, medical assistance,~~ and child care eligibility purposes. The participant who leaves the program as a result of increased earnings from employment shall be eligible for ~~transitional medical assistance and~~ child care without regard to MFIP receipt in three of the six months preceding ineligibility.

**[EFFECTIVE DATE.]** This section is effective July 1, 2002.

Sec. 62. Minnesota Statutes 2000, section 256L.01, subdivision 4, is amended to read:

Subd. 4. [GROSS INDIVIDUAL OR GROSS FAMILY INCOME.] (a) "Gross individual or gross family income" for ~~farm and~~ nonfarm self-employed means income calculated using as the baseline the adjusted gross income reported on the applicant's federal income tax form for the previous year and adding back in reported depreciation, carryover loss, and net operating loss amounts that apply to the business in which the family is currently engaged.

(b) "Gross individual or gross family income" for farm self-employed means income calculated using as the baseline the adjusted gross income reported on the applicant's federal income tax form for the previous year and adding back in reported depreciation amounts that apply to the business in which the family is currently engaged.

(c) Applicants shall report the most recent financial situation of the family if it has changed from the period of time covered by the federal income tax form. The report may be in the form of percentage increase or decrease.

**[EFFECTIVE DATE.]** This section is effective July 1, 2001, or upon receipt of federal approval, whichever is later.

Sec. 63. Minnesota Statutes 2000, section 256L.04, subdivision 2, is amended to read:

Subd. 2. [COOPERATION IN ESTABLISHING THIRD-PARTY LIABILITY, PATERNITY, AND OTHER MEDICAL SUPPORT.] (a) To be eligible for MinnesotaCare, individuals and families must cooperate with the state agency to identify potentially liable third-party payers and assist the state in obtaining third-party payments. "Cooperation" includes, but is not limited to, identifying any third party who may be liable for care and services provided under MinnesotaCare to the enrollee, providing relevant information to assist the state in pursuing a potentially liable third party, and completing forms necessary to recover third-party payments. For a child through age 18 whose gross family income is equal to or less than 225 percent of the federal poverty guidelines, cooperation also includes providing information about a group health plan in which the child is enrolled or eligible to enroll. If the health plan is determined cost-effective by the state agency and premiums are paid by the state or local agency or there is no cost to the enrollee, the MinnesotaCare enrollee must enroll or remain enrolled in the group health plan, and the commissioner may exempt the enrollee from the requirements of section 256L.12. For purposes of this subdivision, coverage provided by the Minnesota comprehensive health association under chapter 62E shall not be considered group health plan coverage or cost-effective by the state and local agency.

(b) A parent, guardian, relative caretaker, or child enrolled in the MinnesotaCare program must cooperate with the department of human services and the local agency in establishing the paternity of an enrolled child and in obtaining medical care support and payments for the child and any other person for whom the person can legally assign rights, in accordance with applicable laws and rules governing the medical assistance program. A child shall not be ineligible for or disenrolled from the MinnesotaCare program solely because the child's parent, relative caretaker, or guardian fails to cooperate in establishing paternity or obtaining medical support.

**[EFFECTIVE DATE.]** This section is effective July 1, 2002.

Sec. 64. Minnesota Statutes 2000, section 256L.05, subdivision 2, is amended to read:

Subd. 2. [COMMISSIONER'S DUTIES.] The commissioner ~~shall use individuals' social security numbers as identifiers for purposes of administering the plan and conduct data matches to verify income. Applicants shall submit evidence of individual and family income, earned and unearned, such as the most recent income tax return, wage slips, or other documentation that is determined by the commissioner as necessary to verify income eligibility~~ or county agency shall use electronic verification as the primary method of income verification. If there is a discrepancy in the electronic verification, an individual may be required to submit additional verification. In addition, the commissioner shall perform random audits to verify reported income and eligibility. The commissioner may execute data sharing arrangements with the department of revenue and any other governmental agency in order to perform income verification related to eligibility and premium payment under the MinnesotaCare program.

Sec. 65. Minnesota Statutes 2000, section 256L.06, subdivision 3, is amended to read:

Subd. 3. [ADMINISTRATION AND COMMISSIONER'S DUTIES.] (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 changes in enrollee income; 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 annual 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.

(d) Nonpayment of the premium will result in disenrollment from the plan ~~within one calendar month after the due date~~ effective for 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. 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 July 1, 2002.

Sec. 66. Minnesota Statutes 2000, 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, and children who enrolled in the MinnesotaCare program after September 30, 1992, pursuant to Laws 1992, chapter 549, article 4, section 17, who have

maintained continuous coverage in the MinnesotaCare program or medical assistance; and children under two; pregnant women; and children through age 18 who have family gross incomes that are equal to or less than ~~150~~ 225 percent of the federal poverty guidelines are eligible without meeting the requirements of ~~subdivision 2, 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~~ subdivisions 2 and 3.

(b) Families enrolled in MinnesotaCare under section 256L.04, subdivision 1, whose income increases above 275 percent of the federal poverty guidelines, are no longer eligible for the program and shall be disenrolled by the commissioner. Individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases above 175 percent of the federal poverty guidelines 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.

(c) Notwithstanding paragraph (b), individuals and families may remain enrolled in MinnesotaCare if ten percent of their annual income is less than the annual premium for a policy with a $500 deductible available through the Minnesota comprehensive health association. Individuals and families who are no longer eligible for MinnesotaCare under this subdivision shall be given an 18-month notice period from the date that ineligibility is determined before disenrollment.

**[EFFECTIVE DATE.]** This section is effective July 1, 2002.

Sec. 67. Minnesota Statutes 2000, section 256L.07, subdivision 2, is amended to read:

Subd. 2. [MUST NOT HAVE ACCESS TO EMPLOYER-SUBSIDIZED COVERAGE.] (a) To be eligible, a family or individual must not have access to subsidized health coverage through an employer and must not have had access to employer-subsidized coverage through a current employer for 18 months prior to application or reapplication. A family or individual whose employer-subsidized coverage is lost due to an employer terminating health care coverage as an employee benefit during the previous 18 months is not eligible.

(b) This subdivision does not apply to a family or individual who was enrolled in MinnesotaCare within six months or less of reapplication and who no longer has employer-subsidized coverage due to the employer terminating health care coverage as an employee benefit.

(c) For purposes of this ~~requirement~~ subdivision, subsidized health coverage means health coverage for which the employer pays at least ~~50~~ 60 percent of the cost of coverage for the employee or dependent, or a higher percentage as specified by the commissioner. Children are eligible for employer-subsidized coverage through either parent, including the noncustodial parent. The commissioner must treat employer contributions to Internal Revenue Code Section 125 plans and any other employer benefits intended to pay health care costs as qualified employer subsidies toward the cost of health coverage for employees for purposes of this subdivision.

Sec. 68. Minnesota Statutes 2000, 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 civilian health and medical program of the uniformed service, CHAMPUS, are not considered insurance or health coverage for purposes of the four-month requirement described in this subdivision.

(c) For purposes of this subdivision, Medicare Part A or B coverage under title XVIII of the Social Security Act, United States Code, title 42, sections 1395c to 1395w-4, is considered health coverage. An applicant or enrollee may not refuse Medicare coverage to establish eligibility for MinnesotaCare.

(d) 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.

**[EFFECTIVE DATE.]** This section is effective July 1, 2002.

Sec. 69. Minnesota Statutes 2000, section 256L.07, is amended by adding a subdivision to read:

Subd. 5. [EXEMPTION FOR PERSONS WITH CONTINUATION COVERAGE.] (a) Families with children and individuals who apply for the MinnesotaCare program upon termination from continuation coverage required under federal or state law are exempt from the requirements of subdivision 3.

(b) For purposes of paragraph (a), "termination from continuation coverage" means involuntary termination for any reason, other than premium nonpayment by the family or individual, including termination due to reaching the end of the maximum period for continuation coverage required under federal or state law.

Sec. 70. Minnesota Statutes 2000, section 256L.07, is amended by adding a subdivision to read:

Subd. 6. [EXEMPTION FOR PERSONS LOSING COVERAGE AS A DEPENDENT.] Individuals who apply for the MinnesotaCare program upon termination of other health coverage due to loss of status as a dependent are exempt from the requirements of subdivision 3.

Sec. 71. Minnesota Statutes 2000, section 256L.12, is amended by adding a subdivision to read:

Subd. 11. [AMERICAN INDIAN ENROLLEES.] For American Indian enrollees, MinnesotaCare shall cover health care services provided at Indian Health Service facilities and facilities operated by a tribe or tribal organization under funding authorized by United States Code, title 25, sections 450f to 450n, or title III of the Indian Self-Determination and Education Assistance Act, Public Law Number 93-638, if those services would otherwise be covered under section 256L.03. Payments for services provided under this subdivision shall be made on a fee-for-service basis, and may, at the option of the tribe or tribal organization, be made at the rates authorized under sections 256.969, subdivision 16, and 256B.0625, subdivision 34, for those MinnesotaCare enrollees eligible for coverage at medical assistance rates. For purposes of this subdivision, "American Indian" has the meaning given to persons to whom services will be provided in the Code of Federal Regulations, title 42, section 36.12.

Sec. 72. Minnesota Statutes 2000, section 256L.15, subdivision 1, is amended to read:

Subdivision 1. [PREMIUM DETERMINATION.] (a) Except as provided in paragraph (b), families with children and individuals shall pay a premium determined according to a sliding fee based on a percentage of the family's gross family income.

(b) Children in households with family income equal to or less than 225 percent of the federal poverty guidelines and the parents and relative caretakers of children under the age of 21 in households with family income equal to or less than 120 percent of the federal poverty guidelines are exempt from paying a premium. Pregnant women and children under age two are exempt from the provisions of section 256L.06, subdivision 3, paragraph (b), clause (3), requiring disenrollment for failure to pay premiums. For pregnant women, this exemption continues until the first day of the month following the 60th day postpartum. Women who remain enrolled during pregnancy or the postpartum period, despite nonpayment of premiums, shall be disenrolled on the first of the month following the 60th day postpartum for the penalty period that otherwise applies under section 256L.06, unless they begin paying premiums.

Sec. 73. Minnesota Statutes 2000, section 256L.15, subdivision 2, is amended to read:

Subd. 2. [SLIDING FEE SCALE TO DETERMINE PERCENTAGE OF GROSS INDIVIDUAL OR FAMILY INCOME.] (a) The commissioner shall establish a sliding fee scale to determine the percentage of 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 gross individual or family income. The sliding fee scale must contain separate tables based on enrollment of one, two, or three or more persons. For single adults and families without children, the sliding fee scale begins with a premium of 1.5 percent of 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. For families with children, the sliding fee scale begins with a premium of 1.5 percent of gross family income with incomes below the children in effect on January 1, 1999, and proceeds through following evenly spaced steps: 1.8, 2.3, 3.1, and 5.0 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 not be adjusted until eligibility renewal.

(b) Enrolled individuals and families whose gross annual income increases above 275 percent of the federal poverty guideline 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.

Sec. 74. Minnesota Statutes 2000, section 256L.16, is amended to read:

256L.16 [PAYMENT RATES; SERVICES FOR FAMILIES AND CHILDREN UNDER THE MINNESOTACARE HEALTH CARE REFORM WAIVER.]

Section 256L.11, subdivision 2, shall not apply to services provided to ~~children~~ families with children who are eligible ~~to receive expanded services~~ according to section ~~256L.03, subdivision 1a~~ 256L.04, subdivision 1a.

Sec. 75. Laws 1999, chapter 245, article 4, section 110, is amended to read:

Sec. 110. [PROGRAMS FOR SENIOR CITIZENS.]

The commissioner of human services shall study the eligibility criteria of and benefits provided to persons age 65 and over through the array of cash assistance and health care programs administered by the department, and the extent to which these programs can be combined, simplified, or coordinated to reduce administrative costs and improve access. The commissioner shall also study potential barriers to enrollment for low-income seniors who would otherwise deplete resources necessary to maintain independent community living. At a minimum, the study must include an evaluation of asset requirements and enrollment sites. The commissioner shall report study findings and recommendations to the legislature by ~~June 30, 2001~~ January 15, 2002.

Sec. 76. [EXPAND DENTAL AUXILIARY PERSONNEL; FOREIGN-TRAINED DENTISTS; DENTAL CLINICS.]

Subdivision 1. [DEVELOPMENT.] (a) The board of dentistry, in consultation with the University of Minnesota school of dentistry, the Minnesota state colleges and universities that offer a dental auxiliary training program, the commissioner of health, and licensed dentists and dental auxiliaries practicing in private practice and at community clinics, shall develop new expanded duties for registered dental assistants and dental hygienists. The new duties must be performed under direct or indirect supervision of a licensed dentist and must include selected technical dental services. These expanded duties must be limited to reversible procedures, including, but not be limited to, placement, contouring, and adjustment of amalgam, composite, glass ionomer, and temporary restoration; pit and fissure sealants; and the adaptation and cementation of stainless steel crowns for primary teeth. These expanded duties shall not include or imply a diagnosis or treatment plan, nor include prescribing medications, cutting hard or soft tissue, or any direct patient care in which formal training has not been completed. The board shall establish a standard of practice and necessary educational qualifications for certification to perform the new duties.

(b) The board shall make recommendations to amend Minnesota Statutes, chapter 150A, to permit a foreign-trained dentist to practice as a dental hygienist or as a registered dental assistant.

(c) The board shall submit the proposed changes to Minnesota Statutes, chapter 150A, to the legislature by January 15, 2002.

Subd. 2. [DENTAL CLINICS.] The commissioner of health, in consultation with the Minnesota state colleges and universities, shall determine the capital improvements needed to establish community-based dental clinics at state colleges and universities to be used as training sites and as public community-based dental clinics for public program recipients during times when the school is not in session and the clinic is not in use. The commissioner shall submit the necessary capital improvement costs for start-up equipment and necessary infrastructure as part of the 2002 legislative capital budget requests.

Sec. 77. [FEDERAL WAIVER REQUEST.]

The commissioner of human services shall seek federal approval to expand the medical assistance program to provide access to discounted prices for prescription drugs to Medicare beneficiaries with no prescription drug coverage. Individuals in this expanded coverage group shall receive a discount for prescription drugs equal to the average rebate paid to the medical assistance program by pharmaceutical manufacturers. Upon receipt of the waiver, the commissioner shall submit a proposal to the legislature for implementation of this expansion to individuals with income at or below 200 percent of the federal poverty guidelines.

Sec. 78. [HEALTH STATUS IMPROVEMENT GRANTS.]

The commissioner of human services shall award grants to improve the quality of health care services provided to children. Priority shall be given to grant applications that:

(1) develop "best practices guidelines" for primary and preventative health care services to all children in Minnesota, regardless of payor;

(2) design and implement community-based education and evaluation programs for physicians and other direct care providers to implement best practice guidelines; and

(3) reduce disparities in access to health care services and in health status of Minnesota children.

Sec. 79. [NOTICE OF PREMIUM CHANGES IN THE EMPLOYED PERSONS WITH DISABILITIES PROGRAM.]

The commissioner of human services shall provide notice to all medical assistance recipients receiving coverage through the employed persons with disabilities program under Minnesota Statutes, section 256B.057, subdivision 9, of the first new premium schedule in effect on September 1, 2001, at least two months before the month in which the first new premium is due.

Sec. 80. [REPEALER.]

(a) Minnesota Statutes 2000, section 16A.76, is repealed effective July 1, 2001.

(b) Minnesota Statutes 2000, section 256.955, subdivision 2b, is repealed effective January 1, 2002.

(c) Minnesota Statutes 2000, sections 256B.0635, subdivision 3; and 256L.15, subdivision 3, are repealed effective July 1, 2002.

ARTICLE 3

CONTINUING CARE

Section 1. Minnesota Statutes 2000, section 245A.13, subdivision 7, is amended to read:

Subd. 7. [RATE RECOMMENDATION.] The commissioner of human services may review rates of a residential program participating in the medical assistance program which is in receivership and that has needs or deficiencies documented by the department of health or the department of human services. If the commissioner of human services determines that a review of the rate established under ~~section 256B.501~~ sections 256B.5012 and 256B.5013 is needed, the commissioner shall:

(1) review the order or determination that cites the deficiencies or needs; and

(2) determine the need for additional staff, additional annual hours by type of employee, and additional consultants, services, supplies, equipment, repairs, or capital assets necessary to satisfy the needs or deficiencies.

Sec. 2. Minnesota Statutes 2000, section 245A.13, subdivision 8, is amended to read:

Subd. 8. [ADJUSTMENT TO THE RATE.] Upon review of rates under subdivision 7, the commissioner may adjust the residential program's payment rate. The commissioner shall review the circumstances, together with the residential ~~program cost report~~ program's most recent income and expense report, to determine whether or not the deficiencies or needs can be corrected or met by reallocating residential program staff, costs, revenues, or any other resources including ~~any~~ investments~~, efficiency incentives, or allowances~~. If the commissioner determines that any deficiency cannot be corrected or the need cannot be met with the payment rate currently being paid, the commissioner shall determine the payment rate adjustment by dividing the additional annual costs established during the commissioner's review by the residential program's actual resident days from the most recent ~~desk-audited cost~~ income and expense report or the estimated resident days in the projected receivership period. The payment rate adjustment ~~must meet the conditions in Minnesota Rules, parts 9553.0010 to 9553.0080, and~~ remains in effect during the period of the receivership or until another date set by the commissioner. Upon the subsequent sale, closure, or transfer of the residential program, the commissioner may recover amounts that were paid as payment rate adjustments under this subdivision. This recovery shall be determined through a review of actual costs and resident days in the receivership period. The costs the commissioner finds to be allowable shall be divided by the actual resident days for the

receivership period. This rate shall be compared to the rate paid throughout the receivership period, with the difference multiplied by resident days, being the amount to be repaid to the commissioner. Allowable costs shall be determined by the commissioner as those ordinary, necessary, and related to resident care by prudent and cost-conscious management. The buyer or transferee shall repay this amount to the commissioner within 60 days after the commissioner notifies the buyer or transferee of the obligation to repay. This provision does not limit the liability of the seller to the commissioner pursuant to section 256B.0641.

Sec. 3. Minnesota Statutes 2000, section 252.275, subdivision 4b, is amended to read:

Subd. 4b. [GUARANTEED FLOOR.] Each county ~~with an original allocation for the preceding year that is equal to or less than the guaranteed floor minimum index shall have a guaranteed floor equal to its original allocation for the preceding year. Each county with an original allocation for the preceding year that is greater than the guaranteed floor minimum index~~ shall have a guaranteed floor equal to the lesser of clause (1) or (2):

(1) the county's original allocation for the preceding year; or

(2) 70 percent of the county's reported expenditures eligible for reimbursement during the 12 months ending on June 30 of the preceding calendar year.

~~For calendar year 1993, the guaranteed floor minimum index shall be $20,000. For each subsequent year, the index shall be adjusted by the projected change in the average value in the United States Department of Labor Bureau of Labor Statistics consumer price index (all urban) for that year.~~

Notwithstanding this subdivision, no county shall be allocated a guaranteed floor of less than $1,000.

When the amount of funds available for allocation is less than the amount available in the previous year, each county's previous year allocation shall be reduced in proportion to the reduction in the statewide funding, to establish each county's guaranteed floor.

Sec. 4. Minnesota Statutes 2000, section 254B.03, subdivision 1, is amended to read:

Subdivision 1. [LOCAL AGENCY DUTIES.] (a) Every local agency shall provide chemical dependency services to persons residing within its jurisdiction who meet criteria established by the commissioner for placement in a chemical dependency residential or nonresidential treatment service. Chemical dependency money must be administered by the local agencies according to law and rules adopted by the commissioner under sections 14.001 to 14.69.

(b) In order to contain costs, the county board shall, with the approval of the commissioner of human services, select eligible vendors of chemical dependency services who can provide economical and appropriate treatment. Unless the local agency is a social services department directly administered by a county or human services board, the local agency shall not be an eligible vendor under section 254B.05. The commissioner may approve proposals from county boards to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided. If a county implements a demonstration or experimental medical services funding plan, the commissioner shall transfer the money as appropriate. If a county selects a vendor located in another state, the county shall ensure that the vendor is in compliance with the rules governing licensure of programs located in the state.

(c) The calendar year ~~1998~~ 2002 rate for vendors may not increase more than ~~three~~ 3.5 percent above the rate approved in effect on January 1, ~~1997~~ 2001. The calendar year ~~1999~~ 2003 rate for vendors may not increase more than ~~three~~ 3.5 percent above the rate in effect on January 1, ~~1998~~ 2002.

(d) A culturally specific vendor that provides assessments under a variance under Minnesota Rules, part 9530.6610, shall be allowed to provide assessment services to persons not covered by the variance.

Sec. 5. Minnesota Statutes 2000, section 254B.09, is amended by adding a subdivision to read:

Subd. 8. [PAYMENTS TO IMPROVE SERVICES TO AMERICAN INDIANS.] The commissioner may set rates for chemical dependency services according to the American Indian Health Improvement Act, Public Law Number 94-437, for eligible vendors. These rates shall supersede rates set in county purchase of service agreements when payments are made on behalf of clients eligible according to Public Law Number 94-437.

Sec. 6. Minnesota Statutes 2000, section 256.01, is amended by adding a subdivision to read:

Subd. 19. [GRANTS FOR CASE MANAGEMENT SERVICES TO PERSONS WITH HIV OR AIDS.] The commissioner may award grants to eligible vendors for the development, implementation, and evaluation of case management services for individuals infected with the human immunodeficiency virus. HIV/AIDs case management services will be provided to increase access to cost effective health care services, to reduce the risk of HIV transmission, to ensure that basic client needs are met, and to increase client access to needed community supports or services.

Sec. 7. Minnesota Statutes 2000, section 256.476, subdivision 1, is amended to read:

Subdivision 1. [PURPOSE AND GOALS.] The commissioner of human services shall establish a consumer support grant program ~~to assist~~ for individuals with functional limitations and their families ~~in purchasing and securing supports which the individuals need to live as independently and productively in the community as possible~~ who wish to purchase and secure their own supports. The commissioner and local agencies shall jointly develop an implementation plan which must include a way to resolve the issues related to county liability. The program shall:

(1) make support grants available to individuals or families as an effective alternative to existing programs and services, such as the developmental disability family support program, ~~the alternative care program,~~ personal care attendant services, home health aide services, and private duty nursing ~~facility~~ services;

(2) provide consumers more control, flexibility, and responsibility over ~~the needed supports~~ their services and supports;

(3) promote local program management and decision making; and

(4) encourage the use of informal and typical community supports.

Sec. 8. Minnesota Statutes 2000, section 256.476, subdivision 2, is amended to read:

Subd. 2. [DEFINITIONS.] For purposes of this section, the following terms have the meanings given them:

(a) "County board" means the county board of commissioners for the county of financial responsibility as defined in section 256G.02, subdivision 4, or its designated representative. When a human services board has been established under sections 402.01 to 402.10, it shall be considered the county board for the purposes of this section.

(b) "Family" means the person's birth parents, adoptive parents or stepparents, siblings or stepsiblings, children or stepchildren, grandparents, grandchildren, niece, nephew, aunt, uncle, or spouse. For the purposes of this section, a family member is at least 18 years of age.

(c) "Functional limitations" means the long-term inability to perform an activity or task in one or more areas of major life activity, including self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living. For the purpose of this section, the inability to perform an activity or task results from a mental, emotional, psychological, sensory, or physical disability, condition, or illness.

(d) "Informed choice" means a voluntary decision made by the person or the person's legal representative, after becoming familiarized with the alternatives to:

(1) select a preferred alternative from a number of feasible alternatives;

(2) select an alternative which may be developed in the future; and

(3) refuse any or all alternatives.

(e) "Local agency" means the local agency authorized by the county board to carry out the provisions of this section.

(f) "Person" or "persons" means a person or persons meeting the eligibility criteria in subdivision 3.

(g) "Authorized representative" means an individual designated by the person or their legal representative to act on their behalf. This individual may be a family member, guardian, representative payee, or other individual designated by the person or their legal representative, if any, to assist in purchasing and arranging for supports. For the purposes of this section, an authorized representative is at least 18 years of age.

(h) "Screening" means the screening of a person's service needs under sections 256B.0911 and 256B.092.

(i) "Supports" means services, care, aids, ~~home~~ environmental modifications, or assistance purchased by the person or the person's family. Examples of supports include respite care, assistance with daily living, and ~~adaptive aids~~ assistive technology. For the purpose of this section, notwithstanding the provisions of section 144A.43, supports purchased under the consumer support program are not considered home care services.

(j) "Program of origination" means the program the individual transferred from when approved for the consumer support grant program.

Sec. 9. Minnesota Statutes 2000, section 256.476, subdivision 3, is amended to read:

Subd. 3. [ELIGIBILITY TO APPLY FOR GRANTS.] (a) A person is eligible to apply for a consumer support grant if the person meets all of the following criteria:

(1) the person is eligible for and has been approved to receive services under medical assistance as determined under sections 256B.055 and 256B.056 ~~or the person is eligible for and has been approved to receive services under alternative care services as determined under section 256B.0913~~ or the person has been approved to receive a grant under the developmental disability family support program under section 252.32;

(2) the person is able to direct and purchase the person's own care and supports, or the person has a family member, legal representative, or other authorized representative who can purchase and arrange supports on the person's behalf;

(3) the person has functional limitations, requires ongoing supports to live in the community, and is at risk of or would continue institutionalization without such supports; and

(4) the person will live in a home. For the purpose of this section, "home" means the person's own home or home of a person's family member. These homes are natural home settings and are not licensed by the department of health or human services.

(b) Persons may not concurrently receive a consumer support grant if they are:

(1) receiving home and community-based services under United States Code, title 42, section 1396h(c); personal care attendant and home health aide services under section 256B.0625; a developmental disability family support grant; or alternative care services under section 256B.0913; or

(2) residing in an institutional or congregate care setting.

(c) A person or person's family receiving a consumer support grant shall not be charged a fee or premium by a local agency for participating in the program.

(d) The commissioner may limit the participation of ~~nursing facility residents, residents of intermediate care facilities for persons with mental retardation, and the~~ recipients of services from federal waiver programs in the consumer support grant program if the participation of these individuals will result in an increase in the cost to the state.

(e) The commissioner shall establish a budgeted appropriation each fiscal year for the consumer support grant program. The number of individuals participating in the program will be adjusted so the total amount allocated to counties does not exceed the amount of the budgeted appropriation. The budgeted appropriation will be adjusted annually to accommodate changes in demand for the consumer support grants.

Sec. 10. Minnesota Statutes 2000, section 256.476, subdivision 4, is amended to read:

Subd. 4. [SUPPORT GRANTS; CRITERIA AND LIMITATIONS.] (a) A county board may choose to participate in the consumer support grant program. If a county board chooses to participate in the program, the local agency shall establish written procedures and criteria to determine the amount and use of support grants. These procedures must include, at least, the availability of respite care, assistance with daily living, and adaptive aids. The local agency may establish monthly or annual maximum amounts for grants and procedures where exceptional resources may be required to meet the health and safety needs of the person on a time-limited basis, however, the total amount awarded to each individual may not exceed the limits established in subdivision 5, paragraph (f).

(b) Support grants to a person or a person's family will be provided through a monthly subsidy payment and be in the form of cash, voucher, or direct county payment to vendor. Support grant amounts must be determined by the local agency. Each service and item purchased with a support grant must meet all of the following criteria:

(1) it must be over and above the normal cost of caring for the person if the person did not have functional limitations;

(2) it must be directly attributable to the person's functional limitations;

(3) it must enable the person or the person's family to delay or prevent out-of-home placement of the person; and

(4) it must be consistent with the needs identified in the service plan, when applicable.

(c) Items and services purchased with support grants must be those for which there are no other public or private funds available to the person or the person's family. Fees assessed to the person or the person's family for health and human services are not reimbursable through the grant.

(d) In approving or denying applications, the local agency shall consider the following factors:

(1) the extent and areas of the person's functional limitations;

(2) the degree of need in the home environment for additional support; and

(3) the potential effectiveness of the grant to maintain and support the person in the family environment or the person's own home.

(e) At the time of application to the program or screening for other services, the person or the person's family shall be provided sufficient information to ensure an informed choice of alternatives by the person, the person's legal representative, if any, or the person's family. The application shall be made to the local agency and shall specify the needs of the person and family, the form and amount of grant requested, the items and services to be reimbursed, and evidence of eligibility for medical assistance ~~or alternative care program~~.

(f) Upon approval of an application by the local agency and agreement on a support plan for the person or person's family, the local agency shall make grants to the person or the person's family. The grant shall be in an amount for the direct costs of the services or supports outlined in the service agreement.

(g) Reimbursable costs shall not include costs for resources already available, such as special education classes, day training and habilitation, case management, other services to which the person is entitled, medical costs covered by insurance or other health programs, or other resources usually available at no cost to the person or the person's family.

(h) The state of Minnesota, the county boards participating in the consumer support grant program, or the agencies acting on behalf of the county boards in the implementation and administration of the consumer support grant program shall not be liable for damages, injuries, or liabilities sustained through the purchase of support by the individual, the individual's family, or the authorized representative under this section with funds received through the consumer support grant program. Liabilities include but are not limited to: workers' compensation liability, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA). For purposes of this section, participating county boards and agencies acting on behalf of county boards are exempt from the provisions of section 268.04.

Sec. 11. Minnesota Statutes 2000, section 256.476, subdivision 5, is amended to read:

Subd. 5. [REIMBURSEMENT, ALLOCATIONS, AND REPORTING.] (a) For the purpose of transferring persons to the consumer support grant program from specific programs or services, such as the developmental disability family support program and ~~alternative care program,~~ personal care ~~attendant~~ assistant services, home health aide services, or ~~nursing facility~~ private duty nursing services, the amount of funds transferred by the commissioner between the developmental disability family support program account, ~~the alternative care account,~~ the medical assistance account, or the consumer support grant account shall be based on each county's participation in transferring persons to the consumer support grant program from those programs and services.

(b) At the beginning of each fiscal year, county allocations for consumer support grants shall be based on:

(1) the number of persons to whom the county board expects to provide consumer supports grants;

(2) their eligibility for current program and services;

(3) the amount of nonfederal dollars expended on those individuals for those programs and services ~~or, in situations where an individual is unable to obtain the support needed from the program of origination due to the unavailability of service providers at the time or the location where the supports are needed, the allocation will be based on the county's best estimate of the nonfederal dollars that would have been expended if the services had been available~~; and

(4) projected dates when persons will start receiving grants. County allocations shall be adjusted periodically by the commissioner based on the actual transfer of persons or service openings, and the nonfederal dollars associated with those persons or service openings, to the consumer support grant program.

(c) The amount of funds transferred by the commissioner from ~~the alternative care account and~~ the medical assistance account for an individual may be changed if it is determined by the county or its agent that the individual's need for support has changed.

(d) The authority to utilize funds transferred to the consumer support grant account for the purposes of implementing and administering the consumer support grant program will not be limited or constrained by the spending authority provided to the program of origination.

(e) The commissioner ~~shall~~ may use up to five percent of each county's allocation, as adjusted, for payments to that county for administrative expenses, to be paid as a proportionate addition to reported direct service expenditures.

(f) ~~Except as provided in this paragraph,~~ The county allocation for each individual or individual's family cannot exceed ~~80 percent of~~ the total nonfederal dollars expended on the individual by the program of origination ~~except for the developmental disabilities family support~~

~~grant program which can be approved up to 100 percent of the nonfederal dollars and in situations as described in paragraph (b), clause (3). In situations where exceptional need exists or the individual's need for support increases, up to 100 percent of the nonfederal dollars expended may be allocated to the county. Allocations that exceed 80 percent of the nonfederal dollars expended on the individual by the program of origination must be approved by the commissioner. The remainder of the amount expended on the individual by the program of origination will be used in the following proportions: half will be made available to the consumer support grant program and participating counties for consumer training, resource development, and other costs, and half will be returned to the state general fund~~.

(g) The commissioner may recover, suspend, or withhold payments if the county board, local agency, or grantee does not comply with the requirements of this section.

(h) Grant funds unexpended by consumers shall return to the state once a year. The annual return of unexpended grant funds shall occur in the quarter following the end of the state fiscal year.

Sec. 12. Minnesota Statutes 2000, section 256.476, subdivision 8, is amended to read:

Subd. 8. [COMMISSIONER RESPONSIBILITIES.] The commissioner shall:

(1) transfer and allocate funds pursuant to this section;

(2) determine allocations based on projected and actual local agency use;

(3) monitor and oversee overall program spending;

(4) evaluate the effectiveness of the program;

(5) provide training and technical assistance for local agencies and consumers to help identify potential applicants to the program; and

(6) develop guidelines for local agency program administration and consumer information~~; and~~

~~(7) apply for a federal waiver or take any other action necessary to maximize federal funding for the program by September 1, 1999~~.

Sec. 13. Minnesota Statutes 2000, section 256.476, is amended by adding a subdivision to read:

Subd. 11. [CONSUMER SUPPORT GRANT PROGRAM AFTER JULY 1, 2001.] (a) Effective July 1, 2001, upon approval of the 1115 federal waiver for consumer-directed home care in section 256B.0627, subdivision 13, the consumer support grant program shall be limited to 200 persons.

(b) If federal approval delays implementation of the 1115 waiver or it is denied, additional individuals may receive consumer support grants according to subdivision 5. The statewide average of medical assistance expenditures for recipients receiving those services during the most recent fiscal year will be used to determine the maximum allowable grant award.

(c) Persons receiving consumer support grants prior to July 1, 2001, may continue to receive a grant amount established prior to July 1, 2001.

Sec. 14. Minnesota Statutes 2000, section 256B.0625, subdivision 7, is amended to read:

Subd. 7. [PRIVATE DUTY NURSING.] Medical assistance covers private duty nursing services in a recipient's home. Recipients who are authorized to receive private duty nursing services in their home may use approved hours outside of the home during hours when normal life activities take them outside of their home ~~and when, without the provision of private duty nursing, their health and safety would be jeopardized~~. To use private duty nursing services at school, the recipient or responsible party must provide written authorization in the care plan identifying the chosen provider and the daily amount of services to be used at school. Medical assistance does not cover private duty nursing services for residents of a hospital, nursing facility, intermediate care

facility, or a health care facility licensed by the commissioner of health, except as authorized in section 256B.64 for ventilator-dependent recipients in hospitals or unless a resident who is otherwise eligible is on leave from the facility and the facility either pays for the private duty nursing services or forgoes the facility per diem for the leave days that private duty nursing services are used. Total hours of service and payment allowed for services outside the home cannot exceed that which is otherwise allowed in an in-home setting according to section 256B.0627. All private duty nursing services must be provided according to the limits established under section 256B.0627. Private duty nursing services may not be reimbursed if the nurse is the ~~spouse of the recipient or the parent or~~ foster care provider of a recipient who is under age 18~~, or the recipient's legal guardian~~.

Sec. 15. Minnesota Statutes 2000, section 256B.0625, subdivision 19a, is amended to read:

Subd. 19a. [PERSONAL CARE ASSISTANT SERVICES.] Medical assistance covers personal care assistant services in a recipient's home. To qualify for personal care assistant services, recipients or responsible parties must be able to identify the recipient's needs, direct and evaluate task accomplishment, and provide for health and safety. Approved hours may be used outside the home when normal life activities take them outside the home ~~and when, without the provision of personal care, their health and safety would be jeopardized~~. To use personal care assistant services at school, the recipient or responsible party must provide written authorization in the care plan identifying the chosen provider and the daily amount of services to be used at school. Total hours for services, whether actually performed inside or outside the recipient's home, cannot exceed that which is otherwise allowed for personal care assistant services in an in-home setting according to section 256B.0627. Medical assistance does not cover personal care assistant services for residents of a hospital, nursing facility, intermediate care facility, health care facility licensed by the commissioner of health, or unless a resident who is otherwise eligible is on leave from the facility and the facility either pays for the personal care assistant services or forgoes the facility per diem for the leave days that personal care assistant services are used. All personal care assistant services must be provided according to section 256B.0627. Personal care assistant services may not be reimbursed if the personal care assistant is the spouse or legal guardian of the recipient or the parent of a recipient under age 18, or the responsible party or the foster care provider of a recipient who cannot direct the recipient's own care unless, in the case of a foster care provider, a county or state case manager visits the recipient as needed, but not less than every six months, to monitor the health and safety of the recipient and to ensure the goals of the care plan are met. Parents of adult recipients, adult children of the recipient or adult siblings of the recipient may be reimbursed for personal care assistant services ~~if they are not the recipient's legal guardian and~~, if they are granted a waiver under section 256B.0627. ~~Until July 1, 2001, and~~ Notwithstanding the provisions of section 256B.0627, subdivision 4, paragraph (b), clause (4), the noncorporate legal guardian or conservator of an adult, who is not the responsible party and not the personal care provider organization, may be granted a hardship waiver under section 256B.0627, to be reimbursed to provide personal care assistant services to the recipient, and shall not be considered to have a service provider interest for purposes of participation on the screening team under section 256B.092, subdivision 7.

Sec. 16. Minnesota Statutes 2000, section 256B.0625, subdivision 19c, is amended to read:

Subd. 19c. [PERSONAL CARE.] Medical assistance covers personal care assistant services provided by an individual who is qualified to provide the services according to subdivision 19a and section 256B.0627, where the services are prescribed by a physician in accordance with a plan of treatment and are supervised by the recipient ~~under the fiscal agent option according to section 256B.0627, subdivision 10,~~ or a qualified professional. "Qualified professional" means a mental health professional as defined in section 245.462, subdivision 18, or 245.4871, subdivision 27; or a registered nurse as defined in sections 148.171 to 148.285. As part of the assessment, the county public health nurse will ~~consult with~~ assist the recipient or responsible party ~~and~~ to identify the most appropriate person to provide supervision of the personal care assistant. The qualified professional shall perform the duties described in Minnesota Rules, part 9505.0335, subpart 4.

Sec. 17. Minnesota Statutes 2000, section 256B.0625, subdivision 20, is amended to read:

Subd. 20. [MENTAL HEALTH CASE MANAGEMENT.] (a) To the extent authorized by rule of the state agency, medical assistance covers case management services to persons with serious and persistent mental illness and children with severe emotional disturbance. Services provided under this section must meet the relevant standards in sections 245.461 to 245.4888, the Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

(b) Entities meeting program standards set out in rules governing family community support services as defined in section 245.4871, subdivision 17, are eligible for medical assistance reimbursement for case management services for children with severe emotional disturbance when these services meet the program standards in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

(c) Medical assistance and MinnesotaCare payment for mental health case management shall be made on a monthly basis. In order to receive payment for an eligible child, the provider must document at least a face-to-face contact with the child, the child's parents, or the child's legal representative. To receive payment for an eligible adult, the provider must document:

(1) at least a face-to-face contact with the adult or the adult's legal representative; or

(2) at least a telephone contact with the adult or the adult's legal representative and document a face-to-face contact with the adult or the adult's legal representative within the preceding two months.

(d) Payment for mental health case management provided by county or state staff shall be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph (b), with separate rates calculated for child welfare and mental health, and within mental health, separate rates for children and adults.

(e) Payment for mental health case management provided by county-contracted vendors shall be based on a monthly rate negotiated by the host county. The negotiated rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the county may negotiate a team rate with a vendor who is a member of the team. The team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county, except to reimburse the county for advance funding provided by the county to the vendor.

(f) If the service is provided by a team which includes contracted vendors and county or state staff, the costs for county or state staff participation in the team shall be included in the rate for county-provided services. In this case, the contracted vendor and the county may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services, the county must document, in the recipient's file, the need for team case management and a description of the roles of the team members.

(g) The commissioner shall calculate the nonfederal share of actual medical assistance and general assistance medical care payments for each county, based on the higher of calendar year 1995 or 1996, by service date, project that amount forward to 1999, and transfer one-half of the result from medical assistance and general assistance medical care to each county's mental health grants under sections 245.4886 and 256E.12 for calendar year 1999. The annualized minimum amount added to each county's mental health grant shall be $3,000 per year for children and $5,000 per year for adults. The commissioner may reduce the statewide growth factor in order to fund these minimums. The annualized total amount transferred shall become part of the base for future mental health grants for each county.

(h) Any net increase in revenue to the county as a result of the change in this section must be used to provide expanded mental health services as defined in sections 245.461 to 245.4888, the Comprehensive Adult and Children's Mental Health Acts, excluding inpatient and residential treatment. For adults, increased revenue may also be used for services and consumer supports which are part of adult mental health projects approved under Laws 1997, chapter 203, article 7, section 25. For children, increased revenue may also be used for respite care and nonresidential

individualized rehabilitation services as defined in section 245.492, subdivisions 17 and 23. "Increased revenue" has the meaning given in Minnesota Rules, part 9520.0903, subpart 3.

(i) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for mental health case management shall be provided by the recipient's county of responsibility, as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds used to match other federal funds.

(j) The commissioner may suspend, reduce, or terminate the reimbursement to a provider that does not meet the reporting or other requirements of this section. The county of responsibility, as defined in sections 256G.01 to 256G.12, is responsible for any federal disallowances. The county may share this responsibility with its contracted vendors.

(k) The commissioner shall set aside a portion of the federal funds earned under this section to repay the special revenue maximization account under section 256.01, subdivision 2, clause (15). The repayment is limited to:

(1) the costs of developing and implementing this section; and

(2) programming the information systems.

(l) Notwithstanding section 256.025, subdivision 2, payments to counties for case management expenditures under this section shall only be made from federal earnings from services provided under this section. Payments to contracted vendors shall include both the federal earnings and the county share.

(m) Notwithstanding section 256B.041, county payments for the cost of mental health case management services provided by county or state staff shall not be made to the state treasurer. For the purposes of mental health case management services provided by county or state staff under this section, the centralized disbursement of payments to counties under section 256B.041 consists only of federal earnings from services provided under this section.

(n) Case management services under this subdivision do not include therapy, treatment, legal, or outreach services.

(o) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital, and the recipient's institutional care is paid by medical assistance, payment for case management services under this subdivision is limited to the last ~~30~~ 180 days of the recipient's residency in that facility and may not exceed more than ~~two~~ six months in a calendar year.

(p) Payment for case management services under this subdivision shall not duplicate payments made under other program authorities for the same purpose.

(q) By July 1, 2000, the commissioner shall evaluate the effectiveness of the changes required by this section, including changes in number of persons receiving mental health case management, changes in hours of service per person, and changes in caseload size.

(r) For each calendar year beginning with the calendar year 2001, the annualized amount of state funds for each county determined under paragraph (g) shall be adjusted by the county's percentage change in the average number of clients per month who received case management under this section during the fiscal year that ended six months prior to the calendar year in question, in comparison to the prior fiscal year.

(s) For counties receiving the minimum allocation of $3,000 or $5,000 described in paragraph (g), the adjustment in paragraph (r) shall be determined so that the county receives the higher of the following amounts:

(1) a continuation of the minimum allocation in paragraph (g); or

(2) an amount based on that county's average number of clients per month who received case management under this section during the fiscal year that ended six months prior to the calendar

year in question, in comparison to the prior fiscal year, times the average statewide grant per person per month for counties not receiving the minimum allocation.

(t) The adjustments in paragraphs (r) and (s) shall be calculated separately for children and adults.

Sec. 18. Minnesota Statutes 2000, section 256B.0625, is amended by adding a subdivision to read:

Subd. 43. [TARGETED CASE MANAGEMENT.] For purposes of subdivisions 43a to 43h, the following terms have the meanings given them:

(1) "home care service recipients" means those individuals receiving the following services under section 256B.0627: skilled nursing visits, home health aide visits, private duty nursing, personal care assistants, or therapies provided through a home health agency;

(2) "home care targeted case management" means the provision of targeted case management services for the purpose of assisting home care service recipients to gain access to needed services and supports so that they may remain in the community;

(3) "institutions" means hospitals, consistent with Code of Federal Regulations, title 42, section 440.10; regional treatment center inpatient services, consistent with section 245.474; nursing facilities; and intermediate care facilities for persons with mental retardation;

(4) "relocation targeted case management" means the provision of targeted case management services for the purpose of assisting recipients to gain access to needed services and supports if they choose to move from an institution to the community. Relocation targeted case management may be provided during the last 180 consecutive days of an eligible recipient's institutional stay; and

(5) "targeted case management" means case management services provided to help recipients gain access to needed medical, social, educational, and other services and supports.

Sec. 19. Minnesota Statutes 2000, section 256B.0625, is amended by adding a subdivision to read:

Subd. 43a. [ELIGIBILITY.] The following persons are eligible for relocation targeted case management or home care-targeted case management:

(1) medical assistance eligible persons residing in institutions who choose to move into the community are eligible for relocation targeted case management services; and

(2) medical assistance eligible persons receiving home care services, who are not eligible for any other medical assistance reimbursable case management service, are eligible for home care-targeted case management services beginning January 1, 2003.

Sec. 20. Minnesota Statutes 2000, section 256B.0625, is amended by adding a subdivision to read:

Subd. 43b. [RELOCATION TARGETED CASE MANAGEMENT PROVIDER QUALIFICATIONS.] The following qualifications and certification standards must be met by providers of relocation targeted case management:

(a) The commissioner must certify each provider or relocation targeted case management before enrollment. The certification process shall examine the provider's ability to meet the requirements in this subdivision and other federal and state requirements of this service. A certified relocation targeted case management provider may subcontract with another provider to deliver relocation targeted case management services. Subcontracted providers must demonstrate the ability to provide the services outlined in subdivision 43d.

(b) A relocation targeted case management provider is an enrolled medical assistance provider who is determined by the commissioner to have all of the following characteristics:

(1) the legal authority to provide public welfare under sections 393.01, subdivision 7; and 393.07; or a federally recognized Indian tribe;

(2) the demonstrated capacity and experience to provide the components of case management to coordinate and link community resources needed by the eligible population;

(3) the administrative capacity and experience to serve the target population for whom it will provide services and ensure quality of services under state and federal requirements;

(4) the legal authority to provide complete investigative and protective services under section 626.556, subdivision 10; and child welfare and foster care services under section 393.07, subdivisions 1 and 2; or a federally recognized Indian tribe;

(5) a financial management system that provides accurate documentation of services and costs under state and federal requirements; and

(6) the capacity to document and maintain individual case records under state and federal requirements.

A provider of targeted case management under subdivision 20 may be deemed a certified provider of relocation targeted case management.

Sec. 21. Minnesota Statutes 2000, section 256B.0625, is amended by adding a subdivision to read:

Subd. 43c. [HOME CARE TARGETED CASE MANAGEMENT PROVIDER QUALIFICATIONS.] The following qualifications and certification standards must be met by providers of home care targeted case management.

(a) The commissioner must certify each provider of home care targeted case management before enrollment. The certification process shall examine the provider's ability to meet the requirements in this subdivision and other state and federal requirements of this service.

(b) A home care targeted case management provider is an enrolled medical assistance provider who has a minimum of a bachelor's degree, a license in a health or human services field, and is determined by the commissioner to have all of the following characteristics:

(1) the demonstrated capacity and experience to provide the components of case management to coordinate and link community resources needed by the eligible population;

(2) the administrative capacity and experience to serve the target population for whom it will provide services and ensure quality of services under state and federal requirements;

(3) a financial management system that provides accurate documentation of services and costs under state and federal requirements;

(4) the capacity to document and maintain individual case records under state and federal requirements; and

(5) the capacity to coordinate with county administrative functions.

Sec. 22. Minnesota Statutes 2000, section 256B.0625, is amended by adding a subdivision to read:

Subd. 43d. [ELIGIBLE SERVICES.] Services eligible for medical assistance reimbursement as targeted case management include:

(1) assessment of the recipient's need for targeted case management services;

(2) development, completion, and regular review of a written individual service plan, which is based upon the assessment of the recipient's needs and choices, and which will ensure access to medical, social, educational, and other related services and supports;

(3) routine contact or communication with the recipient, the recipient's family, primary caregiver, legal representative, substitute care provider, service providers, or other relevant persons identified as necessary to the development or implementation of the goals of the individual service plan;

(4) coordinating referrals for, and the provision of, case management services for the recipient with appropriate service providers, consistent with section 1902(a)(23) of the Social Security Act;

(5) coordinating and monitoring the overall service delivery to ensure quality of services, appropriateness, and continued need;

(6) completing and maintaining necessary documentation that supports and verifies the activities in this subdivision;

(7) traveling to conduct a visit with the recipient or other relevant person necessary to develop or implement the goals of the individual service plan; and

(8) coordinating with the institution discharge planner in the 180-day period before the recipient's discharge.

Sec. 23. Minnesota Statutes 2000, section 256B.0625, is amended by adding a subdivision to read:

Subd. 43e. [TIMELINES.] The following timelines must be met for assigning a case manager:

(1) for relocation targeted case management, an eligible recipient must be assigned a case manager who visits the person within 20 working days of requesting one from their county of financial responsibility as determined under chapter 256G. If a county agency does not provide case management services as required, the recipient may, after written notice to the county agency, obtain targeted-relocation case management services from a home care targeted case management provider under this subdivision; and

(2) for home care targeted case management, an eligible recipient must be assigned a case manager within 20 working days of requesting one from a home care targeted case management provider, as defined in subdivision 43c.

Sec. 24. Minnesota Statutes 2000, section 256B.0625, is amended by adding a subdivision to read:

Subd. 43f. [EVALUATION.] The commissioner shall evaluate the delivery of targeted case management, including, but not limited to, access to case management services, consumer satisfaction with case management services, and quality of case management services.

Sec. 25. Minnesota Statutes 2000, section 256B.0625, is amended by adding a subdivision to read:

Subd. 43g. [CONTACT DOCUMENTATION.] The case manager must document each face-to-face and telephone contact with the recipient and others involved in the recipient's individual service plan.

Sec. 26. Minnesota Statutes 2000, section 256B.0625, is amended by adding a subdivision to read:

Subd. 43h. [PAYMENT RATES.] The commissioner shall set payment rates for targeted case management under this subdivision. Case managers may bill according to the following criteria:

(1) for relocation targeted case management, case managers may bill for direct case management activities, including face-to-face and telephone contacts, in the 180 days preceding an eligible recipient's discharge from an institution;

(2) for home care targeted case management, case managers may bill for direct case management activities, including face-to-face and telephone contacts; and

(3) billings for targeted case management services under this subdivision shall not duplicate payments made under other program authorities for the same purpose.

Sec. 27. Minnesota Statutes 2000, section 256B.0627, subdivision 1, is amended to read:

Subdivision 1. [DEFINITION.] (a) "Activities of daily living" includes eating, toileting, grooming, dressing, bathing, transferring, mobility, and positioning.

(b) "Assessment" means a review and evaluation of a recipient's need for home care services conducted in person. Assessments for private duty nursing shall be conducted by a registered private duty nurse. Assessments for home health agency services shall be conducted by a home health agency nurse. Assessments for personal care assistant services shall be conducted by the county public health nurse or a certified public health nurse under contract with the county. A face-to-face assessment must include: documentation of health status, determination of need, evaluation of service effectiveness, identification of appropriate services, service plan development or modification, coordination of services, referrals and follow-up to appropriate payers and community resources, completion of required reports, recommendation of service authorization, and consumer education. Once the need for personal care assistant services is determined under this section, the county public health nurse or certified public health nurse under contract with the county is responsible for communicating this recommendation to the commissioner and the recipient. A face-to-face assessment for personal care assistant services is conducted on those recipients who have never had a county public health nurse assessment. A face-to-face assessment must occur at least annually or when there is a significant change in the recipient's condition or when there is a change in the need for personal care assistant services. A service update may substitute for the annual face-to-face assessment when there is not a significant change in recipient condition or a change in the need for personal care assistant service. A service update or review for temporary increase includes a review of initial baseline data, evaluation of service effectiveness, redetermination of service need, modification of service plan and appropriate referrals, update of initial forms, obtaining service authorization, and on going consumer education. Assessments for medical assistance home care services for mental retardation or related conditions and alternative care services for developmentally disabled home and community-based waivered recipients may be conducted by the county public health nurse to ensure coordination and avoid duplication. Assessments must be completed on forms provided by the commissioner within 30 days of a request for home care services by a recipient or responsible party.

~~(b)~~ (c) "Care plan" means a written description of personal care assistant services developed by the qualified professional or the recipient's physician with the recipient or responsible party to be used by the personal care assistant with a copy provided to the recipient or responsible party.

(d) "Complex and regular private duty nursing care" means:

(1) complex care is private duty nursing provided to recipients who are ventilator dependent or for whom a physician has certified that were it not for private duty nursing the recipient would meet the criteria for inpatient hospital intensive care unit (ICU) level of care; and

(2) regular care is private duty nursing provided to all other recipients.

(e) "Health-related functions" means functions that can be delegated or assigned by a licensed health care professional under state law to be performed by a personal care attendant.

~~(c)~~ (f) "Home care services" means a health service, determined by the commissioner as medically necessary, that is ordered by a physician and documented in a service plan that is reviewed by the physician at least once every ~~62~~ 60 days for the provision of home health services, or private duty nursing, or at least once every ~~365~~ days for personal care. Home care services are provided to the recipient at the recipient's residence that is a place other than a hospital or long-term care facility or as specified in section 256B.0625.

(g) "Instrumental activities of daily living" includes meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household

chores, communication by telephone and other media, and getting around and participating in the community.

~~(d)~~ (h) "Medically necessary" has the meaning given in Minnesota Rules, parts 9505.0170 to 9505.0475.

~~(e)~~ (i) "Personal care assistant" means a person who:

(1) is at least 18 years old, except for persons 16 to 18 years of age who participated in a related school-based job training program or have completed a certified home health aide competency evaluation;

(2) is able to effectively communicate with the recipient and personal care provider organization;

(3) effective July 1, 1996, has completed one of the training requirements as specified in Minnesota Rules, part 9505.0335, subpart 3, items A to D;

(4) has the ability to, and provides covered personal care assistant services according to the recipient's care plan, responds appropriately to recipient needs, and reports changes in the recipient's condition to the supervising qualified professional or physician;

(5) is not a consumer of personal care assistant services; and

(6) is subject to criminal background checks and procedures specified in section 245A.04.

~~(f)~~ (j) "Personal care provider organization" means an organization enrolled to provide personal care assistant services under the medical assistance program that complies with the following: (1) owners who have a five percent interest or more, and managerial officials are subject to a background study as provided in section 245A.04. This applies to currently enrolled personal care provider organizations and those agencies seeking enrollment as a personal care provider organization. An organization will be barred from enrollment if an owner or managerial official of the organization has been convicted of a crime specified in section 245A.04, or a comparable crime in another jurisdiction, unless the owner or managerial official meets the reconsideration criteria specified in section 245A.04; (2) the organization must maintain a surety bond and liability insurance throughout the duration of enrollment and provides proof thereof. The insurer must notify the department of human services of the cancellation or lapse of policy; and (3) the organization must maintain documentation of services as specified in Minnesota Rules, part 9505.2175, subpart 7, as well as evidence of compliance with personal care assistant training requirements.

~~(g)~~ (k) "Responsible party" means an individual residing with a recipient of personal care assistant services who is capable of providing the supportive care necessary to assist the recipient to live in the community, is at least 18 years old, and is not a personal care assistant. Responsible parties who are parents of minors or guardians of minors or incapacitated persons may delegate the responsibility to another adult during a temporary absence of at least 24 hours but not more than six months. The person delegated as a responsible party must be able to meet the definition of responsible party, except that the delegated responsible party is required to reside with the recipient only while serving as the responsible party. Foster care license holders may be designated the responsible party for residents of the foster care home if case management is provided as required in section 256B.0625, subdivision 19a. For persons who, as of April 1, 1992, are sharing personal care assistant services in order to obtain the availability of 24-hour coverage, an employee of the personal care provider organization may be designated as the responsible party if case management is provided as required in section 256B.0625, subdivision 19a.

~~(h)~~ (l) "Service plan" means a written description of the services needed based on the assessment developed by the nurse who conducts the assessment together with the recipient or responsible party. The service plan shall include a description of the covered home care services, frequency and duration of services, and expected outcomes and goals. The recipient and the provider chosen by the recipient or responsible party must be given a copy of the completed service plan within 30 calendar days of the request for home care services by the recipient or responsible party.

~~(i)~~ (m) "Skilled nurse visits" are provided in a recipient's residence under a plan of care or service plan that specifies a level of care which the nurse is qualified to provide. These services are:

(1) nursing services according to the written plan of care or service plan and accepted standards of medical and nursing practice in accordance with chapter 148;

(2) services which due to the recipient's medical condition may only be safely and effectively provided by a registered nurse or a licensed practical nurse;

(3) assessments performed only by a registered nurse; and

(4) teaching and training the recipient, the recipient's family, or other caregivers requiring the skills of a registered nurse or licensed practical nurse.

(n) "Telehomecare" means the use of telecommunications technology by a home health care professional to deliver home health care services, within the professional's scope of practice, to a patient located at a site other than the site where the practitioner is located.

**[EFFECTIVE DATE.]** Paragraph (d) of this section is effective January 1, 2003.

Sec. 28. Minnesota Statutes 2000, section 256B.0627, subdivision 2, is amended to read:

Subd. 2. [SERVICES COVERED.] Home care services covered under this section include:

(1) nursing services under section 256B.0625, subdivision 6a;

(2) private duty nursing services under section 256B.0625, subdivision 7;

(3) home health ~~aide~~ services under section 256B.0625, subdivision 6a;

(4) personal care assistant services under section 256B.0625, subdivision 19a;

(5) supervision of personal care assistant services provided by a qualified professional under section 256B.0625, subdivision 19a;

(6) ~~consulting~~ qualified professional of personal care assistant services under the fiscal ~~agent~~ intermediary option as specified in subdivision 10;

(7) face-to-face assessments by county public health nurses for services under section 256B.0625, subdivision 19a; and

(8) service updates and review of temporary increases for personal care assistant services by the county public health nurse for services under section 256B.0625, subdivision 19a.

Sec. 29. Minnesota Statutes 2000, section 256B.0627, subdivision 4, is amended to read:

Subd. 4. [PERSONAL CARE ASSISTANT SERVICES.] (a) The personal care assistant services that are eligible for payment are ~~the following:~~ services and supports furnished to an individual, as needed, to assist in accomplishing activities of daily living; instrumental activities of daily living; health-related functions through hands-on assistance, supervision, and cueing; and redirection and intervention for behavior including observation and monitoring.

(b) Payment for services will be made within the limits approved using the prior authorized process established in subdivision 5.

(c) The amount and type of services authorized shall be based on an assessment of the recipient's needs in these areas:

(1) bowel and bladder care;

(2) skin care to maintain the health of the skin;

(3) repetitive maintenance range of motion, muscle strengthening exercises, and other tasks specific to maintaining a recipient's optimal level of function;

(4) respiratory assistance;

(5) transfers and ambulation;

(6) bathing, grooming, and hairwashing necessary for personal hygiene;

(7) turning and positioning;

(8) assistance with furnishing medication that is self-administered;

(9) application and maintenance of prosthetics and orthotics;

(10) cleaning medical equipment;

(11) dressing or undressing;

(12) assistance with eating and meal preparation and necessary grocery shopping;

(13) accompanying a recipient to obtain medical diagnosis or treatment;

(14) assisting, monitoring, or prompting the recipient to complete the services in clauses (1) to (13);

(15) redirection, monitoring, and observation that are medically necessary and an integral part of completing the personal care assistant services described in clauses (1) to (14);

(16) redirection and intervention for behavior, including observation and monitoring;

(17) interventions for seizure disorders, including monitoring and observation if the recipient has had a seizure that requires intervention within the past three months;

(18) tracheostomy suctioning using a clean procedure if the procedure is properly delegated by a registered nurse. Before this procedure can be delegated to a personal care assistant, a registered nurse must determine that the tracheostomy suctioning can be accomplished utilizing a clean rather than a sterile procedure and must ensure that the personal care assistant has been taught the proper procedure; and

(19) incidental household services that are an integral part of a personal care service described in clauses (1) to (18).

For purposes of this subdivision, monitoring and observation means watching for outward visible signs that are likely to occur and for which there is a covered personal care service or an appropriate personal care intervention. For purposes of this subdivision, a clean procedure refers to a procedure that reduces the numbers of microorganisms or prevents or reduces the transmission of microorganisms from one person or place to another. A clean procedure may be used beginning 14 days after insertion.

~~(b)~~ (d) The personal care assistant services that are not eligible for payment are the following:

(1) services not ordered by the physician;

(2) assessments by personal care assistant provider organizations or by independently enrolled registered nurses;

(3) services that are not in the service plan;

(4) services provided by the recipient's spouse, legal guardian for an adult or child recipient, or parent of a recipient under age 18;

(5) services provided by a foster care provider of a recipient who cannot direct the recipient's

own care, unless monitored by a county or state case manager under section 256B.0625, subdivision 19a;

(6) services provided by the residential or program license holder in a residence for more than four persons;

(7) services that are the responsibility of a residential or program license holder under the terms of a service agreement and administrative rules;

(8) ~~sterile procedures;~~

~~(9)~~ injections of fluids into veins~~, muscles, or skin~~;

~~(10)~~ (9) services provided by parents of adult recipients, adult children, or siblings of the recipient, unless these relatives meet one of the following hardship criteria and the commissioner waives this requirement:

(i) the relative resigns from a part-time or full-time job to provide personal care for the recipient;

(ii) the relative goes from a full-time to a part-time job with less compensation to provide personal care for the recipient;

(iii) the relative takes a leave of absence without pay to provide personal care for the recipient;

(iv) the relative incurs substantial expenses by providing personal care for the recipient; or

(v) because of labor conditions, special language needs, or intermittent hours of care needed, the relative is needed in order to provide an adequate number of qualified personal care assistants to meet the medical needs of the recipient;

~~(11)~~ (10) homemaker services that are not an integral part of a personal care assistant services;

~~(12)~~ (11) home maintenance, or chore services;

~~(13)~~ (12) services not specified under paragraph (a); and

~~(14)~~ (13) services not authorized by the commissioner or the commissioner's designee.

(e) The recipient or responsible party may choose to supervise the personal care assistant or to have a qualified professional, as defined in section 256B.0625, subdivision 19c, provide the supervision. As required under section 256B.0625, subdivision 19c, the county public health nurse, as a part of the assessment, will consult with the recipient or responsible party to identify the most appropriate person to provide supervision of the personal care assistant. Health-related delegated tasks performed by the personal care assistant will be under the supervision of a qualified professional or the direction of the recipient's physician. If the recipient has a qualified professional, Minnesota Rules, part 9505.0335, subpart 4, applies.

Sec. 30. Minnesota Statutes 2000, section 256B.0627, subdivision 5, is amended to read:

Subd. 5. [LIMITATION ON PAYMENTS.] Medical assistance payments for home care services shall be limited according to this subdivision.

(a) [LIMITS ON SERVICES WITHOUT PRIOR AUTHORIZATION.] A recipient may receive the following home care services during a calendar year:

(1) up to two face-to-face assessments to determine a recipient's need for personal care assistant services;

(2) one service update done to determine a recipient's need for personal care assistant services; and

(3) up to ~~five~~ nine skilled nurse visits.

(b) [PRIOR AUTHORIZATION; EXCEPTIONS.] All home care services above the limits in paragraph (a) must receive the commissioner's prior authorization, except when:

(1) the home care services were required to treat an emergency medical condition that if not immediately treated could cause a recipient serious physical or mental disability, continuation of severe pain, or death. The provider must request retroactive authorization no later than five working days after giving the initial service. The provider must be able to substantiate the emergency by documentation such as reports, notes, and admission or discharge histories;

(2) the home care services were provided on or after the date on which the recipient's eligibility began, but before the date on which the recipient was notified that the case was opened. Authorization will be considered if the request is submitted by the provider within 20 working days of the date the recipient was notified that the case was opened;

(3) a third-party payor for home care services has denied or adjusted a payment. Authorization requests must be submitted by the provider within 20 working days of the notice of denial or adjustment. A copy of the notice must be included with the request;

(4) the commissioner has determined that a county or state human services agency has made an error; or

(5) the professional nurse determines an immediate need for up to 40 skilled nursing or home health aide visits per calendar year and submits a request for authorization within 20 working days of the initial service date, and medical assistance is determined to be the appropriate payer.

(c) [RETROACTIVE AUTHORIZATION.] A request for retroactive authorization will be evaluated according to the same criteria applied to prior authorization requests.

(d) [ASSESSMENT AND SERVICE PLAN.] Assessments under section 256B.0627, subdivision 1, paragraph (a), shall be conducted initially, and at least annually thereafter, in person with the recipient and result in a completed service plan using forms specified by the commissioner. Within 30 days of recipient or responsible party request for home care services, the assessment, the service plan, and other information necessary to determine medical necessity such as diagnostic or testing information, social or medical histories, and hospital or facility discharge summaries shall be submitted to the commissioner. For personal care assistant services:

(1) The amount and type of service authorized based upon the assessment and service plan will follow the recipient if the recipient chooses to change providers.

(2) If the recipient's medical need changes, the recipient's provider may assess the need for a change in service authorization and request the change from the county public health nurse. Within 30 days of the request, the public health nurse will determine whether to request the change in services based upon the provider assessment, or conduct a home visit to assess the need and determine whether the change is appropriate.

(3) To continue to receive personal care assistant services after the first year, the recipient or the responsible party, in conjunction with the public health nurse, may complete a service update on forms developed by the commissioner according to criteria and procedures in subdivision 1.

(e) [PRIOR AUTHORIZATION.] The commissioner, or the commissioner's designee, shall review the assessment, service update, request for temporary services, service plan, and any additional information that is submitted. The commissioner shall, within 30 days after receiving a complete request, assessment, and service plan, authorize home care services as follows:

(1) [HOME HEALTH SERVICES.] All home health services provided by a ~~licensed nurse or a~~ home health aide must be prior authorized by the commissioner or the commissioner's designee. Prior authorization must be based on medical necessity and cost-effectiveness when compared with other care options. When home health services are used in combination with personal care and private duty nursing, the cost of all home care services shall be considered for cost-effectiveness. The commissioner shall limit ~~nurse and~~ home health aide visits to no more than one visit ~~each~~ per day. The commissioner, or the commissioner's designee, may authorize up to two skilled nurse visits per day.

(2) [PERSONAL CARE ASSISTANT SERVICES.] (i) All personal care assistant services and supervision by a qualified professional, if requested by the recipient, must be prior authorized by the commissioner or the commissioner's designee except for the assessments established in paragraph (a). The amount of personal care assistant services authorized must be based on the recipient's home care rating. A child may not be found to be dependent in an activity of daily living if because of the child's age an adult would either perform the activity for the child or assist the child with the activity and the amount of assistance needed is similar to the assistance appropriate for a typical child of the same age. Based on medical necessity, the commissioner may authorize:

(A) up to two times the average number of direct care hours provided in nursing facilities for the recipient's comparable case mix level; or

(B) up to three times the average number of direct care hours provided in nursing facilities for recipients who have complex medical needs or are dependent in at least seven activities of daily living and need physical assistance with eating or have a neurological diagnosis; or

(C) up to 60 percent of the average reimbursement rate, as of July 1, 1991, for care provided in a regional treatment center for recipients who have Level I behavior, plus any inflation adjustment as provided by the legislature for personal care service; or

(D) up to the amount the commissioner would pay, as of July 1, 1991, plus any inflation adjustment provided for home care services, for care provided in a regional treatment center for recipients referred to the commissioner by a regional treatment center preadmission evaluation team. For purposes of this clause, home care services means all services provided in the home or community that would be included in the payment to a regional treatment center; or

(E) up to the amount medical assistance would reimburse for facility care for recipients referred to the commissioner by a preadmission screening team established under section 256B.0911 or 256B.092; and

(F) a reasonable amount of time for the provision of supervision by a qualified professional of personal care assistant services, if a qualified professional is requested by the recipient or responsible party.

(ii) The number of direct care hours shall be determined according to the annual cost report submitted to the department by nursing facilities. The average number of direct care hours, as established by May 1, 1992, shall be calculated and incorporated into the home care limits on July 1, 1992. These limits shall be calculated to the nearest quarter hour.

(iii) The home care rating shall be determined by the commissioner or the commissioner's designee based on information submitted to the commissioner by the county public health nurse on forms specified by the commissioner. The home care rating shall be a combination of current assessment tools developed under sections 256B.0911 and 256B.501 with an addition for seizure activity that will assess the frequency and severity of seizure activity and with adjustments, additions, and clarifications that are necessary to reflect the needs and conditions of recipients who need home care including children and adults under 65 years of age. The commissioner shall establish these forms and protocols under this section and shall use an advisory group, including representatives of recipients, providers, and counties, for consultation in establishing and revising the forms and protocols.

(iv) A recipient shall qualify as having complex medical needs if the care required is difficult to perform and because of recipient's medical condition requires more time than community-based standards allow or requires more skill than would ordinarily be required and the recipient needs or has one or more of the following:

(A) daily tube feedings;

(B) daily parenteral therapy;

(C) wound or decubiti care;

(D) postural drainage, percussion, nebulizer treatments, suctioning, tracheotomy care, oxygen, mechanical ventilation;

(E) catheterization;

(F) ostomy care;

(G) quadriplegia; or

(H) other comparable medical conditions or treatments the commissioner determines would otherwise require institutional care.

(v) A recipient shall qualify as having Level I behavior if there is reasonable supporting evidence that the recipient exhibits, or that without supervision, observation, or redirection would exhibit, one or more of the following behaviors that cause, or have the potential to cause:

(A) injury to the recipient's own body;

(B) physical injury to other people; or

(C) destruction of property.

(vi) Time authorized for personal care relating to Level I behavior in subclause (v), items (A) to (C), shall be based on the predictability, frequency, and amount of intervention required.

(vii) A recipient shall qualify as having Level II behavior if the recipient exhibits on a daily basis one or more of the following behaviors that interfere with the completion of personal care assistant services under subdivision 4, paragraph (a):

(A) unusual or repetitive habits;

(B) withdrawn behavior; or

(C) offensive behavior.

(viii) A recipient with a home care rating of Level II behavior in subclause (vii), items (A) to (C), shall be rated as comparable to a recipient with complex medical needs under subclause (iv). If a recipient has both complex medical needs and Level II behavior, the home care rating shall be the next complex category up to the maximum rating under subclause (i), item (B).

(3) [PRIVATE DUTY NURSING SERVICES.] All private duty nursing services shall be prior authorized by the commissioner or the commissioner's designee. Prior authorization for private duty nursing services shall be based on medical necessity and cost-effectiveness when compared with alternative care options. The commissioner may authorize medically necessary private duty nursing services in quarter-hour units when:

(i) the recipient requires more individual and continuous care than can be provided during a nurse visit; or

(ii) the cares are outside of the scope of services that can be provided by a home health aide or personal care assistant.

The commissioner may authorize:

(A) up to two times the average amount of direct care hours provided in nursing facilities statewide for case mix classification "K" as established by the annual cost report submitted to the department by nursing facilities in May 1992;

(B) private duty nursing in combination with other home care services up to the total cost allowed under clause (2);

(C) up to 16 hours per day if the recipient requires more nursing than the maximum number of direct care hours as established in item (A) and the recipient meets the hospital admission criteria established under Minnesota Rules, parts ~~9505.0500~~ 9505.0501 to 9505.0540.

The commissioner may authorize up to 16 hours per day of medically necessary private duty nursing services or up to 24 hours per day of medically necessary private duty nursing services until such time as the commissioner is able to make a determination of eligibility for recipients who are cooperatively applying for home care services under the community alternative care program developed under section 256B.49, or until it is determined by the appropriate regulatory agency that a health benefit plan is or is not required to pay for appropriate medically necessary health care services. Recipients or their representatives must cooperatively assist the commissioner in obtaining this determination. Recipients who are eligible for the community alternative care program may not receive more hours of nursing under this section than would otherwise be authorized under section 256B.49.

Beginning January 1, 2003, private duty nursing services shall be authorized for complex and regular care according to section 256B.0627.

(4) [VENTILATOR-DEPENDENT RECIPIENTS.] If the recipient is ventilator-dependent, the monthly medical assistance authorization for home care services shall not exceed what the commissioner would pay for care at the highest cost hospital designated as a long-term hospital under the Medicare program. For purposes of this clause, home care services means all services provided in the home that would be included in the payment for care at the long-term hospital. "Ventilator-dependent" means an individual who receives mechanical ventilation for life support at least six hours per day and is expected to be or has been dependent for at least 30 consecutive days.

(f) [PRIOR AUTHORIZATION; TIME LIMITS.] The commissioner or the commissioner's designee shall determine the time period for which a prior authorization shall be effective. If the recipient continues to require home care services beyond the duration of the prior authorization, the home care provider must request a new prior authorization. Under no circumstances, other than the exceptions in paragraph (b), shall a prior authorization be valid prior to the date the commissioner receives the request or for more than 12 months. A recipient who appeals a reduction in previously authorized home care services may continue previously authorized services, other than temporary services under paragraph (h), pending an appeal under section 256.045. The commissioner must provide a detailed explanation of why the authorized services are reduced in amount from those requested by the home care provider.

(g) [APPROVAL OF HOME CARE SERVICES.] The commissioner or the commissioner's designee shall determine the medical necessity of home care services, the level of caregiver according to subdivision 2, and the institutional comparison according to this subdivision, the cost-effectiveness of services, and the amount, scope, and duration of home care services reimbursable by medical assistance, based on the assessment, primary payer coverage determination information as required, the service plan, the recipient's age, the cost of services, the recipient's medical condition, and diagnosis or disability. The commissioner may publish additional criteria for determining medical necessity according to section 256B.04.

(h) [PRIOR AUTHORIZATION REQUESTS; TEMPORARY SERVICES.] The agency nurse, the independently enrolled private duty nurse, or county public health nurse may request a temporary authorization for home care services by telephone. The commissioner may approve a temporary level of home care services based on the assessment, and service or care plan information, and primary payer coverage determination information as required. Authorization for a temporary level of home care services including nurse supervision is limited to the time specified by the commissioner, but shall not exceed 45 days, unless extended because the county public health nurse has not completed the required assessment and service plan, or the commissioner's determination has not been made. The level of services authorized under this provision shall have no bearing on a future prior authorization.

(i) [PRIOR AUTHORIZATION REQUIRED IN FOSTER CARE SETTING.] Home care services provided in an adult or child foster care setting must receive prior authorization by the department according to the limits established in paragraph (a).

The commissioner may not authorize:

(1) home care services that are the responsibility of the foster care provider under the terms of the foster care placement agreement and administrative rules;

(2) personal care assistant services when the foster care license holder is also the personal care provider or personal care assistant unless the recipient can direct the recipient's own care, or case management is provided as required in section 256B.0625, subdivision 19a;

(3) personal care assistant services when the responsible party is an employee of, or under contract with, or has any direct or indirect financial relationship with the personal care provider or personal care assistant, unless case management is provided as required in section 256B.0625, subdivision 19a; or

(4) personal care assistant and private duty nursing services when the number of foster care residents is greater than four unless the county responsible for the recipient's foster placement made the placement prior to April 1, 1992, requests that personal care assistant and private duty nursing services be provided, and case management is provided as required in section 256B.0625, subdivision 19a.

Sec. 31. Minnesota Statutes 2000, section 256B.0627, subdivision 7, is amended to read:

Subd. 7. [NONCOVERED HOME CARE SERVICES.] The following home care services are not eligible for payment under medical assistance:

(1) skilled nurse visits for the sole purpose of supervision of the home health aide;

(2) a skilled nursing visit:

(i) only for the purpose of monitoring medication compliance with an established medication program for a recipient; or

(ii) to administer or assist with medication administration, including injections, prefilling syringes for injections, or oral medication set-up of an adult recipient, when as determined and documented by the registered nurse, the need can be met by an available pharmacy or the recipient is physically and mentally able to self-administer or prefill a medication;

(3) home care services to a recipient who is eligible for covered services ~~including hospice, if elected by the recipient,~~ under the Medicare program or any other insurance held by the recipient;

(4) services to other members of the recipient's household;

(5) a visit made by a skilled nurse solely to train other home health agency workers;

(6) any home care service included in the daily rate of the community-based residential facility where the recipient is residing;

(7) nursing and rehabilitation therapy services that are reasonably accessible to a recipient outside the recipient's place of residence, excluding the assessment, counseling and education, and personal assistant care;

(8) any home health agency service, excluding personal care assistant services and private duty nursing services, which are performed in a place other than the recipient's residence; and

(9) Medicare evaluation or administrative nursing visits on dual-eligible recipients that do not qualify for Medicare visit billing.

Sec. 32. Minnesota Statutes 2000, section 256B.0627, subdivision 8, is amended to read:

Subd. 8. [SHARED PERSONAL CARE ASSISTANT SERVICES.] (a) Medical assistance payments for shared personal care assistance services shall be limited according to this subdivision.

(b) Recipients of personal care assistant services may share staff and the commissioner shall

provide a rate system for shared personal care assistant services. For two persons sharing services, the rate paid to a provider shall not exceed 1-1/2 times the rate paid for serving a single individual, and for three persons sharing services, the rate paid to a provider shall not exceed twice the rate paid for serving a single individual. These rates apply only to situations in which all recipients were present and received shared services on the date for which the service is billed. No more than three persons may receive shared services from a personal care assistant in a single setting.

(c) Shared service is the provision of personal care assistant services by a personal care assistant to two or three recipients at the same time and in the same setting. For the purposes of this subdivision, "setting" means:

(1) the home or foster care home of one of the individual recipients; or

(2) a child care program in which all recipients served by one personal care assistant are participating, which is licensed under chapter 245A or operated by a local school district or private school; or

(3) outside the home or foster care home of one of the recipients when normal life activities take the recipients outside the home.

The provisions of this subdivision do not apply when a personal care assistant is caring for multiple recipients in more than one setting.

(d) The recipient or the recipient's responsible party, in conjunction with the county public health nurse, shall determine:

(1) whether shared personal care assistant services is an appropriate option based on the individual needs and preferences of the recipient; and

(2) the amount of shared services allocated as part of the overall authorization of personal care assistant services.

The recipient or the responsible party, in conjunction with the supervising qualified professional, if a qualified professional is requested by any one of the recipients or responsible parties, shall arrange the setting and grouping of shared services based on the individual needs and preferences of the recipients. Decisions on the selection of recipients to share services must be based on the ages of the recipients, compatibility, and coordination of their care needs.

(e) The following items must be considered by the recipient or the responsible party and the supervising qualified professional, if a qualified professional has been requested by any one of the recipients or responsible parties, and documented in the recipient's health service record:

(1) the additional qualifications needed by the personal care assistant to provide care to several recipients in the same setting;

(2) the additional training and supervision needed by the personal care assistant to ensure that the needs of the recipient are met appropriately and safely. The provider must provide on-site supervision by a qualified professional within the first 14 days of shared services, and monthly thereafter, if supervision by a qualified provider has been requested by any one of the recipients or responsible parties;

(3) the setting in which the shared services will be provided;

(4) the ongoing monitoring and evaluation of the effectiveness and appropriateness of the service and process used to make changes in service or setting; and

(5) a contingency plan which accounts for absence of the recipient in a shared services setting due to illness or other circumstances and staffing contingencies.

(f) The provider must offer the recipient or the responsible party the option of shared or one-on-one personal care assistant services. The recipient or the responsible party can withdraw from participating in a shared services arrangement at any time.

(g) In addition to documentation requirements under Minnesota Rules, part 9505.2175, a personal care provider must meet documentation requirements for shared personal care assistant services and must document the following in the health service record for each individual recipient sharing services:

(1) permission by the recipient or the recipient's responsible party, if any, for the maximum number of shared services hours per week chosen by the recipient;

(2) permission by the recipient or the recipient's responsible party, if any, for personal care assistant services provided outside the recipient's residence;

(3) permission by the recipient or the recipient's responsible party, if any, for others to receive shared services in the recipient's residence;

(4) revocation by the recipient or the recipient's responsible party, if any, of the shared service authorization, or the shared service to be provided to others in the recipient's residence, or the shared service to be provided outside the recipient's residence;

(5) supervision of the shared personal care assistant services by the qualified professional, if a qualified professional is requested by one of the recipients or responsible parties, including the date, time of day, number of hours spent supervising the provision of shared services, whether the supervision was face-to-face or another method of supervision, changes in the recipient's condition, shared services scheduling issues and recommendations;

(6) documentation by the qualified professional, if a qualified professional is requested by one of the recipients or responsible parties, of telephone calls or other discussions with the personal care assistant regarding services being provided to the recipient who has requested the supervision; and

(7) daily documentation of the shared services provided by each identified personal care assistant including:

(i) the names of each recipient receiving shared services together;

(ii) the setting for the shared services, including the starting and ending times that the recipient received shared services; and

(iii) notes by the personal care assistant regarding changes in the recipient's condition, problems that may arise from the sharing of services, scheduling issues, care issues, and other notes as required by the qualified professional, if a qualified professional is requested by one of the recipients or responsible parties.

(h) Unless otherwise provided in this subdivision, all other statutory and regulatory provisions relating to personal care assistant services apply to shared services.

(i) In the event that supervision by a qualified professional has been requested by one or more recipients, but not by all of the recipients, the supervision duties of the qualified professional shall be limited to only those recipients who have requested the supervision.

Nothing in this subdivision shall be construed to reduce the total number of hours authorized for an individual recipient.

Sec. 33. Minnesota Statutes 2000, section 256B.0627, subdivision 10, is amended to read:

Subd. 10. [FISCAL ~~AGENT~~ INTERMEDIARY OPTION AVAILABLE FOR PERSONAL CARE ASSISTANT SERVICES.] (a) ~~"Fiscal agent option" is an option that allows the recipient to:~~

~~(1) use a fiscal agent instead of a personal care provider organization;~~

~~(2) supervise the personal care assistant; and~~

~~(3) use a consulting professional.~~

The commissioner may allow a recipient of personal care assistant services to use a fiscal ~~agent~~ intermediary to assist the recipient in paying and accounting for medically necessary covered personal care assistant services authorized in subdivision 4 and within the payment parameters of subdivision 5. Unless otherwise provided in this subdivision, all other statutory and regulatory provisions relating to personal care assistant services apply to a recipient using the fiscal ~~agent~~ intermediary option.

(b) The recipient or responsible party shall:

(1) ~~hire, and terminate the personal care assistant and consulting professional, with the fiscal agent~~ recruit, hire, and terminate a qualified professional, if a qualified professional is requested by the recipient or responsible party;

(2) ~~recruit the personal care assistant and consulting professional and orient and train the personal care assistant in areas that do not require professional delegation as determined by the county public health nurse~~ verify and document the credentials of the qualified professional, if a qualified professional is requested by the recipient or responsible party;

(3) ~~supervise and evaluate the personal care assistant in areas that do not require professional delegation as determined in the assessment;~~

~~(4) cooperate with a consulting~~ develop a service plan based on physician orders and public health nurse assessment with the assistance of a qualified professional ~~and implement recommendations pertaining to the health and safety of the recipient~~, if a qualified professional is requested by the recipient or responsible party, that addresses the health and safety of the recipient;

~~(5) hire a qualified professional to train and supervise the performance of delegated tasks done by~~ (4) recruit, hire, and terminate the personal care assistant;

~~(6) monitor services and verify in writing the hours worked by the personal care assistant and the consulting~~ (5) orient and train the personal care assistant with assistance as needed from the qualified professional;

~~(7) develop and revise a care plan with assistance from a consulting~~ (6) supervise and evaluate the personal care assistant with assistance as needed from the recipient's physician or the qualified professional;

~~(8) verify and document the credentials of the consulting~~ (7) monitor and verify in writing and report to the fiscal intermediary the number of hours worked by the personal care assistant and the qualified professional; and

~~(9)~~ (8) enter into a written agreement, as specified in paragraph (f).

(c) The duties of the fiscal ~~agent~~ intermediary shall be to:

(1) bill the medical assistance program for personal care assistant and ~~consulting~~ qualified professional services;

(2) request and secure background checks on personal care assistants and ~~consulting~~ qualified professionals according to section 245A.04;

(3) pay the personal care assistant and ~~consulting~~ qualified professional based on actual hours of services provided;

(4) withhold and pay all applicable federal and state taxes;

(5) verify and ~~document~~ keep records hours worked by the personal care assistant and ~~consulting~~ qualified professional;

(6) make the arrangements and pay unemployment insurance, taxes, workers' compensation, liability insurance, and other benefits, if any;

(7) enroll in the medical assistance program as a fiscal ~~agent~~ intermediary; and

(8) enter into a written agreement as specified in paragraph (f) before services are provided.

(d) The fiscal ~~agent~~ intermediary:

(1) may not be related to the recipient, ~~consulting~~ qualified professional, or the personal care assistant;

(2) must ensure arm's length transactions with the recipient and personal care assistant; and

(3) shall be considered a joint employer of the personal care assistant and ~~consulting~~ qualified professional to the extent specified in this section.

The fiscal ~~agent~~ intermediary or owners of the entity that provides fiscal ~~agent~~ intermediary services under this subdivision must pass a criminal background check as required in section 256B.0627, subdivision 1, paragraph (e).

(e) If the recipient or responsible party requests a qualified professional, the ~~consulting~~ qualified professional providing assistance to the recipient shall meet the qualifications specified in section 256B.0625, subdivision 19c. The ~~consulting~~ qualified professional shall assist the recipient in developing and revising a plan to meet the recipient's ~~assessed~~ needs, ~~and supervise the performance of delegated tasks, as determined by the public health nurse~~ as assessed by the public health nurse. In performing this function, the ~~consulting~~ qualified professional must visit the recipient in the recipient's home at least once annually. The ~~consulting~~ qualified professional must report ~~to the local county public health nurse concerns relating to the health and safety of the recipient, and~~ any suspected abuse, neglect, or financial exploitation of the recipient to the appropriate authorities.

(f) The fiscal ~~agent~~ intermediary, recipient or responsible party, personal care assistant, and ~~consulting~~ qualified professional shall enter into a written agreement before services are started. The agreement shall include:

(1) the duties of the recipient, qualified professional, personal care assistant, and fiscal agent based on paragraphs (a) to (e);

(2) the salary and benefits for the personal care assistant and ~~those providing professional consultation~~ the qualified professional;

(3) the administrative fee of the fiscal ~~agent~~ intermediary and services paid for with that fee, including background check fees;

(4) procedures to respond to billing or payment complaints; and

(5) procedures for hiring and terminating the personal care assistant and ~~those providing professional consultation~~ the qualified professional.

(g) The rates paid for personal care assistant services, qualified professional ~~assistance~~ services, and fiscal ~~agency~~ intermediary services under this subdivision shall be the same rates paid for personal care assistant services and qualified professional services under subdivision 2 respectively. Except for the administrative fee of the fiscal ~~agent~~ intermediary specified in paragraph (f), the remainder of the rates paid to the fiscal ~~agent~~ intermediary must be used to pay for the salary and benefits for the personal care assistant or ~~those providing professional consultation~~ the qualified professional.

(h) As part of the assessment defined in subdivision 1, the following conditions must be met to use or continue use of a fiscal ~~agent~~ intermediary:

(1) the recipient must be able to direct the recipient's own care, or the responsible party for the recipient must be readily available to direct the care of the personal care assistant;

(2) the recipient or responsible party must be knowledgeable of the health care needs of the recipient and be able to effectively communicate those needs;

(3) a face-to-face assessment must be conducted by the local county public health nurse at least annually, or when there is a significant change in the recipient's condition or change in the need for personal care assistant services~~. The county public health nurse shall determine the services that require professional delegation, if any, and the amount and frequency of related supervision~~;

(4) the recipient cannot select the shared services option as specified in subdivision 8; and

(5) parties must be in compliance with the written agreement specified in paragraph (f).

(i) The commissioner shall deny, revoke, or suspend the authorization to use the fiscal ~~agent~~ intermediary option if:

(1) it has been determined by the ~~consulting~~ qualified professional or local county public health nurse that the use of this option jeopardizes the recipient's health and safety;

(2) the parties have failed to comply with the written agreement specified in paragraph (f); or

(3) the use of the option has led to abusive or fraudulent billing for personal care assistant services.

The recipient or responsible party may appeal the commissioner's action according to section 256.045. The denial, revocation, or suspension to use the fiscal ~~agent~~ intermediary option shall not affect the recipient's authorized level of personal care assistant services as determined in subdivision 5.

Sec. 34. Minnesota Statutes 2000, section 256B.0627, subdivision 11, is amended to read:

Subd. 11. [SHARED PRIVATE DUTY NURSING CARE OPTION.] (a) Medical assistance payments for shared private duty nursing services by a private duty nurse shall be limited according to this subdivision. For the purposes of this section, "private duty nursing agency" means an agency licensed under chapter 144A to provide private duty nursing services.

(b) Recipients of private duty nursing services may share nursing staff and the commissioner shall provide a rate methodology for shared private duty nursing. For two persons sharing nursing care, the rate paid to a provider shall not exceed 1.5 times the ~~nonwaivered~~ regular private duty nursing rates paid for serving a single individual ~~who is not ventilator dependent,~~ by a registered nurse or licensed practical nurse. These rates apply only to situations in which both recipients are present and receive shared private duty nursing care on the date for which the service is billed. No more than two persons may receive shared private duty nursing services from a private duty nurse in a single setting.

(c) Shared private duty nursing care is the provision of nursing services by a private duty nurse to two recipients at the same time and in the same setting. For the purposes of this subdivision, "setting" means:

(1) the home or foster care home of one of the individual recipients; or

(2) a child care program licensed under chapter 245A or operated by a local school district or private school; or

(3) an adult day care service licensed under chapter 245A; or

(4) outside the home or foster care home of one of the recipients when normal life activities take the recipients outside the home.

This subdivision does not apply when a private duty nurse is caring for multiple recipients in more than one setting.

(d) The recipient or the recipient's legal representative, and the recipient's physician, in conjunction with the home health care agency, shall determine:

(1) whether shared private duty nursing care is an appropriate option based on the individual needs and preferences of the recipient; and

(2) the amount of shared private duty nursing services authorized as part of the overall authorization of nursing services.

(e) The recipient or the recipient's legal representative, in conjunction with the private duty nursing agency, shall approve the setting, grouping, and arrangement of shared private duty nursing care based on the individual needs and preferences of the recipients. Decisions on the selection of recipients to share services must be based on the ages of the recipients, compatibility, and coordination of their care needs.

(f) The following items must be considered by the recipient or the recipient's legal representative and the private duty nursing agency, and documented in the recipient's health service record:

(1) the additional training needed by the private duty nurse to provide care to two recipients in the same setting and to ensure that the needs of the recipients are met appropriately and safely;

(2) the setting in which the shared private duty nursing care will be provided;

(3) the ongoing monitoring and evaluation of the effectiveness and appropriateness of the service and process used to make changes in service or setting;

(4) a contingency plan which accounts for absence of the recipient in a shared private duty nursing setting due to illness or other circumstances;

(5) staffing backup contingencies in the event of employee illness or absence; and

(6) arrangements for additional assistance to respond to urgent or emergency care needs of the recipients.

(g) The provider must offer the recipient or responsible party the option of shared or one-on-one private duty nursing services. The recipient or responsible party can withdraw from participating in a shared service arrangement at any time.

(h) The private duty nursing agency must document the following in the health service record for each individual recipient sharing private duty nursing care:

(1) permission by the recipient or the recipient's legal representative for the maximum number of shared nursing care hours per week chosen by the recipient;

(2) permission by the recipient or the recipient's legal representative for shared private duty nursing services provided outside the recipient's residence;

(3) permission by the recipient or the recipient's legal representative for others to receive shared private duty nursing services in the recipient's residence;

(4) revocation by the recipient or the recipient's legal representative of the shared private duty nursing care authorization, or the shared care to be provided to others in the recipient's residence, or the shared private duty nursing services to be provided outside the recipient's residence; and

(5) daily documentation of the shared private duty nursing services provided by each identified private duty nurse, including:

(i) the names of each recipient receiving shared private duty nursing services together;

(ii) the setting for the shared services, including the starting and ending times that the recipient received shared private duty nursing care; and

(iii) notes by the private duty nurse regarding changes in the recipient's condition, problems that may arise from the sharing of private duty nursing services, and scheduling and care issues.

(i) Unless otherwise provided in this subdivision, all other statutory and regulatory provisions relating to private duty nursing services apply to shared private duty nursing services.

Nothing in this subdivision shall be construed to reduce the total number of private duty nursing hours authorized for an individual recipient under subdivision 5.

Sec. 35. Minnesota Statutes 2000, section 256B.0627, is amended by adding a subdivision to read:

Subd. 13. [CONSUMER-DIRECTED HOME CARE DEMONSTRATION PROJECT.] (a) Upon the receipt of federal waiver authority, the commissioner shall implement a consumer-directed home care demonstration project. The consumer-directed home care demonstration project must demonstrate and evaluate the outcomes of a consumer-directed service delivery alternative to improve access, increase consumer control and accountability over available resources, and enable the use of supports that are more individualized and cost-effective for eligible medical assistance recipients receiving certain medical assistance home care services. The consumer-directed home care demonstration project will be administered locally by county agencies, tribal governments, or administrative entities under contract with the state in regions where counties choose not to provide this service.

(b) Grant awards for persons who have been receiving medical assistance covered personal care, home health aide, or private duty nursing services for a period of 12 consecutive months or more prior to enrollment in the consumer-directed home care demonstration project will be established on a case-by-case basis using historical service expenditure data. An average monthly expenditure for each continuing enrollee will be calculated based on historical expenditures made on behalf of the enrollee for personal care, home health aide, or private duty nursing services during the 12 month period directly prior to enrollment in the project. The grant award will equal 90 percent of the average monthly expenditure.

(c) Grant awards for project enrollees who have been receiving medical assistance covered personal care, home health aide, or private duty nursing services for a period of less than 12 consecutive months prior to project enrollment will be calculated on a case-by-case basis using the service authorization in place at the time of enrollment. The total number of units of personal care, home health aide, or private duty nursing services the enrollee has been authorized to receive will be converted to the total cost of the authorized services in a given month using the statewide average service payment rates. To determine an estimated monthly expenditure, the total authorized monthly personal care, home health aide or private duty nursing service costs will be reduced by a percentage rate equivalent to the difference between the statewide average service authorization and the statewide average utilization rate for each of the services by medical assistance eligibles during the most recent fiscal year for which 12 months of data is available. The grant award will equal 90 percent of the estimated monthly expenditure.

Sec. 36. Minnesota Statutes 2000, section 256B.0627, is amended by adding a subdivision to read:

Subd. 14. [TELEHOMECARE; SKILLED NURSE VISITS.] Medical assistance covers skilled nurse visits according to section 256B.0625, subdivision 6a, provided via telehomecare, for services which do not require hands-on care between the home care nurse and recipient. The provision of telehomecare must be made via live, two-way interactive audiovisual technology and may be augmented by utilizing store-and-forward technologies. Store-and-forward technology includes telehomecare services that do not occur in real time via synchronous transmissions, and that do not require a face-to-face encounter with the recipient for all or any part of any such telehomecare visit. A communication between the home care nurse and recipient that consists solely of a telephone conversation, facsimile, electronic mail, or a consultation between two health care practitioners, is not to be considered a telehomecare visit. Multiple daily skilled nurse visits provided via telehomecare are allowed. Coverage of telehomecare is limited to two visits per day. All skilled nurse visits provided via telehomecare must be prior authorized by the commissioner or the commissioner's designee and will be covered at the same allowable rate as skilled nurse visits provided in-person.

Sec. 37. Minnesota Statutes 2000, section 256B.0627, is amended by adding a subdivision to read:

Subd. 15. [THERAPIES THROUGH HOME HEALTH AGENCIES.] (a) [PHYSICAL THERAPY.] Medical assistance covers physical therapy and related services, including specialized maintenance therapy. Services provided by a physical therapy assistant shall be reimbursed at the same rate as services performed by a physical therapist when the services of the physical therapy assistant are provided under the direction of a physical therapist who is on the premises. Services provided by a physical therapy assistant that are provided under the direction of a physical therapist who is not on the premises shall be reimbursed at 65 percent of the physical therapist rate. Direction of the physical therapy assistant must be provided by the physical therapist as described in Minnesota Rules, part 9505.0390, subpart 1, item B. The physical therapist and physical therapist assistant may not both bill for services provided to a recipient on the same day.

(b) [OCCUPATIONAL THERAPY.] Medical assistance covers occupational therapy and related services, including specialized maintenance therapy. Services provided by an occupational therapy assistant shall be reimbursed at the same rate as services performed by an occupational therapist when the services of the occupational therapy assistant are provided under the direction of the occupational therapist who is on the premises. Services provided by an occupational therapy assistant under the direction of an occupational therapist who is not on the premises shall be reimbursed at 65 percent of the occupational therapist rate. Direction of the occupational therapy assistant must be provided by the occupational therapist as described in Minnesota Rules, part 9505.0390, subpart 1, item B. The occupational therapist and occupational therapist assistant may not both bill for services provided to a recipient on the same day.

Sec. 38. Minnesota Statutes 2000, section 256B.0627, is amended by adding a subdivision to read:

Subd. 16. [HARDSHIP CRITERIA; PRIVATE DUTY NURSING.] (a) Payment is allowed for extraordinary services that require specialized nursing skills and are provided by parents of minor children, spouses, and legal guardians who are providing private duty nursing care under the following conditions:

(1) the provision of these services is not legally required of the parents, spouses, or legal guardians;

(2) the services are necessary to prevent hospitalization of the recipient; and

(3) the recipient is eligible for state plan home care or a home and community-based waiver and one of the following hardship criteria are met:

(i) the parent, spouse, or legal guardian resigns from a part-time or full-time job to provide nursing care for the recipient; or

(ii) the parent, spouse, or legal guardian goes from a full-time to a part-time job with less compensation to provide nursing care for the recipient; or

(iii) the parent, spouse, or legal guardian takes a leave of absence without pay to provide nursing care for the recipient; or

(iv) because of labor conditions, special language needs, or intermittent hours of care needed, the parent, spouse, or legal guardian is needed in order to provide adequate private duty nursing services to meet the medical needs of the recipient.

(b) Private duty nursing may be provided by a parent, spouse, or legal guardian who is a nurse licensed in Minnesota. Private duty nursing services provided by a parent, spouse, or legal guardian cannot be used in lieu of nursing services covered and available under liable third-party payors, including Medicare. The private duty nursing provided by a parent, spouse, or legal guardian must be included in the service plan. Authorized skilled nursing services provided by the parent, spouse, or legal guardian may not exceed 50 percent of the total approved nursing hours, or

eight hours per day, whichever is less, up to a maximum of 40 hours per week. Nothing in this subdivision precludes the parent's, spouse's, or legal guardian's obligation of assuming the nonreimbursed family responsibilities of emergency backup caregiver and primary caregiver.

(c) A parent or a spouse may not be paid to provide private duty nursing care if the parent or spouse fails to pass a criminal background check according to section 245A.04, or if it has been determined by the home health agency, the case manager, or the physician that the private duty nursing care provided by the parent, spouse, or legal guardian is unsafe.

Sec. 39. Minnesota Statutes 2000, section 256B.0627, is amended by adding a subdivision to read:

Subd. 17. [QUALITY ASSURANCE PLAN FOR PERSONAL CARE ASSISTANT SERVICES.] The commissioner shall establish a quality assurance plan for personal care assistant services that includes:

(1) performance-based provider agreements;

(2) meaningful consumer input, which may include consumer surveys, that measure the extent to which participants receive the services and supports described in the individual plan and participant satisfaction with such services and supports;

(3) ongoing monitoring of the health and well-being of consumers; and

(4) an ongoing public process for development, implementation, and review of the quality assurance plan.

Sec. 40. Minnesota Statutes 2000, section 256B.0911, is amended by adding a subdivision to read:

Subd. 4a. [PREADMISSION SCREENING OF INDIVIDUALS UNDER 65 YEARS OF AGE.] (a) It is the policy of the state of Minnesota to ensure that individuals with disabilities or chronic illness are served in the most integrated setting appropriate to their needs and have the necessary information to make informed choices about home and community-based service options.

(b) Individuals under 65 years of age who are admitted to a nursing facility from a hospital must be screened prior to admission as outlined in subdivision 4.

(c) Individuals under 65 years of age who are admitted to nursing facilities with only a telephone screening must receive a face-to-face assessment from the long-term care consultation team member of the county in which the facility is located or from the recipient's county case manager within 20 working days of admission.

(d) At the face-to-face assessment, the long-term care consultation team member or county case manager must perform the activities required under subdivision 3.

(e) For individuals under 21 years of age, the screening or assessment which recommends nursing facility admission must be approved by the commissioner before the individual is admitted to the nursing facility.

(f) In the event that an individual under 65 years of age is admitted to a nursing facility on an emergency basis, the county must be notified of the admission on the next working day, and a face-to-face assessment as described in paragraph (c) must be conducted within 20 working days of admission.

(g) At the face-to-face assessment, the long-term care consultation team member or the case manager must present information about home and community-based options so the individual can make informed choices. If the individual chooses home and community-based services, the long-term care consultation team member or case manager must complete a written relocation plan within 20 working days of the visit. The plan shall describe the services needed to move out of the

facility and a timeline for the move which is designed to ensure a smooth transition to the individual's home and community.

(h) An individual under 65 years of age residing in a nursing facility shall receive a face-to-face assessment at least every 12 months to review the person's service choices and available alternatives unless the individual indicates, in writing, that annual visits are not desired. In this case, the individual must receive a face-to-face assessment at least once every 36 months for the same purposes.

(i) Notwithstanding the provisions of subdivision 6, the commissioner may pay county agencies directly for face-to-face assessments for individuals who are eligible for medical assistance, under 65 years of age, and being considered for placement or residing in a nursing facility.

Sec. 41. Minnesota Statutes 2000, section 256B.093, subdivision 3, is amended to read:

Subd. 3. [TRAUMATIC BRAIN INJURY PROGRAM DUTIES.] The department shall fund administrative case management under this subdivision using medical assistance administrative funds. The traumatic brain injury program duties include:

(1) recommending to the commissioner in consultation with the medical review agent according to Minnesota Rules, parts 9505.0500 to 9505.0540, the approval or denial of medical assistance funds to pay for out-of-state placements for traumatic brain injury services and in-state traumatic brain injury services provided by designated Medicare long-term care hospitals;

(2) coordinating the traumatic brain injury home and community-based waiver;

(3) ~~approving traumatic brain injury waiver eligibility or care plans or both;~~

~~(4)~~ providing ongoing technical assistance and consultation to county and facility case managers to facilitate care plan development for appropriate, accessible, and cost-effective medical assistance services;

~~(5)~~ (4) providing technical assistance to promote statewide development of appropriate, accessible, and cost-effective medical assistance services and related policy;

~~(6)~~ (5) providing training and outreach to facilitate access to appropriate home and community-based services to prevent institutionalization;

~~(7)~~ (6) facilitating appropriate admissions, continued stay review, discharges, and utilization review for neurobehavioral hospitals and other specialized institutions;

~~(8)~~ (7) providing technical assistance on the use of prior authorization of home care services and coordination of these services with other medical assistance services;

~~(9)~~ (8) developing a system for identification of nursing facility and hospital residents with traumatic brain injury to assist in long-term planning for medical assistance services. Factors will include, but are not limited to, number of individuals served, length of stay, services received, and barriers to community placement; and

~~(10)~~ (9) providing information, referral, and case consultation to access medical assistance services for recipients without a county or facility case manager. Direct access to this assistance may be limited due to the structure of the program.

Sec. 42. Minnesota Statutes 2000, section 256B.49, is amended by adding a subdivision to read:

Subd. 11. [AUTHORITY.] (a) The commissioner is authorized to apply for home and community-based service waivers, as authorized under section 1915(c) of the Social Security Act to serve persons under the age of 65 who are determined to require the level of care provided in a nursing home and persons who require the level of care provided in a hospital. The commissioner shall apply for the home and community-based waivers in order to: (i) promote the support of persons with disabilities in the most integrated settings; (ii) expand the availability of services for persons who are eligible for medical assistance; (iii) promote cost-effective options to institutional care; and (iv) obtain federal financial participation.

(b) The provision of waivered services to medical assistance recipients with disabilities shall comply with the requirements outlined in the federally approved applications for home and community-based services and subsequent amendments, including provision of services according to a service plan designated to meet the needs of the individual. For purposes of this section, the approved home and community-based application is considered the necessary federal requirement.

(c) The commissioner shall seek approval, as authorized under section 1915(c) of the Social Security Act, to allow medical assistance eligibility under this section for children under age 21 without deeming of parental income or assets.

(d) The commissioner shall seek approval, as authorized under section 1915(c) of the Social Security Act, to allow medical assistance eligibility under this section for individuals under age 65 without deeming the spouse's income or assets.

(e) Prior to submitting to the federal government any proposed changes or amendments to federally approved applications for home and community-based services, the commissioner shall notify interested persons serving on departmental advisory groups and task forces and persons who have requested to be notified.

Sec. 43. Minnesota Statutes 2000, section 256B.49, is amended by adding a subdivision to read:

Subd. 12. [INFORMED CHOICE.] Persons who are determined likely to require the level of care provided in a nursing facility or hospital shall be informed of the home and community-based support alternatives to the provision of inpatient hospital services or nursing facility services. Each person must be given the choice of either institutional or home and community-based services using the provisions described in section 256B.77, subdivision 2, paragraph (p).

Sec. 44. Minnesota Statutes 2000, section 256B.49, is amended by adding a subdivision to read:

Subd. 13. [CASE MANAGEMENT.] (a) Each recipient of a home and community-based waiver shall be provided case management services by qualified vendors as described in the federally approved waiver application. The case management service activities provided will include:

(1) assessing the needs of the individual within 20 working days of a recipient's request;

(2) developing the written individual service plan within ten working days after the assessment is completed;

(3) informing the recipient or the recipient's legal guardian or conservator of service options;

(4) assisting the recipient in the identification of potential service providers;

(5) assisting the recipient to access services;

(6) coordinating, evaluating, and monitoring of the services identified in the service plan;

(7) completing the annual reviews of the service plan; and

(8) informing the recipient or legal representative of the right to have assessments completed and service plans developed within specified time periods, and to appeal county action or inaction under section 256.045, subdivision 3.

(b) The case manager may delegate certain aspects of the case management service activities to another individual provided there is oversight by the case manager. The case manager may not delegate those aspects which require professional judgment including assessments, reassessments, and care plan development.

Sec. 45. Minnesota Statutes 2000, section 256B.49, is amended by adding a subdivision to read:

Subd. 14. [ASSESSMENT AND REASSESSMENT.] (a) Assessments of each recipient's strengths, informal support systems, and need for services shall be completed within 20 working

days of the recipient's request. Reassessment of each recipient's strengths, support systems, and need for services shall be conducted at least every 12 months and at other times when there has been a significant change in the recipient's functioning.

(b) Persons with mental retardation or a related condition who apply for services under the nursing facility level waiver programs shall be screened for the appropriate level of care according to section 256B.092.

(c) Recipients who are found eligible for home and community-based services under this section before their 65th birthday may remain eligible for these services after their 65th birthday if they continue to meet all other eligibility factors.

Sec. 46. Minnesota Statutes 2000, section 256B.49, is amended by adding a subdivision to read:

Subd. 15. [INDIVIDUALIZED SERVICE PLAN.] Each recipient of home and community-based waivered services shall be provided a copy of the written service plan which:

(1) is developed and signed by the recipient within ten working days of the completion of the assessment;

(2) meets the assessed needs of the recipient;

(3) reasonably ensures the health and safety of the recipient;

(4) promotes independence;

(5) allows for services to be provided in the most integrated settings; and

(6) provides for an informed choice, as defined in section 256B.77, subdivision 2, paragraph (p), of service and support providers.

Sec. 47. Minnesota Statutes 2000, section 256B.49, is amended by adding a subdivision to read:

Subd. 16. [SERVICES AND SUPPORTS.] Services and supports included in the home and community-based waivers for persons with disabilities shall meet the requirements set out in United States Code, title 42, section 1396n. The services and supports, which are offered as alternatives to institutional care, shall promote consumer choice, community inclusion, self-sufficiency, and self-determination. Beginning January 1, 2003, the commissioner shall simplify and improve access to home and community-based services, to the extent possible, through the establishment of a common service menu that is available to eligible recipients regardless of age, disability type, or waiver program. Consumer-directed community support services shall be offered as an option to all persons eligible for services under subdivision 11 by January 1, 2002. Services and supports shall be arranged and provided consistent with individualized written plans of care for eligible waiver recipients.

Sec. 48. Minnesota Statutes 2000, section 256B.49, is amended by adding a subdivision to read:

Subd. 17. [COST OF SERVICES AND SUPPORTS.] (a) The commissioner shall ensure that the average per capita expenditures estimated in any fiscal year for home and community-based waiver recipients does not exceed the average per capita expenditures that would have been made to provide institutional services for recipients in the absence of the waiver.

(b) The commissioner shall implement on January 1, 2002, one or more aggregate, need-based methods for allocating to local agencies the home and community-based waivered service resources available to support recipients with disabilities in need of the level of care provided in a nursing facility or a hospital. The commissioner shall allocate resources to single counties and county partnerships in a manner that reflects consideration of:

(1) an incentive-based payment process for achieving outcomes;

(2) the need for a state-level risk pool;

(3) the need for retention of management responsibility at the state agency level; and

(4) a phase-in strategy as appropriate.

(c) Until the allocation methods described in paragraph (b) are implemented, the annual allowable reimbursement level of home and community-based waiver services shall be the greater of:

(1) the statewide average payment amount which the recipient is assigned under the waiver reimbursement system in place on June 30, 2001, modified by the percentage of any provider rate increase appropriated for home and community-based services; or

(2) an amount approved by the commissioner based on the recipient's extraordinary needs that cannot be met within the current allowable reimbursement level. The increased reimbursement level must be necessary to allow the recipient to be discharged from an institution or to prevent imminent placement in an institution. The additional reimbursement may be used to secure environmental modifications; assistive technology and equipment; and increased costs for supervision, training, and support services necessary to address the recipient's extraordinary needs. The commissioner may approve an increased reimbursement level for up to one year of the recipient's relocation from an institution or up to six months of a determination that a current waiver recipient is at imminent risk of being placed in an institution.

(d) Beginning January 1, 2003, medically necessary private duty nursing services will be authorized under this section as complex and regular care according to section 256B.0627. The rate established by the commissioner for registered nurse or licensed practical nurse services under any home and community-based waiver as of January 1, 2001, shall not be reduced.

Sec. 49. Minnesota Statutes 2000, section 256B.49, is amended by adding a subdivision to read:

Subd. 18. [PAYMENTS.] The commissioner shall reimburse approved vendors from the medical assistance account for the costs of providing home and community-based services to eligible recipients using the invoice processing procedures of the Medicaid management information system (MMIS). Recipients will be screened and authorized for services according to the federally approved waiver application and its subsequent amendments.

Sec. 50. Minnesota Statutes 2000, section 256B.49, is amended by adding a subdivision to read:

Subd. 19. [HEALTH AND WELFARE.] The commissioner of human services shall take the necessary safeguards to protect the health and welfare of individuals provided services under the waiver.

Sec. 51. Minnesota Statutes 2000, section 256D.35, is amended by adding a subdivision to read:

Subd. 11a. [INSTITUTION.] "Institution" means a hospital, consistent with Code of Federal Regulations, title 42, section 440.10; regional treatment center inpatient services, consistent with section 245.474; a nursing facility; and an intermediate care facility for persons with mental retardation.

Sec. 52. Minnesota Statutes 2000, section 256D.35, is amended by adding a subdivision to read:

Subd. 18a. [SHELTER COSTS.] "Shelter costs" means rent, manufactured home lot rentals; monthly principal, interest, insurance premiums, and property taxes due for mortgages or contract for deed costs; costs for utilities, including heating, cooling, electricity, water, and sewerage; garbage collection fees; and the basic service fee for one telephone.

Sec. 53. Minnesota Statutes 2000, section 256D.44, subdivision 5, is amended to read:

Subd. 5. [SPECIAL NEEDS.] In addition to the state standards of assistance established in subdivisions 1 to 4, payments are allowed for the following special needs of recipients of

Minnesota supplemental aid who are not residents of a nursing home, a regional treatment center, or a group residential housing facility.

(a) The county agency shall pay a monthly allowance for medically prescribed diets payable under the Minnesota family investment program if the cost of those additional dietary needs cannot be met through some other maintenance benefit.

(b) Payment for nonrecurring special needs must be allowed for necessary home repairs or necessary repairs or replacement of household furniture and appliances using the payment standard of the AFDC program in effect on July 16, 1996, for these expenses, as long as other funding sources are not available.

(c) A fee for guardian or conservator service is allowed at a reasonable rate negotiated by the county or approved by the court. This rate shall not exceed five percent of the assistance unit's gross monthly income up to a maximum of $100 per month. If the guardian or conservator is a member of the county agency staff, no fee is allowed.

(d) The county agency shall continue to pay a monthly allowance of $68 for restaurant meals for a person who was receiving a restaurant meal allowance on June 1, 1990, and who eats two or more meals in a restaurant daily. The allowance must continue until the person has not received Minnesota supplemental aid for one full calendar month or until the person's living arrangement changes and the person no longer meets the criteria for the restaurant meal allowance, whichever occurs first.

(e) A fee of ten percent of the recipient's gross income or $25, whichever is less, is allowed for representative payee services provided by an agency that meets the requirements under SSI regulations to charge a fee for representative payee services. This special need is available to all recipients of Minnesota supplemental aid regardless of their living arrangement.

(f) Notwithstanding the language in this subdivision, an amount equal to the maximum allotment authorized by the federal Food Stamp Program for a single individual which is in effect on the first day of January of the previous year will be added to the standards of assistance established in subdivisions 1 to 4 for individuals under the age of 65 who are relocating from an institution and who are shelter needy. An eligible individual who receives this benefit prior to age 65 may continue to receive the benefit after the age of 65.

"Shelter needy" means that the assistance unit incurs monthly shelter costs that exceed 40 percent of the assistance unit's gross income before the application of this special needs standard. "Gross income" for the purposes of this section is the applicant's or recipient's income as defined in section 256D.35, subdivision 10, or the standard specified in subdivision 3, whichever is greater. A recipient of a federal or state housing subsidy, that limits shelter costs to a percentage of gross income, shall not be considered shelter needy for purposes of this paragraph.

Sec. 54. [SEMI-INDEPENDENT LIVING SERVICES (SILS) STUDY.]

The commissioner of human services, in consultation with county representatives and other interested persons, shall develop recommendations revising the funding methodology for SILS as defined in Minnesota Statutes, section 252.275, subdivisions 3, 4, 4b, and 4c, and report by January 15, 2002, to the chair of the house of representatives health and human services finance committee and the chair of the senate health, human services and corrections budget division.

Sec. 55. [WAIVER REQUEST REGARDING SPOUSAL INCOME.]

By September 1, 2001, the commissioner of human services shall seek federal approval to allow recipients of home and community-based waivers authorized under Minnesota Statutes, section 256B.49, to choose either a waiver of deeming of spousal income or the spousal impoverishment protections authorized under United States Code, title 42, section 1396r-5, with the addition of the group residential housing rate set according to Minnesota Statutes, section 256I.03, subdivision 5, to the personal needs allowance authorized by Minnesota Statutes, section 256B.0575.

Sec. 56. [GRANTS TO PROVIDE BRAIN INJURY SUPPORT.]

Subdivision 1. [GRANTS.] Within the limits of the appropriations made specifically for this purpose, the commissioner of health shall make grants of up to $300,000 to nonprofit corporations to continue a pilot project that provides information, connects to community resources, and provides support and problem solving on an ongoing basis to individuals with traumatic brain injuries.

Subd. 2. [REPORT.] The commissioner shall prepare a report identifying the results of the pilot project and making recommendations on continuation of the project. The report must be forwarded to the legislature no later than January 15, 2004.

Sec. 57. [REPEALER.]

(a) Minnesota Statutes 2000, sections 145.9245; 256.476, subdivision 7; 256B.0912; 256B.0915, subdivisions 3a, 3b, and 3c; 256B.49, subdivisions 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10, are repealed.

(b) Minnesota Rules, parts 9505.2455; 9505.2458; 9505.2460; 9505.2465; 9505.2470; 9505.2473; 9505.2475; 9505.2480; 9505.2485; 9505.2486; 9505.2490; 9505.2495; 9505.2496; 9505.2500; 9505.3010; 9505.3015; 9505.3020; 9505.3025; 9505.3030; 9505.3035; 9505.3040; 9505.3065; 9505.3085; 9505.3135; 9505.3500; 9505.3510; 9505.3520; 9505.3530; 9505.3535; 9505.3540; 9505.3545; 9505.3550; 9505.3560; 9505.3570; 9505.3575; 9505.3580; 9505.3585; 9505.3600; 9505.3610; 9505.3620; 9505.3622; 9505.3624; 9505.3626; 9505.3630; 9505.3635; 9505.3640; 9505.3645; 9505.3650; 9505.3660; and 9505.3670, are repealed.

ARTICLE 4

CONSUMER INFORMATION AND ASSISTANCE

AND COMMUNITY-BASED CARE

Section 1. Minnesota Statutes 2000, section 256.975, is amended by adding a subdivision to read:

Subd. 7. [CONSUMER INFORMATION AND ASSISTANCE; SENIOR LINKAGE.] (a) The Minnesota board on aging shall operate a statewide information and assistance service to aid older Minnesotans and their families in making informed choices about long-term care options and health care benefits. Language services to persons with limited English language skills must be made available. The service, known as Senior LinkAge Line, must be available during business hours through a statewide toll-free number and must also be available through the Internet.

(b) The service must assist older adults, caregivers, and providers in accessing information about choices in long-term care services that are purchased through private providers or available through public options. The service must:

(1) develop a comprehensive database that includes detailed listings in both consumer- and provider-oriented formats;

(2) make the database accessible on the Internet and through other telecommunication and media-related tools;

(3) link callers to interactive long-term care screening tools and making these tools available through the Internet by integrating the tools with the database;

(4) develop community education materials with a focus on planning for long-term care and evaluating independent living, housing, and service options;

(5) conduct an outreach campaign to assist older adults and their caregivers in finding information on the Internet and through other means of communication;

(6) implement a messaging system for overflow callers and respond to these callers by the next business day;

(7) link callers with county human services and other providers to receive more in-depth assistance and consultation related to long-term care options; and

(8) link callers with quality profiles for nursing facilities and other providers developed by the commissioner of human services.

Sec. 2. [256.9754] [COMMUNITY SERVICES DEVELOPMENT GRANTS PROGRAM.]

Subdivision 1. [DEFINITIONS.] For purposes of this section, the following terms have the meanings given.

(a) "Community" means a town, township, city, or targeted neighborhood within a city, or a consortium of towns, townships, cities, or targeted neighborhoods within cities.

(b) "Older adult services" means any services available under the elderly waiver program or alternative care grant program; nursing facility services; transportation services; respite services; and other community-based services identified as necessary either to maintain lifestyle choices for older Minnesotans or to promote independence.

(c) "Older adult" refers to individuals 65 years of age and older.

Subd. 2. [CREATION.] The community services development grants program is created under the administration of the commissioner of human services.

Subd. 3. [PROVISION OF GRANTS.] The commissioner shall make grants available to communities, providers of older adult services identified in subdivision 1, or to a consortium of providers of older adult services, to establish new older adult services. Grants may be provided for capital and other costs including, but not limited to, start-up and training costs, equipment, and supplies related to the establishment of new older adult services or other residential or service alternatives to nursing facility care. Grants may also be made to renovate current buildings, provide transportation services, or expand state-funded programs in the area.

Subd. 4. [ELIGIBILITY.] Grants may be awarded only to communities and providers or to a consortium of providers that have a local match of 50 percent of the costs for the project in the form of donations, local tax dollars, in-kind donations, or other local match.

Sec. 3. Minnesota Statutes 2000, section 256B.0911, subdivision 1, is amended to read:

Subdivision 1. [PURPOSE AND GOAL.] (a) The purpose of ~~the preadmission screening program~~ long-term care consultation services is to assist persons with long-term or chronic care needs in making long-term care decisions and selecting options that meet their needs and reflect their preferences. The availability of, and access to, information and other types of assistance is also intended to prevent or delay certified nursing facility placements ~~by assessing applicants and residents and offering cost-effective alternatives appropriate for the person's needs~~ and to provide transition assistance after admission. Further, the goal of ~~the program~~ these services is to contain costs associated with unnecessary certified nursing facility admissions. The commissioners of human services and health shall seek to maximize use of available federal and state funds and establish the broadest program possible within the funding available.

(b) These services must be coordinated with services provided under sections 256.975, subdivision 7, and 256.9772, and with services provided by other public and private agencies in the community to offer a variety of cost-effective alternatives to persons with disabilities and elderly persons. The county agency providing long-term care consultation services shall encourage the use of volunteers from families, religious organizations, social clubs, and similar civic and service organizations to provide community-based services.

Sec. 4. Minnesota Statutes 2000, section 256B.0911, is amended by adding a subdivision to read:

Subd. 1a. [DEFINITIONS.] For purposes of this section, the following definitions apply:

(a) "Long-term care consultation services" means:

(1) providing information and education to the general public regarding availability of the services authorized under this section;

(2) an intake process that provides access to the services described in this section;

(3) assessment of the health, psychological, and social needs of referred individuals;

(4) assistance in identifying services needed to maintain an individual in the least restrictive environment;

(5) providing recommendations on cost-effective community services that are available to the individual;

(6) development of an individual's community support plan;

(7) providing information regarding eligibility for Minnesota health care programs;

(8) preadmission screening to determine the need for a nursing facility level of care;

(9) preliminary determination of Minnesota health care programs eligibility for individuals who need a nursing facility level of care, with appropriate referrals for final determination;

(10) providing recommendations for nursing facility placement when there are no cost-effective community services available; and

(11) assistance to transition people back to community settings after facility admission.

(b) "Minnesota health care programs" means the medical assistance program under chapter 256B, the alternative care program under section 256B.0913, and the prescription drug program under section 256.955.

Sec. 5. Minnesota Statutes 2000, section 256B.0911, subdivision 3, is amended to read:

Subd. 3. [~~PERSONS RESPONSIBLE FOR CONDUCTING THE PREADMISSION SCREENING~~ LONG-TERM CARE CONSULTATION TEAM.] (a) A ~~local screening~~ long-term care consultation team shall be established by the county board of commissioners. Each local ~~screening~~ consultation team shall consist of ~~screeners who are a~~ at least one social worker and ~~a~~ at least one public health nurse from their respective county agencies. The board may designate public health or social services as the lead agency for long-term care consultation services. If a county does not have a public health nurse available, it may request approval from the commissioner to assign a county registered nurse with at least one year experience in home care to participate on the team. ~~The screening team members must confer regarding the most appropriate care for each individual screened.~~ Two or more counties may collaborate to establish a joint local ~~screening~~ consultation team or teams.

(b) ~~In assessing a person's needs, screeners shall have a physician available for consultation and shall consider the assessment of the individual's attending physician, if any. The individual's physician shall be included if the physician chooses to participate. Other personnel may be included on the team as deemed appropriate by the county agencies.~~ The team is responsible for providing long-term care consultation services to all persons located in the county who request the services, regardless of eligibility for Minnesota health care programs.

Sec. 6. Minnesota Statutes 2000, section 256B.0911, is amended by adding a subdivision to read:

Subd. 3a. [ASSESSMENT AND SUPPORT PLANNING.] (a) Persons requesting assessment, services planning, or other assistance intended to support community-based living must be visited by a long-term care consultation team within ten working days after the date on which an assessment was requested or recommended. Assessments must be conducted according to paragraphs (b) to (g).

(b) The county may utilize a team of either the social worker or public health nurse, or both, to conduct the assessment in a face-to-face interview. The consultation team members must confer regarding the most appropriate care for each individual screened or assessed.

(c) The long-term care consultation team must assess the health and social needs of the person, using an assessment form provided by the commissioner.

(d) The team must conduct the assessment in a face-to-face interview with the person being assessed and the person's legal representative, if applicable.

(e) The team must provide the person, or the person's legal representative, with written recommendations for facility- or community-based services. The team must document that the most cost-effective alternatives available were offered to the individual. For purposes of this requirement, "cost-effective alternatives" means community services and living arrangements that cost the same as or less than nursing facility care.

(f) If the person chooses to use community-based services, the team must provide the person or the person's legal representative with a written community support plan, regardless of whether the individual is eligible for Minnesota health care programs. The person may request assistance in developing a community support plan without participating in a complete assessment.

(g) The team must give the person receiving assessment or support planning, or the person's legal representative, materials supplied by the commissioner containing the following information:

(1) the purpose of preadmission screening and assessment;

(2) information about Minnesota health care programs;

(3) the person's freedom to accept or reject the recommendations of the team;

(4) the person's right to confidentiality under the Minnesota Government Data Practices Act, chapter 13; and

(5) the person's right to appeal the decision regarding the need for nursing facility level of care or the county's final decisions regarding public programs eligibility according to section 256.045, subdivision 3.

Sec. 7. Minnesota Statutes 2000, section 256B.0911, is amended by adding a subdivision to read:

Subd. 3b. [TRANSITION ASSISTANCE.] (a) A long-term care consultation team shall provide assistance to persons residing in a nursing facility, hospital, regional treatment center, or intermediate care facility for persons with mental retardation who request or are referred for assistance. Transition assistance must include assessment, community support plan development, referrals to Minnesota health care programs, and referrals to programs that provide assistance with housing.

(b) The county shall develop transition processes with institutional social workers and discharge planners to ensure that:

(1) persons admitted to facilities receive information about transition assistance that is available;

(2) the assessment is completed for persons within ten working days of the date of request or recommendation for assessment; and

(3) there is a plan for transition and follow-up for the individual's return to the community. The plan must require notification of other local agencies when a person who may require assistance is screened by one county for admission to a facility located in another county.

(c) If a person who is eligible for a Minnesota health care program is admitted to a nursing facility, the nursing facility must include a consultation team member or the case manager in the discharge planning process.

Sec. 8. Minnesota Statutes 2000, section 256B.0911, is amended by adding a subdivision to read:

Subd. 3c. [ACCESS DEMONSTRATIONS.] (a) The commissioner shall establish demonstration projects that are intended to target critical areas for improvement in long-term care consultation services, and to organize resources in a more efficient, effective, and preferred way. The demonstrations may include:

(1) development and implementation of strategies to increase the number of people who leave nursing facilities, hospitals, regional treatment centers, and intermediate care facilities for persons with mental retardation and return to community living, based on demonstration proposals that:

(i) focus on transitional planning between care settings;

(ii) engage a variety of providers and care settings;

(iii) include participants from both greater Minnesota and metro communities;

(iv) emphasize regional or other cooperative approaches; and

(v) identify potential obstacles to individuals returning to community settings and propose recommendations to address those obstacles and ways to improve the identification of people who need transitional assistance;

(2) improved access to and expansion of the availability of long-term care consultation services, and improved integration of these services with other local activities designed to support people in community living;

(3) identification of activities that increase public awareness of and information about the various forms of long-term care assistance available, and develop and implement replicable training efforts; and

(4) selection of sites based on outcome and other performance criteria outlined in an application process. Projects can be single-county or multicounty managed. Project budgets may include payments to increase the amount of and encourage innovation in the development of transitional services within demonstration sites. Payments for increased assessments, support plan development, and other activities, as approved in the budget proposal for selected project sites, shall be incorporated into the reimbursement for long-term care consultation services as described in subdivision 6. Projected transition assessments included as part of selected demonstration sites shall be calculated at the rate for county case management services.

(b) The commissioner of human services shall submit a report to the legislature describing demonstration models, implementation activities, and projected outcomes by February 15, 2002. A final report on the performance of the models and recommendations for strategies to address relocation or transitional assistance shall be completed by December 15, 2003.

Sec. 9. Minnesota Statutes 2000, section 256B.0911, is amended by adding a subdivision to read:

Subd. 4a. [PREADMISSION SCREENING ACTIVITIES RELATED TO NURSING FACILITY ADMISSIONS.] (a) All applicants to Medicaid certified nursing facilities, including certified boarding care facilities, must be screened prior to admission regardless of income, assets, or funding sources for nursing facility care, except as described in subdivision 4b. The purpose of the screening is to determine the need for nursing facility level of care as described in paragraph (d) and to complete activities required under federal law related to mental illness and mental retardation as outlined in paragraph (b).

(b) A person who has a diagnosis or possible diagnosis of mental illness, mental retardation, or a related condition must receive a preadmission screening before admission regardless of the exemptions outlined in subdivision 4b, paragraph (b), to identify the need for further evaluation and specialized services, unless the admission prior to screening is authorized by the local mental

health authority or the local developmental disabilities case manager, or unless authorized by the county agency according to Public Law Number 100-508.

The following criteria apply to the preadmission screening:

(1) the county must use forms and criteria developed by the commissioner to identify persons who require referral for further evaluation and determination of the need for specialized services; and

(2) the evaluation and determination of the need for specialized services must be done by:

(i) a qualified independent mental health professional, for persons with a primary or secondary diagnosis of a serious mental illness; or

(ii) a qualified mental retardation professional, for persons with a primary or secondary diagnosis of mental retardation or related conditions. For purposes of this requirement, a qualified mental retardation professional must meet the standards for a qualified mental retardation professional under Code of Federal Regulations, title 42, section 483.430.

(c) The local county mental health authority or the state mental retardation authority under Public Law Numbers 100-203 and 101-508 may prohibit admission to a nursing facility if the individual does not meet the nursing facility level of care criteria or needs specialized services as defined in Public Law Numbers 100-203 and 101-508. For purposes of this section, "specialized services" for a person with mental retardation or a related condition means active treatment as that term is defined under Code of Federal Regulations, title 42, section 483.440 (a)(1).

(d) The determination of the need for nursing facility level of care must be made according to criteria developed by the commissioner. In assessing a person's needs, consultation team members shall have a physician available for consultation and shall consider the assessment of the individual's attending physician, if any. The individual's physician must be included if the physician chooses to participate. Other personnel may be included on the team as deemed appropriate by the county.

Sec. 10. Minnesota Statutes 2000, section 256B.0911, is amended by adding a subdivision to read:

Subd. 4b. [EXEMPTIONS AND EMERGENCY ADMISSIONS.] (a) Exemptions from the federal screening requirements outlined in subdivision 4a, paragraphs (b) and (c), are limited to:

(1) a person who, having entered an acute care facility from a certified nursing facility, is returning to a certified nursing facility; and

(2) a person transferring from one certified nursing facility in Minnesota to another certified nursing facility in Minnesota.

(b) Persons who are exempt from preadmission screening for purposes of level of care determination include:

(1) persons described in paragraph (a);

(2) an individual who has a contractual right to have nursing facility care paid for indefinitely by the veterans' administration;

(3) an individual enrolled in a demonstration project under section 256B.69, subdivision 8, at the time of application to a nursing facility;

(4) an individual currently being served under the alternative care program or under a home and community-based services waiver authorized under section 1915(c) of the federal Social Security Act; and

(5) individuals admitted to a certified nursing facility for a short-term stay, which is expected to be 14 days or less in duration based upon a physician's certification, and who have been assessed

and approved for nursing facility admission within the previous six months. This exemption applies only if the consultation team member determines at the time of the initial assessment of the six-month period that it is appropriate to use the nursing facility for short-term stays and that there is an adequate plan of care for return to the home or community-based setting. If a stay exceeds 14 days, the individual must be referred no later than the first county working day following the 14th resident day for a screening, which must be completed within five working days of the referral. The payment limitations in subdivision 7 apply to an individual found at screening to not meet the level of care criteria for admission to a certified nursing facility.

(c) Persons admitted to a Medicaid-certified nursing facility from the community on an emergency basis as described in paragraph (d) or from an acute care facility on a nonworking day must be screened the first working day after admission.

(d) Emergency admission to a nursing facility prior to screening is permitted when all of the following conditions are met:

(1) a person is admitted from the community to a certified nursing or certified boarding care facility during county nonworking hours;

(2) a physician has determined that delaying admission until preadmission screening is completed would adversely affect the person's health and safety;

(3) there is a recent precipitating event that precludes the client from living safely in the community, such as sustaining an injury, sudden onset of acute illness, or a caregiver's inability to continue to provide care;

(4) the attending physician has authorized the emergency placement and has documented the reason that the emergency placement is recommended; and

(5) the county is contacted on the first working day following the emergency admission.

Transfer of a patient from an acute care hospital to a nursing facility is not considered an emergency except for a person who has received hospital services in the following situations: hospital admission for observation, care in an emergency room without hospital admission, or following hospital 24-hour bed care.

Sec. 11. Minnesota Statutes 2000, section 256B.0911, is amended by adding a subdivision to read:

Subd. 4c. [SCREENING REQUIREMENTS.] (a) A person may be screened for nursing facility admission by telephone or in a face-to-face screening interview. Consultation team members shall identify each individual's needs using the following categories:

(1) the person needs no face-to-face screening interview to determine the need for nursing facility level of care based on information obtained from other health care professionals;

(2) the person needs an immediate face-to-face screening interview to determine the need for nursing facility level of care and complete activities required under subdivision 4a; or

(3) the person may be exempt from screening requirements as outlined in subdivision 4b, but will need transitional assistance after admission or in-person follow-along after a return home.

(b) Persons admitted on a nonemergency basis to a Medicaid-certified nursing facility must be screened prior to admission.

(c) The long-term care consultation team shall recommend a case mix classification for persons admitted to a certified nursing facility when sufficient information is received to make that classification. The nursing facility is authorized to conduct all case mix assessments for persons who have been screened prior to admission for whom the county did not recommend a case mix classification. The nursing facility is authorized to conduct all case mix assessments for persons admitted to the facility prior to a preadmission screening. The county retains the responsibility of distributing appropriate case mix forms to the nursing facility.

(d) The county screening or intake activity must include processes to identify persons who may require transition assistance as described in subdivision 3b.

Sec. 12. Minnesota Statutes 2000, section 256B.0911, subdivision 5, is amended to read:

Subd. 5. [~~SIMPLIFICATION OF FORMS~~ ADMINISTRATIVE ACTIVITY.] The commissioner shall minimize the number of forms required in the ~~preadmission screening process~~ provision of long-term care consultation services and shall limit the screening document to items necessary for ~~care~~ community support plan approval, reimbursement, program planning, evaluation, and policy development.

Sec. 13. Minnesota Statutes 2000, section 256B.0911, subdivision 6, is amended to read:

Subd. 6. [PAYMENT FOR ~~PREADMISSION SCREENING~~ LONG-TERM CARE CONSULTATION SERVICES.] (a) The total ~~screening~~ payment for each county must be paid monthly by certified nursing facilities in the county. The monthly amount to be paid by each nursing facility for each fiscal year must be determined by dividing the county's annual allocation for ~~screenings~~ long-term care consultation services by 12 to determine the monthly payment and allocating the monthly payment to each nursing facility based on the number of licensed beds in the nursing facility. Payments to counties in which there is no certified nursing facility must be made by increasing the payment rate of the two facilities located nearest to the county seat.

(b) The commissioner shall include the total annual payment ~~for screening~~ determined under paragraph (a) for each nursing facility reimbursed under section 256B.431 or 256B.434 according to section 256B.431, subdivision 2b, paragraph (g), or 256B.435.

(c) In the event of the layaway, delicensure and decertification, or removal from layaway of 25 percent or more of the beds in a facility, the commissioner may adjust the per diem payment amount in paragraph (b) and may adjust the monthly payment amount in paragraph (a). The effective date of an adjustment made under this paragraph shall be on or after the first day of the month following the effective date of the layaway, delicensure and decertification, or removal from layaway.

(d) Payments for ~~screening activities~~ long-term care consultation services are available to the county or counties to cover staff salaries and expenses to provide the ~~screening function~~ services described in subdivision 1a. The ~~lead agency~~ county shall employ, or contract with other agencies to employ, within the limits of available funding, sufficient personnel to ~~conduct the preadmission screening activity~~ provide long-term care consultation services while meeting the state's long-term care outcomes and objectives as defined in section 256B.0917, subdivision 1. The ~~local agency~~ county shall be accountable for meeting local objectives as approved by the commissioner in the CSSA biennial plan.

~~(d)~~ (e) Notwithstanding section 256B.0641, overpayments attributable to payment of the screening costs under the medical assistance program may not be recovered from a facility.

~~(e)~~ (f) The commissioner of human services shall amend the Minnesota medical assistance plan to include reimbursement for the local ~~screening~~ consultation teams.

(g) The county may bill, as case management services, assessments, support planning, and follow-along provided to persons determined to be eligible for case management under Minnesota health care programs. No individual or family member shall be charged for an initial assessment or initial support plan development provided under subdivision 3a or 3b.

Sec. 14. Minnesota Statutes 2000, section 256B.0911, subdivision 7, is amended to read:

Subd. 7. [REIMBURSEMENT FOR CERTIFIED NURSING FACILITIES.] (a) Medical assistance reimbursement for nursing facilities shall be authorized for a medical assistance recipient only if a preadmission screening has been conducted prior to admission or the ~~local~~ county ~~agency~~ has authorized an exemption. Medical assistance reimbursement for nursing facilities shall not be provided for any recipient who the local screener has determined does not meet the level of care criteria for nursing facility placement or, if indicated, has not had a level II

~~PASARR~~ OBRA evaluation as required under the federal Omnibus Budget Reconciliation Act of 1987 completed unless an admission for a recipient with mental illness is approved by the local mental health authority or an admission for a recipient with mental retardation or related condition is approved by the state mental retardation authority.

(b) The nursing facility must not bill a person who is not a medical assistance recipient for resident days that preceded the date of completion of screening activities as required under subdivisions 4a, 4b, and 4c. The nursing facility must include unreimbursed resident days in the nursing facility resident day totals reported to the commissioner.

(c) The commissioner shall make a request to the health care financing administration for a waiver allowing ~~screening~~ team approval of Medicaid payments for certified nursing facility care. An individual has a choice and makes the final decision between nursing facility placement and community placement after the screening team's recommendation, except as provided in ~~paragraphs (b) and (c)~~ subdivision 4a, paragraph (c).

~~(c) The local county mental health authority or the state mental retardation authority under Public Law Numbers 100-203 and 101-508 may prohibit admission to a nursing facility, if the individual does not meet the nursing facility level of care criteria or needs specialized services as defined in Public Law Numbers 100-203 and 101-508. For purposes of this section, "specialized services" for a person with mental retardation or a related condition means "active treatment" as that term is defined in Code of Federal Regulations, title 42, section 483.440(a)(1).~~

~~(e) Appeals from the screening team's recommendation or the county agency's final decision shall be made according to section 256.045, subdivision 3.~~

Sec. 15. Minnesota Statutes 2000, section 256B.0913, subdivision 1, is amended to read:

Subdivision 1. [PURPOSE AND GOALS.] The purpose of the alternative care program is to provide funding for ~~or access to~~ home and community-based services for ~~frail~~ elderly persons, in order to limit nursing facility placements. The program is designed to support ~~frail~~ elderly persons in their desire to remain in the community as independently and as long as possible and to support informal caregivers in their efforts to provide care for ~~frail~~ elderly people. Further, the goals of the program are:

(1) to contain medical assistance expenditures by ~~providing~~ funding care in the community ~~at a cost the same or less than nursing facility costs~~; and

(2) to maintain the moratorium on new construction of nursing home beds.

Sec. 16. Minnesota Statutes 2000, section 256B.0913, subdivision 2, is amended to read:

Subd. 2. [ELIGIBILITY FOR SERVICES.] Alternative care services are available to ~~all frail older~~ Minnesotans~~. This includes:~~

~~(1) persons who are receiving medical assistance and served under the medical assistance program or the Medicaid waiver program;~~

~~(2) persons~~ age 65 or older who are not eligible for medical assistance without a spenddown or waiver obligation but who would be eligible for medical assistance within 180 days of admission to a nursing facility and ~~served under~~ subject to subdivisions 4 to 13~~; and~~

~~(3) persons who are paying for their services out-of-pocket~~.

Sec. 17. Minnesota Statutes 2000, section 256B.0913, subdivision 4, is amended to read:

Subd. 4. [ELIGIBILITY FOR FUNDING FOR SERVICES FOR NONMEDICAL ASSISTANCE RECIPIENTS.] (a) Funding for services under the alternative care program is available to persons who meet the following criteria:

(1) the person has been ~~screened by the county screening team or, if previously screened and served under the alternative care program, assessed by the local county social worker or public~~

~~health nurse~~ determined by a community assessment under section 256B.0911, to be a person who would require the level of care provided in a nursing facility, but for the provision of services under the alternative care program;

(2) the person is age 65 or older;

(3) the person would be ~~financially~~ eligible for medical assistance within 180 days of admission to a nursing facility;

(4) the person ~~meets the asset transfer requirements of~~ is not ineligible for the medical assistance program due to an asset transfer penalty;

(5) ~~the screening team would recommend nursing facility admission or continued stay for the person if alternative care services were not available;~~

~~(6)~~ the person needs services that are not ~~available at that time in the county~~ funded through other ~~county,~~ state~~,~~ or federal funding ~~sources~~; and

~~(7)~~ (6) the monthly cost of the alternative care services funded by the program for this person does not exceed 75 percent of the statewide ~~average monthly medical assistance payment for nursing facility care at the individual's case mix classification~~ weighted average monthly nursing facility rate of the case mix resident class to which the individual alternative care client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, less the recipient's maintenance needs allowance as described in section 256B.0915, subdivision 1d, paragraph (a), until the first day of the state fiscal year in which the resident assessment system, under section 256B.437, for nursing home rate determination is implemented. Effective on the first day of the state fiscal year in which a resident assessment system, under section 256B.437, for nursing home rate determination is implemented and the first day of each subsequent state fiscal year, the monthly cost of alternative care services for this person shall not exceed the alternative care monthly cap for the case mix resident class to which the alternative care client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, which was in effect on the last day of the previous state fiscal year, and adjusted by the greater of any legislatively adopted home and community-based services cost-of-living percentage increase or any legislatively adopted statewide percent rate increase for nursing facilities. This monthly limit does not prohibit the alternative care client from payment for additional services, but in no case may the cost of additional services purchased under this section exceed the difference between the client's monthly service limit defined under section 256B.0915, subdivision 3, and the alternative care program monthly service limit defined in this paragraph. If medical supplies and equipment or ~~adaptations~~ environmental modifications are or will be purchased for an alternative care services recipient, the costs may be prorated on a monthly basis ~~throughout the year in which they are purchased~~ for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's other alternative care services exceeds the monthly limit established in this paragraph, the annual cost of the alternative care services shall be determined. In this event, the annual cost of alternative care services shall not exceed 12 times the monthly limit ~~calculated~~ described in this paragraph.

(b) ~~Individuals who meet the criteria in paragraph (a) and who have been approved for alternative care funding are called 180-day eligible clients.~~

~~(c) The statewide average payment for nursing facility care is the statewide average monthly nursing facility rate in effect on July 1 of the fiscal year in which the cost is incurred, less the statewide average monthly income of nursing facility residents who are age 65 or older and who are medical assistance recipients in the month of March of the previous fiscal year. This monthly limit does not prohibit the 180-day eligible client from paying for additional services needed or desired.~~

~~(d) In determining the total costs of alternative care services for one month, the costs of all services funded by the alternative care program, including supplies and equipment, must be included.~~

~~(e)~~ Alternative care funding under this subdivision is not available for a person who is a medical assistance recipient or who would be eligible for medical assistance without a spenddown~~, unless authorized by the commissioner~~ or waiver obligation. A person whose initial application for medical assistance is being processed may be served under the alternative care program for a period up to 60 days. If the individual is found to be eligible for medical assistance, ~~the county must bill~~ medical assistance must be billed for services payable under the federally approved elderly waiver plan and delivered from the date the individual was found eligible for ~~services reimbursable under~~ the federally approved elderly waiver ~~program~~ plan. Notwithstanding this provision, upon federal approval, alternative care funds may not be used to pay for any service the cost of which is payable by medical assistance or which is used by a recipient to meet a medical assistance income spenddown or waiver obligation.

~~(f)~~ (c) Alternative care funding is not available for a person who resides in a licensed nursing home ~~or~~, certified boarding care home, hospital, or intermediate care facility, except for case management services which are ~~being~~ provided in support of the discharge planning process to a nursing home resident or certified boarding care home resident who is ineligible for case management funded by medical assistance.

Sec. 18. Minnesota Statutes 2000, section 256B.0913, subdivision 5, is amended to read:

Subd. 5. [SERVICES COVERED UNDER ALTERNATIVE CARE.] (a) Alternative care funding may be used for payment of costs of:

(1) adult foster care;

(2) adult day care;

(3) home health aide;

(4) homemaker services;

(5) personal care;

(6) case management;

(7) respite care;

(8) assisted living;

(9) residential care services;

(10) care-related supplies and equipment;

(11) meals delivered to the home;

(12) transportation;

(13) skilled nursing;

(14) chore services;

(15) companion services;

(16) nutrition services;

(17) training for direct informal caregivers;

(18) telemedicine devices to monitor recipients in their own homes as an alternative to hospital care, nursing home care, or home visits; ~~and~~

(19) "other services" ~~including~~ includes discretionary funds and direct cash payments to clients, ~~approved by the county agency~~ following approval by the commissioner, subject to the provisions of paragraph ~~(m)~~ (j). Total annual payments for " other services" for all clients within a county

may not exceed either ten percent of that county's annual alternative care program base allocation or $5,000, whichever is greater. In no case shall this amount exceed the county's total annual alternative care program base allocation; and

(20) environmental modifications.

(b) The county agency must ensure that the funds are not used ~~only to supplement and not~~ to supplant services available through other public assistance or services programs.

(c) Unless specified in statute, the service definitions and standards for alternative care services shall be the same as the service definitions and standards ~~defined~~ specified in the federally approved elderly waiver plan. Except for the county agencies' approval of direct cash payments to clients as described in paragraph (j) or for a provider of supplies and equipment when the monthly cost of the supplies and equipment is less than $250, persons or agencies must be employed by or under a contract with the county agency or the public health nursing agency of the local board of health in order to receive funding under the alternative care program. Supplies and equipment may be purchased from a vendor not certified to participate in the Medicaid program if the cost for the item is less than that of a Medicaid vendor.

(d) The adult foster care rate shall be considered a difficulty of care payment and shall not include room and board. The adult foster care ~~daily~~ rate shall be negotiated between the county agency and the foster care provider. ~~The rate established under this section shall not exceed 75 percent of the state average monthly nursing home payment for the case mix classification to which the individual receiving foster care is assigned, and it must allow for other alternative care services to be authorized by the case manager.~~ The alternative care payment for the foster care service in combination with the payment for other alternative care services, including case management, must not exceed the limit specified in subdivision 4, paragraph (a), clause (6).

(e) Personal care services ~~may be provided by a personal care provider organization.~~ must meet the service standards defined in the federally approved elderly waiver plan, except that a county agency may contract with a client's relative ~~of the client~~ who meets the relative hardship waiver requirement as defined in section 256B.0627, subdivision 4, paragraph (b), clause (10), to provide personal care services~~, but must ensure nursing~~ if the county agency ensures supervision of this service by a registered nurse or mental health practitioner. ~~Covered personal care services defined in section 256B.0627, subdivision 4, must meet applicable standards in Minnesota Rules, part 9505.0335.~~

(f) ~~A county may use alternative care funds to purchase medical supplies and equipment without prior approval from the commissioner when: (1) there is no other funding source; (2) the supplies and equipment are specified in the individual's care plan as medically necessary to enable the individual to remain in the community according to the criteria in Minnesota Rules, part 9505.0210, item A; and (3) the supplies and equipment represent an effective and appropriate use of alternative care funds. A county may use alternative care funds to purchase supplies and equipment from a non-Medicaid certified vendor if the cost for the items is less than that of a Medicaid vendor. A county is not required to contract with a provider of supplies and equipment if the monthly cost of the supplies and equipment is less than $250.~~

~~(g)~~ For purposes of this section, residential care services are services which are provided to individuals living in residential care homes. Residential care homes are currently licensed as board and lodging establishments and are registered with the department of health as providing special services under section 157.17 and are not subject to registration under chapter 144D. Residential care services are defined as "supportive services" and "health-related services." "Supportive services" means the provision of up to 24-hour supervision and oversight. Supportive services includes: (1) transportation, when provided by the residential care ~~center~~ home only; (2) socialization, when socialization is part of the plan of care, has specific goals and outcomes established, and is not diversional or recreational in nature; (3) assisting clients in setting up meetings and appointments; (4) assisting clients in setting up medical and social services; (5) providing assistance with personal laundry, such as carrying the client's laundry to the laundry room. Assistance with personal laundry does not include any laundry, such as bed linen, that is included in the room and board rate. "Health-related services" are limited to minimal assistance

with dressing, grooming, and bathing and providing reminders to residents to take medications that are self-administered or providing storage for medications, if requested. Individuals receiving residential care services cannot receive homemaking services funded under this section.

~~(h)~~ (g) For the purposes of this section, "assisted living" refers to supportive services provided by a single vendor to clients who reside in the same apartment building of three or more units which are not subject to registration under chapter 144D and are licensed by the department of health as a class A home care provider or a class E home care provider. Assisted living services are defined as up to 24-hour supervision, and oversight, supportive services as defined in clause (1), individualized home care aide tasks as defined in clause (2), and individualized home management tasks as defined in clause (3) provided to residents of a residential center living in their units or apartments with a full kitchen and bathroom. A full kitchen includes a stove, oven, refrigerator, food preparation counter space, and a kitchen utensil storage compartment. Assisted living services must be provided by the management of the residential center or by providers under contract with the management or with the county.

(1) Supportive services include:

(i) socialization, when socialization is part of the plan of care, has specific goals and outcomes established, and is not diversional or recreational in nature;

(ii) assisting clients in setting up meetings and appointments; and

(iii) providing transportation, when provided by the residential center only.

~~Individuals receiving assisted living services will not receive both assisted living services and homemaking services. Individualized means services are chosen and designed specifically for each resident's needs, rather than provided or offered to all residents regardless of their illnesses, disabilities, or physical conditions.~~

(2) Home care aide tasks means:

(i) preparing modified diets, such as diabetic or low sodium diets;

(ii) reminding residents to take regularly scheduled medications or to perform exercises;

(iii) household chores in the presence of technically sophisticated medical equipment or episodes of acute illness or infectious disease;

(iv) household chores when the resident's care requires the prevention of exposure to infectious disease or containment of infectious disease; and

(v) assisting with dressing, oral hygiene, hair care, grooming, and bathing, if the resident is ambulatory, and if the resident has no serious acute illness or infectious disease. Oral hygiene means care of teeth, gums, and oral prosthetic devices.

(3) Home management tasks means:

(i) housekeeping;

(ii) laundry;

(iii) preparation of regular snacks and meals; and

(iv) shopping.

Individuals receiving assisted living services shall not receive both assisted living services and homemaking services. Individualized means services are chosen and designed specifically for each resident's needs, rather than provided or offered to all residents regardless of their illnesses, disabilities, or physical conditions. Assisted living services as defined in this section shall not be authorized in boarding and lodging establishments licensed according to sections 157.011 and 157.15 to 157.22.

~~(i)~~ (h) For establishments registered under chapter 144D, assisted living services under this section means either the services described ~~and licensed~~ in paragraph (g) and delivered by a class E home care provider licensed by the department of health or the services described under section 144A.4605 and delivered by an assisted living home care provider or a class A home care provider licensed by the commissioner of health.

~~(j) For the purposes of this section, reimbursement~~ (i) Payment for assisted living services and residential care services shall be a monthly rate negotiated and authorized by the county agency based on an individualized service plan for each resident and may not cover direct rent or food costs. ~~The rate~~

(1) The individualized monthly negotiated payment for assisted living services as described in paragraph (g) or (h), and residential care services as described in paragraph (f), shall not exceed the nonfederal share in effect on July 1 of the state fiscal year for which the rate limit is being calculated of the greater of either the statewide or any of the geographic groups' weighted average monthly ~~medical assistance~~ nursing facility payment rate of the case mix resident class to which the ~~180-day~~ alternative care eligible client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, ~~unless the~~ less the maintenance needs allowance as described in section 256B.0915, subdivision 1d, paragraph (a), until the first day of the state fiscal year in which a resident assessment system, under section 256B.437, of nursing home rate determination is implemented. Effective on the first day of the state fiscal year in which a resident assessment system, under section 256B.437, of nursing home rate determination is implemented and the first day of each subsequent state fiscal year, the individualized monthly negotiated payment for the services described in this clause shall not exceed the limit described in this clause which was in effect on the last day of the previous state fiscal year and which has been adjusted by the greater of any legislatively adopted home and community-based services cost-of-living percentage increase or any legislatively adopted statewide percent rate increase for nursing facilities.

(2) The individualized monthly negotiated payment for assisted living services ~~are provided by a home care~~ described under section 144A.4605 and delivered by a provider licensed by the department of health as a class A home care provider or an assisted living home care provider and ~~are~~ provided in a building that is registered as a housing with services establishment under chapter 144D and that provides 24-hour supervision in combination with the payment for other alternative care services, including case management, must not exceed the limit specified in subdivision 4, paragraph (a), clause (6).

~~(k) For purposes of this section, companion services are defined as nonmedical care, supervision and oversight, provided to a functionally impaired adult. Companions may assist the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on medical care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the recipient. This service must be approved by the case manager as part of the care plan. Companion services must be provided by individuals or organizations who are under contract with the local agency to provide the service. Any person related to the waiver recipient by blood, marriage or adoption cannot be reimbursed under this service. Persons providing companion services will be monitored by the case manager.~~

~~(l) For purposes of this section, training for direct informal caregivers is defined as a classroom or home course of instruction which may include: transfer and lifting skills, nutrition, personal and physical cares, home safety in a home environment, stress reduction and management, behavioral management, long-term care decision making, care coordination and family dynamics. The training is provided to an informal unpaid caregiver of a 180-day eligible client which enables the caregiver to deliver care in a home setting with high levels of quality. The training must be approved by the case manager as part of the individual care plan. Individuals, agencies, and educational facilities which provide caregiver training and education will be monitored by the case manager.~~

~~(m)~~ (j) A county agency may make payment from their alternative care program allocation for "other services" ~~provided to an alternative care program recipient if those services prevent,~~

~~shorten, or delay institutionalization. These services may~~ which include use of "discretionary funds" for services that are not otherwise defined in this section and direct cash payments to the ~~recipient~~ client for the purpose of purchasing the ~~recipient's~~ services. The following provisions apply to payments under this paragraph:

(1) a cash payment to a client under this provision cannot exceed 80 percent of the monthly payment limit for that client as specified in subdivision 4, paragraph (a), clause ~~(7)~~ (6);

(2) a county may not approve any cash payment for a client who meets either of the following:

(i) has been assessed as having a dependency in orientation, unless the client has an authorized representative ~~under section 256.476, subdivision 2, paragraph (g), or for a client who~~. An "authorized representative" means an individual who is at least 18 years of age and is designated by the person or the person's legal representative to act on the person's behalf. This individual may be a family member, guardian, representative payee, or other individual designated by the person or the person's legal representative, if any, to assist in purchasing and arranging for supports; or

(ii) is concurrently receiving adult foster care, residential care, or assisted living services;

(3) ~~any service approved under this section must be a service which meets the purpose and goals of the program as listed in subdivision 1;~~

~~(4) cash payments must also meet the criteria of and are governed by the procedures and liability protection established in section 256.476, subdivision 4, paragraphs (b) through (h), and recipients of cash grants must meet the requirements in section 256.476, subdivision 10; and~~ cash payments to a person or a person's family will be provided through a monthly payment and be in the form of cash, voucher, or direct county payment to a vendor. Fees or premiums assessed to the person for eligibility for health and human services are not reimbursable through this service option. Services and goods purchased through cash payments must be identified in the person's individualized care plan and must meet all of the following criteria:

(i) they must be over and above the normal cost of caring for the person if the person did not have functional limitations;

(ii) they must be directly attributable to the person's functional limitations;

(iii) they must have the potential to be effective at meeting the goals of the program;

(iv) they must be consistent with the needs identified in the individualized service plan. The service plan shall specify the needs of the person and family, the form and amount of payment, the items and services to be reimbursed, and the arrangements for management of the individual grant; and

(v) the person, the person's family, or the legal representative shall be provided sufficient information to ensure an informed choice of alternatives. The local agency shall document this information in the person's care plan, including the type and level of expenditures to be reimbursed;

(4) the county, lead agency under contract, or tribal government under contract to administer the alternative care program shall not be liable for damages, injuries, or liabilities sustained through the purchase of direct supports or goods by the person, the person's family, or the authorized representative with funds received through the cash payments under this section. Liabilities include, but are not limited to, workers' compensation, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA);

(5) persons receiving grants under this section shall have the following responsibilities:

(i) spend the grant money in a manner consistent with their individualized service plan with the local agency;

(ii) notify the local agency of any necessary changes in the grant-expenditures;

(iii) arrange and pay for supports; and

(iv) inform the local agency of areas where they have experienced difficulty securing or maintaining supports; and

~~(5)~~ (6) the county shall report client outcomes, services, and costs under this paragraph in a manner prescribed by the commissioner.

(k) Upon implementation of direct cash payments to clients under this section, any person determined eligible for the alternative care program who chooses a cash payment approved by the county agency shall receive the cash payment under this section and not under section 256.476 unless the person was receiving a consumer support grant under section 256.476 before implementation of direct cash payments under this section.

Sec. 19. Minnesota Statutes 2000, section 256B.0913, subdivision 6, is amended to read:

Subd. 6. [ALTERNATIVE CARE PROGRAM ADMINISTRATION.] The alternative care program is administered by the county agency. This agency is the lead agency responsible for the local administration of the alternative care program as described in this section. However, it may contract with the public health nursing service to be the lead agency. The commissioner may contract with federally recognized Indian tribes with a reservation in Minnesota to serve as the lead agency responsible for the local administration of the alternative care program as described in the contract.

Sec. 20. Minnesota Statutes 2000, section 256B.0913, subdivision 7, is amended to read:

Subd. 7. [CASE MANAGEMENT.] Providers of case management services for persons receiving services funded by the alternative care program must meet the qualification requirements and standards specified in section 256B.0915, subdivision 1b. The case manager must ~~ensure the health and safety of the individual client and~~ not approve alternative care funding for a client in any setting in which the case manager cannot reasonably ensure the client's health and safety. The case manager is responsible for the cost-effectiveness of the alternative care individual care plan and must not approve any care plan in which the cost of services funded by alternative care and client contributions exceeds the limit specified in section 256B.0915, subdivision 3, paragraph (b). The county may allow a case manager employed by the county to delegate certain aspects of the case management activity to another individual employed by the county provided there is oversight of the individual by the case manager. The case manager may not delegate those aspects which require professional judgment including assessments, reassessments, and care plan development.

Sec. 21. Minnesota Statutes 2000, section 256B.0913, subdivision 8, is amended to read:

Subd. 8. [REQUIREMENTS FOR INDIVIDUAL CARE PLAN.] (a) The case manager shall implement the plan of care for each ~~180-day eligible~~ alternative care client and ensure that a client's service needs and eligibility are reassessed at least every 12 months. The plan shall include any services prescribed by the individual's attending physician as necessary to allow the individual to remain in a community setting. In developing the individual's care plan, the case manager should include the use of volunteers from families and neighbors, religious organizations, social clubs, and civic and service organizations to support the formal home care services. The county shall be held harmless for damages or injuries sustained through the use of volunteers under this subdivision including workers' compensation liability. ~~The lead agency shall provide documentation to the commissioner verifying that the individual's alternative care is not available at that time through any other public assistance or service program.~~ The lead agency shall provide documentation in each individual's plan of care and, if requested, to the commissioner that the most cost-effective alternatives available have been offered to the individual and that the individual was free to choose among available qualified providers, both public and private. The case manager must give the individual a ten-day written notice of any decrease in or termination of alternative care services.

(b) If the county administering alternative care services is different than the county of financial responsibility, the care plan may be implemented without the approval of the county of financial responsibility.

Sec. 22. Minnesota Statutes 2000, section 256B.0913, subdivision 9, is amended to read:

Subd. 9. [CONTRACTING PROVISIONS FOR PROVIDERS.] ~~The lead agency shall document to the commissioner that the agency made reasonable efforts to inform potential providers of the anticipated need for services under the alternative care program or waiver programs under sections 256B.0915 and 256B.49, including a minimum of 14 days' written advance notice of the opportunity to be selected as a service provider and an annual public meeting with providers to explain and review the criteria for selection. The lead agency shall also document to the commissioner that the agency allowed potential providers an opportunity to be selected to contract with the county agency. Funds reimbursed to counties under this subdivision~~ Alternative care funds paid to service providers are subject to audit by the commissioner for fiscal and utilization control.

The lead agency must select providers for contracts or agreements using the following criteria and other criteria established by the county:

(1) the need for the particular services offered by the provider;

(2) the population to be served, including the number of clients, the length of time services will be provided, and the medical condition of clients;

(3) the geographic area to be served;

(4) quality assurance methods, including appropriate licensure, certification, or standards, and supervision of employees when needed;

(5) rates for each service and unit of service exclusive of county administrative costs;

(6) evaluation of services previously delivered by the provider; and

(7) contract or agreement conditions, including billing requirements, cancellation, and indemnification.

The county must evaluate its own agency services under the criteria established for other providers. ~~The county shall provide a written statement of the reasons for not selecting providers.~~

Sec. 23. Minnesota Statutes 2000, section 256B.0913, subdivision 10, is amended to read:

Subd. 10. [ALLOCATION FORMULA.] (a) The alternative care appropriation for fiscal years 1992 and beyond shall cover only ~~180-day~~ alternative care eligible clients. Prior to July 1 of each year, the commissioner shall allocate to county agencies the state funds available for alternative care for persons eligible under subdivision 2.

(b) ~~Prior to July 1 of each year, the commissioner shall allocate to county agencies the state funds available for alternative care for persons eligible under subdivision 2. The allocation for fiscal year 1992 shall be calculated using a base that is adjusted to exclude the medical assistance share of alternative care expenditures. The adjusted base is calculated by multiplying each county's allocation for fiscal year 1991 by the percentage of county alternative care expenditures for 180-day eligible clients. The percentage is determined based on expenditures for services rendered in fiscal year 1989 or calendar year 1989, whichever is greater.~~ The adjusted base for each county is the county's current fiscal year base allocation plus any targeted funds approved during the current fiscal year. Calculations for paragraphs (c) and (d) are to be made as follows: for each county, the determination of alternative care program expenditures shall be based on payments for services rendered from April 1 through March 31 in the base year, to the extent that claims have been submitted and paid by June 1 of that year.

(c) If the ~~county~~ alternative care program expenditures ~~for 180-day eligible clients~~ as defined in

paragraph (b) are 95 percent or more of ~~its~~ the county's adjusted base allocation, the allocation for the next fiscal year is 100 percent of the adjusted base, plus inflation to the extent that inflation is included in the state budget.

(d) If the ~~county~~ alternative care program expenditures ~~for 180-day eligible clients~~ as defined in paragraph (b) are less than 95 percent of ~~its~~ the county's adjusted base allocation, the allocation for the next fiscal year is the adjusted base allocation less the amount of unspent funds below the 95 percent level.

(e) ~~For fiscal year 1992 only, a county may receive an increased allocation if annualized service costs for the month of May 1991 for 180-day eligible clients are greater than the allocation otherwise determined. A county may apply for this increase by reporting projected expenditures for May to the commissioner by June 1, 1991. The amount of the allocation may exceed the amount calculated in paragraph (b). The projected expenditures for May must be based on actual 180-day eligible client caseload and the individual cost of clients' care plans. If a county does not report its expenditures for May, the amount in paragraph (c) or (d) shall be used.~~

~~(f) Calculations for paragraphs (c) and (d) are to be made as follows: for each county, the determination of expenditures shall be based on payments for services rendered from April 1 through March 31 in the base year, to the extent that claims have been submitted by June 1 of that year. Calculations for paragraphs (c) and (d) must also include the funds transferred to the consumer support grant program for clients who have transferred to that program from April 1 through March 31 in the base year.~~

~~(g) For the biennium ending June 30, 2001, the allocation of state funds to county agencies shall be calculated as described in paragraphs (c) and (d).~~ If the annual legislative appropriation for the alternative care program is inadequate to fund the combined county allocations for ~~fiscal year 2000 or 2001~~ a biennium, the commissioner shall distribute to each county the entire annual appropriation as that county's percentage of the computed base as calculated in ~~paragraph (f)~~ paragraphs (c) and (d).

Sec. 24. Minnesota Statutes 2000, section 256B.0913, subdivision 11, is amended to read:

Subd. 11. [TARGETED FUNDING.] (a) The purpose of targeted funding is to make additional money available to counties with the greatest need. Targeted funds are not intended to be distributed equitably among all counties, but rather, allocated to those with long-term care strategies that meet state goals.

(b) The funds available for targeted funding shall be the total appropriation for each fiscal year minus county allocations determined under subdivision 10 as adjusted for any inflation increases provided in appropriations for the biennium.

(c) The commissioner shall allocate targeted funds to counties that demonstrate to the satisfaction of the commissioner that they have developed feasible plans to increase alternative care spending. In making targeted funding allocations, the commissioner shall use the following priorities:

(1) counties that received a lower allocation in fiscal year 1991 than in fiscal year 1990. Counties remain in this priority until they have been restored to their fiscal year 1990 level plus inflation;

(2) counties that sustain a base allocation reduction for failure to spend 95 percent of the allocation if they demonstrate that the base reduction should be restored;

(3) counties that propose projects to divert community residents from nursing home placement or convert nursing home residents to community living; and

(4) counties that can otherwise justify program growth by demonstrating the existence of waiting lists, demographically justified needs, or other unmet needs.

(d) Counties that would receive targeted funds according to paragraph (c) must demonstrate to

the commissioner's satisfaction that the funds would be appropriately spent by showing how the funds would be used to further the state's alternative care goals as described in subdivision 1, and that the county has the administrative and service delivery capability to use them.

(e) The commissioner shall request applications ~~by June 1 each year, for county agencies to apply~~ for targeted funds by November 1 of each year. The counties selected for targeted funds shall be notified of the amount of their additional funding ~~by August 1 of each year~~. Targeted funds allocated to a county agency in one year shall be treated as part of the county's base allocation for that year in determining allocations for subsequent years. No reallocations between counties shall be made.

~~(f) The allocation for each year after fiscal year 1992 shall be determined using the previous fiscal year's allocation, including any targeted funds, as the base and then applying the criteria under subdivision 10, paragraphs (c), (d), and (f), to the current year's expenditures.~~

Sec. 25. Minnesota Statutes 2000, section 256B.0913, subdivision 12, is amended to read:

Subd. 12. [CLIENT PREMIUMS.] (a) A premium is required for all ~~180-day~~ alternative care eligible clients to help pay for the cost of participating in the program. The amount of the premium for the alternative care client shall be determined as follows:

(1) when the alternative care client's income less recurring and predictable medical expenses is greater than the ~~medical assistance income standard~~ recipient's maintenance needs allowance as defined in section 256B.0915, subdivision 1d, paragraph (a), but less than 150 percent of the federal poverty guideline effective on July 1 of the state fiscal year in which the premium is being computed, and total assets are less than $10,000, the fee is zero;

(2) when the alternative care client's income less recurring and predictable medical expenses is greater than 150 percent of the federal poverty guideline effective on July 1 of the state fiscal year in which the premium is being computed, and total assets are less than $10,000, the fee is 25 percent of the cost of alternative care services or the difference between 150 percent of the federal poverty guideline effective on July 1 of the state fiscal year in which the premium is being computed and the client's income less recurring and predictable medical expenses, whichever is less; and

(3) when the alternative care client's total assets are greater than $10,000, the fee is 25 percent of the cost of alternative care services.

For married persons, total assets are defined as the total marital assets less the estimated community spouse asset allowance, under section 256B.059, if applicable. For married persons, total income is defined as the client's income less the monthly spousal allotment, under section 256B.058.

All alternative care services except case management shall be included in the estimated costs for the purpose of determining 25 percent of the costs.

The monthly premium shall be calculated based on the cost of the first full month of alternative care services and shall continue unaltered until the next reassessment is completed or at the end of 12 months, whichever comes first. Premiums are due and payable each month alternative care services are received unless the actual cost of the services is less than the premium.

(b) The fee shall be waived by the commissioner when:

(1) a person who is residing in a nursing facility is receiving case management only;

(2) a person is applying for medical assistance;

(3) a married couple is requesting an asset assessment under the spousal impoverishment provisions;

(4) ~~a person is a medical assistance recipient, but has been approved for alternative care-funded assisted living services;~~

~~(5)~~ a person is found eligible for alternative care, but is not yet receiving alternative care services; or

~~(6)~~ (5) a person's fee under paragraph (a) is less than $25.

(c) The county agency must collect the premium from the client and forward the amounts collected to the commissioner in the manner and at the times prescribed by the commissioner. Money collected must be deposited in the general fund and is appropriated to the commissioner for the alternative care program. The client must supply the county with the client's social security number at the time of application. If a client fails or refuses to pay the premium due, the county shall supply the commissioner with the client's social security number and other information the commissioner requires to collect the premium from the client. The commissioner shall collect unpaid premiums using the Revenue Recapture Act in chapter 270A and other methods available to the commissioner. The commissioner may require counties to inform clients of the collection procedures that may be used by the state if a premium is not paid.

(d) The commissioner shall begin to adopt emergency or permanent rules governing client premiums within 30 days after July 1, 1991, including criteria for determining when services to a client must be terminated due to failure to pay a premium.

Sec. 26. Minnesota Statutes 2000, section 256B.0913, subdivision 13, is amended to read:

Subd. 13. [COUNTY BIENNIAL PLAN.] The county biennial plan for ~~the preadmission screening program~~ long-term care consultation services under section 256B.0911, the alternative care program under this section, and waivers for the elderly under section 256B.0915, ~~and waivers for the disabled under section 256B.49,~~ shall be incorporated into the biennial Community Social Services Act plan and shall meet the regulations and timelines of that plan. ~~This county biennial plan shall include:~~

~~(1) information on the administration of the preadmission screening program;~~

~~(2) information on the administration of the home and community-based services waivers for the elderly under section 256B.0915, and for the disabled under section 256B.49; and~~

~~(3) information on the administration of the alternative care program.~~

Sec. 27. Minnesota Statutes 2000, section 256B.0913, subdivision 14, is amended to read:

Subd. 14. [~~REIMBURSEMENT~~ PAYMENT AND RATE ADJUSTMENTS.] (a) ~~Reimbursement~~ Payment for ~~expenditures for the~~ provided alternative care services as approved by the client's case manager shall be through the invoice processing procedures of the department's Medicaid Management Information System (MMIS). To receive ~~reimbursement~~ payment, the county or vendor must submit invoices within 12 months following the date of service. The county agency and its vendors under contract shall not be reimbursed for services which exceed the county allocation.

(b) If a county collects less than 50 percent of the client premiums due under subdivision 12, the commissioner may withhold up to three percent of the county's final alternative care program allocation determined under subdivisions 10 and 11.

(c) The county shall negotiate individual rates with vendors and may ~~be reimbursed~~ authorize service payment for actual costs up to ~~the greater of~~ the county's current approved rate ~~or 60 percent of the maximum rate in fiscal year 1994 and 65 percent of the maximum rate in fiscal year 1995 for each alternative care service~~. Notwithstanding any other rule or statutory provision to the contrary, the commissioner shall not be authorized to increase rates by an annual inflation factor, unless so authorized by the legislature.

(d) ~~On July 1, 1993, the commissioner shall increase the maximum rate for home delivered meals to $4.50 per meal~~ To improve access to community services and eliminate payment disparities between the alternative care program and the elderly waiver program, the commissioner shall establish statewide maximum service rate limits and eliminate county-specific service rate limits.

(1) Effective July 1, 2001, for service rate limits, except those in subdivision 5, paragraphs (d) and (i), the rate limit for each service shall be the greater of the alternative care statewide maximum rate or the elderly waiver statewide maximum rate.

(2) Counties may negotiate individual service rates with vendors for actual costs up to the statewide maximum service rate limit.

Sec. 28. Minnesota Statutes 2000, section 256B.0915, subdivision 1d, is amended to read:

Subd. 1d. [POSTELIGIBILITY TREATMENT OF INCOME AND RESOURCES FOR ELDERLY WAIVER.] ~~(a)~~ Notwithstanding the provisions of section 256B.056, the commissioner shall make the following amendment to the medical assistance elderly waiver program effective July 1, 1999, or upon federal approval, whichever is later.

A recipient's maintenance needs will be an amount equal to the Minnesota supplemental aid equivalent rate as defined in section 256I.03, subdivision 5, plus the medical assistance personal needs allowance as defined in section 256B.35, subdivision 1, paragraph (a), when applying posteligibility treatment of income rules to the gross income of elderly waiver recipients, except for individuals whose income is in excess of the special income standard according to Code of Federal Regulations, title 42, section 435.236. Recipient maintenance needs shall be adjusted under this provision each July 1.

~~(b) The commissioner of human services shall secure approval of additional elderly waiver slots sufficient to serve persons who will qualify under the revised income standard described in paragraph (a) before implementing section 256B.0913, subdivision 16.~~

~~(c) In implementing this subdivision, the commissioner shall consider allowing persons who would otherwise be eligible for the alternative care program but would qualify for the elderly waiver with a spenddown to remain on the alternative care program.~~

Sec. 29. Minnesota Statutes 2000, section 256B.0915, subdivision 3, is amended to read:

Subd. 3. [LIMITS OF CASES, RATES, ~~REIMBURSEMENT~~ PAYMENTS, AND FORECASTING.] (a) The number of medical assistance waiver recipients that a county may serve must be allocated according to the number of medical assistance waiver cases open on July 1 of each fiscal year. Additional recipients may be served with the approval of the commissioner.

(b) The monthly limit for the cost of waivered services to an individual elderly waiver client shall be the ~~statewide average payment~~ weighted average monthly nursing facility rate of the case mix resident class to which the elderly waiver client would be assigned under ~~the medical assistance case mix reimbursement system.~~ Minnesota Rules, parts 9549.0050 to 9549.0059, less the recipient's maintenance needs allowance as described in subdivision 1d, paragraph (a), until the first day of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented. Effective on the first day of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented and the first day of each subsequent state fiscal year, the monthly limit for the cost of waivered services to an individual elderly waiver client shall be the rate of the case mix resident class to which the waiver client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, in effect on the last day of the previous state fiscal year, adjusted by the greater of any legislatively adopted home and community-based services cost-of-living percentage increase or any legislatively adopted statewide percent rate increase for nursing facilities.

(c) If extended medical supplies and equipment or ~~adaptations~~ environmental modifications are or will be purchased for an elderly waiver ~~services recipient, the~~ client, the costs may be prorated ~~on a monthly basis throughout the year in which they are purchased~~ for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's ~~other~~ waivered services exceeds the monthly limit established in ~~this~~ paragraph (b), the annual cost of ~~the~~ all waivered services shall be determined. In this event, the annual cost of all waivered services shall not exceed 12 times the monthly limit ~~calculated in this paragraph. The statewide average payment~~

~~rate is calculated by determining the statewide average monthly nursing home rate, effective July 1 of the fiscal year in which the cost is incurred, less the statewide average monthly income of nursing home residents who are age 65 or older, and who are medical assistance recipients in the month of March of the previous state fiscal year. The annual cost divided by 12 of elderly or disabled waivered services~~ of waivered services as described in paragraph (b).

(d) For a person who is a nursing facility resident at the time of requesting a determination of eligibility for elderly ~~or disabled~~ waivered services ~~shall be the greater of the monthly payment for: (i)~~, a monthly conversion limit for the cost of elderly waivered services may be requested. The monthly conversion limit for the cost of elderly waiver services shall be the resident class assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, for that resident in the nursing facility where the resident currently resides~~; or (ii) the statewide average payment of the case mix resident class to which the resident would be assigned under the medical assistance case mix reimbursement system, provided that~~ until July 1 of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented. Effective on July 1 of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented, the monthly conversion limit for the cost of elderly waiver services shall be the per diem nursing facility rate as determined by the resident assessment system as described in section 256B.437 for that resident in the nursing facility where the resident currently resides multiplied by 365 and divided by 12, less the recipient's maintenance needs allowance as described in subdivision 1d. The limit under this clause only applies to persons discharged from a nursing facility after a minimum 30-day stay and found eligible for waivered services on or after July 1, 1997. The following costs must be included in determining the total monthly costs for the waiver client:

(1) cost of all waivered services, including extended medical supplies and equipment and environmental modifications; and

(2) cost of skilled nursing, home health aide, and personal care services reimbursable by medical assistance.

~~(c)~~ (e) Medical assistance funding for skilled nursing services, private duty nursing, home health aide, and personal care services for waiver recipients must be approved by the case manager and included in the individual care plan.

~~(d) For both the elderly waiver and the nursing facility disabled waiver, a county may purchase extended supplies and equipment without prior approval from the commissioner when there is no other funding source and the supplies and equipment are specified in the individual's care plan as medically necessary to enable the individual to remain in the community according to the criteria in Minnesota Rules, part 9505.0210, items A and B.~~ (f) A county is not required to contract with a provider of supplies and equipment if the monthly cost of the supplies and equipment is less than $250.

~~(e)~~ (g) The adult foster care ~~daily~~ rate ~~for the elderly and disabled waivers~~ shall be considered a difficulty of care payment and shall not include room and board. The adult foster care service rate shall be negotiated between the county agency and the foster care provider. ~~The rate established under this section shall not exceed the state average monthly nursing home payment for the case mix classification to which the individual receiving foster care is assigned; the rate must allow for other waiver and medical assistance home care services to be authorized by the case manager.~~ The elderly waiver payment for the foster care service in combination with the payment for all other elderly waiver services, including case management, must not exceed the limit specified in paragraph (b).

~~(f) The assisted living and residential care service rates for elderly and community alternatives for disabled individuals (CADI) waivers shall be made to the vendor as a monthly rate negotiated with the county agency based on an individualized service plan for each resident. The rate shall not exceed the nonfederal share of the greater of either the statewide or any of the geographic groups' weighted average monthly medical assistance nursing facility payment rate of the case mix resident class to which the elderly or disabled client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, unless the services are provided by a home care provider~~

~~licensed by the department of health and are provided in a building that is registered as a housing with services establishment under chapter 144D and that provides 24-hour supervision. For alternative care assisted living projects established under Laws 1988, chapter 689, article 2, section 256, monthly rates may not exceed 65 percent of the greater of either the statewide or any of the geographic groups' weighted average monthly medical assistance nursing facility payment rate for the case mix resident class to which the elderly or disabled client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059. The rate may not cover direct rent or food costs.~~

(h) Payment for assisted living service shall be a monthly rate negotiated and authorized by the county agency based on an individualized service plan for each resident and may not cover direct rent or food costs.

(1) The individualized monthly negotiated payment for assisted living services as described in section 256B.0913, subdivision 5, paragraph (g) or (h), and residential care services as described in section 256B.0913, subdivision 5, paragraph (f), shall not exceed the nonfederal share, in effect on July 1 of the state fiscal year for which the rate limit is being calculated, of the greater of either the statewide or any of the geographic groups' weighted average monthly nursing facility rate of the case mix resident class to which the elderly waiver eligible client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, less the maintenance needs allowance as described in subdivision 1d, paragraph (a), until the July 1 of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented. Effective on July 1 of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented and July 1 of each subsequent state fiscal year, the individualized monthly negotiated payment for the services described in this clause shall not exceed the limit described in this clause which was in effect on June 30 of the previous state fiscal year and which has been adjusted by the greater of any legislatively adopted home and community-based services cost-of-living percentage increase or any legislatively adopted statewide percent rate increase for nursing facilities.

(2) The individualized monthly negotiated payment for assisted living services described in section 144A.4605 and delivered by a provider licensed by the department of health as a Class A home care provider or an assisted living home care provider and provided in a building that is registered as a housing with services establishment under chapter 144D and that provides 24-hour supervision in combination with the payment for other elderly waiver services, including case management, must not exceed the limit specified in paragraph (b).

~~(g)~~ (i) The county shall negotiate individual service rates with vendors and may ~~be reimbursed~~ authorize payment for actual costs up to the ~~greater of the~~ county's current approved rate ~~or 60 percent of the maximum rate in fiscal year 1994 and 65 percent of the maximum rate in fiscal year 1995 for each service within each program~~. Persons or agencies must be employed by or under a contract with the county agency or the public health nursing agency of the local board of health in order to receive funding under the elderly waiver program, except as a provider of supplies and equipment when the monthly cost of the supplies and equipment is less than $250.

~~(h) On July 1, 1993, the commissioner shall increase the maximum rate for home-delivered meals to $4.50 per meal.~~

~~(i)~~ (j) Reimbursement for the medical assistance recipients under the approved waiver shall be made from the medical assistance account through the invoice processing procedures of the department's Medicaid Management Information System (MMIS), only with the approval of the client's case manager. The budget for the state share of the Medicaid expenditures shall be forecasted with the medical assistance budget, and shall be consistent with the approved waiver.

(k) To improve access to community services and eliminate payment disparities between the alternative care program and the elderly waiver, the commissioner shall establish statewide maximum service rate limits and eliminate county-specific service rate limits.

(1) Effective July 1, 2001, for service rate limits, except those described or defined in paragraphs (g) and (h), the rate limit for each service shall be the greater of the alternative care statewide maximum rate or the elderly waiver statewide maximum rate.

(2) Counties may negotiate individual service rates with vendors for actual costs up to the statewide maximum service rate limit.

~~(j)~~ (l) Beginning July 1, 1991, the state shall reimburse counties according to the payment schedule in section 256.025 for the county share of costs incurred under this subdivision on or after January 1, 1991, for individuals who are receiving medical assistance.

~~(k) For the community alternatives for disabled individuals waiver, and nursing facility disabled waivers, county may use waiver funds for the cost of minor adaptations to a client's residence or vehicle without prior approval from the commissioner if there is no other source of funding and the adaptation:~~

~~(1) is necessary to avoid institutionalization;~~

~~(2) has no utility apart from the needs of the client; and~~

~~(3) meets the criteria in Minnesota Rules, part 9505.0210, items A and B.~~

~~For purposes of this subdivision, "residence" means the client's own home, the client's family residence, or a family foster home. For purposes of this subdivision, "vehicle" means the client's vehicle, the client's family vehicle, or the client's family foster home vehicle.~~

~~(l) The commissioner shall establish a maximum rate unit for baths provided by an adult day care provider that are not included in the provider's contractual daily or hourly rate. This maximum rate must equal the home health aide extended rate and shall be paid for baths provided to clients served under the elderly and disabled waivers.~~

Sec. 30. Minnesota Statutes 2000, section 256B.0915, subdivision 5, is amended to read:

Subd. 5. [REASSESSMENTS FOR WAIVER CLIENTS.] A reassessment of a client served under the elderly ~~or disabled~~ waiver must be conducted at least every 12 months and at other times when the case manager determines that there has been significant change in the client's functioning. This may include instances where the client is discharged from the hospital.

Sec. 31. Minnesota Statutes 2000, section 256B.0917, is amended by adding a subdivision to read:

Subd. 13. [COMMUNITY SERVICE GRANTS.] The commissioner shall award contracts for grants to public and private nonprofit agencies to establish services that strengthen a community's ability to provide a system of home and community-based services for elderly persons. The commissioner shall use a request for proposal process. Communities that have a planned closure of a nursing facility approved under section 256B.437 shall be given preference for grants. The commissioner shall consider grants for:

(1) caregiver support and respite care projects under subdivision 6;

(2) on-site coordination under section 256.9731;

(3) the living-at-home/block nurse grant under subdivisions 7 to 10; and

(4) services identified as needed for community transition.

Sec. 32. [RESPITE CARE.]

The Minnesota board on aging shall present recommendations to the legislature by February 1, 2002, on the provision of in-home and out-of-home respite care services on a sliding scale basis under the federal Older Americans Act.

Sec. 33. [REPEALER.]

(a) Minnesota Statutes 2000, sections 256B.0911, subdivisions 2, 2a, 4, 8, and 9; 256B.0913, subdivisions 3, 15a, 15b, 15c, and 16; and 256B.0915, subdivisions 3a, 3b, and 3c, are repealed.

(b) Minnesota Rules, parts 9505.2390; 9505.2395; 9505.2396; 9505.2400; 9505.2405; 9505.2410; 9505.2413; 9505.2415; 9505.2420; 9505.2425; 9505.2426; 9505.2430; 9505.2435; 9505.2440; 9505.2445; 9505.2450; 9505.2455; 9505.2458; 9505.2460; 9505.2465; 9505.2470; 9505.2473; 9505.2475; 9505.2480; 9505.2485; 9505.2486; 9505.2490; 9505.2495; 9505.2496; and 9505.2500, are repealed.

ARTICLE 5

LONG-TERM CARE SYSTEM REFORM AND REIMBURSEMENT

Section 1. Minnesota Statutes 2000, section 144.0721, subdivision 1, is amended to read:

Subdivision 1. [APPROPRIATENESS AND QUALITY.] Until the date of implementation of the revised case mix system based on the minimum data set, the commissioner of health shall assess the appropriateness and quality of care and services furnished to private paying residents in nursing homes and boarding care homes that are certified for participation in the medical assistance program under United States Code, title 42, sections 1396-1396p. These assessments shall be conducted until the date of implementation of the revised case mix system based on the minimum data set, in accordance with section 144.072, with the exception of provisions requiring recommendations for changes in the level of care provided to the private paying residents.

Sec. 2. [144.0724] [RESIDENT REIMBURSEMENT CLASSIFICATION.]

Subdivision 1. [RESIDENT REIMBURSEMENT CLASSIFICATIONS.] The commissioner of health shall establish resident reimbursement classifications based upon the assessments of residents of nursing homes and boarding care homes conducted under this section and according to section 256B.438. The reimbursement classifications established under this section shall be implemented after June 30, 2002, but no later than January 1, 2003.

Subd. 2. [DEFINITIONS.] For purposes of this section, the following terms have the meanings given.

(a) [ASSESSMENT REFERENCE DATE.] "Assessment reference date" means the last day of the minimum data set observation period. The date sets the designated endpoint of the common observation period, and all minimum data set items refer back in time from that point.

(b) [CASE MIX INDEX.] "Case mix index" means the weighting factors assigned to the RUG-III classifications.

(c) [INDEX MAXIMIZATION.] "Index maximization" means classifying a resident who could be assigned to more than one category, to the category with the highest case mix index.

(d) [MINIMUM DATA SET.] "Minimum data set" means the assessment instrument specified by the Health Care Financing Administration and designated by the Minnesota department of health.

(e) [REPRESENTATIVE.] "Representative" means a person who is the resident's guardian or conservator, the person authorized to pay the nursing home expenses of the resident, a representative of the nursing home ombudsman's office whose assistance has been requested, or any other individual designated by the resident.

(f) [RESOURCE UTILIZATION GROUPS OR RUG.] "Resource utilization groups" or "RUG" means the system for grouping a nursing facility's residents according to their clinical and functional status identified in data supplied by the facility's minimum data set.

Subd. 3. [RESIDENT REIMBURSEMENT CLASSIFICATIONS.] (a) Resident reimbursement classifications shall be based on the minimum data set, version 2.0 assessment instrument, or its successor version mandated by the Health Care Financing Administration that nursing facilities are required to complete for all residents. The commissioner of health shall establish resident classes according to the 34 group, resource utilization groups, version III or RUG-III model. Resident classes must be established based on the individual items on the minimum data set and must be completed according to the facility manual for case mix

classification issued by the Minnesota department of health. The facility manual for case mix classification shall be drafted by the Minnesota department of health and presented to the chairs of health and human services legislative committees by December 31, 2001.

(b) Each resident must be classified based on the information from the minimum data set according to general domains in clauses (1) to (7):

(1) extensive services where a resident requires intravenous feeding or medications, suctioning, tracheostomy care, or is on a ventilator or respirator;

(2) rehabilitation where a resident requires physical, occupational, or speech therapy;

(3) special care where a resident has cerebral palsy; quadriplegia; multiple sclerosis; pressure ulcers; fever with vomiting, weight loss, or dehydration; tube feeding and aphasia; or is receiving radiation therapy;

(4) clinically complex status where a resident has burns, coma, septicemia, pneumonia, internal bleeding, chemotherapy, wounds, kidney failure, urinary tract infections, oxygen, or transfusions;

(5) impaired cognition where a resident has poor cognitive performance;

(6) behavior problems where a resident exhibits wandering, has hallucinations, or is physically or verbally abusive toward others, unless the resident's other condition would place the resident in other categories; and

(7) reduced physical functioning where a resident has no special clinical conditions.

(c) The commissioner of health shall establish resident classification according to a 34 group model based on the information on the minimum data set and within the general domains listed in paragraph (b), clauses (1) to (7). Detailed descriptions of each resource utilization group shall be defined in the facility manual for case mix classification issued by the Minnesota department of health. The 34 groups are described as follows:

(1) SE3: requires four or five extensive services;

(2) SE2: requires two or three extensive services;

(3) SE1: requires one extensive service;

(4) RAD: requires rehabilitation services and is dependent in activity of daily living (ADL) at a count of 17 or 18;

(5) RAC: requires rehabilitation services and ADL count is 14 to 16;

(6) RAB: requires rehabilitation services and ADL count is ten to 13;

(7) RAA: requires rehabilitation services and ADL count is four to nine;

(8) SSC: requires special care and ADL count is 17 or 18;

(9) SSB: requires special care and ADL count is 15 or 16;

(10) SSA: requires special care and ADL count is seven to 14;

(11) CC2: clinically complex with depression and ADL count is 17 or 18;

(12) CC1: clinically complex with no depression and ADL count is 17 or 18;

(13) CB2: clinically complex with depression and ADL count is 12 to 16;

(14) CB1: clinically complex with no depression and ADL count is 12 to 16;

(15) CA2: clinically complex with depression and ADL count is four to 11;

(16) CA1: clinically complex with no depression and ADL count is four to 11;

(17) IB2: impaired cognition with nursing rehabilitation and ADL count is six to ten;

(18) IB1: impaired cognition with no nursing rehabilitation and ADL count is six to ten;

(19) IA2: impaired cognition with nursing rehabilitation and ADL count is four or five;

(20) IA1: impaired cognition with no nursing rehabilitation and ADL count is four or five;

(21) BB2: behavior problems with nursing rehabilitation and ADL count is six to ten;

(22) BB1: behavior problems with no nursing rehabilitation and ADL count is six to ten;

(23) BA2: behavior problems with nursing rehabilitation and ADL count is four to five;

(24) BA1: behavior problems with no nursing rehabilitation and ADL count is four to five;

(25) PE2: reduced physical functioning with nursing rehabilitation and ADL count is 16 to 18;

(26) PE1: reduced physical functioning with no nursing rehabilitation and ADL count is 16 to 18;

(27) PD2: reduced physical functioning with nursing rehabilitation and ADL count is 11 to 15;

(28) PD1: reduced physical functioning with no nursing rehabilitation and ADL count is 11 to 15;

(29) PC2: reduced physical functioning with nursing rehabilitation and ADL count is nine or ten;

(30) PC1: reduced physical functioning with no nursing rehabilitation and ADL count is nine or ten;

(31) PB2: reduced physical functioning with nursing rehabilitation and ADL count is six to eight;

(32) PB1: reduced physical functioning with no nursing rehabilitation and ADL count is six to eight;

(33) PA2: reduced physical functioning with nursing rehabilitation and ADL count is four or five; and

(34) PA1: reduced physical functioning with no nursing rehabilitation and ADL count is four or five.

Subd. 4. [RESIDENT ASSESSMENT SCHEDULE.] (a) A facility must conduct and electronically submit to the commissioner of health case mix assessments that conform with the assessment schedule defined by the Code of Federal Regulations, title 42, section 483.20, and published by the United States Department of Health and Human Services, Health Care Financing Administration, in the Long Term Care Assessment Instrument User's Manual, version 2.0, October 1995, and subsequent clarifications made in the Long-Term Care Assessment Instrument Questions and Answers, version 2.0, August 1996. The commissioner of health may substitute successor manuals or question and answer documents published by the United States Department of Health and Human Services, Health Care Financing Administration, to replace or supplement the current version of the manual or document.

(b) The assessments used to determine a case mix classification for reimbursement include the following:

(1) a new admission assessment must be completed by day 14 following admission;

(2) an annual assessment must be completed within 366 days of the last comprehensive assessment;

(3) a significant change assessment must be completed within 14 days of the identification of a significant change; and

(4) the second quarterly assessment following either a new admission assessment, an annual assessment, or a significant change assessment. Each quarterly assessment must be completed within 92 days of the previous assessment.

Subd. 5. [SHORT STAYS.] (a) A facility must submit to the commissioner of health an initial admission assessment for all residents who stay in the facility less than 14 days.

(b) Notwithstanding the admission assessment requirements of paragraph (a), a facility may elect to accept a default rate with a case mix index of 1.0 for all facility residents who stay less than 14 days in lieu of submitting an initial assessment. Facilities may make this election to be effective on the day of implementation of the revised case mix system.

(c) After implementation of the revised case mix system, nursing facilities must elect one of the options described in paragraphs (a) and (b) on the annual report to the commissioner of human services filed for each report year ending September 30. The election shall be effective on the following July 1.

(d) For residents who are admitted or readmitted and leave the facility on a frequent basis and for whom readmission is expected, the resident may be discharged on an extended leave status. This status does not require reassessment each time the resident returns to the facility unless a significant change in the resident's status has occurred since the last assessment. The case mix classification for these residents is determined by the facility election made in paragraphs (a) and (b).

Subd. 6. [PENALTIES FOR LATE OR NONSUBMISSION.] A facility that fails to complete or submit an assessment for a RUG-III classification within seven days of the time requirements in subdivisions 4 and 5 is subject to a reduced rate for that resident. The reduced rate shall be the lowest rate for that facility. The reduced rate is effective on the day of admission for new admission assessments or on the day that the assessment was due for all other assessments and continues in effect until the first day of the month following the date of submission of the resident's assessment.

Subd. 7. [NOTICE OF RESIDENT REIMBURSEMENT CLASSIFICATION.] (a) A facility must elect between the options in paragraphs (1) and (2) to provide notice to a resident of the resident's case mix classification.

(1) The commissioner of health shall provide to a nursing facility a notice for each resident of the reimbursement classification established under subdivision 1. The notice must inform the resident of the classification that was assigned, the opportunity to review the documentation supporting the classification, the opportunity to obtain clarification from the commissioner, and the opportunity to request a reconsideration of the classification. The commissioner must send notice of resident classification by first class mail. A nursing facility is responsible for the distribution of the notice to each resident, to the person responsible for the payment of the resident's nursing home expenses, or to another person designated by the resident. This notice must be distributed within three working days after the facility's receipt of the notice from the commissioner of health.

(2) A facility may choose to provide a classification notice, as prescribed by the commissioner of health, to a resident upon receipt of the confirmation of the case mix classification calculated by a facility or a corrected case mix classification as indicated on the final validation report from the commissioner. A nursing facility is responsible for the distribution of the notice to each resident, to the person responsible for the payment of the resident's nursing home expenses, or to another person designated by the resident. This notice must be distributed within three working days after the facility's receipt of the validation report from the commissioner. If a facility elects this option, the commissioner of health shall provide the facility with a list of residents and their case mix classifications as determined by the commissioner. A nursing facility may make this election to be effective on the day of implementation of the revised case mix system.

(3) After implementation of the revised case mix system, a nursing facility shall elect a notice of resident reimbursement classification procedure as described in paragraph (1) or (2) on the annual report to the commissioner of human services filed for each report year ending September 30. The election will be effective the following July 1.

(b) If a facility submits a correction to an assessment conducted under subdivision 3 that results in a change in case mix classification, the facility shall give written notice to the resident or the resident's representative about the item that was corrected and the reason for the correction. The notice of corrected assessment may be provided at the same time that the resident or resident's representative is provided the resident's corrected notice of classification.

Subd. 8. [REQUEST FOR RECONSIDERATION OF RESIDENT CLASSIFICATIONS.] (a) The resident, or resident's representative, or the nursing facility or boarding care home may request that the commissioner of health reconsider the assigned reimbursement classification. The request for reconsideration must be submitted in writing to the commissioner within 30 days of the day the resident or the resident's representative receives the resident classification notice. The request for reconsideration must include the name of the resident, the name and address of the facility in which the resident resides, the reasons for the reconsideration, the requested classification changes, and documentation supporting the requested classification. The documentation accompanying the reconsideration request is limited to documentation which establishes that the needs of the resident at the time of the assessment justify a classification which is different than the classification established by the commissioner of health.

(b) Upon request, the nursing facility must give the resident or the resident's representative a copy of the assessment form and the other documentation that was given to the commissioner of health to support the assessment findings. The nursing facility shall also provide access to and a copy of other information from the resident's record that has been requested by or on behalf of the resident to support a resident's reconsideration request. A copy of any requested material must be provided within three working days of receipt of a written request for the information. If a facility fails to provide the material within this time, it is subject to the issuance of a correction order and penalty assessment under sections 144.653 and 144A.10. Notwithstanding those sections, any correction order issued under this subdivision must require that the nursing facility immediately comply with the request for information and that as of the date of the issuance of the correction order, the facility shall forfeit to the state a $100 fine for the first day of noncompliance, and an increase in the $100 fine by $50 increments for each day the noncompliance continues.

(c) In addition to the information required under paragraphs (a) and (b), a reconsideration request from a nursing facility must contain the following information: (i) the date the reimbursement classification notices were received by the facility; (ii) the date the classification notices were distributed to the resident or the resident's representative; and (iii) a copy of a notice sent to the resident or to the resident's representative. This notice must inform the resident or the resident's representative that a reconsideration of the resident's classification is being requested, the reason for the request, that the resident's rate will change if the request is approved by the commissioner, the extent of the change, that copies of the facility's request and supporting documentation are available for review, and that the resident also has the right to request a reconsideration. If the facility fails to provide the required information with the reconsideration request, the request must be denied, and the facility may not make further reconsideration requests on that specific reimbursement classification.

(d) Reconsideration by the commissioner must be made by individuals not involved in reviewing the assessment, audit, or reconsideration that established the disputed classification. The reconsideration must be based upon the initial assessment and upon the information provided to the commissioner under paragraphs (a) and (b). If necessary for evaluating the reconsideration request, the commissioner may conduct on-site reviews. Within 15 working days of receiving the request for reconsideration, the commissioner shall affirm or modify the original resident classification. The original classification must be modified if the commissioner determines that the assessment resulting in the classification did not accurately reflect the needs or assessment characteristics of the resident at the time of the assessment. The resident and the nursing facility or boarding care home shall be notified within five working days after the decision is made. A

decision by the commissioner under this subdivision is the final administrative decision of the agency for the party requesting reconsideration.

(e) The resident classification established by the commissioner shall be the classification that applies to the resident while the request for reconsideration is pending.

(f) The commissioner may request additional documentation regarding a reconsideration necessary to make an accurate reconsideration determination.

Subd. 9. [AUDIT AUTHORITY.] (a) The commissioner shall audit the accuracy of resident assessments performed under section 256B.438 through desk audits, on-site review of residents and their records, and interviews with staff and families. The commissioner shall reclassify a resident if the commissioner determines that the resident was incorrectly classified.

(b) The commissioner is authorized to conduct on-site audits on an unannounced basis.

(c) A facility must grant the commissioner access to examine the medical records relating to the resident assessments selected for audit under this subdivision. The commissioner may also observe and speak to facility staff and residents.

(d) The commissioner shall consider documentation under the time frames for coding items on the minimum data set as set out in the Resident Assessment Instrument Manual published by the Health Care Financing Administration.

(e) The commissioner shall develop an audit selection procedure that includes the following factors:

(1) The commissioner may target facilities that demonstrate an atypical pattern of scoring minimum data set items, nonsubmission of assessments, late submission of assessments, or a previous history of audit changes of greater than 35 percent. The commissioner shall select at least 20 percent of the most current assessments submitted to the state for audit. Audits of assessments selected in the targeted facilities must focus on the factors leading to the audit. If the number of targeted assessments selected does not meet the threshold of 20 percent of the facility residents, then a stratified sample of the remainder of assessments shall be drawn to meet the quota. If the total change exceeds 35 percent, the commissioner may conduct an expanded audit up to 100 percent of the remaining current assessments.

(2) Facilities that are not a part of the targeted group shall be placed in a general pool from which facilities will be selected on a random basis for audit. Every facility shall be audited annually. If a facility has two successive audits in which the percentage of change is five percent or less and the facility has not been the subject of a targeted audit in the past 36 months, the facility may be audited biannually. A stratified sample of 15 percent of the most current assessments shall be selected for audit. If more than 20 percent of the RUGS-III classifications after the audit are changed, the audit shall be expanded to a second 15 percent sample. If the total change between the first and second samples exceed 35 percent, the commissioner may expand the audit to all of the remaining assessments.

(3) If a facility qualifies for an expanded audit, the commissioner may audit the facility again within six months. If a facility has two expanded audits within a 24-month period, that facility will be audited at least every six months for the next 18 months.

(4) The commissioner may conduct special audits if the commissioner determines that circumstances exist that could alter or affect the validity of case mix classifications of residents. These circumstances include, but are not limited to, the following:

(i) frequent changes in the administration or management of the facility;

(ii) an unusually high percentage of residents in a specific case mix classification;

(iii) a high frequency in the number of reconsideration requests received from a facility;

(iv) frequent adjustments of case mix classifications as the result of reconsiderations or audits;

(v) a criminal indictment alleging provider fraud; or

(vi) other similar factors that relate to a facility's ability to conduct accurate assessments.

(f) Within 15 working days of completing the audit process, the commissioner shall mail the written results of the audit to the facility, along with a written notice for each resident affected to be forwarded by the facility. The notice must contain the resident's classification and a statement informing the resident, the resident's authorized representative, and the facility of their right to review the commissioner's documents supporting the classification and to request a reconsideration of the classification. This notice must also include the address and telephone number of the area nursing home ombudsman.

Subd. 10. [TRANSITION.] After implementation of this section, reconsiderations requested for classifications made under section 144.0722, subdivision 1, shall be determined under section 144.0722, subdivision 3.

Sec. 3. Minnesota Statutes 2000, section 144A.071, subdivision 1, is amended to read:

Subdivision 1. [FINDINGS.] The legislature declares that a moratorium on the licensure and medical assistance certification of new nursing home beds and construction projects that exceed ~~$750,000~~ $1,000,000 is necessary to control nursing home expenditure growth and enable the state to meet the needs of its elderly by providing high quality services in the most appropriate manner along a continuum of care.

Sec. 4. Minnesota Statutes 2000, section 144A.071, subdivision 1a, is amended to read:

Subd. 1a. [DEFINITIONS.] For purposes of sections 144A.071 to 144A.073, the following terms have the meanings given them:

(a) "attached fixtures" has the meaning given in Minnesota Rules, part 9549.0020, subpart 6.

(b) "buildings" has the meaning given in Minnesota Rules, part 9549.0020, subpart 7.

(c) "capital assets" has the meaning given in section 256B.421, subdivision 16.

(d) "commenced construction" means that all of the following conditions were met: the final working drawings and specifications were approved by the commissioner of health; the construction contracts were let; a timely construction schedule was developed, stipulating dates for beginning, achieving various stages, and completing construction; and all zoning and building permits were applied for.

(e) "completion date" means the date on which a certificate of occupancy is issued for a construction project, or if a certificate of occupancy is not required, the date on which the construction project is available for facility use.

(f) "construction" means any erection, building, alteration, reconstruction, modernization, or improvement necessary to comply with the nursing home licensure rules.

(g) "construction project" means:

(1) a capital asset addition to, or replacement of a nursing home or certified boarding care home that results in new space or the remodeling of or renovations to existing facility space;

(2) the remodeling or renovation of existing facility space the use of which is modified as a result of the project described in clause (1). This existing space and the project described in clause (1) must be used for the functions as designated on the construction plans on completion of the project described in clause (1) for a period of not less than 24 months; or

(3) capital asset additions or replacements that are completed within 12 months before or after the completion date of the project described in clause (1).

(h) "new licensed" or "new certified beds" means:

(1) newly constructed beds in a facility or the construction of a new facility that would increase the total number of licensed nursing home beds or certified boarding care or nursing home beds in the state; or

(2) newly licensed nursing home beds or newly certified boarding care or nursing home beds that result from remodeling of the facility that involves relocation of beds but does not result in an increase in the total number of beds, except when the project involves the upgrade of boarding care beds to nursing home beds, as defined in section 144A.073, subdivision 1. "Remodeling" includes any of the type of conversion, renovation, replacement, or upgrading projects as defined in section 144A.073, subdivision 1.

(i) "project construction costs" means the cost of the facility capital asset additions, replacements, renovations, or remodeling projects, construction site preparation costs, and related soft costs. Project construction costs ~~also~~ include the cost of any remodeling or renovation of existing facility space which is modified as a result of the construction project. Project construction costs also includes the cost of new technology implemented as part of the construction project.

(j) "technology" means information systems or devices that make documentation, charting, and staff time more efficient or encourage and allow for care through alternative settings including, but not limited to, touch screens, monitors, hand-helds, swipe cards, motion detectors, pagers, telemedicine, medication dispensers, and equipment to monitor vital signs and self-injections, and to observe skin and other conditions.

Sec. 5. Minnesota Statutes 2000, section 144A.071, subdivision 2, is amended to read:

Subd. 2. [MORATORIUM.] The commissioner of health, in coordination with the commissioner of human services, shall deny each request for new licensed or certified nursing home or certified boarding care beds except as provided in subdivision 3 or 4a, or section 144A.073. "Certified bed" means a nursing home bed or a boarding care bed certified by the commissioner of health for the purposes of the medical assistance program, under United States Code, title 42, sections 1396 et seq.

The commissioner of human services, in coordination with the commissioner of health, shall deny any request to issue a license under section 252.28 and chapter 245A to a nursing home or boarding care home, if that license would result in an increase in the medical assistance reimbursement amount.

In addition, the commissioner of health must not approve any construction project whose cost exceeds ~~$750,000~~ $1,000,000, unless:

(a) any construction costs exceeding ~~$750,000~~ $1,000,000 are not added to the facility's appraised value and are not included in the facility's payment rate for reimbursement under the medical assistance program; or

(b) the project:

(1) has been approved through the process described in section 144A.073;

(2) meets an exception in subdivision 3 or 4a;

(3) is necessary to correct violations of state or federal law issued by the commissioner of health;

(4) is necessary to repair or replace a portion of the facility that was damaged by fire, lightning, groundshifts, or other such hazards, including environmental hazards, provided that the provisions of subdivision 4a, clause (a), are met;

(5) as of May 1, 1992, the facility has submitted to the commissioner of health written

documentation evidencing that the facility meets the "commenced construction" definition as specified in subdivision 1a, clause (d), or that substantial steps have been taken prior to April 1, 1992, relating to the construction project. "Substantial steps" require that the facility has made arrangements with outside parties relating to the construction project and include the hiring of an architect or construction firm, submission of preliminary plans to the department of health or documentation from a financial institution that financing arrangements for the construction project have been made; or

(6) is being proposed by a licensed nursing facility that is not certified to participate in the medical assistance program and will not result in new licensed or certified beds.

Prior to the final plan approval of any construction project, the commissioner of health shall be provided with an itemized cost estimate for the project construction costs. If a construction project is anticipated to be completed in phases, the total estimated cost of all phases of the project shall be submitted to the commissioner and shall be considered as one construction project. Once the construction project is completed and prior to the final clearance by the commissioner, the total project construction costs for the construction project shall be submitted to the commissioner. If the final project construction cost exceeds the dollar threshold in this subdivision, the commissioner of human services shall not recognize any of the project construction costs or the related financing costs in excess of this threshold in establishing the facility's property-related payment rate.

The dollar thresholds for construction projects are as follows: for construction projects other than those authorized in clauses (1) to (6), the dollar threshold is ~~$750,000~~ $1,000,000. For projects authorized after July 1, 1993, under clause (1), the dollar threshold is the cost estimate submitted with a proposal for an exception under section 144A.073, plus inflation as calculated according to section 256B.431, subdivision 3f, paragraph (a). For projects authorized under clauses (2) to (4), the dollar threshold is the itemized estimate project construction costs submitted to the commissioner of health at the time of final plan approval, plus inflation as calculated according to section 256B.431, subdivision 3f, paragraph (a).

The commissioner of health shall adopt rules to implement this section or to amend the emergency rules for granting exceptions to the moratorium on nursing homes under section 144A.073.

Sec. 6. Minnesota Statutes 2000, section 144A.071, subdivision 4a, is amended to read:

Subd. 4a. [EXCEPTIONS FOR REPLACEMENT BEDS.] It is in the best interest of the state to ensure that nursing homes and boarding care homes continue to meet the physical plant licensing and certification requirements by permitting certain construction projects. Facilities should be maintained in condition to satisfy the physical and emotional needs of residents while allowing the state to maintain control over nursing home expenditure growth.

The commissioner of health in coordination with the commissioner of human services, may approve the renovation, replacement, upgrading, or relocation of a nursing home or boarding care home, under the following conditions:

(a) to license or certify beds in a new facility constructed to replace a facility or to make repairs in an existing facility that was destroyed or damaged after June 30, 1987, by fire, lightning, or other hazard provided:

(i) destruction was not caused by the intentional act of or at the direction of a controlling person of the facility;

(ii) at the time the facility was destroyed or damaged the controlling persons of the facility maintained insurance coverage for the type of hazard that occurred in an amount that a reasonable person would conclude was adequate;

(iii) the net proceeds from an insurance settlement for the damages caused by the hazard are applied to the cost of the new facility or repairs;

(iv) the new facility is constructed on the same site as the destroyed facility or on another site subject to the restrictions in section 144A.073, subdivision 5;

(v) the number of licensed and certified beds in the new facility does not exceed the number of licensed and certified beds in the destroyed facility; and

(vi) the commissioner determines that the replacement beds are needed to prevent an inadequate supply of beds.

Project construction costs incurred for repairs authorized under this clause shall not be considered in the dollar threshold amount defined in subdivision 2;

(b) to license or certify beds that are moved from one location to another within a nursing home facility, provided the total costs of remodeling performed in conjunction with the relocation of beds does not exceed ~~$750,000~~ $1,000,000;

(c) to license or certify beds in a project recommended for approval under section 144A.073;

(d) to license or certify beds that are moved from an existing state nursing home to a different state facility, provided there is no net increase in the number of state nursing home beds;

(e) to certify and license as nursing home beds boarding care beds in a certified boarding care facility if the beds meet the standards for nursing home licensure, or in a facility that was granted an exception to the moratorium under section 144A.073, and if the cost of any remodeling of the facility does not exceed ~~$750,000~~ $1,000,000. If boarding care beds are licensed as nursing home beds, the number of boarding care beds in the facility must not increase beyond the number remaining at the time of the upgrade in licensure. The provisions contained in section 144A.073 regarding the upgrading of the facilities do not apply to facilities that satisfy these requirements;

(f) to license and certify up to 40 beds transferred from an existing facility owned and operated by the Amherst H. Wilder Foundation in the city of St. Paul to a new unit at the same location as the existing facility that will serve persons with Alzheimer's disease and other related disorders. The transfer of beds may occur gradually or in stages, provided the total number of beds transferred does not exceed 40. At the time of licensure and certification of a bed or beds in the new unit, the commissioner of health shall delicense and decertify the same number of beds in the existing facility. As a condition of receiving a license or certification under this clause, the facility must make a written commitment to the commissioner of human services that it will not seek to receive an increase in its property-related payment rate as a result of the transfers allowed under this paragraph;

(g) to license and certify nursing home beds to replace currently licensed and certified boarding care beds which may be located either in a remodeled or renovated boarding care or nursing home facility or in a remodeled, renovated, newly constructed, or replacement nursing home facility within the identifiable complex of health care facilities in which the currently licensed boarding care beds are presently located, provided that the number of boarding care beds in the facility or complex are decreased by the number to be licensed as nursing home beds and further provided that, if the total costs of new construction, replacement, remodeling, or renovation exceed ten percent of the appraised value of the facility or $200,000, whichever is less, the facility makes a written commitment to the commissioner of human services that it will not seek to receive an increase in its property-related payment rate by reason of the new construction, replacement, remodeling, or renovation. The provisions contained in section 144A.073 regarding the upgrading of facilities do not apply to facilities that satisfy these requirements;

(h) to license as a nursing home and certify as a nursing facility a facility that is licensed as a boarding care facility but not certified under the medical assistance program, but only if the commissioner of human services certifies to the commissioner of health that licensing the facility as a nursing home and certifying the facility as a nursing facility will result in a net annual savings to the state general fund of $200,000 or more;

(i) to certify, after September 30, 1992, and prior to July 1, 1993, existing nursing home beds in a facility that was licensed and in operation prior to January 1, 1992;

(j) to license and certify new nursing home beds to replace beds in a facility acquired by the Minneapolis community development agency as part of redevelopment activities in a city of the first class, provided the new facility is located within three miles of the site of the old facility. Operating and property costs for the new facility must be determined and allowed under section 256B.431 or 256B.434;

(k) to license and certify up to 20 new nursing home beds in a community-operated hospital and attached convalescent and nursing care facility with 40 beds on April 21, 1991, that suspended operation of the hospital in April 1986. The commissioner of human services shall provide the facility with the same per diem property-related payment rate for each additional licensed and certified bed as it will receive for its existing 40 beds;

(l) to license or certify beds in renovation, replacement, or upgrading projects as defined in section 144A.073, subdivision 1, so long as the cumulative total costs of the facility's remodeling projects do not exceed ~~$750,000~~ $1,000,000;

(m) to license and certify beds that are moved from one location to another for the purposes of converting up to five four-bed wards to single or double occupancy rooms in a nursing home that, as of January 1, 1993, was county-owned and had a licensed capacity of 115 beds;

(n) to allow a facility that on April 16, 1993, was a 106-bed licensed and certified nursing facility located in Minneapolis to layaway all of its licensed and certified nursing home beds. These beds may be relicensed and recertified in a newly-constructed teaching nursing home facility affiliated with a teaching hospital upon approval by the legislature. The proposal must be developed in consultation with the interagency committee on long-term care planning. The beds on layaway status shall have the same status as voluntarily delicensed and decertified beds, except that beds on layaway status remain subject to the surcharge in section 256.9657. This layaway provision expires July 1, 1998;

(o) to allow a project which will be completed in conjunction with an approved moratorium exception project for a nursing home in southern Cass county and which is directly related to that portion of the facility that must be repaired, renovated, or replaced, to correct an emergency plumbing problem for which a state correction order has been issued and which must be corrected by August 31, 1993;

(p) to allow a facility that on April 16, 1993, was a 368-bed licensed and certified nursing facility located in Minneapolis to layaway, upon 30 days prior written notice to the commissioner, up to 30 of the facility's licensed and certified beds by converting three-bed wards to single or double occupancy. Beds on layaway status shall have the same status as voluntarily delicensed and decertified beds except that beds on layaway status remain subject to the surcharge in section 256.9657, remain subject to the license application and renewal fees under section 144A.07 and shall be subject to a $100 per bed reactivation fee. In addition, at any time within three years of the effective date of the layaway, the beds on layaway status may be:

(1) relicensed and recertified upon relocation and reactivation of some or all of the beds to an existing licensed and certified facility or facilities located in Pine River, Brainerd, or International Falls; provided that the total project construction costs related to the relocation of beds from layaway status for any facility receiving relocated beds may not exceed the dollar threshold provided in subdivision 2 unless the construction project has been approved through the moratorium exception process under section 144A.073;

(2) relicensed and recertified, upon reactivation of some or all of the beds within the facility which placed the beds in layaway status, if the commissioner has determined a need for the reactivation of the beds on layaway status.

The property-related payment rate of a facility placing beds on layaway status must be adjusted by the incremental change in its rental per diem after recalculating the rental per diem as provided in section 256B.431, subdivision 3a, paragraph (c). The property-related payment rate for a facility relicensing and recertifying beds from layaway status must be adjusted by the incremental change in its rental per diem after recalculating its rental per diem using the number of beds after the

relicensing to establish the facility's capacity day divisor, which shall be effective the first day of the month following the month in which the relicensing and recertification became effective. Any beds remaining on layaway status more than three years after the date the layaway status became effective must be removed from layaway status and immediately delicensed and decertified;

(q) to license and certify beds in a renovation and remodeling project to convert 12 four-bed wards into 24 two-bed rooms, expand space, and add improvements in a nursing home that, as of January 1, 1994, met the following conditions: the nursing home was located in Ramsey county; had a licensed capacity of 154 beds; and had been ranked among the top 15 applicants by the 1993 moratorium exceptions advisory review panel. The total project construction cost estimate for this project must not exceed the cost estimate submitted in connection with the 1993 moratorium exception process;

(r) to license and certify up to 117 beds that are relocated from a licensed and certified 138-bed nursing facility located in St. Paul to a hospital with 130 licensed hospital beds located in South St. Paul, provided that the nursing facility and hospital are owned by the same or a related organization and that prior to the date the relocation is completed the hospital ceases operation of its inpatient hospital services at that hospital. After relocation, the nursing facility's status under section 256B.431, subdivision 2j, shall be the same as it was prior to relocation. The nursing facility's property-related payment rate resulting from the project authorized in this paragraph shall become effective no earlier than April 1, 1996. For purposes of calculating the incremental change in the facility's rental per diem resulting from this project, the allowable appraised value of the nursing facility portion of the existing health care facility physical plant prior to the renovation and relocation may not exceed $2,490,000;

(s) to license and certify two beds in a facility to replace beds that were voluntarily delicensed and decertified on June 28, 1991;

(t) to allow 16 licensed and certified beds located on July 1, 1994, in a 142-bed nursing home and 21-bed boarding care home facility in Minneapolis, notwithstanding the licensure and certification after July 1, 1995, of the Minneapolis facility as a 147-bed nursing home facility after completion of a construction project approved in 1993 under section 144A.073, to be laid away upon 30 days' prior written notice to the commissioner. Beds on layaway status shall have the same status as voluntarily delicensed or decertified beds except that they shall remain subject to the surcharge in section 256.9657. The 16 beds on layaway status may be relicensed as nursing home beds and recertified at any time within five years of the effective date of the layaway upon relocation of some or all of the beds to a licensed and certified facility located in Watertown, provided that the total project construction costs related to the relocation of beds from layaway status for the Watertown facility may not exceed the dollar threshold provided in subdivision 2 unless the construction project has been approved through the moratorium exception process under section 144A.073.

The property-related payment rate of the facility placing beds on layaway status must be adjusted by the incremental change in its rental per diem after recalculating the rental per diem as provided in section 256B.431, subdivision 3a, paragraph (c). The property-related payment rate for the facility relicensing and recertifying beds from layaway status must be adjusted by the incremental change in its rental per diem after recalculating its rental per diem using the number of beds after the relicensing to establish the facility's capacity day divisor, which shall be effective the first day of the month following the month in which the relicensing and recertification became effective. Any beds remaining on layaway status more than five years after the date the layaway status became effective must be removed from layaway status and immediately delicensed and decertified;

(u) to license and certify beds that are moved within an existing area of a facility or to a newly constructed addition which is built for the purpose of eliminating three- and four-bed rooms and adding space for dining, lounge areas, bathing rooms, and ancillary service areas in a nursing home that, as of January 1, 1995, was located in Fridley and had a licensed capacity of 129 beds;

(v) to relocate 36 beds in Crow Wing county and four beds from Hennepin county to a 160-bed facility in Crow Wing county, provided all the affected beds are under common ownership;

(w) to license and certify a total replacement project of up to 49 beds located in Norman county that are relocated from a nursing home destroyed by flood and whose residents were relocated to other nursing homes. The operating cost payment rates for the new nursing facility shall be determined based on the interim and settle-up payment provisions of Minnesota Rules, part 9549.0057, and the reimbursement provisions of section 256B.431, except that subdivision 26, paragraphs (a) and (b), shall not apply until the second rate year after the settle-up cost report is filed. Property-related reimbursement rates shall be determined under section 256B.431, taking into account any federal or state flood-related loans or grants provided to the facility;

(x) to license and certify a total replacement project of up to 129 beds located in Polk county that are relocated from a nursing home destroyed by flood and whose residents were relocated to other nursing homes. The operating cost payment rates for the new nursing facility shall be determined based on the interim and settle-up payment provisions of Minnesota Rules, part 9549.0057, and the reimbursement provisions of section 256B.431, except that subdivision 26, paragraphs (a) and (b), shall not apply until the second rate year after the settle-up cost report is filed. Property-related reimbursement rates shall be determined under section 256B.431, taking into account any federal or state flood-related loans or grants provided to the facility;

(y) to license and certify beds in a renovation and remodeling project to convert 13 three-bed wards into 13 two-bed rooms and 13 single-bed rooms, expand space, and add improvements in a nursing home that, as of January 1, 1994, met the following conditions: the nursing home was located in Ramsey county, was not owned by a hospital corporation, had a licensed capacity of 64 beds, and had been ranked among the top 15 applicants by the 1993 moratorium exceptions advisory review panel. The total project construction cost estimate for this project must not exceed the cost estimate submitted in connection with the 1993 moratorium exception process;

(z) to license and certify up to 150 nursing home beds to replace an existing 285 bed nursing facility located in St. Paul. The replacement project shall include both the renovation of existing buildings and the construction of new facilities at the existing site. The reduction in the licensed capacity of the existing facility shall occur during the construction project as beds are taken out of service due to the construction process. Prior to the start of the construction process, the facility shall provide written information to the commissioner of health describing the process for bed reduction, plans for the relocation of residents, and the estimated construction schedule. The relocation of residents shall be in accordance with the provisions of law and rule;

(aa) to allow the commissioner of human services to license an additional 36 beds to provide residential services for the physically handicapped under Minnesota Rules, parts 9570.2000 to 9570.3400, in a 198-bed nursing home located in Red Wing, provided that the total number of licensed and certified beds at the facility does not increase;

(bb) to license and certify a new facility in St. Louis county with 44 beds constructed to replace an existing facility in St. Louis county with 31 beds, which has resident rooms on two separate floors and an antiquated elevator that creates safety concerns for residents and prevents nonambulatory residents from residing on the second floor. The project shall include the elimination of three- and four-bed rooms;

(cc) to license and certify four beds in a 16-bed certified boarding care home in Minneapolis to replace beds that were voluntarily delicensed and decertified on or before March 31, 1992. The licensure and certification is conditional upon the facility periodically assessing and adjusting its resident mix and other factors which may contribute to a potential institution for mental disease declaration. The commissioner of human services shall retain the authority to audit the facility at any time and shall require the facility to comply with any requirements necessary to prevent an institution for mental disease declaration, including delicensure and decertification of beds, if necessary; ~~or~~

(dd) to license and certify 72 beds in an existing facility in Mille Lacs county with 80 beds as part of a renovation project. The renovation must include construction of an addition to accommodate ten residents with beginning and midstage dementia in a self-contained living unit; creation of three resident households where dining, activities, and support spaces are located near resident living quarters; designation of four beds for rehabilitation in a self-contained area; designation of 30 private rooms; and other improvements;

(ee) to license and certify beds in a facility that has undergone replacement or remodeling as part of a planned closure under section 256B.437;

(ff) to transfer up to 98 beds of a 129 licensed bed facility located in Anoka county that, as of March 25, 2001, is in the active process of closing, to a 122 licensed bed nonprofit nursing facility located in the city of Columbia Heights, or its affiliate. The transfer is effective when the receiving facility notifies the commissioner in writing of the number of beds accepted. The commissioner shall place all transferred beds on layaway status held in the name of the receiving facility. The layaway adjustment provisions of section 256B.431, subdivision 30, do not apply to this layaway. The receiving facility may only remove the beds from layaway for recertification and relicensure at the receiving facility's current site, or at a newly constructed facility located in Anoka county. The receiving facility must receive statutory authorization before removing the beds from layaway status;

(gg) to license and certify up to 120 new nursing facility beds to replace beds in a facility in Anoka county, which was licensed for 98 beds as of July 1, 2000, provided the new facility is located within four miles of the existing facility and is in Anoka county. Operating and property rates will be determined and allowed under section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, or section 256B.434 or 256B.435. The provisions of section 256B.431, subdivision 26, paragraphs (a) and (b), do not apply until the second rate year following settle-up; or

(hh) to license and certify a total replacement project of up to 124 beds located in Wilkin county that are in need of relocation from a nursing home substantially destroyed by flood. The operating cost payment rates for the new nursing facility shall be determined based on the interim and settle-up payment provisions of Minnesota Rules, part 9549.0057, and the reimbursement provisions of section 256B.431, except that section 256B.431, subdivision 26, paragraphs (a) and (b), shall not apply until the second rate year after the settle-up cost report is filed. Property-related reimbursement rates shall be determined under section 256B.431, taking into account any federal or state flood-related loans or grants provided to the facility.

Sec. 7. Minnesota Statutes 2000, section 144A.073, subdivision 2, is amended to read:

Subd. 2. [REQUEST FOR PROPOSALS.] At the authorization by the legislature of additional medical assistance expenditures for exceptions to the moratorium on nursing homes, the interagency committee shall publish in the State Register a request for proposals for nursing home projects to be licensed or certified under section 144A.071, subdivision 4a, clause (c). The public notice of this funding and the request for proposals must specify how the approval criteria will be prioritized by the advisory review panel, the interagency long-term care planning committee, and the commissioner. The notice must describe the information that must accompany a request and state that proposals must be submitted to the interagency committee within 90 days of the date of publication. The notice must include the amount of the legislative appropriation available for the additional costs to the medical assistance program of projects approved under this section. If no money is appropriated for a year, the interagency committee shall publish a notice to that effect, and no proposals shall be requested. If money is appropriated, the interagency committee shall initiate the application and review process described in this section at least twice each biennium and up to four times each biennium, according to dates established by rule. Authorized funds shall be allocated proportionally to the number of processes. Funds not encumbered by an earlier process within a biennium shall carry forward to subsequent iterations of the process. ~~Authorization for expenditures does not carry forward into the following biennium.~~ To be considered for approval, a proposal must include the following information:

(1) whether the request is for renovation, replacement, upgrading, conversion, or relocation;

(2) a description of the problem the project is designed to address;

(3) a description of the proposed project;

(4) an analysis of projected costs of the nursing facility proposal, which are not required to exceed the cost threshold referred to in section 144A.071, subdivision 1, to be considered under

this section, including initial construction and remodeling costs; site preparation costs; technology costs; financing costs, including the current estimated long-term financing costs of the proposal, which consists of estimates of the amount and sources of money, reserves if required under the proposed funding mechanism, annual payments schedule, interest rates, length of term, closing costs and fees, insurance costs, and any completed marketing study or underwriting review; and estimated operating costs during the first two years after completion of the project;

(5) for proposals involving replacement of all or part of a facility, the proposed location of the replacement facility and an estimate of the cost of addressing the problem through renovation;

(6) for proposals involving renovation, an estimate of the cost of addressing the problem through replacement;

(7) the proposed timetable for commencing construction and completing the project;

(8) a statement of any licensure or certification issues, such as certification survey deficiencies;

(9) the proposed relocation plan for current residents if beds are to be closed so that the department of human services can estimate the total costs of a proposal; and

(10) other information required by permanent rule of the commissioner of health in accordance with subdivisions 4 and 8.

Sec. 8. [144A.161] [NURSING FACILITY RESIDENT RELOCATION.]

Subdivision 1. [DEFINITIONS.] The definitions in this subdivision apply to subdivisions 2 to 10.

(a) "Closure" means the cessation of operations of a nursing home and the delicensure and decertification of all beds within the facility.

(b) "Curtailment," "reduction," or "change" refers to any change in operations which would result in or encourage the relocation of residents.

(c) "Facility" means a nursing home licensed pursuant to this chapter, or a certified boarding care home licensed pursuant to sections 144.50 to 144.56.

(d) "Licensee" means the owner of the facility or the owner's designee or the commissioner of health for a facility in receivership.

(e) "Local agency" means the county or multicounty social service agency authorized under sections 393.01 and 393.07, as the agency responsible for providing social services for the county in which the nursing home is located.

(f) "Plan" means a process developed under subdivision 3, paragraph (b), for the closure, curtailment, reduction, or change in operations in a facility and the subsequent relocation of residents.

(g) "Relocation" means the discharge of a resident and movement of the resident to another facility or living arrangement as a result of the closing, curtailment, reduction, or change in operations of a nursing home or boarding care home.

Subd. 2. [INITIAL NOTICE FROM LICENSEE.] (a) The licensee of the facility shall notify the following parties in writing when there is an intent to close, curtail, reduce, or change operations or services which would result in or encourage the relocation of residents: the commissioner of health, the commissioner of human services, the local agency, the office of ombudsman for older Minnesotans, and the ombudsman for mental health/mental retardation.

(b) The written notice shall include the names, telephone numbers, facsimile numbers, and e-mail addresses of the persons responsible for coordinating the licensee's efforts in the planning process, and the number of residents potentially affected by the closure, curtailment, reduction, or change in operations.

Subd. 3. [PLANNING PROCESS.] (a) The local agency shall, within five working days of receiving initial notice of the licensee's intent to close, curtail, reduce, or change operations, provide the licensee and all parties identified in subdivision 2, paragraph (a), with the names, telephone numbers, facsimile numbers, and e-mail addresses of those persons responsible for coordinating local agency efforts in the planning process.

(b) The licensee shall convene a meeting with the local agency to jointly develop a plan regarding the closure, curtailment, or change in facility operations. The licensee shall notify representatives of the departments of health and human services of the date, time, and location of the meeting so that representatives from the departments may attend. The licensee must allow a minimum of 28 days for this planning process from the day of the initial notice. However, the plan may be finalized on an earlier schedule agreed to by all parties. To the extent practicable, consistent with requirements to protect the safety and health of residents, the commissioner may authorize the planning process under this subdivision to occur concurrent with the 60 day notice required under subdivision 5, paragraph (e). The plan shall:

(1) identify the expected date of closure, curtailment, reduction, or change in operations;

(2) outline the process for public notification of the closure, curtailment, reduction, or change in operations;

(3) identify and make efforts to include other stakeholders in the planning process;

(4) outline the process to ensure 60-day advance written notice to residents, family members, and designated representatives;

(5) present an aggregate description of the resident population remaining to be relocated and their needs;

(6) outline the individual resident assessment process to be utilized;

(7) identify an inventory of available relocation options, including home and community-based services;

(8) identify a timeline for submission of the list identified in subdivision 5, paragraph (h); and

(9) identify a schedule for the timely completion of each element of the plan.

Subd. 4. [RESPONSIBILITIES OF LICENSEE FOR RESIDENT RELOCATIONS.] The licensee shall provide for the safe, orderly, and appropriate relocation of residents. The licensee and facility staff shall cooperate with representatives from the local agency, the department of health, the department of human services, the office of ombudsman for older Minnesotans, and ombudsman for mental health/mental retardation, in planning for and implementing the relocation of residents. The discharge and relocation of residents must comply with all applicable state and federal requirements.

Subd. 5. [RESPONSIBILITIES PRIOR TO RELOCATION.] (a) The licensee shall provide an initial notice as described in subdivision 2, when there is an intent to close, curtail, reduce, or change in operations which would result in or encourage the relocation of residents.

(b) The licensee shall establish an interdisciplinary team responsible for coordinating and implementing the plan as outlined in subdivision 3, paragraph (b). The interdisciplinary team shall include representatives from the local agency, the office of ombudsman for older Minnesotans, facility staff that provide direct care services to the residents, and facility administration.

(c) The licensee shall provide a list to the local agency that includes the following information on each resident to be relocated:

(1) the resident's name;

(2) date of birth;

(3) social security number;

(4) medical assistance identification number;

(5) all diagnoses; and

(6) the name and contact information for the resident's family or other designated representative.

(d) The licensee shall consult with the local agency on the availability and development of available resources, and on the resident relocation process.

(e) At least 60 days before the proposed date of closing, curtailment, reduction, or change in operations as agreed to in the plan, the licensee shall send a written notice of closure, curtailment, reduction, or change in operations to each resident being relocated, the resident's family member or designated representative, and the resident's attending physician. The notice must include the following:

(1) the date of the proposed closure, curtailment, reduction, or change in operations;

(2) the name, address, telephone number, facsimile number, and e-mail address of the individual or individuals in the facility responsible for providing assistance and information;

(3) notification of upcoming meetings for residents, families and designated representatives, and resident and family councils to discuss the relocation of residents;

(4) the name, address, and telephone number of the local agency contact person;

(5) the name, address, and telephone number of the office of ombudsman for older Minnesotans and the ombudsman for mental health/mental retardation; and

(6) a notice of resident rights during discharge and relocation, in a form approved by the office of ombudsman for older Minnesotans.

The notice must comply with all applicable state and federal requirements for notice of transfer or discharge of nursing home residents.

(f) The licensee shall request the attending physician provide or arrange for the release of medical information needed to update resident medical records and prepare all required forms and discharge summaries.

(g) The licensee shall provide sufficient preparation to residents to ensure safe, orderly and appropriate discharge, and relocation. The licensee shall assist residents in finding placements that respond to personal preferences, such as desired geographic location.

(h) The licensee shall prepare a resource list with several relocation options for each resident. The list must contain the following information for each relocation option, when applicable:

(1) the name, address, and telephone and facsimile numbers of each facility with appropriate, available beds or services;

(2) the certification level of the available beds;

(3) the types of services available;

(4) the name, address, and telephone and facsimile numbers of appropriate available home and community-based placements, services and settings, or other options for individuals with special needs.

The list shall be made available to residents and their families or designated representatives, and upon request to the office of ombudsman for older Minnesotans and ombudsman for mental health/mental retardation, and the local agency.

(i) Following the establishment of the plan under subdivision 3, paragraph (b), the licensee shall conduct meetings with residents, families and designated representatives, and resident and family councils to notify them of the process for resident relocation. Representatives from the local county social services agency, the office of ombudsman for older Minnesotans, the ombudsman for mental health and mental retardation, the commissioner of health, and the commissioner of human services shall receive advance notice of the meetings.

(j) The licensee shall assist residents desiring to make site visits to facilities with available beds or other appropriate living options to which the resident may relocate, unless it is medically inadvisable, as documented by the attending physician in the resident's care record. The licensee shall provide transportation for site visits to facilities or other living options within a 50-mile radius to which the resident may relocate. The licensee shall provide available written materials to residents on a potential new facility or living option.

(k) The licensee shall complete an inventory of resident personal possessions and provide a copy of the final inventory to the resident and the resident's designated representative prior to relocation. The licensee shall be responsible for the transfer of the resident's possessions for all relocations within a 50-mile radius of the facility. The licensee shall complete the transfer of resident possessions in a timely manner, but no later than the date of the actual physical relocation of the resident.

(l) The licensee shall complete a final accounting of personal funds held in trust by the facility and provide a copy of this accounting to the resident and the resident's family or the resident's designated representative. The licensee shall be responsible for the transfer of all personal funds held in trust by the facility. The licensee shall complete the transfer of all personal funds in a timely manner.

(m) The licensee shall assist residents with the transfer and reconnection of service for telephones or other personal communication devices or services. The licensee shall pay the costs associated with reestablishing service for telephones or other personal communication devices or services, such as connection fees or other one-time charges. The transfer or reconnection of personal communication devices or services shall be completed in a timely manner.

(n) The licensee shall provide the resident, the resident's family or designated representative, and the resident's attending physician final written notice prior to the relocation of the resident. The notice must:

(1) be provided seven days prior to the actual relocation, unless the resident agrees to waive the right to advance notice; and

(2) identify the date of the anticipated relocation and the destination to which the resident is being relocated.

(o) The licensee shall provide the receiving facility or other health, housing, or care entity with complete and accurate resident records including information on family members, designated representatives, guardians, social service caseworkers, or other contact information. These records must also include all information necessary to provide appropriate medical care and social services. This includes, but is not limited to, information on preadmission screening, Level I and Level II screening, Minimum Data Set (MDS) and all other assessments, resident diagnoses, social, behavioral, and medication information.

Subd. 6. [RESPONSIBILITIES OF THE LICENSEE DURING RELOCATION.] (a) The licensee shall arrange for the safe transport of residents to the new facility or placement.

(b) The licensee must ensure that there is no disruption in the provision of meals, medications, or treatments of the resident during the relocation process.

(c) Beginning the week following development of the initial relocation plan, the licensee shall submit biweekly status reports to the commissioners of the department of health and the department of human services or their designees, and to the local agency. The initial status report must identify:

(1) the relocation plan developed;

(2) the interdisciplinary team members; and

(3) the number of residents to be relocated.

(d) Subsequent status reports must identify:

(1) any modifications to the plan;

(2) any change of interdisciplinary team members;

(3) the number of residents relocated;

(4) the destination to which residents have been relocated;

(5) the number of residents remaining to be relocated; and

(6) issues or problems encountered during the process and resolution of these issues.

Subd. 7. [RESPONSIBILITIES OF THE LICENSEE FOLLOWING RELOCATION.] The licensee shall retain or make arrangements for the retention of all remaining resident records, for the period required by law. The licensee shall provide the department of health access to these records. The licensee shall notify the department of health of the location of any resident records that have not been transferred to the new facility or other health care entity.

Subd. 8. [RESPONSIBILITIES OF THE LOCAL AGENCY.] (a) The local agency shall participate in the meeting as outlined in subdivision 3, paragraph (b), to develop a relocation plan.

(b) The local agency shall designate a representative to the interdisciplinary team established by the licensee responsible for coordinating the relocation efforts.

(c) The local agency shall serve as a resource in the relocation process.

(d) Concurrent with the notice sent to residents from the licensee as provided in subdivision 5, paragraph (e), the local agency shall provide written notice to residents, family, or designated representatives describing:

(1) the county's role in the relocation process and in the follow-up to relocations;

(2) a local agency contact name, address, and telephone number; and

(3) the name, address, and telephone number of the office of ombudsman for older Minnesotans and the ombudsman for mental health/mental retardation.

(e) The local agency designee shall meet with appropriate facility staff to coordinate any assistance in the relocation process. This coordination shall include participating in group meetings with residents, families, and designated representatives to explain the relocation process.

(f) The local agency shall monitor compliance with all components of the plan. If the licensee is not in compliance, the local agency shall notify the commissioners of the department of health and the department of human services.

(g) The local agency shall report to the commissioners of health and human services any relocations that endanger the health, safety, or well-being of residents. The local agency shall pursue remedies to protect the resident during the relocation process, including, but not limited to, assisting the resident with filing an appeal of transfer or discharge, notification of all appropriate licensing boards and agencies, and other remedies available to the county under section 626.557, subdivision 10.

(h) A member of the local agency staff shall visit residents relocated within one hundred miles of the county within 30 days after the relocation. Local agency staff shall interview the resident and family or designated representative, observe the resident on site, and review and discuss pertinent medical or social records with facility staff to:

(1) assess the adjustment of the resident to the new placement;

(2) recommend services or methods to meet any special needs of the resident; and

(3) identify residents at risk.

(i) The local agency shall have the authority to conduct subsequent follow-up visits in cases where the adjustment of the resident to the new placement is in question.

(j) Within 60 days of the completion of the follow-up visits, the local agency shall submit a written summary of the follow-up work to the department of health and the department of human services, in a manner approved by the commissioners.

(k) The local agency shall submit to the department of health and the department of human services a report of any issues that may require further review or monitoring.

(l) The local agency shall be responsible for the safe and orderly relocation of residents in cases where an emergent need arises or when the licensee has abrogated its responsibilities under the plan.

Subd. 9. [FUNDING.] The commissioner of human services shall negotiate with the local agency to determine an amount of administrative funding within appropriations specified for this purpose to make available to the local agency for the costs of work related to the relocation process in accordance with section 256B.437, subdivision 9.

Subd. 10. [PENALTIES.] According to sections 144.653 and 144A.10, the licensee shall be subject to correction orders and civil monetary penalties of up to $500 per day for each violation of this statute.

Sec. 9. [144A.1888] [REUSE OF FACILITIES.]

Notwithstanding any local ordinance related to development, planning, or zoning to the contrary, the conversion or reuse of a nursing home that closes or that curtails, reduces, or changes operations shall be considered a conforming use permitted under local law, provided that the facility is converted to another long-term care service approved by a regional planning group under section 256B.437 that serves a smaller number of persons than the number of persons served before the closure or curtailment, reduction, or change in operations.

Sec. 10. Minnesota Statutes 2000, section 256B.431, subdivision 2e, is amended to read:

Subd. 2e. [CONTRACTS FOR SERVICES FOR VENTILATOR-DEPENDENT PERSONS.] The commissioner may contract with a nursing facility eligible to receive medical assistance payments to provide services to a ventilator-dependent person identified by the commissioner according to criteria developed by the commissioner, including:

(1) nursing facility care has been recommended for the person by a preadmission screening team;

(2) ~~the person has been assessed at case mix classification K;~~

~~(3)~~ the person has been hospitalized ~~for at least six months~~ and no longer requires inpatient acute care hospital services; and

~~(4)~~ (3) the commissioner has determined that necessary services for the person cannot be provided under existing nursing facility rates.

The commissioner may issue a request for proposals to provide services to a ventilator-dependent person to nursing facilities eligible to receive medical assistance payments and shall select nursing facilities from among respondents according to criteria developed by the commissioner, including:

(1) the cost-effectiveness and appropriateness of services;

(2) the nursing facility's compliance with federal and state licensing and certification standards; and

(3) the proximity of the nursing facility to a ventilator-dependent person identified by the commissioner who requires nursing facility placement.

The commissioner may negotiate an adjustment to the operating cost payment rate for a nursing facility selected by the commissioner from among respondents to the request for proposals. The negotiated adjustment must reflect only the actual additional cost of meeting the specialized care needs of a ventilator-dependent person identified by the commissioner for whom necessary services cannot be provided under existing nursing facility rates and which are not otherwise covered under Minnesota Rules, parts 9549.0010 to 9549.0080 or 9505.0170 to 9505.0475. For persons who are initially admitted to a nursing facility before July 1, 2001, and have their payment rate under this subdivision negotiated after July 1, 2001, the negotiated payment rate must not exceed 200 percent of the highest multiple bedroom payment rate for ~~a Minnesota nursing~~ the facility, as initially established by the commissioner for the rate year for case mix classification K. For persons initially admitted to a nursing facility on or after July 1, 2001, the negotiated payment rate must not exceed 300 percent of the facility's multiple bedroom payment rate for case mix classification K. The negotiated adjustment shall not affect the payment rate charged to private paying residents under the provisions of section 256B.48, subdivision 1.

Sec. 11. Minnesota Statutes 2000, section 256B.431, is amended by adding a subdivision to read:

Subd. 31. [NURSING FACILITY RATE INCREASES BEGINNING JULY 1, 2001, AND JULY 1, 2002.] (a) For the rate years beginning July 1, 2001, and July 1, 2002, the commissioner shall make available to each nursing facility reimbursed under this section or section 256B.434 an adjustment of 3.0 percent to the total operating payment rates in effect on June 30, 2001, and June 30, 2002, respectively. The operating payment rate in effect on June 30, 2001, must include the adjustment in subdivision 2i, paragraph (c). The adjustment must be used to increase the wages of all employees except management fees, the administrator, and central office staff and to pay associated costs for FICA, the Medicare tax, workers' compensation premiums, and federal and state unemployment insurance.

Money received by a facility as a result of the additional rate increase provided under this paragraph must be used only for wage increases implemented on or after July 1, 2001, or July 1, 2002, respectively, and must not be used for wage increases implemented prior to those dates.

(b) Nursing facilities may apply for the wage-related payment rate adjustment calculated under paragraph (a). The application must be made to the commissioner and contain a plan by which the nursing facility will distribute the payment rate adjustment to employees of the nursing facility. For nursing facilities in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative constitutes the plan. A negotiated agreement may constitute the plan only if the agreement is finalized after the date of enactment of all increases for the rate year. The commissioner shall review the plan to ensure that the wage-related payment rate adjustment per diem is used as provided in paragraph (a). To be eligible, a facility must submit its plan for the wage distribution by December 31 each year. If a facility's plan for wage distribution is effective for its employees after July 1 of the year that the funds are available, the payment rate adjustment per diem is effective the same date as its plan.

(c) A hospital-attached nursing facility may include costs in their distribution plan for wages and wage-related costs of employees in the organization's shared services departments, provided that:

(1) the nursing facility and the hospital share common ownership; and

(2) adjustments for hospital services using the diagnostic-related grouping payment rates per admission under medical assistance or Medicare are less than three percent during the 12 months prior to the effective date of this increase.

If a hospital-attached facility meets the qualifications in this paragraph, the difference between the rate increase approved for nursing facility services and the rate increase approved for hospital services may be permitted as a distribution in the hospital-attached facility's plan regardless of whether the use of those funds is shown as being attributable to employee hours worked in the nursing facility or employee hours worked in the hospital.

For the purposes of this paragraph, a hospital-attached nursing facility is one that meets the definition under subdivision 2j, or, in the case of a facility reimbursed under section 256B.434, met this definition at the time their last payment rate was established under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section.

(d) A copy of the approved distribution plan must be made available to all employees by giving each employee a copy or by posting it in an area of the nursing facility to which all employees have access. If an employee does not receive the wage adjustment described in the facility's approved plan and is unable to resolve the problem with the facility's management or through the employee's union representative, the employee may contact the commissioner at an address or telephone number provided by the commissioner and included in the approved plan.

(e) Notwithstanding section 256B.48, subdivision 1, clause (a), upon the request of a nursing facility, the commissioner may authorize the facility to raise per diem rates for private-pay residents on July 1 by the amount anticipated to be required upon implementation of the wage-related increase available under this subdivision. The commissioner shall require any amounts collected under this paragraph to be placed in an escrow account until the medical assistance rate is finalized. The commissioner shall conduct audits as necessary to ensure that:

(1) the amounts collected are retained in escrow until medical assistance rates are increased to reflect the wage-related adjustment; and

(2) any amounts collected from private-pay residents in excess of the final medical assistance wage-related rate increase are repaid to the private-pay residents with interest at the rate used by the commissioner of revenue for the late payment of taxes and in effect on the date the distribution plan is approved by the commissioner of human services.

(f) For the rate year beginning July 1, 2001, the commissioner shall make available to each nursing facility that is reimbursed under this section or section 256B.434 and had 35 or fewer admissions during calendar year 2000 an adjustment of 1.0 percent to the total operating payment rates in effect on June 30, 2001.

The operating payment rate in effect on June 30, 2001, must include the adjustment in subdivision 2i, paragraph (c).

Sec. 12. Minnesota Statutes 2000, section 256B.431, is amended by adding a subdivision to read:

Subd. 32. [PAYMENT DURING FIRST 90 DAYS.] (a) For rate years beginning on or after July 1, 2001, the total payment rate for a facility reimbursed under this section, section 256B.434, or any other section for the first 90 paid days after admission shall be:

(1) for the first 30 paid days, the rate shall be 120 percent of the facility's medical assistance rate for each case mix class; and

(2) for the next 60 paid days after the first 30 paid days, the rate shall be 110 percent of the facility's medical assistance rate for each case mix class.

(b) Beginning with the 91st paid day after admission, the payment rate shall be the rate otherwise determined under this section, section 256B.434, or any other section.

Sec. 13. Minnesota Statutes 2000, section 256B.431, is amended by adding a subdivision to read:

Subd. 34. [STAGED REDUCTION IN RATE DISPARITIES.] (a) The commissioner, by June

30, 2001, shall provide each nursing facility with information on how its per diem operating payment rates for each case mix category compare to the median per diem rates for facilities in geographic group three, as determined under Minnesota Rules, part 9549.0052.

(b) The commissioner shall provide nursing facilities reimbursed under this section or section 256B.434 with the following staged rate increases, for each case mix category operating payment per diem that is below the median for facilities in geographic group three:

(1) effective July 1, 2001, the commissioner shall allow increases in the total operating payment per diems for each facility of up to 38 percent of the difference between that facility's operating payment rate in effect on June 30, 2001, for each case mix category and 85 percent of the median payment rate in effect on June 30, 2001, for that category for facilities in geographic group three;

(2) effective July 1, 2002, the commissioner shall allow increases in the total operating payment per diems for each facility by 38 percent of the difference between that facility's operating payment rate in effect on June 30, 2002, for each case mix category and 85 percent of the median payment rate in effect on June 30, 2002, for that category for facilities in geographic group three; and

(3) effective July 1, 2003, the commissioner shall allow increases in the total operating payment per diems for each facility by 24 percent of the difference between that facility's operating payment rate in effect on June 30, 2003, for each case mix category and 100 percent of the median payment rate in effect on June 30, 2003, for each case mix category for facilities in geographic group three.

(c) In order to receive the rate increases provided in paragraph (b), facilities must apply to the commissioner. A facility must submit an application for each rate increase by December 31 of the calendar year in which the increase is allowed, using a form provided by the commissioner. The application must include a plan for use of the rate increase and any other information deemed necessary by the commissioner to determine the amount of an increase that will be allowed. The commissioner shall deny a request for a rate increase, or reduce the rate increase provided, if the commissioner determines that the proposed plan for using the rate increase is not an approved use of funding under Minnesota Rules, parts 9549.0010 to 9549.0080. A facility whose request has been denied or reduced may reapply for a rate increase. Rate increases approved by the commissioner shall be effective on the first day of the month following the month which the application was received by the commissioner, but not before July 1 of the year in which it is allowed.

(d) A facility must make a copy of the approved application available to residents, their designated representatives, and employees, by posting it in an area of the facility to which these individuals have access, or by providing these individuals with copies.

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

Sec. 14. Minnesota Statutes 2000, section 256B.433, subdivision 3a, is amended to read:

Subd. 3a. [EXEMPTION FROM REQUIREMENT FOR SEPARATE THERAPY BILLING.] The provisions of subdivision 3 do not apply to nursing facilities that are reimbursed according to the provisions of section 256B.431 ~~and are located in a county participating in the prepaid medical assistance program~~. Nursing facilities that are reimbursed according to the provisions of section 256B.434 and are located in a county participating in the prepaid medical assistance program are exempt from the maximum therapy rent revenue provisions of subdivision 3, paragraph (c).

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

Sec. 15. Minnesota Statutes 2000, section 256B.434, subdivision 4, is amended to read:

Subd. 4. [ALTERNATE RATES FOR NURSING FACILITIES.] (a) For nursing facilities which have their payment rates determined under this section rather than section 256B.431, the commissioner shall establish a rate under this subdivision. The nursing facility must enter into a written contract with the commissioner.

(b) A nursing facility's case mix payment rate for the first rate year of a facility's contract under this section is the payment rate the facility would have received under section 256B.431.

(c) A nursing facility's case mix payment rates for the second and subsequent years of a facility's contract under this section are the previous rate year's contract payment rates plus an inflation adjustment. The index for the inflation adjustment must be based on the change in the Consumer Price Index-All Items (United States City average) (CPI-U) forecasted by Data Resources, Inc., as forecasted in the fourth quarter of the calendar year preceding the rate year. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined. For the rate years beginning on July 1, 1999, ~~and~~ July 1, 2000, July 1, 2001, and July 1, 2002, this paragraph shall apply only to the property-related payment rate. In determining the amount of the property-related payment rate adjustment under this paragraph, the commissioner shall determine the proportion of the facility's rates that are property-related based on the facility's most recent cost report.

(d) The commissioner shall develop additional incentive-based payments of up to five percent above the standard contract rate for achieving outcomes specified in each contract. The specified facility-specific outcomes must be measurable and approved by the commissioner. The commissioner may establish, for each contract, various levels of achievement within an outcome. After the outcomes have been specified the commissioner shall assign various levels of payment associated with achieving the outcome. Any incentive-based payment cancels if there is a termination of the contract. In establishing the specified outcomes and related criteria the commissioner shall consider the following state policy objectives:

(1) improved cost effectiveness and quality of life as measured by improved clinical outcomes;

(2) successful diversion or discharge to community alternatives;

(3) decreased acute care costs;

(4) improved consumer satisfaction;

(5) the achievement of quality; or

(6) any additional outcomes proposed by a nursing facility that the commissioner finds desirable.

Sec. 16. [256B.437] [NURSING FACILITY VOLUNTARY CLOSURES AND PLANNING AND DEVELOPMENT OF COMMUNITY-BASED ALTERNATIVES.]

Subdivision 1. [DEFINITIONS.] (a) The definitions in this subdivision apply to subdivisions 2 to 9.

(b) "Closure" means the cessation of operations of a nursing facility and delicensure and decertification of all beds within the facility.

(c) "Closure plan" means a plan to close a nursing facility and reallocate a portion of the resulting savings to provide planned closure rate adjustments at other facilities.

(d) "Commencement of closure" means the date on which residents and designated representatives are notified of a planned closure in accordance with section 144A.161, subdivision 5, paragraph (e), as part of an approved closure plan.

(e) "Completion of closure" means the date on which the final resident of the nursing facility designated for closure in an approved closure plan is discharged from the facility.

(f) "Partial closure" means the delicensure and decertification of a portion of the beds within the facility.

(g) "Planned closure rate adjustment" means an increase in a nursing facility's operating rates resulting from a planned closure or a planned partial closure of another facility.

Subd. 2. [REGIONAL LONG-TERM CARE PLANNING AND DEVELOPMENT.] (a) The commissioner of human services shall establish a process to adjust the capacity and distribution of long-term care services to equalize the supply and demand for different types of services. The process must include community and regional planning, expansion or establishment of needed services, and voluntary nursing facility closures.

(b) The commissioner shall issue a request for proposals to contract with regional long-term care planning groups. At least one of the planning groups must be an American Indian long-term care planning group. Each group must:

(1) consist of county health and social services agencies, consumers, housing agencies, a representative of nursing facilities, a representative of home and community-based services providers, a union representative, and area agencies on aging in the geographic area; and

(2) serve an area that has at least 2,000 people who are 85 years of age or older. American Indian long-term care planning groups are exempt from this requirement.

In awarding contracts, the commissioner shall give preference to groups that represent an entire area agency on aging region where there is not already a planning and development group established under section 256B.0917. An area not included in a proposal must be included in a group convened by the area agency on aging of that planning and service area through a contract negotiated by the commissioner.

(c) Each regional long-term care planning group shall:

(1) conduct a detailed assessment of the region's long-term care services system. This assessment must be completed within 90 days of the contract award and must evaluate the adequacy of nursing facility beds and the impact of potential nursing facility closures. The commissioner of health and the commissioner of human services, as appropriate, shall provide data to the group on nursing facility bed distribution, housing-with-service options, the closure of nursing facilities in the planning area that occur outside of the planned closure process, the approval of planned closures in the planning area, the addition of new community long-term care services in the area, the closure of existing community long-term care services in the area, and other available data;

(2) plan options for increasing community capacity to provide more home and community-based services to reduce reliance on nursing facility services;

(3) develop community services alternatives to ensure that sufficient community-based services are available to meet demand;

(4) assist a nursing facility in the development of a proposal to the commissioner for voluntary bed closures under this section;

(5) monitor the success of alternatives to nursing facility care that are developed that meet the needs of communities;

(6) respond to requests from the commissioner for information about long-term care planning and development activities in the region; and

(7) review and comment on nursing facility proposals submitted under this section.

Subd. 2a. [PLANNING AND DEVELOPMENT OF COMMUNITY-BASED SERVICES.] (a) The purpose of this subdivision is to promote the planning and development of community-based services prior to the transitioning or closure of nursing facilities. This process will support early intervention, advocacy, and consumer protection while providing incentives for the nursing facilities to transition to meet community needs.

(b) The commissioner shall establish a process to support and facilitate expansion of community-based services under the county-administered alternative care program and the elderly waiver program. The process shall utilize community assessments and planning developed for the community health services plan and plan update and for the Community Social Services Act plan.

(c) The plan shall include recommendations for development of community-based services, and both planning and implementation shall be implemented within the amount of funding made available to the county board for these purposes.

(d) The plan, within the funding allocated, shall:

(1) identify the need for services for all residents in each community within the county based on demographic and caseload information;

(2) involve providers, consumers, cities, townships, and businesses in the planning process;

(3) address the need for all alternative care and elderly waiver services for eligible recipients;

(4) assess the need for other supportive services such as transit, housing, and workforce and economic development;

(5) estimate the cost and timelines for development; and

(6) coordinate with the county mental health plan, the community health services plan, and community social services plan.

(e) The county board shall cooperate in planning and implementation with any county having a nursing facility that includes their county in the immediate service area within the funding allocated for these purposes.

(f) The commissioner of health, in cooperation with the commissioner of human services and county boards, shall jointly report to the legislature by January 15 of each year regarding the development of community-based services, transition or closure of nursing facilities, and consumer outcomes achieved.

Subd. 3. [APPLICATIONS FOR PLANNED CLOSURE OF NURSING FACILITIES.] (a) By July 15, 2001, the commissioner of human services shall implement and announce a program for closure or partial closure of nursing facilities. The announcement must specify:

(1) the criteria in subdivision 4 that will be used by the commissioner to approve or reject applications;

(2) the information that must accompany an application; and

(3) that applications may combine planned closure rate adjustments with moratorium exception funding, in which case a single application may serve both purposes.

Between August 1, 2001, and June 30, 2003, the commissioner may approve planned closures of up to 5,140 nursing facility beds, less the number of licensed beds in facilities that close during the same time period without approved closure plans or that have notified the commissioner of health of their intent to close without an approved closure plan.

(b) A facility or facilities reimbursed under section 256B.431 or 256B.434 with a closure plan approved by the commissioner under subdivision 6 may assign a planned closure rate adjustment to another facility or facilities that are not closing or in the case of a partial closure, to itself. A facility may also elect to have a planned closure rate adjustment shared equally by the five nursing facilities with the lowest total operating payment rates in the state development region designated under section 462.385, in which the facility that is closing is located. The planned closure rate adjustment must be calculated under subdivision 7. Facilities that close without a closure plan, or whose closure plan is not approved by the commissioner, are not eligible to assign a planned closure rate adjustment under subdivision 7. The commissioner shall calculate the amount the facility would have been eligible to assign under subdivision 7, and shall use this amount to provide equal rate adjustments to the five nursing facilities with the lowest total operating payment rates in the state development region designated under section 462.385, in which the facility that closed is located.

(c) To be considered for approval, an application must include:

(1) a description of the proposed closure plan, which must include identification of the facility or facilities to receive a planned closure rate adjustment and the amount and timing of a planned closure rate adjustment proposed for each facility;

(2) the proposed timetable for any proposed closure, including the proposed dates for announcement to residents, commencement of closure, and completion of closure;

(3) the proposed relocation plan for current residents of any facility designated for closure. The proposed relocation plan must be designed to comply with all applicable state and federal statutes and regulations, including, but not limited to, section 144A.161;

(4) a description of the relationship between the nursing facility that is proposed for closure and the nursing facility or facilities proposed to receive the planned closure rate adjustment. If these facilities are not under common ownership, copies of any contracts, purchase agreements, or other documents establishing a relationship or proposed relationship must be provided;

(5) documentation, in a format approved by the commissioner, that all the nursing facilities receiving a planned closure rate adjustment under the plan have accepted joint and several liability for recovery of overpayments under section 256B.0641, subdivision 2, for the facilities designated for closure under the plan; and

(6) comments by the affected regional planning and development groups on the facility proposal.

(d) The application must address the criteria listed in subdivision 4.

Subd. 4. [CRITERIA FOR REVIEW OF APPLICATION.] In reviewing and approving closure proposals, the commissioner shall consider, but not be limited to, the following criteria:

(1) improved quality of care and quality of life for consumers;

(2) closure of a nursing facility that has a poor physical plant;

(3) the existence of excess nursing facility beds, measured in terms of beds per thousand persons aged 85 or older. The excess must be measured in reference to:

(i) the county in which the facility is located;

(ii) the county and all contiguous counties;

(iii) the region in which the facility is located; or

(iv) the facility's service area;

the facility shall indicate in its application the service area it believes is appropriate for this measurement. A facility in a county that is in the lowest quartile of counties with reference to beds per thousand persons aged 85 or older is not in an area of excess capacity;

(4) low-occupancy rates, provided that the unoccupied beds are not the result of a personnel shortage. In analyzing occupancy rates, the commissioner shall examine waiting lists in the applicant facility and at facilities in the surrounding area, as determined under clause (3);

(5) evidence of coordination between the community planning process and the facility application;

(6) proposed usage of funds available from a planned closure rate adjustment for care-related purposes;

(7) innovative use planned for the closed facility's physical plant;

(8) evidence that the proposal serves the interests of the state; and

(9) evidence of other factors that affect the viability of the facility, including excessive nursing pool costs.

Subd. 5. [CERTIFICATION.] Upon receipt of an application for planned closure, the commissioner of human services shall provide a copy of the application to the commissioner of health. The commissioner of health shall certify to the commissioner of human services within 14 days whether the application, if implemented, will satisfy the requirements of section 144A.161. The commissioner of human services shall reject all applications for which the commissioner of health fails to make the certification required under this subdivision within 14 days.

Subd. 6. [REVIEW AND APPROVAL OF APPLICATIONS.] (a) The commissioner of human services, in consultation with the commissioner of health, shall approve or disapprove an application within 30 days after receiving it.

(b) The commissioner shall not approve an application that results in a closure, curtailment, reduction, or change of operations combined with the establishment of new long-term care facilities or services offered in the existing facilities or in new facilities provided by the same corporation, agency, or individual, unless:

(1) the employees at the time of the closure, curtailment, reduction, or change of operations are given by seniority the first priority for hiring into positions for which they are qualified in the new facility or service; and

(2) the exclusive bargaining representative at the time of the closure, curtailment, reduction, or change of operations is recognized as the exclusive bargaining representative for the new long-term care facilities or services.

(c) Approval of a planned closure expires 18 months after approval by the commissioner of human services, unless commencement of closure has begun.

(d) The commissioner of human services may change any provision of the application to which the applicant, the regional planning group, and the commissioner agree.

Subd. 7. [PLANNED CLOSURE RATE ADJUSTMENT.] (a) The commissioner of human services shall calculate the amount of the planned closure rate adjustment available under subdivision 3, paragraph (b), for up to 5,140 beds according to clauses (1) to (4):

(1) the amount available is the net reduction of nursing facility beds multiplied by $2,080;

(2) the total number of beds in the nursing facility or facilities receiving the planned closure rate adjustment must be identified;

(3) capacity days are determined by multiplying the number determined under clause (2) by 365; and

(4) the planned closure rate adjustment is the amount available in clause (1), divided by capacity days determined under clause (3).

(b) A planned closure rate adjustment under this section is effective on the first day of the month following completion of closure of the facility designated for closure in the application and becomes part of the nursing facility's total operating payment rate.

(c) Applicants may use the planned closure rate adjustment to allow for a property payment for a new nursing facility or an addition to an existing nursing facility. Applications approved under this subdivision are exempt from other requirements for moratorium exceptions under section 144A.073, subdivisions 2 and 3.

(d) Upon the request of a closing facility, the commissioner must allow the facility a closure rate adjustment equal to a 50 percent payment rate increase to reimburse relocation costs or other costs related to facility closure. This rate increase is effective on the date the facility's occupancy decreases to 90 percent of capacity days after the written notice of closure is distributed under section 144A.161, subdivision 5, and shall remain in effect for a period of up to 60 days. The commissioner shall delay the implementation of the planned closure rate adjustments to offset the cost of this rate adjustment.

Subd. 8. [OTHER RATE ADJUSTMENTS.] Facilities subject to this section remain eligible for any applicable rate adjustments provided under section 256B.431, 256B.434, or any other section.

Subd. 9. [COUNTY COSTS.] The commissioner of human services may allocate up to $400 total state and federal funds per nursing facility bed that is closing, within the limits of the appropriation specified for this purpose, to be used for relocation costs incurred by counties for planned closures under this section or resident relocation under section 144A.161. To be eligible for this allocation, a county in which a nursing facility closes must provide to the commissioner a detailed statement in a form provided by the commissioner of additional costs, not to exceed $400 per bed closed, that are directly incurred related to the county's required role in the relocation process.

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

Sec. 17. [256B.438] [IMPLEMENTATION OF A CASE MIX SYSTEM FOR NURSING FACILITIES BASED ON THE MINIMUM DATA SET.]

Subdivision 1. [SCOPE.] This section establishes the method and criteria used to determine resident reimbursement classifications based upon the assessments of residents of nursing homes and boarding care homes whose payment rates are established under section 256B.431, 256B.434, or 256B.435. Resident reimbursement classifications shall be established according to the 34 group, resource utilization groups, version III or RUG-III model as described in section 144.0724. Reimbursement classifications established under this section shall be implemented after June 30, 2002, but no later than January 1, 2003.

Subd. 2. [DEFINITIONS.] For purposes of this section, the following terms have the meanings given.

(a) [ASSESSMENT REFERENCE DATE.] "Assessment reference date" has the meaning given in section 144.0724, subdivision 2, paragraph (a).

(b) [CASE MIX INDEX.] "Case mix index" has the meaning given in section 144.0724, subdivision 2, paragraph (b).

(c) [INDEX MAXIMIZATION.] "Index maximization" has the meaning given in section 144.0724, subdivision 2, paragraph (c).

(d) [MINIMUM DATA SET.] "Minimum data set" has the meaning given in section 144.0724, subdivision 2, paragraph (d).

(e) [REPRESENTATIVE.] "Representative" has the meaning given in section 144.0724, subdivision 2, paragraph (e).

(f) [RESOURCE UTILIZATION GROUPS OR RUG.] "Resource utilization groups" or "RUG" has the meaning given in section 144.0724, subdivision 2, paragraph (f).

Subd. 3. [CASE MIX INDICES.] (a) The commissioner of human services shall assign a case mix index to each resident class based on the Health Care Financing Administration's staff time measurement study and adjusted for Minnesota-specific wage indices. The case mix indices assigned to each resident class shall be published in the Minnesota State Register at least 120 days prior to the implementation of the 34 group, RUG-III resident classification system.

(b) An index maximization approach shall be used to classify residents.

(c) After implementation of the revised case mix system, the commissioner of human services may annually rebase case mix indices and base rates using more current data on average wage rates and staff time measurement studies. This rebasing shall be calculated under subdivision 7, paragraph (b). The commissioner shall publish in the Minnesota State Register adjusted case mix indices at least 45 days prior to the effective date of the adjusted case mix indices.

Subd. 4. [RESIDENT ASSESSMENT SCHEDULE.] (a) Nursing facilities shall conduct and submit case mix assessments according to the schedule established by the commissioner of health under section 144.0724, subdivisions 4 and 5.

(b) The resident reimbursement classifications established under section 144.0724, subdivision 3, shall be effective the day of admission for new admission assessments. The effective date for significant change assessments shall be the assessment reference date. The effective date for annual and second quarterly assessments shall be the first day of the month following assessment reference date.

Subd. 5. [NOTICE OF RESIDENT REIMBURSEMENT CLASSIFICATION.] Nursing facilities shall provide notice to a resident of the resident's case mix classification according to procedures established by the commissioner of health under section 144.0724, subdivision 7.

Subd. 6. [RECONSIDERATION OF RESIDENT CLASSIFICATION.] Any request for reconsideration of a resident classification must be made under section 144.0724, subdivision 8.

Subd. 7. [RATE DETERMINATION UPON TRANSITION TO RUG-III PAYMENT RATES.] (a) The commissioner of human services shall determine payment rates at the time of transition to the RUG based payment model in a facility-specific, budget-neutral manner. The case mix indices as defined in subdivision 3 shall be used to allocate the case mix adjusted component of total payment across all case mix groups. To transition from the current calculation methodology to the RUG based methodology, the commissioner of health shall report to the commissioner of human services the resident days classified according to the categories defined in subdivision 3 for the 12-month reporting period ending September 30, 2001, for each nursing facility. The commissioner of human services shall use this data to compute the standardized days for the reporting period under the RUG system.

(b) The commissioner of human services shall determine the case mix adjusted component of the rate as follows:

(1) determine the case mix portion of the 11 case mix rates in effect on June 30, 2002, or the 34 case mix rates in effect on or after June 30, 2003;

(2) multiply each amount in clause (1) by the number of resident days assigned to each group for the reporting period ending September 30, 2001, or the most recent year for which data is available;

(3) compute the sum of the amounts in clause (2);

(4) determine the total RUG standardized days for the reporting period ending September 30, 2001, or the most recent year for which data is available using the new indices calculated under subdivision 3, paragraph (c);

(5) divide the amount in clause (3) by the amount in clause (4) which shall be the average case mix adjusted component of the rate under the RUG method; and

(6) multiply this average rate by the case mix weight in subdivision 3 for each RUG group.

(c) The noncase mix component will be allocated to each RUG group as a constant amount to determine the transition payment rate. Any other rate adjustments that are effective on or after July 1, 2002, shall be applied to the transition rates determined under this section.

Sec. 18. [256B.439] [LONG-TERM CARE QUALITY PROFILES.]

Subdivision 1. [DEVELOPMENT AND IMPLEMENTATION OF QUALITY PROFILES.] (a) The commissioner of human services shall develop and implement a quality profile system for nursing facilities and, beginning not later than July 1, 2003, other providers of long-term care services. The system must be developed and implemented to the extent possible without the collection of significant amounts of new data. The system must not duplicate the requirements of section 256B.5011, 256B.5012, or 256B.5013. The system must be designed to provide information on quality:

(1) to consumers and their families to facilitate informed choices of service providers;

(2) to providers to enable them to measure the results of their quality improvement efforts and compare quality achievements with other service providers; and

(3) to public and private purchasers of long-term care services to enable them to purchase high-quality care.

(b) The system must be developed in consultation with the long-term care task force and representatives of consumers, providers, and labor unions. Within the limits of available appropriations, the commissioner may employ consultants to assist with this project.

Subd. 2. [QUALITY MEASUREMENT TOOLS.] The commissioner of human services shall identify and apply existing quality measurement tools to:

(1) emphasize quality of care and its relationship to quality of life; and

(2) address the needs of various users of long-term care services, including, but not limited to, short-stay residents, persons with behavioral problems, persons with dementia, and persons who are members of minority groups.

The tools must be identified and applied, to the extent possible, without requiring providers to supply information beyond current state and federal requirements.

Subd. 3. [CONSUMER SURVEYS.] Following identification of the quality measurement tool, the commissioner of human services shall conduct surveys of long-term care service consumers to develop quality profiles of providers. To the extent possible, surveys must be conducted face-to-face by state employees or contractors. At the discretion of the commissioner, surveys may be conducted by telephone or by provider staff. Surveys must be conducted periodically to update quality profiles of individual service providers.

Subd. 4. [DISSEMINATION OF QUALITY PROFILES.] By July 1, 2002, the commissioner of human services shall implement a system to disseminate the quality profiles developed from consumer surveys using the quality measurement tools. Profiles must be disseminated to consumers, providers, and purchasers of long-term care services through all feasible printed and electronic outlets. The commissioner shall conduct a public awareness campaign to inform potential users regarding profile contents and potential uses.

Sec. 19. Minnesota Statutes 2000, section 256B.5012, subdivision 3, is amended to read:

Subd. 3. [PROPERTY PAYMENT RATE.] (a) The property payment rate effective October 1, 2000, is based on the facility's modified property payment rate in effect on September 30, 2000. The modified property payment rate is the actual property payment rate exclusive of the effect of gains or losses on disposal of capital assets or adjustments for excess depreciation claims. Effective October 1, 2000, a facility minimum property rate of $8.13 shall be applied to all existing ICF/MR facilities. Facilities with a modified property payment rate effective September 30, 2000, which is below the minimum property rate shall receive an increase effective October 1, 2000, equal to the difference between the minimum property payment rate and the modified property payment rate in effect as of September 30, 2000. Facilities with a modified property payment rate at or above the minimum property payment rate effective September 30, 2000, shall receive the modified property payment rate effective October 1, 2000.

(b) ~~Within the limits of appropriations specifically for this purpose,~~ Facility property payment rates shall be increased annually for inflation, effective January 1, 2002. The increase shall be based on each facility's property payment rate in effect on September 30, 2000. Modified property payment rates effective September 30, 2000, shall be arrayed from highest to lowest before applying the minimum property payment rate in paragraph (a). For modified property payment rates at the 90th percentile or above, the annual inflation increase shall be zero. For modified property payment rates below the 90th percentile but equal to or above the 75th percentile, the annual inflation increase shall be one percent. For modified property payment rates below the 75th percentile, the annual inflation increase shall be two percent.

Sec. 20. Minnesota Statutes 2000, section 256B.5012, is amended by adding a subdivision to read:

Subd. 4. [ICF/MR RATE INCREASES BEGINNING JULY 1, 2001, AND JULY 1, 2002.] (a) For the rate years beginning July 1, 2001, and July 1, 2002, the commissioner shall make available to each facility reimbursed under this section an adjustment to the total operating payment rate of 3.5 percent. Of this adjustment, 3.0 percentage points must be used to provide an employee wage increase as provided under paragraph (b) and 0.5 percentage points must be used for operating costs.

(b) The adjustment under this paragraph must be used to increase the wages of all employees except administrative and central office employees and to pay associated costs for FICA, the Medicare tax, workers' compensation premiums, and federal and state unemployment insurance, provided that this increase must be used only for wage increases implemented on or after the first day of the rate year and must not be used for wage increases implemented prior to that date.

(c) For each facility, the commissioner shall make available an adjustment using the percentage specified in paragraph (a) multiplied by the total payment rate, excluding the property-related payment rate, in effect on the preceding June 30. The total payment rate shall include the adjustment provided in section 256B.501, subdivision 12.

(d) A facility whose payment rates are governed by closure agreements, receivership agreements, or Minnesota Rules, part 9553.0075, is not eligible for an adjustment otherwise granted under this subdivision.

(e) A facility may apply for the wage-related payment rate adjustment provided under paragraph (b). The application must be made to the commissioner and contain a plan by which the facility will distribute the wage-related portion of the payment rate adjustment to employees of the facility. For facilities in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative constitutes the plan. A negotiated agreement may constitute the plan only if the agreement is finalized after the date of enactment of all rate increases for the rate year. The commissioner shall review the plan to ensure that the payment rate adjustment per diem is used as provided in this subdivision. To be eligible, a facility must submit its plan by March 31, 2002, and March 31, 2003, respectively. If a facility's plan is effective for its employees after the first day of the applicable rate year that the funds are available, the payment rate adjustment per diem is effective the same date as its plan.

(f) A copy of the approved distribution plan must be made available to all employees by giving each employee a copy or by posting it in an area of the facility to which all employees have access. If an employee does not receive the wage adjustment described in the facility's approved plan and is unable to resolve the problem with the facility's management or through the employee's union representative, the employee may contact the commissioner at an address or telephone number provided by the commissioner and included in the approved plan.

Sec. 21. Minnesota Statutes 2000, section 626.557, subdivision 12b, is amended to read:

Subd. 12b. [DATA MANAGEMENT.] (a) [COUNTY DATA.] In performing any of the duties of this section as a lead agency, the county social service agency shall maintain appropriate records. Data collected by the county social service agency under this section are welfare data under section 13.46. Notwithstanding section 13.46, subdivision 1, paragraph (a), data under this paragraph that are inactive investigative data on an individual who is a vendor of services are private data on individuals, as defined in section 13.02. The identity of the reporter may only be disclosed as provided in paragraph (c).

Data maintained by the common entry point are confidential data on individuals or protected nonpublic data as defined in section 13.02. Notwithstanding section 138.163, the common entry point shall destroy data three calendar years after date of receipt.

(b) [LEAD AGENCY DATA.] The commissioners of health and human services shall prepare

an investigation memorandum for each report alleging maltreatment investigated under this section. During an investigation by the commissioner of health or the commissioner of human services, data collected under this section are confidential data on individuals or protected nonpublic data as defined in section 13.02. Upon completion of the investigation, the data are classified as provided in clauses (1) to (3) and paragraph (c).

(1) The investigation memorandum must contain the following data, which are public:

(i) the name of the facility investigated;

(ii) a statement of the nature of the alleged maltreatment;

(iii) pertinent information obtained from medical or other records reviewed;

(iv) the identity of the investigator;

(v) a summary of the investigation's findings;

(vi) statement of whether the report was found to be substantiated, inconclusive, false, or that no determination will be made;

(vii) a statement of any action taken by the facility;

(viii) a statement of any action taken by the lead agency; and

(ix) when a lead agency's determination has substantiated maltreatment, a statement of whether an individual, individuals, or a facility were responsible for the substantiated maltreatment, if known.

The investigation memorandum must be written in a manner which protects the identity of the reporter and of the vulnerable adult and may not contain the names or, to the extent possible, data on individuals or private data listed in clause (2).

(2) Data on individuals collected and maintained in the investigation memorandum are private data, including:

(i) the name of the vulnerable adult;

(ii) the identity of the individual alleged to be the perpetrator;

(iii) the identity of the individual substantiated as the perpetrator; and

(iv) the identity of all individuals interviewed as part of the investigation.

(3) Other data on individuals maintained as part of an investigation under this section are private data on individuals upon completion of the investigation.

(c) [IDENTITY OF REPORTER.] The subject of the report may compel disclosure of the name of the reporter only with the consent of the reporter or upon a written finding by a court that the report was false and there is evidence that the report was made in bad faith. This subdivision does not alter disclosure responsibilities or obligations under the rules of criminal procedure, except that where the identity of the reporter is relevant to a criminal prosecution, the district court shall do an in-camera review prior to determining whether to order disclosure of the identity of the reporter.

(d) [DESTRUCTION OF DATA.] Notwithstanding section 138.163, data maintained under this section by the commissioners of health and human services must be destroyed under the following schedule:

(1) data from reports determined to be false, two years after the finding was made;

(2) data from reports determined to be inconclusive, four years after the finding was made;

(3) data from reports determined to be substantiated, seven years after the finding was made; and

(4) data from reports which were not investigated by a lead agency and for which there is no final disposition, two years from the date of the report.

(e) [SUMMARY OF REPORTS.] The commissioners of health and human services shall each annually ~~prepare a summary of~~ report to the legislature and the governor on the number and type of reports of alleged maltreatment involving licensed facilities reported under this section, the number of those requiring investigation under this section, and the resolution of those investigations. The report shall identify:

(1) whether and where backlogs of cases result in a failure to conform with statutory time frames;

(2) where adequate coverage requires additional appropriations and staffing; and

(3) any other trends that affect the safety of vulnerable adults.

(f) [RECORD RETENTION POLICY.] Each lead agency must have a record retention policy.

(g) [EXCHANGE OF INFORMATION.] Lead agencies, prosecuting authorities, and law enforcement agencies may exchange not public data, as defined in section 13.02, if the agency or authority requesting the data determines that the data are pertinent and necessary to the requesting agency in initiating, furthering, or completing an investigation under this section. Data collected under this section must be made available to prosecuting authorities and law enforcement officials, local county agencies, and licensing agencies investigating the alleged maltreatment under this section. The lead agency shall exchange not public data with the vulnerable adult maltreatment review panel established in section 256.021 if the data are pertinent and necessary for a review requested under that section. Upon completion of the review, not public data received by the review panel must be returned to the lead agency.

(h) [COMPLETION TIME.] Each lead agency shall keep records of the length of time it takes to complete its investigations.

(i) [NOTIFICATION OF OTHER AFFECTED PARTIES.] A lead agency may notify other affected parties and their authorized representative if the agency has reason to believe maltreatment has occurred and determines the information will safeguard the well-being of the affected parties or dispel widespread rumor or unrest in the affected facility.

(j) [FEDERAL REQUIREMENTS.] Under any notification provision of this section, where federal law specifically prohibits the disclosure of patient identifying information, a lead agency may not provide any notice unless the vulnerable adult has consented to disclosure in a manner which conforms to federal requirements.

Sec. 22. Laws 1999, chapter 245, article 3, section 45, as amended by Laws 2000, chapter 312, section 3, is amended to read:

Sec. 45. [STATE LICENSURE CONFLICTS WITH FEDERAL REGULATIONS.]

(a) Notwithstanding the provisions of Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval.

(b) This section expires July 1, ~~2001~~ 2003.

Sec. 23. Laws 2000, chapter 364, section 2, is amended to read:

Sec. 2. [MORATORIUM EXCEPTION PROCESS.]

For ~~fiscal year~~ the biennium beginning July 1, ~~2000~~ 2001, when approving nursing home moratorium exception projects under Minnesota Statutes, section 144A.073, the commissioner of health shall give priority to ~~proposals~~ a proposal to build a replacement ~~facilities~~ facility in the city of Anoka or within ten miles of the city of Anoka.

Sec. 24. [DEVELOPMENT OF NEW NURSING FACILITY REIMBURSEMENT SYSTEM.]

(a) The commissioner of human services shall develop and report to the legislature by January 15, 2003, a system to replace the current nursing facility reimbursement system established under Minnesota Statutes, sections 256B.431, 256B.434, and 256B.435.

(b) The system must be developed in consultation with the long-term care task force and with representatives of consumers, providers, and labor unions. Within the limits of available appropriations, the commissioner may employ consultants to assist with this project.

(c) The new reimbursement system must:

(1) provide incentives to enhance quality of life and quality of care;

(2) recognize cost differences in the care of different types of populations, including subacute care and dementia care;

(3) establish rates that are sufficient without being excessive;

(4) be affordable for the state and for private-pay residents;

(5) be sensitive to changing conditions in the long-term care environment;

(6) avoid creating access problems related to insufficient funding;

(7) allow providers maximum flexibility in their business operations; and

(8) recognize the need for capital investment to improve physical plants.

(d) Notwithstanding Minnesota Statutes, section 256B.435, the commissioner must not implement a performance-based contracting system for nursing facilities prior to July 1, 2003. The commissioner shall continue to reimburse nursing facilities under Minnesota Statutes, section 256B.431 or 256B.434, until otherwise directed by law.

Sec. 25. [MINIMUM STAFFING STANDARDS REPORT.]

By January 15, 2002, the commissioner of health and the commissioner of human services shall report to the legislature on whether they should translate the minimum nurse staffing requirement in Minnesota Statutes, section 144A.04, subdivision 7, paragraph (a), upon the transition to the RUG-III classification system, or whether they should establish different time-based standards, and how to accomplish either.

Sec. 26. [TIME MOTION STUDY.]

(a) The commissioner of human services shall conduct a time motion study to determine the amount of time devoted to the care of high-need nursing facility residents, including, but not limited to, persons with Alzheimer's disease and other dementias, persons with multiple sclerosis, and persons with mental illness.

(b) The commissioner shall report the results of the study to the legislature by January 15, 2003, with an analysis of whether these costs are adequately reimbursed under the current reimbursement system and with recommendations for adjusting nursing facility reimbursement rates as necessary to account for these costs.

Sec. 27. [PROVIDER RATE INCREASES.]

(a) The commissioner of human services shall increase reimbursement rates by 3.5 percent

each year of the biennium for the providers listed in paragraph (b). The increases are effective for services rendered on or after July 1 of each year.

(b) The rate increases described in this section must be provided to home and community-based waivered services for:

(1) persons with mental retardation or related conditions under Minnesota Statutes, section 256B.501;

(2) home and community-based waivered services for the elderly under Minnesota Statutes, section 256B.0915;

(3) waivered services under community alternatives for disabled individuals under Minnesota Statutes, section 256B.49;

(4) community alternative care waivered services under Minnesota Statutes, section 256B.49;

(5) traumatic brain injury waivered services under Minnesota Statutes, section 256B.49;

(6) nursing services and home health services under Minnesota Statutes, section 256B.0625, subdivision 6a;

(7) personal care services and nursing supervision of personal care services under Minnesota Statutes, section 256B.0625, subdivision 19a;

(8) private duty nursing services under Minnesota Statutes, section 256B.0625, subdivision 7;

(9) day training and habilitation services for adults with mental retardation or related conditions under Minnesota Statutes, sections 252.40 to 252.46;

(10) alternative care services under Minnesota Statutes, section 256B.0913;

(11) adult residential program grants under Minnesota Rules, parts 9535.2000 to 9535.3000;

(12) adult and family community support grants under Minnesota Rules, parts 9535.1700 to 9535.1760;

(13) the group residential housing supplementary service rate under Minnesota Statutes, section 256I.05, subdivision 1a;

(14) adult mental health integrated fund grants under Minnesota Statutes, section 245.4661;

(15) semi-independent living services under Minnesota Statutes, section 252.275, including SILS funding under county social services grants formerly funded under Minnesota Statutes, chapter 256I;

(16) community support services for deaf and hard-of-hearing adults with mental illness who use or wish to use sign language as their primary means of communication; and

(17) living skills training programs for persons with intractable epilepsy who need assistance in the transition to independent living.

(c) Providers that receive a rate increase under this section shall use 0.5 percentage points of the additional revenue for operating cost increases and 3.0 percentage points of the additional revenue to increase wages for all employees other than the administrator and central office staff and to pay associated costs for FICA, the Medicare tax, workers' compensation premiums, and federal and state unemployment insurance. For public employees, the portion of this increase reserved to increase wages for certain staff is available and pay rates shall be increased only to the extent that they comply with laws governing public employees collective bargaining. Money received by a provider for pay increases under this section must be used only for wage increases implemented on or after the first day of the state fiscal year in which the increase is available and must not be used for wage increases implemented prior to that date.

(d) A copy of the provider's plan for complying with paragraph (c) must be made available to all employees by giving each employee a copy or by posting it in an area of the provider's operation to which all employees have access. If an employee does not receive the wage adjustment described in the plan and is unable to resolve the problem with the provider, the employee may contact the employee's union representative. If the employee is not covered by a collective bargaining agreement, the employee may contact the commissioner at a phone number provided by the commissioner and included in the provider's plan.

Sec. 28. [REGULATORY FLEXIBILITY.]

(a) By July 1, 2001, the commissioners of health and human services shall:

(1) develop a summary of federal nursing facility and community long-term care regulations that hamper state flexibility and place burdens on the goal of achieving high-quality care and optimum outcomes for consumers of services; and

(2) share this summary with the legislature, other states, national groups that advocate for state interests with Congress, and the Minnesota congressional delegation.

(b) The commissioners shall conduct ongoing follow-up with the entities to which this summary is provided and with the health care financing administration to achieve maximum regulatory flexibility, including the possibility of pilot projects to demonstrate regulatory flexibility on less than a statewide basis.

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

Sec. 29. [REPORT.]

By January 15, 2003, the commissioner of health and the commissioner of human services shall report to the senate health and family security committee and the house health and human services policy committee on the number of closures that have taken place under this article, alternatives to nursing facility care that have been developed, any problems with access to long-term care services that have resulted, and any recommendations for continuation of the regional long-term care planning process and the closure process after June 30, 2003.

Sec. 30. [REVISOR INSTRUCTION.]

The revisor of statutes shall delete any reference to Minnesota Statutes, section 144A.16, in Minnesota Statutes and Minnesota Rules.

Sec. 31. [REPEALER.]

(a) Minnesota Statutes 2000, sections 144A.16; and 256B.434, subdivision 5, are repealed.

(b) Minnesota Rules, parts 4655.6810; 4655.6820; 4655.6830; 4658.1600; 4658.1605; 4658.1610; 4658.1690; 9546.0010; 9546.0020; 9546.0030; 9546.0040; 9546.0050; and 9546.0060, are repealed.

## ARTICLE 6

## WORKFORCE RECRUITMENT AND RETENTION

Section 1. Minnesota Statutes 2000, section 116L.11, subdivision 4, is amended to read:

Subd. 4. [QUALIFYING CONSORTIUM.] "Qualifying consortium" means an entity that ~~may include~~ includes a public or private institution of higher education~~, work force center, county,~~ and one ~~or more~~ eligible ~~employers, but must include a public or private institution of higher education and one or more eligible employers~~ employer.

Sec. 2. Minnesota Statutes 2000, section 116L.12, subdivision 4, is amended to read:

Subd. 4. [GRANTS.] Within the limits of available appropriations, the board shall make grants not to exceed $400,000 each to qualifying consortia to operate local, regional, or statewide training

and retention programs. Grants may be made from TANF funds, general fund appropriations, and any other funding sources available to the board, provided the requirements of those funding sources are satisfied. Grant awards must establish specific, measurable outcomes and timelines for achieving those outcomes.

Sec. 3. Minnesota Statutes 2000, section 116L.12, subdivision 5, is amended to read:

Subd. 5. [LOCAL MATCH REQUIREMENTS.] A consortium must ~~provide at least a 50 percent match from local resources for money appropriated under this section. The local match requirement must be satisfied on an overall program basis but need not be satisfied for each particular client. The local match requirement may be reduced for consortia that include a relatively large number of small employers whose financial contribution has been reduced in accordance with section 116L.15. In-kind services and expenditures under section 116L.13, subdivision 2, may be used to meet this local match requirement. The grant application must specify the financial contribution from each member of the consortium~~ satisfy the match requirements established in section 116L.02, paragraph (a).

Sec. 4. Minnesota Statutes 2000, section 116L.13, subdivision 1, is amended to read:

Subdivision 1. [MARKETING AND RECRUITMENT.] A qualifying consortium must implement a marketing and outreach strategy to recruit into the health care and human services fields persons from one or more of the potential employee target groups. Recruitment strategies must include:

(1) a screening process to evaluate whether potential employees may be disqualified as the result of a required background check or are otherwise unlikely to succeed in the position for which they are being recruited; and

(2) a process for modifying course work to meet the training needs of non-English-speaking persons, when appropriate.

Sec. 5. [116L.146] [EXPEDITED GRANT PROCESS.]

(a) The board may authorize grants not to exceed $50,000 each through an expedited grant approval process to:

(1) eligible employers to provide training programs for up to 50 workers; or

(2) a public or private institution of higher education to:

(i) do predevelopment or curriculum development for training programs prior to submission for program funding under section 116L.12;

(ii) convert an existing curriculum for distance learning through interactive television or other communication methods; or

(iii) enable a training program to be offered when it would otherwise be canceled due to an enrollment shortfall of one or two students when the program is offered in a health-related field with a documented worker shortage and is part of a training program not exceeding two years in length.

(b) The board shall develop application procedures and evaluation policies for grants made under this section.

Sec. 6. [256.956] [LONG-TERM CARE EMPLOYEE HEALTH INSURANCE ASSISTANCE PROGRAM.]

Subdivision 1. [DEFINITIONS.] (a) For the purpose of this section, the definitions have the meanings given them.

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

(c) "Dependent" means an unmarried child who is under the age of 19 years. For the purpose of this definition, a dependent includes a child for whom an eligible employee or an eligible employee's spouse has been appointed legal guardian or an adopted child as defined under section 62A.27. A dependent does not include:

(1) a child of an eligible employee who is eligible for health coverage through medical assistance without a spenddown or through an employer-subsidized health plan where an employer other than the employer of the eligible employee pays at least 50 percent of the cost of coverage for the child; or

(2) a child of an eligible employee who is excluded from coverage under title XXI of the Social Security Act, United States Code, title 42, section 1397aa et seq.

(d) "Eligible employee" means an individual employed for at least 20 hours by an employer in a position other than as an administrator or in the central office. An "employee" does not include an individual who:

(1) works on a temporary or substitute basis;

(2) is hired as an independent contractor; or

(3) is a state employee.

(e) "Employer" means any of the following:

(1) a nursing facility reimbursed under section 256B.431 or 256B.434;

(2) a facility reimbursed under sections 256B.501 and 256B.5011 and Laws 1993, First Special Session chapter 1, article 4, section 11; or

(3) a provider who meets the following requirements:

(i) provides home and community-based waivered services for persons with mental retardation or related conditions under section 256B.501; home and community-based waivered services for the elderly under section 256B.0915; waivered services under community alternatives for disabled individuals under section 256B.49; community alternative care waivered services under section 256B.49; traumatic brain injury waivered services under section 256B.49; nursing services and home health services under section 256B.0625, subdivision 6a; personal care services and nursing supervision of personal care services under section 256B.0625, subdivision 19a; private duty nursing services under section 256B.0625, subdivision 7; day training and habilitation services for adults with mental retardation or related conditions under sections 252.40 to 252.46; alternative care services under section 256B.0913; adult residential program grants under Minnesota Rules, parts 9535.2000 to 9535.3000; adult and family community support grants under Minnesota Rules, parts 9535.1700 to 9535.1760; semi-independent living services under section 252.275, including SILS funding under county social services grants formerly funded under chapter 256I; community support services for deaf and hard-of-hearing adults with mental illness who use or wish to use sign language as their primary means of communication; or living skills training programs for persons with intractable epilepsy who need assistance in the transition to independent living; and

(ii) the revenue received by the provider from medical assistance that equals or exceeds 20 percent of the total revenue received by the provider from all payment sources.

Employer includes both for-profit and nonprofit entities.

(f) "Program" means the long-term care employee health insurance assistance program.

Subd. 2. [PROGRAM.] (a) The commissioner shall establish and administer the long-term care employee health insurance assistance program to provide the advantages of pooling for the purchase of health coverage for long-term care employers.

(b) The commissioner shall solicit bids from health maintenance organizations licensed under chapter 62D to provide health coverage to the dependents of eligible employees. Health

maintenance organizations shall submit proposals in good faith that meet the requirements of the request for proposal from the commissioner, provided that the requirements can reasonably be met by the health maintenance organization. Coverage shall be offered on a guaranteed-issue and renewal basis. No health maintenance organization is required to provide coverage to an eligible employee's dependent who does not reside within the health maintenance organization's approved service area.

(c) The commissioner shall, consistent with the provisions of this section, determine coverage options, premium arrangements, contractual arrangements, and all other matters necessary to administer the program.

(d) The commissioner may extend the program to include coverage for the eligible employee and noneligible employee. The cost of coverage for these employees shall be the responsibility of the employer or employee. In determining whether to extend the program to include coverage for the employees, the commissioner shall evaluate the feasibility of the state establishing a stop-loss insurance fund for the purpose of lowering the cost of premiums for the employees.

(e) The commissioner shall consult with representatives of the long-term care industry on issues related to the administration of the program.

Subd. 3. [EMPLOYER REQUIREMENTS.] (a) All employers may participate in the program subject to the requirements of this section. The commissioner shall establish procedures for an employer to apply for coverage through this program. These procedures may include requiring eligible employees to provide relevant financial information to determine the eligibility of their dependents.

(b) A participating employer must offer dependent coverage to all employees. For purposes of this paragraph, dependent includes the children excluded under subdivision 1, paragraph (c).

(c) The participating employer must provide to the commissioner any employee information deemed necessary by the commissioner to determine eligibility and premium payments and must notify the commissioner upon a change in an employee's or an employee's dependent's eligibility.

(d) The initial term of the employer's coverage must be for at least one year but may be made automatically renewable from term to term in the absence of notice of termination by either the employer or the commissioner.

Subd. 4. [INDIVIDUAL ELIGIBILITY.] (a) The commissioner may require a probationary period for new employees of no more than 90 days before the dependents of a new employee become eligible for coverage through the program.

(b) A participating employer may elect to offer coverage through the program to:

(1) the eligible and noneligible employees, if the program is extended by the commissioner to include these individuals;

(2) children of eligible and noneligible employees who are under the age of 25 years and who are full-time students; and

(3) the spouses of eligible and noneligible employees.

The cost of coverage for the individuals described in this paragraph, the dependents of noneligible employees, and any child of an eligible or noneligible employee who is not considered a dependent in accordance with subdivision 1, paragraph (c), shall be the responsibility of the employer or employee.

(c) The commissioner may require a certain percentage of participation of the individuals described in paragraph (b) before coverage can be offered through the program.

Subd. 5. [COVERAGE.] (a) The health plan offered must meet all applicable requirements of chapters 62A and 62D and sections 62J.71 to 62J.73; 62M.01 to 62M.16; 62Q.1055; 62Q.106;

62Q.12; 62Q.135; 62Q.14; 62Q.145; 62Q.19; 62Q.23; 62Q.43; 62Q.47; 62Q.52 to 62Q.58; and 62Q.68 to 62Q.73.

(b) The health plan offered must meet all underwriting requirements of chapter 62L and must provide periodic open enrollments for eligible employees where a choice in coverage exists.

(c) The commissioner shall establish the benefits to be provided under this program in accordance with the following:

(1) the benefits provided must comply with title XXI of the Social Security Act, United States Code, title 42, section 1397aa et seq., and be at least equivalent to the lowest benchmark allowable under title XXI;

(2) preventive and restorative dental services must be included; and

(3) except for a $20 copay per visit for emergency care, there shall be no deductibles, copayments, or coinsurance requirements.

(d) The health plan requirements described in paragraph (c) apply only to coverage offered to the dependents of eligible employees.

Subd. 6. [PREMIUMS.] (a) The commissioner shall determine premium rates and rating methods for the coverage offered through the program.

(b) The commissioner shall pay the premiums for the dependents of eligible employees directly to the health maintenance organization.

(c) Payment of any remaining premiums must be collected by the participating employer and paid directly to the health maintenance organization.

(d) Any premiums paid by the state under this section are not subject to taxes or surcharges imposed under chapter 297I, chapter 295, or section 256.9657 and shall be excluded when determining a health maintenance organization's total premium under section 62E.11.

**[EFFECTIVE DATE.]** This section is effective January 15, 2003, or upon federal approval of a federal waiver to receive enhanced matching funds under the state's children's health insurance program, whichever occurs latest.

Sec. 7. Minnesota Statutes 2000, section 256B.431, is amended by adding a subdivision to read:

Subd. 33. [EMPLOYEE SCHOLARSHIP COSTS AND TRAINING IN ENGLISH AS A SECOND LANGUAGE.] (a) For the rate year beginning July 1, 2001, the commissioner shall provide to each nursing facility reimbursed under this section, section 256B.434, or any other section an adjustment of 25 cents to the total operating payment rate to be used:

(1) for employee scholarships that satisfy the following requirements:

(i) scholarships are available to all employees who work an average of at least 20 hours per week at the facility except the administrator, department supervisors, registered nurses, and licensed practical nurses; and

(ii) the course of study is expected to lead to employment in a health-related career, including medical care interpreter services and social work; and

(2) to provide job-related training on the job site in English as a second language.

(b) A facility receiving a rate adjustment under this subdivision must report to the commissioner on a form supplied by the commissioner the following information: the amount received from this rate adjustment; the amount used for training in English as a second language; the number of persons receiving the training; the name of the person or entity providing the training; and for each scholarship recipient, the name of the recipient, the amount awarded, the educational institution attended, the nature of the educational program, and the program completion date.

(c) Amounts spent by a facility for scholarships or for training in English as a second language that satisfy the requirements of this subdivision shall be included in the facility's total payment rates for the purposes of determining future rates under this section, section 256B.434, or any other section.

Sec. 8. Minnesota Statutes 2000, section 256B.5012, is amended by adding a subdivision to read:

Subd. 5. [EMPLOYEE SCHOLARSHIP COSTS.] (a) For the rate year beginning July 1, 2001, the commissioner shall provide to each facility reimbursed under this section an adjustment of 25 cents to the total payment rate to be used:

(1) for employee scholarships that satisfy the following requirements:

(i) scholarships are available to all employees who work an average of at least 20 hours per week at the facility except the administrator, department supervisors, registered nurses, and licensed practical nurses; and

(ii) the course of study is expected to lead to employment in a health-related career, including medical care interpreter services and social work; and

(2) to provide job-related training on the job site in English as a second language.

(b) A facility receiving a rate adjustment under this subdivision must report to the commissioner on a form supplied by the commissioner the following information: the amount received from this rate adjustment; the amount used for training in English as a second language; the number of persons receiving the training; the name of the person or entity providing the training; and for each scholarship recipient, the name of the recipient, the amount awarded, the educational institution attended, the nature of the educational program, and the program completion date.

(c) Amounts spent by a facility for scholarships or for training in English as a second language that satisfy the requirements of this subdivision shall be included in the facility's total payment rates for the purposes of determining future rates under this section or any other section.

Sec. 9. Minnesota Statutes 2000, section 256L.07, subdivision 2, is amended to read:

Subd. 2. [MUST NOT HAVE ACCESS TO EMPLOYER-SUBSIDIZED COVERAGE.] (a) To be eligible, a family or individual must not have access to subsidized health coverage through an employer and must not have had access to employer-subsidized coverage through a current employer for 18 months prior to application or reapplication. A family or individual whose employer-subsidized coverage is lost due to an employer terminating health care coverage as an employee benefit during the previous 18 months is not eligible.

(b) For purposes of this requirement, subsidized health coverage means health coverage for which the employer pays at least 50 percent of the cost of coverage for the employee or dependent, or a higher percentage as specified by the commissioner. Children are eligible for employer-subsidized coverage through either parent, including the noncustodial parent. Children who are eligible for coverage under the long-term care employee health insurance assistance program established under section 256.956 are considered to have access to subsidized health coverage under this subdivision. The commissioner must treat employer contributions to Internal Revenue Code Section 125 plans and any other employer benefits intended to pay health care costs as qualified employer subsidies toward the cost of health coverage for employees for purposes of this subdivision.

**[EFFECTIVE DATE.]** This section is effective upon implementation of Minnesota Statutes, section 256.956.

Sec. 10. [EMPLOYEE SCHOLARSHIP COSTS.]

(a) The commissioner of human services shall increase reimbursement rates by .25 percent for

the providers listed in paragraph (d), effective for services rendered on or after July 1, 2001, to be used:

(1) for employee scholarships that satisfy the following requirements:

(i) scholarships are available to all employees who work an average of at least 20 hours per week at the facility except the administrator, department supervisors, registered nurses, and licensed practical nurses; and

(ii) the course of study is expected to lead to employment in a health-related career, including medical care interpreter services and social work; and

(2) to provide job-related training on the job site in English as a second language.

(b) A provider receiving a rate adjustment under this subdivision must report to the commissioner on a form supplied by the commissioner the following information: the amount received from this rate adjustment; the amount used for training in English as a second language; the number of persons receiving the training; the name of the person or entity providing the training; and for each scholarship recipient, the name of the recipient, the amount awarded, the educational institution attended, the nature of the educational program, and the program completion date.

(c) Amounts spent by a provider for scholarships or for training in English as a second language that satisfy the requirements of this section shall be included in the provider's total payment rates for the purposes of determining future rates.

(d) The rate increases described in this section shall be provided to home and community-based waivered services for persons with mental retardation or related conditions under Minnesota Statutes, section 256B.501; home and community-based waivered services for the elderly under Minnesota Statutes, section 256B.0915; waivered services under community alternatives for disabled individuals under Minnesota Statutes, section 256B.49; community alternative care waivered services under Minnesota Statutes, section 256B.49; traumatic brain injury waivered services under Minnesota Statutes, section 256B.49; nursing services and home health services under Minnesota Statutes, section 256B.0625, subdivision 6a; personal care services and nursing supervision of personal care services under Minnesota Statutes, section 256B.0625, subdivision 19a; private duty nursing services under Minnesota Statutes, section 256B.0625, subdivision 7; day training and habilitation services for adults with mental retardation or related conditions under Minnesota Statutes, sections 252.40 to 252.46; alternative care services under Minnesota Statutes, section 256B.0913; adult residential program grants under Minnesota Rules, parts 9535.2000 to 9535.3000; adult and family community support grants under Minnesota Rules, parts 9535.1700 to 9535.1760; the group residential housing supplementary service rate under section 256I.05, subdivision 1a; adult mental health integrated fund grants under Minnesota Statutes, section 245.4661; and semi-independent living services under Minnesota Statutes, section 252.275.

Sec. 11. [CHIP WAIVER.]

The commissioner of human services shall seek all waivers necessary to obtain enhanced matching funds under the state children's health insurance program established as title XXI of the Social Security Act, United States Code, title 42, section 1397aa et seq.

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

Sec. 12. [S-CHIP ALLOTMENT.] Upon implementation of section 256.956, the commissioner shall claim eligible expenditures against Minnesota's available funding under the state children's health insurance program in the following order:

(1) expenditures made according to Minnesota Statutes, section 256B.057, subdivision 8;

(2) expenditures for outreach and other state or local expenditures that are authorized to be claimed under Laws 1998, chapter 407, article 5, section 46;

(3) expenditures under the long-term care employee health insurance assistance program; and

(4) expenditures that may be eligible for matching funds under S-CHIP that otherwise may be claimed as Medicaid expenditures.

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

Sec. 13. [REPEALER.]

Minnesota Statutes 2000, section 116L.12, subdivisions 2 and 7, are repealed.

ARTICLE 7

REGULATION OF SUPPLEMENTAL NURSING SERVICES AGENCIES

Section 1. Minnesota Statutes 2000, section 144.057, is amended to read:

144.057 [BACKGROUND STUDIES ON LICENSEES AND SUPPLEMENTAL NURSING SERVICES AGENCY PERSONNEL.]

Subdivision 1. [BACKGROUND STUDIES REQUIRED.] The commissioner of health shall contract with the commissioner of human services to conduct background studies of:

(1) individuals providing services which have direct contact, as defined under section 245A.04, subdivision 3, with patients and residents in hospitals, boarding care homes, outpatient surgical centers licensed under sections 144.50 to 144.58; nursing homes and home care agencies licensed under chapter 144A; residential care homes licensed under chapter 144B, and board and lodging establishments that are registered to provide supportive or health supervision services under section 157.17; ~~and~~

(2) beginning July 1, 1999, all other employees in nursing homes licensed under chapter 144A, and boarding care homes licensed under sections 144.50 to 144.58. A disqualification of an individual in this section shall disqualify the individual from positions allowing direct contact or access to patients or residents receiving services;

(3) individuals employed by a supplemental nursing services agency, as defined under section 144A.70, who are providing services in health care facilities; and

(4) controlling persons of a supplemental nursing services agency, as defined under section 144A.70.

If a facility or program is licensed by the department of human services and subject to the background study provisions of chapter 245A and is also licensed by the department of health, the department of human services is solely responsible for the background studies of individuals in the jointly licensed programs.

Subd. 2. [RESPONSIBILITIES OF DEPARTMENT OF HUMAN SERVICES.] The department of human services shall conduct the background studies required by subdivision 1 in compliance with the provisions of chapter 245A and Minnesota Rules, parts 9543.3000 to 9543.3090. For the purpose of this section, the term "residential program" shall include all facilities described in subdivision 1. The department of human services shall provide necessary forms and instructions, shall conduct the necessary background studies of individuals, and shall provide notification of the results of the studies to the facilities, supplemental nursing services agencies, individuals, and the commissioner of health. Individuals shall be disqualified under the provisions of chapter 245A and Minnesota Rules, parts 9543.3000 to 9543.3090. If an individual is disqualified, the department of human services shall notify the facility, the supplemental nursing services agency, and the individual and shall inform the individual of the right to request a reconsideration of the disqualification by submitting the request to the department of health.

Subd. 3. [RECONSIDERATIONS.] The commissioner of health shall review and decide reconsideration requests, including the granting of variances, in accordance with the procedures

and criteria contained in chapter 245A and Minnesota Rules, parts 9543.3000 to 9543.3090. The commissioner's decision shall be provided to the individual and to the department of human services. The commissioner's decision to grant or deny a reconsideration of disqualification is the final administrative agency action.

Subd. 4. [RESPONSIBILITIES OF FACILITIES AND AGENCIES.] Facilities and agencies described in subdivision 1 shall be responsible for cooperating with the departments in implementing the provisions of this section. The responsibilities imposed on applicants and licensees under chapter 245A and Minnesota Rules, parts 9543.3000 to 9543.3090, shall apply to these facilities and supplemental nursing services agencies. The provision of section 245A.04, subdivision 3, paragraph (e), shall apply to applicants, licensees, registrants, or an individual's refusal to cooperate with the completion of the background studies. Supplemental nursing services agencies subject to the registration requirements in section 144A.71 must maintain records verifying compliance with the background study requirements under this section.

Sec. 2. [144A.70] [REGISTRATION OF SUPPLEMENTAL NURSING SERVICES AGENCIES; DEFINITIONS.]

Subdivision 1. [SCOPE.] As used in sections 144A.70 to 144A.74, the terms defined in this section have the meanings given them.

Subd. 2. [COMMISSIONER.] "Commissioner" means the commissioner of health.

Subd. 3. [CONTROLLING PERSON.] "Controlling person" means a business entity, officer, program administrator, or director whose responsibilities include the direction of the management or policies of a supplemental nursing services agency. Controlling person also means an individual who, directly or indirectly, beneficially owns an interest in a corporation, partnership, or other business association that is a controlling person.

Subd. 4. [HEALTH CARE FACILITY.] "Health care facility" means a hospital, boarding care home, or outpatient surgical center licensed under sections 144.50 to 144.58; a nursing home or home care agency licensed under chapter 144A; a housing with services establishment registered under chapter 144D; or a board and lodging establishment that is registered to provide supportive or health supervision services under section 157.17.

Subd. 5. [PERSON.] "Person" includes an individual, firm, corporation, partnership, or association.

Subd. 6. [SUPPLEMENTAL NURSING SERVICES AGENCY.] "Supplemental nursing services agency" means a person, firm, corporation, partnership, or association engaged for hire in the business of providing or procuring temporary employment in health care facilities for nurses, nursing assistants, nurse aides, and orderlies. Supplemental nursing services agency does not include an individual who only engages in providing the individual's services on a temporary basis to health care facilities. Supplemental nursing services agency also does not include any nursing service agency that is limited to providing temporary nursing personnel solely to one or more health care facilities owned or operated by the same person, firm, corporation, or partnership.

Sec. 3. [144A.71] [SUPPLEMENTAL NURSING SERVICES AGENCY REGISTRATION.]

Subdivision 1. [DUTY TO REGISTER.] A person who operates a supplemental nursing services agency shall register the agency with the commissioner. Each separate location of the business of a supplemental nursing services agency shall register the agency with the commissioner. Each separate location of the business of a supplemental nursing services agency shall have a separate registration.

Subd. 2. [APPLICATION INFORMATION AND FEE.] The commissioner shall establish forms and procedures for processing each supplemental nursing services agency registration application. An application for a supplemental nursing services agency registration must include at least the following:

(1) the names and addresses of the owner or owners of the supplemental nursing services agency;

(2) if the owner is a corporation, copies of its articles of incorporation and current bylaws, together with the names and addresses of its officers and directors;

(3) any other relevant information that the commissioner determines is necessary to properly evaluate an application for registration; and

(4) the annual registration fee for a supplemental nursing services agency, which is $891.

Subd. 3. [REGISTRATION NOT TRANSFERABLE.] A registration issued by the commissioner according to this section is effective for a period of one year from the date of its issuance unless the registration is revoked or suspended under section 144A.72, subdivision 2, or unless the supplemental nursing services agency is sold or ownership or management is transferred. When a supplemental nursing services agency is sold or ownership or management is transferred, the registration of the agency must be voided and the new owner or operator may apply for a new registration.

Sec. 4. [144A.72] [REGISTRATION REQUIREMENTS; PENALTIES.]

Subdivision 1. [MINIMUM CRITERIA.] The commissioner shall require that, as a condition of registration:

(1) the supplemental nursing services agency shall document that each temporary employee provided to health care facilities currently meets the minimum licensing, training, and continuing education standards for the position in which the employee will be working;

(2) the supplemental nursing services agency shall comply with all pertinent requirements relating to the health and other qualifications of personnel employed in health care facilities;

(3) the supplemental nursing services agency must not restrict in any manner the employment opportunities of its employees;

(4) the supplemental nursing services agency, when supplying temporary employees to a health care facility, and when requested by the facility to do so, shall agree that at least 30 percent of the total personnel hours supplied are during night, holiday, or weekend shifts;

(5) the supplemental nursing services agency shall carry medical malpractice insurance to insure against the loss, damage, or expense incident to a claim arising out of the death or injury of any person as the result of negligence or malpractice in the provision of health care services by the supplemental nursing services agency or by any employee of the agency; and

(6) the supplemental nursing services agency must not, in any contract with any employee or health care facility, require the payment of liquidated damages, employment fees, or other compensation should the employee be hired as a permanent employee of a health care facility.

Subd. 2. [PENALTIES.] A pattern of failure to comply with this section shall subject the supplemental nursing services agency to revocation or nonrenewal of its registration. Violations of section 144A.74 are subject to a fine equal to 200 percent of the amount billed or received in excess of the maximum permitted under that section.

Sec. 5. [144A.73] [COMPLAINT SYSTEM.]

The commissioner shall establish a system for reporting complaints against a supplemental nursing services agency or its employees. Complaints may be made by any member of the public. Written complaints must be forwarded to the employer of each person against whom a complaint is made. The employer shall promptly report to the commissioner any corrective action taken.

Sec. 6. [144A.74] [MAXIMUM CHARGES.]

A supplemental nursing services agency must not bill or receive payments from a health care facility at a rate higher than 150 percent of the average wage rate by employee classification as identified by the commissioner of economic security. The maximum rate must include all charges for administrative fees, contract fees, or other special charges in addition to the hourly rates for the temporary nursing pool personnel supplied to a nursing home.

Sec. 7. [256B.039] [REPORTING OF SUPPLEMENTAL NURSING SERVICES AGENCY USE.]

Beginning March 1, 2002, the commissioner shall to report to the legislature annually on the use of supplemental nursing services, including the number of hours worked by supplemental nursing services agency personnel and payments to supplemental nursing services agencies.

ARTICLE 8

LONG-TERM CARE INSURANCE

Section 1. Minnesota Statutes 2000, section 62A.48, subdivision 4, is amended to read:

Subd. 4. [LOSS RATIO.] The anticipated loss ratio for long-term care policies must not be less than 65 percent for policies issued on a group basis or 60 percent for policies issued on an individual or mass-market basis. This subdivision does not apply to policies issued on or after January 1, 2002, that comply with sections 62S.021 and 62S.081.

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

Sec. 2. Minnesota Statutes 2000, section 62A.48, is amended by adding a subdivision to read:

Subd. 10. [REGULATION OF PREMIUMS AND PREMIUM INCREASES.] Policies issued under sections 62A.46 to 62A.56 on or after January 1, 2002, must comply with sections 62S.021, 62S.081, 62S.265, and 62S.266 to the same extent as policies issued under chapter 62S.

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

Sec. 3. Minnesota Statutes 2000, section 62A.48, is amended by adding a subdivision to read:

Subd. 11. [NONFORFEITURE BENEFITS.] Policies issued under sections 62A.46 to 62A.56 on or after January 1, 2002, must comply with section 62S.02, subdivision 2, to the same extent as policies issued under chapter 62S.

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

Sec. 4. Minnesota Statutes 2000, section 62S.01, is amended by adding a subdivision to read:

Subd. 13a. [EXCEPTIONAL INCREASE.] (a) "Exceptional increase" means only those premium rate increases filed by an insurer as exceptional for which the commissioner determines that the need for the premium rate increase is justified due to changes in laws or rules applicable to long-term care coverage in this state, or due to increased and unexpected utilization that affects the majority of insurers of similar products.

(b) Except as provided in section 62S.265, exceptional increases are subject to the same requirements as other premium rate schedule increases. The commissioner may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase. The commissioner, in determining that the necessary basis for an exceptional increase exists, shall also determine any potential offsets to higher claims costs.

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

Sec. 5. Minnesota Statutes 2000, section 62S.01, is amended by adding a subdivision to read:

Subd. 17a. [INCIDENTAL.] "Incidental," as used in section 62S.265, subdivision 10, means that the value of the long-term care benefits provided is less than ten percent of the total value of the benefits provided over the life of the policy. These values must be measured as of the date of issue.

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

Sec. 6. Minnesota Statutes 2000, section 62S.01, is amended by adding a subdivision to read:

Subd. 23a. [QUALIFIED ACTUARY.] "Qualified actuary" means a member in good standing of the American Academy of Actuaries.

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

Sec. 7. Minnesota Statutes 2000, section 62S.01, is amended by adding a subdivision to read:

Subd. 25a. [SIMILAR POLICY FORMS.] "Similar policy forms" means all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition in section 62S.01, subdivision 15, clause (1), are not considered similar to certificates or policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: institutional long-term care benefits only, noninstitutional long-term care benefits only, or comprehensive long-term care benefits.

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

Sec. 8. [62S.021] [LONG-TERM CARE INSURANCE; INITIAL FILING.]

Subdivision 1. [APPLICABILITY.] This section applies to any long-term care policy issued in this state on or after January 1, 2002, under this chapter or sections 62A.46 to 62A.56.

Subd. 2. [REQUIRED SUBMISSION TO COMMISSIONER.] An insurer shall provide the following information to the commissioner 30 days prior to making a long-term care insurance form available for sale:

(1) a copy of the disclosure documents required in section 62S.081; and

(2) an actuarial certification consisting of at least the following:

(i) a statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;

(ii) a statement that the policy design and coverage provided have been reviewed and taken into consideration;

(iii) a statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration; and

(iv) a complete description of the basis for contract reserves that are anticipated to be held under the form, to include:

(A) sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;

(B) a statement that the assumptions used for reserves contain reasonable margins for adverse experience;

(C) a statement that the net valuation premium for renewal years does not increase, except for attained age rating where permitted;

(D) a statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses, or if such a statement cannot be made, a complete description of the situations in which this does not occur. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship. If the gross premiums for certain age groups appear to be inconsistent with this requirement, the commissioner may request a demonstration under item (i) based on a standard age distribution; and

(E) either a statement that the premium rate schedule is not less than the premium rate schedule

for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits, or a comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.

Subd. 3. [ACTUARIAL DEMONSTRATION.] The commissioner may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration must include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both. If the commissioner asks for additional information under this subdivision, the 30-day time limit in subdivision 2 does not include the time during which the insurer is preparing the requested information.

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

Sec. 9. [62S.081] [REQUIRED DISCLOSURE OF RATING PRACTICES TO CONSUMERS.]

Subdivision 1. [APPLICATION.] This section applies as follows:

(a) Except as provided in paragraph (b), this section applies to any long-term care policy or certificate issued in this state on or after January 1, 2002.

(b) For certificates issued on or after the effective date of this section under a policy of group long-term care insurance as defined in section 62S.01, subdivision 15, that was in force on the effective date of this section, this section applies on the policy anniversary following June 30, 2002.

Subd. 2. [REQUIRED DISCLOSURES.] Other than policies for which no applicable premium rate or rate schedule increases can be made, insurers shall provide all of the information listed in this subdivision to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that time; in this case, an insurer shall provide all of the information listed in this subdivision to the applicant no later than at the time of delivery of the policy or certificate:

(1) a statement that the policy may be subject to rate increases in the future;

(2) an explanation of potential future premium rate revisions and the policyholder's or certificate holder's option in the event of a premium rate revision;

(3) the premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase;

(4) a general explanation of applying premium rate or rate schedule adjustments that must include:

(i) a description of when premium rate or rate schedule adjustments will be effective, for example the next anniversary date or the next billing date; and

(ii) the right to a revised premium rate or rate schedule as provided in clause (3) if the premium rate or rate schedule is changed; and

(5)(i) information regarding each premium rate increase on this policy form or similar policy forms over the past ten years for this state or any other state that, at a minimum, identifies:

(A) the policy forms for which premium rates have been increased;

(B) the calendar years when the form was available for purchase; and

(C) the amount or percent of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics;

(ii) the insurer may, in a fair manner, provide additional explanatory information related to the rate increases;

(iii) an insurer has the right to exclude from the disclosure premium rate increases that apply only to blocks of business acquired from other nonaffiliated insurers or the long-term care policies acquired from other nonaffiliated insurers when those increases occurred prior to the acquisition;

(iv) if an acquiring insurer files for a rate increase on a long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers on or before the later of the effective date of this section, or the end of a 24-month period following the acquisition of the block of policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling company must include the disclosure of that rate increase according to item (i); and

(v) if the acquiring insurer in item (iv) files for a subsequent rate increase, even within the 24-month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers referenced in item (iv), the acquiring insurer shall make all disclosures required by this subdivision, including disclosure of the earlier rate increase referenced in item (iv).

Subd. 3. [ACKNOWLEDGMENT.] An applicant shall sign an acknowledgment at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required under subdivision 2. If, due to the method of application, the applicant cannot sign an acknowledgment at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

Subd. 4. [FORMS.] An insurer shall use the forms in Appendices B and F of the Long-term Care Insurance Model Regulation adopted by the National Association of Insurance Commissioners to comply with the requirements of subdivisions 1 and 2.

Subd. 5. [NOTICE OF INCREASE.] An insurer shall provide notice of an upcoming premium rate schedule increase, after the increase has been approved by the commissioner, to all policyholders or certificate holders, if applicable, at least 45 days prior to the implementation of the premium rate schedule increase by the insurer. The notice must include the information required by subdivision 2 when the rate increase is implemented.

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

Sec. 10. Minnesota Statutes 2000, section 62S.26, is amended to read:

62S.26 [LOSS RATIO.]

(a) The minimum loss ratio must be at least 60 percent, calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, the commissioner shall give consideration to all relevant factors, including:

(1) statistical credibility of incurred claims experience and earned premiums;

(2) the period for which rates are computed to provide coverage;

(3) experienced and projected trends;

(4) concentration of experience within early policy duration;

(5) expected claim fluctuation;

(6) experience refunds, adjustments, or dividends;

(7) renewability features;

(8) all appropriate expense factors;

(9) interest;

(10) experimental nature of the coverage;

(11) policy reserves;

(12) mix of business by risk classification; and

(13) product features such as long elimination periods, high deductibles, and high maximum limits.

(b) This section does not apply to policies or certificates that are subject to sections 62S.021, 62S.081, and 62S.265, and that comply with those sections.

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

Sec. 11. [62S.265] [PREMIUM RATE SCHEDULE INCREASES.]

Subdivision 1. [APPLICABILITY.] (a) Except as provided in paragraph (b), this section applies to any long-term care policy or certificate issued in this state on or after January 1, 2002, under this chapter or sections 62A.46 to 62A.56.

(b) For certificates issued on or after the effective date of this section under a group long-term care insurance policy as defined in section 62S.01, subdivision 15, issued under this chapter, that was in force on the effective date of this section, this section applies on the policy anniversary following June 30, 2002.

Subd. 2. [NOTICE.] An insurer shall file a requested premium rate schedule increase, including an exceptional increase, to the commissioner for prior approval at least 60 days prior to the notice to the policyholders and shall include:

(1) all information required by section 62S.081;

(2) certification by a qualified actuary that:

(i) if the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated; and

(ii) the premium rate filing complies with this section;

(3) an actuarial memorandum justifying the rate schedule change request that includes:

(i) lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale;

(A) annual values for the five years preceding and the three years following the valuation date must be provided separately;

(B) the projections must include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;

(C) the projections must demonstrate compliance with subdivision 3; and

(D) for exceptional increases, the projected experience must be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase and, if the commissioner determines that offsets to higher claim costs may exist, the insurer shall use appropriate net projected experience;

(ii) disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;

(iii) disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied upon by the actuary;

(iv) a statement that policy design, underwriting, and claims adjudication practices have been taken into consideration; and

(v) if it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer shall file composite rates reflecting projections of new certificates;

(4) a statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commissioner; and

(5) sufficient information for review and approval of the premium rate schedule increase by the commissioner.

Subd. 3. [REQUIREMENTS PERTAINING TO RATE INCREASES.] All premium rate schedule increases must be determined according to the following requirements:

(1) exceptional increases must provide that 70 percent of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

(2) premium rate schedule increases must be calculated so that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

(i) the accumulated value of the initial earned premium times 58 percent;

(ii) 85 percent of the accumulated value of prior premium rate schedule increases on an earned basis;

(iii) the present value of future projected initial earned premiums times 58 percent; and

(iv) 85 percent of the present value of future projected premiums not in item (iii) on an earned basis;

(3) if a policy form has both exceptional and other increases, the values in clause (2), items (ii) and (iv), must also include 70 percent for exceptional rate increase amounts; and

(4) all present and accumulated values used to determine rate increases must use the maximum valuation interest rate for contract reserves permitted for valuation of whole life insurance policies issued in this state on the same date. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

Subd. 4. [PROJECTIONS.] For each rate increase that is implemented, the insurer shall file for approval by the commissioner updated projections, as described in subdivision 2, clause (3), item (i), annually for the next three years and include a comparison of actual results to projected values. The commissioner may extend the period to greater than three years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in subdivision 11, the projections required by this subdivision must be provided to the policyholder in lieu of filing with the commissioner.

Subd. 5. [LIFETIME PROJECTIONS.] If any premium rate in the revised premium rate schedule is greater than 200 percent of the comparable rate in the initial premium schedule, lifetime projections, as described in subdivision 2, clause (3), item (i), must be filed for approval by the commissioner every five years following the end of the required period in subdivision 4. For group insurance policies that meet the conditions in subdivision 11, the projections required by this subdivision must be provided to the policyholder in lieu of filing with the commissioner.

Subd. 6. [EFFECT OF ACTUAL EXPERIENCE.] (a) If the commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in subdivision 3, the commissioner may require the insurer to implement any of the following:

(1) premium rate schedule adjustments; or

(2) other measures to reduce the difference between the projected and actual experience.

(b) In determining whether the actual experience adequately matches the projected experience, consideration must be given to subdivision 2, clause (3), item (v), if applicable.

Subd. 7. [CONTINGENT BENEFIT UPON LAPSE.] If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:

(1) a plan, subject to commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or a demonstration that appropriate administration and claims processing have been implemented or are in effect; otherwise, the commissioner may impose the condition in subdivision 8, paragraph (b); and

(2) the original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to subdivision 3 had the greater of the original anticipated lifetime loss ratio or 58 percent been used in the calculations described in subdivision 3, clause (2), items (i) and (iii).

Subd. 8. [PROJECTED LAPSE RATES.] (a) For a rate increase filing that meets the following criteria, the commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the 12 months following each increase to determine if significant adverse lapsation has occurred or is anticipated:

(1) the rate increase is not the first rate increase requested for the specific policy form or forms;

(2) the rate increase is not an exceptional increase; and

(3) the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

(b) If significant adverse lapsation has occurred, is anticipated in the filing, or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the commissioner may determine that a rate spiral exists. Following the determination that a rate spiral exists, the commissioner may require the insurer to offer, without underwriting, to all in-force insureds subject to the rate increase, the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates. The offer must:

(1) be subject to the approval of the commissioner;

(2) be based upon actuarially sound principles, but not be based upon attained age; and

(3) provide that maximum benefits under any new policy accepted by an insured are reduced by comparable benefits already paid under the existing policy.

(c) The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase must be limited to the lesser of the maximum rate increase determined based on the combined experience and the maximum rate increase determined based only upon the experience of the insureds originally issued the form plus ten percent.

Subd. 9. [PERSISTENT PRACTICE OF INADEQUATE INITIAL RATES.] If the

commissioner determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the commissioner may, in addition to the provisions of subdivision 8, prohibit the insurer from either of the following:

(1) filing and marketing comparable coverage for a period of up to five years; or

(2) offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

Subd. 10. [INCIDENTAL LONG-TERM CARE BENEFITS.] Subdivisions 1 to 9 do not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in section 62S.01, subdivision 17a, if the policy complies with all of the following provisions:

(1) the interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

(2) the portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following:

(i) for life insurance, section 61A.25;

(ii) for individual deferred annuities, section 61A.245; and

(iii) for variable annuities, section 61A.21;

(3) the policy meets the disclosure requirements of sections 62S.10 and 62S.11 if the policy is governed by chapter 62S and of section 62A.50 if the policy is governed by sections 62A.46 to 62A.56;

(4) the portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements as applicable in the following:

(i) policy illustrations to the extent required by state law applicable to life insurance;

(ii) disclosure requirements in state law applicable to annuities; and

(iii) disclosure requirements applicable to variable annuities; and

(5) an actuarial memorandum is filed with the commissioner that includes:

(i) a description of the basis on which the long-term care rates were determined;

(ii) a description of the basis for the reserves;

(iii) a summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(iv) a description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

(v) a description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(vi) the estimated average annual premium per policy and the average issue age;

(vii) a statement as to whether underwriting is performed at the time of application. The statement must indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement must indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(viii) a description of the effect of the long-term care policy provision on the required

premiums, nonforfeiture values, and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

Subd. 11. [LARGE GROUP POLICIES.] Subdivisions 6 and 9 do not apply to group long-term care insurance policies as defined in section 62S.01, subdivision 15, where:

(1) the policies insure 250 or more persons, and the policyholder has 5,000 or more eligible employees of a single employer; or

(2) the policyholder, and not the certificate holders, pays a material portion of the premium, which is not less than 20 percent of the total premium for the group in the calendar year prior to the year in which a rate increase is filed.

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

Sec. 12. [62S.266] [NONFORFEITURE BENEFIT REQUIREMENT.]

Subdivision 1. [APPLICABILITY.] This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

Subd. 2. [REQUIREMENT.] An insurer must offer each prospective policyholder a nonforfeiture benefit in compliance with the following requirements:

(1) a policy or certificate offered with nonforfeiture benefits must have coverage elements, eligibility, benefit triggers, and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer must be the benefit described in subdivision 5; and

(2) the offer must be in writing if the nonforfeiture benefit is not otherwise described in the outline of coverage or other materials given to the prospective policyholder.

Subd. 3. [EFFECT OF REJECTION OF OFFER.] If the offer required to be made under subdivision 2 is rejected, the insurer shall provide the contingent benefit upon lapse described in this section.

Subd. 4. [CONTINGENT BENEFIT UPON LAPSE.] (a) After rejection of the offer required under subdivision 2, for individual and group policies without nonforfeiture benefits issued after the effective date of this section, the insurer shall provide a contingent benefit upon lapse.

(b) If a group policyholder elects to make the nonforfeiture benefit an option to the certificate holder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

(c) The contingent benefit on lapse must be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium based on the insured's issue age provided in this paragraph, and the policy or certificate lapses within 120 days of the due date of the premium increase. Unless otherwise required, policyholders shall be notified at least 30 days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase

| Issue Age | Percent Increase Over Initial Premium |
|---|---|
| 29 and Under | 200 |
| 30-34 | 190 |
| 35-39 | 170 |
| 40-44 | 150 |
| 45-49 | 130 |
| 50-54 | 110 |
| 55-59 | 90 |

| | |
|---|---|
| 60 | 70 |
| 61 | 66 |
| 62 | 62 |
| 63 | 58 |
| 64 | 54 |
| 65 | 50 |
| 66 | 48 |
| 67 | 46 |
| 68 | 44 |
| 69 | 42 |
| 70 | 40 |
| 71 | 38 |
| 72 | 36 |
| 73 | 34 |
| 74 | 32 |
| 75 | 30 |
| 76 | 28 |
| 77 | 26 |
| 78 | 24 |
| 79 | 22 |
| 80 | 20 |
| 81 | 19 |
| 82 | 18 |
| 83 | 17 |
| 84 | 16 |
| 85 | 15 |
| 86 | 14 |
| 87 | 13 |
| 88 | 12 |
| 89 | 11 |
| 90 and over | 10 |

(d) On or before the effective date of a substantial premium increase as defined in paragraph (c), the insurer shall:

(1) offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(2) offer to convert the coverage to a paid-up status with a shortened benefit period according to the terms of subdivision 5. This option may be elected at any time during the 120-day period referenced in paragraph (c); and

(3) notify the policyholder or certificate holder that a default or lapse at any time during the 120-day period referenced in paragraph (c) is deemed to be the election of the offer to convert in clause (2).

Subd. 5. [NONFORFEITURE BENEFITS; REQUIREMENTS.] (a) Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse, must be as described in this subdivision.

(b) For purposes of this subdivision, "attained age rating" is defined as a schedule of premiums starting from the issue date which increases with age at least one percent per year prior to age 50, and at least three percent per year beyond age 50.

(c) For purposes of this subdivision, the nonforfeiture benefit must be of a shortened benefit period providing paid-up, long-term care insurance coverage after lapse. The same benefits, amounts, and frequency in effect at the time of lapse, but not increased thereafter, will be payable

for a qualifying claim, but the lifetime maximum dollars or days of benefits must be determined as specified in paragraph (d).

(d) The standard nonforfeiture credit will be equal to 100 percent of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, so long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit must not be less than 30 times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of this subdivision.

(e) The nonforfeiture benefit must begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse must be effective during the first three years as well as thereafter.

(f) Notwithstanding paragraph (e), for a policy or certificate with attained age rating, the nonforfeiture benefit must begin on the earlier of:

(1) the end of the tenth year following the policy or certificate issue date; or

(2) the end of the second year following the date the policy or certificate is no longer subject to attained age rating.

(g) Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

Subd. 6. [BENEFIT LIMIT.] All benefits paid by the insurer while the policy or certificate is in premium-paying status and in the paid-up status will not exceed the maximum benefits which would be payable if the policy or certificate had remained in premium-paying status.

Subd. 7. [MINIMUM BENEFITS; INDIVIDUAL AND GROUP POLICIES.] There must be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.

Subd. 8. [APPLICATION; EFFECTIVE DATES.] This section becomes effective January 1, 2002, and applies as follows:

(a) Except as provided in paragraph (b), this section applies to any long-term care policy issued in this state on or after the effective date of this section.

(b) For certificates issued on or after the effective date of this section, under a group long-term care insurance policy that was in force on the effective date of this section, the provisions of this section do not apply.

Subd. 9. [EFFECT ON LOSS RATIO.] Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse are subject to the loss ratio requirements of section 62A.48, subdivision 4, or 62S.26, treating the policy as a whole, except for policies or certificates that are subject to sections 62S.021, 62S.081, and 62S.265 and that comply with those sections.

Subd. 10. [PURCHASED BLOCKS OF BUSINESS.] To determine whether contingent nonforfeiture upon lapse provisions are triggered under subdivision 4, paragraph (c), a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

Subd. 11. [LEVEL PREMIUM CONTRACTS.] A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts must be offered that meets the following requirements:

(1) the nonforfeiture provision must be appropriately captioned;

(2) the nonforfeiture provision must provide a benefit available in the event of a default in the

payment of any premiums and must state that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying contracts approved by the commissioner for the same contract form; and

(3) the nonforfeiture provision must provide at least one of the following:

(i) reduced paid-up insurance;

(ii) extended term insurance;

(iii) shortened benefit period; or

(iv) other similar offerings approved by the commissioner.

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

Sec. 13. Minnesota Statutes 2000, section 256.975, is amended by adding a subdivision to read:

Subd. 8. [PROMOTION OF LONG-TERM CARE INSURANCE.] The Minnesota board on aging, either directly or through contract, shall promote the provision of employer-sponsored, long-term care insurance. The board shall encourage private and public sector employers to make long-term care insurance available to employees, provide interested employers with information on the long-term care insurance product offered to state employees, and provide technical assistance to employers in designing long-term care insurance products and contacting companies offering long-term care insurance products.

ARTICLE 9

MENTAL HEALTH AND CIVIL COMMITMENT

Section 1. [62Q.471] [EXCLUSION FOR SUICIDE ATTEMPTS PROHIBITED.]

(a) No health plan may exclude or reduce coverage for health care for an enrollee that is otherwise covered under the health plan, on the basis that the need for the health care arose out of a suicide or suicide attempt by the enrollee.

(b) For purposes of this section, "health plan" has the meaning given in section 62Q.01, subdivision 3, but includes the coverages described in section 62A.011, clauses (7) and (10).

**[EFFECTIVE DATE.]** This section is effective January 1, 2002, and applies to contracts issued or renewed on or after that date.

Sec. 2. [62Q.527] [COVERAGE OF NONFORMULARY DRUGS FOR MENTAL ILLNESS AND EMOTIONAL DISTURBANCE.]

Subdivision 1. [DEFINITIONS.] (a) For purposes of this section, the following terms have the meanings given to them.

(b) "Emotional disturbance" has the meaning given in section 245.4871, subdivision 15.

(c) "Mental illness" has the meaning given in section 245.462, subdivision 20, paragraph (a).

(d) "Health plan" has the meaning given in section 62Q.01, subdivision 3, but includes the coverages described in clauses (7) and (10).

Subd. 2. [REQUIRED COVERAGE.] A health plan that provides prescription drug coverage must provide coverage for an antipsychotic drug prescribed to treat emotional disturbance or mental illness regardless of whether the drug is in the health plan’s drug formulary, if the health care provider prescribing the drug:

(1) indicates to the dispensing pharmacist, orally or in writing according to section 151.21, that the prescription must be dispensed as communicated; and

(2) certifies in writing to the health plan company that the drug prescribed will best treat the patient's condition. The health plan is not required to provide coverage for the drug if the drug was removed from the formulary for safety reasons. For drugs covered under this section, no health plan company, which has received the certification from the health care provider, may:

(i) impose a special deductible, copayment, coinsurance, or other special payment requirement that the health plan does not apply to drugs that are in the health plan's drug formulary; or

(ii) require written certification from the prescribing provider each time a prescription is refilled or renewed that the drug prescribed will best treat the patient's condition.

Subd. 3. [CONTINUING CARE.] Enrollees receiving a prescribed drug to treat a diagnosed mental illness or emotional disturbance, may continue to receive the prescribed drug without the imposition of a special deductible, copayment, coinsurance, or other special payment requirements, when a health plan's drug formulary changes or an enrollee changes health plans and the medication has been shown to effectively treat the patient's condition. In order to be eligible for this continuing care benefit:

(1) the patient must have been treated with the drug for 90 days prior to a change in a health plan's drug formulary or a change in the enrollee's health plan;

(2) the health care provider prescribing the drug indicates to the dispensing pharmacist, orally or in writing according to section 151.21, that the prescription must be dispensed as communicated; and

(3) annually certifies in writing to the health plan company that the drug prescribed will best treat the patient's condition. The health plan is not required to provide coverage for the drug if the drug was removed from the formulary for safety reasons.

Subd. 4. [EXCEPTION TO FORMULARY.] A health plan company shall promptly grant an exception to the formulary when the health care provider prescribing the drug conveys to the health plan that:

(1) the formulary drug causes an adverse reaction;

(2) the formulary drug is contraindicated; or

(3) the prescriber demonstrates to the health plan that a prescription drug must be dispensed as written to provide maximum medical benefit to the patient.

**[EFFECTIVE DATE.]** This section is effective July 1, 2001, and applies to contracts issued or renewed on or after that date.

Sec. 3. [62Q.535] [COVERAGE FOR COURT-ORDERED MENTAL HEALTH SERVICES.]

Subdivision 1. [MENTAL HEALTH SERVICES.] For purposes of this section, mental health services means all covered services that are intended to treat or ameliorate an emotional, behavioral, or psychiatric condition and that are covered by the policy, contract, or certificate of coverage of the enrollee's health plan company or by law.

Subd. 2. [COVERAGE REQUIRED.] All health plan companies that provide coverage for mental health services must cover or provide mental health services ordered by a court of competent jurisdiction under a court order that is issued on the basis of a behavioral care evaluation performed by a licensed psychiatrist or a doctoral level licensed psychologist, which includes a diagnosis and an individual treatment plan for care in the most appropriate, least restrictive environment. The health plan company must be given a copy of the court order and the behavioral care evaluation. The health plan company shall be financially liable for the evaluation if performed by a participating provider of the health plan company and shall be financially liable for the care included in the court-ordered individual treatment plan if the care is covered by the health plan and ordered to be provided by a participating provider or another provider as required by rule or law. This court-ordered coverage must not be subject to a separate medical necessity determination by a health plan company under its utilization procedures.

**[EFFECTIVE DATE.]** This section is effective July 1, 2001, and applies to contracts issued or renewed on or after that date.

Sec. 4. [244.054] [DISCHARGE PLANS; OFFENDERS WITH SERIOUS AND PERSISTENT MENTAL ILLNESS.]

Subdivision 1. [OFFER TO DEVELOP PLAN.] The commissioner of human services, in collaboration with the commissioner of corrections, shall offer to develop a discharge plan for community-based services for every offender with serious and persistent mental illness, as defined in section 245.462, subdivision 20, paragraph (c), who is being released from a correctional facility. If an offender is being released pursuant to section 244.05, the offender may choose to have the discharge plan made one of the conditions of the offender's supervised release and shall follow the conditions to the extent that services are available and offered to the offender.

Subd. 2. [CONTENT OF PLAN.] If an offender chooses to have a discharge plan developed, the commissioner of human services shall develop and implement a discharge plan, which must include at least the following:

(1) at least 90 days before the offender is due to be discharged, the commissioner of human services shall designate an agent of the department of human services with mental health training to serve as the primary person responsible for carrying out discharge planning activities;

(2) at least 75 days before the offender is due to be discharged, the offender's designated agent shall:

(i) obtain informed consent and releases of information from the offender that are needed for transition services;

(ii) contact the county human services department in the community where the offender expects to reside following discharge, and inform the department of the offender's impending discharge and the planned date of the offender's return to the community; determine whether the county or a designated contracted provider will provide case management services to the offender; refer the offender to the case management services provider; and confirm that the case management services provider will have opened the offender's case prior to the offender's discharge; and

(iii) refer the offender to appropriate staff in the county human services department in the community where the offender expects to reside following discharge, for enrollment of the offender if eligible in medical assistance or general assistance medical care, using special procedures established by process and department of human services bulletin;

(3) at least 2-1/2 months before discharge, the offender's designated agent shall secure timely appointments for the offender with a psychiatrist no later than 30 days following discharge, and with other program staff at a community mental health provider that is able to serve former offenders with serious and persistent mental illness;

(4) at least 30 days before discharge, the offender's designated agent shall convene a predischarge assessment and planning meeting of key staff from the programs in which the offender has participated while in the correctional facility, the offender, and the supervising agent assigned to the offender. At the meeting, attendees shall provide background information and continuing care recommendations for the offender, including information on the offender's risk for relapse; current medications, including dosage and frequency; therapy and behavioral goals; diagnostic and assessment information, including results of a chemical dependency evaluation; confirmation of appointments with a psychiatrist and other program staff in the community; a relapse prevention plan; continuing care needs; needs for housing, employment, and finance support and assistance; and recommendations for successful community integration, including chemical dependency treatment or support if chemical dependency is a risk factor. Immediately following this meeting, the offender's designated agent shall summarize this background information and continuing care recommendations in a written report;

(5) immediately following the predischarge assessment and planning meeting, the provider of mental health case management services who will serve the offender following discharge shall

offer to make arrangements and referrals for housing, financial support, benefits assistance, employment counseling, and other services required in sections 245.461 to 245.486;

(6) at least ten days before the offender's first scheduled postdischarge appointment with a mental health provider, the offender's designated agent shall transfer the following records to the offender's case management services provider and psychiatrist: the predischarge assessment and planning report, medical records, and pharmacy records. These records may be transferred only if the offender provides informed consent for their release;

(7) upon discharge, the offender's designated agent shall ensure that the offender leaves the correctional facility with at least a ten-day supply of all necessary medications; and

(8) upon discharge, the prescribing authority at the offender's correctional facility shall telephone in prescriptions for all necessary medications to a pharmacy in the community where the offender plans to reside. The prescriptions must provide at least a 30-day supply of all necessary medications, and must be able to be refilled once for one additional 30-day supply.

Sec. 5. [244.25] [TRANSITIONAL SERVICES FOR MENTALLY ILL OFFENDERS RELEASED FROM PRISON; PILOT PROGRAM.]

The commissioner of corrections, in collaboration with the commissioner of human services, shall establish a pilot project grant program with goals and evaluation criteria and make grants to provide startup funding for two counties or two groups of counties to provide transitional housing and other community support services for former state inmates who have been diagnosed with a serious mental illness and who have been discharged from prison. Grant applicants must submit a proposed comprehensive plan for providing the housing and support services and evaluating the provision of services, and must provide a 25 percent funding match. The commissioner shall make grants available to successful applicants by February 1, 2002. Grant recipients are eligible for funding under this section for the first three years of operation of their programs for housing and support services.

Sec. 6. Minnesota Statutes 2000, section 245.462, is amended by adding a subdivision to read:

Subd. 7a. [CRISIS INTERVENTION SERVICES.] Crisis intervention services are short-term, intensive, nonresidential mental health services that include assessment, mental health rehabilitative services, and a crisis disposition plan. Crisis intervention services are intended to help the recipient return to a baseline level of functioning or prevent further harmful consequences due to the psychiatric symptoms.

Sec. 7. Minnesota Statutes 2000, section 245.462, is amended by adding a subdivision to read:

Subd. 7b. [CRISIS STABILIZATION SERVICES.] "Crisis stabilization services" is defined in section 256B.0624, subdivision 2, paragraph (e).

Sec. 8. Minnesota Statutes 2000, section 245.462, is amended by adding a subdivision to read:

Subd. 14a. [MENTAL HEALTH CRISIS.] "Mental health crisis" is defined in section 256B.0624, subdivision 2, paragraph (a).

Sec. 9. Minnesota Statutes 2000, section 245.462, is amended by adding a subdivision to read:

Subd. 14b. [MENTAL HEALTH EMERGENCY.] "Mental health emergency" is defined in section 256B.0624, subdivision 2, paragraph (b).

Sec. 10. Minnesota Statutes 2000, section 245.462, is amended by adding a subdivision to read:

Subd. 14c. [MENTAL HEALTH CRISIS SERVICES.] "Mental health crisis services" means crisis assessment, crisis intervention, and crisis stabilization services.

Sec. 11. Minnesota Statutes 2000, section 245.462, subdivision 18, is amended to read:

Subd. 18. [MENTAL HEALTH PROFESSIONAL.] "Mental health professional" means a

person providing clinical services in the treatment of mental illness who is qualified in at least one of the following ways:

(1) in psychiatric nursing: a registered nurse who is licensed under sections 148.171 to 148.285, and who is certified as a clinical specialist in adult psychiatric and mental health nursing by a national nurse certification organization or who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;

(2) in clinical social work: a person licensed as an independent clinical social worker under section 148B.21, subdivision 6, or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;

(3) in psychology: ~~a psychologist~~ an individual licensed by the board of psychology under sections 148.88 to 148.98 who has stated to the board of psychology competencies in the diagnosis and treatment of mental illness;

(4) in psychiatry: a physician licensed under chapter 147 and certified by the American board of psychiatry and neurology or eligible for board certification in psychiatry;

(5) in marriage and family therapy: the mental health professional must be a marriage and family therapist licensed under sections 148B.29 to 148B.39 with at least two years of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness; or

(6) in allied fields: a person with a master's degree from an accredited college or university in one of the behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness.

Sec. 12. Minnesota Statutes 2000, section 245.466, subdivision 2, is amended to read:

Subd. 2. [ADULT MENTAL HEALTH SERVICES.] The adult mental health service system developed by each county board must include the following services:

(1) education and prevention services in accordance with section 245.468;

(2) emergency services in accordance with section 245.469;

(3) outpatient services in accordance with section 245.470;

(4) community support program services in accordance with section 245.4711;

(5) residential treatment services in accordance with section 245.472;

(6) acute care hospital inpatient treatment services in accordance with section 245.473;

(7) regional treatment center inpatient services in accordance with section 245.474;

(8) screening in accordance with section 245.476; ~~and~~

(9) case management in accordance with sections 245.462, subdivision 3; and 245.4711; and

(10) mental health crisis services in accordance with section 245.470, subdivision 3.

Sec. 13. Minnesota Statutes 2000, section 245.470, is amended by adding a subdivision to read:

Subd. 3. [MENTAL HEALTH CRISIS SERVICES.] County boards must provide or contract for enough mental health crisis services within the county to meet the needs of adults with mental illness residing in the county who are determined, through an assessment by a mental health professional, to be experiencing a mental health crisis or mental health emergency. The mental health crisis services provided must be medically necessary, as defined in section 62Q.53,

subdivision 2, and appropriate or socially necessary for the safety of the adult or others regardless of the setting.

Sec. 14. Minnesota Statutes 2000, section 245.474, subdivision 2, is amended to read:

Subd. 2. [QUALITY OF SERVICE.] The commissioner shall biennially determine the needs of all adults with mental illness who are served by regional treatment centers or at any state facility or program as defined in section 246.50, subdivision 3, by administering a client-based evaluation system. The client-based evaluation system must include at least the following independent measurements: behavioral development assessment; habilitation program assessment; medical needs assessment; maladaptive behavioral assessment; and vocational behavior assessment. The commissioner shall ~~propose~~ by rule establish staff ratios ~~to the legislature~~ for the mental health and support units in regional treatment centers as indicated by the results of the client-based evaluation system and the types of state-operated services needed. The ~~proposed~~ staffing ratios shall include professional, nursing, direct care, medical, clerical, and support staff based on the client-based evaluation system. The commissioner shall recompute staffing ratios and ~~recommendations~~ amend rules on staff ratios as necessary on a biennial basis.

Sec. 15. Minnesota Statutes 2000, section 245.474, is amended by adding a subdivision to read:

Subd. 4. [STAFF SAFETY TRAINING.] The commissioner shall by rule require all staff in mental health and support units at regional treatment centers who have contact with persons with mental illness or severe emotional disturbance to be appropriately trained in violence reduction and violence prevention, and shall establish criteria for such training. Training programs shall be developed with input from consumer advocacy organizations, and shall employ violence prevention techniques as preferable to physical interaction.

Sec. 16. Minnesota Statutes 2000, section 245.4871, is amended by adding a subdivision to read:

Subd. 9b. [CRISIS INTERVENTION SERVICES.] Crisis intervention services are short-term, intensive, nonresidential mental health services that include assessment, mental health rehabilitative services, and a crisis disposition plan. Crisis intervention services are intended to help the recipient return to a baseline level of functioning or prevent further harmful consequences due to the psychiatric symptoms.

Sec. 17. Minnesota Statutes 2000, section 245.4871, is amended by adding a subdivision to read:

Subd. 9c. [CRISIS STABILIZATION SERVICES.] "Crisis stabilization services" is defined in section 256B.0624, subdivision 2, paragraph (e).

Sec. 18. Minnesota Statutes 2000, section 245.4871, is amended by adding a subdivision to read:

Subd. 24a. [MENTAL HEALTH CRISIS.] "Mental health crisis" is defined in section 256B.0624, subdivision 2, paragraph (a).

Sec. 19. Minnesota Statutes 2000, section 245.4871, is amended by adding a subdivision to read:

Subd. 24b. [MENTAL HEALTH EMERGENCY.] "Mental health emergency" is defined in section 256B.0624, subdivision 2, paragraph (b).

Sec. 20. Minnesota Statutes 2000, section 245.4871, is amended by adding a subdivision to read:

Subd. 24c. [MENTAL HEALTH CRISIS SERVICES.] "Mental health crisis services" means crisis assessment, crisis intervention, and crisis stabilization services.

Sec. 21. Minnesota Statutes 2000, section 245.4871, subdivision 27, is amended to read:

Subd. 27. [MENTAL HEALTH PROFESSIONAL.] "Mental health professional" means a person providing clinical services in the diagnosis and treatment of children's emotional disorders. A mental health professional must have training and experience in working with children consistent with the age group to which the mental health professional is assigned. A mental health professional must be qualified in at least one of the following ways:

(1) in psychiatric nursing, the mental health professional must be a registered nurse who is licensed under sections 148.171 to 148.285 and who is certified as a clinical specialist in child and adolescent psychiatric or mental health nursing by a national nurse certification organization or who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;

(2) in clinical social work, the mental health professional must be a person licensed as an independent clinical social worker under section 148B.21, subdivision 6, or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental disorders;

(3) in psychology, the mental health professional must be ~~a psychologist~~ an individual licensed by the board of psychology under sections 148.88 to 148.98 who has stated to the board of psychology competencies in the diagnosis and treatment of mental disorders;

(4) in psychiatry, the mental health professional must be a physician licensed under chapter 147 and certified by the American board of psychiatry and neurology or eligible for board certification in psychiatry;

(5) in marriage and family therapy, the mental health professional must be a marriage and family therapist licensed under sections 148B.29 to 148B.39 with at least two years of post-master's supervised experience in the delivery of clinical services in the treatment of mental disorders or emotional disturbances; or

(6) in allied fields, the mental health professional must be a person with a master's degree from an accredited college or university in one of the behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of emotional disturbances.

Sec. 22. Minnesota Statutes 2000, section 245.4875, subdivision 2, is amended to read:

Subd. 2. [CHILDREN'S MENTAL HEALTH SERVICES.] The children's mental health service system developed by each county board must include the following services:

(1) education and prevention services according to section 245.4877;

(2) mental health identification and intervention services according to section 245.4878;

(3) emergency services according to section 245.4879;

(4) outpatient services according to section 245.488;

(5) family community support services according to section 245.4881;

(6) day treatment services according to section 245.4884, subdivision 2;

(7) residential treatment services according to section 245.4882;

(8) acute care hospital inpatient treatment services according to section 245.4883;

(9) screening according to section 245.4885;

(10) case management according to section 245.4881;

(11) therapeutic support of foster care according to section 245.4884, subdivision 4; ~~and~~

(12) professional home-based family treatment according to section 245.4884, subdivision 4; and

(13) mental health crisis services according to section 245.488, subdivision 3.

Sec. 23. Minnesota Statutes 2000, section 245.4876, subdivision 1, is amended to read:

Subdivision 1. [CRITERIA.] Children's mental health services required by sections 245.487 to 245.4888 must be:

(1) based, when feasible, on research findings;

(2) based on individual clinical, cultural, and ethnic needs, and other special needs of the children being served;

(3) delivered in a manner that improves family functioning when clinically appropriate;

(4) provided in the most appropriate, least restrictive setting that meets the requirements in subdivision 1a, and that is available to the county board to meet the child's treatment needs;

(5) accessible to all age groups of children;

(6) appropriate to the developmental age of the child being served;

(7) delivered in a manner that provides accountability to the child for the quality of service delivered and continuity of services to the child during the years the child needs services from the local system of care;

(8) provided by qualified individuals as required in sections 245.487 to 245.4888;

(9) coordinated with children's mental health services offered by other providers;

(10) provided under conditions that protect the rights and dignity of the individuals being served; and

(11) provided in a manner and setting most likely to facilitate progress toward treatment goals.

Sec. 24. Minnesota Statutes 2000, section 245.4876, is amended by adding a subdivision to read:

Subd. 1a. [APPROPRIATE SETTING TO RECEIVE SERVICES.] A child must be provided with mental health services in the least restrictive setting that is appropriate to the needs and current condition of the individual child. For a child to receive mental health services in a residential treatment or acute care hospital inpatient setting, the family may not be required to demonstrate that services were first provided in a less restrictive setting and that the child failed to make progress toward or meet treatment goals in the less restrictive setting.

Sec. 25. Minnesota Statutes 2000, section 245.488, is amended by adding a subdivision to read:

Subd. 3. [MENTAL HEALTH CRISIS SERVICES.] County boards must provide or contract for mental health crisis services within the county to meet the needs of children with emotional disturbance residing in the county who are determined, through an assessment by a mental health professional, to be experiencing a mental health crisis or mental health emergency. The mental health crisis services provided must be medically necessary, as defined in section 62Q.53, subdivision 2, and necessary for the safety of the child or others regardless of the setting.

Sec. 26. Minnesota Statutes 2000, section 245.4885, subdivision 1, is amended to read:

Subdivision 1. [SCREENING REQUIRED.] The county board shall, prior to admission, except in the case of emergency admission, screen all children referred for treatment of severe emotional disturbance to a residential treatment facility or informally admitted to a regional treatment center

if public funds are used to pay for the services. The county board shall also screen all children admitted to an acute care hospital for treatment of severe emotional disturbance if public funds other than reimbursement under chapters 256B and 256D are used to pay for the services. If a child is admitted to a residential treatment facility or acute care hospital for emergency treatment or held for emergency care by a regional treatment center under section 253B.05, subdivision 1, screening must occur within three working days of admission. Screening shall determine whether the proposed treatment:

(1) is necessary;

(2) is appropriate to the child's individual treatment needs;

(3) cannot be effectively provided in the child's home; and

(4) provides a length of stay as short as possible consistent with the individual child's need.

When a screening is conducted, the county board may not determine that referral or admission to a residential treatment facility or acute care hospital is not appropriate solely because services were not first provided to the child in a less restrictive setting and the child failed to make progress toward or meet treatment goals in the less restrictive setting. Screening shall include both a diagnostic assessment and a functional assessment which evaluates family, school, and community living situations. If a diagnostic assessment or functional assessment has been completed by a mental health professional within 180 days, a new diagnostic or functional assessment need not be completed unless in the opinion of the current treating mental health professional the child's mental health status has changed markedly since the assessment was completed. The child's parent shall be notified if an assessment will not be completed and of the reasons. A copy of the notice shall be placed in the child's file. Recommendations developed as part of the screening process shall include specific community services needed by the child and, if appropriate, the child's family, and shall indicate whether or not these services are available and accessible to the child and family.

During the screening process, the child, child's family, or child's legal representative, as appropriate, must be informed of the child's eligibility for case management services and family community support services and that an individual family community support plan is being developed by the case manager, if assigned.

Screening shall be in compliance with section 256F.07 or 260C.212, whichever applies. Wherever possible, the parent shall be consulted in the screening process, unless clinically inappropriate.

The screening process, and placement decision, and recommendations for mental health services must be documented in the child's record.

An alternate review process may be approved by the commissioner if the county board demonstrates that an alternate review process has been established by the county board and the times of review, persons responsible for the review, and review criteria are comparable to the standards in clauses (1) to (4).

Sec. 27. Minnesota Statutes 2000, section 245.4886, subdivision 1, is amended to read:

Subdivision 1. [STATEWIDE PROGRAM; ESTABLISHMENT.] The commissioner shall establish a statewide program to assist counties in providing services to children with severe emotional disturbance as defined in section 245.4871, subdivision 15, and their families; and to young adults meeting the criteria for transition services in section 245.4875, subdivision 8, and their families. Services must be designed to help each child to function and remain with the child's family in the community. Transition services to eligible young adults must be designed to foster independent living in the community. The commissioner shall make grants to counties to establish, operate, or contract with private providers to provide the following services in the following order of priority when these cannot be reimbursed under section 256B.0625:

(1) family community support services including crisis placement and crisis respite care as specified in section 245.4871, subdivision 17;

(2) case management services as specified in section 245.4871, subdivision 3;

(3) day treatment services as specified in section 245.4871, subdivision 10;

(4) professional home-based family treatment as specified in section 245.4871, subdivision 31; and

(5) therapeutic support of foster care as specified in section 245.4871, subdivision 34.

Funding appropriated beginning July 1, 1991, must be used by county boards to provide family community support services and case management services. Additional services shall be provided in the order of priority as identified in this subdivision.

Sec. 28. Minnesota Statutes 2000, section 245.99, subdivision 4, is amended to read:

Subd. 4. [ADMINISTRATION OF CRISIS HOUSING ASSISTANCE.] The commissioner may contract with organizations or government units experienced in housing assistance to operate the program under this section. This program is not an entitlement. The commissioner may take any of the following steps whenever the commissioner projects that funds will be inadequate to meet demand in a given fiscal year:

(1) transfer funds from mental health grants in the same appropriation; and

(2) impose statewide restrictions as to the type and amount of assistance available to each recipient under this program, including reducing the income eligibility level, limiting reimbursement to a percentage of each recipient's costs, limiting housing assistance to 60 days per recipient, or closing the program for the remainder of the fiscal year.

Sec. 29. Minnesota Statutes 2000, section 253.28, is amended by adding a subdivision to read:

Subd. 1a. [STATE-OPERATED SERVICES AUTHORIZATION.] According to section 246.0136, the commissioner of human services is authorized to implement, as an enterprise activity, state-operated adult mental health services developed for the purposes of preventing inpatient hospitalization or facilitating the transition from hospital to community placement, that qualify under the standards for adult mental health rehabilitative services in section 256B.0623 and adult mental health crisis response services in section 256B.0624, once those options are incorporated as part of the approved state medical assistance plan.

Sec. 30. Minnesota Statutes 2000, section 253B.02, subdivision 10, is amended to read:

Subd. 10. [INTERESTED PERSON.] "Interested person" means:

(1) an adult, including but not limited to, a public official, including a local welfare agency acting under section 626.5561, and the legal guardian, spouse, parent, legal counsel, adult child, next of kin, or other person designated by a proposed patient; or

(2) a health plan company.

Sec. 31. Minnesota Statutes 2000, section 253B.03, subdivision 5, is amended to read:

Subd. 5. [PERIODIC ASSESSMENT.] A patient has the right to periodic medical assessment, including assessment of the medical necessity of continuing care and, if the treatment facility declines to provide continuing care, the right to receive specific written reasons why continuing care is declined at the time of the assessment. The treatment facility shall assess the physical and mental condition of every patient as frequently as necessary, but not less often than annually. If the patient refuses to be examined, the facility shall document in the patient's chart its attempts to examine the patient. If a person is committed as mentally retarded for an indeterminate period of time, the three-year judicial review must include the annual reviews for each year as outlined in Minnesota Rules, part 9525.0075, subpart 6.

Sec. 32. Minnesota Statutes 2000, section 253B.03, subdivision 10, is amended to read:

Subd. 10. [NOTIFICATION.] All persons admitted or committed to a treatment facility shall be notified in writing of their rights ~~under this chapter~~ regarding hospitalization and other treatment at the time of admission. This notification must include:

(1) patient rights specified in this section and section 144.651, including nursing home discharge rights;

(2) the right to obtain treatment and services voluntarily under this chapter;

(3) the right to voluntary admission and release under section 253B.04;

(4) rights in case of an emergency admission under section 253B.05, including the right to documentation in support of an emergency hold and the right to a summary hearing before a judge if the patient believes an emergency hold is improper;

(5) the right to request expedited review under section 62M.05 if additional days of inpatient stay are denied;

(6) the right to continuing benefits pending appeal and to an expedited administrative hearing under section 256.045 if the patient is a recipient of medical assistance, general assistance medical care, or MinnesotaCare; and

(7) the right to an external appeal process under section 62Q.73, including the right to a second opinion.

Sec. 33. Minnesota Statutes 2000, section 253B.03, is amended by adding a subdivision to read:

Subd. 11. [PROXY.] A legally authorized health care proxy, agent, guardian, or conservator may exercise the patient's rights on the patient's behalf.

Sec. 34. Minnesota Statutes 2000, section 253B.04, subdivision 1, is amended to read:

Subdivision 1. [VOLUNTARY ADMISSION AND TREATMENT.] (a) Voluntary admission is preferred over involuntary commitment and treatment. Any person 16 years of age or older may request to be admitted to a treatment facility as a voluntary patient for observation, evaluation, diagnosis, care and treatment without making formal written application. Any person under the age of 16 years may be admitted as a patient with the consent of a parent or legal guardian if it is determined by independent examination that there is reasonable evidence that (1) the proposed patient has a mental illness, or is mentally retarded or chemically dependent; and (2) the proposed patient is suitable for treatment. The head of the treatment facility shall not arbitrarily refuse any person seeking admission as a voluntary patient. In making decisions regarding admissions, the facility shall use clinical admission criteria consistent with the current applicable inpatient admission standards established by the American Psychiatric Association or the American Academy of Child and Adolescent Psychiatry. These criteria must be no more restrictive than, and must be consistent with, the requirements of section 62Q.53. The facility may not refuse to admit a person voluntarily solely because the person does not meet the criteria for involuntary holds under section 253B.05 or the definition of mental illness under section 253B.02, subdivision 13.

(b) In addition to the consent provisions of paragraph (a), a person who is 16 or 17 years of age who refuses to consent personally to admission may be admitted as a patient for mental illness or chemical dependency treatment with the consent of a parent or legal guardian if it is determined by an independent examination that there is reasonable evidence that the proposed patient is chemically dependent or has a mental illness and is suitable for treatment. The person conducting the examination shall notify the proposed patient and the parent or legal guardian of this determination.

Sec. 35. Minnesota Statutes 2000, section 253B.04, subdivision 1a, is amended to read:

Subd. 1a. [VOLUNTARY TREATMENT OR ADMISSION FOR PERSONS WITH MENTAL ILLNESS.] (a) A person with a mental illness may seek or voluntarily agree to accept treatment or admission to a facility. If the mental health provider determines that the person lacks

the capacity to give informed consent for the treatment or admission, and in the absence of a health care power of attorney that authorizes consent, the designated agency or its designee may give informed consent for mental health treatment or admission to a treatment facility on behalf of the person.

(b) The designated agency shall apply the following criteria in determining the person's ability to give informed consent:

(1) whether the person demonstrates an awareness of the person's illness, and the reasons for treatment, its risks, benefits and alternatives, and the possible consequences of refusing treatment; and

(2) whether the person communicates verbally or nonverbally a clear choice concerning treatment that is a reasoned one, not based on delusion, even though it may not be in the person's best interests.

(c) The basis for the designated agency's decision that the person lacks the capacity to give informed consent for treatment or admission, and that the patient has voluntarily accepted treatment or admission, must be documented in writing.

(d) A mental health provider that provides treatment in reliance on the written consent given by the designated agency under this subdivision or by a substitute decision maker appointed by the court is not civilly or criminally liable for performing treatment without consent. This paragraph does not affect any other liability that may result from the manner in which the treatment is performed.

(e) A person who receives treatment or is admitted to a facility under this subdivision or subdivision 1b has the right to refuse treatment at any time or to be released from a facility as provided under subdivision 2. The person or any interested person acting on the person's behalf may seek court review within five days for a determination of whether the person's agreement to accept treatment or admission is voluntary. At the time a person agrees to treatment or admission to a facility under this subdivision, the designated agency or its designee shall inform the person in writing of the person's rights under this paragraph.

(f) This subdivision does not authorize the administration of neuroleptic medications. Neuroleptic medications may be administered only as provided in section 253B.092.

Sec. 36. Minnesota Statutes 2000, section 253B.04, is amended by adding a subdivision to read:

Subd. 1b. [COURT APPOINTMENT OF SUBSTITUTE DECISION MAKER.] If the designated agency or its designee declines or refuses to give informed consent under subdivision 1a, the person who is seeking treatment or admission, or an interested person acting on behalf of the person, may petition the court for appointment of a substitute decision maker who may give informed consent for voluntary treatment and services. In making this determination, the court shall apply the criteria in subdivision 1a, paragraph (b).

Sec. 37. Minnesota Statutes 2000, section 253B.045, subdivision 6, is amended to read:

Subd. 6. [COVERAGE.] ~~A health plan company must provide coverage, according to the terms of the policy, contract, or certificate of coverage, for all medically necessary covered services as determined by section 62Q.53 provided to an enrollee that are ordered by the court under this chapter.~~ (a) For purposes of this section, "mental health services" means all covered services that are intended to treat or ameliorate an emotional, behavioral, or psychiatric condition and that are covered by the policy, contract, or certificate of coverage of the enrollee's health plan company or by law.

(b) All health plan companies that provide coverage for mental health services must cover or provide mental health services ordered by a court of competent jurisdiction under a court order that is issued on the basis of a behavioral care evaluation performed by a licensed psychiatrist or a doctoral level licensed psychologist, which includes a diagnosis and an individual treatment plan for care in the most appropriate, least restrictive environment. The health plan company must be

given a copy of the court order and the behavioral care evaluation. The health plan company shall be financially liable for the evaluation if performed by a participating provider of the health plan company and shall be financially liable for the care included in the court-ordered individual treatment plan if the care is covered by the health plan company and ordered to be provided by a participating provider or another provider as required by rule or law. This court-ordered coverage must not be subject to a separate medical necessity determination by a health plan company under its utilization procedures.

Sec. 38. Minnesota Statutes 2000, section 253B.05, subdivision 1, is amended to read:

Subdivision 1. [EMERGENCY HOLD.] (a) Any person may be admitted or held for emergency care and treatment in a treatment facility with the consent of the head of the treatment facility upon a written statement by an examiner that:

(1) the examiner has examined the person not more than 15 days prior to admission~~.~~;

(2) the examiner is of the opinion, for stated reasons, that the person is mentally ill, mentally retarded or chemically dependent, and is in ~~imminent~~ danger of causing injury to self or others if not immediately ~~restrained~~, detained; and

(3) an order of the court cannot be obtained in time to prevent the anticipated injury.

(b) If the proposed patient has been brought to the treatment facility by another person, the examiner shall make a good faith effort to obtain a statement of information that is available from that person, which must be taken into consideration in deciding whether to place the proposed patient on an emergency hold. The statement of information must include direct observations of the proposed patient's behaviors, reliable knowledge of recent and past behavior, and information regarding psychiatric history, past treatment, and current mental health providers. The examiner shall also inquire into the existence of health care directives under chapter 145, and advance psychiatric directives under section 253B.03, subdivision 6d.

(c) The examiner's statement shall be: (1) sufficient authority for a peace or health officer to transport a patient to a treatment facility, (2) stated in behavioral terms and not in conclusory language, and (3) of sufficient specificity to provide an adequate record for review. If ~~imminent~~ danger to specific individuals is a basis for the emergency hold, the statement must identify those individuals, to the extent practicable. A copy of the examiner's statement shall be personally served on the person immediately upon admission and a copy shall be maintained by the treatment facility.

Sec. 39. Minnesota Statutes 2000, section 253B.07, subdivision 1, is amended to read:

Subdivision 1. [PREPETITION SCREENING.] (a) Prior to filing a petition for commitment of or early intervention for a proposed patient, an interested person shall apply to the designated agency in the county of the proposed patient's residence or presence for conduct of a preliminary investigation, except when the proposed patient has been acquitted of a crime under section 611.026 and the county attorney is required to file a petition for commitment. The designated agency shall appoint a screening team to conduct an investigation ~~which shall include~~. The petitioner may not be a member of the screening team. The investigation must include:

(i) a personal interview with the proposed patient and other individuals who appear to have knowledge of the condition of the proposed patient. If the proposed patient is not interviewed, specific reasons must be documented;

(ii) identification and investigation of specific alleged conduct which is the basis for application;

(iii) identification, exploration, and listing of the specific reasons for rejecting or recommending alternatives to involuntary placement;

(iv) in the case of a commitment based on mental illness, the following information, if it is known or available~~: information~~, that may be relevant to the administration of neuroleptic

medications, ~~if necessary,~~ including the existence of a declaration under section 253B.03, subdivision 6d, or a health care directive under chapter 145C or a guardian, conservator, proxy, or agent with authority to make health care decisions for the proposed patient; information regarding the capacity of the proposed patient to make decisions regarding administration of neuroleptic medication; and whether the proposed patient is likely to consent or refuse consent to administration of the medication; and

(v) seeking input from the proposed patient's health plan company to provide the court with information about services the enrollee needs and the least restrictive alternatives.

(vi) in the case of a commitment based on mental illness, information listed in clause (iv) for other purposes relevant to treatment.

(b) In conducting the investigation required by this subdivision, the screening team shall have access to all relevant medical records of proposed patients currently in treatment facilities. Data collected pursuant to this clause shall be considered private data on individuals. The prepetition screening report is not admissible as evidence except by agreement of counsel and is not admissible in any court proceedings unrelated to the commitment proceedings.

(c) The prepetition screening team shall provide a notice, written in easily understood language, to the proposed patient, the petitioner, persons named in a declaration under chapter 145C or section 253B.03, subdivision 6d, and, with the proposed patient's consent, other interested parties. The team shall ask the patient if the patient wants the notice read and shall read the notice to the patient upon request. The notice must contain information regarding the process, purpose, and legal effects of civil commitment and early intervention. The notice must inform the proposed patient that:

(1) if a petition is filed, the patient has certain rights, including the right to a court-appointed attorney, the right to request a second examiner, the right to attend hearings, and the right to oppose the proceeding and to present and contest evidence; and

(2) if the proposed patient is committed to a state regional treatment center or group home, the patient will be billed for the cost of care and the state has the right to make a claim against the patient's estate for this cost.

The ombudsman for mental health and mental retardation shall develop a form for the notice, which includes the requirements of this paragraph.

(d) When the prepetition screening team recommends commitment, a written report shall be sent to the county attorney for the county in which the petition is to be filed. The statement of facts contained in the written report must meet the requirements of subdivision 2, paragraph (b).

~~(d)~~ (e) The prepetition screening team shall refuse to support a petition if the investigation does not disclose evidence sufficient to support commitment. Notice of the prepetition screening team's decision shall be provided to the prospective petitioner and to the proposed patient.

~~(e)~~ (f) If the interested person wishes to proceed with a petition contrary to the recommendation of the prepetition screening team, application may be made directly to the county attorney, who ~~may~~ shall determine whether or not to proceed with the petition. Notice of the county attorney's determination shall be provided to the interested party.

~~(f)~~ (g) If the proposed patient has been acquitted of a crime under section 611.026, the county attorney shall apply to the designated county agency in the county in which the acquittal took place for a preliminary investigation unless substantially the same information relevant to the proposed patient's current mental condition, as could be obtained by a preliminary investigation, is part of the court record in the criminal proceeding or is contained in the report of a mental examination conducted in connection with the criminal proceeding. If a court petitions for commitment pursuant to the rules of criminal or juvenile procedure or a county attorney petitions pursuant to acquittal of a criminal charge under section 611.026, the prepetition investigation, if required by this section, shall be completed within seven days after the filing of the petition.

Sec. 40. Minnesota Statutes 2000, section 253B.09, subdivision 1, is amended to read:

Subdivision 1. [STANDARD OF PROOF.] (a) If the court finds by clear and convincing evidence that the proposed patient is a mentally ill, mentally retarded, or chemically dependent person and after careful consideration of reasonable alternative dispositions, including but not limited to, dismissal of petition, voluntary outpatient care, voluntary admission to a treatment facility, appointment of a guardian or conservator, or release before commitment as provided for in subdivision 4, it finds that there is no suitable alternative to judicial commitment, the court shall commit the patient to the least restrictive treatment program or alternative programs which can meet the patient's treatment needs consistent with section 253B.03, subdivision 7.

(b) In deciding on the least restrictive program, the court shall consider a range of treatment alternatives including, but not limited to, community-based nonresidential treatment, community residential treatment, partial hospitalization, acute care hospital, and regional treatment center services. The court shall also consider the proposed patient's treatment preferences and willingness to participate voluntarily in the treatment ordered. The court may not commit a patient to a facility or program that is not capable of meeting the patient's needs.

(c) For purposes of findings under this chapter, none of the following constitute a refusal to accept appropriate mental health treatment:

(1) a willingness to take medication but a reasonable disagreement about type or dosage;

(2) a good-faith effort to follow a reasonable alternative treatment plan, including treatment as specified in a valid advance directive under chapter 145C or section 253B.03, subdivision 6d;

(3) an inability to obtain access to appropriate treatment because of inadequate health care coverage or an insurer's refusal or delay in providing coverage for the treatment; or

(4) an inability to obtain access to needed mental health services because the provider will only accept patients who are under a court order or because the provider gives persons under a court order a priority over voluntary patients in obtaining treatment and services.

Sec. 41. Minnesota Statutes 2000, section 253B.10, subdivision 4, is amended to read:

Subd. 4. [PRIVATE TREATMENT.] Patients or other responsible persons are required to pay the necessary charges for patients committed or transferred to private treatment facilities. ~~Private treatment facilities may refuse to accept a committed person.~~ Insurers must provide court-ordered treatment and services as ordered by the court under section 253B.045, subdivision 6, or as required under chapter 62M.

Sec. 42. Minnesota Statutes 2000, section 256.969, subdivision 3a, is amended to read:

Subd. 3a. [PAYMENTS.] Acute care hospital billings under the medical assistance program must not be submitted until the recipient is discharged. However, the commissioner shall establish monthly interim payments for inpatient hospitals that have individual patient lengths of stay over 30 days regardless of diagnostic category. Except as provided in section 256.9693, medical assistance reimbursement for treatment of mental illness shall be reimbursed based on diagnostic classifications. ~~The commissioner may selectively contract with hospitals for services within the diagnostic categories relating to mental illness and chemical dependency under competitive bidding when reasonable geographic access by recipients can be assured. No physician shall be denied the privilege of treating a recipient required to use a hospital under contract with the commissioner, as long as the physician meets credentialing standards of the individual hospital.~~ Individual hospital payments established under this section and sections 256.9685, 256.9686, and 256.9695, in addition to third party and recipient liability, for discharges occurring during the rate year shall not exceed, in aggregate, the charges for the medical assistance covered inpatient services paid for the same period of time to the hospital. This payment limitation shall be calculated separately for medical assistance and general assistance medical care services. The limitation on general assistance medical care shall be effective for admissions occurring on or after July 1, 1991. Services that have rates established under subdivision 11 or 12, must be limited separately from other services. After consulting with the affected hospitals, the commissioner may

consider related hospitals one entity and may merge the payment rates while maintaining separate provider numbers. The operating and property base rates per admission or per day shall be derived from the best Medicare and claims data available when rates are established. The commissioner shall determine the best Medicare and claims data, taking into consideration variables of recency of the data, audit disposition, settlement status, and the ability to set rates in a timely manner. The commissioner shall notify hospitals of payment rates by December 1 of the year preceding the rate year. The rate setting data must reflect the admissions data used to establish relative values. Base year changes from 1981 to the base year established for the rate year beginning January 1, 1991, and for subsequent rate years, shall not be limited to the limits ending June 30, 1987, on the maximum rate of increase under subdivision 1. The commissioner may adjust base year cost, relative value, and case mix index data to exclude the costs of services that have been discontinued by the October 1 of the year preceding the rate year or that are paid separately from inpatient services. Inpatient stays that encompass portions of two or more rate years shall have payments established based on payment rates in effect at the time of admission unless the date of admission preceded the rate year in effect by six months or more. In this case, operating payment rates for services rendered during the rate year in effect and established based on the date of admission shall be adjusted to the rate year in effect by the hospital cost index.

Sec. 43. [256.9693] [CONTINUING CARE PROGRAM FOR PERSONS WITH MENTAL ILLNESS.]

The commissioner shall establish a continuing care benefit program for persons with mental illness in which persons with mental illness may obtain acute care hospital inpatient treatment for mental illness for up to 45 days beyond that allowed by section 256.969. Persons with mental illness who are eligible for medical assistance may obtain inpatient treatment under this program in hospital beds for which the commissioner contracts under this section. The commissioner may selectively contract with hospitals to provide this benefit through competitive bidding when reasonable geographic access by recipients can be assured. Payments under this section shall not affect payments under section 256.969. The commissioner may contract externally with a utilization review organization to authorize persons with mental illness to access the continuing care benefit program. The commissioner shall, as part of the contracting process, establish admission criteria to allow persons with mental illness to access the continuing care benefit program. If a court orders acute care hospital inpatient treatment for mental illness for a person, the person may obtain the treatment under the continuing care benefit program. The commissioner shall not require, as part of the admission criteria, any commitment or petition under chapter 253B as a condition of accessing the program. This benefit is not available for people who are also eligible for Medicare and who have not exhausted their annual or lifetime inpatient psychiatric benefit under Medicare. If the recipient is enrolled in a prepaid health plan, this benefit is included in the health plan's coverage.

Sec. 44. [256B.0623] [ADULT REHABILITATIVE MENTAL HEALTH SERVICES.]

Subdivision 1. [SCOPE.] Medical assistance covers adult rehabilitative mental health services as defined in subdivision 2, subject to federal approval, if provided to recipients as defined in subdivision 3 and provided by a qualified provider entity meeting the standards in this section and by a qualified individual provider working within the provider's scope of practice and identified in the recipient's individual treatment plan as defined in section 245.462, subdivision 14, and if determined to be medically necessary according to section 62Q.53.

Subd. 2. [DEFINITIONS.] For purposes of this section, the following terms have the meanings given them.

(a) "Adult rehabilitative mental health services" means mental health services which are rehabilitative and enable the recipient to develop and enhance psychiatric stability, social competencies, personal and emotional adjustment, and independent living and community skills, when these abilities are impaired by the symptoms of mental illness. Adult rehabilitative mental health services are also appropriate when provided to enable a recipient to retain stability and functioning, if the recipient would be at risk of significant functional decompensation or more restrictive service settings without these services.

(1) Adult rehabilitative mental health services instruct, assist, and support the recipient in areas such as: interpersonal communication skills, community resource utilization and integration skills, crisis assistance, relapse prevention skills, health care directives, budgeting and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills, transportation skills, medication education and monitoring, mental illness symptom management skills, household management skills, employment-related skills, and transition to community living services.

(2) These services shall be provided to the recipient on a one-to-one basis in the recipient's home or another community setting or in groups.

(b) "Medication education services" means services provided individually or in groups which focus on educating the recipient about mental illness and symptoms; the role and effects of medications in treating symptoms of mental illness; and the side effects of medications. Medication education is coordinated with medication management services, and does not duplicate it. Medication education services are provided by physicians, pharmacists, or registered nurses.

(c) "Transition to community living services" means services which maintain continuity of contact between the rehabilitation services provider and the recipient and which facilitate discharge from a hospital, residential treatment program under Minnesota Rules, chapter 9505, board and lodging facility, or nursing home. Transition to community living services are not intended to provide other areas of adult rehabilitative mental health services.

Subd. 3. [ELIGIBILITY.] An eligible recipient is an individual who:

(1) is age 18 or older;

(2) is diagnosed with a medical condition, such as mental illness or traumatic brain injury, for which adult rehabilitative mental health services are needed;

(3) has substantial disability and functional impairment in three or more of the areas listed in section 245.462, subdivision 11a, so that self-sufficiency is markedly reduced; and

(4) has had a recent diagnostic assessment by a qualified professional that documents adult rehabilitative mental health services are medically necessary to address identified disability and functional impairments and individual recipient goals.

Subd. 4. [PROVIDER ENTITY STANDARDS.] (a) The provider entity must be:

(1) a county operated entity certified by the state; or

(2) a noncounty entity certified by the entity's host county.

(b) The certification process is a determination as to whether the entity meets the standards in this subdivision. The certification must specify which adult rehabilitative mental health services the entity is qualified to provide.

(c) If an entity seeks to provide services outside its host county, it must obtain additional certification from each county in which it will provide services. The additional certification must be based on the adequacy of the entity's knowledge of that county's local health and human service system, and the ability of the entity to coordinate its services with the other services available in that county.

(d) Recertification must occur at least every two years.

(e) The commissioner may intervene at any time and decertify providers with cause. The decertification is subject to appeal to the state. A county board may recommend that the state decertify a provider for cause.

(f) The adult rehabilitative mental health services provider entity must meet the following standards:

(1) have capacity to recruit, hire, manage, and train mental health professionals, mental health practitioners, and mental health rehabilitation workers;

(2) have adequate administrative ability to ensure availability of services;

(3) ensure adequate preservice and inservice training for staff;

(4) ensure that mental health professionals, mental health practitioners, and mental health rehabilitation workers are skilled in the delivery of the specific adult rehabilitative mental health services provided to the individual eligible recipient;

(5) ensure that staff is capable of implementing culturally specific services that are culturally competent and appropriate as determined by the recipient's culture, beliefs, values, and language as identified in the individual treatment plan;

(6) ensure enough flexibility in service delivery to respond to the changing and intermittent care needs of a recipient as identified by the recipient and the individual treatment plan;

(7) ensure that the mental health professional or mental health practitioner, who is under the clinical supervision of a mental health professional, involved in a recipient's services participates in the development of the individual treatment plan;

(8) assist the recipient in arranging needed crisis assessment, intervention, and stabilization services;

(9) ensure that services are coordinated with other recipient mental health services providers and the county mental health authority and the federally recognized American Indian authority and necessary others after obtaining the consent of the recipient. Services must also be coordinated with the recipient's case manager or care coordinator, if the recipient is receiving case management or care coordination services;

(10) develop and maintain recipient files, individual treatment plans, and contact charting;

(11) develop and maintain staff training and personnel files;

(12) submit information as required by the state;

(13) establish and maintain a quality assurance plan to evaluate the outcome of services provided;

(14) keep all necessary records required by law;

(15) deliver services as required by section 245.461;

(16) comply with all applicable laws;

(17) be an enrolled Medicaid provider;

(18) maintain a quality assurance plan to determine specific service outcomes and the recipient's satisfaction with services; and

(19) develop and maintain written policies and procedures regarding service provision and administration of the provider entity.

(g) The commissioner shall develop statewide procedures for provider certification, including timelines for counties to certify qualified providers.

Subd. 5. [QUALIFICATIONS OF PROVIDER STAFF.] Adult rehabilitative mental health services must be provided by qualified individual provider staff of a certified provider entity. Individual provider staff must be qualified under one of the following criteria:

(1) a mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (5);

(2) a mental health practitioner as defined in section 245.462, subdivision 17. The mental health practitioner must work under the clinical supervision of a mental health professional; or

(3) a mental health rehabilitation worker. A mental health rehabilitation worker means a staff person working under the direction of a mental health practitioner or mental health professional, and under the clinical supervision of a mental health professional in the implementation of rehabilitative mental health services as identified in the recipient's individual treatment plan; and who:

(i) is at least 21 years of age;

(ii) has a high school diploma or equivalent;

(iii) has successfully completed 30 hours of training during the past two years in all of the following areas: recipient rights, recipient-centered individual treatment planning, behavioral terminology, mental illness, co-occurring mental illness and substance abuse, psychotropic medications and side effects, functional assessment, local community resources, adult vulnerability, recipient confidentiality; and

(iv) meets the qualifications in (A) or (B):

(A) has an associate of arts degree in one of the behavioral sciences or human services, or is a registered nurse without a bachelor's degree, or who within the previous ten years has:

(1) three years of personal life experience with serious and persistent mental illness;

(2) three years of life experience as a primary caregiver to an adult with a serious mental illness or traumatic brain injury; or

(3) 4,000 hours of supervised paid work experience in the delivery of mental health services to adults with a serious mental illness or traumatic brain injury; or

(B)(1) be fluent in the non-English language or competent in the culture of the ethnic group to which at least 50 percent of the mental health rehabilitation worker's clients belong;

(2) receives during the first 2,000 hours of work, monthly documented individual clinical supervision by a mental health professional;

(3) has 18 hours of documented field supervision by a mental health professional or practitioner during the first 160 hours of contact work with recipients, and at least six hours of field supervision quarterly during the following year;

(4) has review and cosignature of charting of recipient contacts during field supervision by a mental health professional or practitioner; and

(5) has 40 hours of additional continuing education on mental health topics during the first year of employment.

Subd. 6. [REQUIRED TRAINING AND SUPERVISION.] (a) Mental health rehabilitation workers must receive ongoing continuing education training of at least 30 hours every two years in areas of mental illness and mental health services and other areas specific to the population being served. Mental health rehabilitation workers must also be subject to the ongoing direction and clinical supervision standards in paragraphs (c) and (d).

(b) Mental health practitioners must receive ongoing continuing education training as required by their professional license; or if the practitioner is not licensed, the practitioner must receive ongoing continuing education training of at least 30 hours every two years in areas of mental illness and mental health services. Mental health practitioners must meet the ongoing clinical supervision standards in paragraph (c).

(c) A mental health professional providing clinical supervision of staff delivering adult rehabilitative mental health services must provide the following guidance:

(1) review the information in the recipient's file;

(2) review and approve initial and updates of individual treatment plans;

(3) meet with mental health rehabilitation workers and practitioners, individually or in small groups, at least monthly to discuss treatment topics of interest to the workers and practitioners;

(4) meet with mental health rehabilitation workers and practitioners, individually or in small groups, at least monthly to discuss treatment plans of recipients, and approve by signature and document in the recipient's file any resulting plan updates;

(5) meet at least twice a month with the directing mental health practitioner, if there is one, to review needs of the adult rehabilitative mental health services program, review staff on-site observations and evaluate mental health rehabilitation workers, plan staff training, review program evaluation and development, and consult with the directing practitioner;

(6) be available for urgent consultation as the individual recipient needs or the situation necessitates; and

(7) provide clinical supervision by full- or part-time mental health professionals employed by or under contract with the provider entity.

(d) An adult rehabilitative mental health services provider entity must have a treatment director who is a mental health practitioner or mental health professional. The treatment director must ensure the following:

(1) while delivering direct services to recipients, a newly hired mental health rehabilitation worker must be directly observed delivering services to recipients by the mental health practitioner or mental health professional for at least six hours per 40 hours worked during the first 160 hours that the mental health rehabilitation worker works;

(2) the mental health rehabilitation worker must receive ongoing on-site direct service observation by a mental health professional or mental health practitioner for at least six hours for every six months of employment;

(3) progress notes are reviewed from on-site service observation prepared by the mental health rehabilitation worker and mental health practitioner for accuracy and consistency with actual recipient contact and the individual treatment plan and goals;

(4) immediate availability by phone or in person for consultation by a mental health professional or a mental health practitioner to the mental health rehabilitation services worker during service provision;

(5) oversee the identification of changes in individual recipient treatment strategies, revise the plan and communicate treatment instructions and methodologies as appropriate to ensure that treatment is implemented correctly;

(6) model service practices which: respect the recipient, include the recipient in planning and implementation of the individual treatment plan, recognize the recipient's strengths, collaborate and coordinate with other involved parties and providers;

(7) ensure that mental health practitioners and mental health rehabilitation workers are able to effectively communicate with the recipients, significant others, and providers; and

(8) oversee the record of the results of on-site observation and charting evaluation and corrective actions taken to modify the work of the mental health practitioners and mental health rehabilitation workers.

(e) A mental health practitioner who is providing treatment direction for a provider entity must receive supervision at least monthly from a mental health professional to:

(1) identify and plan for general needs of the recipient population served;

(2) identify and plan to address provider entity program needs and effectiveness;

(3) identify and plan provider entity staff training and personnel needs and issues; and

(4) plan, implement, and evaluate provider entity quality improvement programs.

Subd. 7. [PERSONNEL FILE.] The adult rehabilitative mental health services provider entity must maintain a personnel file on each staff. Each file must contain:

(1) an annual performance review;

(2) a summary of on-site service observations and charting review;

(3) a criminal background check of all direct service staff;

(4) evidence of academic degree and qualifications;

(5) a copy of professional license;

(6) any job performance recognition and disciplinary actions;

(7) any individual staff written input into own personnel file;

(8) all clinical supervision provided; and

(9) documentation of compliance with continuing education requirements.

Subd. 8. [DIAGNOSTIC ASSESSMENT.] Providers of adult rehabilitative mental health services must complete a diagnostic assessment as defined in section 245.462, subdivision 9, within five days after the recipient's second visit or within 30 days after intake, whichever occurs first. In cases where a diagnostic assessment is available that reflects the recipient's current status, and has been completed within 180 days preceding admission, an update must be completed. An update shall include a written summary by a mental health professional of the recipient's current mental health status and service needs. If the recipient's mental health status has changed significantly since the adult's most recent diagnostic assessment, a new diagnostic assessment is required.

Subd. 9. [FUNCTIONAL ASSESSMENT.] Providers of adult rehabilitative mental health services must complete a written functional assessment as defined in section 245.462, subdivision 11a, for each recipient. The functional assessment must be completed within 30 days of intake, and reviewed and updated at least every six months after it is developed, unless there is a significant change in the functioning of the recipient. If there is a significant change in functioning, the assessment must be updated. A single functional assessment can meet case management and adult rehabilitative mental health services requirements, if agreed to by the recipient. Unless the recipient refuses, the recipient must have significant participation in the development of the functional assessment.

Subd. 10. [INDIVIDUAL TREATMENT PLAN.] All providers of adult rehabilitative mental health services must develop and implement an individual treatment plan for each recipient. The provisions in clauses (1) and (2) apply:

(1) Individual treatment plan means a plan of intervention, treatment, and services for an individual recipient written by a mental health professional or by a mental health practitioner under the clinical supervision of a mental health professional. The individual treatment plan must be based on diagnostic and functional assessments. To the extent possible, the development and implementation of a treatment plan must be a collaborative process involving the recipient, and with the permission of the recipient, the recipient's family and others in the recipient's support system. Providers of adult rehabilitative mental health services must develop the individual treatment plan within 30 calendar days of intake. The treatment plan must be updated at least every six months thereafter, or more often when there is significant change in the recipient's situation or functioning, or in services or service methods to be used, or at the request of the recipient or the recipient's legal guardian.

(2) The individual treatment plan must include:

(i) a list of problems identified in the assessment;

(ii) the recipient's strengths and resources;

(iii) concrete, measurable goals to be achieved, including time frames for achievement;

(iv) specific objectives directed toward the achievement of each one of the goals;

(v) documentation of participants in the treatment planning. The recipient, if possible, must be a participant. The recipient or the recipient's legal guardian must sign the treatment plan, or documentation must be provided why this was not possible. A copy of the plan must be given to the recipient or legal guardian. Referral to formal services must be arranged, including specific providers where applicable;

(vi) cultural considerations, resources, and needs of the recipient must be included;

(vii) planned frequency and type of services must be initiated; and

(viii) clear progress notes on outcome of goals.

(3) The individual community support plan defined in section 245.462, subdivision 12, may serve as the individual treatment plan if there is involvement of a mental health case manager, and with the approval of the recipient. The individual community support plan must include the criteria in clause (2).

Subd. 11. [RECIPIENT FILE.] Providers of adult rehabilitative mental health services must maintain a file for each recipient that contains the following information:

(1) diagnostic assessment or verification of its location, that is current and that was reviewed by a mental health professional who is employed by or under contract with the provider entity;

(2) functional assessments;

(3) individual treatment plans signed by the recipient and the mental health professional, or if the recipient refused to sign the plan, the date and reason stated by the recipient as to why the recipient would not sign the plan;

(4) recipient history;

(5) signed release forms;

(6) recipient health information and current medications;

(7) emergency contacts for the recipient;

(8) case records which document the date of service, the place of service delivery, signature of the person providing the service, nature, extent and units of service, and place of service delivery;

(9) contacts, direct or by telephone, with recipient's family or others, other providers, or other resources for service coordination;

(10) summary of recipient case reviews by staff; and

(11) written information by the recipient that the recipient requests be included in the file.

Subd. 12. [ADDITIONAL REQUIREMENTS.] (a) Providers of adult rehabilitative mental health services must comply with the requirements relating to referrals for case management in section 245.467, subdivision 4.

(b) Adult rehabilitative mental health services are provided for most recipients in the recipient's home and community. Services may also be provided at the home of a relative or significant other, job site, psychosocial clubhouse, drop-in center, social setting, classroom, or other places in the community. Except for "transition to community services," the place of service does not include a

regional treatment center, nursing home, residential treatment facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0670 (Rule 36), or an acute care hospital.

(c) Adult rehabilitative mental health services may be provided in group settings if appropriate to each participating recipient's needs and treatment plan. A group is defined as two to ten clients, at least one of whom is a recipient, who is concurrently receiving a service which is identified in this section. The service and group must be specified in the recipient's treatment plan. No more than two qualified staff may bill Medicaid for services provided to the same group of recipients. If two adult rehabilitative mental health workers bill for recipients in the same group session, they must each bill for different recipients.

Subd. 13. [EXCLUDED SERVICES.] The following services are excluded from reimbursement as adult rehabilitative mental health services:

(1) recipient transportation services;

(2) a service provided and billed by a provider who is not enrolled to provide adult rehabilitative mental health service;

(3) adult rehabilitative mental health services performed by volunteers;

(4) provider performance of household tasks, chores, or related activities, such as laundering clothes, moving the recipient's household, housekeeping, and grocery shopping for the recipient;

(5) direct billing of time spent "on call" when not delivering services to recipients;

(6) activities which are primarily social or recreational in nature, rather than rehabilitative, for the individual recipient, as determined by the individual's needs and treatment plan;

(7) job-specific skills services, such as on-the-job training;

(8) provider service time included in case management reimbursement;

(9) outreach services to potential recipients;

(10) a mental health service that is not medically necessary; and

(11) any services provided by a hospital, board and lodging, or residential facility to an individual who is a patient in or resident of that facility.

Subd. 14. [BILLING WHEN SERVICES ARE PROVIDED BY QUALIFIED STATE STAFF.] When rehabilitative services are provided by qualified state staff who are assigned to pilot projects under section 245.4661, the county or other local entity to which the qualified state staff are assigned may consider these staff part of the local provider entity for which certification is sought under this section, and may bill the medical assistance program for qualifying services provided by the qualified state staff. Notwithstanding section 256.025, subdivision 2, payments for services provided by state staff who are assigned to adult mental health initiatives shall only be made from federal funds.

Sec. 45. [256B.0624] [ADULT MENTAL HEALTH CRISIS RESPONSE SERVICES.]

Subdivision 1. [SCOPE.] Medical assistance covers adult mental health crisis response services as defined in subdivision 2, paragraphs (c) to (e), subject to federal approval, if provided to a recipient as defined in subdivision 3 and provided by a qualified provider entity as defined in this section and by a qualified individual provider working within the provider's scope of practice and as defined in this subdivision and identified in the recipient's individual crisis treatment plan as defined in subdivisions 10 and 13 and if determined to be medically necessary.

Subd. 2. [DEFINITIONS.] For purposes of this section, the following terms have the meanings given them.

(a) "Mental health crisis" is a behavioral, emotional, or psychiatric situation which, but for the

provision of crisis response services, would likely result in significantly reduced levels of functioning in primary activities of daily living, or in an emergency situation, or in the placement of the recipient in a more restrictive setting, including, but not limited to, inpatient hospitalization.

(b) "Mental health emergency" is a behavioral, emotional, or psychiatric situation which causes an immediate need for mental health services and is consistent with section 62Q.55.

A mental health crisis or emergency is determined for medical assistance service reimbursement by a physician, a mental health professional, or crisis mental health practitioner with input from the recipient whenever possible.

(c) "Mental health crisis assessment" means an immediate face-to-face assessment by a physician, a mental health professional, or mental health practitioner under the clinical supervision of a mental health professional, following a screening that suggests that the adult may be experiencing a mental health crisis or mental health emergency situation.

(d) "Mental health mobile crisis intervention services" means face-to-face, short-term intensive mental health services initiated during a mental health crisis or mental health emergency to help the recipient cope with immediate stressors, identify and utilize available resources and strengths, and begin to return to the recipient's baseline level of functioning.

(1) This service is provided on-site by a mobile crisis intervention team outside of an inpatient hospital setting. Mental health mobile crisis intervention services must be available 24 hours a day, seven days a week.

(2) The initial screening must consider other available services to determine which service intervention would best address the recipient's needs and circumstances.

(3) The mobile crisis intervention team must be available to meet promptly face-to-face with a person in mental health crisis or emergency in a community setting.

(4) The intervention must consist of a mental health crisis assessment and a crisis treatment plan.

(5) The treatment plan must include recommendations for any needed crisis stabilization services for the recipient.

(e) "Mental health crisis stabilization services" means individualized mental health services provided to a recipient following crisis intervention services, which are designed to restore the recipient to the recipient's prior functional level. Mental health crisis stabilization services may be provided in the recipient's home, the home of a family member or friend of the recipient, another community setting, or a short-term supervised, licensed residential program. Mental health crisis stabilization does not include partial hospitalization or day treatment.

Subd. 3. [ELIGIBILITY.] An eligible recipient is an individual who:

(1) is age 18 or older;

(2) is screened as possibly experiencing a mental health crisis or emergency where a mental health crisis assessment is needed; and

(3) is assessed as experiencing a mental health crisis or emergency, and mental health crisis intervention or crisis intervention and stabilization services are determined to be medically necessary.

Subd. 4. [PROVIDER ENTITY STANDARDS.] (a) A provider entity is an entity that meets the standards listed in paragraph (b) and:

(1) is a county board operated entity; or

(2) is a provider entity that is under contract with the county board in the county where the potential crisis or emergency is occurring. To provide services under this section, the provider

entity must directly provide the services; or if services are subcontracted, the provider entity must maintain responsibility for services and billing.

(b) The adult mental health crisis response services provider entity must meet the following standards:

(1) has the capacity to recruit, hire, and manage and train mental health professionals, practitioners, and rehabilitation workers;

(2) has adequate administrative ability to ensure availability of services;

(3) is able to ensure adequate preservice and in-service training;

(4) is able to ensure that staff providing these services are skilled in the delivery of mental health crisis response services to recipients;

(5) is able to ensure that staff are capable of implementing culturally specific treatment identified in the individual treatment plan that is meaningful and appropriate as determined by the recipient's culture, beliefs, values, and language;

(6) is able to ensure enough flexibility to respond to the changing intervention and care needs of a recipient as identified by the recipient during the service partnership between the recipient and providers;

(7) is able to ensure that mental health professionals and mental health practitioners have the communication tools and procedures to communicate and consult promptly about crisis assessment and interventions as services occur;

(8) is able to coordinate these services with county emergency services and mental health crisis services;

(9) is able to ensure that mental health crisis assessment and mobile crisis intervention services are available 24 hours a day, seven days a week;

(10) is able to ensure that services are coordinated with other mental health service providers, county mental health authorities, or federally recognized American Indian authorities and others as necessary, with the consent of the adult. Services must also be coordinated with the recipient's case manager if the adult is receiving case management services;

(11) is able to ensure that crisis intervention services are provided in a manner consistent with sections 245.461 to 245.486;

(12) is able to submit information as required by the state;

(13) maintains staff training and personnel files;

(14) is able to establish and maintain a quality assurance and evaluation plan to evaluate the outcomes of services and recipient satisfaction;

(15) is able to keep records as required by applicable laws;

(16) is able to comply with all applicable laws and statutes;

(17) is an enrolled medical assistance provider; and

(18) develops and maintains written policies and procedures regarding service provision and administration of the provider entity, including safety of staff and recipients in high-risk situations.

Subd. 5. [MOBILE CRISIS INTERVENTION STAFF QUALIFICATIONS.] For provision of adult mental health mobile crisis intervention services, a mobile crisis intervention team is comprised of at least two mental health professionals as defined in section 245.462, subdivision 18, clauses (1) to (5), or a combination of at least one mental health professional and one mental health practitioner as defined in section 245.462, subdivision 17, with the required mental health

crisis training and under the clinical supervision of a mental health professional on the team. The team must have at least two people with at least one member providing on-site crisis intervention services when needed. Team members must be experienced in mental health assessment, crisis intervention techniques, and clinical decision-making under emergency conditions and have knowledge of local services and resources. The team must recommend and coordinate the team's services with appropriate local resources such as the county social services agency, mental health services, and local law enforcement when necessary.

Subd. 6. [INITIAL SCREENING, CRISIS ASSESSMENT, AND MOBILE INTERVENTION TREATMENT PLANNING.] (a) Prior to initiating mobile crisis intervention services, a screening of the potential crisis situation must be conducted. The screening may use the resources of crisis assistance and emergency services as defined in sections 245.462, subdivision 6, and 245.469, subdivisions 1 and 2. The screening must gather information, determine whether a crisis situation exists, identify parties involved, and determine an appropriate response.

(b) If a crisis exists, a crisis assessment must be completed. A crisis assessment evaluates any immediate needs for which emergency services are needed and, as time permits, the recipient's current life situation, sources of stress, mental health problems and symptoms, strengths, cultural considerations, support network, vulnerabilities, and current functioning.

(c) If the crisis assessment determines mobile crisis intervention services are needed, the intervention services must be provided promptly. As opportunity presents during the intervention, at least two members of the mobile crisis intervention team must confer directly or by telephone about the assessment, treatment plan, and actions taken and needed. At least one of the team members must be on site providing crisis intervention services. If providing on-site crisis intervention services, a mental health practitioner must seek clinical supervision as required in subdivision 9.

(d) The mobile crisis intervention team must develop an initial, brief crisis treatment plan as soon as appropriate but no later than 24 hours after the initial face-to-face intervention. The plan must address the needs and problems noted in the crisis assessment and include measurable short-term goals, cultural considerations, and frequency and type of services to be provided to achieve the goals and reduce or eliminate the crisis. The treatment plan must be updated as needed to reflect current goals and services.

(e) The team must document which short-term goals have been met, and when no further crisis intervention services are required.

(f) If the recipient's crisis is stabilized, but the recipient needs a referral to other services, the team must provide referrals to these services. If the recipient has a case manager, planning for other services must be coordinated with the case manager.

Subd. 7. [CRISIS STABILIZATION SERVICES.] (a) Crisis stabilization services must be provided by qualified staff of a crisis stabilization services provider entity and must meet the following standards:

(1) a crisis stabilization treatment plan must be developed which meets the criteria in subdivision 11;

(2) staff must be qualified as defined in subdivision 8; and

(3) services must be delivered according to the treatment plan and include face-to-face contact with the recipient by qualified staff for further assessment, help with referrals, updating of the crisis stabilization treatment plan, supportive counseling, skills training, and collaboration with other service providers in the community.

(b) If crisis stabilization services are provided in a supervised, licensed residential setting, the recipient must be contacted face-to-face daily by a qualified mental health practitioner or mental health professional. The program must have 24-hour-a-day residential staffing which may include staff who do not meet the qualifications in subdivision 8. The residential staff must have 24-hour-a-day immediate direct or telephone access to a qualified mental health professional or practitioner.

(c) If crisis stabilization services are provided in a supervised, licensed residential setting that serves no more than four adult residents, and no more than two are recipients of crisis stabilization services, the residential staff must include, for at least eight hours per day, at least one individual who meets the qualifications in subdivision 8.

(d) If crisis stabilization services are provided in a supervised, licensed residential setting that serves more than four adult residents, and one or more are recipients of crisis stabilization services, the residential staff must include, for 24 hours per day, at least one individual who meets the qualifications in subdivision 8. During the first 48 hours that a recipient is in the residential program, the residential program must have at least two staff working 24 hours a day. Staffing levels may be adjusted thereafter according to the needs of the recipient as specified in the crisis stabilization treatment plan.

Subd. 8. [ADULT CRISIS STABILIZATION STAFF QUALIFICATIONS.] (a) Adult mental health crisis stabilization services must be provided by qualified individual staff of a qualified provider entity. Individual provider staff must have the following qualifications:

(1) be a mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (5);

(2) be a mental health practitioner as defined in section 245.462, subdivision 17. The mental health practitioner must work under the clinical supervision of a mental health professional; or

(3) be a mental health rehabilitation worker who meets the criteria in section 256B.0623, subdivision 5, clause (3); works under the direction of a mental health practitioner as defined in section 245.462, subdivision 17, or under direction of a mental health professional; and works under the clinical supervision of a mental health professional.

(b) Mental health practitioners and mental health rehabilitation workers must have completed at least 30 hours of training in crisis intervention and stabilization during the past two years.

Subd. 9. [SUPERVISION.] Mental health practitioners may provide crisis assessment and mobile crisis intervention services if the following clinical supervision requirements are met:

(1) the mental health provider entity must accept full responsibility for the services provided;

(2) the mental health professional of the provider entity, who is an employee or under contract with the provider entity, must be immediately available by phone or in person for clinical supervision;

(3) the mental health professional is consulted, in person or by phone, during the first three hours when a mental health practitioner provides on-site service;

(4) the mental health professional must:

(i) review and approve of the tentative crisis assessment and crisis treatment plan;

(ii) document the consultation; and

(iii) sign the crisis assessment and treatment plan within the next business day;

(5) if the mobile crisis intervention services continue into a second calendar day, a mental health professional must contact the recipient face-to-face on the second day to provide services and update the crisis treatment plan; and

(6) the on-site observation must be documented in the recipient's record and signed by the mental health professional.

Subd. 10. [RECIPIENT FILE.] Providers of mobile crisis intervention or crisis stabilization services must maintain a file for each recipient containing the following information:

(1) individual crisis treatment plans signed by the recipient, mental health professional, and

mental health practitioner who developed the crisis treatment plan, or if the recipient refused to sign the plan, the date and reason stated by the recipient as to why the recipient would not sign the plan;

(2) signed release forms;

(3) recipient health information and current medications;

(4) emergency contacts for the recipient;

(5) case records which document the date of service, place of service delivery, signature of the person providing the service, and the nature, extent, and units of service. Direct or telephone contact with the recipient's family or others should be documented;

(6) required clinical supervision by mental health professionals;

(7) summary of the recipient's case reviews by staff; and

(8) any written information by the recipient that the recipient wants in the file.

Documentation in the file must comply with all requirements of the commissioner.

Subd. 11. [TREATMENT PLAN.] The individual crisis stabilization treatment plan must include, at a minimum:

(1) a list of problems identified in the assessment;

(2) a list of the recipient's strengths and resources;

(3) concrete, measurable short-term goals and tasks to be achieved, including time frames for achievement;

(4) specific objectives directed toward the achievement of each one of the goals;

(5) documentation of the participants involved in the service planning. The recipient, if possible, must be a participant. The recipient or the recipient's legal guardian must sign the service plan or documentation must be provided why this was not possible. A copy of the plan must be given to the recipient and the recipient's legal guardian. The plan should include services arranged, including specific providers where applicable;

(6) planned frequency and type of services initiated;

(7) a crisis response action plan if a crisis should occur;

(8) clear progress notes on outcome of goals;

(9) a written plan must be completed within 24 hours of beginning services with the recipient; and

(10) a treatment plan must be developed by a mental health professional or mental health practitioner under the clinical supervision of a mental health professional. The mental health professional must approve and sign all treatment plans.

Subd. 12. [EXCLUDED SERVICES.] The following services are excluded from reimbursement under this section:

(1) room and board services;

(2) services delivered to a recipient while admitted to an inpatient hospital;

(3) recipient transportation costs may be covered under other medical assistance provisions, but transportation services are not an adult mental health crisis response service;

(4) services provided and billed by a provider who is not enrolled under medical assistance to provide adult mental health crisis response services;

(5) services performed by volunteers;

(6) direct billing of time spent "on call" when not delivering services to a recipient;

(7) provider service time included in case management reimbursement. When a provider is eligible to provide more than one type of medical assistance service, the recipient must have a choice of provider for each service, unless otherwise provided for by law;

(8) outreach services to potential recipients; and

(9) a mental health service that is not medically necessary.

Sec. 46. Minnesota Statutes 2000, section 256B.0625, subdivision 20, is amended to read:

Subd. 20. [MENTAL HEALTH CASE MANAGEMENT.] (a) To the extent authorized by rule of the state agency, medical assistance covers case management services to persons with serious and persistent mental illness and children with severe emotional disturbance. Services provided under this section must meet the relevant standards in sections 245.461 to 245.4888, the Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

(b) Entities meeting program standards set out in rules governing family community support services as defined in section 245.4871, subdivision 17, are eligible for medical assistance reimbursement for case management services for children with severe emotional disturbance when these services meet the program standards in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

(c) Medical assistance and MinnesotaCare payment for mental health case management shall be made on a monthly basis. In order to receive payment for an eligible child, the provider must document at least a face-to-face contact with the child, the child's parents, or the child's legal representative. To receive payment for an eligible adult, the provider must document:

(1) at least a face-to-face contact with the adult or the adult's legal representative; or

(2) at least a telephone contact with the adult or the adult's legal representative and document a face-to-face contact with the adult or the adult's legal representative within the preceding two months.

(d) Payment for mental health case management provided by county or state staff shall be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph (b), with separate rates calculated for child welfare and mental health, and within mental health, separate rates for children and adults.

(e) Payment for mental health case management provided by Indian health services or by agencies operated by Indian tribes may be made according to this section or other relevant federally approved rate setting methodology.

(f) Payment for mental health case management provided by ~~county-contracted~~ vendors who contract with a county or Indian tribe shall be based on a monthly rate negotiated by the host county or tribe. The negotiated rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the county or tribe may negotiate a team rate with a vendor who is a member of the team. The team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county or tribe, except to reimburse the county or tribe for advance funding provided by the county or tribe to the vendor.

~~(f)~~ (g) If the service is provided by a team which includes contracted vendors, tribal staff, and county or state staff, the costs for county or state staff participation in the team shall be included in the rate for county-provided services. In this case, the contracted vendor, the tribal agency, and the county may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services, ~~the county~~ each entity must document, in the

recipient's file, the need for team case management and a description of the roles of the team members.

~~(g)~~ (h) The commissioner shall calculate the nonfederal share of actual medical assistance and general assistance medical care payments for each county, based on the higher of calendar year 1995 or 1996, by service date, project that amount forward to 1999, and transfer one-half of the result from medical assistance and general assistance medical care to each county's mental health grants under sections 245.4886 and 256E.12 for calendar year 1999. The annualized minimum amount added to each county's mental health grant shall be $3,000 per year for children and $5,000 per year for adults. The commissioner may reduce the statewide growth factor in order to fund these minimums. The annualized total amount transferred shall become part of the base for future mental health grants for each county.

~~(h)~~ (i) Any net increase in revenue to the county or tribe as a result of the change in this section must be used to provide expanded mental health services as defined in sections 245.461 to 245.4888, the Comprehensive Adult and Children's Mental Health Acts, excluding inpatient and residential treatment. For adults, increased revenue may also be used for services and consumer supports which are part of adult mental health projects approved under Laws 1997, chapter 203, article 7, section 25. For children, increased revenue may also be used for respite care and nonresidential individualized rehabilitation services as defined in section 245.492, subdivisions 17 and 23. "Increased revenue" has the meaning given in Minnesota Rules, part 9520.0903, subpart 3.

~~(i)~~ (j) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for mental health case management shall be provided by the recipient's county of responsibility, as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds used to match other federal funds. If the service is provided by a tribal agency, the nonfederal share, if any, shall be provided by the recipient's tribe.

~~(j)~~ (k) The commissioner may suspend, reduce, or terminate the reimbursement to a provider that does not meet the reporting or other requirements of this section. The county of responsibility, as defined in sections 256G.01 to 256G.12, or, if applicable, the tribal agency, is responsible for any federal disallowances. The county or tribe may share this responsibility with its contracted vendors.

~~(k)~~ (l) The commissioner shall set aside a portion of the federal funds earned under this section to repay the special revenue maximization account under section 256.01, subdivision 2, clause (15). The repayment is limited to:

(1) the costs of developing and implementing this section; and

(2) programming the information systems.

~~(l)~~ (m) Notwithstanding section 256.025, subdivision 2, payments to counties and tribal agencies for case management expenditures under this section shall only be made from federal earnings from services provided under this section. Payments to ~~contracted~~ county-contracted vendors shall include both the federal earnings and the county share.

~~(m)~~ (n) Notwithstanding section 256B.041, county payments for the cost of mental health case management services provided by county or state staff shall not be made to the state treasurer. For the purposes of mental health case management services provided by county or state staff under this section, the centralized disbursement of payments to counties under section 256B.041 consists only of federal earnings from services provided under this section.

~~(n)~~ (o) Case management services under this subdivision do not include therapy, treatment, legal, or outreach services.

~~(o)~~ (p) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital, and the recipient's institutional care is paid by medical assistance, payment for case management services under this subdivision is limited to the last 30 days of the recipient's residency in that facility and may not exceed more than two months in a calendar year.

~~(p)~~ (q) Payment for case management services under this subdivision shall not duplicate payments made under other program authorities for the same purpose.

~~(q)~~ (r) By July 1, 2000, the commissioner shall evaluate the effectiveness of the changes required by this section, including changes in number of persons receiving mental health case management, changes in hours of service per person, and changes in caseload size.

~~(r)~~ (s) For each calendar year beginning with the calendar year 2001, the annualized amount of state funds for each county determined under paragraph ~~(g)~~ (h) shall be adjusted by the county's percentage change in the average number of clients per month who received case management under this section during the fiscal year that ended six months prior to the calendar year in question, in comparison to the prior fiscal year.

~~(s)~~ (t) For counties receiving the minimum allocation of $3,000 or $5,000 described in paragraph ~~(g)~~ (h), the adjustment in paragraph ~~(r)~~ (s) shall be determined so that the county receives the higher of the following amounts:

(1) a continuation of the minimum allocation in paragraph ~~(g)~~ (h); or

(2) an amount based on that county's average number of clients per month who received case management under this section during the fiscal year that ended six months prior to the calendar year in question, ~~in comparison to the prior fiscal year,~~ times the average statewide grant per person per month for counties not receiving the minimum allocation.

~~(t)~~ (u) The adjustments in paragraphs ~~(r) and~~ (s) and (t) shall be calculated separately for children and adults.

Sec. 47. Minnesota Statutes 2000, section 256B.0625, is amended by adding a subdivision to read:

Subd. 45. [APPEAL PROCESS.] If a county contract or certification is required to enroll as an authorized provider of mental health services under medical assistance, and if a county refuses to grant the necessary contract or certification, the provider may appeal the county decision to the commissioner. A recipient may initiate an appeal on behalf of a provider who has been denied certification. The commissioner shall determine whether the provider meets applicable standards under state laws and rules based on an independent review of the facts, including comments from the county review. If the commissioner finds that the provider meets the applicable standards, the commissioner shall enroll the provider as an authorized provider. The commissioner shall develop procedures for providers and recipients to appeal a county decision to refuse to enroll a provider. After the commissioner makes a decision regarding an appeal, the county, provider, or recipient may request that the commissioner reconsider the commissioner's initial decision. The commissioner's reconsideration decision is final and not subject to further appeal.

Sec. 48. Minnesota Statutes 2000, section 256B.0625, is amended by adding a subdivision to read:

Subd. 46. [MENTAL HEALTH PROVIDER TRAVEL TIME.] Medical assistance covers provider travel time if a recipient's individual treatment plan requires the provision of mental health services outside of the provider's normal place of business. This does not include any travel time which is included in other billable services, and is only covered when the mental health service being provided to a recipient is covered under medical assistance.

Sec. 49. [256B.761] [REIMBURSEMENT FOR MENTAL HEALTH SERVICES.]

Effective for services rendered on or after July 1, 2001, payment for medication management provided to psychiatric patients, outpatient mental health services, day treatment services, home-based mental health services, and family community support services shall be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the 50th percentile of 1999 charges.

Sec. 50. [256B.82] [PREPAID PLANS AND MENTAL HEALTH REHABILITATIVE SERVICES.]

Medical assistance and MinnesotaCare prepaid health plans may include coverage for adult mental health rehabilitative services under section 256B.0623 and adult mental health crisis response services under section 256B.0624, beginning January 1, 2004.

By January 15, 2003, the commissioner shall report to the legislature how these services should be included in prepaid plans. The commissioner shall consult with mental health advocates, health plans, and counties in developing this report. The report recommendations must include a plan to ensure coordination of these services between health plans and counties, assure recipient access to essential community providers, and monitor the health plans' delivery of services through utilization review and quality standards.

Sec. 51. [256B.83] [MAINTENANCE OF EFFORT FOR CERTAIN MENTAL HEALTH SERVICES.]

Any net increase in revenue to the county as a result of the change in section 256B.0623 or 256B.0624 must be used to provide expanded mental health services as defined in sections 245.461 to 245.486, the Comprehensive Adult Mental Health Act, excluding inpatient and residential treatment. Increased revenue may also be used for services and consumer supports, which are part of adult mental health projects approved under section 245.4661. "Increased revenue" has the meaning given in Minnesota Rules, part 9520.0903, subpart 3.

Sec. 52. Minnesota Statutes 2000, section 260C.201, subdivision 1, is amended to read:

Subdivision 1. [DISPOSITIONS.] (a) If the court finds that the child is in need of protection or services or neglected and in foster care, it shall enter an order making any of the following dispositions of the case:

(1) place the child under the protective supervision of the local social services agency or child-placing agency in the home of a parent of the child under conditions prescribed by the court directed to the correction of the child's need for protection or services, or:

(i) the court may order the child into the home of a parent who does not otherwise have legal custody of the child, however, an order under this section does not confer legal custody on that parent;

(ii) if the court orders the child into the home of a father who is not adjudicated, he must cooperate with paternity establishment proceedings regarding the child in the appropriate jurisdiction as one of the conditions prescribed by the court for the child to continue in his home;

(iii) the court may order the child into the home of a noncustodial parent with conditions and may also order both the noncustodial and the custodial parent to comply with the requirements of a case plan under subdivision 2;

(2) transfer legal custody to one of the following:

(i) a child-placing agency; or

(ii) the local social services agency.

In placing a child whose custody has been transferred under this paragraph, the agencies shall follow the requirements of section 260C.193, subdivision 3;

(3) if the child has been adjudicated as a child in need of protection or services because the child is in need of special ~~treatment and~~ services or care ~~for reasons of physical or mental health~~ to treat or ameliorate a physical or mental disability, the court may order the child's parent, guardian, or custodian to provide it. The court may order the child's health plan company to provide mental health services to the child. Section 62Q.535 applies to an order for mental health services directed to the child's health plan company. If the health plan, parent, guardian, or custodian fails or is unable to provide this treatment or care, the court may order it provided. Absent specific written findings by the court that the child's disability is the result of abuse or neglect by the child's parent or guardian, the court shall not transfer legal custody of the child for the purpose of obtaining

special treatment or care solely because the parent is unable to provide the treatment or care. If the court's order for mental health treatment is based on a diagnosis made by a treatment professional, the court may order that the diagnosing professional not provide the treatment to the child if it finds that such an order is in the child's best interests; or

(4) if the court believes that the child has sufficient maturity and judgment and that it is in the best interests of the child, the court may order a child 16 years old or older to be allowed to live independently, either alone or with others as approved by the court under supervision the court considers appropriate, if the county board, after consultation with the court, has specifically authorized this dispositional alternative for a child.

(b) If the child was adjudicated in need of protection or services because the child is a runaway or habitual truant, the court may order any of the following dispositions in addition to or as alternatives to the dispositions authorized under paragraph (a):

(1) counsel the child or the child's parents, guardian, or custodian;

(2) place the child under the supervision of a probation officer or other suitable person in the child's own home under conditions prescribed by the court, including reasonable rules for the child's conduct and the conduct of the parents, guardian, or custodian, designed for the physical, mental, and moral well-being and behavior of the child; or with the consent of the commissioner of corrections, place the child in a group foster care facility which is under the commissioner's management and supervision;

(3) subject to the court's supervision, transfer legal custody of the child to one of the following:

(i) a reputable person of good moral character. No person may receive custody of two or more unrelated children unless licensed to operate a residential program under sections 245A.01 to 245A.16; or

(ii) a county probation officer for placement in a group foster home established under the direction of the juvenile court and licensed pursuant to section 241.021;

(4) require the child to pay a fine of up to $100. The court shall order payment of the fine in a manner that will not impose undue financial hardship upon the child;

(5) require the child to participate in a community service project;

(6) order the child to undergo a chemical dependency evaluation and, if warranted by the evaluation, order participation by the child in a drug awareness program or an inpatient or outpatient chemical dependency treatment program;

(7) if the court believes that it is in the best interests of the child and of public safety that the child's driver's license or instruction permit be canceled, the court may order the commissioner of public safety to cancel the child's license or permit for any period up to the child's 18th birthday. If the child does not have a driver's license or permit, the court may order a denial of driving privileges for any period up to the child's 18th birthday. The court shall forward an order issued under this clause to the commissioner, who shall cancel the license or permit or deny driving privileges without a hearing for the period specified by the court. At any time before the expiration of the period of cancellation or denial, the court may, for good cause, order the commissioner of public safety to allow the child to apply for a license or permit, and the commissioner shall so authorize;

(8) order that the child's parent or legal guardian deliver the child to school at the beginning of each school day for a period of time specified by the court; or

(9) require the child to perform any other activities or participate in any other treatment programs deemed appropriate by the court.

To the extent practicable, the court shall enter a disposition order the same day it makes a finding that a child is in need of protection or services or neglected and in foster care, but in no

event more than 15 days after the finding unless the court finds that the best interests of the child will be served by granting a delay. If the child was under eight years of age at the time the petition was filed, the disposition order must be entered within ten days of the finding and the court may not grant a delay unless good cause is shown and the court finds the best interests of the child will be served by the delay.

(c) If a child who is 14 years of age or older is adjudicated in need of protection or services because the child is a habitual truant and truancy procedures involving the child were previously dealt with by a school attendance review board or county attorney mediation program under section 260A.06 or 260A.07, the court shall order a cancellation or denial of driving privileges under paragraph (b), clause (7), for any period up to the child's 18th birthday.

(d) In the case of a child adjudicated in need of protection or services because the child has committed domestic abuse and been ordered excluded from the child's parent's home, the court shall dismiss jurisdiction if the court, at any time, finds the parent is able or willing to provide an alternative safe living arrangement for the child, as defined in Laws 1997, chapter 239, article 10, section 2.

Sec. 53. [DEVELOPMENT OF PAYMENT SYSTEM FOR ADULT RESIDENTIAL SERVICES GRANTS.]

The commissioner of human services shall review funding methods for adult residential services grants under Minnesota Rules, parts 9535.2000 to 9535.3000, and shall develop a payment system that takes into account client difficulty of care as manifested by client physical, mental, or behavioral conditions. The payment system must provide reimbursement for education, consultation, and support services provided to families and other individuals as an extension of the treatment process. The commissioner shall present recommendations and draft legislation for an adult residential services payment system to the legislature by January 15, 2002. The recommendations must address whether additional funding for adult residential services grants is necessary for the provision of high quality services under a payment reimbursement system.

Sec. 54. [NOTICE REGARDING ESTABLISHMENT OF CONTINUING CARE BENEFIT PROGRAM.]

When the continuing care benefit program for persons with mental illness under Minnesota Statutes, section 256.9693, is established, the commissioner of human services shall notify counties, health plan companies with prepaid medical assistance contracts, health care providers, and enrollees of the benefit program through bulletins, workshops, and other meetings.

Sec. 55. [STUDY OF CHILDREN'S MENTAL HEALTH SYSTEM.]

The commissioner of human services shall conduct a comprehensive study of the children's mental health system, including, but not limited to, governance, funding for services, family involvement in the provision of services, the involvement of schools and other entities in the provision of services, and the use of a public health model for early intervention and treatment services. This study shall be conducted in consultation with the commissioner of health; the commissioner of children, families, and learning; the providers of mental health services in schools; other providers of mental health services; parents of children receiving mental health services; local children's mental health collaboratives; counties; and other interested parties. The study shall include an assessment and evaluation of the family services collaboratives and mental health collaboratives. The commissioner shall report findings and recommendations for changes to the children's mental health system to the legislature by January 15, 2002.

Sec. 56. [STUDY; LENGTH OF STAY FOR MEDICARE-ELIGIBLE PERSONS.]

The commissioner of human services shall study and make recommendations on how Medicare-eligible persons with mental illness may obtain acute care hospital inpatient treatment for mental illness for a length of stay beyond that allowed by the diagnostic classifications for mental illness according to Minnesota Statutes, section 256.969, subdivision 3a. The study and recommendations shall be reported to the legislature by January 15, 2002.

Sec. 57. [TRANSITIONAL SERVICES FOR MENTALLY ILL OFFENDERS PILOT PROGRAM REPORT.]

By January 15, 2003, the commissioner of corrections shall report to the chairs and ranking minority members of the house and senate committees and divisions having jurisdiction over criminal justice policy and funding on the effectiveness of the grants made and pilot projects funded under section 244.25.

ARTICLE 10

ASSISTANCE PROGRAMS

Section 1. Minnesota Statutes 2000, section 256.98, subdivision 8, is amended to read:

Subd. 8. [DISQUALIFICATION FROM PROGRAM.] (a) Any person found to be guilty of wrongfully obtaining assistance by a federal or state court or by an administrative hearing determination, or waiver thereof, through a disqualification consent agreement, or as part of any approved diversion plan under section 401.065, or any court-ordered stay which carries with it any probationary or other conditions, in the Minnesota family ~~assistance~~ investment program, the food stamp program, the general assistance program, the group residential housing program, or the Minnesota supplemental aid program shall be disqualified from that program. In addition, any person disqualified from the Minnesota family investment program shall also be disqualified from the food stamp program. The needs of that individual shall not be taken into consideration in determining the grant level for that assistance unit:

(1) for one year after the first offense;

(2) for two years after the second offense; and

(3) permanently after the third or subsequent offense.

The period of program disqualification shall begin on the date stipulated on the advance notice of disqualification without possibility of postponement for administrative stay or administrative hearing and shall continue through completion unless and until the findings upon which the sanctions were imposed are reversed by a court of competent jurisdiction. The period for which sanctions are imposed is not subject to review. The sanctions provided under this subdivision are in addition to, and not in substitution for, any other sanctions that may be provided for by law for the offense involved. A disqualification established through hearing or waiver shall result in the disqualification period beginning immediately unless the person has become otherwise ineligible for assistance. If the person is ineligible for assistance, the disqualification period begins when the person again meets the eligibility criteria of the program from which they were disqualified and makes application for that program.

(b) A family receiving assistance through child care assistance programs under chapter 119B with a family member who is found to be guilty of wrongfully obtaining child care assistance by a federal court, state court, or an administrative hearing determination or waiver, through a disqualification consent agreement, as part of an approved diversion plan under section 401.065, or a court-ordered stay with probationary or other conditions, is disqualified from child care assistance programs. The disqualifications must be for periods of three months, six months, and two years for the first, second, and third offenses respectively. Subsequent violations must result in permanent disqualification. During the disqualification period, disqualification from any child care program must extend to all child care programs and must be immediately applied.

Sec. 2. Minnesota Statutes 2000, section 256D.053, subdivision 1, is amended to read:

Subdivision 1. [PROGRAM ESTABLISHED.] The Minnesota food assistance program is established to provide food assistance to legal noncitizens residing in this state who are ineligible to participate in the federal Food Stamp Program solely due to the provisions of section 402 or 403 of Public Law Number 104-193, as authorized by Title VII of the 1997 Emergency Supplemental Appropriations Act, Public Law Number 105-18, and as amended by Public Law Number 105-185.

~~Beginning July 1, 2002, the Minnesota food assistance program is limited to those noncitizens described in this subdivision who are 50 years of age or older.~~

Sec. 3. Minnesota Statutes 2000, section 256D.425, subdivision 1, is amended to read:

Subdivision 1. [PERSONS ENTITLED TO RECEIVE AID.] A person who is aged, blind, or 18 years of age or older and disabled and who is receiving supplemental security benefits under Title XVI on the basis of age, blindness, or disability (or would be eligible for such benefits except for excess income) is eligible for a payment under the Minnesota supplemental aid program, if the person's net income is less than the standards in section 256D.44. Persons who are not receiving supplemental security income benefits under Title XVI of the Social Security Act or disability insurance benefits under Title II of the Social Security Act due to exhausting time limited benefits are not eligible to receive benefits under the MSA program. Persons who are not receiving social security or other maintenance benefits for failure to meet or comply with the social security or other maintenance program requirements are not eligible to receive benefits under the MSA program. Persons who are found ineligible for supplemental security income because of excess income, but whose income is within the limits of the Minnesota supplemental aid program, must have blindness or disability determined by the state medical review team.

Sec. 4. [256J.021] [SEPARATE STATE PROGRAM FOR USE OF STATE MONEY.]

(a) Beginning October 1, 2001, and each year thereafter, the commissioner of human services must treat financial assistance expenditures made to or on behalf of any minor child under section 256J.02, subdivision 2, clause (1), who is a resident of this state under section 256J.12, and who is part of a two-parent eligible household as expenditures under a separately funded state program and report those expenditures to the federal Department of Health and Human Services as separate state program expenditures under Code of Federal Regulations, title 45, section 263.5.

(b) One parent in a two-parent eligible household may meet all of the family's hourly work or work activity requirements specified under sections 256J.49 to 256J.72, or the hourly requirement may be divided between the caregivers as best meets the family's needs as documented in the caregiver's workplans.

Sec. 5. Minnesota Statutes 2000, section 256J.08, subdivision 55a, is amended to read:

Subd. 55a. [MFIP STANDARD OF NEED.] "MFIP standard of need" means the appropriate standard used to determine MFIP benefit payments for the MFIP unit and applies to:

(1) the transitional standard, sections 256J.08, subdivision 85, and 256J.24, subdivision 5; and

(2) the shared household standard, section 256J.24, subdivision 9~~; and~~

~~(3) the interstate transition standard, section 256J.43~~.

Sec. 6. Minnesota Statutes 2000, section 256J.08, is amended by adding a subdivision to read:

Subd. 67a. [PERSON TRAINED IN DOMESTIC VIOLENCE.] "Person trained in domestic violence" means an individual who works for an organization that is designated by the Minnesota center for crime victims services as providing services to victims of domestic violence, or a county staff person who has received similar specialized training, and includes any other person or organization designated by a qualifying organization under this section.

**[EFFECTIVE DATE.]** This section is effective October 1, 2001.

Sec. 7. Minnesota Statutes 2000, section 256J.21, subdivision 2, is amended to read:

Subd. 2. [INCOME EXCLUSIONS.] (a) The following must be excluded in determining a family's available income:

(1) payments for basic care, difficulty of care, and clothing allowances received for providing family foster care to children or adults under Minnesota Rules, parts 9545.0010 to 9545.0260 and 9555.5050 to 9555.6265, and payments received and used for care and maintenance of a third-party beneficiary who is not a household member;

(2) reimbursements for employment training received through the Job Training Partnership Act, United States Code, title 29, chapter 19, sections 1501 to 1792b;

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

(4) all educational assistance, except the county agency must count graduate student teaching assistantships, fellowships, and other similar paid work as earned income and, after allowing deductions for any unmet and necessary educational expenses, shall count scholarships or grants awarded to graduate students that do not require teaching or research as unearned income;

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

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

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

(ii) federal income tax refunds;

(8)(i) federal earned income credits;

(ii) Minnesota working family credits;

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

(iv) federal or state tax rebates;

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

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

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

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

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

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

(15) emergency assistance payments;

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

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

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

(19) Supplemental Security Income (SSI), including retroactive SSI payments and other income of an SSI recipient;

(20) Minnesota supplemental aid, including retroactive payments;

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

(22) adoption assistance payments under section 259.67;

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

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

(25) rent rebates;

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

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

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

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

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

(31) reverse mortgages;

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

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

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

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

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

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

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

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

(40) security and utility deposit refunds;

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

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

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

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

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

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

(47) participant performance bonuses under section 256J.555.

Sec. 8. Minnesota Statutes 2000, section 256J.24, subdivision 2, is amended to read:

Subd. 2. [MANDATORY ASSISTANCE UNIT COMPOSITION.] Except for minor caregivers and their children who must be in a separate assistance unit from the other persons in the household, when the following individuals live together, they must be included in the assistance unit:

(1) a minor child, including a pregnant minor;

(2) the minor child's minor siblings, minor half-siblings, and minor step-siblings;

(3) the minor child's natural parents, adoptive parents, and stepparents; and

(4) the spouse of a pregnant woman.

A minor child must have a caregiver for the child to be included in the assistance unit.

Sec. 9. Minnesota Statutes 2000, section 256J.24, subdivision 9, is amended to read:

Subd. 9. [SHARED HOUSEHOLD STANDARD; MFIP.] (a) Except as prohibited in paragraph (b), the county agency must use the shared household standard when the household includes one or more unrelated members, as that term is defined in section 256J.08, subdivision 86a. The county agency must use the shared household standard, unless a member of the assistance unit is a victim of ~~domestic~~ family violence and has an ~~approved safety~~ alternative employment plan, regardless of the number of unrelated members in the household.

(b) The county agency must not use the shared household standard when all unrelated members are one of the following:

(1) a recipient of public assistance benefits, including food stamps, Supplemental Security Income, adoption assistance, relative custody assistance, or foster care payments;

(2) a roomer or boarder, or a person to whom the assistance unit is paying room or board;

(3) a minor child under the age of 18;

(4) a minor caregiver living with the minor caregiver's parents or in an approved supervised living arrangement;

(5) a caregiver who is not the parent of the minor child in the assistance unit; or

(6) an individual who provides child care to a child in the MFIP assistance unit.

(c) The shared household standard must be discontinued if it is not approved by the United States Department of Agriculture under the MFIP waiver.

Sec. 10. Minnesota Statutes 2000, section 256J.24, subdivision 10, is amended to read:

Subd. 10. [MFIP EXIT LEVEL.] ~~(a) In state fiscal years 2000 and 2001,~~ The commissioner shall adjust the MFIP earned income disregard to ensure that most participants do not lose eligibility for MFIP until their income reaches at least 120 percent of the federal poverty guidelines in effect in October of each fiscal year. The adjustment to the disregard shall be based on a household size of three, and the resulting earned income disregard percentage must be applied to all household sizes. The adjustment under this subdivision must be implemented at the same time as the October food stamp cost-of-living adjustment is reflected in the food portion of MFIP transitional standard as required under subdivision 5a.

~~(b) In state fiscal year 2002 and thereafter, the earned income disregard percentage must be the same as the percentage implemented in October 2000.~~

Sec. 11. Minnesota Statutes 2000, section 256J.32, subdivision 4, is amended to read:

Subd. 4. [FACTORS TO BE VERIFIED.] The county agency shall verify the following at application:

(1) identity of adults;

(2) presence of the minor child in the home, if questionable;

(3) relationship of a minor child to caregivers in the assistance unit;

(4) age, if necessary to determine MFIP eligibility;

(5) immigration status;

(6) social security number according to the requirements of section 256J.30, subdivision 12;

(7) income;

(8) self-employment expenses used as a deduction;

(9) source and purpose of deposits and withdrawals from business accounts;

(10) spousal support and child support payments made to persons outside the household;

(11) real property;

(12) vehicles;

(13) checking and savings accounts;

(14) savings certificates, savings bonds, stocks, and individual retirement accounts;

(15) pregnancy, if related to eligibility;

(16) inconsistent information, if related to eligibility;

(17) medical insurance;

(18) burial accounts;

(19) school attendance, if related to eligibility;

(20) residence;

(21) a claim of ~~domestic~~ family violence if used as a basis for a ~~deferral or exemption~~ waiver from the 60-month time limit in section 256J.42 ~~or~~ and regular employment and training services requirements in section 256J.56;

(22) disability if used as an exemption from employment and training services requirements under section 256J.56; and

(23) information needed to establish an exception under section 256J.24, subdivision 9.

**[EFFECTIVE DATE.]** This section is effective October 1, 2001.

Sec. 12. Minnesota Statutes 2000, section 256J.37, subdivision 9, is amended to read:

Subd. 9. [UNEARNED INCOME.] ~~(a)~~ The county agency must apply unearned income to the MFIP standard of need. When determining the amount of unearned income, the county agency must deduct the costs necessary to secure payments of unearned income. These costs include legal fees, medical fees, and mandatory deductions such as federal and state income taxes.

~~(b) Effective July 1, 2001, the county agency shall count $100 of the value of public and assisted rental subsidies provided through the Department of Housing and Urban Development (HUD) as unearned income. The full amount of the subsidy must be counted as unearned income when the subsidy is less than $100.~~

~~(c) The provisions of paragraph (b) shall not apply to MFIP participants who are exempt from the employment and training services component because they are:~~

~~(i) individuals who are age 60 or older;~~

~~(ii) individuals who are suffering from a professionally certified permanent or temporary illness, injury, or incapacity which is expected to continue for more than 30 days and which prevents the person from obtaining or retaining employment; or~~

~~(iii) caregivers whose presence in the home is required because of the professionally certified illness or incapacity of another member in the assistance unit, a relative in the household, or a foster child in the household.~~

~~(d) The provisions of paragraph (b) shall not apply to an MFIP assistance unit where the parental caregiver receives supplemental security income.~~

Sec. 13. Minnesota Statutes 2000, section 256J.39, subdivision 2, is amended to read:

Subd. 2. [PROTECTIVE AND VENDOR PAYMENTS.] Alternatives to paying assistance directly to a participant may be used when:

(1) a county agency determines that a vendor payment is the most effective way to resolve an emergency situation pertaining to basic needs;

(2) a caregiver makes a written request to the county agency asking that part or all of the assistance payment be issued by protective or vendor payments for shelter and utility service only. The caregiver may withdraw this request in writing at any time;

(3) the vendor payment is part of a sanction under section 256J.46;

(4) the vendor payment is required under section 256J.24, subdivision 8, or 256J.26~~, or 256J.43~~;

(5) protective payments are required for minor parents under section 256J.14; or

(6) a caregiver has exhibited a continuing pattern of mismanaging funds as determined by the county agency.

The director of a county agency, or the director's designee, must approve a proposal for protective or vendor payment for money mismanagement when there is a pattern of mismanagement under clause (6). During the time a protective or vendor payment is being made, the county agency must provide services designed to alleviate the causes of the mismanagement.

The continuing need for and method of payment must be documented and reviewed every 12 months. The director of a county agency or the director's designee must approve the continuation of protective or vendor payments. When it appears that the need for protective or vendor payments

will continue or is likely to continue beyond two years because the county agency's efforts have not resulted in sufficiently improved use of assistance on behalf of the minor child, judicial appointment of a legal guardian or other legal representative must be sought by the county agency.

Sec. 14. Minnesota Statutes 2000, section 256J.42, subdivision 1, is amended to read:

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

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

Sec. 15. Minnesota Statutes 2000, section 256J.42, subdivision 3, is amended to read:

Subd. 3. [ADULTS LIVING ~~ON AN~~ IN INDIAN ~~RESERVATION~~ COUNTRY.] In determining the number of months for which an adult has received assistance under MFIP-S, the county agency must disregard any month during which the adult lived ~~on an~~ in Indian ~~reservation~~ country if during the month at least 50 percent of the adults living ~~on the reservation~~ in Indian country were not employed.

Sec. 16. Minnesota Statutes 2000, section 256J.42, subdivision 4, is amended to read:

Subd. 4. [VICTIMS OF ~~DOMESTIC~~ FAMILY VIOLENCE.] Any cash assistance received by an assistance unit in a month when a caregiver ~~is complying~~ complied with a safety plan or after October 1, 2001, complied or is complying with an alternative employment plan under ~~the MFIP-S employment and training component~~ section 256J.49, subdivision 1a, does not count toward the 60-month limitation on assistance.

Sec. 17. Minnesota Statutes 2000, section 256J.42, subdivision 5, is amended to read:

Subd. 5. [EXEMPTION FOR CERTAIN FAMILIES.] (a) Any cash assistance received by an assistance unit does not count toward the 60-month limit on assistance during a month in which the caregiver (1) is in ~~the~~ a category in section 256J.56~~, paragraph (a), clause (1)~~; (2) is earning income and participating in work activities, as defined in section 256J.49, subdivision 13, for at least 40 hours per week for a two-parent family, 20 hours per week for a single-parent family with a child under age six years, or 30 hours per week for a single-parent family with a child age 6 years or older. If the individualized plan requires fewer hours of work activities, then it is the number of hours required in the plan; or (3) is in an education or training program, including, but not limited to, an English as a second language (ESL) program, in which the combination of work activities and education are for at least 40 hours per week for a two-parent family, or 20 hours per week for a single-parent family with a child under age six years, or 30 hours per week for a single-parent family with a child age 6 years or older. If the individualized plan requires fewer hours of work activities, then it is the number of hours required in the plan.

(b) ~~From July 1, 1997, until the date MFIP is operative in the caregiver's county of financial responsibility, any cash assistance received by a caregiver who is complying with Minnesota Statutes 1996, section 256.73, subdivision 5a, and Minnesota Statutes 1998, section 256.736, if applicable, does not count toward the 60-month limit on assistance. Thereafter, any cash assistance~~

~~received by a minor caregiver who is complying with the requirements of sections 256J.14 and 256J.54, if applicable, does not count towards the 60-month limit on assistance.~~

~~(e)~~ Any diversionary assistance or emergency assistance received does not count toward the 60-month limit.

~~(d)~~ (c) Any cash assistance received by an 18- or 19-year-old caregiver who is complying with the requirements of section 256J.54 does not count toward the 60-month limit.

Sec. 18. [256J.422] [60-MONTH TIME LIMIT REVIEW; EXTENSION; APPEAL.]

Subdivision 1. [EXTENSION OF 60-MONTH TIME LIMIT.] At the end of the participant's eligibility period when TANF assistance has been exhausted, the participant's time limit will be extended provided the participant meets the MFIP eligibility criteria. Participants must comply with MFIP requirements or be subject to a sanction. The county may choose not to provide an extension for participants if after a face-to-face review, the participant does not fall under any of the categories in subdivision 2.

Subd. 2. [REVIEW.] (a) A county representative may schedule a face-to-face review with a participant who is nearing the 60-month time limit on TANF assistance. The face-to-face review must be conducted with a county representative, a representative from a legal rights organization that primarily represents low-income individuals or an advocate, and the participant, unless the participant requests that a representative or advocate not be present during the review. A face-to-face review with the participant must be conducted before the participant is denied an extension. The county representative makes the final determination regarding the extension of assistance.

(b) In the face-to-face review, the individuals in attendance shall determine if:

(1) the participant's plan is inappropriate or if it should be modified in order for the participant to reduce barriers or achieve goals that will lead to long-term self-sufficiency;

(2) the participant falls under any of the exempt categories in section 256J.42;

(3) there are other substantial barriers that need to be addressed, which include, but are not limited to, language barriers, physical or mental health needs, or learning disabilities;

(4) there are services that were required to be provided or necessary in order to fulfill the requirements of the plan that were unavailable to the participant;

(5) there are educational opportunities that will lead to self-sufficiency that were not allowed or offered to the participant;

(6) the participant's plan is appropriate and the participant is meeting the expectations of the participant's individualized plan, or in a two-parent family, at least one participant has an appropriate plan and is meeting the expectations of that individualized plan;

(7) the employment held by the participant will not provide a wage of at least 120 percent of the federal poverty guidelines for the same family size, or in a two-parent family, when at least one parent is cooperating with the program requirements, the employment held by the cooperating participant will not provide a wage of at least 120 percent of the federal poverty guidelines for the same family size; or

(8) there are other issues that need to be addressed before the participant is denied an extension.

Subd. 3. [APPEAL OF COUNTY DECISION.] If the county denies an extension under subdivision 2, the participant may appeal the decision under section 256J.40. Assistance must continue until the appeal is resolved.

Sec. 19. Minnesota Statutes 2000, section 256J.45, subdivision 1, is amended to read:

Subdivision 1. [COUNTY AGENCY TO PROVIDE ORIENTATION.] A county agency must

provide orientation to each MFIP caregiver ~~who is not exempt under section 256J.56, paragraph (a), clause (6) or (8)~~ unless the caregiver: (1) is a single parent, or one parent in a two-parent family, employed at least 35 hours per week; or (2) a second parent in a two-parent family who is employed for 20 or more hours per week provided the first parent is employed at least 35 hours per week, with a face-to-face orientation. The county agency must inform caregivers who are not exempt under ~~section 256J.56, paragraph (a), clause (6) or (8),~~ clause (1) or (2) that failure to attend the orientation is considered an occurrence of noncompliance with program requirements, and will result in the imposition of a sanction under section 256J.46. If the client complies with the orientation requirement prior to the first day of the month in which the grant reduction is proposed to occur, the orientation sanction shall be lifted.

Sec. 20. Minnesota Statutes 2000, section 256J.45, subdivision 2, is amended to read:

Subd. 2. [GENERAL INFORMATION.] The ~~MFIP-S~~ MFIP orientation must consist of a presentation that informs caregivers of:

(1) the necessity to obtain immediate employment;

(2) the work incentives under ~~MFIP-S~~ MFIP, including the availability of the federal earned income tax credit and the Minnesota working family tax credit;

(3) the requirement to comply with the employment plan and other requirements of the employment and training services component of ~~MFIP-S~~ MFIP, including a description of the range of work and training activities that are allowable under ~~MFIP-S~~ MFIP to meet the individual needs of participants;

(4) the consequences for failing to comply with the employment plan and other program requirements, and that the county agency may not impose a sanction when failure to comply is due to the unavailability of child care or other circumstances where the participant has good cause under subdivision 3;

(5) the rights, responsibilities, and obligations of participants;

(6) the types and locations of child care services available through the county agency;

(7) the availability and the benefits of the early childhood health and developmental screening under sections 121A.16 to 121A.19; 123B.02, subdivision 16; and 123B.10;

(8) the caregiver's eligibility for transition year child care assistance under section 119B.05;

(9) the caregiver's eligibility for extended medical assistance when the caregiver loses eligibility for ~~MFIP-S~~ MFIP due to increased earnings or increased child or spousal support;

(10) the caregiver's option to choose an employment and training provider and information about each provider, including but not limited to, services offered, program components, job placement rates, job placement wages, and job retention rates;

(11) the caregiver's option to request approval of an education and training plan according to section 256J.52; ~~and~~

(12) the work study programs available under the higher education system; and

(13) effective October 1, 2001, information about the 60-month time limit exemption and waivers of regular employment and training requirements for family violence victims and referral information about shelters and programs for victims of family violence.

Sec. 21. Minnesota Statutes 2000, section 256J.46, subdivision 1, is amended to read:

Subdivision 1. [~~SANCTIONS FOR~~ PARTICIPANTS NOT COMPLYING WITH PROGRAM REQUIREMENTS.] (a) A participant who fails without good cause to comply with the requirements of this chapter, and who is not subject to a sanction under subdivision 2, shall be subject to a sanction as provided in this subdivision. A participant who fails to comply with an

alternative employment plan must have the plan reviewed by a person trained in domestic violence and the county or a job counselor to determine if components of the alternative employment plan are still appropriate. If the activities are no longer appropriate, the plan must be revised with a person trained in domestic violence and approved by the county or a job counselor. A participant who fails to comply with a plan that is determined not to need revision will lose their exemption and be required to comply with regular employment services activities.

A sanction must not be imposed for the sole purpose of failing to participate in work activities for a specified number of hours if the participant is a single parent or one parent in a two-parent family and is employed at least 35 hours per week.

A sanction under this subdivision becomes effective the month following the month in which a required notice is given. A sanction must not be imposed when a participant comes into compliance with the requirements for orientation under section 256J.45 or third-party liability for medical services under section 256J.30, subdivision 10, prior to the effective date of the sanction. A sanction must not be imposed when a participant comes into compliance with the requirements for employment and training services under sections 256J.49 to 256J.72 ten days prior to the effective date of the sanction. For purposes of this subdivision, each month that a participant fails to comply with a requirement of this chapter shall be considered a separate occurrence of noncompliance. A participant who has had one or more sanctions imposed must remain in compliance with the provisions of this chapter for six months in order for a subsequent occurrence of noncompliance to be considered a first occurrence.

(b) Sanctions for noncompliance shall be imposed as follows:

(1) For the first occurrence of noncompliance by a participant in a single-parent household or by one participant in a two-parent household, the job counselor must initiate personal contact with the participant by either having a personal meeting with the participant or a telephone conversation with the participant, and thoroughly review the exemption and good cause categories with the participant to determine if the participant falls under one or more of the categories. If the participant does not fall under an exemption or good cause category, the assistance unit's grant shall be reduced by ten percent of the MFIP standard of need for an assistance unit of the same size with the residual grant paid to the participant. The reduction in the grant amount must be in effect for a minimum of one month and shall be removed in the month following the month that the participant returns to compliance.

(2) For a second or subsequent occurrence of noncompliance, or when both participants in a two-parent household are out of compliance at the same time, the assistance unit's shelter costs shall be vendor paid up to the amount of the cash portion of the MFIP grant for which the participant's assistance unit is eligible. At county option, the assistance unit's utilities may also be vendor paid up to the amount of the cash portion of the MFIP grant remaining after vendor payment of the assistance unit's shelter costs. The residual amount of the grant after vendor payment, if any, must be reduced by an amount equal to 30 percent of the MFIP standard of need for an assistance unit of the same size before the residual grant is paid to the assistance unit. The reduction in the grant amount must be in effect for a minimum of one month and shall be removed in the month following the month that a participant in a one-parent household returns to compliance. In a two-parent household, the grant reduction must be in effect for a minimum of one month and shall be removed in the month following the month both participants return to compliance. The vendor payment of shelter costs and, if applicable, utilities shall be removed six months after the month in which the participant or participants return to compliance.

(3) The food portion of the MFIP grant must not be sanctioned.

(c) No later than during the second month that a sanction under paragraph (b), clause (2), is in effect due to noncompliance with employment services, the participant's case file must be reviewed to determine if:

(i) the continued noncompliance can be explained and mitigated by providing a needed preemployment activity, as defined in section 256J.49, subdivision 13, clause (16);

(ii) the participant qualifies for a good cause exception under section 256J.57; ~~or~~

(iii) the participant qualifies for an exemption under section 256J.56; or

(iv) the participant qualifies for a waiver under section 256J.52, subdivision 6.

If the lack of an identified activity can explain the noncompliance, the county must work with the participant to provide the identified activity, and the county must restore the participant's grant amount to the full amount for which the assistance unit is eligible. The grant must be restored retroactively to the first day of the month in which the participant was found to lack preemployment activities or to qualify for an exemption ~~or~~, a good cause exception, or a family violence waiver.

If the participant is found to qualify for a good cause exception or ~~an~~ exemption, or a family violence waiver, the county must restore the participant's grant to the full amount for which the assistance unit is eligible.

(d) In the two-parent MFIP program under section 256J.021 if only one caregiver is out of compliance with the requirements for employment and training under sections 256J.49 to 256J.72, the MFIP grant shall be reduced by either ten percent or 30 percent of the noncompliant parent's portion of the transitional standard, whichever is applicable to the sanction occurrence.

**[EFFECTIVE DATE.]** The language in this section related to domestic or family violence is effective October 1, 2001.

Sec. 22. Minnesota Statutes 2000, section 256J.48, subdivision 1, is amended to read:

Subdivision 1. [EMERGENCY FINANCIAL ASSISTANCE.] County human service agencies shall grant emergency financial assistance to any needy pregnant woman or needy family with a child under the age of 21 who is or was within six months prior to application living with an eligible caregiver relative specified in section 256J.08.

Except for ongoing special diets, emergency assistance is available to a family ~~during one 30-day period in~~ for up to two times a year, not to exceed a maximum of 120 days within a consecutive 12-month period. A county shall issue assistance for needs that accrue before ~~that 30-day period~~ the eligibility period only when it is necessary to resolve emergencies arising or continuing during the ~~30-day~~ period of eligibility. ~~When emergency needs continue, a county may issue assistance for up to 30 days beyond the initial 30-day period of eligibility, but only when assistance is authorized during the initial period.~~

Sec. 23. Minnesota Statutes 2000, section 256J.48, is amended by adding a subdivision to read:

Subd. 1a. [PROCESSING EMERGENCY APPLICATIONS.] Within seven days of receiving the application, or sooner if the immediacy and severity of the situation warrants it, families must be notified in writing whether their application was approved, denied, or pended.

Sec. 24. Minnesota Statutes 2000, section 256J.49, is amended by adding a subdivision to read:

Subd. 1a. [ALTERNATIVE EMPLOYMENT PLAN.] "Alternative employment plan" means a plan that is based on an individualized assessment of need and is developed with a person trained in domestic violence and approved by the county or a job counselor. The plan may address safety, legal or emotional issues, and other demands on the family as a result of the family violence. The information in section 256J.515, clauses (1) to (8), must be included as part of the development of the alternative employment plan. The primary goal of an alternative employment plan is to ensure the safety of the caregiver and children. To the extent it is consistent with ensuring safety, an alternative employment plan shall also include activities that are designed to lead to self-sufficiency. An activity is inconsistent with ensuring safety if, in the opinion of a person trained in domestic violence, the activity would endanger the safety of the participant or children. An alternative employment plan may not automatically include a provision that requires a participant to obtain an order for protection or to attend counseling.

**[EFFECTIVE DATE.]** This section is effective October 1, 2001.

Sec. 25. Minnesota Statutes 2000, section 256J.49, subdivision 2, is amended to read:

Subd. 2. [~~DOMESTIC~~ FAMILY VIOLENCE.] "~~Domestic~~ Family violence" means:

(1) physical acts that result, or threaten to result in, physical injury to an individual;

(2) sexual abuse;

(3) sexual activity involving a minor child;

(4) being forced as the caregiver of a minor child to engage in nonconsensual sexual acts or activities;

(5) threats of, or attempts at, physical or sexual abuse;

(6) mental abuse; or

(7) neglect or deprivation of medical care.

Claims of family violence must be documented by the applicant or participant providing a sworn statement, which is supported by collateral documentation. Collateral documentation may consist of any one of the following:

(1) police, government agency, or court records;

(2) a statement from a battered woman's shelter staff with knowledge of circumstances or credible evidence that supports the sworn statement;

(3) a statement from a sexual assault or domestic violence advocate with knowledge of the circumstances or credible evidence that supports a sworn statement;

(4) a statement from professionals from whom the applicant or recipient has sought assistance for the abuse; or

(5) a sworn statement from any other individual with knowledge of circumstances or credible evidence that supports the sworn statement.

**[EFFECTIVE DATE.]** This section is effective October 1, 2001.

Sec. 26. Minnesota Statutes 2000, 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 is tied to the participant's employment goal. For purposes of the MFIP program, any activity that is included in a participant's approved employment plan meets the definition of work activity as counted under the federal participation standards. Work activity includes, but is not limited to:

(1) unsubsidized employment;

(2) subsidized private sector or public sector employment, including grant diversion as specified in section 256J.69;

(3) work experience, including CWEP as specified in section 256J.67, and including work associated with the refurbishing of publicly assisted housing if sufficient private sector employment is not available;

(4) on-the-job training as specified in section 256J.66;

(5) job search, either supervised or unsupervised;

(6) job readiness assistance;

(7) job clubs, including job search workshops;

(8) job placement;

(9) job development;

(10) job-related counseling;

(11) job coaching;

(12) job retention services;

(13) job-specific training or education;

(14) job skills training directly related to employment;

(15) the self-employment investment demonstration (SEID), as specified in section 256J.65;

(16) preemployment activities, based on availability and resources, such as volunteer work, literacy programs and related activities, citizenship classes, English as a second language (ESL) classes as limited by the provisions of section 256J.52, subdivisions 3, paragraph (d), and 5, paragraph (c), or participation in dislocated worker services, chemical dependency treatment, mental health services, peer group networks, displaced homemaker programs, strength-based resiliency training, parenting education, or other programs designed to help families reach their employment goals and enhance their ability to care for their children;

(17) community service programs;

(18) vocational educational training or educational programs that can reasonably be expected to lead to employment, as limited by the provisions of section 256J.53;

(19) apprenticeships;

(20) satisfactory attendance in general educational development diploma classes or an adult diploma program;

(21) satisfactory attendance at secondary school, if the participant has not received a high school diploma;

(22) adult basic education classes;

(23) internships;

(24) bilingual employment and training services;

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

(26) activities included in ~~a safety~~ an alternative employment plan that is developed under section 256J.52, subdivision 6.

**[EFFECTIVE DATE.]** This section is effective October 1, 2001.

Sec. 27. Minnesota Statutes 2000, section 256J.50, subdivision 5, is amended to read:

Subd. 5. [PARTICIPATION REQUIREMENTS FOR ALL CASES.] (a) For two-parent cases, participation is required concurrent with the receipt of MFIP cash assistance.

For single-parent cases, participation is required concurrent with the receipt of MFIP cash assistance for all counties except Blue Earth and Nicollet, effective July 1, 2000, and is required for Blue Earth and Nicollet counties effective January 1, 2001. For Blue Earth and Nicollet counties only, from July 1, 2000 to December 31, 2000, mandatory participation for single-parent cases must be required within six months of eligibility for cash assistance.

(b) Beginning January 1, 1998, with the exception of caregivers required to attend high school under the provisions of section 256J.54, subdivision 5, MFIP caregivers, upon completion of the secondary assessment, must develop an employment plan and participate in work activities.

(c) Upon completion of the secondary assessment:

(1) In single-parent families with no children under six years of age, the job counselor and the caregiver must develop an employment plan that includes 20 to 35 hours per week of work activities for the period January 1, 1998, to September 30, 1998; 25 to 35 hours of work activities per week in federal fiscal year 1999; and 30 to 35 hours per week of work activities in federal fiscal year 2000 and thereafter.

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

(3) In two-parent families, the job counselor and the caregivers must develop employment plans which result in a combined total of at least 55 hours per week of work activities, of which at least 30 hours must be completed by one of the parents.

Sec. 28. Minnesota Statutes 2000, section 256J.50, subdivision 10, is amended to read:

Subd. 10. [REQUIRED NOTIFICATION TO VICTIMS OF ~~DOMESTIC~~ FAMILY VIOLENCE.] County agencies and their contractors must provide universal notification to all applicants and recipients of ~~MFIP-S~~ MFIP that:

(1) referrals to counseling and supportive services are available for victims of ~~domestic~~ family violence;

(2) nonpermanent resident battered individuals married to United States citizens or permanent residents may be eligible to petition for permanent residency under the federal Violence Against Women Act, and that referrals to appropriate legal services are available;

(3) victims of ~~domestic~~ family violence are ~~exempt from~~ eligible for an extension of the 60-month limit on assistance ~~while the individual is complying with an approved safety plan, as defined in section 256J.49, subdivision 11~~; and

(4) victims of ~~domestic~~ family violence may choose to ~~be exempt or deferred from~~ have regular work requirements ~~for up to 12 months~~ waived while the individual is complying with an ~~approved safety~~ alternative employment plan as defined in section 256J.49, subdivision ~~11~~ 1a.

If an alternative plan is denied, the county or a job counselor must provide reasons why the plan is not approved and document how the denial of the plan does not interfere with the safety of the participant or children.

Notification must be in writing and orally at the time of application and recertification, when the individual is referred to the title IV-D child support agency, and at the beginning of any job training or work placement assistance program.

**[EFFECTIVE DATE.]** This section is effective October 1, 2001.

Sec. 29. Minnesota Statutes 2000, section 256J.50, is amended by adding a subdivision to read:

Subd. 12. [ACCESS TO PERSONS TRAINED IN DOMESTIC VIOLENCE.] In a county where there is no staff person who is trained in domestic violence, as that term is defined in section 256J.08, subdivision 67a, the county must work with the nearest organization that is designated as providing services to victims of domestic violence to develop a process, which ensures that domestic violence victims have access to a person trained in domestic violence.

**[EFFECTIVE DATE.]** This section is effective October 1, 2001.

Sec. 30. Minnesota Statutes 2000, section 256J.515, is amended to read:

256J.515 [OVERVIEW OF EMPLOYMENT AND TRAINING SERVICES.]

During the first meeting with participants, job counselors must ensure that an overview of employment and training services is provided that:

(1) stresses the necessity and opportunity of immediate employment;

(2) outlines the job search resources offered;

(3) outlines education or training opportunities available;

(4) describes the range of work activities, including activities under section 256J.49, subdivision 13, clause (18), that are allowable under MFIP to meet the individual needs of participants;

(5) explains the requirements to comply with an employment plan;

(6) explains the consequences for failing to comply; ~~and~~

(7) explains the services that are available to support job search and work and education; and

(8) provides referral information about shelters and programs for victims of family violence, the time limit exemption, and waivers of regular employment and training requirements for family violence victims.

Failure to attend the overview of employment and training services without good cause results in the imposition of a sanction under section 256J.46.

Effective October 1, 2001, a participant who has an alternative employment plan under section 256J.52, subdivision 6, as defined in section 256J.49, subdivision 1a, or who is in the process of developing such a plan, is exempt from the requirement to attend the overview.

Sec. 31. Minnesota Statutes 2000, section 256J.52, subdivision 2, is amended to read:

Subd. 2. [INITIAL ASSESSMENT.] (a) The job counselor must, with the cooperation of the participant, assess the participant's ability to obtain and retain employment. This initial assessment must include a review of the participant's education level, prior employment or work experience, transferable work skills, and existing job markets.

(b) In assessing the participant, the job counselor must determine if the participant needs refresher courses for professional certification or licensure, in which case, the job search plan under subdivision 3 must include the courses necessary to obtain the certification or licensure, in addition to other work activities, provided the combination of the courses and other work activities are at least for 40 hours per week.

(c) If a participant can demonstrate to the satisfaction of the county agency that lack of proficiency in English is a barrier to obtaining suitable employment, the job counselor must include participation in an intensive English as a second language program if available or otherwise a regular English as a second language program in the individual's employment plan under subdivision 5. Lack of proficiency in English is not necessarily a barrier to employment.

(d) The job counselor ~~may~~ shall approve an education or training plan, and postpone the job search requirement, if less than 30 percent of the statewide MFIP caseload is participating in education and training, and if the participant has a proposal for an education program which:

(1) can be completed within ~~12~~ 24 months;

(2) meets the criteria of section 256J.53, subdivisions 2, 3, and 5; and

(3) is likely, without additional training, to lead to monthly employment earnings which, after subtraction of the earnings disregard under section 256J.21, equal or exceed the family wage level for the participant's assistance unit.

(e) A participant who, at the time of the initial assessment, presents a plan that includes farming as a self-employed work activity must have an employment plan developed under subdivision 5 that includes the farming as an approved work activity.

(f) Effective October 1, 2001, an alternative employment plan must be offered and explained to a participant who at any time declares or reveals current or past family violence. If the participant is interested, an alternative employment plan must be developed and approved for the participant if the current or past violence affects the ability of the person to participate with regular employment service activities or denial of an alternative employment plan would interfere with the safety of the participant or children.

Sec. 32. Minnesota Statutes 2000, section 256J.52, subdivision 3, is amended to read:

Subd. 3. [JOB SEARCH; JOB SEARCH SUPPORT PLAN.] (a) If, after the initial assessment, the job counselor determines that the participant possesses sufficient skills that the participant is likely to succeed in obtaining suitable employment, the participant must conduct job search for a period of up to eight weeks, for at least 30 hours per week. ~~The participant must accept any offer of suitable employment. Upon agreement by the job counselor and the participant, a job search support plan may limit a job search to jobs that are consistent with the participant's employment goal.~~ The job counselor and participant must develop a job search support plan which specifies, at a minimum: a job goal which realistically reflects the individual's skills, abilities, and work experience and meets the definition of suitable employment, and for which there are job openings in the geographic area of the participant's job search or an area to which the participant is willing to relocate; whether the job search is to be supervised or unsupervised; support services that will be provided while the participant conducts job search activities; the courses necessary to obtain certification or licensure, if applicable, and after obtaining the license or certificate, the client must comply with subdivision 5; and how frequently the participant must report to the job counselor on the status of the participant's job search activities. The job goal specified in the job search support plan must be intended to enable the participant to progress toward employment that provides wages sufficient to allow the participant to transition off of MFIP. The job search support plan must also specify that the participant fulfill no more than half of the required hours of job search through attending adult basic education or English as a second language classes, if one or both of those activities are approved by the job counselor.

(b) During the eight-week job search period, either the job counselor or the participant may request a review of the participant's job search plan and progress towards obtaining ~~suitable employment~~ participant's job goal under paragraph (a). If a review is requested by the participant, the job counselor must concur that the review is appropriate for the participant at that time. If a review is conducted, the job counselor may make a determination to conduct a secondary assessment prior to the conclusion of the job search.

(c) Failure to conduct the required job search, to accept any offer of ~~suitable~~ employment consistent with the participant's job goal under paragraph (a), to develop or comply with a job search support plan, or voluntarily quitting suitable employment without good cause results in the imposition of a sanction under section 256J.46. If at the end of eight weeks the participant has not obtained suitable employment, the job counselor must conduct a secondary assessment of the participant under subdivision ~~3~~ 4.

(d) In order for an English as a second language (ESL) class to be an approved work activity, a participant must be at or below a spoken language proficiency level of SPL5 or its equivalent, as measured by a nationally recognized test. A participant may not be approved for more than a total of 24 months of ESL activities while participating in the employment and training services component of MFIP. In approving ESL as a work activity, the job counselor must give preference to enrollment in an intensive ESL program, if one is available, over a regular ESL program. If an intensive ESL program is approved, the restriction in paragraph (a) that no more than half of the required hours of job search is fulfilled through attending ESL classes does not apply.

Sec. 33. Minnesota Statutes 2000, section 256J.52, subdivision 6, is amended to read:

Subd. 6. [~~SAFETY~~ ALTERNATIVE EMPLOYMENT PLAN AND FAMILY VIOLENCE

WAIVER PROVISIONS.] ~~Notwithstanding subdivisions 1 to 5, a participant who is a victim of domestic violence and who agrees to develop or has developed a safety plan meeting the definition under section 256J.49, subdivision 11, is deferred from the requirements of this section, sections 256J.54, and 256J.55 for a period of three months from the date the safety plan is approved. A participant deferred under this subdivision must submit a safety plan status report to the county agency on a quarterly basis. Based on a review of the status report, the county agency may approve or renew the participant's deferral each quarter, provided the personal safety of the participant is still at risk and the participant is complying with the plan. A participant who is deferred under this subdivision may be deferred for a total of 12 months under a safety plan, provided the individual is complying with the terms of the plan.~~ Participants who have a safety plan under section 256J.49, subdivision 11, prior to October 1, 2001, will have that plan converted to an alternative employment plan upon their plan renewal date. An alternative employment plan must be reviewed at the end of the first six months to determine if the activities contained in the alternative employment plan are still appropriate. It is the responsibility of the county or a job counselor to contact the participant and notify them that their plan is up for review, and document whether the participant wishes to renew the plan. If the participant does not wish to renew the plan, or if the participant fails to respond after reasonable efforts to contact the participant are made by the county or a job counselor, the participant must participate in regular employment services activities. If the participant requests renewal of the plan or if there is a dispute over whether the plan is still appropriate, the participant must receive the assistance of a person trained in domestic violence. If the person trained in domestic violence recommends that the activities are still appropriate, the county or a job counselor must renew the alternative employment plan or provide written reasons why the plan is not approved and document how denial of the plan renewal does not interfere with the safety of the participant or children. If the person trained in domestic violence recommends that the activities are no longer appropriate, the plan must be revised with the assistance of a person trained in domestic violence. The county or a job counselor must approve the revised plan or provide written reasons why the plan is not approved and document how denial of the plan renewal does not interfere with the safety of the participant or children. After the first six months reviews may take place quarterly. During the time a participant is cooperating with the development or revision of an alternative employment plan, the participant is not subject to a sanction for noncompliance with regular employment services activities.

Sec. 34. Minnesota Statutes 2000, section 256J.53, subdivision 1, is amended to read:

Subdivision 1. [LENGTH OF PROGRAM.] In order for a post-secondary education or training program to be approved work activity as defined in section 256J.49, subdivision 13, clause (18), it must be a program lasting ~~12~~ 24 months or less, and the participant must meet the requirements of subdivisions 2 and 3. ~~A program lasting up to 24 months may be approved on an exception basis if the conditions specified in subdivisions 2 to 4 are met. A participant may not be approved for more than a total of 24 months of post-secondary education or training.~~

Sec. 35. Minnesota Statutes 2000, section 256J.53, subdivision 2, is amended to read:

Subd. 2. [DOCUMENTATION SUPPORTING PROGRAM.] (a) In order for a post-secondary education or training program to be an approved activity in a participant's employment plan, the participant or the employment and training service provider must provide documentation that:

(1) the participant's employment plan identifies specific goals that can only be met with the additional education or training;

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

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

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

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

(b) The job counselor shall approve an education or training program that meets the requirements under paragraph (a).

Sec. 36. Minnesota Statutes 2000, section 256J.53, subdivision 3, is amended to read:

Subd. 3. [SATISFACTORY PROGRESS REQUIRED.] In order for a ~~post-secondary education or training program to be an approved activity in a participant's employment plan~~ participant to continue with post-secondary education or training, the participant must maintain satisfactory progress in the program. "Satisfactory progress" in an education or training program means (1) the participant remains in good standing while the participant is enrolled in the program, as defined by the education or training institution, or (2) the participant makes satisfactory progress as the term is defined in the participant's employment plan.

Sec. 37. [256J.555] [PARTICIPANT PERFORMANCE BONUSES.]

If a county elects to provide participant performance bonuses under section 256J.625, subdivision 4, paragraph (d), a participant enrolled in employment and training services is eligible to receive the cash bonuses if the participant has been in compliance with all the requirements of the participant's job search support plan or employment plan for the previous six months. A participant may receive each bonus only once. Income received from the cash bonuses is excluded in determining MFIP eligibility and benefits. Bonuses are available for the completion of the following goals:

(1) for continuous employment of at least 20 hours per week for six months, the bonus is $200. The caregiver is eligible to receive this bonus if the participant remains on MFIP while employed or if the participant has exited MFIP as the result of employment;

(2) for continuous employment of at least 20 hours per week for 12 months, the bonus is $300. The caregiver is eligible to receive this bonus if the participant remains on MFIP while employed or if the participant has exited MFIP as the result of employment;

(3) for employment that leads to earnings sufficient for a caregiver to transition off of MFIP and stay off for six months, the bonus is $300;

(4) for completion of an English as a second language program, the bonus is $300;

(5) for completion of a high school diploma or GED, the bonus is $300; and

(6) for completion of a job skills training program from a certified provider, the bonus is $300.

Sec. 38. Minnesota Statutes 2000, section 256J.56, is amended to read:

256J.56 [EMPLOYMENT AND TRAINING SERVICES COMPONENT; EXEMPTIONS.]

(a) An MFIP caregiver is exempt from the requirements of sections 256J.52 to 256J.55 if the caregiver belongs to any of the following groups:

(1) individuals who are age 60 or older;

(2) individuals who are suffering from a professionally certified permanent or temporary illness, injury, or incapacity which is expected to continue for more than 30 days and which prevents the person from obtaining or retaining employment. Persons in this category with a temporary illness, injury, or incapacity must be reevaluated at least quarterly;

(3) caregivers whose presence in the home is required as a caregiver because of ~~the~~ a professionally certified illness or incapacity of another member in the assistance unit, a relative in the household, or a foster child in the household;

(4) women who are pregnant, if the pregnancy has resulted in a professionally certified incapacity that prevents the woman from obtaining or retaining employment;

(5) caregivers of a child under the age of one year who personally provide full-time care for the

child. This exemption may be used for only 12 months in a lifetime. In two-parent households, only one parent or other relative may qualify for this exemption;

(6) ~~individuals who are single parents, or one parent in a two-parent family, employed at least 35 hours per week;~~

~~(7)~~ individuals experiencing a personal or family crisis that makes them incapable of participating in the program, as determined by the county agency. If the participant does not agree with the county agency's determination, the participant may seek professional certification, as defined in section 256J.08, that the participant is incapable of participating in the program. Persons in this exemption category must be reevaluated every 60 days. A personal or family crisis related to family violence, as determined by the county or a job counselor with the assistance of a person trained in domestic violence, should not result in an exemption, but should be addressed through the development or revision of an alternative employment plan under section 256J.52, subdivision 6;

~~(8)~~ (7) second parents in two-parent families employed for 20 or more hours per week, provided the first parent is employed at least 35 hours per week; or

~~(9)~~ (8) caregivers with a child or an adult in the household who meets the disability or medical criteria for home care services under section 256B.0627, subdivision 1, paragraph (c), or a home and community-based waiver services program under chapter 256B, or meets the criteria for severe emotional disturbance under section 245.4871, subdivision 6, or for serious and persistent mental illness under section 245.462, subdivision 20, paragraph (c). ~~Caregivers in this exemption category are presumed to be prevented from obtaining or retaining employment.~~

(b) A caregiver who is exempt under clause (5) must enroll in and attend an early childhood and family education class, a parenting class, or some similar activity, if available, during the period of time the caregiver is exempt under this section. Notwithstanding section 256J.46, failure to attend the required activity shall not result in the imposition of a sanction.

~~(b)~~ (c) The county agency must provide employment and training services to MFIP caregivers who are exempt under this section, but who volunteer to participate. Exempt volunteers may request approval for any work activity under section 256J.49, subdivision 13. The hourly participation requirements for nonexempt caregivers under section 256J.50, subdivision 5, do not apply to exempt caregivers who volunteer to participate.

Sec. 39. Minnesota Statutes 2000, section 256J.62, subdivision 2a, is amended to read:

Subd. 2a. [CASELOAD-BASED FUNDS ALLOCATION.] Effective for state fiscal year 2000, and for all subsequent years, money shall be allocated to counties and eligible tribal providers based on their average number of MFIP cases as a proportion of the statewide total number of MFIP cases:

(1) the average number of cases must be based upon counts of MFIP or tribal TANF cases as of March 31, June 30, September 30, and December 31 of the previous calendar year, less the number of child only cases and cases where all the caregivers are age 60 or over. Two-parent cases, with the exception of those with a caregiver age 60 or over, will be multiplied by a factor of two;

(2) the MFIP or tribal TANF case count for each eligible tribal provider shall be based upon the number of MFIP or tribal TANF cases who are enrolled in, or are eligible for enrollment in the tribe; and the case must be an active MFIP case; and the case members must reside within the tribal program's service delivery area; and

(3) MFIP or tribal TANF cases counted for determining allocations to tribal providers shall be removed from the case counts of the respective counties where they reside to prevent duplicate counts~~;~~.

~~(4) prior to allocating funds to counties and tribal providers, $1,000,000 shall be set aside to allow the commissioner to use these set-aside funds to provide funding to county or tribal~~

~~providers who experience an unforeseen influx of participants or other emergent situations beyond their control; and~~

~~(5) the commissioner shall use a portion of the funds in clause (4) to offset a reduction in funds allocated to any county between state fiscal year 1999 and state fiscal year 2000 that results from the adjustment in clause (3). The funding provided under this clause must reduce by half the reduction for state fiscal year 2000 that any county would otherwise experience in the absence of this clause.~~

~~Any funds specified in this clause that remain unspent by March 31 of each year shall be reallocated out to county and tribal providers using the funding formula detailed in clauses (1) to (5).~~

Sec. 40. Minnesota Statutes 2000, section 256J.62, subdivision 9, is amended to read:

Subd. 9. [CONTINUATION OF CERTAIN SERVICES.] At the request of the caregiver, the county may continue to provide case management, counseling or other support services to a participant following the participant's achievement of the employment goal, for up to 12 months following termination of the participant's eligibility for MFIP, as long as the participant's household income is below 200 percent of the federal poverty guidelines.

~~A county may expend funds for a specific employment and training service for the duration of that service to a participant if the funds are obligated or expended prior to the participant losing MFIP eligibility.~~

Sec. 41. Minnesota Statutes 2000, section 256J.625, is amended to read:

256J.625 [LOCAL INTERVENTION GRANTS FOR SELF-SUFFICIENCY.]

Subdivision 1. [ESTABLISHMENT; GUARANTEED MINIMUM ALLOCATION.] ~~(a)~~ The commissioner shall make grants under this subdivision to assist county and tribal TANF programs to more effectively serve hard-to-employ MFIP participants. Funds appropriated for local intervention grants for self-sufficiency must be allocated first in amounts equal to the guaranteed minimum in ~~paragraph (b)~~ subdivision 1b, and second according to the provisions of subdivision 2. Any remaining funds must be allocated according to the formula in subdivision 3.

Subd. 1a. [LOCAL SERVICE UNIT PLAN REQUIRED.] Counties or tribes must have an approved local service unit plan under section 256J.50, subdivision 7, paragraph (b), in order to receive and expend funds under subdivisions 2 and 3. If a county or tribe does not submit a local service unit plan under section 256J.50, subdivision 7, paragraph (b), or if the plan is not approved at the full amount allocated to the county or tribe under subdivision 3, the remaining funds under subdivision 3 may be used by the commissioner to contract with other public, private, or nonprofit entities in the county or region to deliver services that meet the purposes of subdivision 4.

~~(b)~~ Subd. 1b. [GUARANTEED MINIMUM.] Each county or tribal program shall receive a guaranteed minimum annual allocation ~~of $25,000~~. The minimum annual allocation for each county or tribe that has fewer than 25 long-term dependent adults on MFIP based on the formula in subdivision 3 is $5,000, and the minimum annual allocation for each county or tribe that has 25 or more long-term dependent adults on MFIP based on the formula in subdivision 3 is $10,000.

Subd. 2. [SET-ASIDE FUNDS.] (a) Of the funds appropriated for grants under this section, after the allocation in subdivision ~~1, paragraph (b)~~ 1b, is made, ~~20 percent of the remaining funds~~ $3,576,000 each year shall be retained by the commissioner and awarded to counties or tribes whose approved plans demonstrate additional need based on their identification of hard-to-employ families and working participants in need of job retention and wage advancement services, strong anticipated outcomes for families and an effective plan for monitoring performance, or, use of a multicounty, multi-entity or regional approach to serve hard-to-employ families and working participants in need of job retention and wage advancement services who are identified as a target population to be served in the plan submitted under section 256J.50, subdivision 7, paragraph (b). In distributing funds under this paragraph, the commissioner must achieve a geographic balance. The commissioner may award funds under this paragraph to other public, private, or nonprofit

entities to deliver services in a county or region where the entity or entities submit a plan that demonstrates a strong capability to fulfill the terms of the plan and where the plan shows an innovative or multi-entity approach.

(b) For fiscal year 2001 only, of the funds available under this subdivision the commissioner must allocate funding in the amounts specified in article 1, section 2, subdivision 7, for an intensive intervention transitional employment training project and for nontraditional career assistance and training programs. These allocations must occur before any set-aside funds are allocated under paragraph (a).

~~Subd. 2a. [ALTERNATIVE DISTRIBUTION FORMULA.] (a) By January 31, 2001, the commissioner of human services must develop and present to the appropriate legislative committees a distribution formula that is an alternative to the formula allocation specified in subdivision 3. The proposed distribution formula must target hard-to-employ MFIP participants, and it must include an incentive-based component that is designed to encourage county and tribal programs to effectively serve hard-to-employ participants. The commissioner's proposal must also be designed to be implemented for fiscal years 2002 and 2003 in place of the formula allocation specified in subdivision 3.~~

~~(b) Notwithstanding the provisions of subdivision 2, paragraph (a), if the commissioner does not develop a proposed formula as required in paragraph (a), the set-aside funds for fiscal years 2002 and 2003 that the commissioner would otherwise distribute under subdivision 2, paragraph (a), must not be distributed under that provision. Funds available under subdivision 2, paragraph (a), must instead be allocated in equal amounts to each county and tribal program in fiscal years 2002 and 2003.~~

Subd. 3. [FORMULA ALLOCATION.] Funds remaining after the allocations in subdivisions ~~1~~ 1b and 2 must be allocated ~~as follows:~~ to counties and tribes based on the average proportion of the MFIP caseload that has received MFIP assistance for 24 of the last 36 months, as sampled on March 31, June 30, September 30, and December 31 of the previous calendar year, less the number of child-only cases and cases where all the caregivers are age 60 or over. Two-parent cases, with the exception of those with a caregiver age 60 or over, will be multiplied by a factor of two.

~~(1) 85 percent shall be allocated in proportion to each county's and tribal TANF program's one-parent MFIP cases that have received MFIP assistance for at least 25 months, as sampled on December 31 of the previous calendar year, excluding cases where all caregivers are age 60 or over.~~

~~(2) 15 percent shall be allocated to each county's and tribal TANF program's two-parent MFIP cases that have received MFIP assistance for at least 25 months, as sampled on December 31 of the previous calendar year, excluding cases where all caregivers are age 60 or over.~~

Subd. 4. [USE OF FUNDS.] (a) A county or tribal program, or other public, private, or nonprofit entity in the county or region may use funds allocated under this ~~subdivision~~ section to provide services to MFIP participants who are hard-to-employ and their families. Services provided must be intended to reduce the number of MFIP participants who are expected to reach the 60-month time limit under section 256J.42. Counties, tribes, and other entities receiving funds under subdivision 2 or 3 must submit semiannual progress reports to the commissioner which detail program outcomes.

(b) Funds allocated under this section may not be used to provide benefits that are defined as "assistance" in Code of Federal Regulations, title 45, section 260.31, to an assistance unit that is only receiving the food portion of MFIP benefits.

(c) A county may use funds allocated under this section for that part of the match for federal access to jobs transportation funds that is TANF-eligible. A county may also use funds allocated under this section to enhance transportation choices for eligible recipients up to 150 percent of the federal poverty guidelines.

(d) A county may use funds allocated under this section to provide any or all of the participant performance bonuses to MFIP participants as defined in section 256J.555. The dollar amount of the bonus or bonuses provided must not exceed the amounts in section 256J.555.

Subd. 5. [SUNSET.] The grant program under this section sunsets on June 30, 2003.

Sec. 42. Minnesota Statutes 2000, section 256J.645, is amended to read:

256J.645 [INDIAN TRIBE ~~MFIP-S~~ MFIP EMPLOYMENT ~~AND TRAINING~~ SERVICES.]

Subdivision 1. [AUTHORIZATION TO ENTER INTO AGREEMENTS.] Effective July 1, 1997, the commissioner may enter into agreements with federally recognized Indian tribes with a reservation in the state to provide ~~MFIP-S~~ MFIP employment ~~and training~~ services to members of the Indian tribe and to other caregivers who are a part of the tribal member's ~~MFIP-S~~ MFIP assistance unit. For purposes of this section, "Indian tribe" means a tribe, band, nation, or other federally recognized group or community of Indians. The commissioner may also enter into an agreement with a consortium of Indian tribes providing the governing body of each Indian tribe in the consortium complies with the provisions of this section.

Subd. 2. [TRIBAL REQUIREMENTS.] The Indian tribe must:

(1) agree to fulfill the responsibilities provided under the employment ~~and training~~ services component of ~~MFIP-S~~ MFIP regarding operation of ~~MFIP-S~~ MFIP employment ~~and training~~ services, as designated by the commissioner;

(2) operate its employment ~~and training~~ services program within a geographic service area not to exceed the counties within which a border of the reservation falls;

(3) operate its program in conformity with section 13.46 and any applicable federal regulations in the use of data about ~~MFIP-S~~ MFIP recipients;

(4) coordinate operation of its program with the county agency, ~~Job Training Partnership~~ Workforce Investment Act programs, and other support services or employment-related programs in the counties in which the tribal unit's program operates;

(5) provide financial and program participant activity recordkeeping and reporting in the manner and using the forms and procedures specified by the commissioner and permit inspection of its program and records by representatives of the state; and

(6) have the Indian tribe's employment ~~and training~~ service provider certified by the commissioner of economic security, or approved by the county.

Subd. 3. [FUNDING.] If the commissioner and an Indian tribe are parties to an agreement under this subdivision, the agreement ~~may~~ shall annually provide to the Indian tribe the funding ~~amount in clause (1) or (2):~~ allocated in section 256J.62, subdivisions 1 and 2a.

~~(1) if the Indian tribe operated a tribal STRIDE program during state fiscal year 1997, the amount to be provided is the amount the Indian tribe received from the state for operation of its tribal STRIDE program in state fiscal year 1997, except that the amount provided for a fiscal year may increase or decrease in the same proportion that the total amount of state and federal funds available for MFIP-S employment and training services increased or decreased that fiscal year; or~~

~~(2) if the Indian tribe did not operate a tribal STRIDE program during state fiscal year 1997, the commissioner may provide to the Indian tribe for the first year of operations the amount determined by multiplying the state allocation for MFIP-S employment and training services to each county agency in the Indian tribe's service delivery area by the percentage of MFIP-S recipients in that county who were members of the Indian tribe during the previous state fiscal year. The resulting amount shall also be the amount that the commissioner may provide to the Indian tribe annually thereafter through an agreement under this subdivision, except that the amount provided for a fiscal year may increase or decrease in the same proportion that the total amount of state and federal funds available for MFIP-S employment and training services increased or decreased that fiscal year.~~

Subd. 4. [COUNTY AGENCY REQUIREMENT.] Indian tribal members receiving ~~MFIP-S~~ MFIP benefits and residing in the service area of an Indian tribe operating employment ~~and training~~ services under an agreement with the commissioner must be referred by county agencies in the service area to the Indian tribe for employment ~~and training~~ services.

Sec. 43. Minnesota Statutes 2000, section 256K.03, subdivision 5, is amended to read:

Subd. 5. [EXEMPTION CATEGORIES.] (a) The applicant will be exempt from the job search requirements and development of a job search plan and an employability development plan under subdivisions 3, 4, and 8 if the applicant belongs to any of the following groups:

(1) individuals who are age 60 or older;

(2) individuals who are suffering from a professionally certified permanent or temporary illness, injury, or incapacity which is expected to continue for more than 30 days and which prevents the person from obtaining or retaining employment. Persons in this category with a temporary illness, injury, or incapacity must be reevaluated at least quarterly;

(3) caregivers whose presence in the home is needed as a caregiver because of ~~the~~ a professionally certified illness or incapacity of another member in the assistance unit, a relative in the household, or a foster child in the household;

(4) women who are pregnant, if the pregnancy has resulted in a professionally certified incapacity that prevents the woman from obtaining and retaining employment;

(5) caregivers of a child under the age of one year who personally provide full-time care for the child. This exemption may be used for only 12 months in a lifetime. In two-parent households, only one parent or other relative may qualify for this exemption;

(6) ~~individuals who are single parents or one parent in a two-parent family employed at least 35 hours per week;~~

~~(7)~~ individuals experiencing a personal or family crisis that makes them incapable of participating in the program, as determined by the county agency. If the participant does not agree with the county agency's determination, the participant may seek professional certification, as defined in section 256J.08, that the participant is incapable of participating in the program. Persons in this exemption category must be reevaluated every 60 days; or

~~(8)~~ (7) second parents in two-parent families employed for 20 or more hours per week provided the first parent is employed at least 35 hours per week.

(b) A caregiver who is exempt under clause (5) must enroll in and attend an early childhood and family education class, a parenting class, or some similar activity, if available, during the period of time the caregiver is exempt under this section. Notwithstanding section 256J.46, failure to attend the required activity shall not result in the imposition of a sanction.

Sec. 44. [DOMESTIC VIOLENCE TRAINING FOR COUNTY AGENCIES.]

During fiscal year 2002, the commissioner of human services will provide training for county agency staff to receive specialized domestic violence training in order to carry out the responsibilities in Minnesota Statutes, sections 256J.46, subdivision 1a; 256J.49, subdivision 1a; 256J.52, subdivision 6; and 256J.56, subdivision 6. This training must be similar to the training provided to individuals who work for an organization designated by the Minnesota center for crime victims services as providing services to victims of domestic violence.

Sec. 45. [SANCTION REPORT.]

The request for the report under this section must be referred to the legislative audit commission for consideration. If approved, the legislative auditor, with input from previous and current MFIP participants, shall investigate inconsistent or illegal sanctions that were imposed on MFIP participants from January of 1998 to the present. The legislative auditor shall report the

nature of erroneous sanction activity, the scope or extent of the errors or problems among sanctioned cases, and provide recommendations or corrective actions to reconcile past illegal or inconsistent sanctions, and recommend solutions that will ensure that MFIP sanctions are imposed fairly and consistently in the future. The report to the members of the senate and house committees having jurisdiction over MFIP issues is due by January 15, 2002.

Sec. 46. [REVISOR INSTRUCTION.]

In the next edition of Minnesota Statutes and Minnesota Rules, the revisor shall change all references to Minnesota Family Investment Program-Statewide (MFIP-S) to Minnesota Family Investment Program (MFIP).

Sec. 47. [REPEALER.]

(a) Minnesota Statutes 2000, sections 256J.08, subdivision 50a; 256J.12, subdivision 3; 256J.43; and 256J.53, subdivision 4, are repealed.

(b) Minnesota Statutes 2000, section 256J.49, subdivision 11, is repealed October 1, 2001.

(c) Minnesota Statutes 2000, section 256D.066, is repealed.

(d) Minnesota Statutes 2000, sections 256.01, subdivision 18; 256J.32, subdivision 7a; and Laws 2000, chapter 488, article 10, section 30, are repealed effective July 1, 2001.

(e) Laws 1997, chapter 203, article 9, section 21; Laws 1998, chapter 407, article 6, section 111; and Laws 2000, chapter 488, article 10, section 28, are repealed.

ARTICLE 11

CHILD WELFARE AND FOSTER CARE

Section 1. Minnesota Statutes 2000, section 13.461, subdivision 17, is amended to read:

Subd. 17. [~~VULNERABLE ADULT~~ MALTREATMENT REVIEW ~~PANEL~~ PANELS.] Data of the vulnerable adult maltreatment review panel or the child maltreatment review panel are classified under section 256.021 or section 3.

Sec. 2. Minnesota Statutes 2000, section 245.814, subdivision 1, is amended to read:

Subdivision 1. [INSURANCE FOR FOSTER HOME PROVIDERS.] The commissioner of human services shall within the appropriation provided purchase and provide insurance to individuals licensed as foster home providers to cover their liability for:

(1) injuries or property damage caused or sustained by persons in foster care in their home; and

(2) actions arising out of alienation of affections sustained by the birth parents of a foster child or birth parents or children of a foster adult.

For purposes of this subdivision, insurance for homes licensed to provide adult foster care shall be limited to family adult foster care homes as defined in section 144D.01, subdivision 7.

Sec. 3. [256.022] [CHILD MALTREATMENT REVIEW PANEL.]

Subdivision 1. [CREATION.] The commissioner of human services shall establish a review panel for purposes of reviewing investigating agency determinations regarding maltreatment of a child in a facility in response to requests received under section 626.556, subdivision 10i, paragraph (b). The review panel consists of the commissioners of health; human services; children, families, and learning; corrections; the ombudsman for crime victims; and the ombudsman for mental health and mental retardation; or their designees.

Subd. 2. [REVIEW PROCEDURE.] (a) The panel shall hold quarterly meetings for purposes of conducting reviews under this section. If an interested person acting on behalf of a child requests a review under this section, the panel shall review the request at its next quarterly meeting. If the

next quarterly meeting is within ten days of the panel's receipt of the request for review, the review may be delayed until the next subsequent meeting. The panel shall review the request and the final determination regarding maltreatment made by the investigating agency and may review any other data on the investigation maintained by the agency that are pertinent and necessary to its review of the determination. If more than one person requests a review under this section with respect to the same determination, the review panel shall combine the requests into one review. Upon receipt of a request for a review, the panel shall notify the alleged perpetrator of maltreatment that a review has been requested and provide an approximate timeline for conducting the review.

(b) Within 30 days of the review under this section, the panel shall notify the investigating agency and the interested person who requested the review as to whether the panel agrees with the determination or whether the investigating agency must reconsider the determination. If the panel determines that the agency must reconsider the determination, the panel must make specific investigative recommendations to the agency. Within 30 days the investigating agency shall conduct a review and report back to the panel with its reconsidered determination and the specific rationale for its determination.

Subd. 3. [REPORT.] By January 15 of each year, the panel shall submit a report to the committees of the legislature with jurisdiction over section 626.556 regarding the number of requests for review it receives under this section, the number of cases where the panel requires the investigating agency to reconsider its final determination, the number of cases where the final determination is changed, and any recommendations to improve the review or investigative process.

Subd. 4. [DATA.] Data of the review panel created as part of a review under this section are private data on individuals as defined in section 13.02.

Sec. 4. Minnesota Statutes 2000, section 257.0725, is amended to read:

257.0725 [ANNUAL REPORT.]

The commissioner of human services shall publish an annual report on child maltreatment and on children in out-of-home placement. The commissioner shall confer with counties, child welfare organizations, child advocacy organizations, the courts, and other groups on how to improve the content and utility of the department's annual report. In regard to child maltreatment, the report shall include the number and kinds of maltreatment reports received and any other data that the commissioner determines is appropriate to include in a report on child maltreatment. In regard to children in out-of-home placement, the report shall include, by county and statewide, information on legal status, living arrangement, age, sex, race, accumulated length of time in placement, reason for most recent placement, race of family with whom placed, and other information deemed appropriate on all children in out-of-home placement. Out-of-home placement includes placement in any facility by an authorized child-placing agency.

Sec. 5. Minnesota Statutes 2000, section 626.556, subdivision 2, is amended to read:

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

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

(b) "Person responsible for the child's care" means (1) an individual functioning within the

family unit and having responsibilities for the care of the child such as a parent, guardian, or other person having similar care responsibilities, or (2) an individual functioning outside the family unit and having responsibilities for the care of the child such as a teacher, school administrator, or other lawful custodian of a child having either full-time or short-term care responsibilities including, but not limited to, day care, babysitting whether paid or unpaid, counseling, teaching, and coaching.

(c) "Neglect" means:

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

(2) failure to protect a child from conditions or actions which imminently and seriously endanger the child's physical or mental health when reasonably able to do so;

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

(4) failure to ensure that the child is educated as defined in sections 120A.22 and 260C.163, subdivision 11;

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

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

(7) "medical neglect" as defined in section 260C.007, subdivision 4, clause (5);

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

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

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

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

(2) striking a child with a closed fist;

(3) shaking a child under age three;

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

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

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

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

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

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

(e) "Report" means any report received by the local welfare agency, police department, or county sheriff pursuant to this section.

(f) "Facility" means a licensed or unlicensed day care facility, residential facility, agency, hospital, sanitarium, or other facility or institution required to be licensed under sections 144.50 to 144.58, 241.021, or 245A.01 to 245A.16, or chapter 245B; or a school as defined in sections 120A.05, subdivisions 9, 11, and 13; and 124D.10; or a nonlicensed personal care provider organization as defined in sections 256B.04, subdivision 16, and 256B.0625, subdivision 19a.

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

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

(i) "Assessment" includes authority to interview the child, the person or persons responsible for the child's care, the alleged perpetrator, and any other person with knowledge of the abuse or neglect for the purpose of gathering the facts, assessing the risk to the child, and formulating a plan.

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

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

(l) "Threatened injury" means a statement, overt act, condition, or status that represents a substantial risk of physical or sexual abuse or mental injury.

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

(n) "Maltreatment of a child in a facility" means physical abuse, sexual abuse, or neglect that occurs while a child is under the care of a facility, or the following acts committed by a person other than a child receiving services, with a child or in the presence of a child who is or should be under the supervision of the facility:

(1) an act against a child that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:

(i) sections 609.221 to 609.224 (assault in the first through fifth degrees); or

(ii) section 609.52 (theft);

(2) conduct that is not an accident or authorized conduct that produces or could reasonably be expected to produce physical pain or injury or mental injury, including, but not limited to, the following:

(i) hitting, slapping, kicking, pinching, biting, or shaking;

(ii) use of an aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including an unreasonable, forced separation of the child from other persons, except aversive or deprivation procedures for developmentally disabled children authorized under section 245.825; or

(iii) use of an unreasonable restraint, including tying, caging, chaining, or any other unreasonable physical or manual method of restricting or prohibiting movement;

(3) in the absence of legal authority, willfully using, withholding, or disposing of funds or property of a child receiving services in a facility that is not considered to be contraband by the facility or school;

(4) sexual conduct with a child or in the presence of a child that a reasonable person would consider to be sexual behavior or exposing the child to sexual behavior or material that is inappropriate for the age and developmental level of the child; or

(5) sexual contact as defined in section 609.341 between a facility staff, or an associate of the facility staff, and a child receiving services.

For purposes of this paragraph, a child is not abused for the sole reason that a person is engaged in authorized conduct.

(o) "Authorized conduct" means the provision of program services, education for schools, health care, or other personal care services; or provision of services or education under a written program plan, individual education plan, or school discipline plan, done in the best interests of the child by an individual, facility, or employee or person providing services or education in a facility under the rights, privileges, and responsibilities conferred by state license, certification, or registration.

(p) "Accident" means a sudden, unforeseen, and unexpected occurrence or event that:

(1) was not likely to occur and could not have been prevented by the exercise of due care; and

(2) if occurring while a child is receiving services from a facility, occurs when the facility and the staff person providing the services in the facility are in compliance with applicable law relevant to the occurrence or event.

Sec. 6. Minnesota Statutes 2000, section 626.556, is amended by adding a subdivision to read:

Subd. 3d. [FACILITY PROCEDURES; INTERNAL REPORTING.] (a) Except for child foster care and family child care, a facility licensed under sections 245A.01 to 245A.16 and chapter 245B shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. The procedure must include the definitions of maltreatment and the phone numbers for the local welfare agency, police department, county sheriff, and agency responsible for assessing or investigating maltreatment under this section. Procedures must include a method for providing children or family members with written information on where to report suspected maltreatment. Mandated reporters in a facility must receive orientation on this procedure before having direct contact with children and annual training on reporting of maltreatment.

(b) If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. The facility remains responsible for complying with the immediate reporting requirements of this section. A facility with an internal

reporting procedure that receives an internal report from a mandated reporter shall give the mandated reporter a written notice if the facility has not reported the incident to the agency responsible for assessing or investigating maltreatment. The written notice must be provided within two working days of receipt of the internal report in a manner that protects the confidentiality of the reporter. The written notice to the mandated reporter must inform the reporter that if the reporter is not satisfied with the action taken by the facility, the reporter may report externally.

(c) A facility may not prohibit a mandated reporter from reporting externally and may not retaliate against a mandated reporter who, in good faith, reports an incident to the agency responsible for assessing or investigating maltreatment.

Sec. 7. Minnesota Statutes 2000, section 626.556, subdivision 10, is amended to read:

Subd. 10. [DUTIES OF LOCAL WELFARE AGENCY AND LOCAL LAW ENFORCEMENT AGENCY UPON RECEIPT OF A REPORT.] (a) If the report alleges neglect, physical abuse, or sexual abuse by a parent, guardian, or individual functioning within the family unit as a person responsible for the child's care, the local welfare agency shall immediately conduct an assessment including gathering information on the existence of substance abuse and offer protective social services for purposes of preventing further abuses, safeguarding and enhancing the welfare of the abused or neglected minor, and preserving family life whenever possible. If the report alleges a violation of a criminal statute involving sexual abuse, physical abuse, or neglect or endangerment, under section 609.378, the local law enforcement agency and local welfare agency shall coordinate the planning and execution of their respective investigation and assessment efforts to avoid a duplication of fact-finding efforts and multiple interviews. Each agency shall prepare a separate report of the results of its investigation. In cases of alleged child maltreatment resulting in death, the local agency may rely on the fact-finding efforts of a law enforcement investigation to make a determination of whether or not maltreatment occurred. When necessary the local welfare agency shall seek authority to remove the child from the custody of a parent, guardian, or adult with whom the child is living. In performing any of these duties, the local welfare agency shall maintain appropriate records.

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

(b) When a local agency receives a report or otherwise has information indicating that a child who is a client, as defined in section 245.91, has been the subject of physical abuse, sexual abuse, or neglect at an agency, facility, or program as defined in section 245.91, it shall, in addition to its other duties under this section, immediately inform the ombudsman established under sections 245.91 to 245.97.

(c) Authority of the local welfare agency responsible for assessing the child abuse or neglect report and of the local law enforcement agency for investigating the alleged abuse or neglect includes, but is not limited to, authority to interview, without parental consent, the alleged victim and any other minors who currently reside with or who have resided with the alleged offender. The interview may take place at school or at any facility or other place where the alleged victim or other minors might be found or the child may be transported to, and the interview conducted at, a place appropriate for the interview of a child designated by the local welfare agency or law enforcement agency. The interview may take place outside the presence of the alleged offender or parent, legal custodian, guardian, or school official. Except as provided in this paragraph, the parent, legal custodian, or guardian shall be notified by the responsible local welfare or law enforcement agency no later than the conclusion of the investigation or assessment that this interview has occurred. Notwithstanding rule 49.02 of the Minnesota rules of procedure for juvenile courts, the juvenile court may, after hearing on an ex parte motion by the local welfare agency, order that, where reasonable cause exists, the agency withhold notification of this

interview from the parent, legal custodian, or guardian. If the interview took place or is to take place on school property, the order shall specify that school officials may not disclose to the parent, legal custodian, or guardian the contents of the notification of intent to interview the child on school property, as provided under this paragraph, and any other related information regarding the interview that may be a part of the child's school record. A copy of the order shall be sent by the local welfare or law enforcement agency to the appropriate school official.

(d) When the local welfare or local law enforcement agency determines that an interview should take place on school property, written notification of intent to interview the child on school property must be received by school officials prior to the interview. The notification shall include the name of the child to be interviewed, the purpose of the interview, and a reference to the statutory authority to conduct an interview on school property. For interviews conducted by the local welfare agency, the notification shall be signed by the chair of the local social services agency or the chair's designee. The notification shall be private data on individuals subject to the provisions of this paragraph. School officials may not disclose to the parent, legal custodian, or guardian the contents of the notification or any other related information regarding the interview until notified in writing by the local welfare or law enforcement agency that the investigation or assessment has been concluded. Until that time, the local welfare or law enforcement agency shall be solely responsible for any disclosures regarding the nature of the assessment or investigation.

Except where the alleged offender is believed to be a school official or employee, the time and place, and manner of the interview on school premises shall be within the discretion of school officials, but the local welfare or law enforcement agency shall have the exclusive authority to determine who may attend the interview. The conditions as to time, place, and manner of the interview set by the school officials shall be reasonable and the interview shall be conducted not more than 24 hours after the receipt of the notification unless another time is considered necessary by agreement between the school officials and the local welfare or law enforcement agency. Where the school fails to comply with the provisions of this paragraph, the juvenile court may order the school to comply. Every effort must be made to reduce the disruption of the educational program of the child, other students, or school staff when an interview is conducted on school premises.

(e) Where the alleged offender or a person responsible for the care of the alleged victim or other minor prevents access to the victim or other minor by the local welfare agency, the juvenile court may order the parents, legal custodian, or guardian to produce the alleged victim or other minor for questioning by the local welfare agency or the local law enforcement agency outside the presence of the alleged offender or any person responsible for the child's care at reasonable places and times as specified by court order.

(f) Before making an order under paragraph (e), the court shall issue an order to show cause, either upon its own motion or upon a verified petition, specifying the basis for the requested interviews and fixing the time and place of the hearing. The order to show cause shall be served personally and shall be heard in the same manner as provided in other cases in the juvenile court. The court shall consider the need for appointment of a guardian ad litem to protect the best interests of the child. If appointed, the guardian ad litem shall be present at the hearing on the order to show cause.

(g) The commissioner, the ombudsman for mental health and mental retardation, the local welfare agencies responsible for investigating reports, and the local law enforcement agencies have the right to enter facilities as defined in subdivision 2 and to inspect and copy the facility's records, including medical records, as part of the investigation. Notwithstanding the provisions of chapter 13, they also have the right to inform the facility under investigation that they are conducting an investigation, to disclose to the facility the names of the individuals under investigation for abusing or neglecting a child, and to provide the facility with a copy of the report and the investigative findings.

(h) The local welfare agency shall collect available and relevant information to ascertain whether maltreatment occurred and whether protective services are needed. Information collected includes, when relevant, information with regard to the person reporting the alleged maltreatment,

including the nature of the reporter's relationship to the child and to the alleged offender, and the basis of the reporter's knowledge for the report; the child allegedly being maltreated; the alleged offender; the child's caretaker; and other collateral sources having relevant information related to the alleged maltreatment. The local welfare agency may make a determination of no maltreatment early in an assessment, and close the case and retain immunity, if the collected information shows no basis for a full assessment or investigation.

Information relevant to the assessment or investigation must be asked for, and may include:

(1) the child's sex and age, prior reports of maltreatment, information relating to developmental functioning, credibility of the child's statement, and whether the information provided under this clause is consistent with other information collected during the course of the assessment or investigation;

(2) the alleged offender's age, a record check for prior reports of maltreatment, and criminal charges and convictions. The local welfare agency must provide the alleged offender with an opportunity to make a statement. The alleged offender may submit supporting documentation relevant to the assessment or investigation;

(3) collateral source information regarding the alleged maltreatment and care of the child. Collateral information includes, when relevant: (i) a medical examination of the child; (ii) prior medical records relating to the alleged maltreatment or the care of the child maintained by any facility, clinic, or health care professional and an interview with the treating professionals; and (iii) interviews with the child's caretakers, including the child's parent, guardian, foster parent, child care provider, teachers, counselors, family members, relatives, and other persons who may have knowledge regarding the alleged maltreatment and the care of the child; and

(4) information on the existence of domestic abuse and violence in the home of the child, and substance abuse.

Nothing in this paragraph precludes the local welfare agency from collecting other relevant information necessary to conduct the assessment or investigation. Notwithstanding section 13.384 or 144.335, the local welfare agency has access to medical data and records for purposes of clause (3). Notwithstanding the data's classification in the possession of any other agency, data acquired by the local welfare agency during the course of the assessment or investigation are private data on individuals and must be maintained in accordance with subdivision 11.

(i) In the initial stages of an assessment or investigation, the local welfare agency shall conduct a face-to-face observation of the child reported to be maltreated and a face-to-face interview of the alleged offender. The interview with the alleged offender may be postponed if it would jeopardize an active law enforcement investigation.

(j) The local welfare agency shall use a question and answer interviewing format with questioning as nondirective as possible to elicit spontaneous responses. The following interviewing methods and procedures must be used whenever possible when collecting information:

(1) audio recordings of all interviews with witnesses and collateral sources; and

(2) in cases of alleged sexual abuse, audio-video recordings of each interview with the alleged victim and child witnesses.

Sec. 8. Minnesota Statutes 2000, section 626.556, subdivision 10b, is amended to read:

Subd. 10b. [DUTIES OF COMMISSIONER; NEGLECT OR ABUSE IN FACILITY.] (a) This section applies to the commissioners of human services, health, and children, families, and learning. The commissioner of the agency responsible for assessing or investigating the report shall immediately investigate if the report alleges that:

(1) a child who is in the care of a facility as defined in subdivision 2 is neglected, physically abused, ~~or~~ sexually abused, or is the victim of maltreatment in a facility by an individual in that

facility, or has been so neglected or abused or been the victim of maltreatment in a facility by an individual in that facility within the three years preceding the report; or

(2) a child was neglected, physically abused, ~~or~~ sexually abused, or is the victim of maltreatment in a facility by an individual in a facility defined in subdivision 2, while in the care of that facility within the three years preceding the report.

The commissioner of the agency responsible for assessing or investigating the report shall arrange for the transmittal to the commissioner of reports received by local agencies and may delegate to a local welfare agency the duty to investigate reports. In conducting an investigation under this section, the commissioner has the powers and duties specified for local welfare agencies under this section. The commissioner of the agency responsible for assessing or investigating the report or local welfare agency may interview any children who are or have been in the care of a facility under investigation and their parents, guardians, or legal custodians.

(b) Prior to any interview, the commissioner of the agency responsible for assessing or investigating the report or local welfare agency shall notify the parent, guardian, or legal custodian of a child who will be interviewed in the manner provided for in subdivision 10d, paragraph (a). If reasonable efforts to reach the parent, guardian, or legal custodian of a child in an out-of-home placement have failed, the child may be interviewed if there is reason to believe the interview is necessary to protect the child or other children in the facility. The commissioner of the agency responsible for assessing or investigating the report or local agency must provide the information required in this subdivision to the parent, guardian, or legal custodian of a child interviewed without parental notification as soon as possible after the interview. When the investigation is completed, any parent, guardian, or legal custodian notified under this subdivision shall receive the written memorandum provided for in subdivision 10d, paragraph (c).

(c) In conducting investigations under this subdivision the commissioner or local welfare agency shall obtain access to information consistent with subdivision 10, paragraphs (h), (i), and (j).

(d) Except for foster care and family child care, the commissioner has the primary responsibility for the investigations and notifications required under subdivisions 10d and 10f for reports that allege maltreatment related to the care provided by or in facilities licensed by the commissioner. The commissioner may request assistance from the local social services agency.

Sec. 9. Minnesota Statutes 2000, section 626.556, subdivision 10d, is amended to read:

Subd. 10d. [NOTIFICATION OF NEGLECT OR ABUSE IN FACILITY.] (a) When a report is received that alleges neglect, physical abuse, ~~or~~ sexual abuse, or maltreatment of a child while in the care of a licensed or unlicensed day care facility, residential facility, agency, hospital, sanitarium, or other facility or institution required to be licensed according to sections 144.50 to 144.58; 241.021; or 245A.01 to 245A.16; or chapter 245B, or a school as defined in sections 120A.05, subdivisions 9, 11, and 13; and 124D.10; or a nonlicensed personal care provider organization as defined in section 256B.04, subdivision 16, and 256B.0625, subdivision 19a, the commissioner of the agency responsible for assessing or investigating the report or local welfare agency investigating the report shall provide the following information to the parent, guardian, or legal custodian of a child alleged to have been neglected, physically abused, ~~or~~ sexually abused, or the victim of maltreatment of a child in the facility: the name of the facility; the fact that a report alleging neglect, physical abuse, ~~or~~ sexual abuse, or maltreatment of a child in the facility has been received; the nature of the alleged neglect, physical abuse, ~~or~~ sexual abuse, or maltreatment of a child in the facility; that the agency is conducting an investigation; any protective or corrective measures being taken pending the outcome of the investigation; and that a written memorandum will be provided when the investigation is completed.

(b) The commissioner of the agency responsible for assessing or investigating the report or local welfare agency may also provide the information in paragraph (a) to the parent, guardian, or legal custodian of any other child in the facility if the investigative agency knows or has reason to believe the alleged neglect, physical abuse, ~~or~~ sexual abuse, or maltreatment of a child in the facility has occurred. In determining whether to exercise this authority, the commissioner of the

agency responsible for assessing or investigating the report or local welfare agency shall consider the seriousness of the alleged neglect, physical abuse, ~~or~~ sexual abuse, or maltreatment of a child in the facility; the number of children allegedly neglected, physically abused, ~~or~~ sexually abused, or victims of maltreatment of a child in the facility; the number of alleged perpetrators; and the length of the investigation. The facility shall be notified whenever this discretion is exercised.

(c) When the commissioner of the agency responsible for assessing or investigating the report or local welfare agency has completed its investigation, every parent, guardian, or legal custodian notified of the investigation by the commissioner or local welfare agency shall be provided with the following information in a written memorandum: the name of the facility investigated; the nature of the alleged neglect, physical abuse, ~~or~~ sexual abuse, or maltreatment of a child in the facility; the investigator's name; a summary of the investigation findings; a statement whether maltreatment was found; and the protective or corrective measures that are being or will be taken. The memorandum shall be written in a manner that protects the identity of the reporter and the child and shall not contain the name, or to the extent possible, reveal the identity of the alleged perpetrator or of those interviewed during the investigation. If maltreatment is determined to exist, the commissioner or local welfare agency shall also provide the written memorandum to the parent, guardian, or legal custodian of each child in the facility ~~if maltreatment is determined to exist~~ who had contact with the individual responsible for the maltreatment. When the facility is the responsible party for maltreatment, the commissioner or local welfare agency shall also provide the written memorandum to the parent, guardian, or legal custodian of each child who received services in the population of the facility where the maltreatment occurred. This notification must be provided to the parent, guardian, or legal custodian of each child receiving services from the time the maltreatment occurred until either the individual responsible for maltreatment is no longer in contact with a child or children in the facility or the conclusion of the investigation.

Sec. 10. Minnesota Statutes 2000, section 626.556, subdivision 10e, is amended to read:

Subd. 10e. [DETERMINATIONS.] Upon the conclusion of every assessment or investigation it conducts, the local welfare agency shall make two determinations: first, whether maltreatment has occurred; and second, whether child protective services are needed. When maltreatment is determined in an investigation involving a facility, the investigating agency shall also determine whether the facility or individual was responsible for the maltreatment using the mitigating factors in paragraph (d). Determinations under this subdivision must be made based on a preponderance of the evidence.

(a) For the purposes of this subdivision, "maltreatment" means any of the following acts or omissions ~~committed by a person responsible for the child's care~~:

(1) physical abuse as defined in subdivision 2, paragraph (d);

(2) neglect as defined in subdivision 2, paragraph (c);

(3) sexual abuse as defined in subdivision 2, paragraph (a); ~~or~~

(4) mental injury as defined in subdivision 2, paragraph (k); or

(5) maltreatment of a child in a facility as defined in subdivision 2, paragraph (n).

(b) For the purposes of this subdivision, a determination that child protective services are needed means that the local welfare agency has documented conditions during the assessment or investigation sufficient to cause a child protection worker, as defined in section 626.559, subdivision 1, to conclude that a child is at significant risk of maltreatment if protective intervention is not provided and that the individuals responsible for the child's care have not taken or are not likely to take actions to protect the child from maltreatment or risk of maltreatment.

(c) This subdivision does not mean that maltreatment has occurred solely because the child's parent, guardian, or other person responsible for the child's care in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the child, in lieu of medical care. However, if lack of medical care may result in serious danger to the child's health, the local welfare agency may ensure that necessary medical services are provided to the child.

(d) When determining whether the facility or individual is the responsible party for determined maltreatment in a facility, the investigating agency shall consider at least the following mitigating factors:

(1) whether the actions of the facility or the individual caregivers were according to, and followed the terms of, an erroneous physician order, prescription, individual care plan, or directive; however, this is not a mitigating factor when the facility or caregiver was responsible for the issuance of the erroneous order, prescription, individual care plan, or directive or knew or should have known of the errors and took no reasonable measures to correct the defect before administering care;

(2) comparative responsibility between the facility, other caregivers, and requirements placed upon an employee, including the facility's compliance with related regulatory standards and the adequacy of facility policies and procedures, facility training, an individual's participation in the training, the caregiver's supervision, and facility staffing levels and the scope of the individual employee's authority and discretion; and

(3) whether the facility or individual followed professional standards in exercising professional judgment.

Individual counties may implement more detailed definitions or criteria that indicate which allegations to investigate, as long as a county's policies are consistent with the definitions in the statutes and rules and are approved by the county board. Each local welfare agency shall periodically inform mandated reporters under subdivision 3 who work in the county of the definitions of maltreatment in the statutes and rules and any additional definitions or criteria that have been approved by the county board.

Sec. 11. Minnesota Statutes 2000, section 626.556, subdivision 10f, is amended to read:

Subd. 10f. [NOTICE OF DETERMINATIONS.] Within ten working days of the conclusion of an assessment, the local welfare agency or agency responsible for assessing or investigating the report shall notify the parent or guardian of the child, the person determined to be maltreating the child, and if applicable, the director of the facility, of the determination and a summary of the specific reasons for the determination. The notice must also include a certification that the information collection procedures under subdivision 10, paragraphs (h), (i), and (j), were followed and a notice of the right of a data subject to obtain access to other private data on the subject collected, created, or maintained under this section. In addition, the notice shall include the length of time that the records will be kept under subdivision 11c. The investigating agency shall notify the parent or guardian of the child who is the subject of the report, and any person or facility determined to have maltreated a child, of their appeal or review rights under this section or section 3.

Sec. 12. Minnesota Statutes 2000, section 626.556, subdivision 10i, is amended to read:

Subd. 10i. [ADMINISTRATIVE RECONSIDERATION OF FINAL DETERMINATION OF MALTREATMENT; REVIEW PANEL.] (a) An individual or facility that the commissioner or a local social service agency determines has maltreated a child, or ~~the child's designee~~ an interested person acting on behalf of the child, regardless of the determination, who contests the investigating agency's final determination regarding maltreatment, may request the investigating agency to reconsider its final determination regarding maltreatment. The request for reconsideration must be submitted in writing to the investigating agency within 15 calendar days after receipt of notice of the final determination regarding maltreatment or, if the request is made by an interested person who is not entitled to notice, within 15 days after receipt of the notice by the parent or guardian of the child.

(b) If the investigating agency denies the request or fails to act upon the request within 15 calendar days after receiving the request for reconsideration, the person or facility entitled to a fair hearing under section 256.045 may submit to the commissioner of human services a written request for a hearing under that section. For reports involving maltreatment of a child in a facility, an interested person acting on behalf of the child may request a review by the child maltreatment

review panel under section 3 if the investigating agency denies the request or fails to act upon the request or if the interested person contests a reconsidered determination. The investigating agency shall notify persons who request reconsideration of their rights under this paragraph. The request must be submitted in writing to the review panel and a copy sent to the investigating agency within 30 calendar days of receipt of notice of a denial of a request for reconsideration or of a reconsidered determination. The request must specifically identify the aspects of the agency determination with which the person is dissatisfied.

(c) If, as a result of ~~the~~ a reconsideration or review, the investigating agency changes the final determination of maltreatment, that agency shall notify the parties specified in subdivisions 10b, 10d, and 10f.

(d) If an individual or facility contests the investigating agency's final determination regarding maltreatment by requesting a fair hearing under section 256.045, the commissioner of human services shall assure that the hearing is conducted and a decision is reached within 90 days of receipt of the request for a hearing. The time for action on the decision may be extended for as many days as the hearing is postponed or the record is held open for the benefit of either party.

(e) For purposes of this subdivision, "interested person acting on behalf of the child" means a parent or legal guardian; stepparent; grandparent; guardian ad litem; adult stepbrother, stepsister, or sibling; or adult aunt or uncle; unless the person has been determined to be the perpetrator of the maltreatment.

Sec. 13. Minnesota Statutes 2000, section 626.556, subdivision 11, is amended to read:

Subd. 11. [RECORDS.] (a) Except as provided in paragraph (b) or (c) and subdivisions 10b, 10d, 10g, and 11b, all records concerning individuals maintained by a local welfare agency or agency responsible for assessing or investigating the report under this section, including any written reports filed under subdivision 7, shall be private data on individuals, except insofar as copies of reports are required by subdivision 7 to be sent to the local police department or the county sheriff. Reports maintained by any police department or the county sheriff shall be private data on individuals except the reports shall be made available to the investigating, petitioning, or prosecuting authority, including county medical examiners or county coroners. Section 13.82, subdivisions 7, 5a, and 5b, apply to law enforcement data other than the reports. The local social services agency or agency responsible for assessing or investigating the report shall make available to the investigating, petitioning, or prosecuting authority, including county medical examiners or county coroners or their professional delegates, any records which contain information relating to a specific incident of neglect or abuse which is under investigation, petition, or prosecution and information relating to any prior incidents of neglect or abuse involving any of the same persons. The records shall be collected and maintained in accordance with the provisions of chapter 13. In conducting investigations and assessments pursuant to this section, the notice required by section 13.04, subdivision 2, need not be provided to a minor under the age of ten who is the alleged victim of abuse or neglect. An individual subject of a record shall have access to the record in accordance with those sections, except that the name of the reporter shall be confidential while the report is under assessment or investigation except as otherwise permitted by this subdivision. Any person conducting an investigation or assessment under this section who intentionally discloses the identity of a reporter prior to the completion of the investigation or assessment is guilty of a misdemeanor. After the assessment or investigation is completed, the name of the reporter shall be confidential. The subject of the report may compel disclosure of the name of the reporter only with the consent of the reporter or upon a written finding by the court that the report was false and that there is evidence that the report was made in bad faith. This subdivision does not alter disclosure responsibilities or obligations under the rules of criminal procedure.

(b) Upon request of the legislative auditor, data on individuals maintained under this section must be released to the legislative auditor in order for the auditor to fulfill the auditor's duties under section 3.971. The auditor shall maintain the data in accordance with chapter 13.

(c) The investigating agency shall exchange not public data with the child maltreatment review panel under section 3 if the data are pertinent and necessary for a review requested under section

3. Upon completion of the review, the not public data received by the review panel must be returned to the investigating agency.

Sec. 14. Minnesota Statutes 2000, section 626.556, subdivision 12, is amended to read:

Subd. 12. [DUTIES OF FACILITY OPERATORS.] Any operator, employee, or volunteer worker at any facility who intentionally neglects, physically abuses, or sexually abuses any child in the care of that facility may be charged with a violation of section 609.255, 609.377, or 609.378. Any operator of a facility who knowingly permits conditions to exist which result in neglect, physical abuse, ~~or~~ sexual abuse, or maltreatment of a child in a facility while in the care of that facility may be charged with a violation of section 609.378. The facility operator shall inform all mandated reporters employed by or otherwise associated with the facility of the duties required of mandated reporters and shall inform all mandatory reporters of the prohibition against retaliation for reports made in good faith under this section.

Sec. 15. Minnesota Statutes 2000, section 626.559, subdivision 2, is amended to read:

Subd. 2. [JOINT TRAINING.] The commissioners of human services and public safety shall cooperate in the development of a joint program for training child abuse services professionals in the appropriate techniques for child abuse assessment and investigation. The program shall include but need not be limited to the following areas:

(1) the public policy goals of the state as set forth in section 260C.001 and the role of the assessment or investigation in meeting these goals;

(2) the special duties of child protection workers and law enforcement officers under section 626.556;

(3) the appropriate methods for directing and managing affiliated professionals who may be utilized in providing protective services and strengthening family ties;

(4) the appropriate methods for interviewing alleged victims of child abuse and other minors in the course of performing an assessment or an investigation;

(5) the dynamics of child abuse and neglect within family systems and the appropriate methods for interviewing parents in the course of the assessment or investigation, including training in recognizing cases in which one of the parents is a victim of domestic abuse and in need of special legal or medical services;

(6) the legal, evidentiary considerations that may be relevant to the conduct of an assessment or an investigation;

(7) the circumstances under which it is appropriate to remove the alleged abuser or the alleged victim from the home;

(8) the protective social services that are available to protect alleged victims from further abuse, to prevent child abuse and domestic abuse, and to preserve the family unit, and training in the preparation of case plans to coordinate services for the alleged child abuse victim with services for any parents who are victims of domestic abuse; ~~and~~

(9) the methods by which child protection workers and law enforcement workers cooperate in conducting assessments and investigations in order to avoid duplication of efforts; and

(10) appropriate methods for interviewing alleged victims of child abuse and conducting investigations in cases where the alleged victim is developmentally, physically, or mentally disabled.

Sec. 16. [CHILD WELFARE COST CONSOLIDATION REPORT.]

By January 15, 2002, the commissioner of human services shall report to the chairs and ranking minority members of appropriate legislative committees the feasibility and cost of creating a single benefit package for all children removed from the care of a parent or guardian pursuant to a

court order under Minnesota Statutes, chapter 260C, regardless of a particular child's legal status. Legal status includes any placement away from the parent or guardian, including foster or other residential care, guardianship with the commissioner, adoption, or legal custody with a relative except a birth or adoptive parent. The report shall be prepared after consultation with public and private child-placing agencies, foster and adoptive parents, relatives who are legal custodians, judges, county attorneys, attorneys for children and parents, guardians ad litem, representatives of the councils on Asian-Pacific, African American, American Indian, and Spanish-speaking Minnesotans, and other appropriate child protection system stakeholders. The benefit package addressed in the report shall include the cost of room and board, additional monthly payments associated with special efforts a caretaker must make or special skills or training a caretaker must have in order to adequately address the daily needs of the child, the availability of respite care, and any other costs associated with safely maintaining a particular child in a legally secure home and adequately addressing any special needs the child may have.

Sec. 17. [STUDY OF OUTCOMES FOR CHILDREN IN THE CHILD WELFARE SYSTEM.]

(a) The commissioner of human services, in consultation with local social services agencies, councils of color, representatives of communities of color, child advocates, representatives of courts, and other interested parties, shall study why African American children in Minnesota are disproportionately represented in child welfare out-of-home placements. The commissioner also shall study each stage of the proceedings concerning children in need of protection or services, including the point at which children enter the child welfare system, each decision-making point in the child welfare system, and the outcomes for children in the child welfare system, to determine why outcomes for children differ by race. The commissioner shall use child welfare performance and outcome indicators and data and other available data as part of this study. The commissioner also shall study and determine if there are decision-making points in the child protection system that lead to different outcomes for children and how those decision-making points affect outcomes for children. The commissioner shall report and make legislative recommendations on the following:

(1) amend the child protection statutes to reduce any identified disparities in the child protection system relating to outcomes for children of color, as compared to white children;

(2) reduce any identified bias in the child protection system;

(3) reduce the number and duration of out-of-home placements for African American children; and

(4) improve the long-term outcomes for African American children in out-of-home placements.

(b) The commissioner of human services shall submit the report and recommended legislation to the chairs and ranking minority members of the committees in the house of representatives and senate with jurisdiction over child protection and out-of-home placement issues by January 15, 2002.

ARTICLE 12

CHILD SUPPORT

Section 1. Minnesota Statutes 2000, section 13B.06, subdivision 4, is amended to read:

Subd. 4. [METHOD TO PROVIDE DATA.] To comply with the requirements of this section, a financial institution ~~may either:~~

~~(1) provide to the public authority a list containing only the names and other necessary personal identifying information of all account holders for the public authority to compare against its list of child support obligors for the purpose of identifying which obligors maintain an account at the financial institution; the names of the obligors who maintain an account at the institution shall then be transmitted to the financial institution which shall provide the public authority with account information on those obligors; or~~

~~(2)~~ must obtain a list of child support obligors from the public authority and compare that data to the data maintained at the financial institution to identify which of the identified obligors maintains an account at the financial institution.

~~A financial institution shall elect either method in writing upon written request of the public authority, and the election remains in effect unless the public authority agrees in writing to a change.~~

~~The commissioner shall keep track of the number of financial institutions that elect to report under clauses (1) and (2) respectively and shall report this information to the legislature by December 1, 1999.~~

Sec. 2. Minnesota Statutes 2000, section 13B.06, subdivision 7, is amended to read:

Subd. 7. [FEES.] A financial institution may charge and collect a fee from the public authority for providing account information to the public authority. The commissioner may pay a financial institution up to $150 each quarter if the commissioner and the financial institution have entered into a signed agreement that complies with federal law. The commissioner shall develop procedures for the financial institutions to charge and collect the fee. Payment of the fee is limited by the amount of the appropriation for this purpose. If the appropriation is insufficient, or if fund availability in the fourth quarter would allow payments for actual costs in excess of $150, the commissioner shall prorate the available funds among the financial institutions that have submitted a claim for the fee. No financial institution shall charge or collect a fee that exceeds its actual costs of complying with this section. The commissioner, together with an advisory group consisting of representatives of the financial institutions in the state, shall ~~determine a fee structure that minimizes the cost to the state and reasonably meets the needs of the financial institutions, and shall report to the chairs of the judiciary committees in the house of representatives and the senate by February 1, 1998, a recommended fee structure for inclusion in this section~~ evaluate whether the fee paid to financial institutions compensates them for their actual costs, including start-up costs, of complying with this section and shall submit a report to the legislature by July 1, 2002, with a recommendation for retaining or modifying the fee.

Sec. 3. Minnesota Statutes 2000, section 256.01, subdivision 2, is amended to read:

Subd. 2. [SPECIFIC POWERS.] Subject to the provisions of section 241.021, subdivision 2, the commissioner of human services shall:

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

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

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

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

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

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

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

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

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

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

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

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

(6) Act as the agent of and cooperate with the federal government in matters of mutual concern relative to and in conformity with the provisions of Laws 1939, chapter 431, including the administration of any federal funds granted to the state to aid in the performance of any functions of the commissioner as specified in Laws 1939, chapter 431, and including the promulgation of rules making uniformly available medical care benefits to all recipients of public assistance, at such times as the federal government increases its participation in assistance expenditures for medical care to recipients of public assistance, the cost thereof to be borne in the same proportion as are grants of aid to said recipients.

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

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

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

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

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

(12) Have the authority to conduct and administer experimental projects to test methods and procedures of administering assistance and services to recipients or potential recipients of public welfare. To carry out such experimental projects, it is further provided that the commissioner of human services is authorized to waive the enforcement of existing specific statutory program requirements, rules, and standards in one or more counties. The order establishing the waiver shall provide alternative methods and procedures of administration, shall not be in conflict with the basic purposes, coverage, or benefits provided by law, and in no event shall the duration of a project exceed four years. It is further provided that no order establishing an experimental project as authorized by the provisions of this section shall become effective until the following conditions have been met:

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

(b) A comprehensive plan, including estimated project costs, shall be approved by the legislative advisory commission and filed with the commissioner of administration.

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

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

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

(b) Notwithstanding the provisions of paragraph (a), if the disallowance results from knowing noncompliance by one or more counties with a specific program instruction, and that knowing noncompliance is a matter of official county board record, the commissioner may require payment or recover from the county or counties, in the manner prescribed in paragraph (a), an amount equal to the portion of the total disallowance which resulted from the noncompliance, and may distribute the balance of the disallowance according to paragraph (a).

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

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

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

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

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

(c) If the required reports are not received by the deadlines established in clause (b), the commissioner may delay payments and withhold funds from the county board until the next reporting period. When the report is needed to account for the use of federal funds and the late report results in a reduction in federal funding, the commissioner shall withhold from the county boards with late reports an amount equal to the reduction in federal funding until full federal funding is received.

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

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

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

(g) Counties subject to withholding of funds under paragraph (c) or forfeiture or repayment of funds under paragraph (e) shall not reduce or withhold benefits or services to clients to cover costs incurred due to actions taken by the commissioner under paragraph (c) or (e).

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

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

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

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

(22) Operate the department's communication systems account established in Laws 1993, First Special Session chapter 1, article 1, section 2, subdivision 2, to manage shared communication costs necessary for the operation of the programs the commissioner supervises. A communications account may also be established for each regional treatment center which operates communications systems. Each account must be used to manage shared communication costs necessary for the operations of the programs the commissioner supervises. The commissioner may distribute the costs of operating and maintaining communication systems to participants in a manner that reflects actual usage. Costs may include acquisition, licensing, insurance, maintenance, repair, staff time and other costs as determined by the commissioner. Nonprofit organizations and state, county, and local government agencies involved in the operation of programs the commissioner supervises may participate in the use of the department's communications technology and share in the cost of operation. The commissioner may accept on behalf of the state any gift, bequest, devise or personal property of any kind, or money tendered to the state for any lawful purpose pertaining to the communication activities of the department. Any money received for this purpose must be deposited in the department's communication systems accounts. Money collected by the commissioner for the use of communication systems must be deposited in the state communication systems account and is appropriated to the commissioner for purposes of this section.

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

(24) Incorporate cost reimbursement claims from First Call Minnesota into the federal cost reimbursement claiming processes of the department according to federal law, rule, and regulations. Any reimbursement received is appropriated to the commissioner and shall be disbursed to First Call Minnesota according to normal department payment schedules.

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

(26) In consultation with county child support representatives and county attorneys, adopt rules, in accordance with chapter 14, that are necessary for the operation of a statewide child support county performance management program.

Sec. 4. Minnesota Statutes 2000, section 256.741, subdivision 1, is amended to read:

Subdivision 1. [PUBLIC ASSISTANCE.] (a) The term "direct support" as used in this chapter and chapters 257, 518, and 518C refers to an assigned support payment from an obligor which is paid directly to a recipient of TANF or MFIP.

(b) The term "public assistance" as used in this chapter and chapters 257, 518, and 518C, includes any form of assistance provided under the AFDC program formerly codified in sections 256.72 to 256.87, MFIP and MFIP-R formerly codified under chapter 256, MFIP under chapter 256J, work first program under chapter 256K; child care assistance provided through the child care fund under chapter 119B; any form of medical assistance under chapter 256B; MinnesotaCare under chapter 256L; and foster care as provided under title IV-E of the Social Security Act.

~~(b)~~ (c) The term "child support agency" as used in this section refers to the public authority responsible for child support enforcement.

~~(c)~~ (d) The term "public assistance agency" as used in this section refers to a public authority providing public assistance to an individual.

Sec. 5. Minnesota Statutes 2000, section 256.741, subdivision 5, is amended to read:

Subd. 5. [COOPERATION WITH CHILD SUPPORT ENFORCEMENT.] After notification from a public assistance agency that an individual has applied for or is receiving any form of public assistance, the child support agency shall determine whether the party is cooperating with the agency in establishing paternity, child support, modification of an existing child support order, or enforcement of an existing child support order. The public assistance agency shall notify each applicant or recipient in writing of the right to claim a good cause exemption from cooperating with the requirements in this section. A copy of the notice must be furnished to the applicant or recipient, and the applicant or recipient and a representative from the public authority shall acknowledge receipt of the notice by signing and dating a copy of the notice. The individual shall cooperate with the child support agency by:

(1) providing all known information regarding the alleged father or obligor, including name, address, social security number, telephone number, place of employment or school, and the names and addresses of any relatives;

(2) appearing at interviews, hearings and legal proceedings;

(3) submitting to genetic tests including genetic testing of the child, under a judicial or administrative order; and

(4) providing additional information known by the individual as necessary for cooperating in good faith with the child support agency.

The caregiver of a minor child must cooperate with the efforts of the public authority to collect support according to this subdivision. A caregiver must ~~forward to~~ notify the public authority of all support the caregiver receives during the period the assignment of support required under subdivision 2 is in effect. ~~Support received by a caregiver and not forwarded to the public authority must be repaid to the child support enforcement unit for any month following the date on which initial eligibility is determined~~ Direct support retained by a caregiver must be counted as unearned income when determining the amount of the assistance payment, ~~except as provided under subdivision 8, paragraph (b), clause (4)~~ and repaid to the child support agency for any month when the direct support retained is greater than the court-ordered child support and the assistance payment and the obligor owes support arrears.

Sec. 6. Minnesota Statutes 2000, section 256.741, subdivision 8, is amended to read:

Subd. 8. [REFUSAL TO COOPERATE WITH SUPPORT REQUIREMENTS.] (a) Failure by a caregiver to satisfy any of the requirements of subdivision 5 constitutes refusal to cooperate, and the sanctions under paragraph (b) apply. The IV-D agency must determine whether a caregiver has refused to cooperate according to subdivision 5.

(b) Determination by the IV-D agency that a caregiver has refused to cooperate has the following effects:

(1) a caregiver is subject to the applicable sanctions under section 256J.46;

(2) a caregiver who is not a parent of a minor child in an assistance unit may choose to remove the child from the assistance unit unless the child is required to be in the assistance unit; and

(3) a parental caregiver who refuses to cooperate is ineligible for medical assistance~~; and~~

~~(4) direct support retained by a caregiver must be counted as unearned income when determining the amount of the assistance payment~~.

Sec. 7. Minnesota Statutes 2000, section 256.979, subdivision 5, is amended to read:

Subd. 5. [PATERNITY ESTABLISHMENT AND CHILD SUPPORT ORDER ESTABLISHMENT AND MODIFICATION BONUS INCENTIVES.] (a) A bonus incentive program is created to increase the number of paternity establishments and establishment and modifications of child support orders done by county child support enforcement agencies.

(b) A bonus must be awarded to a county child support agency for each ~~case~~ child for which the agency completes a paternity or child support order establishment or modification through judicial or administrative processes.

(c) The rate of bonus incentive is $100 per child for each paternity or child support order establishment and modification set in a specific dollar amount.

(d) No bonus shall be paid for a modification that is a result of a termination of child care costs according to section 518.551, subdivision 5, paragraph (b), or due solely to a reduction of child care expenses.

Sec. 8. Minnesota Statutes 2000, section 256.979, subdivision 6, is amended to read:

Subd. 6. [CLAIMS FOR BONUS INCENTIVE.] (a) The commissioner of human services and the county agency shall develop procedures for the claims process and criteria using automated systems where possible.

(b) Only one county agency may receive a bonus per paternity establishment or child support order establishment or modification for each ~~case~~ child. The county agency completing the action or procedure needed to establish paternity or a child support order or modify an order is the county agency entitled to claim the bonus incentive.

(c) Disputed claims must be submitted to the commissioner of human services and the commissioner's decision is final.

~~(d) For purposes of this section, "case" means a family unit for whom the county agency is providing child support enforcement services.~~

Sec. 9. Minnesota Statutes 2000, section 393.07, is amended by adding a subdivision to read:

Subd. 9a. [ADMINISTRATIVE PENALTIES.] (a) The public authority, as defined in section 518.54, may sanction an employer or payor of funds up to $700 for failing to comply with section 518.5513, subdivision 5, paragraph (a), clauses (5) and (8), if:

(1) the public authority mails the employer or payor of funds a notice of an administrative sanction, at the employer's or payor's of funds last known address, which includes the date the sanction will take effect, the amount of the sanction, the reason for imposing the sanction, and the corrective action that must be taken to avoid the sanction; and

(2) the employer or payor of funds fails to correct the violation before the effective date of the sanction.

(b) The public authority shall include with the sanction notice an additional notice of the right to appeal the sanction and the process for making the appeal.

(c) Unless an appeal is made, the administrative determination of the sanction is final and binding.

Sec. 10. Minnesota Statutes 2000, section 518.551, subdivision 13, is amended to read:

Subd. 13. [DRIVER'S LICENSE SUSPENSION.] (a) Upon motion of an obligee, which has been properly served on the obligor and upon which there has been an opportunity for hearing, if a court finds that the obligor has been or may be issued a driver's license by the commissioner of public safety and the obligor is in arrears in court-ordered child support or maintenance payments, or both, in an amount equal to or greater than three times the obligor's total monthly support and maintenance payments and is not in compliance with a written payment agreement regarding both current support and arrearages approved by the court, a child support magistrate, or the public authority, the court shall order the commissioner of public safety to suspend the obligor's driver's license. The court's order must be stayed for 90 days in order to allow the obligor to execute a written payment agreement regarding both current support and arrearages, which payment agreement must be approved by either the court or the public authority responsible for child support enforcement. If the obligor has not executed or is not in compliance with a written payment agreement regarding both current support and arrearages after the 90 days expires, the court's order becomes effective and the commissioner of public safety shall suspend the obligor's driver's license. The remedy under this subdivision is in addition to any other enforcement remedy available to the court. An obligee may not bring a motion under this paragraph within 12 months of a denial of a previous motion under this paragraph.

(b) If a public authority responsible for child support enforcement determines that the obligor has been or may be issued a driver's license by the commissioner of public safety and the obligor is in arrears in court-ordered child support or maintenance payments or both in an amount equal to or greater than three times the obligor's total monthly support and maintenance payments and not in compliance with a written payment agreement regarding both current support and arrearages approved by the court, a child support magistrate, or the public authority, the public authority shall direct the commissioner of public safety to suspend the obligor's driver's license. The remedy under this subdivision is in addition to any other enforcement remedy available to the public authority.

(c) At least 90 days prior to notifying the commissioner of public safety according to paragraph (b), the public authority must mail a written notice to the obligor at the obligor's last known address, that it intends to seek suspension of the obligor's driver's license and that the obligor must request a hearing within 30 days in order to contest the suspension. If the obligor makes a written request for a hearing within 30 days of the date of the notice, a court hearing must be held. Notwithstanding any law to the contrary, the obligor must be served with 14 days' notice in writing specifying the time and place of the hearing and the allegations against the obligor. The notice may be served personally or by mail. If the public authority does not receive a request for a hearing within 30 days of the date of the notice, and the obligor does not execute a written payment agreement regarding both current support and arrearages approved by the public authority within 90 days of the date of the notice, the public authority shall direct the commissioner of public safety to suspend the obligor's driver's license under paragraph (b).

(d) At a hearing requested by the obligor under paragraph (c), and on finding that the obligor is in arrears in court-ordered child support or maintenance payments or both in an amount equal to or greater than three times the obligor's total monthly support and maintenance payments, the district court or child support magistrate shall order the commissioner of public safety to suspend the obligor's driver's license or operating privileges unless the court or child support magistrate determines that the obligor has executed and is in compliance with a written payment agreement regarding both current support and arrearages approved by the court, a child support magistrate, or the public authority.

(e) An obligor whose driver's license or operating privileges are suspended may provide proof to the public authority responsible for child support enforcement that the obligor is in compliance with all written payment agreements regarding both current support and arrearages. Within 15 days of the receipt of that proof, the public authority shall inform the commissioner of public safety that the obligor's driver's license or operating privileges should no longer be suspended.

(f) On January 15, 1997, and every two years after that, the commissioner of human services

shall submit a report to the legislature that identifies the following information relevant to the implementation of this section:

(1) the number of child support obligors notified of an intent to suspend a driver's license;

(2) the amount collected in payments from the child support obligors notified of an intent to suspend a driver's license;

(3) the number of cases paid in full and payment agreements executed in response to notification of an intent to suspend a driver's license;

(4) the number of cases in which there has been notification and no payments or payment agreements;

(5) the number of driver's licenses suspended; and

(6) the cost of implementation and operation of the requirements of this section.

(g) In addition to the criteria established under this section for the suspension of an obligor's driver's license, a court, a child support magistrate, or the public authority may direct the commissioner of public safety to suspend the license of a party who has failed, after receiving notice, to comply with a subpoena relating to a paternity or child support proceeding. Notice to an obligor of intent to suspend must be served by first class mail at the obligor's last known address. The notice must inform the obligor of the right to request a hearing. If the obligor makes a written request within ten days of the date of the hearing, a hearing must be held. At the hearing, the only issues to be considered are mistake of fact and whether the obligor received the subpoena.

(h) The license of an obligor who fails to remain in compliance with an approved payment agreement may be suspended if the obligor misses one month's payment. Notice to the obligor of ~~an~~ intent to suspend under this paragraph must be ~~served by first class mail~~ mailed to the obligor at the obligor's last known address ~~and must include a notice of hearing~~. This notice must inform the obligor that unless the delinquency on the payment agreement is paid in full within 30 days of the date of notice or the obligor requests a hearing, the public authority will direct the department of public safety to suspend the obligor's license. If the obligor does not pay the delinquency in full or request a hearing within 30 days of the date of notice, the public authority may direct the department of public safety to suspend the obligor's license. If the obligor requests a hearing to determine failure to comply with the payment agreement, the notice of hearing must be ~~served upon~~ mailed to the obligor at the obligor's last known address not less than ten days before the date of the hearing. If the obligor appears at the hearing and the ~~judge~~ district court or child support magistrate determines that the obligor has failed to comply with an approved payment agreement, the ~~judge~~ district court or child support magistrate shall ~~notify~~ order the department of public safety to suspend the obligor's license ~~under paragraph (c)~~. If the obligor fails to appear at the hearing, the public authority may ~~notify~~ direct the department of public safety to suspend the obligor's license ~~under paragraph (c)~~.

Sec. 11. Minnesota Statutes 2000, section 518.5513, subdivision 5, is amended to read:

Subd. 5. [ADMINISTRATIVE AUTHORITY.] (a) The public authority may take the following actions relating to establishment of paternity or to establishment, modification, or enforcement of support orders, without the necessity of obtaining an order from any judicial or administrative tribunal:

(1) recognize and enforce orders of child support agencies of other states;

(2) upon request for genetic testing by a child, parent, or any alleged parent, and using the procedure in paragraph (b), order the child, parent, or alleged parent to submit to blood or genetic testing for the purpose of establishing paternity;

(3) subpoena financial or other information needed to establish, modify, or enforce a child support order and ~~request sanctions~~ sanction a party for failure to respond to a subpoena;

(4) upon notice to the obligor, obligee, and the appropriate court, direct the obligor or other payor to change the payee to the central collections unit under sections 518.5851 to 518.5853;

(5) order income withholding of child support under section 518.6111 and sanction an employer or payor of funds pursuant to section 393.07, subdivision 9a, for failing to comply with an income withholding notice;

(6) secure assets to satisfy the debt or arrearage in cases in which there is a support debt or arrearage by:

(i) intercepting or seizing periodic or lump sum payments from state or local agencies, including unemployment benefits, workers' compensation payments, judgments, settlements, lotteries, and other lump sum payments;

(ii) attaching and seizing assets of the obligor held in financial institutions or public or private retirement funds; and

(iii) imposing liens in accordance with section 548.091 and, in appropriate cases, forcing the sale of property and the distribution of proceeds;

(7) for the purpose of securing overdue support, increase the amount of the monthly support payments by an additional amount equal to 20 percent of the monthly support payment to include amounts for debts or arrearages; and

(8) subpoena an employer or payor of funds to provide promptly information on the employment, compensation, and benefits of an individual employed by that employer as an employee or contractor, and ~~to request sanctions~~ sanction an employer or payor of funds pursuant to section 393.07, subdivision 9a, for failure to respond to the subpoena ~~as provided by law~~.

(b) A request for genetic testing by a child, parent, or alleged parent must be supported by a sworn statement by the person requesting genetic testing alleging paternity, which sets forth facts establishing a reasonable possibility of the requisite sexual contact between the parties, or denying paternity, and setting forth facts establishing a reasonable possibility of the nonexistence of sexual contact between the alleged parties. The order for genetic tests may be served anywhere within the state and served outside the state in the same manner as prescribed by law for service of subpoenas issued by the district court of this state. If the child, parent, or alleged parent fails to comply with the genetic testing order, the public authority may seek to enforce that order in district court through a motion to compel testing. No results obtained through genetic testing done in response to an order issued under this section may be used in any criminal proceeding.

(c) Subpoenas may be served anywhere within the state and served outside the state in the same manner as prescribed by law for service of process of subpoenas issued by the district court of this state. When a subpoena under this subdivision is served on a third-party recordkeeper, written notice of the subpoena shall be mailed to the person who is the subject of the subpoenaed material at the person's last known address within three days of the day the subpoena is served. This notice provision does not apply if there is reasonable cause to believe the giving of the notice may lead to interference with the production of the subpoenaed documents.

(d) A person served with a subpoena may make a written objection to the public authority or court before the time specified in the subpoena for compliance. The public authority or the court shall cancel or modify the subpoena, if appropriate. The public authority shall pay the reasonable costs of producing the documents, if requested.

(e) Subpoenas are enforceable in the same manner as subpoenas of the district court. Upon motion of the county attorney, the court may issue an order directing the production of the records. Failure to comply with the court order may subject the person who fails to comply to civil or criminal contempt of court.

(f) The administrative actions under this subdivision are subject to due process safeguards, including requirements for notice, opportunity to contest the action, and opportunity to appeal the order to the judge, judicial officer, or child support magistrate.

Sec. 12. Minnesota Statutes 2000, section 518.575, subdivision 1, is amended to read:

Subdivision 1. [MAKING NAMES PUBLIC.] At least once each year, the commissioner of human services, in consultation with the attorney general, ~~shall~~ may publish a list of the names and other identifying information of no more than 25 persons who (1) are child support obligors, (2) are at least $10,000 in arrears, (3) are not in compliance with a written payment agreement regarding both current support and arrearages approved by the court, a child support magistrate, or the public authority, (4) cannot currently be located by the public authority for the purposes of enforcing a support order, and (5) have not made a support payment except tax intercept payments, in the preceding 12 months.

Identifying information may include the obligor's name, last known address, amount owed, date of birth, photograph, the number of children for whom support is owed, and any additional information about the obligor that would assist in identifying or locating the obligor. The commissioner and attorney general may use posters, media presentations, electronic technology, and other means that the commissioner and attorney general determine are appropriate for dissemination of the information, including publication on the Internet. The commissioner and attorney general may make any or all of the identifying information regarding these persons public. Information regarding an obligor who meets the criteria in this subdivision will only be made public subsequent to that person's selection by the commissioner and attorney general.

Before making public the name of the obligor, the department of human services shall send a notice to the obligor's last known address which states the department's intention to make public information on the obligor. The notice must also provide an opportunity to have the obligor's name removed from the list by paying the arrearage or by entering into an agreement to pay the arrearage, or by providing information to the public authority that there is good cause not to make the information public. The notice must include the final date when the payment or agreement can be accepted.

The department of human services shall obtain the written consent of the obligee to make the name of the obligor public.

Sec. 13. Minnesota Statutes 2000, section 518.5851, is amended by adding a subdivision to read:

Subd. 7. [UNCLAIMED SUPPORT FUNDS.] "Unclaimed support funds" means any support payments collected by the public authority from the obligor, which have not been disbursed to the obligee or public authority.

Sec. 14. Minnesota Statutes 2000, section 518.5853, is amended by adding a subdivision to read:

Subd. 12. [UNCLAIMED SUPPORT FUNDS.] (a) If support payments have not been disbursed to an obligee because the obligee is not located, the public authority shall continue locate efforts for one year from the date the public authority determines that the obligee is not located.

(b) If the public authority is unable to locate the obligee after one year, the public authority shall mail a written notice to the obligee at the obligee's last known address. The notice shall give the obligee 60 days to contact the public authority. If the obligee does not contact the public authority within 60 days from the date of notice, the public authority shall:

(1) close the nonpublic assistance portion of the case;

(2) disburse unclaimed support funds to pay public assistance arrears. If public assistance arrears remain after disbursing the unclaimed support funds, the public authority may continue enforcement and collection of child support until all public assistance arrears have been paid. If there are no public assistance arrears, or unclaimed support funds remain after paying public assistance arrears, remaining unclaimed support funds shall be returned to the obligor; and

(3) mail, when all public assistance arrears have been paid the public authority, to the obligor at

the obligor's last known address a written notice of termination of income withholding and case closure due to the public authority's inability to locate the obligee. The notice must indicate that the obligor's support or maintenance obligation will remain in effect until further order of the court and must inform the obligor that the obligor can contact the public authority for assistance to modify the order. A copy of the form prepared by the state court administrator's office under section 518.64, subdivision 5, must be included with the notice.

(c) If the obligor is not located when attempting to return unclaimed support funds, the public authority shall continue locate efforts for one year from the date the public authority determines that the obligor is not located. If the public authority is unable to locate the obligor after one year, the funds shall be treated as unclaimed property according to federal law and chapter 345.

Sec. 15. Minnesota Statutes 2000, section 518.6111, subdivision 5, is amended to read:

Subd. 5. [PAYOR OF FUNDS RESPONSIBILITIES.] (a) An order for or notice of withholding is binding on a payor of funds upon receipt. Withholding must begin no later than the first pay period that occurs after 14 days following the date of receipt of the order for or notice of withholding. In the case of a financial institution, preauthorized transfers must occur in accordance with a court-ordered payment schedule.

(b) A payor of funds shall withhold from the income payable to the obligor the amount specified in the order or notice of withholding and amounts specified under subdivisions 6 and 9 and shall remit the amounts withheld to the public authority within seven business days of the date the obligor is paid the remainder of the income. The payor of funds shall include with the remittance the social security number of the obligor, the case type indicator as provided by the public authority and the date the obligor is paid the remainder of the income. The obligor is considered to have paid the amount withheld as of the date the obligor received the remainder of the income. A payor of funds may combine all amounts withheld from one pay period into one payment to each public authority, but shall separately identify each obligor making payment.

(c) A payor of funds shall not discharge, or refuse to hire, or otherwise discipline an employee as a result of wage or salary withholding authorized by this section. A payor of funds shall be liable to the obligee for any amounts required to be withheld. A payor of funds that fails to withhold or transfer funds in accordance with this section is also liable to the obligee for interest on the funds at the rate applicable to judgments under section 549.09, computed from the date the funds were required to be withheld or transferred. A payor of funds is liable for reasonable attorney fees of the obligee or public authority incurred in enforcing the liability under this paragraph. A payor of funds that has failed to comply with the requirements of this section is subject to contempt sanctions under section 518.615. If the payor of funds is an employer or independent contractor and violates this subdivision, a court may award the obligor twice the wages lost as a result of this violation. If a court finds a payor of funds violated this subdivision, the court shall impose a civil fine of not less than $500. The liabilities in this paragraph apply to intentional noncompliance with this section.

(d) If a single employee is subject to multiple withholding orders or multiple notices of withholding for the support of more than one child, the payor of funds shall comply with all of the orders or notices to the extent that the total amount withheld from the obligor's income does not exceed the limits imposed under the Consumer Credit Protection Act, United States Code, title 15, section 1673(b), giving priority to amounts designated in each order or notice as current support as follows:

(1) if the total of the amounts designated in the orders for or notices of withholding as current support exceeds the amount available for income withholding, the payor of funds shall allocate to each order or notice an amount for current support equal to the amount designated in that order or notice as current support, divided by the total of the amounts designated in the orders or notices as current support, multiplied by the amount of the income available for income withholding; and

(2) if the total of the amounts designated in the orders for or notices of withholding as current support does not exceed the amount available for income withholding, the payor of funds shall pay the amounts designated as current support, and shall allocate to each order or notice an amount for

past due support, equal to the amount designated in that order or notice as past due support, divided by the total of the amounts designated in the orders or notices as past due support, multiplied by the amount of income remaining available for income withholding after the payment of current support.

(e) When an order for or notice of withholding is in effect and the obligor's employment is terminated, the obligor and the payor of funds shall notify the public authority of the termination within ten days of the termination date. The termination notice shall include the obligor's home address and the name and address of the obligor's new payor of funds, if known.

(f) A payor of funds may deduct one dollar from the obligor's remaining salary for each payment made pursuant to an order for or notice of withholding under this section to cover the expenses of withholding.

Sec. 16. Minnesota Statutes 2000, section 518.6195, is amended to read:

518.6195 [COLLECTION; ARREARS ONLY.]

(a) Remedies available for the collection and enforcement of support in this chapter and chapters 256, 257, and 518C also apply to cases in which the child or children for whom support is owed are emancipated and the obligor owes past support or has an accumulated arrearage as of the date of the youngest child's emancipation. Child support arrearages under this section include arrearages for child support, medical support, child care, pregnancy and birth expenses, and unreimbursed medical expenses as defined in section 518.171.

(b) This section applies retroactively to any support arrearage that accrued on or before the date of enactment and to all arrearages accruing after the date of enactment.

(c) Past support or pregnancy and confinement expenses ordered for which the obligor has specific court ordered terms for repayment may not be enforced using drivers' and occupational or professional license suspension, credit bureau reporting, and additional income withholding under section 518.6111, subdivision 10, paragraph (a), unless the obligor fails to comply with the terms of the court order for repayment.

(d) If an arrearage exists at the time a support order would otherwise terminate and section 518.6111, subdivision 10, paragraph (c), does not apply to this section, the arrearage shall be repaid in an amount equal to the current support order plus an additional 20 percent of the monthly child support obligation until all arrears have been paid in full, absent a court order to the contrary.

(e) If an arrearage exists according to a support order which fails to establish a monthly support obligation in a specific dollar amount, the public authority, if it provides child support services, or the obligee, may establish a payment agreement which shall equal what the obligor would pay for current support after application of section 518.551, plus an additional 20 percent of the current support obligation, until all arrears have been paid in full. If the obligor fails to enter into or comply with a payment agreement, the public authority, if it provides child support services, or the obligee, may move the district court or child support magistrate, if section 484.702 applies, for an order establishing repayment terms. It shall be presumed that the obligor is able to repay arrears at a rate which at a minimum equals a current monthly obligation after application of section 518.551, plus an additional 20 percent of the current monthly obligation.

Sec. 17. Minnesota Statutes 2000, section 518.64, subdivision 2, is amended to read:

Subd. 2. [MODIFICATION.] (a) The terms of an order respecting maintenance or support may be modified upon a showing of one or more of the following: (1) substantially increased or decreased earnings of a party; (2) substantially increased or decreased need of a party or the child or children that are the subject of these proceedings; (3) receipt of assistance under the AFDC program formerly codified under sections 256.72 to 256.87 or 256B.01 to 256B.40, or chapter 256J or 256K; (4) a change in the cost of living for either party as measured by the federal bureau of statistics, any of which makes the terms unreasonable and unfair; (5) extraordinary medical expenses of the child not provided for under section 518.171; or (6) the addition of work-related or education-related child care expenses of the obligee or a substantial increase or decrease in existing work-related or education-related child care expenses.

On a motion to modify support, the needs of any child the obligor has after the entry of the support order that is the subject of a modification motion shall be considered as provided by section 518.551, subdivision 5f.

(b) It is presumed that there has been a substantial change in circumstances under paragraph (a) and the terms of a current support order shall be rebuttably presumed to be unreasonable and unfair if:

(1) the application of the child support guidelines in section 518.551, subdivision 5, to the current circumstances of the parties results in a calculated court order that is at least 20 percent and at least $50 per month higher or lower than the current support order;

(2) the medical support provisions of the order established under section 518.171 are not enforceable by the public authority or the custodial parent;

(3) health coverage ordered under section 518.171 is not available to the child for whom the order is established by the parent ordered to provide; or

(4) the existing support obligation is in the form of a statement of percentage and not a specific dollar amount.

(c) On a motion for modification of maintenance, including a motion for the extension of the duration of a maintenance award, the court shall apply, in addition to all other relevant factors, the factors for an award of maintenance under section 518.552 that exist at the time of the motion. On a motion for modification of support, the court:

(1) shall apply section 518.551, subdivision 5, and shall not consider the financial circumstances of each party's spouse, if any; and

(2) shall not consider compensation received by a party for employment in excess of a 40-hour work week, provided that the party demonstrates, and the court finds, that:

(i) the excess employment began after entry of the existing support order;

(ii) the excess employment is voluntary and not a condition of employment;

(iii) the excess employment is in the nature of additional, part-time employment, or overtime employment compensable by the hour or fractions of an hour;

(iv) the party's compensation structure has not been changed for the purpose of affecting a support or maintenance obligation;

(v) in the case of an obligor, current child support payments are at least equal to the guidelines amount based on income not excluded under this clause; and

(vi) in the case of an obligor who is in arrears in child support payments to the obligee, any net income from excess employment must be used to pay the arrearages until the arrearages are paid in full.

(d) A modification of support or maintenance, including interest that accrued pursuant to section 548.091, may be made retroactive only with respect to any period during which the petitioning party has pending a motion for modification but only from the date of service of notice of the motion on the responding party and on the public authority if public assistance is being furnished or the county attorney is the attorney of record. However, modification may be applied to an earlier period if the court makes express findings that:

(1) the party seeking modification was precluded from serving a motion by reason of a significant physical or mental disability, a material misrepresentation of another party, or fraud upon the court and that the party seeking modification, when no longer precluded, promptly served a motion;

(2) the party seeking modification was a recipient of federal Supplemental Security Income

(SSI), Title II Older Americans, Survivor's Disability Insurance (OASDI), other disability benefits, or public assistance based upon need during the period for which retroactive modification is sought; ~~or~~

(3) the order for which the party seeks amendment was entered by default, the party shows good cause for not appearing, and the record contains no factual evidence, or clearly erroneous evidence regarding the individual obligor's ability to pay~~.~~; or

(4) the party seeking modification was institutionalized or incarcerated for an offense other than nonsupport of a child during the period for which retroactive modification is sought and lacked the financial ability to pay the support ordered during that time period. In determining whether to allow the retroactive modification, the court shall consider whether and when a request was made to the public authority for support modification.

The court may provide that a reduction in the amount allocated for child care expenses based on a substantial decrease in the expenses is effective as of the date the expenses decreased.

(e) Except for an award of the right of occupancy of the homestead, provided in section 518.63, all divisions of real and personal property provided by section 518.58 shall be final, and may be revoked or modified only where the court finds the existence of conditions that justify reopening a judgment under the laws of this state, including motions under section 518.145, subdivision 2. The court may impose a lien or charge on the divided property at any time while the property, or subsequently acquired property, is owned by the parties or either of them, for the payment of maintenance or support money, or may sequester the property as is provided by section 518.24.

(f) The court need not hold an evidentiary hearing on a motion for modification of maintenance or support.

(g) Section 518.14 shall govern the award of attorney fees for motions brought under this subdivision.

Sec. 18. Minnesota Statutes 2000, section 518.641, subdivision 1, is amended to read:

Subdivision 1. [REQUIREMENT.] (a) An order ~~for~~ establishing, modifying, or enforcing maintenance or child support shall provide for a biennial adjustment in the amount to be paid based on a change in the cost of living. An order that provides for a cost-of-living adjustment shall specify the cost-of-living index to be applied and the date on which the cost-of-living adjustment shall become effective. The court may use the consumer price index for all urban consumers, Minneapolis-St. Paul (CPI-U), the consumer price index for wage earners and clerical, Minneapolis-St. Paul (CPI-W), or another cost-of-living index published by the department of labor which it specifically finds is more appropriate. Cost-of-living increases under this section shall be compounded. The court may also increase the amount by more than the cost-of-living adjustment by agreement of the parties or by making further findings.

(b) The adjustment becomes effective on the first of May of the year in which it is made, for cases in which payment is made to the public authority. For cases in which payment is not made to the public authority, application for an adjustment may be made in any month but no application for an adjustment may be made sooner than two years after the date of the dissolution decree. A court may waive the requirement of the cost-of-living clause if it expressly finds that the obligor's occupation or income, or both, does not provide for cost-of-living adjustment or that the order for maintenance or child support has a provision such as a step increase that has the effect of a cost-of-living clause. The court may waive a cost-of-living adjustment in a maintenance order if the parties so agree in writing. The commissioner of human services may promulgate rules for child support adjustments under this section in accordance with the rulemaking provisions of chapter 14. Notice of this statute must comply with section 518.68, subdivision 2.

Sec. 19. Minnesota Statutes 2000, section 518.641, subdivision 2, is amended to read:

Subd. 2. [~~CONDITIONS~~ NOTICE.] No adjustment under this section may be made unless the order provides for it and ~~until the following conditions are met:~~

~~(a) the obligee serves notice of the application for adjustment by mail on the obligor at the obligor's last known address at least 20 days before the effective date of the adjustment;~~

~~(b) the notice to the obligor informs the obligor of the date on which the adjustment in payments will become effective;~~

~~(c) after receipt of notice and before the effective day of the adjustment, the obligor fails to request a hearing on the issue of whether the adjustment should take effect, and ex parte, to stay imposition of the adjustment pending outcome of the hearing; or~~

~~(d) the public authority~~ the public authority or the obligee, if the obligee is requesting the cost-of-living adjustment, sends notice of ~~its application for~~ the intended adjustment to the obligor at the obligor's last known address at least 20 days before the effective date of the adjustment~~, and~~. The notice ~~informs~~ shall inform the obligor of the date on which the adjustment will become effective and the procedures for contesting the adjustment ~~according to section 484.702~~.

Sec. 20. Minnesota Statutes 2000, section 518.641, is amended by adding a subdivision to read:

Subd. 2a. [PROCEDURES FOR CONTESTING ADJUSTMENT.] (a) To contest cost-of-living adjustments initiated by the public authority or an obligee who has applied for or is receiving child support and maintenance collection services from the public authority, other than income withholding only services, the obligor, before the effective date of the adjustment, must:

(1) file a motion contesting the cost-of-living adjustment with the court administrator; and

(2) serve the motion by first-class mail on the public authority and the obligee.

The hearing shall take place in the expedited child support process as governed by section 484.702.

(b) To contest cost-of-living adjustments initiated by an obligee who is not receiving child support and maintenance collection services from the public authority, or for an obligee who receives income withholding only services from the public authority, the obligor must, before the effective date of the adjustment:

(1) file a motion contesting the cost-of-living adjustment with the court administrator; and

(2) serve the motion by first-class mail on the obligee.

The hearing shall take place in district court.

(c) Upon receipt of a motion contesting the cost-of-living adjustment, the cost-of-living adjustment shall be stayed pending further order of the court.

(d) The court administrator shall make available pro se motion forms for contesting a cost-of-living adjustment under this subdivision.

Sec. 21. Minnesota Statutes 2000, section 518.641, subdivision 3, is amended to read:

Subd. 3. [RESULT OF HEARING.] If, at a hearing pursuant to this section, the obligor establishes an insufficient cost of living or other increase in income that prevents fulfillment of the adjusted maintenance or child support obligation, the court or child support magistrate may direct that all or part of the adjustment not take effect. If, at the hearing, the obligor does not establish this insufficient increase in income, the adjustment shall take effect as of the date it would have become effective had no hearing been requested.

Sec. 22. Minnesota Statutes 2000, section 548.091, subdivision 1a, is amended to read:

Subd. 1a. [CHILD SUPPORT JUDGMENT BY OPERATION OF LAW.] (a) Any payment or installment of support required by a judgment or decree of dissolution or legal separation, determination of parentage, an order under chapter 518C, an order under section 256.87, or an order under section 260B.331 or 260C.331, that is not paid or withheld from the obligor's income as required under section 518.6111, or which is ordered as child support by judgment, decree, or

order by a court in any other state, is a judgment by operation of law on and after the date it is due, is entitled to full faith and credit in this state and any other state, and shall be entered and docketed by the court administrator on the filing of affidavits as provided in subdivision 2a. Except as otherwise provided by paragraph (b), interest accrues from the date the unpaid amount due is greater than the current support due at the annual rate provided in section 549.09, subdivision 1, plus two percent, not to exceed an annual rate of 18 percent. A payment or installment of support that becomes a judgment by operation of law between the date on which a party served notice of a motion for modification under section 518.64, subdivision 2, and the date of the court's order on modification may be modified under that subdivision.

(b) Notwithstanding the provisions of section 549.09, upon motion to the court and upon proof by the obligor of 36 consecutive months of complete and timely payments of both current support and court-ordered paybacks of a child support debt or arrearage, the court may order interest on the remaining debt or arrearage to stop accruing. Timely payments are those made in the month in which they are due. If, after that time, the obligor fails to make complete and timely payments of both current support and court-ordered paybacks of child support debt or arrearage, the public authority or the obligee may move the court for the reinstatement of interest as of the month in which the obligor ceased making complete and timely payments.

The court shall provide copies of all orders issued under this section to the public authority. The commissioner of human services shall prepare and make available to the court and the parties forms to be submitted by the parties in support of a motion under this paragraph.

(c) Notwithstanding the provisions of section 549.09, upon motion to the court, the court may order interest on a child support debt to stop accruing where the court finds that the obligor is:

(1) unable to pay support because of a significant physical or mental disability; ~~or~~

(2) a recipient of Supplemental Security Income (SSI), Title II Older Americans Survivor's Disability Insurance (OASDI), other disability benefits, or public assistance based upon need; or

(3) institutionalized or incarcerated for at least 30 days for an offense other than nonsupport of the child or children involved, and is otherwise financially unable to pay support.

Sec. 23. [REPEALER.]

Minnesota Statutes 2000, section 518.641, subdivisions 4 and 5, are repealed.

ARTICLE 13

DEPARTMENT OF HUMAN SERVICES LICENSING

Section 1. Minnesota Statutes 2000, section 13.46, subdivision 4, is amended to read:

Subd. 4. [LICENSING DATA.] (a) As used in this subdivision:

(1) "licensing data" means all data collected, maintained, used, or disseminated by the welfare system pertaining to persons licensed or registered or who apply for licensure or registration or who formerly were licensed or registered under the authority of the commissioner of human services;

(2) "client" means a person who is receiving services from a licensee or from an applicant for licensure; and

(3) "personal and personal financial data" means social security numbers, identity of and letters of reference, insurance information, reports from the bureau of criminal apprehension, health examination reports, and social/home studies.

(b)(1) Except as provided in paragraph (c), the following data on current and former licensees are public: name, address, telephone number of licensees, licensed capacity, type of client preferred, variances granted, type of dwelling, name and relationship of other family members, previous license history, class of license, and the existence and status of complaints. When

disciplinary action has been taken against a licensee or the complaint is resolved, the following data are public: the substance of the complaint, the findings of the investigation of the complaint, the record of informal resolution of a licensing violation, orders of hearing, findings of fact, conclusions of law, and specifications of the final disciplinary action contained in the record of disciplinary action.

(2) The following data on persons subject to disqualification under section 245A.04 in connection with a license to provide family day care for children, child care center services, foster care for children in the provider's home, or foster care or day care services for adults in the provider's home, are public: the nature of any disqualification set aside under section 245A.04, subdivision 3b, and the reasons for setting aside the disqualification; and the reasons for granting any variance under section 245A.04, subdivision 9.

(3) When maltreatment is substantiated under section 626.556 or 626.557 and the victim and the substantiated perpetrator are affiliated with a program licensed under chapter 245A, the commissioner of human services, local social services agency, or county welfare agency may inform the license holder where the maltreatment occurred of the identity of the substantiated perpetrator and the victim.

(c) The following are private data on individuals under section 13.02, subdivision 12, or nonpublic data under section 13.02, subdivision 9: personal and personal financial data on family day care program and family foster care program applicants and licensees and their family members who provide services under the license.

(d) The following are private data on individuals: the identity of persons who have made reports concerning licensees or applicants that appear in inactive investigative data, and the records of clients or employees of the licensee or applicant for licensure whose records are received by the licensing agency for purposes of review or in anticipation of a contested matter. The names of reporters under sections 626.556 and 626.557 may be disclosed only as provided in section 626.556, subdivision 11, or 626.557, subdivision 12b.

(e) Data classified as private, confidential, nonpublic, or protected nonpublic under this subdivision become public data if submitted to a court or administrative law judge as part of a disciplinary proceeding in which there is a public hearing concerning the disciplinary action.

(f) Data generated in the course of licensing investigations that relate to an alleged violation of law are investigative data under subdivision 3.

(g) Data that are not public data collected, maintained, used, or disseminated under this subdivision that relate to or are derived from a report as defined in section 626.556, subdivision 2, are subject to the destruction provisions of section 626.556, subdivision 11.

(h) Upon request, not public data collected, maintained, used, or disseminated under this subdivision that relate to or are derived from a report of substantiated maltreatment as defined in section 626.556 or 626.557 may be exchanged with the department of health for purposes of completing background studies pursuant to section 144.057.

(i) Data on individuals collected according to licensing activities under chapter 245A, and data on individuals collected by the commissioner of human services according to maltreatment investigations under sections 626.556 and 626.557, may be shared with the department of human rights, the department of health, the department of corrections, the ombudsman for mental health and retardation, and the individual's professional regulatory board when there is reason to believe that laws or standards under the jurisdiction of those agencies may have been violated.

(j) In addition to the notice of determinations required under section 626.556, subdivision 10f, if the commissioner or the local social services agency has determined that an individual is a substantiated perpetrator of maltreatment of a child based on sexual abuse, as defined in section 626.556, subdivision 2, and the commissioner or local social services agency knows that the individual is a person responsible for a child's care in another facility, the commissioner or local social services agency shall notify the head of that facility of this determination. The notification

must include an explanation of the individual's available appeal rights and the status of any appeal. If a notice is given under this paragraph, the government entity making the notification shall provide a copy of the notice to the individual who is the subject of the notice.

Sec. 2. Minnesota Statutes 2000, section 144.057, subdivision 3, is amended to read:

Subd. 3. [RECONSIDERATIONS.] The commissioner of health shall review and decide reconsideration requests, including the granting of variances, in accordance with the procedures and criteria contained in chapter 245A and Minnesota Rules, parts 9543.3000 to 9543.3090. The commissioner's decision shall be provided to the individual and to the department of human services. Except as provided under section 245A.04, subdivisions 3b, paragraphs (e) and (f); and 3c, paragraph (a), the commissioner's decision to grant or deny a reconsideration of disqualification is the final administrative agency action.

Sec. 3. Minnesota Statutes 2000, section 214.104, is amended to read:

214.104 [HEALTH-RELATED LICENSING BOARDS; DETERMINATIONS REGARDING ~~DISQUALIFICATIONS FOR~~ MALTREATMENT.]

(a) A health-related licensing board shall make determinations as to whether ~~licensees~~ regulated persons who are under the board's jurisdiction should be ~~disqualified under section 245A.04, subdivision 3d, from positions allowing direct contact with persons receiving services~~ the subject of disciplinary or corrective action because of substantiated maltreatment under section 626.556 or 626.557. ~~A determination under this section may be done as part of an investigation under section 214.103.~~ The board shall make a determination ~~within 90 days of~~ upon receipt, and after the review, of an investigation memorandum or other notice of substantiated maltreatment under section 626.556 or 626.557, or of a notice from the commissioner of human services that a background study of a ~~licensee~~ regulated person shows substantiated maltreatment. ~~The board shall also make a determination under this section upon consideration of the licensure of an individual who was subject to disqualification before licensure because of substantiated maltreatment.~~

~~(b) In making a determination under this section, the board shall consider the nature and extent of any injury or harm resulting from the conduct that would constitute grounds for disqualification, the seriousness of the misconduct, the extent that disqualification is necessary to protect persons receiving services or the public, and other factors specified in section 245A.04, subdivision 3b, paragraph (b).~~

~~(c) The board shall determine the duration and extent of the disqualification or may establish conditions under which the licensee may hold a position allowing direct contact with persons receiving services or in a licensed facility.~~

(b) Upon completion of its review of a report of substantiated maltreatment, the board shall notify the commissioner of human services ~~and the lead agency that conducted an investigation under section 626.556 or 626.557, as applicable,~~ of its determination. The board shall notify the commissioner of human services if, following a review of the report of substantiated maltreatment, the board determines that it does not have jurisdiction in the matter and the commissioner shall make the appropriate disqualification decision regarding the regulated person as otherwise provided in chapter 245A. The board shall also notify the commissioner of health or the commissioner of human services immediately upon receipt of knowledge of a facility or program allowing a regulated person to provide direct contact services at the facility or program while not complying with requirements placed on the regulated person.

(c) In addition to any other remedy provided by law, the board may, through its designated board member, temporarily suspend the license of a licensee; deny a credential to an applicant; or require the regulated person to be continuously supervised, if the board finds there is probable cause to believe the regulated person referred to the board according to paragraph (a) poses an immediate risk of harm to vulnerable persons. The board shall consider all relevant information available, which may include but is not limited to:

(1) the extent the action is needed to protect persons receiving services or the public;

(2) the recency of the maltreatment;

(3) the number of incidents of maltreatment;

(4) the intrusiveness or violence of the maltreatment; and

(5) the vulnerability of the victim of maltreatment.

The action shall take effect upon written notice to the regulated person, served by certified mail, specifying the statute violated. The board shall notify the commissioner of health or the commissioner of human services of the suspension or denial of a credential. The action shall remain in effect until the board issues a temporary stay or a final order in the matter after a hearing or upon agreement between the board and the regulated person. At the time the board issues the notice, the regulated person shall inform the board of all settings in which the regulated person is employed or practices. The board shall inform all known employment and practice settings of the board action and schedule a disciplinary hearing to be held under chapter 14. The board shall provide the regulated person with at least 30 days' notice of the hearing, unless the parties agree to a hearing date that provides less than 30 days' notice, and shall schedule the hearing to begin no later than 90 days after issuance of the notice of hearing.

Sec. 4. Minnesota Statutes 2000, section 245A.03, subdivision 2b, is amended to read:

Subd. 2b. [EXCEPTION.] The provision in subdivision 2, clause (2), does not apply to:

(1) a child care provider who as an applicant for licensure or as a license holder has received a license denial under section 245A.05, a ~~fine~~ conditional license under section 245A.06, or a sanction under section 245A.07 from the commissioner that has not been reversed on appeal; or

(2) a child care provider, or a child care provider who has a household member who, as a result of a licensing process, has a disqualification under this chapter that has not been set aside by the commissioner.

Sec. 5. Minnesota Statutes 2000, section 245A.04, subdivision 3, is amended to read:

Subd. 3. [BACKGROUND STUDY OF THE APPLICANT; DEFINITIONS.] (a) Before the commissioner issues a license, the commissioner shall conduct a study of the individuals specified in paragraph ~~(c)~~ (d), clauses (1) to (5), according to rules of the commissioner.

Beginning January 1, 1997, the commissioner shall also conduct a study of employees providing direct contact services for nonlicensed personal care provider organizations described in paragraph ~~(c)~~ (d), clause (5).

The commissioner shall recover the cost of these background studies through a fee of no more than $12 per study charged to the personal care provider organization.

Beginning August 1, 1997, the commissioner shall conduct all background studies required under this chapter for adult foster care providers who are licensed by the commissioner of human services and registered under chapter 144D. The commissioner shall conduct these background studies in accordance with this chapter. The commissioner shall initiate a pilot project to conduct up to 5,000 background studies under this chapter in programs with joint licensure as home and community-based services and adult foster care for people with developmental disabilities when the license holder does not reside in the foster care residence.

(b) Beginning July 1, 1998, the commissioner shall conduct a background study on individuals specified in paragraph ~~(c)~~ (d), clauses (1) to (5), who perform direct contact services in a nursing home or a home care agency licensed under chapter 144A or a boarding care home licensed under sections 144.50 to 144.58, when the subject of the study resides outside Minnesota; the study must be at least as comprehensive as that of a Minnesota resident and include a search of information from the criminal justice data communications network in the state where the subject of the study resides.

(c) Beginning August 1, 2001, the commissioner shall conduct all background studies required under this chapter and initiated by supplemental nursing services agencies registered under section 144A.71, subdivision 1. Studies for the agencies must be initiated annually by each agency. The commissioner shall conduct the background studies according to this chapter. The commissioner shall recover the cost of the background studies through a fee of no more than $8 per study, charged to the supplemental nursing services agency. Money collected under this paragraph is appropriated to the commissioner to pay the costs of background studies.

(d) The applicant, license holder, ~~the~~ registrant under section 144A.71, subdivision 1, bureau of criminal apprehension, ~~the~~ commissioner of health, and county agencies, after written notice to the individual who is the subject of the study, shall help with the study by giving the commissioner criminal conviction data and reports about the maltreatment of adults substantiated under section 626.557 and the maltreatment of minors in licensed programs substantiated under section 626.556. The individuals to be studied shall include:

(1) the applicant;

(2) persons over the age of 13 living in the household where the licensed program will be provided;

(3) current employees or contractors of the applicant who will have direct contact with persons served by the facility, agency, or program;

(4) volunteers or student volunteers who have direct contact with persons served by the program to provide program services, if the contact is not directly supervised by the individuals listed in clause (1) or (3); and

(5) any person who, as an individual or as a member of an organization, exclusively offers, provides, or arranges for personal care assistant services under the medical assistance program as authorized under sections 256B.04, subdivision 16, and 256B.0625, subdivision 19a.

The juvenile courts shall also help with the study by giving the commissioner existing juvenile court records on individuals described in clause (2) relating to delinquency proceedings held within either the five years immediately preceding the application or the five years immediately preceding the individual's 18th birthday, whichever time period is longer. The commissioner shall destroy juvenile records obtained pursuant to this subdivision when the subject of the records reaches age 23.

For purposes of this section and Minnesota Rules, part 9543.3070, a finding that a delinquency petition is proven in juvenile court shall be considered a conviction in state district court.

For purposes of this subdivision, "direct contact" means providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by a program. For purposes of this subdivision, "directly supervised" means an individual listed in clause (1), (3), or (5) is within sight or hearing of a volunteer to the extent that the individual listed in clause (1), (3), or (5) is capable at all times of intervening to protect the health and safety of the persons served by the program who have direct contact with the volunteer.

A study of an individual in clauses (1) to (5) shall be conducted at least upon application for initial license or registration under section 144A.71, subdivision 1, and reapplication for a license or registration. The commissioner is not required to conduct a study of an individual at the time of reapplication for a license or if the individual has been continuously affiliated with a foster care provider licensed by the commissioner of human services and registered under chapter 144D, other than a family day care or foster care license, if: (i) a study of the individual was conducted either at the time of initial licensure or when the individual became affiliated with the license holder; (ii) the individual has been continuously affiliated with the license holder since the last study was conducted; and (iii) the procedure described in paragraph ~~(d)~~ (e) has been implemented and was in effect continuously since the last study was conducted. For the purposes of this section, a physician licensed under chapter 147 is considered to be continuously affiliated upon the license holder's receipt from the commissioner of health or human services of the physician's background

study results. For individuals who are required to have background studies under clauses (1) to (5) and who have been continuously affiliated with a foster care provider that is licensed in more than one county, criminal conviction data may be shared among those counties in which the foster care programs are licensed. A county agency's receipt of criminal conviction data from another county agency shall meet the criminal data background study requirements of this section.

The commissioner may also conduct studies on individuals specified in clauses (3) and (4) when the studies are initiated by:

(i) personnel pool agencies;

(ii) temporary personnel agencies;

(iii) educational programs that train persons by providing direct contact services in licensed programs; and

(iv) professional services agencies that are not licensed and which contract with licensed programs to provide direct contact services or individuals who provide direct contact services.

Studies on individuals in items (i) to (iv) must be initiated annually by these agencies, programs, and individuals. Except for personal care provider organizations and supplemental nursing services agencies, no applicant, license holder, or individual who is the subject of the study shall pay any fees required to conduct the study.

(1) At the option of the licensed facility, rather than initiating another background study on an individual required to be studied who has indicated to the licensed facility that a background study by the commissioner was previously completed, the facility may make a request to the commissioner for documentation of the individual's background study status, provided that:

(i) the facility makes this request using a form provided by the commissioner;

(ii) in making the request the facility informs the commissioner that either:

(A) the individual has been continuously affiliated with a licensed facility since the individual's previous background study was completed, or since October 1, 1995, whichever is shorter; or

(B) the individual is affiliated only with a personnel pool agency, a temporary personnel agency, an educational program that trains persons by providing direct contact services in licensed programs, or a professional services agency that is not licensed and which contracts with licensed programs to provide direct contact services or individuals who provide direct contact services; and

(iii) the facility provides notices to the individual as required in paragraphs (a) to ~~(d)~~ (e), and that the facility is requesting written notification of the individual's background study status from the commissioner.

(2) The commissioner shall respond to each request under paragraph (1) with a written or electronic notice to the facility and the study subject. If the commissioner determines that a background study is necessary, the study shall be completed without further request from a licensed agency or notifications to the study subject.

(3) When a background study is being initiated by a licensed facility or a foster care provider that is also registered under chapter 144D, a study subject affiliated with multiple licensed facilities may attach to the background study form a cover letter indicating the additional facilities' names, addresses, and background study identification numbers. When the commissioner receives such notices, each facility identified by the background study subject shall be notified of the study results. The background study notice sent to the subsequent agencies shall satisfy those facilities' responsibilities for initiating a background study on that individual.

~~(d)~~ (e) If an individual who is affiliated with a program or facility regulated by the department of human services or department of health or who is affiliated with a nonlicensed personal care provider organization, is convicted of a crime constituting a disqualification under subdivision 3d,

the probation officer or corrections agent shall notify the commissioner of the conviction. The commissioner, in consultation with the commissioner of corrections, shall develop forms and information necessary to implement this paragraph and shall provide the forms and information to the commissioner of corrections for distribution to local probation officers and corrections agents. The commissioner shall inform individuals subject to a background study that criminal convictions for disqualifying crimes will be reported to the commissioner by the corrections system. A probation officer, corrections agent, or corrections agency is not civilly or criminally liable for disclosing or failing to disclose the information required by this paragraph. Upon receipt of disqualifying information, the commissioner shall provide the notifications required in subdivision 3a, as appropriate to agencies on record as having initiated a background study or making a request for documentation of the background study status of the individual. This paragraph does not apply to family day care and child foster care programs.

~~(e)~~ (f) The individual who is the subject of the study must provide the applicant or license holder with sufficient information to ensure an accurate study including the individual's first, middle, and last name; home address, city, county, and state of residence for the past five years; zip code; sex; date of birth; and driver's license number. The applicant or license holder shall provide this information about an individual in paragraph ~~(c)~~ (d), clauses (1) to (5), on forms prescribed by the commissioner. By January 1, 2000, for background studies conducted by the department of human services, the commissioner shall implement a system for the electronic transmission of: (1) background study information to the commissioner; and (2) background study results to the license holder. The commissioner may request additional information of the individual, which shall be optional for the individual to provide, such as the individual's social security number or race.

~~(f)~~ (g) Except for child foster care, adult foster care, and family day care homes, a study must include information related to names of substantiated perpetrators of maltreatment of vulnerable adults that has been received by the commissioner as required under section 626.557, subdivision 9c, paragraph (i), and the commissioner's records relating to the maltreatment of minors in licensed programs, information from juvenile courts as required in paragraph ~~(c)~~ (d) for persons listed in paragraph ~~(c)~~ (d), clause (2), and information from the bureau of criminal apprehension. For child foster care, adult foster care, and family day care homes, the study must include information from the county agency's record of substantiated maltreatment of adults, and the maltreatment of minors, information from juvenile courts as required in paragraph ~~(c)~~ (d) for persons listed in paragraph ~~(c)~~ (d), clause (2), and information from the bureau of criminal apprehension. The commissioner may also review arrest and investigative information from the bureau of criminal apprehension, the commissioner of health, a county attorney, county sheriff, county agency, local chief of police, other states, the courts, or the Federal Bureau of Investigation if the commissioner has reasonable cause to believe the information is pertinent to the disqualification of an individual listed in paragraph ~~(c)~~ (d), clauses (1) to (5). The commissioner is not required to conduct more than one review of a subject's records from the Federal Bureau of Investigation if a review of the subject's criminal history with the Federal Bureau of Investigation has already been completed by the commissioner and there has been no break in the subject's affiliation with the license holder who initiated the background studies.

When the commissioner has reasonable cause to believe that further pertinent information may exist on the subject, the subject shall provide a set of classifiable fingerprints obtained from an authorized law enforcement agency. For purposes of requiring fingerprints, the commissioner shall be considered to have reasonable cause under, but not limited to, the following circumstances:

(1) information from the bureau of criminal apprehension indicates that the subject is a multistate offender;

(2) information from the bureau of criminal apprehension indicates that multistate offender status is undetermined; or

(3) the commissioner has received a report from the subject or a third party indicating that the subject has a criminal history in a jurisdiction other than Minnesota.

~~(g)~~ (h) The failure or refusal of an ~~applicant's or license holder's failure or refusal~~ applicant,

license holder, or registrant under section 144A.71, subdivision 1, to cooperate with the commissioner is reasonable cause to disqualify a subject, deny a license application or immediately suspend, suspend, or revoke a license or registration. Failure or refusal of an individual to cooperate with the study is just cause for denying or terminating employment of the individual if the individual's failure or refusal to cooperate could cause the applicant's application to be denied or the license holder's license to be immediately suspended, suspended, or revoked.

~~(h)~~ (i) The commissioner shall not consider an application to be complete until all of the information required to be provided under this subdivision has been received.

~~(i)~~ (j) No person in paragraph ~~(c)~~ (d), clause (1), (2), (3), (4), or (5), who is disqualified as a result of this section may be retained by the agency in a position involving direct contact with persons served by the program.

~~(j)~~ (k) Termination of persons in paragraph ~~(c)~~ (d), clause (1), (2), (3), (4), or (5), made in good faith reliance on a notice of disqualification provided by the commissioner shall not subject the applicant or license holder to civil liability.

~~(k)~~ (l) The commissioner may establish records to fulfill the requirements of this section.

~~(l)~~ (m) The commissioner may not disqualify an individual subject to a study under this section because that person has, or has had, a mental illness as defined in section 245.462, subdivision 20.

~~(m)~~ (n) An individual subject to disqualification under this subdivision has the applicable rights in subdivision 3a, 3b, or 3c.

~~(n)~~ (o) For the purposes of background studies completed by tribal organizations performing licensing activities otherwise required of the commissioner under this chapter, after obtaining consent from the background study subject, tribal licensing agencies shall have access to criminal history data in the same manner as county licensing agencies and private licensing agencies under this chapter.

Sec. 6. Minnesota Statutes 2000, section 245A.04, subdivision 3a, is amended to read:

Subd. 3a. [NOTIFICATION TO SUBJECT AND LICENSE HOLDER OF STUDY RESULTS; DETERMINATION OF RISK OF HARM.] (a) The commissioner shall notify the applicant ~~or~~, license holder, or registrant under section 144A.71, subdivision 1 and the individual who is the subject of the study, in writing or by electronic transmission, of the results of the study. When the study is completed, a notice that the study was undertaken and completed shall be maintained in the personnel files of the program. For studies on individuals pertaining to a license to provide family day care or group family day care, foster care for children in the provider's own home, or foster care or day care services for adults in the provider's own home, the commissioner is not required to provide a separate notice of the background study results to the individual who is the subject of the study unless the study results in a disqualification of the individual.

The commissioner shall notify the individual studied if the information in the study indicates the individual is disqualified from direct contact with persons served by the program. The commissioner shall disclose the information causing disqualification and instructions on how to request a reconsideration of the disqualification to the individual studied. An applicant or license holder who is not the subject of the study shall be informed that the commissioner has found information that disqualifies the subject from direct contact with persons served by the program. However, only the individual studied must be informed of the information contained in the subject's background study unless the ~~only~~ basis for the disqualification is failure to cooperate, substantiated maltreatment under section 626.556 or 626.557, the Data Practices Act provides for release of the information, or the individual studied authorizes the release of the information. When a disqualification is based on the subject's failure to cooperate with the background study or substantiated maltreatment under section 626.556 or 626.557, the agency that initiated the study shall be informed by the commissioner of the reason for the disqualification.

(b) Except as provided in subdivision 3d, paragraph (b), if the commissioner determines that the individual studied has a disqualifying characteristic, the commissioner shall review the

information immediately available and make a determination as to the subject's immediate risk of harm to persons served by the program where the individual studied will have direct contact. The commissioner shall consider all relevant information available, including the following factors in determining the immediate risk of harm: the recency of the disqualifying characteristic; the recency of discharge from probation for the crimes; the number of disqualifying characteristics; the intrusiveness or violence of the disqualifying characteristic; the vulnerability of the victim involved in the disqualifying characteristic; and the similarity of the victim to the persons served by the program where the individual studied will have direct contact. The commissioner may determine that the evaluation of the information immediately available gives the commissioner reason to believe one of the following:

(1) The individual poses an imminent risk of harm to persons served by the program where the individual studied will have direct contact. If the commissioner determines that an individual studied poses an imminent risk of harm to persons served by the program where the individual studied will have direct contact, the individual and the license holder must be sent a notice of disqualification. The commissioner shall order the license holder to immediately remove the individual studied from direct contact. The notice to the individual studied must include an explanation of the basis of this determination.

(2) The individual poses a risk of harm requiring continuous supervision while providing direct contact services during the period in which the subject may request a reconsideration. If the commissioner determines that an individual studied poses a risk of harm that requires continuous supervision, the individual and the license holder must be sent a notice of disqualification. The commissioner shall order the license holder to immediately remove the individual studied from direct contact services or assure that the individual studied is within sight or hearing of another staff person when providing direct contact services during the period in which the individual may request a reconsideration of the disqualification. If the individual studied does not submit a timely request for reconsideration, or the individual submits a timely request for reconsideration, but the disqualification is not set aside for that license holder, the license holder will be notified of the disqualification and ordered to immediately remove the individual from any position allowing direct contact with persons receiving services from the license holder.

(3) The individual does not pose an imminent risk of harm or a risk of harm requiring continuous supervision while providing direct contact services during the period in which the subject may request a reconsideration. If the commissioner determines that an individual studied does not pose a risk of harm that requires continuous supervision, only the individual must be sent a notice of disqualification. The license holder must be sent a notice that more time is needed to complete the individual's background study. If the individual studied submits a timely request for reconsideration, and if the disqualification is set aside for that license holder, the license holder will receive the same notification received by license holders in cases where the individual studied has no disqualifying characteristic. If the individual studied does not submit a timely request for reconsideration, or the individual submits a timely request for reconsideration, but the disqualification is not set aside for that license holder, the license holder will be notified of the disqualification and ordered to immediately remove the individual from any position allowing direct contact with persons receiving services from the license holder.

(c) County licensing agencies performing duties under this subdivision may develop an alternative system for determining the subject's immediate risk of harm to persons served by the program, providing the notices under paragraph (b), and documenting the action taken by the county licensing agency. Each county licensing agency's implementation of the alternative system is subject to approval by the commissioner. Notwithstanding this alternative system, county licensing agencies shall complete the requirements of paragraph (a).

Sec. 7. Minnesota Statutes 2000, section 245A.04, subdivision 3b, is amended to read:

Subd. 3b. [RECONSIDERATION OF DISQUALIFICATION.] (a) The individual who is the subject of the disqualification may request a reconsideration of the disqualification.

The individual must submit the request for reconsideration to the commissioner in writing. A request for reconsideration for an individual who has been sent a notice of disqualification under

subdivision 3a, paragraph (b), clause (1) or (2), must be submitted within 30 calendar days of the disqualified individual's receipt of the notice of disqualification. A request for reconsideration for an individual who has been sent a notice of disqualification under subdivision 3a, paragraph (b), clause (3), must be submitted within 15 calendar days of the disqualified individual's receipt of the notice of disqualification. An individual who was determined to have maltreated a child under section 626.556 or a vulnerable adult under section 626.557, and who was disqualified under this section on the basis of serious or recurring maltreatment, may request reconsideration of both the maltreatment and the disqualification determinations. The request for reconsideration of the maltreatment determination and the disqualification must be submitted within 30 calendar days of the individual's receipt of the notice of disqualification. Removal of a disqualified individual from direct contact shall be ordered if the individual does not request reconsideration within the prescribed time, and for an individual who submits a timely request for reconsideration, if the disqualification is not set aside. The individual must present information showing that:

(1) the information the commissioner relied upon is incorrect or inaccurate. If the basis of a reconsideration request is that a maltreatment determination or disposition under section 626.556 or 626.557 is incorrect, and the commissioner has issued a final order in an appeal of that determination or disposition under section 256.045 or 245A.08, subdivision 5, the commissioner's order is conclusive on the issue of maltreatment. If the individual did not request reconsideration of the maltreatment determination, the maltreatment determination is deemed conclusive; or

(2) the subject of the study does not pose a risk of harm to any person served by the applicant ~~or~~, license holder, or registrant under section 144A.71, subdivision 1.

(b) The commissioner shall rescind the disqualification if the commissioner finds that the information relied on to disqualify the subject is incorrect. The commissioner may set aside the disqualification under this section if the commissioner finds that the ~~information the commissioner relied upon is incorrect or the~~ individual does not pose a risk of harm to any person served by the applicant ~~or~~, license holder, or registrant under section 144A.71, subdivision 1. In determining that an individual does not pose a risk of harm, the commissioner shall consider the consequences of the event or events that lead to disqualification, whether there is more than one disqualifying event, the vulnerability of the victim at the time of the event, the time elapsed without a repeat of the same or similar event, documentation of successful completion by the individual studied of training or rehabilitation pertinent to the event, and any other information relevant to reconsideration. In reviewing a disqualification under this section, the commissioner shall give preeminent weight to the safety of each person to be served by the license holder ~~or~~, applicant, or registrant under section 144A.71, subdivision 1, over the interests of the license holder ~~or~~, applicant, or registrant under section 144A.71, subdivision 1.

(c) Unless the information the commissioner relied on in disqualifying an individual is incorrect, the commissioner may not set aside the disqualification of an individual in connection with a license to provide family day care for children, foster care for children in the provider's own home, or foster care or day care services for adults in the provider's own home if:

(1) less than ten years have passed since the discharge of the sentence imposed for the offense; and the individual has been convicted of a violation of any offense listed in sections 609.20 (manslaughter in the first degree), 609.205 (manslaughter in the second degree), criminal vehicular homicide under 609.21 (criminal vehicular homicide and injury), 609.215 (aiding suicide or aiding attempted suicide), felony violations under 609.221 to 609.2231 (assault in the first, second, third, or fourth degree), 609.713 (terroristic threats), 609.235 (use of drugs to injure or to facilitate crime), 609.24 (simple robbery), 609.245 (aggravated robbery), 609.25 (kidnapping), 609.255 (false imprisonment), 609.561 or 609.562 (arson in the first or second degree), 609.71 (riot), burglary in the first or second degree under 609.582 (burglary), 609.66 (dangerous weapon), 609.665 (spring guns), 609.67 (machine guns and short-barreled shotguns), 609.749 (harassment; stalking), 152.021 or 152.022 (controlled substance crime in the first or second degree), 152.023, subdivision 1, clause (3) or (4), or subdivision 2, clause (4) (controlled substance crime in the third degree), 152.024, subdivision 1, clause (2), (3), or (4) (controlled substance crime in the fourth degree), 609.224, subdivision 2, paragraph (c) (fifth-degree assault by a caregiver against a vulnerable adult), 609.228 (great bodily harm caused by distribution of

drugs), 609.23 (mistreatment of persons confined), 609.231 (mistreatment of residents or patients), 609.2325 (criminal abuse of a vulnerable adult), 609.233 (criminal neglect of a vulnerable adult), 609.2335 (financial exploitation of a vulnerable adult), 609.234 (failure to report), 609.265 (abduction), 609.2664 to 609.2665 (manslaughter of an unborn child in the first or second degree), 609.267 to 609.2672 (assault of an unborn child in the first, second, or third degree), 609.268 (injury or death of an unborn child in the commission of a crime), 617.293 (disseminating or displaying harmful material to minors), a gross misdemeanor offense under 609.324, subdivision 1 (other prohibited acts), a gross misdemeanor offense under 609.378 (neglect or endangerment of a child), a gross misdemeanor offense under 609.377 (malicious punishment of a child), 609.72, subdivision 3 (disorderly conduct against a vulnerable adult); or an attempt or conspiracy to commit any of these offenses, as each of these offenses is defined in Minnesota Statutes; or an offense in any other state, the elements of which are substantially similar to the elements of any of the foregoing offenses;

(2) regardless of how much time has passed since the discharge of the sentence imposed for the offense, the individual was convicted of a violation of any offense listed in sections 609.185 to 609.195 (murder in the first, second, or third degree), 609.2661 to 609.2663 (murder of an unborn child in the first, second, or third degree), a felony offense under 609.377 (malicious punishment of a child), a felony offense under 609.324, subdivision 1 (other prohibited acts), a felony offense under 609.378 (neglect or endangerment of a child), 609.322 (solicitation, inducement, and promotion of prostitution), 609.342 to 609.345 (criminal sexual conduct in the first, second, third, or fourth degree), 609.352 (solicitation of children to engage in sexual conduct), 617.246 (use of minors in a sexual performance), 617.247 (possession of pictorial representations of a minor), 609.365 (incest), a felony offense under sections 609.2242 and 609.2243 (domestic assault), a felony offense of spousal abuse, a felony offense of child abuse or neglect, a felony offense of a crime against children, or an attempt or conspiracy to commit any of these offenses as defined in Minnesota Statutes, or an offense in any other state, the elements of which are substantially similar to any of the foregoing offenses;

(3) within the seven years preceding the study, the individual committed an act that constitutes maltreatment of a child under section 626.556, subdivision 10e, and that resulted in substantial bodily harm as defined in section 609.02, subdivision 7a, or substantial mental or emotional harm as supported by competent psychological or psychiatric evidence; or

(4) within the seven years preceding the study, the individual was determined under section 626.557 to be the perpetrator of a substantiated incident of maltreatment of a vulnerable adult that resulted in substantial bodily harm as defined in section 609.02, subdivision 7a, or substantial mental or emotional harm as supported by competent psychological or psychiatric evidence.

In the case of any ground for disqualification under clauses (1) to (4), if the act was committed by an individual other than the applicant ~~or~~, license holder, or registrant under section 144A.71, subdivision 1, residing in the applicant's or license holder's home, or the home of a registrant under section 144A.71, subdivision 1, the applicant ~~or~~, license holder, or registrant under section 144A.71, subdivision 1, may seek reconsideration when the individual who committed the act no longer resides in the home.

The disqualification periods provided under clauses (1), (3), and (4) are the minimum applicable disqualification periods. The commissioner may determine that an individual should continue to be disqualified from licensure or registration under section 144A.71, subdivision 1, because the license holder ~~or~~, applicant, or registrant under section 144A.71, subdivision 1, poses a risk of harm to a person served by that individual after the minimum disqualification period has passed.

(d) The commissioner shall respond in writing or by electronic transmission to all reconsideration requests for which the basis for the request is that the information relied upon by the commissioner to disqualify is incorrect or inaccurate within 30 working days of receipt of a request and all relevant information. If the basis for the request is that the individual does not pose a risk of harm, the commissioner shall respond to the request within 15 working days after receiving the request for reconsideration and all relevant information. If the request is based on

both the correctness or accuracy of the information relied on to disqualify the individual and the risk of harm, the commissioner shall respond to the request within 45 working days after receiving the request for reconsideration and all relevant information. If the disqualification is set aside, the commissioner shall notify the applicant or license holder in writing or by electronic transmission of the decision.

(e) Except as provided in subdivision 3c, ~~the commissioner's decision to disqualify an individual, including the decision to grant or deny a rescission or set aside a disqualification under this section, is the final administrative agency action and shall not be subject to further review in a contested case under chapter 14 involving a negative licensing appeal taken in response to the disqualification or involving an accuracy and completeness appeal under section 13.04~~ if a disqualification is not set aside or is not rescinded, an individual who was disqualified on the basis of a preponderance of evidence that the individual committed an act or acts that meet the definition of any of the crimes lists in subdivision 3d, paragraph (a), clauses (1) to (4); or for failure to make required reports under section 626.556, subdivision 3, or 626.557, subdivision 3, pursuant to subdivision 3d, paragraph (a), clause (4), may request a fair hearing under section 256.045. Except as provided under subdivision 3c, the commissioner's final order for an individual under this paragraph is conclusive on the issue of maltreatment and disqualification, including for purposes of subsequent studies conducted under subdivision 3, and is the only administrative appeal of the final agency determination, specifically, including a challenge to the accuracy and completeness of data under section 13.04.

(f) Except as provided under subdivision 3c, if an individual was disqualified on the basis of a determination of maltreatment under section 626.556 or 626.557, which was serious or recurring, and the individual has requested reconsideration of the maltreatment determination under section 626.556, subdivision 10i, or 626.557, subdivision 9d, and also requested reconsideration of the disqualification under this subdivision, reconsideration of the maltreatment determination and reconsideration of the disqualification shall be consolidated into a single reconsideration. For maltreatment and disqualification determinations made by county agencies, the consolidated reconsideration shall be conducted by the county agency. Except as provided under subdivision 3c, if an individual who was disqualified on the basis of serious or recurring maltreatment requests a fair hearing on the maltreatment determination under section 626.556, subdivision 10i, or 626.557, subdivision 9d, the scope of the fair hearing under section 256.045 shall include the maltreatment determination and the disqualification. Except as provided under subdivision 3c, the commissioner's final order for an individual under this paragraph is conclusive on the issue of maltreatment and disqualification, including for purposes of subsequent studies conducted under subdivision 3, and is the only administrative appeal of the final agency determination, specifically, including a challenge to the accuracy and completeness of data under section 13.04.

Sec. 8. Minnesota Statutes 2000, section 245A.04, subdivision 3c, is amended to read:

Subd. 3c. [CONTESTED CASE.] (a) Notwithstanding subdivision 3b, paragraphs (e) and (f), if a disqualification is not set aside, a person who is an employee of an employer, as defined in section 179A.03, subdivision 15, may request a contested case hearing under chapter 14. If the disqualification which was not set aside or was not rescinded was based on a maltreatment determination, the scope of the contested case hearing includes the maltreatment determination and the disqualification. In such cases, a fair hearing shall not be conducted under section 256.045. Rules adopted under this chapter may not preclude an employee in a contested case hearing for disqualification from submitting evidence concerning information gathered under subdivision 3, paragraph (e).

(b) If a disqualification for which reconsideration was requested and which was not set aside or was not rescinded under subdivision 3b is the basis for a denial of a license under section 245A.05 or a licensing sanction under section 245A.07, the license holder has the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8550 to 1400.8612. The appeal must be submitted in accordance with section 245A.05 or 245A.07, subdivision 3. As provided for under section 245A.08, subdivision 2a, the scope of the consolidated contested case hearing shall include the disqualification and the licensing sanction or denial of a license. If the disqualification was based on a determination of substantiated serious or recurring maltreatment under section 626.556

or 626.557, the appeal must be submitted in accordance with sections 245A.07, subdivision 3, and 626.556, subdivision 10i, or 626.557, subdivision 9d. As provided for under section 245A.08, subdivision 2a, the scope of the contested case hearing shall include the maltreatment determination, the disqualification, and the licensing sanction or denial of a license. In such cases, a fair hearing shall not be conducted under section 256.045.

(c) If a maltreatment determination or disqualification, which was not set aside or was not rescinded under subdivision 3b, is the basis for a denial of a license under section 245A.05 or a licensing sanction under section 245A.07, and the disqualified subject is an individual other than the license holder and upon whom a background study must be conducted under subdivision 3, the hearing of all parties may be consolidated into a single contested case hearing upon consent of all parties and the administrative law judge.

(d) The commissioner's final order under section 245A.08, subdivision 5, is conclusive on the issue of maltreatment and disqualification, including for purposes of subsequent background studies. The contested case hearing under this subdivision is the only administrative appeal of the final agency determination, specifically, including a challenge to the accuracy and completeness of data under section 13.04.

Sec. 9. Minnesota Statutes 2000, section 245A.04, subdivision 3d, is amended to read:

Subd. 3d. [DISQUALIFICATION.] (a) Except as provided in paragraph (b), when a background study completed under subdivision 3 shows any of the following: a conviction of one or more crimes listed in clauses (1) to (4); the individual has admitted to or a preponderance of the evidence indicates the individual has committed an act or acts that meet the definition of any of the crimes listed in clauses (1) to (4); or an investigation results in an administrative determination listed under clause (4), the individual shall be disqualified from any position allowing direct contact with persons receiving services from the license holder, or registrant under section 144A.71, subdivision 1, and for individuals studied under section 245A.04, subdivision 3, paragraph (c), clauses (2), (6), and (7), the individual shall also be disqualified from access to a person receiving services from the license holder:

(1) regardless of how much time has passed since the discharge of the sentence imposed for the offense, and unless otherwise specified, regardless of the level of the conviction, the individual was convicted of any of the following offenses: sections 609.185 (murder in the first degree); 609.19 (murder in the second degree); 609.195 (murder in the third degree); 609.2661 (murder of an unborn child in the first degree); 609.2662 (murder of an unborn child in the second degree); 609.2663 (murder of an unborn child in the third degree); 609.322 (solicitation, inducement, and promotion of prostitution); 609.342 (criminal sexual conduct in the first degree); 609.343 (criminal sexual conduct in the second degree); 609.344 (criminal sexual conduct in the third degree); 609.345 (criminal sexual conduct in the fourth degree); 609.352 (solicitation of children to engage in sexual conduct); 609.365 (incest); felony offense under 609.377 (malicious punishment of a child); a felony offense under 609.378 (neglect or endangerment of a child); a felony offense under 609.324, subdivision 1 (other prohibited acts); 617.246 (use of minors in sexual performance prohibited); 617.247 (possession of pictorial representations of minors); a felony offense under sections 609.2242 and 609.2243 (domestic assault), a felony offense of spousal abuse, a felony offense of child abuse or neglect, a felony offense of a crime against children; or attempt or conspiracy to commit any of these offenses as defined in Minnesota Statutes, or an offense in any other state or country, where the elements are substantially similar to any of the offenses listed in this clause;

(2) if less than 15 years have passed since the discharge of the sentence imposed for the offense; and the individual has received a felony conviction for a violation of any of these offenses: sections 609.20 (manslaughter in the first degree); 609.205 (manslaughter in the second degree); 609.21 (criminal vehicular homicide and injury); 609.215 (suicide); 609.221 to 609.2231 (assault in the first, second, third, or fourth degree); repeat offenses under 609.224 (assault in the fifth degree); repeat offenses under 609.3451 (criminal sexual conduct in the fifth degree); 609.713 (terroristic threats); 609.235 (use of drugs to injure or facilitate crime); 609.24 (simple robbery); 609.245 (aggravated robbery); 609.25 (kidnapping); 609.255 (false imprisonment);

609.561 (arson in the first degree); 609.562 (arson in the second degree); 609.563 (arson in the third degree); repeat offenses under 617.23 (indecent exposure; penalties); repeat offenses under 617.241 (obscene materials and performances; distribution and exhibition prohibited; penalty); 609.71 (riot); 609.66 (dangerous weapons); 609.67 (machine guns and short-barreled shotguns); 609.749 (harassment; stalking; penalties); 609.228 (great bodily harm caused by distribution of drugs); 609.2325 (criminal abuse of a vulnerable adult); 609.2664 (manslaughter of an unborn child in the first degree); 609.2665 (manslaughter of an unborn child in the second degree); 609.267 (assault of an unborn child in the first degree); 609.2671 (assault of an unborn child in the second degree); 609.268 (injury or death of an unborn child in the commission of a crime); 609.52 (theft); 609.2335 (financial exploitation of a vulnerable adult); 609.521 (possession of shoplifting gear); 609.582 (burglary); 609.625 (aggravated forgery); 609.63 (forgery); 609.631 (check forgery; offering a forged check); 609.635 (obtaining signature by false pretense); 609.27 (coercion); 609.275 (attempt to coerce); 609.687 (adulteration); 260C.301 (grounds for termination of parental rights); and chapter 152 (drugs; controlled substance). An attempt or conspiracy to commit any of these offenses, as each of these offenses is defined in Minnesota Statutes; or an offense in any other state or country, the elements of which are substantially similar to the elements of the offenses in this clause. If the individual studied is convicted of one of the felonies listed in this clause, but the sentence is a gross misdemeanor or misdemeanor disposition, the lookback period for the conviction is the period applicable to the disposition, that is the period for gross misdemeanors or misdemeanors;

(3) if less than ten years have passed since the discharge of the sentence imposed for the offense; and the individual has received a gross misdemeanor conviction for a violation of any of the following offenses: sections 609.224 (assault in the fifth degree); 609.2242 and 609.2243 (domestic assault); violation of an order for protection under 518B.01, subdivision 14; 609.3451 (criminal sexual conduct in the fifth degree); repeat offenses under 609.746 (interference with privacy); repeat offenses under 617.23 (indecent exposure); 617.241 (obscene materials and performances); 617.243 (indecent literature, distribution); 617.293 (harmful materials; dissemination and display to minors prohibited); 609.71 (riot); 609.66 (dangerous weapons); 609.749 (harassment; stalking; penalties); 609.224, subdivision 2, paragraph (c) (assault in the fifth degree by a caregiver against a vulnerable adult); 609.23 (mistreatment of persons confined); 609.231 (mistreatment of residents or patients); 609.2325 (criminal abuse of a vulnerable adult); 609.233 (criminal neglect of a vulnerable adult); 609.2335 (financial exploitation of a vulnerable adult); 609.234 (failure to report maltreatment of a vulnerable adult); 609.72, subdivision 3 (disorderly conduct against a vulnerable adult); 609.265 (abduction); 609.378 (neglect or endangerment of a child); 609.377 (malicious punishment of a child); 609.324, subdivision 1a (other prohibited acts; minor engaged in prostitution); 609.33 (disorderly house); 609.52 (theft); 609.582 (burglary); 609.631 (check forgery; offering a forged check); 609.275 (attempt to coerce); or an attempt or conspiracy to commit any of these offenses, as each of these offenses is defined in Minnesota Statutes; or an offense in any other state or country, the elements of which are substantially similar to the elements of any of the offenses listed in this clause. If the defendant is convicted of one of the gross misdemeanors listed in this clause, but the sentence is a misdemeanor disposition, the lookback period for the conviction is the period applicable to misdemeanors; or

(4) if less than seven years have passed since the discharge of the sentence imposed for the offense; and the individual has received a misdemeanor conviction for a violation of any of the following offenses: sections 609.224 (assault in the fifth degree); 609.2242 (domestic assault); violation of an order for protection under 518B.01 (Domestic Abuse Act); violation of an order for protection under 609.3232 (protective order authorized; procedures; penalties); 609.746 (interference with privacy); 609.79 (obscene or harassing phone calls); 609.795 (letter, telegram, or package; opening; harassment); 617.23 (indecent exposure; penalties); 609.2672 (assault of an unborn child in the third degree); 617.293 (harmful materials; dissemination and display to minors prohibited); 609.66 (dangerous weapons); 609.665 (spring guns); 609.2335 (financial exploitation of a vulnerable adult); 609.234 (failure to report maltreatment of a vulnerable adult); 609.52 (theft); 609.27 (coercion); or an attempt or conspiracy to commit any of these offenses, as each of these offenses is defined in Minnesota Statutes; or an offense in any other state or country, the elements of which are substantially similar to the elements of any of the offenses listed in this clause; failure to make required reports under section 626.556, subdivision 3, or 626.557,

subdivision 3, for incidents in which: (i) the final disposition under section 626.556 or 626.557 was substantiated maltreatment, and (ii) the maltreatment was recurring or serious; or substantiated serious or recurring maltreatment of a minor under section 626.556 or of a vulnerable adult under section 626.557 for which there is a preponderance of evidence that the maltreatment occurred, and that the subject was responsible for the maltreatment.

For the purposes of this section, "serious maltreatment" means sexual abuse; maltreatment resulting in death; or maltreatment resulting in serious injury which reasonably requires the care of a physician whether or not the care of a physician was sought; or abuse resulting in serious injury. For purposes of this section, "abuse resulting in serious injury" means: bruises, bites, skin laceration or tissue damage; fractures; dislocations; evidence of internal injuries; head injuries with loss of consciousness; extensive second-degree or third-degree burns and other burns for which complications are present; extensive second-degree or third-degree frostbite, and others for which complications are present; irreversible mobility or avulsion of teeth; injuries to the eyeball; ingestion of foreign substances and objects that are harmful; near drowning; and heat exhaustion or sunstroke. For purposes of this section, "care of a physician" is treatment received or ordered by a physician, but does not include diagnostic testing, assessment, or observation. For the purposes of this section, "recurring maltreatment" means more than one incident of maltreatment for which there is a preponderance of evidence that the maltreatment occurred, and that the subject was responsible for the maltreatment. For purposes of this section, "access" means physical access to an individual receiving services or the individual's personal property without continuous, direct supervision as defined in section 245A.04, subdivision 3.

(b) ~~If~~ Except for background studies related to child foster care, adult foster care, or family child care licensure, when the subject of a background study is ~~licensed~~ regulated by a health-related licensing board as defined in chapter 214, and the regulated person has been determined to have been responsible for substantiated maltreatment under section 626.556 or 626.557, instead of the commissioner making a decision regarding disqualification, the board shall make ~~the~~ a determination ~~regarding a disqualification under this subdivision based on a finding of substantiated maltreatment under section 626.556 or 626.557. The commissioner shall notify the health-related licensing board if a background study shows that a licensee would be disqualified because of substantiated maltreatment and the board shall make a determination under section 214.104.~~ whether to impose disciplinary or corrective action under chapter 214.

(1) The commissioner shall notify the health-related licensing board:

(i) upon completion of a background study that produces a record showing that the individual was determined to have been responsible for substantiated maltreatment;

(ii) upon the commissioner's completion of an investigation that determined the individual was responsible for substantiated maltreatment; or

(iii) upon receipt from another agency of a finding of substantiated maltreatment for which the individual was responsible.

(2) The commissioner's notice shall indicate whether the individual would have been disqualified by the commissioner for the substantiated maltreatment if the individual were not regulated by the board. The commissioner shall concurrently send this notice to the individual.

(3) Notwithstanding the exclusion from this subdivision for individuals who provide child foster care, adult foster care, or family child care, when the commissioner or a local agency has reason to believe that the direct contact services provided by the individual may fall within the jurisdiction of a health-related licensing board, a referral shall be made to the board as provided in this section.

(4) If, upon review of the information provided by the commissioner, a health-related licensing board informs the commissioner that the board does not have jurisdiction to take disciplinary or corrective action, the commissioner shall make the appropriate disqualification decision regarding the individual as otherwise provided in this chapter.

(5) The commissioner has the authority to monitor the facility's compliance with any requirements that the health-related licensing board places on regulated persons practicing in a facility either during the period pending a final decision on a disciplinary or corrective action or as a result of a disciplinary or corrective action. The commissioner has the authority to order the immediate removal of a regulated person from direct contact or access when a board issues an order of temporary suspension based on a determination that the regulated person poses an immediate risk of harm to persons receiving services in a licensed facility.

(6) A facility that allows a regulated person to provide direct contact services while not complying with the requirements imposed by the health-related licensing board is subject to action by the commissioner as specified under sections 245A.06 and 245A.07.

(7) The commissioner shall notify a health-related licensing board immediately upon receipt of knowledge of noncompliance with requirements placed on a facility or upon a person regulated by the board.

Sec. 10. Minnesota Statutes 2000, section 245A.05, is amended to read:

245A.05 [DENIAL OF APPLICATION.]

The commissioner may deny a license if an applicant fails to comply with applicable laws or rules, or knowingly withholds relevant information from or gives false or misleading information to the commissioner in connection with an application for a license or during an investigation. An applicant whose application has been denied by the commissioner must be given notice of the denial. Notice must be given by certified mail. The notice must state the reasons the application was denied and must inform the applicant of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8550 to 1400.8612. The applicant may appeal the denial by notifying the commissioner in writing by certified mail within 20 calendar days after receiving notice that the application was denied. Section 245A.08 applies to hearings held to appeal the commissioner's denial of an application.

Sec. 11. Minnesota Statutes 2000, section 245A.06, is amended to read:

245A.06 [CORRECTION ORDER AND ~~FINES~~ CONDITIONAL LICENSE.]

Subdivision 1. [CONTENTS OF CORRECTION ORDERS ~~OR FINES~~ AND CONDITIONAL LICENSES.] (a) If the commissioner finds that the applicant or license holder has failed to comply with an applicable law or rule and this failure does not imminently endanger the health, safety, or rights of the persons served by the program, the commissioner may issue a correction order and an order of conditional license to ~~or impose a fine on~~ the applicant or license holder. When issuing a conditional license, the commissioner shall consider the nature, chronicity, or severity of the violation of law or rule and the effect of the violation on the health, safety, or rights of persons served by the program. The correction order or ~~fine~~ conditional license must state:

(1) the conditions that constitute a violation of the law or rule;

(2) the specific law or rule violated;

(3) the time allowed to correct each violation; and

(4) if a ~~fine is imposed, the amount of the fine~~ license is made conditional, the length and terms of the conditional license.

(b) Nothing in this section prohibits the commissioner from proposing a sanction as specified in section 245A.07, prior to issuing a correction order or ~~fine~~ conditional license.

Subd. 2. [RECONSIDERATION OF CORRECTION ORDERS.] If the applicant or license holder believes that the contents of the commissioner's correction order are in error, the applicant or license holder may ask the department of human services to reconsider the parts of the correction order that are alleged to be in error. The request for reconsideration must be in writing and received by the commissioner within 20 calendar days after receipt of the correction order by the applicant or license holder, and:

(1) specify the parts of the correction order that are alleged to be in error;

(2) explain why they are in error; and

(3) include documentation to support the allegation of error.

A request for reconsideration does not stay any provisions or requirements of the correction order. The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14.

Subd. 3. [FAILURE TO COMPLY.] If the commissioner finds that the applicant or license holder has not corrected the violations specified in the correction order or conditional license, the commissioner may impose a fine and order other licensing sanctions pursuant to section 245A.07. ~~If a fine was imposed and the violation was not corrected, the commissioner may impose an additional fine. This section does not prohibit the commissioner from seeking a court order, denying an application, or suspending, revoking, or making conditional the license in addition to imposing a fine.~~

Subd. 4. [NOTICE OF ~~FINE~~ CONDITIONAL LICENSE; RECONSIDERATION OF ~~FINE~~ CONDITIONAL LICENSE.] ~~A license holder who is ordered to pay a fine~~ If a license is made conditional, the license holder must be notified of the order by certified mail. The notice must be mailed to the address shown on the application or the last known address of the license holder. The notice must state the reasons the ~~fine~~ conditional license was ordered and must inform the license holder of the ~~responsibility for payment of fines in subdivision 7 and the~~ right to request reconsideration of the ~~fine~~ conditional license by the commissioner. The license holder may request reconsideration of the order ~~to forfeit a fine~~ of conditional license by notifying the commissioner by certified mail ~~within 20 calendar days after receiving the order~~. The request must be in writing and must be received by the commissioner within ten calendar days after the license holder received the order. The license holder may submit with the request for reconsideration written argument or evidence in support of the request for reconsideration. A timely request for reconsideration shall stay ~~forfeiture of the fine~~ imposition of the terms of the conditional license until the commissioner issues a decision on the request for reconsideration. ~~The request for reconsideration must be in writing and:~~

~~(1) specify the parts of the violation that are alleged to be in error;~~

~~(2) explain why they are in error;~~

~~(3) include documentation to support the allegation of error; and~~

~~(4) any other information relevant to the fine or the amount of the fine.~~

The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14.

~~Subd. 5. [FORFEITURE OF FINES.] The license holder shall pay the fines assessed on or before the payment date specified in the commissioner's order. If the license holder fails to fully comply with the order, the commissioner shall issue a second fine or suspend the license until the license holder complies. If the license holder receives state funds, the state, county, or municipal agencies or departments responsible for administering the funds shall withhold payments and recover any payments made while the license is suspended for failure to pay a fine.~~

~~Subd. 5a. [ACCRUAL OF FINES.] A license holder shall promptly notify the commissioner of human services, in writing, when a violation specified in an order to forfeit is corrected. If upon reinspection the commissioner determines that a violation has not been corrected as indicated by the order to forfeit, the commissioner may issue a second fine. The commissioner shall notify the license holder by certified mail that a second fine has been assessed. The license holder may request reconsideration of the second fine under the provisions of subdivision 4.~~

~~Subd. 6. [AMOUNT OF FINES.] Fines shall be assessed as follows:~~

~~(1) the license holder shall forfeit $1,000 for each occurrence of violation of law or rule prohibiting the maltreatment of children or the maltreatment of vulnerable adults, including but not limited to corporal punishment, illegal or unauthorized use of physical, mechanical, or chemical restraints, and illegal or unauthorized use of aversive or deprivation procedures;~~

~~(2) the license holder shall forfeit $200 for each occurrence of a violation of law or rule governing matters of health, safety, or supervision, including but not limited to the provision of adequate staff to child or adult ratios; and~~

~~(3) the license holder shall forfeit $100 for each occurrence of a violation of law or rule other than those included in clauses (1) and (2).~~

~~For the purposes of this section, "occurrence" means each violation identified in the commissioner's forfeiture order.~~

~~Subd. 7. [RESPONSIBILITY FOR PAYMENT OF FINES.] When a fine has been assessed, the license holder may not avoid payment by closing, selling, or otherwise transferring the licensed program to a third party. In such an event, the license holder will be personally liable for payment. In the case of a corporation, each controlling individual is personally and jointly liable for payment.~~

~~Fines for child care centers must be assessed according to this section.~~

Sec. 12. Minnesota Statutes 2000, section 245A.07, is amended to read:

245A.07 [SANCTIONS.]

Subdivision 1. [SANCTIONS AVAILABLE.] In addition to ~~ordering forfeiture of fines~~ making a license conditional under section 245A.06, the commissioner may propose to suspend~~,~~ or revoke~~, or make conditional~~ the license, impose a fine, or secure an injunction against the continuing operation of the program of a license holder who does not comply with applicable law or rule. When applying sanctions authorized under this section, the commissioner shall consider the nature, chronicity, or severity of the violation of law or rule and the effect of the violation on the health, safety, or rights of persons served by the program.

Subd. 2. [~~IMMEDIATE SUSPENSION IN CASES OF IMMINENT DANGER TO HEALTH, SAFETY, OR RIGHTS~~ TEMPORARY IMMEDIATE SUSPENSION.] If the license holder's actions or failure to comply with applicable law or rule ~~has placed~~ poses an imminent risk of harm to the health, safety, or rights of persons served by the program ~~in imminent danger~~, the commissioner shall act immediately to temporarily suspend the license. No state funds shall be made available or be expended by any agency or department of state, county, or municipal government for use by a license holder regulated under this chapter while a license is under immediate suspension. A notice stating the reasons for the immediate suspension and informing the license holder of the right to ~~a contested case~~ an expedited hearing under chapter 14 and Minnesota Rules, parts 1400.8550 to 1400.8612, must be delivered by personal service to the address shown on the application or the last known address of the license holder. The license holder may appeal an order immediately suspending a license. The appeal of an order immediately suspending a license must be made in writing by certified mail and must be received by the commissioner within five calendar days after the license holder receives notice that the license has been immediately suspended. A license holder and any controlling individual shall discontinue operation of the program upon receipt of the commissioner's order to immediately suspend the license.

Subd. 2a. [IMMEDIATE SUSPENSION EXPEDITED HEARING.] (a) Within five working days of receipt of the license holder's timely appeal, the commissioner shall request assignment of an administrative law judge. The request must include a proposed date, time, and place of a hearing. A hearing must be conducted by an administrative law judge within 30 calendar days of the request for assignment, unless an extension is requested by either party and granted by the administrative law judge for good cause. The commissioner shall issue a notice of hearing by certified mail at least ten working days before the hearing. The scope of the hearing shall be

limited solely to the issue of whether the temporary immediate suspension should remain in effect pending the commissioner's final order under section 245A.08, regarding a licensing sanction issued under subdivision 3 following the immediate suspension. The burden of proof in expedited hearings under this subdivision shall be limited to the commissioner's demonstration that reasonable cause exists to believe that the license holder's actions or failure to comply with applicable law or rule poses an imminent risk of harm to the health, safety, or rights of persons served by the program.

(b) The administrative law judge shall issue findings of fact, conclusions, and a recommendation within ten working days from the date of hearing. The commissioner's final order shall be issued within ten working days from receipt of the recommendation of the administrative law judge. Within 90 calendar days after a final order affirming an immediate suspension, the commissioner shall make a determination regarding whether a final licensing sanction shall be issued under subdivision 3. The license holder shall continue to be prohibited from operation of the program during this 90-day period.

Subd. 3. [LICENSE SUSPENSION, REVOCATION, ~~DENIAL~~ OR ~~CONDITIONAL LICENSE~~ FINE.] The commissioner may suspend~~,~~ or revoke~~, make conditional, or deny~~ a license, or impose a fine if ~~an applicant or~~ a license holder fails to comply fully with applicable laws or rules, or knowingly withholds relevant information from or gives false or misleading information to the commissioner in connection with an application for a license or during an investigation. A license holder who has had a license suspended, revoked, ~~or made conditional~~ or has been ordered to pay a fine must be given notice of the action by certified mail. The notice must be mailed to the address shown on the application or the last known address of the license holder. The notice must state the reasons the license was suspended, revoked, or ~~made conditional~~ a fine was ordered.

(a) If the license was suspended or revoked, the notice must inform the license holder of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8550 to 1400.8612. The license holder may appeal an order suspending or revoking a license. The appeal of an order suspending or revoking a license must be made in writing by certified mail and must be received by the commissioner within ten calendar days after the license holder receives notice that the license has been suspended or revoked.

(b) ~~If the license was made conditional, the notice must inform the license holder of the right to request a reconsideration by the commissioner. The request for reconsideration must be made in writing by certified mail and must be received by the commissioner within ten calendar days after the license holder receives notice that the license has been made conditional. The license holder may submit with the request for reconsideration written argument or evidence in support of the request for reconsideration. The commissioner's disposition of a request for reconsideration is final and is not subject to appeal under chapter 14~~ (1) If the license holder was ordered to pay a fine, the notice must inform the license holder of the responsibility for payment of fines and the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8550 to 1400.8612. The appeal of an order to pay a fine must be made in writing by certified mail and must be received by the commissioner within ten calendar days after the license holder receives notice that the fine has been ordered.

(2) The license holder shall pay the fines assessed on or before the payment date specified. If the license holder fails to fully comply with the order, the commissioner may issue a second fine or suspend the license until the license holder complies. If the license holder receives state funds, the state, county, or municipal agencies or departments responsible for administering the funds shall withhold payments and recover any payments made while the license is suspended for failure to pay a fine. A timely appeal shall stay payment of the fine until the commissioner issues a final order.

(3) A license holder shall promptly notify the commissioner of human services, in writing, when a violation specified in the order to forfeit a fine is corrected. If upon reinspection the commissioner determines that a violation has not been corrected as indicated by the order to forfeit a fine, the commissioner may issue a second fine. The commissioner shall notify the license holder by certified mail that a second fine has been assessed. The license holder may appeal the second fine as provided under this subdivision.

(4) Fines shall be assessed as follows: the license holder shall forfeit $1,000 for each determination of maltreatment of a child under section 626.556 or the maltreatment of a vulnerable adult under section 626.557; the license holder shall forfeit $200 for each occurrence of a violation of law or rule governing matters of health, safety, or supervision, including, but not limited to, the provision of adequate staff-to-child or adult ratios and the failure to submit a background study; and the license holder shall forfeit $100 for each occurrence of a violation of law or rule other than those subject to a $1,000 or $200 fine above. For purposes of this section, "occurrence" means each violation identified in the commissioner's fine order.

(5) When a fine has been assessed, the license holder may not avoid payment by closing, selling, or otherwise transferring the licensed program to a third party. In such an event, the license holder will be personally liable for payment. In the case of a corporation, each controlling individual is personally and jointly liable for payment.

Subd. 4. [ADOPTION AGENCY VIOLATIONS.] If a license holder licensed to place children for adoption fails to provide services as described in the disclosure form required by section 259.37, subdivision 2, the sanctions under this section may be imposed.

Sec. 13. Minnesota Statutes 2000, section 245A.08, is amended to read:

245A.08 [HEARINGS.]

Subdivision 1. [RECEIPT OF APPEAL; CONDUCT OF HEARING.] Upon receiving a timely appeal or petition pursuant to section 245A.04, subdivision 3c, 245A.05, or 245A.07, subdivision 3, the commissioner shall issue a notice of and order for hearing to the appellant under chapter 14 and Minnesota Rules, parts 1400.8550 to 1400.8612.

Subd. 2. [CONDUCT OF HEARINGS.] At any hearing provided for by section 245A.04, subdivision 3c, 245A.05, or 245A.07, subdivision 3, the appellant may be represented by counsel and has the right to call, examine, and cross-examine witnesses. The administrative law judge may require the presence of witnesses and evidence by subpoena on behalf of any party.

Subd. 2a. [CONSOLIDATED CONTESTED CASE HEARINGS FOR SANCTIONS BASED ON MALTREATMENT DETERMINATIONS AND DISQUALIFICATIONS.] (a) When a denial of a license under section 245A.05 or a licensing sanction under section 245A.07, subdivision 3, is based on a disqualification for which reconsideration was requested and which was not set aside or was not rescinded under section 245A.04, subdivision 3b, the scope of the contested case hearing shall include the disqualification and the licensing sanction or denial of a license. When the licensing sanction or denial of a license is based on a determination of maltreatment under section 626.556 or 626.557, or a disqualification for serious or recurring maltreatment which was not set aside or was not rescinded, the scope of the contested case hearing shall include the maltreatment determination, disqualification, and the licensing sanction or denial of a license. In such cases, a fair hearing under section 256.045 shall not be conducted as provided for in sections 626.556, subdivision 10i, and 626.557, subdivision 9d.

(b) In consolidated contested case hearings regarding sanctions issued in family child care, child foster care, and adult foster care, the county attorney shall defend the commissioner's orders in accordance with section 245A.16, subdivision 4.

(c) The commissioner's final order under subdivision 5 is the final agency action on the issue of maltreatment and disqualification, including for purposes of subsequent background studies under section 245A.04, subdivision 3, and is the only administrative appeal of the final agency determination, specifically, including a challenge to the accuracy and completeness of data under section 13.04.

(d) When consolidated hearings under this subdivision involve a licensing sanction based on a previous maltreatment determination for which the commissioner has issued a final order in an appeal of that determination under section 256.045, or the individual failed to exercise the right to appeal the previous maltreatment determination under section 626.556, subdivision 10i, or 626.557, subdivision 9d, the commissioner's order is conclusive on the issue of maltreatment. In

such cases, the scope of the administrative law judge's review shall be limited to the disqualification and the licensing sanction or denial of a license. In the case of a denial of a license or a licensing sanction issued to a facility based on a maltreatment determination regarding an individual who is not the license holder or a household member, the scope of the administrative law judge's review includes the maltreatment determination.

(e) If a maltreatment determination or disqualification, which was not set aside or was not rescinded under section 245A.04, subdivision 3b, is the basis for a denial of a license under section 245A.05 or a licensing sanction under section 245A.07, and the disqualified subject is an individual other than the license holder and upon whom a background study must be conducted under section 245A.04, subdivision 3, the hearings of all parties may be consolidated into a single contested case hearing upon consent of all parties and the administrative law judge.

Subd. 3. [BURDEN OF PROOF.] (a) At a hearing regarding ~~suspension, immediate suspension, or revocation of a license for family day care or foster care~~ a licensing sanction under section 245.07, including consolidated hearings under subdivision 2a, the commissioner may demonstrate reasonable cause for action taken by submitting statements, reports, or affidavits to substantiate the allegations that the license holder failed to comply fully with applicable law or rule. If the commissioner demonstrates that reasonable cause existed, the burden of proof ~~in hearings involving suspension, immediate suspension, or revocation of a family day care or foster care license~~ shifts to the license holder to demonstrate by a preponderance of the evidence that the license holder was in full compliance with those laws or rules that the commissioner alleges the license holder violated, at the time that the commissioner alleges the violations of law or rules occurred.

(b) At a hearing on denial of an application, the applicant bears the burden of proof to demonstrate by a preponderance of the evidence that the appellant has complied fully with ~~sections 245A.01 to 245A.15~~ this chapter and other applicable law or rule and that the application should be approved and a license granted.

~~(c) At all other hearings under this section, the commissioner bears the burden of proof to demonstrate, by a preponderance of the evidence, that the violations of law or rule alleged by the commissioner occurred.~~

Subd. 4. [RECOMMENDATION OF ADMINISTRATIVE LAW JUDGE.] The administrative law judge shall recommend whether or not the commissioner's order should be affirmed. The recommendations must be consistent with this chapter and the rules of the commissioner. The recommendations must be in writing and accompanied by findings of fact and conclusions and must be mailed to the parties by certified mail to their last known addresses as shown on the license or application.

Subd. 5. [NOTICE OF THE COMMISSIONER'S FINAL ORDER.] After considering the findings of fact, conclusions, and recommendations of the administrative law judge, the commissioner shall issue a final order. The commissioner shall consider, but shall not be bound by, the recommendations of the administrative law judge. The appellant must be notified of the commissioner's final order as required by chapter 14 and Minnesota Rules, parts 1400.8550 to 1400.8612. The notice must also contain information about the appellant's rights under chapter 14 and Minnesota Rules, parts 1400.8550 to 1400.8612. The institution of proceedings for judicial review of the commissioner's final order shall not stay the enforcement of the final order except as provided in section 14.65. A license holder and each controlling individual of a license holder whose license has been revoked because of noncompliance with applicable law or rule must not be granted a license for five years following the revocation. An applicant whose application was denied must not be granted a license for two years following a denial, unless the applicant's subsequent application contains new information which constitutes a substantial change in the conditions that caused the previous denial.

Sec. 14. Minnesota Statutes 2000, section 245A.16, subdivision 1, is amended to read:

Subdivision 1. [DELEGATION OF AUTHORITY TO AGENCIES.] (a) County agencies and private agencies that have been designated or licensed by the commissioner to perform licensing

functions and activities under section 245A.04, to recommend denial of applicants under section 245A.05, to issue correction orders, to issue variances, and recommend ~~fines~~ a conditional license under section 245A.06, or to recommend suspending~~,~~ or revoking~~, and making licenses probationary~~ a license or issuing a fine under section 245A.07, shall comply with rules and directives of the commissioner governing those functions and with this section.

(b) For family day care programs, the commissioner may authorize licensing reviews every two years after a licensee has had at least one annual review.

Sec. 15. Minnesota Statutes 2000, section 245B.08, subdivision 3, is amended to read:

Subd. 3. [SANCTIONS AVAILABLE.] Nothing in this subdivision shall be construed to limit the commissioner's authority to suspend~~,~~ or revoke~~, or make conditional~~ a license or issue a fine at any time ~~a license~~ under section 245A.07; make correction orders and ~~require fines~~ make a license conditional for failure to comply with applicable laws or rules under section 245A.06; or deny an application for license under section 245A.05.

Sec. 16. Minnesota Statutes 2000, section 256.045, subdivision 3, is amended to read:

Subd. 3. [STATE AGENCY HEARINGS.] (a) State agency hearings are available for the following: (1) any person applying for, receiving or having received public assistance, medical care, or a program of social services granted by the state agency or a county agency or the federal Food Stamp Act whose application for assistance is denied, not acted upon with reasonable promptness, or whose assistance is suspended, reduced, terminated, or claimed to have been incorrectly paid; (2) any patient or relative aggrieved by an order of the commissioner under section 252.27; (3) a party aggrieved by a ruling of a prepaid health plan; (4) except as provided under chapter 245A, any individual or facility determined by a lead agency to have maltreated a vulnerable adult under section 626.557 after they have exercised their right to administrative reconsideration under section 626.557; (5) any person whose claim for foster care payment according to a placement of the child resulting from a child protection assessment under section 626.556 is denied or not acted upon with reasonable promptness, regardless of funding source; (6) any person to whom a right of appeal according to this section is given by other provision of law; (7) an applicant aggrieved by an adverse decision to an application for a hardship waiver under section 256B.15; ~~or~~ (8) except as provided under chapter 245A, an individual or facility determined to have maltreated a minor under section 626.556, after the individual or facility has exercised the right to administrative reconsideration under section 626.556; or (9) except as provided under chapter 245A, an individual disqualified under section 245A.04, subdivision 3d, on the basis of serious or recurring maltreatment; a preponderance of the evidence that the individual has committed an act or acts that meet the definition of any of the crimes listed in section 245A.04, subdivision 3d, paragraph (a), clauses (1) to (4); or for failing to make reports required under section 626.556, subdivision 3, or 626.557, subdivision 3. Hearings regarding a maltreatment determination under clause (4) or (8) and a disqualification under this clause in which the basis for a disqualification is serious or recurring maltreatment, which has not been set aside or rescinded under section 245A.04, subdivision 3b, shall be consolidated into a single fair hearing. In such cases, the scope of review by the human services referee shall include both the maltreatment determination and the disqualification. The failure to exercise the right to an administrative reconsideration shall not be a bar to a hearing under this section if federal law provides an individual the right to a hearing to dispute a finding of maltreatment. Individuals and organizations specified in this section may contest the specified action, decision, or final disposition before the state agency by submitting a written request for a hearing to the state agency within 30 days after receiving written notice of the action, decision, or final disposition, or within 90 days of such written notice if the applicant, recipient, patient, or relative shows good cause why the request was not submitted within the 30-day time limit.

The hearing for an individual or facility under clause (4) ~~or~~, (8), or (9) is the only administrative appeal to the final agency determination specifically, including a challenge to the accuracy and completeness of data under section 13.04. Hearings requested under clause (4) apply only to incidents of maltreatment that occur on or after October 1, 1995. Hearings requested by nursing assistants in nursing homes alleged to have maltreated a resident prior to October 1, 1995,

shall be held as a contested case proceeding under the provisions of chapter 14. Hearings requested under clause (8) apply only to incidents of maltreatment that occur on or after July 1, 1997. A hearing for an individual or facility under clause (8) is only available when there is no juvenile court or adult criminal action pending. If such action is filed in either court while an administrative review is pending, the administrative review must be suspended until the judicial actions are completed. If the juvenile court action or criminal charge is dismissed or the criminal action overturned, the matter may be considered in an administrative hearing.

For purposes of this section, bargaining unit grievance procedures are not an administrative appeal.

The scope of hearings involving claims to foster care payments under clause (5) shall be limited to the issue of whether the county is legally responsible for a child's placement under court order or voluntary placement agreement and, if so, the correct amount of foster care payment to be made on the child's behalf and shall not include review of the propriety of the county's child protection determination or child placement decision.

(b) A vendor of medical care as defined in section 256B.02, subdivision 7, or a vendor under contract with a county agency to provide social services under section 256E.08, subdivision 4, is not a party and may not request a hearing under this section, except if assisting a recipient as provided in subdivision 4.

(c) An applicant or recipient is not entitled to receive social services beyond the services included in the amended community social services plan developed under section 256E.081, subdivision 3, if the county agency has met the requirements in section 256E.081.

(d) The commissioner may summarily affirm the county or state agency's proposed action without a hearing when the sole issue is an automatic change due to a change in state or federal law.

Sec. 17. Minnesota Statutes 2000, section 256.045, subdivision 3b, is amended to read:

Subd. 3b. [STANDARD OF EVIDENCE FOR MALTREATMENT AND DISQUALIFICATION HEARINGS.] The state human services referee shall determine that maltreatment has occurred if a preponderance of evidence exists to support the final disposition under sections 626.556 and 626.557. For purposes of hearings regarding disqualification, the state human services referee shall affirm the proposed disqualification in an appeal under subdivision 3, paragraph (a), clause (9), if a preponderance of the evidence shows the individual has:

(1) committed maltreatment under section 626.556 or 626.557, which is serious or recurring;

(2) committed an act or acts meeting the definition of any of the crimes listed in section 245A.04, subdivision 3d, paragraph (a), clauses (1) to (4); or

(3) failed to make required reports under section 626.556 or 626.557, for incidents in which:

(i) the final disposition under section 626.556 or 626.557 was substantiated maltreatment; and

(ii) the maltreatment was recurring or serious; or substantiated serious or recurring maltreatment of a minor under section 626.556 or of a vulnerable adult under section 626.557 for which there is a preponderance of evidence that the maltreatment occurred, and that the subject was responsible for the maltreatment. If the disqualification is affirmed, the state human services referee shall determine whether the individual poses a risk of harm in accordance with the requirements of section 245A.04, subdivision 3b.

The state human services referee shall recommend an order to the commissioner of health or human services, as applicable, who shall issue a final order. The commissioner shall affirm, reverse, or modify the final disposition. Any order of the commissioner issued in accordance with this subdivision is conclusive upon the parties unless appeal is taken in the manner provided in subdivision 7. Except as provided under section 245A.04, subdivisions 3b, paragraphs (e) and (f), and 3c, in any licensing appeal under chapter 245A and sections 144.50 to 144.58 and 144A.02 to 144A.46, the commissioner's determination as to maltreatment is conclusive.

Sec. 18. Minnesota Statutes 2000, section 256.045, subdivision 4, is amended to read:

Subd. 4. [CONDUCT OF HEARINGS.] (a) All hearings held pursuant to subdivision 3, 3a, 3b, or 4a shall be conducted according to the provisions of the federal Social Security Act and the regulations implemented in accordance with that act to enable this state to qualify for federal grants-in-aid, and according to the rules and written policies of the commissioner of human services. County agencies shall install equipment necessary to conduct telephone hearings. A state human services referee may schedule a telephone conference hearing when the distance or time required to travel to the county agency offices will cause a delay in the issuance of an order, or to promote efficiency, or at the mutual request of the parties. Hearings may be conducted by telephone conferences unless the applicant, recipient, former recipient, person, or facility contesting maltreatment objects. The hearing shall not be held earlier than five days after filing of the required notice with the county or state agency. The state human services referee shall notify all interested persons of the time, date, and location of the hearing at least five days before the date of the hearing. Interested persons may be represented by legal counsel or other representative of their choice, including a provider of therapy services, at the hearing and may appear personally, testify and offer evidence, and examine and cross-examine witnesses. The applicant, recipient, former recipient, person, or facility contesting maltreatment shall have the opportunity to examine the contents of the case file and all documents and records to be used by the county or state agency at the hearing at a reasonable time before the date of the hearing and during the hearing. In hearings under subdivision 3, paragraph (a), clauses (4) ~~and~~, (8), and (9), either party may subpoena the private data relating to the investigation prepared by the agency under section 626.556 or 626.557 that is not otherwise accessible under section 13.04, provided the identity of the reporter may not be disclosed.

(b) The private data obtained by subpoena in a hearing under subdivision 3, paragraph (a), clause (4) ~~or~~, (8), or (9), must be subject to a protective order which prohibits its disclosure for any other purpose outside the hearing provided for in this section without prior order of the district court. Disclosure without court order is punishable by a sentence of not more than 90 days imprisonment or a fine of not more than $700, or both. These restrictions on the use of private data do not prohibit access to the data under section 13.03, subdivision 6. Except for appeals under subdivision 3, paragraph (a), clauses (4), (5), ~~and~~ (8), and (9), upon request, the county agency shall provide reimbursement for transportation, child care, photocopying, medical assessment, witness fee, and other necessary and reasonable costs incurred by the applicant, recipient, or former recipient in connection with the appeal. All evidence, except that privileged by law, commonly accepted by reasonable people in the conduct of their affairs as having probative value with respect to the issues shall be submitted at the hearing and such hearing shall not be "a contested case" within the meaning of section 14.02, subdivision 3. The agency must present its evidence prior to or at the hearing, and may not submit evidence after the hearing except by agreement of the parties at the hearing, provided the petitioner has the opportunity to respond.

Sec. 19. Minnesota Statutes 2000, section 626.556, subdivision 10i, is amended to read:

Subd. 10i. [ADMINISTRATIVE RECONSIDERATION OF FINAL DETERMINATION OF MALTREATMENT AND DISQUALIFICATION BASED ON SERIOUS OR RECURRING MALTREATMENT.] (a) Except as provided under paragraph (e), an individual or facility that the commissioner or a local social service agency determines has maltreated a child, or the child's designee, regardless of the determination, who contests the investigating agency's final determination regarding maltreatment, may request the investigating agency to reconsider its final determination regarding maltreatment. The request for reconsideration must be submitted in writing to the investigating agency within 15 calendar days after receipt of notice of the final determination regarding maltreatment. An individual who was determined to have maltreated a child under this section and who was disqualified on the basis of serious or recurring maltreatment under section 245A.04, subdivision 3d, may request reconsideration of the maltreatment determination and the disqualification. The request for reconsideration of the maltreatment determination and the disqualification must be submitted within 30 calendar days of the individual's receipt of the notice of disqualification under section 245A.04, subdivision 3a.

(b) Except as provided under paragraphs (e) and (f), if the investigating agency denies the

request or fails to act upon the request within 15 calendar days after receiving the request for reconsideration, the person or facility entitled to a fair hearing under section 256.045 may submit to the commissioner of human services a written request for a hearing under that section.

(c) If, as a result of the reconsideration, the investigating agency changes the final determination of maltreatment, that agency shall notify the parties specified in subdivisions 10b, 10d, and 10f.

(d) Except as provided under paragraph (f), if an individual or facility contests the investigating agency's final determination regarding maltreatment by requesting a fair hearing under section 256.045, the commissioner of human services shall assure that the hearing is conducted and a decision is reached within 90 days of receipt of the request for a hearing. The time for action on the decision may be extended for as many days as the hearing is postponed or the record is held open for the benefit of either party.

(e) If an individual was disqualified under section 245A.04, subdivision 3d, on the basis of a determination of maltreatment, which was serious or recurring, and the individual has requested reconsideration of the maltreatment determination under paragraph (a) and requested reconsideration of the disqualification under section 245A.04, subdivision 3b, reconsideration of the maltreatment determination and reconsideration of the disqualification shall be consolidated into a single reconsideration. If an individual disqualified on the basis of a determination of maltreatment, which was serious or recurring requests a fair hearing under paragraph (b), the scope of the fair hearing shall include the maltreatment determination and the disqualification.

(f) If a maltreatment determination or a disqualification based on serious or recurring maltreatment is the basis for a denial of a license under section 245A.05 or a licensing sanction under section 245A.07, the license holder has the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8550 to 1400.8612. As provided for under section 245A.08, subdivision 2a, the scope of the contested case hearing shall include the maltreatment determination, disqualification, and licensing sanction or denial of a license. In such cases, a fair hearing regarding the maltreatment determination shall not be conducted under paragraph (b). If the disqualified subject is an individual other than the license holder and upon whom a background study must be conducted under section 245A.04, subdivision 3, the hearings of all parties may be consolidated into a single contested case hearing upon consent of all parties and the administrative law judge.

Sec. 20. Minnesota Statutes 2000, section 626.557, subdivision 3, is amended to read:

Subd. 3. [TIMING OF REPORT.] (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:

(1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or

(2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4).

(b) A person not required to report under the provisions of this section may voluntarily report as described above.

(c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.

(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.

(e) A mandated reporter who knows or has reason to believe that an error under section

626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or facility at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c.

Sec. 21. Minnesota Statutes 2000, section 626.557, subdivision 9d, is amended to read:

Subd. 9d. [ADMINISTRATIVE RECONSIDERATION OF FINAL DISPOSITION OF MALTREATMENT AND DISQUALIFICATION BASED ON SERIOUS OR RECURRING MALTREATMENT; REVIEW PANEL.] (a) Except as provided under paragraph (e), any individual or facility which a lead agency determines has maltreated a vulnerable adult, or the vulnerable adult or an interested person acting on behalf of the vulnerable adult, regardless of the lead agency's determination, who contests the lead agency's final disposition of an allegation of maltreatment, may request the lead agency to reconsider its final disposition. The request for reconsideration must be submitted in writing to the lead agency within 15 calendar days after receipt of notice of final disposition or, if the request is made by an interested person who is not entitled to notice, within 15 days after receipt of the notice by the vulnerable adult or the vulnerable adult's legal guardian. An individual who was determined to have maltreated a vulnerable adult under this section and who was disqualified on the basis of serious or recurring maltreatment under section 245A.04, subdivision 3d, may request reconsideration of the maltreatment determination and the disqualification. The request for reconsideration of the maltreatment determination and the disqualification must be submitted within 30 calendar days of the individual's receipt of the notice of disqualification under section 245A.04, subdivision 3a.

(b) Except as provided under paragraphs (e) and (f), if the lead agency denies the request or fails to act upon the request within 15 calendar days after receiving the request for reconsideration, the person or facility entitled to a fair hearing under section 256.045, may submit to the commissioner of human services a written request for a hearing under that statute. The vulnerable adult, or an interested person acting on behalf of the vulnerable adult, may request a review by the vulnerable adult maltreatment review panel under section 256.021 if the lead agency denies the request or fails to act upon the request, or if the vulnerable adult or interested person contests a reconsidered disposition. The lead agency shall notify persons who request reconsideration of their rights under this paragraph. The request must be submitted in writing to the review panel and a copy sent to the lead agency within 30 calendar days of receipt of notice of a denial of a request for reconsideration or of a reconsidered disposition. The request must specifically identify the aspects of the agency determination with which the person is dissatisfied.

(c) If, as a result of a reconsideration or review, the lead agency changes the final disposition, it shall notify the parties specified in subdivision 9c, paragraph (d).

(d) For purposes of this subdivision, "interested person acting on behalf of the vulnerable adult" means a person designated in writing by the vulnerable adult to act on behalf of the vulnerable adult, or a legal guardian or conservator or other legal representative, a proxy or health care agent appointed under chapter 145B or 145C, or an individual who is related to the vulnerable adult, as defined in section 245A.02, subdivision 13.

(e) If an individual was disqualified under section 245A.04, subdivision 3d, on the basis of a determination of maltreatment, which was serious or recurring, and the individual has requested reconsideration of the maltreatment determination under paragraph (a) and reconsideration of the disqualification under section 245A.04, subdivision 3b, reconsideration of the maltreatment determination and requested reconsideration of the disqualification shall be consolidated into a single reconsideration. If an individual who was disqualified on the basis of serious or recurring maltreatment requests a fair hearing under paragraph (b), the scope of the fair hearing shall include the maltreatment determination and the disqualification.

(f) If a maltreatment determination or a disqualification based on serious or recurring

maltreatment is the basis for a denial of a license under section 245A.05 or a licensing sanction under section 245A.07, the license holder has the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8550 to 1400.8612. As provided for under section 245A.08, the scope of the contested case hearing shall include the maltreatment determination, disqualification, and licensing sanction or denial of a license. In such cases, a fair hearing shall not be conducted under paragraph (b). If the disqualified subject is an individual other than the license holder and upon whom a background study must be conducted under section 245A.04, subdivision 3, the hearings of all parties may be consolidated into a single contested case hearing upon consent of all parties and the administrative law judge.

(g) Until August 1, 2002, an individual or facility that was determined by the commissioner of human services or the commissioner of health to be responsible for neglect under section 626.5572, subdivision 17, after October 1, 1995, and before August 1, 2001, that believes that the finding of neglect does not meet an amended definition of neglect may request a reconsideration of the determination of neglect. The commissioner of human services or the commissioner of health shall mail a notice to the last known address of individuals who are eligible to seek this reconsideration. The request for reconsideration must state how the established findings no longer meet the elements of the definition of neglect. The commissioner shall review the request for reconsideration and make a determination within 15 calendar days. The commissioner's decision on this reconsideration is the final agency action.

(1) For purposes of compliance with the data destruction schedule under section 626.557, subdivision 12b, paragraph (d), when a finding of substantiated maltreatment has been changed as a result of a reconsideration under this paragraph, the date of the original finding of a substantiated maltreatment must be used to calculate the destruction date.

(2) For purposes of any background studies under section 245A.04, when a determination of substantiated maltreatment has been changed as a result of a reconsideration under this paragraph, any prior disqualification of the individual under section 245A.04 that was based on this determination of maltreatment shall be rescinded, and for future background studies under section 245A.04 the commissioner must not use the previous determination of substantiated maltreatment as a basis for disqualification or as a basis for referring the individual's maltreatment history to a health-related licensing board under section 245A.04, subdivision 3d, paragraph (b).

Sec. 22. Minnesota Statutes 2000, section 626.5572, subdivision 17, is amended to read:

Subd. 17. [NEGLECT.] "Neglect" means:

(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

(c) For purposes of this section, a vulnerable adult is not neglected for the sole reason that:

(1) the vulnerable adult or a person with authority to make health care decisions for the vulnerable adult under sections 144.651, 144A.44, chapter 145B, 145C, or 252A, or section 253B.03, or 525.539 to 525.6199, refuses consent or withdraws consent, consistent with that authority and within the boundary of reasonable medical practice, to any therapeutic conduct, including any care, service, or procedure to diagnose, maintain, or treat the physical or mental condition of the vulnerable adult, or, where permitted under law, to provide nutrition and

hydration parenterally or through intubation; this paragraph does not enlarge or diminish rights otherwise held under law by:

(i) a vulnerable adult or a person acting on behalf of a vulnerable adult, including an involved family member, to consent to or refuse consent for therapeutic conduct; or

(ii) a caregiver to offer or provide or refuse to offer or provide therapeutic conduct; or

(2) the vulnerable adult, a person with authority to make health care decisions for the vulnerable adult, or a caregiver in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the vulnerable adult in lieu of medical care, provided that this is consistent with the prior practice or belief of the vulnerable adult or with the expressed intentions of the vulnerable adult;

(3) the vulnerable adult, who is not impaired in judgment or capacity by mental or emotional dysfunction or undue influence, engages in sexual contact with:

(i) a person including a facility staff person when a consensual sexual personal relationship existed prior to the caregiving relationship; or

(ii) a personal care attendant, regardless of whether the consensual sexual personal relationship existed prior to the caregiving relationship; or

(4) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult which~~: (i)~~ does not result in injury or harm which reasonably requires medical or mental health care; or~~, if it reasonably requires care,~~

(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician; and:

(i) the necessary care is ~~sought and~~ provided in a timely fashion as dictated by the condition of the vulnerable adult; ~~and the injury or harm that required care does not result in substantial acute, or chronic injury or illness, or permanent disability above and beyond the vulnerable adult's preexisting condition~~;

(ii) is after receiving care, the health status of the vulnerable adult can be reasonably expected to be restored to the vulnerable adult's preexisting condition;

(iii) the error is not part of a pattern of errors by the individual;

(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally ~~by the employee or person providing services~~ in the facility ~~in order to evaluate and identify corrective action~~;

(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and

~~(iii) is~~ (vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency~~; and~~

~~(iv) is not part of a pattern of errors by the individual~~.

(d) Nothing in this definition requires a caregiver, if regulated, to provide services in excess of those required by the caregiver's license, certification, registration, or other regulation.

(e) If the findings of an investigation by a lead agency result in a determination of substantiated maltreatment for the sole reason that the actions required of a facility under paragraph (c), clause (5), item (iv), (v), or (vi), were not taken, then the facility is subject to a correction order. This must not alter the lead agency's determination of mitigating factors under section 626.557, subdivision 9c, paragraph (c).

Sec. 23. [FEDERAL LAW CHANGE REQUEST OR WAIVER.]

The commissioner of health or human services, whichever is appropriate, shall pursue changes to federal law necessary to allow greater discretion on disciplinary activities of unlicensed health care workers, and apply for necessary federal waivers or approval that would allow for a set-aside process related to disqualifications for nurse aides in nursing homes by July 1, 2002.

Sec. 24. [WAIVER FROM FEDERAL RULES AND REGULATIONS.]

By January 2002, the commissioner of health shall work with providers to examine federal rules and regulations prohibiting neglect, abuse, and financial exploitation of residents in licensed nursing facilities and shall apply for federal waivers to:

(1) allow the use of Minnesota Statutes, section 626.5572, to control the identification and prevention of maltreatment of residents in licensed nursing facilities, rather than the definitions under federal rules and regulations; and

(2) allow the use of Minnesota Statutes, sections 214.104, 245A.04, and 626.557, to control the disqualification or discipline of any persons providing services to residents in licensed nursing facilities, rather than the nurse aide registry or other exclusionary provisions of federal rules and regulations.

Sec. 25. [EFFECTIVE DATES.]

(a) Sections 20; 21, paragraph (g); and 22 are effective the day following final enactment.

(b) Sections 1; 3; 5; 9; 23; and 24 are effective July 1, 2001.

(c) Sections 2; 4; 7; 8; 10 to 19; and 21, paragraphs (a), (b), (e), and (f), are effective January 1, 2002.

ARTICLE 14

MISCELLANEOUS

Section 1. [144.582] [PROHIBITING CERTAIN ACTIONS AGAINST NURSES.]

Subdivision 1. [PROHIBITED ACTIONS.] Except as provided in subdivision 2, a hospital or other entity licensed under sections 144.50 to 144.58, and its agent; a hospice licensed under section 144A.48, and its agent; or another health care facility licensed by the commissioner of health, and the facility's agent, is prohibited from taking action against a nurse solely on the grounds that the nurse fails to accept an assignment of additional consecutive hours at the facility in excess of an agreed upon, predetermined work shift, if the nurse declines to work additional hours because doing so may, in the nurse's judgment, jeopardize patient safety. A nurse who fails to accept additional hours under this subdivision must document in writing why, in the nurse's judgment, the additional work hours may jeopardize patient safety. This subdivision does not apply to a nursing facility, an intermediate care facility for persons with mental retardation, or a licensed boarding care facility.

Subd. 2. [EMERGENCY.] Notwithstanding subdivision 1, a nurse may be scheduled for duty or required to continue on duty for more than one normal work period in an emergency.

Subd. 3. [DEFINITIONS.] For purposes of this section, the following terms have the meanings given them:

(1) "emergency" means a period when replacement staff are not able to report for duty for the next shift because of unusual circumstances such as a disease outbreak, adverse weather conditions, natural disasters, or, in the case of nurse supervisors, a strike;

(2) "normal work period" means 12 or fewer consecutive hours consistent with a predetermined work shift;

(3) "nurse" has the meaning given in section 148.171, subdivision 9; and

(4) "taking action against" means discharging; disciplining; threatening; reporting to the board of nursing; discriminating against; or penalizing regarding compensation, terms, conditions, location, or privileges of employment.

Subd. 4. [NOTIFICATION.] Each health care facility subject to subdivision 1 shall post on each nursing unit in an area to which all employees have access the following statement: "This facility is prohibited by law from taking any action against a nurse who fails to accept a request or order to work additional hours at the facility in excess of the predetermined work shift if, in the nurse's judgment, working the additional hours may jeopardize patient safety." The facility shall also post adjacent to the statement the telephone number of the Minnesota department of health facility and provider compliance division.

Sec. 2. Minnesota Statutes 2000, section 148.212, is amended to read:

148.212 [TEMPORARY PERMIT.]

Upon receipt of the applicable licensure or reregistration fee and permit fee, and in accordance with rules of the board, the board may issue a nonrenewable temporary permit to practice professional or practical nursing to an applicant for licensure or reregistration who is not the subject of a pending investigation or disciplinary action, nor disqualified for any other reason, under the following circumstances:

(a) The applicant for licensure by examination under section 148.211, subdivision 1, has graduated from an approved nursing program within the 60 days preceding board receipt of an affidavit of graduation or transcript and has been authorized by the board to write the licensure examination for the first time in the United States. The permit holder must practice professional or practical nursing under the direct supervision of a registered nurse. The permit is valid from the date of issue until the date the board takes action on the application or for 60 days whichever occurs first.

(b) The applicant for licensure by endorsement under section 148.211, subdivision 2, is currently licensed to practice professional or practical nursing in another state, territory, or Canadian province. The permit is valid from submission of a proper request until the date of board action on the application.

(c) The applicant for licensure by endorsement under section 148.211, subdivision 2, or for reregistration under section 148.231, subdivision 5, is currently registered in a formal, structured refresher course or its equivalent for nurses that includes clinical practice.

(d) The applicant for licensure by examination under section 148.211, subdivision 1, has been issued a Commission on Graduates of Foreign Nursing Schools certificate, has completed all requirements for licensure except the examination, and has been authorized by the board to write the licensure examination for the first time in the United States. The permit holder must practice professional nursing under the direct supervision of a registered nurse. The permit is valid from the date of issue until the date the board takes action on the application or for 60 days, whichever occurs first.

Sec. 3. Minnesota Statutes 2000, section 148.263, subdivision 2, is amended to read:

Subd. 2. [INSTITUTIONS.] (a) The chief nursing executive or chief administrative officer of any hospital, clinic, prepaid medical plan, or other health care institution or organization located in this state shall report to the board any action taken by the institution or organization or any of its administrators or committees to revoke, suspend, limit, or condition a nurse's privilege to practice in the institution, or as part of the organization, any denial of privileges, any dismissal from employment, or any other disciplinary action. The institution or organization shall also report the resignation of any nurse before the conclusion of any disciplinary proceeding, or before commencement of formal charges, but after the nurse had knowledge that formal charges were contemplated or in preparation. The reporting described by this subdivision is required only if the action pertains to grounds for disciplinary action under section 148.261.

(b) This subdivision does not require any entity to report the refusal of a nurse to accept an assignment of additional hours in excess of an agreed upon, predetermined work schedule.

Sec. 4. Minnesota Statutes 2000, section 148.284, is amended to read:

148.284 [CERTIFICATION OF ADVANCED PRACTICE REGISTERED NURSES.]

(a) No person shall practice advanced practice registered nursing or use any title, abbreviation, or other designation tending to imply that the person is an advanced practice registered nurse, clinical nurse specialist, nurse anesthetist, nurse-midwife, or nurse practitioner unless the person is certified for such advanced practice registered nursing by a national nurse certification organization.

(b) Paragraph (a) does not apply to an advanced practice registered nurse who is within six months after completion of an advanced practice registered nurse course of study and is awaiting certification, provided that the person has not previously failed the certification examination.

(c) An advanced practice registered nurse who has completed a formal course of study as an advanced practice registered nurse and has been certified by a national nurse certification organization prior to January 1, 1999, may continue to practice in the field of nursing in which the advanced practice registered nurse is practicing as of July 1, 1999, regardless of the type of certification held if the advanced practice registered nurse is not eligible for the proper certification.

Sec. 5. Minnesota Statutes 2000, section 214.001, is amended by adding a subdivision to read:

Subd. 4. [INFORMATION FROM COUNCIL OF HEALTH BOARDS.] The chair of a standing committee in either house of the legislature may request information from the council of health boards on proposals relating to the regulation of health occupations.

Sec. 6. Minnesota Statutes 2000, section 214.002, subdivision 1, is amended to read:

Subdivision 1. [WRITTEN REPORT.] Within 15 days of the introduction of a bill proposing new or expanded regulation of an occupation, the proponents of the new or expanded regulation shall submit a written report to the chair of the standing committee in each house of the legislature to which the bill was referred and to the council of health boards setting out the information required by this section. If a committee chair requests that the report be submitted earlier, but no fewer than five days from introduction of the bill, the proponents shall comply with the request.

Sec. 7. Minnesota Statutes 2000, section 214.01, is amended by adding a subdivision to read:

Subd. 1a. [COUNCIL OF HEALTH BOARDS.] "Council of health boards" means a collaborative body established by the health-related licensing boards.

Sec. 8. [214.025] [COUNCIL OF HEALTH BOARDS.]

The health-related licensing boards may establish a council of health boards consisting of representatives of the health-related licensing boards and the emergency medical services regulatory board. When reviewing legislation or legislative proposals relating to the regulation of health occupations, the council shall include the commissioner of health or a designee.

Sec. 9. [214.105] [HEALTH-RELATED LICENSING BOARDS AND COMMISSIONER OF HEALTH; DEFAULT ON FEDERAL LOANS OR SERVICE OBLIGATIONS.]

Subdivision 1. [SUSPENSION OF LICENSE.] If the commissioner of health or a health-related licensing board receives a report from a federal agency certifying that a person licensed by the commissioner or board is in nonpayment, default, or breach of a repayment or service obligation under any federal educational loan, loan repayment, or service conditional scholarship program, the commissioner or board may suspend the person's license within 30 days of receipt of the report. The commissioner or board shall consider the reasons for nonpayment, default, or breach of a repayment or service obligation and may not suspend the person's license in cases of total and permanent disability or long-term temporary disability lasting more than a year. Prior to the suspension, the person must be given notice of the board's or commissioner's intended action and must be given the opportunity for a hearing before the board or commissioner before the suspension takes effect.

Subd. 2. [ISSUANCE, REINSTATEMENT, RENEWAL OF LICENSE.] The commissioner or a health-related licensing board shall not issue, reinstate, or renew a license that has been suspended under this section until the person whose license was suspended provides the commissioner or board with a written release issued by the federal agency that reported the person to the commissioner or board. The written release must state that the person is making payments on the loan or satisfying the service requirements in accordance with an agreement approved by the federal agency. If the person has continued to meet all other requirements for licensure during the period of license suspension, the commissioner or board must reinstate the person's license upon receipt of the written release.

Sec. 10. Minnesota Statutes 2000, section 245.98, is amended by adding a subdivision to read:

Subd. 6. [TREATMENT.] (a) The commissioner of human services shall develop and maintain a comprehensive program for the treatment of problem and pathological gambling. This program should include primary treatment, crisis intervention, assessment and pretreatment services, transitional and after-care services, and intervention and support services, including financial, budget, and debt restitution counseling. The program should also provide services for family members and other victims whether or not the pathological or problem gambler is in treatment. The program should encourage multidisciplinary providers and different programming models, including inpatient, residential, halfway houses, and treatment in chemical dependency programs and other institutions.

(b) The commissioner of human services shall develop programs for gambling prevention, intervention, and treatment for underserved populations, including youth and seniors, and high-risk or vulnerable populations. The commissioner shall consult with appropriate councils, representatives, and agency groups to gather information about specific populations and tailor appropriate gambling-related services for those populations.

Sec. 11. Minnesota Statutes 2000, section 245.982, is amended to read:

245.982 [COMPULSIVE GAMBLING PROGRAM SUPPORT.]

In order to address ~~the~~ problem ~~of~~ and compulsive gambling ~~in this~~, the state~~, the compulsive gambling fund should attempt to assess the beneficiaries of gambling, on a percentage basis according to the revenue they receive from gambling, for the costs of programs to help problem gamblers and their families. In that light, the governor is requested to contact the chairs of the 11 tribal governments in this state and request a contribution of funds for the compulsive gambling program. The governor should seek a total supplemental contribution of $643,000. Funds received from the tribal governments in this state shall be deposited in the Indian gaming revolving account~~ of Minnesota should make sure that its prevention and treatment efforts are sufficient to meet the needs of problem gamblers and their families. Furthermore, the costs of compulsive gambling programs should be funded out of the lottery prize fund, and if available, with support from other gambling enterprises instead of with state general fund appropriations.

Sec. 12. Minnesota Statutes 2000, section 256I.05, subdivision 1d, is amended to read:

Subd. 1d. [SUPPLEMENTARY SERVICE RATES FOR CERTAIN FACILITIES SERVING PERSONS WITH MENTAL ILLNESS OR CHEMICAL DEPENDENCY.] Notwithstanding the provisions of subdivisions 1a and 1c ~~for the fiscal year ending June 30, 1998~~, a county agency may negotiate a supplementary service rate in addition to the board and lodging rate for facilities licensed and registered by the Minnesota department of health under section 157.17 prior to December 31, 1996, if the facility meets the following criteria:

(1) at least 75 percent of the residents have a primary diagnosis of mental illness, chemical dependency, or both, and have related special needs;

(2) the facility provides 24-hour, on-site, year-round supportive services by qualified staff capable of intervention in a crisis of persons with late-state inebriety or mental illness who are vulnerable to abuse or neglect;

(3) the services at the facility include, but are not limited to:

(i) secure central storage of medication;

(ii) reminders and monitoring of medication for self-administration;

(iii) support for developing an individual medical and social service plan, updating the plan, and monitoring compliance with the plan; and

(iv) assistance with setting up meetings, appointments, and transportation to access medical, chemical health, and mental health service providers;

(4) each resident has a documented need for at least one of the services provided;

(5) each resident has been offered an opportunity to apply for admission to a licensed residential treatment program for mental illness, chemical dependency, or both, have refused that offer, and the offer and their refusal has been documented to writing; and

(6) the residents are not eligible for home and community-based services waivers because of their unique need for community support.

The total supplementary service rate must not exceed ~~$575~~ 43.2 percent of the nonfederal share of the adult case mix class A rate established for purposes of the community alternatives for disabled individuals program.

Sec. 13. Minnesota Statutes 2000, section 256I.05, subdivision 1e, is amended to read:

Subd. 1e. [SUPPLEMENTARY RATE FOR CERTAIN FACILITIES.] Notwithstanding the provisions of subdivisions 1a and 1c, beginning July 1, ~~1999~~ 2001, a county agency shall negotiate a supplementary rate in addition to the rate specified in subdivision 1, equal to ~~25~~ 41 percent of the amount specified in subdivision 1a, including any legislatively authorized inflationary adjustments, for a group residential housing provider that:

(1) is located in Hennepin county and has had a group residential housing contract with the county since June 1996;

(2) operates in three separate locations a 56-bed facility, a 40-bed facility, and a 30-bed facility; and

(3) serves a chemically dependent clientele, providing 24 hours per day supervision and limiting a resident's maximum length of stay to 13 months out of a consecutive 24-month period.

Sec. 14. Minnesota Statutes 2000, section 256I.05, is amended by adding a subdivision to read:

Subd. 1f. [SUPPLEMENTARY SERVICE RATE INCREASES ON OR AFTER JULY 1, 2001.] For rate years beginning on or after July 1, 2001, a county agency may increase the supplementary service rate for recipients of assistance under section 256I.04 who reside in a residence that is licensed by the commissioner of health as a boarding care home but is not certified for purposes of the medical assistance program. The supplementary service rate shall not exceed the nonfederal share of the statewide weighted average monthly medical assistance nursing facility payment rate for case mix class A.

Sec. 15. [299A.76] [SUICIDE STATISTICS.]

(a) The commissioner of public safety shall not:

(1) include any statistics on committing suicide or attempting suicide in any compilation of crime statistics published by the commissioner; or

(2) label as a crime statistic, any data on committing suicide or attempting suicide.

(b) This section does not apply to the crimes of aiding suicide under section 609.215, subdivision 1, or aiding attempted suicide under section 609.215, subdivision 2, or to statistics on a suicide directly related to the commission of a crime.

Sec. 16. Minnesota Statutes 2000, section 609.115, subdivision 9, is amended to read:

Subd. 9. [COMPULSIVE GAMBLING ASSESSMENT REQUIRED.] (a) If a person is convicted of theft under section 609.52, embezzlement of public funds under section 609.54, or forgery under section 609.625, 609.63, or 609.631, the probation officer shall determine in the report prepared under subdivision 1 whether or not compulsive gambling contributed to the commission of the offense. If so, the report shall contain the results of a compulsive gambling assessment conducted in accordance with this subdivision. The probation officer shall make an appointment for the offender to undergo the assessment if so indicated.

(b) The compulsive gambling assessment report must include a recommended level of treatment for the offender if the assessor concludes that the offender is in need of compulsive gambling treatment. The assessment must be conducted by an assessor qualified under section 245.98, subdivision 2a, to perform these assessments or to provide compulsive gambling treatment. An assessor providing a compulsive gambling assessment may not have any direct or shared financial interest or referral relationship resulting in shared financial gain with a treatment provider. If an independent assessor is not available, the probation officer may use the services of an assessor with a financial interest or referral relationship as authorized under rules adopted by the commissioner of human services under section 245.98, subdivision 2a.

(c) The commissioner of human services shall reimburse the assessor for the costs associated with a compulsive gambling assessment at a rate established by the commissioner up to a maximum of ~~$100~~ $200 for each assessment. The commissioner shall reimburse these costs after receiving written verification from the probation officer that the assessment was performed and found acceptable.

Sec. 17. Laws 1998, chapter 407, article 8, section 9, is amended to read:

Sec. 9. [PREVALENCE STUDY.]

~~If funding is available,~~ (a) The compulsive gambling program shall provide ~~baseline prevalence~~ studies to identify ~~those at highest risk of developing a compulsive gambling problem, including a replication in 1999 of the 1994 adult prevalence survey~~ the prevalence of pathological and problem gambling and, to the extent possible, the demographic and socioeconomic characteristics of these gamblers. The study must be completed by January 15, 2003.

(b) The compulsive gambling program shall also study the impact of problem gambling on Minnesota. The studies may include the effect of gambling on children of parental gamblers, the prevalence of gambling in underserved populations and developmentally disabled populations, the impact of gambling on crime, and the prevalence of school-based gambling.

Sec. 18. Laws 1999, chapter 152, section 4, is amended to read:

Sec. 4. [REPORT.]

The task force shall present a report recommending a new payment rate structure to the legislature by January 15, 2000, and shall make recommendations to the commissioner of human services regarding the implementation of the pilot project for the individualized payment rate structure, so the pilot project can be implemented by January 1, 2002, as required in section 3. The task force expires on ~~March 15, 2000~~ December 30, 2003.

Sec. 19. Laws 1999, chapter 245, article 10, section 10, as amended by Laws 2000, chapter 488, article 9, section 30, is amended to read:

Sec. 10. [REPEALER.]

~~(a) Minnesota Statutes 1998, section 256.973, is repealed effective June 30, 2002.~~

~~(b)~~ Laws 1997, chapter 225, article 6, section 8, is repealed.

Sec. 20. [DAY TRAINING AND HABILITATION PAYMENT STRUCTURE PILOT PROJECT.]

Subdivision 1. [INDIVIDUALIZED PAYMENT RATE STRUCTURE.] Notwithstanding Minnesota Statutes, sections 252.451, subdivision 5; and 252.46; and Minnesota Rules, part 9525.1290, subpart 1, items A and B, after federal waivers have been approved and the legislature has authorized the pilot project, the commissioner of human services shall initiate a pilot project for the individualized payment rate structure described in this section and section 3. The pilot project shall include actual transfers of funds, not simulated transfers. The pilot project may include all or some of the vendors in up to eight counties, with no more than two counties from the seven-county Minneapolis-St. Paul metropolitan area.

Subd. 2. [SUNSET.] The pilot project shall sunset upon implementation of a new statewide rate structure to be recommended by the task force described in subdivision 3, in its report to the legislature on December 1, 2003. The rates of vendors participating in the pilot project must be modified to be consistent with the new statewide rate structure, if implemented.

Subd. 3. [TASK FORCE RESPONSIBILITIES.] The day training and habilitation task force established under Laws 1999, chapter 152, section 4, shall evaluate at least six months of the pilot project authorized under subdivision 1, and by December 1, 2003, shall report to the legislature with recommendations regarding whether the pilot project individualized payment rate structure should be implemented statewide and with recommendations for any amendments that should be made before statewide implementation. These recommendations shall be made in a report to the chairs of the house health and human services policy and finance committees and the senate health and family security committee and finance division.

Subd. 4. [RATE SETTING.] (a) The rate structure under this section is intended to allow a county to authorize an individual rate for each client in the vendor's program based on the needs and expected outcomes of the individual client. Rates shall be based on an authorized package of services for each individual over a typical time frame. Rates may be established across multiple sites run by a single vendor.

(b) With county concurrence, a vendor shall establish up to four levels of service, A through D, based on the intensity of services provided to an individual client of day training and habilitation services. Service level A shall be the highest intensity of services, marked primarily, but not exclusively, by a one-to-one client-to-staff ratio. Service level D shall be the lowest intensity of services. The county shall document the vendor's description of the type and amount of services associated with each service level.

(c) For each vendor, a county board shall establish a dollar value for one hour of service at each of the service levels defined in paragraph (b). In establishing these values for existing vendors transitioning from the payment rate structure under Minnesota Statutes, section 252.46, subdivision 1, the county board shall follow the formula and guidelines developed by the day training and habilitation task force under paragraph (e).

(d) A vendor may elect to maintain a single transportation rate or may elect to establish up to five types of transportation services: public transportation, public special transportation, nonambulatory transportation, out-of-service area transportation, and ambulatory transportation. For vendors that elect to establish multiple transportation services, the county board shall establish a dollar value for a round trip on each type of transportation service offered through the vendor. With vendor concurrence, the county may also establish a uniform one-way trip value for some or all of the transportation service types.

(e) In conducting the pilot project, the county board shall ensure that the vendor translates the vendor's existing program and transportation rates to the rates and values in the pilot project by using the conversion calculations for services and transportation approved by the day training and habilitation task force established under Laws 1999, chapter 152, and included in the task force's recommendations to the legislature. The conversion calculation may be amended by the task force with the approval of the commissioner and any amendments shall become effective upon notification to the pilot project counties from the commissioner. The calculation shall take the total reimbursement dollars available to the vendor and divide by the units of service expected at each service level and of each transportation type. In determining the total reimbursement dollars available to a vendor, the vendor shall multiply the vendor's current per diem rate for both

services and transportation, including any new rate increases, by the vendor's actual utilization for the year prior to implementation of the pilot project. Vendors shall be allowed to allocate available reimbursement dollars between service and transportation before the vendor's service level and transportation values are calculated. After translating its existing service and transportation rates to the service level and transportation values under the pilot, the vendor shall project its expected reimbursement income using the expected service and transportation packages for its existing clients, based on current service authorizations. If the projected reimbursement income is less than the vendor would have received under the payment structure of Minnesota Statutes, section 252.46, the vendor and the county, with the approval of the commissioner, shall adjust the vendor's service level and transportation values to eliminate the shortfall. The commissioner shall report all adjustments to the day training and habilitation task force for consideration of possible modifications to the pilot project individualized payment rate structure.

Subd. 5. [INDIVIDUAL RATE AUTHORIZATION.] (a) As part of its annual authorization of services for each client under Minnesota Statutes, section 252.44, paragraph (a), clause (1), and Minnesota Rules, part 9525.0016, subpart 12, the county shall authorize and document a service package and a transportation package as follows:

(1) the service package shall include the amount and type of services at each applicable service level to be provided to the client over a package period. An individual client may receive services at multiple service levels over the course of the package period. The service package rate shall be the sum of the amount of services at each level over the package period, multiplied by the dollar value for each service level;

(2) the transportation package shall include the amount and type of transportation services to be provided to the client over the package period. The transportation package rate shall be the sum of the amount of transportation services, multiplied by the dollar value associated with the type of transportation service authorized for the client;

(3) the package period shall be established by the county, and may be one week, two weeks, or one month; and

(4) the individual rate authorization may be reviewed and modified by the county at any time and must be reviewed and reauthorized by the county at least annually.

(b) For purposes of the pilot project, a service day under Minnesota Statutes, sections 245B.06 and 252.44, includes any day in which a client receives any reimbursable service from a vendor or attends employment arranged by the vendor.

Subd. 6. [BILLING FOR SERVICES.] The vendor shall bill for, and shall be reimbursed for, the service package rate and transportation package rate for the package period as authorized by the county for each client in the vendor's program. The length of the package period shall not affect the timing or frequency of vendors' submissions of claims for payment under the Medicaid Management Information System II (MMIS) or its successors.

Subd. 7. [NOTIFICATION OF CHANGE IN CLIENT NEEDS.] The vendor shall notify an individual client's case manager if the vendor has knowledge of a material change in the client's needs that may indicate a need for a change in service authorization. Factors that would require such notice include, but are not limited to, significant changes in medical status, residential placement, attendance patterns, behavioral needs, or skill functioning. The vendor shall notify the case manager as soon as possible but no later than 30 calendar days after becoming aware of the change in needs. The service authorization for the client shall not change until the county authorizes a new service and transportation package for the client in accordance with the provisions in Minnesota Statutes, section 256B.092.

Subd. 8. [COUNTY BOARD RESPONSIBILITIES.] For each vendor with rates established under this section, the county board shall document the vendor's description of the type and amount of services associated with each service level, the vendor's service level values, the vendor's transportation values, and the package period that will be used to determine the rate for each individual client. The county shall establish a package period of one week, two weeks, or one month.

Sec. 21. [DEAF/BLIND SERVICES STUDY.]

The department of human services shall convene and lead an interagency workgroup for the purpose of studying and developing recommendations regarding:

(1) how the state can most effectively and efficiently use state appropriations and other resources to provide needed services to deaf/blind children, adults, and their families;

(2) how state agencies can work together to enhance and ensure that a seamless service delivery system exists across agency lines for persons who are deaf/blind; and

(3) how other existing barriers to the effective and efficient delivery of service for deaf/blind Minnesotans can be removed.

The workgroup shall include representatives from the departments of human services, economic security, children, families, and learning; the state academy for the deaf; the state academy for the blind; the Minnesota commission serving deaf and hard-of-hearing; a consumer who is deaf/blind; a parent of a deaf/blind child from the metro area and a parent of a deaf/blind child from greater Minnesota; and anyone else that the workgroup finds necessary to complete its work.

The departments of human services, economic security, and children, families, and learning shall share equally in the costs of the workgroup.

The workgroup shall report its findings and recommendations to the legislature by February 1, 2002.

Sec. 22. [ESTABLISHMENT OF NEW FEE FOR COMPULSIVE GAMBLING TREATMENT PROVIDERS.]

The commissioner of human services, in consultation with compulsive gambling treatment providers, shall establish a fee structure, which increases the rates provided for purposes of gambling treatment. The fee structure must reflect the real costs associated with providing treatment services and should be sufficient to attract new and retain existing compulsive gambling treatment providers. The new rate structure must be implemented no later than October 1, 2001.

Sec. 23. [PROGRAM OPTIONS FOR CERTAIN PERSONS WITH DEVELOPMENTAL DISABILITIES.]

(a) The commissioner of human services shall ensure that services continue to be available to persons with developmental disabilities who were covered by social services supplemental grants prior to July 1, 2001. Services shall be provided in priority order as follows:

(1) to the extent possible, the commissioner shall establish for these persons targeted slots under the home and community-based waivered services program for persons with mental retardation or related conditions;

(2) those persons who cannot be accommodated under clause (1) shall, to the extent possible, be provided services through other home and community-based waivered services programs;

(3) notwithstanding Minnesota Statutes, section 256I.04, subdivision 2a, those persons who cannot be served by a waiver program under clause (1) or (2) shall be eligible for services under Minnesota Statutes, chapter 256I; and

(4) any remaining persons shall continue to receive services through community social services supplemental grants to the affected counties.

(b) This section applies only to individuals receiving services under social services supplemental grants as of June 30, 2001.

Sec. 24. [STUDY OF DAY TRAINING AND HABILITATION VENDOR RATES.]

The commissioner shall identify the vendors with the lowest rates or underfunded programs in the state and make recommendations to reconcile the discrepancies prior to the implementation of the individualized payment rate structure.

Sec. 25. [FEDERAL APPROVAL.]

The commissioner shall seek any amendments to the state Medicaid plan and any waivers necessary to permit implementation of the day training and habilitation individualized payment structure pilot project within the timelines specified. When the necessary waivers are approved by the federal government, the commissioner shall obtain authorization from the legislature before implementing the pilot project.

Sec. 26. [REPEALER.]

Minnesota Statutes 2000, section 256E.06, subdivision 2b, is repealed.

Sec. 27. [EFFECTIVE DATE.]

The repealer in section 26 is effective July 1, 2003.

## ARTICLE 15

## APPROPRIATIONS

Section 1. [HEALTH AND HUMAN SERVICES APPROPRIATIONS.]

The sums shown in the columns marked "APPROPRIATIONS" are appropriated from the general fund, or any other fund named, to the agencies and for the purposes specified in the following sections of this article, to be available for the fiscal years indicated for each purpose. The figures "2002" and "2003" where used in this article, mean that the appropriation or appropriations listed under them are available for the fiscal year ending June 30, 2002, or June 30, 2003, respectively. Where a dollar amount appears in parentheses, it means a reduction of an appropriation.

SUMMARY BY FUND

| APPROPRIATIONS | 2002 | 2003 | BIENNIAL TOTAL |
|---|---|---|---|
| General | $3,194,208,000 | $3,538,825,000 | $6,733,033,000 |
| State Government Special Revenue | 38,548,000 | 40,671,000 | 79,219,000 |
| Health Care Access | 233,995,000 | 308,027,000 | 542,022,000 |
| Federal TANF | 295,060,000 | 302,841,000 | 597,901,000 |
| Lottery Cash Flow | 4,090,000 | 3,540,000 | 7,630,000 |
| TOTAL | $3,765,901,000 | $4,193,904,000 | $7,959,805,000 |

| | APPROPRIATIONS Available for the Year Ending June 30 2002 | 2003 |
|---|---|---|
| Sec. 2. COMMISSIONER OF HUMAN SERVICES | | |
| Subdivision 1. Total Appropriation | $3,587,334,000 | $4,015,082,000 |
| Summary by Fund | | |
| General | 3,074,144,000 | 3,414,047,000 |

| | | |
|---|---|---|
| State Government Special Revenue | 520,000 | 534,000 |
| Health Care Access | 220,060,000 | 300,660,000 |
| Federal TANF | 288,520,000 | 296,301,000 |
| Lottery Cash Flow | 4,090,000 | 3,540,000 |
| TOTAL | 3,587,334,000 | 4,015,082,000 |

[RECEIPTS FOR SYSTEMS PROJECTS.] Appropriations and federal receipts for information system projects for MAXIS, PRISM, MMIS, and SSIS must be deposited in the state system account authorized in Minnesota Statutes, section 256.014. Money appropriated for computer projects approved by the Minnesota office of technology, funded by the legislature, and approved by the commissioner of finance may be transferred from one project to another and from development to operations as the commissioner of human services considers necessary. Any unexpended balance in the appropriation for these projects does not cancel but is available for ongoing development and operations.

[GIFTS.] Notwithstanding Minnesota Statutes, chapter 7, the commissioner may accept on behalf of the state additional funding from sources other than state funds for the purpose of financing the cost of assistance program grants or nongrant administration. All additional funding is appropriated to the commissioner for use as designated by the grantor of funding.

[SYSTEMS CONTINUITY.] In the event of disruption of technical systems or computer operations, the commissioner may use available grant appropriations to ensure continuity of payments for maintaining the health, safety, and well-being of clients served by programs administered by the department of human services. Grant funds must be used in a manner consistent with the original intent of the appropriation.

[SPECIAL REVENUE FUND INFORMATION.] On December 1, 2001, and December 1, 2002, the commissioner shall provide the chairs of the house health and human services finance committee and the senate health, human services, and corrections budget division with detailed fund balance information for each special revenue fund account.

[FEDERAL ADMINISTRATIVE

REIMBURSEMENT.] Federal administrative reimbursement resulting from MinnesotaCare outreach grants and the Minnesota senior health options project are appropriated to the commissioner for these activities.

[NONFEDERAL SHARE TRANSFERS.] The nonfederal share of activities for which federal administrative reimbursement is appropriated to the commissioner may be transferred to the special revenue fund.

[MAJOR SYSTEMS ONE-TIME TRANSFER.] $29,000,000 of funds available in the state systems account authorized in Minnesota Statutes, section 256.014, is transferred in fiscal year 2002 to the general fund.

[TANF FUNDS APPROPRIATED TO OTHER ENTITIES.] Any expenditures from the TANF block grant shall be expended in accordance with the requirements and limitations of part A of title IV of the Social Security Act, as amended, and any other applicable federal requirement or limitation. Prior to any expenditure of these funds, the commissioner shall assure that funds are expended in compliance with the requirements and limitations of federal law and that any reporting requirements of federal law are met. It shall be the responsibility of any entity to which these funds are appropriated to implement a memorandum of understanding with the commissioner that provides the necessary assurance of compliance prior to any expenditure of funds. The commissioner shall receipt TANF funds appropriated to other state agencies and coordinate all related interagency accounting transactions necessary to implement these appropriations. Unexpended TANF funds appropriated to any state, local, or nonprofit entity cancel at the end of the state fiscal year unless appropriating language permits otherwise.

[TANF FUNDS TRANSFERRED TO OTHER FEDERAL GRANTS.] The commissioner must authorize transfers from TANF to other federal block grants so that funds are available to meet the annual expenditure needs as appropriated. Transfers may be authorized prior to the expenditure year with the agreement of the receiving entity. Transferred funds must be expended in the year for which the funds were appropriated unless appropriation language permits otherwise. In accelerating transfer authorizations, the commissioner must aim to preserve the future potential transfer capacity from TANF to other block grants.

[TANF MAINTENANCE OF EFFORT.] (a) In order to meet the basic maintenance of effort (MOE) requirements of the TANF block grant specified under Code of Federal Regulations, title 45, section 263.1, the commissioner may only report nonfederal money expended for allowable activities listed in the following clauses as TANF MOE expenditures:

(1) MFIP cash and food assistance benefits under Minnesota Statutes, chapter 256J;

(2) the child care assistance programs under Minnesota Statutes, sections 119B.03 and 119B.05, and county child care administrative costs under Minnesota Statutes, section 119B.15;

(3) state and county MFIP administrative costs under Minnesota Statutes, chapters 256J and 256K;

(4) state, county, and tribal MFIP employment services under Minnesota Statutes, chapters 256J and 256K; and

(5) expenditures made on behalf of noncitizen MFIP recipients who qualify for the medical assistance without federal financial participation program under Minnesota Statutes, section 256B.06, subdivision 4, paragraphs (d), (e), and (j).

(b) The commissioner shall ensure that sufficient qualified nonfederal expenditures are made each year to meet the state's TANF MOE requirements. For the activities listed in paragraph (a), clauses (2) to (5), the commissioner may only report expenditures that are excluded from the definition of assistance under Code of Federal Regulations, title 45, section 260.31.

(c) By August 31 of each year, the commissioner shall make a preliminary calculation to determine the likelihood that the state will meet its annual federal work participation requirement under Code of Federal Regulations, title 45, sections 261.21 and 261.23, after adjustment for any caseload reduction credit under Code of Federal Regulations, title 45, section 261.41. If the commissioner determines that the state will meet its federal work participation rate for the federal fiscal year ending that September, the commissioner may reduce the expenditure under paragraph (a), clause (1), to the extent allowed under Code of Federal Regulations, title 45, section 263.1(a)(2).

(d) For fiscal years beginning with state fiscal

year 2003, the commissioner shall assure that the maintenance of effort used by the commissioner of finance for the February and November forecasts required under Minnesota Statutes, section 16A.103, contains expenditures under paragraph (a), clause (1), equal to at least 25 percent of the total required under Code of Federal Regulations, title 45, section 263.1.

(e) If nonfederal expenditures for the programs and purposes listed in paragraph (a) are insufficient to meet the state's TANF MOE requirements, the commissioner shall recommend additional allowable sources of nonfederal expenditures to the legislature, if the legislature is or will be in session to take action to specify additional sources of nonfederal expenditures for TANF MOE before a federal penalty is imposed. The commissioner shall otherwise provide notice to the legislative commission on planning and fiscal policy under paragraph (g).

(f) If the commissioner uses authority granted under Laws 1999, chapter 245, article 1, section 10, or similar authority granted by a subsequent legislature, to meet the state's TANF MOE requirements in a reporting period, the commissioner shall inform the chairs of the appropriate legislative committees about all transfers made under that authority for this purpose.

(g) If the commissioner determines that nonfederal expenditures for the programs under paragraph (a), are insufficient to meet TANF MOE expenditure requirements, and if the legislature is not or will not be in session to take timely action to avoid a federal penalty, the commissioner may report nonfederal expenditures from other allowable sources as TANF MOE expenditures after the requirements of this paragraph are met. The commissioner may report nonfederal expenditures in addition to those specified under paragraph (a) as nonfederal TANF MOE expenditures, but only ten days after the commissioner of finance has first submitted the commissioner's recommendations for additional allowable sources of nonfederal TANF MOE expenditures to the members of the legislative commission on planning and fiscal policy for their review.

(h) The commissioner of finance shall not incorporate any changes in federal TANF expenditures or nonfederal expenditures for

TANF MOE that may result from reporting additional allowable sources of nonfederal TANF MOE expenditures under the interim procedures in paragraph (g) into the February or November forecasts required under Minnesota Statutes, section 16A.103, unless the commissioner of finance has approved the additional sources of expenditures under paragraph (g).

(i) The provisions of Minnesota Statutes, section 256.011, subdivision 3, which require that federal grants or aids secured or obtained under that subdivision be used to reduce any direct appropriations provided by law, do not apply if the grants or aids are federal TANF funds.

(j) Notwithstanding section 14 of this article, paragraphs (a) to (j) expire June 30, 2005.

| | | |
|---|---|---|
| Subd. 2. Agency Management | | |
| General | 38,519,000 | 38,053,000 |
| State Government Special Revenue | 403,000 | 415,000 |
| Health Care Access | 3,631,000 | 3,673,000 |
| Federal TANF | 165,000 | 165,000 |
| The amounts that may be spent from the appropriation for each purpose are as follows: | | |
| (a) Financial Operations | | |
| General | 6,872,000 | 7,041,000 |
| Health Care Access | 815,000 | 828,000 |
| Federal TANF | 165,000 | 165,000 |
| (b) Legal & Regulation Operations | | |
| General | 8,405,000 | 8,239,000 |
| State Government Special Revenue | 403,000 | 415,000 |
| Health Care Access | 239,000 | 244,000 |
| (c) Management Operations | | |
| General | 23,242,000 | 22,773,000 |
| Health Care Access | 2,577,000 | 2,601,000 |
| Subd. 3. Administrative Reimbursement/ Passthrough | | |
| Federal TANF | 58,605 | 56,992 |
| Subd. 4. Children's Services Grants | | |

| | | |
|---|---|---|
| General | 66,147,000 | 71,129,000 |
| Federal TANF | 6,290,000 | 6,290,000 |

[ADOPTION ASSISTANCE INCENTIVE GRANTS.] Federal funds available during the biennium ending June 30, 2003, for adoption incentive grants are appropriated to the commissioner for these purposes.

[EMPLOYMENT AND TRAINING.] (a) $1,810,000 is appropriated from the state's federal TANF block grant to the commissioner in fiscal year 2002 and in fiscal year 2003 for employment and training grants.

(b) $5,000,000 is appropriated from the state's federal TANF block grant to the commissioner in fiscal year 2002 and in fiscal year 2003 for welfare-to-work programs administered by the commissioner of economic security that have utilized all of the federal welfare-to-work funding received. The commissioner of economic security shall establish guidelines for distributing the available funds to local workforce service areas based on current expenditures and the documented need.

(c) The appropriations in paragraphs (a) and (b) shall not become part of the base level funding for the 2004-2005 biennium.

[TANF TRANSFER TO SOCIAL SERVICES.] $4,650,000 is appropriated to the commissioner in fiscal year 2002 and in fiscal year 2003 for purposes of increasing services for families with children whose incomes are at or below 200 percent of the federal poverty guidelines. The commissioner shall authorize a sufficient transfer of funds from the state's federal TANF block grant to the state's federal social services block grant to meet this appropriation.

[SOCIAL SERVICES BLOCK GRANT FUNDS FOR CONCURRENT PERMANENCY PLANNING.] Notwithstanding Minnesota Statutes, section 256E.07, $4,650,000 in fiscal year 2002 and $4,650,000 in fiscal year 2003 in social services block grant funds allocated to the commissioner under title XX of the Social Security Act are available for distribution to counties under the formula in Minnesota Statutes, section 260C.213, for the purposes of concurrent permanency planning.

[CHILDREN'S MENTAL HEALTH GRANTS.] Of the general fund appropriation, $1,000,000 in fiscal year 2002 and $1,000,000 in fiscal year 2003 is for children's mental health

grants under Minnesota Statutes, section 245.4886.

Subd. 5. Children's Services Management

| | | |
|---|---|---|
| General | 5,645,000 | 5,724,000 |

[FEDERAL FINANCIAL PARTICIPATION MAXIMIZATION FOR OUT-OF-HOME CARE.] The commissioner of human services and the commissioner of corrections shall cooperate in efforts to maximize federal financial participation in the costs of providing out-of-home placements for juveniles.

Subd. 6. Basic Health Care Grants

Summary by Fund

| | | |
|---|---|---|
| General | 1,164,615,000 | 1,386,582,000 |
| Health Care Access | 198,568,000 | 277,503,000 |

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) MinnesotaCare Grants

| | | |
|---|---|---|
| Health Care Access | 197,818,000 | 276,753,000 |

[MINNESOTACARE FEDERAL RECEIPTS.] Receipts received as a result of federal participation pertaining to administrative costs of the Minnesota health care reform waiver shall be deposited as nondedicated revenue in the health care access fund. Receipts received as a result of federal participation pertaining to grants shall be deposited in the federal fund and shall offset health care access funds for payments to providers.

[MINNESOTACARE FUNDING.] The commissioner may expend money appropriated from the health care access fund for MinnesotaCare in either fiscal year of the biennium.

[DENTAL ACCESS GRANTS.] Of this appropriation, $1,000,000 in fiscal year 2002 is to be distributed as dental access grants in accordance with Minnesota Statutes, section 256B.53. If the amount appropriated is not used within the fiscal year, the commissioner of finance shall transfer any remaining amount to the commissioner of health to be distributed as rural hospital capital improvement grants for fiscal year 2003.

[HEALTH CARE SAFETY NET ENDOWMENT FUND.] The commissioner of

finance shall transfer $150,000,000 from the health care access fund to the health care safety net endowment fund.

(b) MA Basic Health Care Grants - Families and Children

| | | |
|---|---|---|
| General | 475,611,000 | 575,996,000 |

[INDIAN HEALTH SERVICES FEDERAL MATCH.] In the event the federal medical assistance percentage rate increases to 100 percent for services provided as a result of a referral by the federal Indian health service or a tribal provider, the commissioner is authorized to increase the payment rate for referrals by ten percent as an incentive for the completion of documentation required for increased federal participation. Unspent state medical assistance appropriations resulting from the increase in the federal medical assistance percentage rate shall be transferred to the appropriate account and are available to the commissioner for covering the costs of out-stationed health care program eligibility services on reservations. The base appropriation for the 2004-2005 biennium for these services must not exceed the state medical assistance savings. These actions are intended to improve access to health care and assist in eliminating disparities in health status for American Indian people.

[PROVIDER SURCHARGE OFFSET.] The commissioner shall reduce future billings under Minnesota Statutes, section 256.9657, to offset $1,600,000 in excess provider surcharges erroneously collected from a health care system established in 1994. The future billings must be reduced by $400,000 in each of the fiscal years beginning with fiscal year 2002 through fiscal year 2005, for a total reduction of $1,600,000. Notwithstanding section 14, this provision expires on June 30, 2005.

[PMAP RATES.] Prepaid medical assistance, general assistance medical care, and MinnesotaCare program rates set by the commissioner under Minnesota Statutes, section 256B.69, effective on or after January 1, 2002, shall not reflect any increase in cost due to changes made to Minnesota Statutes, sections 62Q.56 and 62Q.58, by the 2001 legislature. Notwithstanding section 14, this paragraph shall not expire.

[COLLECTION OF HOSPITAL OVERPAYMENTS.] (a) The commissioner

shall not commence collection of hospital overpayments resulting from a determination that medical assistance and general assistance payments exceeded the charge limit during the period from 1994 to 1997 until after any available appeals have been exhausted.

(b) For small rural hospitals, as defined in Minnesota Statutes, section 144.148, any amounts then due to the state may be funded through the grant program provided in section 3 for those hospitals.

(c) MA Basic Health Care Grants - Elderly and Disabled

| | | |
|---|---|---|
| General | 520,190,000 | 609,372,000 |

(d) General Assistance Medical Care

| | | |
|---|---|---|
| General | 157,384,000 | 179,229,000 |

(e) Health Care Grants - Other Assistance

| | | |
|---|---|---|
| General | 11,430,000 | 21,985,000 |
| Health Care Access | 750,000 | 750,000 |

[STOP-LOSS FUND ACCOUNT.] Of the general fund appropriation, $200,000 in fiscal year 2002 and $385,000 in fiscal year 2003 is to the commissioner to be deposited in the stop-loss fund account to be distributed in accordance with Minnesota Statutes, section 256.956.

Subd. 7. Basic Health Care Management

| | | |
|---|---|---|
| General | 22,467,000 | 24,091,000 |
| Health Care Access | 16,528,000 | 18,135,000 |

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) Health Care Policy Administration

| | | |
|---|---|---|
| General | 3,595,000 | 4,938,000 |
| Health Care Access | 578,000 | 595,000 |

[OUTREACH EFFORTS.] (a) Of the general fund appropriation, $120,000 each year is to the commissioner to:

(1) coordinate a public/private partnership to provide a statewide outreach campaign on the importance of health coverage and the availability of coverage through both public assistance health care programs and the private health insurance market. The campaign shall include messages directed to the general population as well as culturally specific and community-based messages; and

(2) award grants to public or private organizations to provide local community-based outreach to assist families with children in obtaining health coverage. In awarding these grants, the commissioner shall consider the following:

(i) the ability to contact or serve non-English-speaking families;

(ii) the ability to provide trained workers at accessible outreach centers to assist families with children by offering services ranging from providing information up to on-site enrollment in a health care program; and

(iii) the ability to serve geographic areas and populations with the greatest disparity in health coverage and health status.

(b) The commissioner shall include specific performance expectations that will require grantees to track the number of enrollees in state programs, monitor these grants, and may terminate a grant if the outreach effort does not increase enrollment in the state health care programs.

(c) The commissioner shall provide applications and other health care program information to provider offices, hospitals, local human services agencies, community health sites, and elementary schools to encourage and assist these sites in conducting outreach efforts. These sites may assist families with children by offering services ranging from providing information up to on-site enrollment in public assistance programs.

[LONG-TERM CARE EMPLOYEE INSURANCE PROGRAM ADMINISTRATION.] Of the general fund appropriation, $500,000 in fiscal year 2002 and $1,750,000 in fiscal year 2003 is for the administrative costs associated with the long-term care employee insurance program under Minnesota Statutes, section 256.956.

(b) Health Care Operations

| | | |
|---|---|---|
| General | 18,872,000 | 19,153,000 |
| Health Care Access | 15,950,000 | 17,540,000 |

[PREPAID MEDICAL PROGRAMS.] The nonfederal share of the prepaid medical assistance program fund, which has been appropriated to fund county managed care advocacy and enrollment operating costs, shall

be disbursed as grants using either a reimbursement or block grant mechanism and may also be transferred between grants and nongrant administration costs with approval of the commissioner of finance.

Subd. 8. State-Operated Services

| | | |
|---|---|---|
| General | 211,440,000 | 206,465,000 |

[MITIGATION RELATED TO STATE-OPERATED SERVICES RESTRUCTURING.] Money appropriated to finance mitigation expenses related to restructuring state-operated services programs and administrative services may be transferred between fiscal years within the biennium.

[STATE-OPERATED SERVICES CHEMICAL DEPENDENCY PROGRAMS.] When the operations of the state-operated services chemical dependency fund created in Minnesota Statutes, section 246.18, subdivision 2, are impeded by projected cash deficiencies resulting from delays in the receipt of grants, dedicated income, or other similar receivables, and when the deficiencies would be corrected within the budget period involved, the commissioner of finance may transfer general fund cash reserves into this account as necessary to meet cash demands. The cash flow transfers must be returned to the general fund in the fiscal year that the transfer was made. Any interest earned on general fund cash flow transfers accrues to the general fund and not the state-operated services chemical dependency fund.

[STATE-OPERATED SERVICES RESTRUCTURING.] For purposes of restructuring state-operated services, any state-operated services employee whose position is to be eliminated shall be afforded the options provided in applicable collective bargaining agreements. All salary and mitigation allocations from fiscal year 2002 shall be carried forward into fiscal year 2003. Provided there is no conflict with any collective bargaining agreement, any state-operated services position reduction must only be accomplished through mitigation, attrition, transfer, and other measures as provided in state or applicable collective bargaining agreements and in Minnesota Statutes, section 252.50, subdivision 11, and not through layoff.

[REPAIRS AND BETTERMENTS.] The commissioner may transfer unencumbered

appropriation balances between fiscal years for the state residential facilities repairs and betterments account and special equipment.

[NAMES REQUIRED ON GRAVES.] (a) Of this appropriation, $300,000 in fiscal year 2002 is to replace numbers with the names of individuals at all graves located at regional treatment centers operated or formerly operated by the commissioner.

(b) Twenty percent of this appropriation must be transferred to a consumer run disability rights organization located in St. Paul for community organizing, coordination, fundraising, and administrative costs.

(c) Any unexpended portion of this appropriation shall not cancel but shall be available in fiscal year 2003 for these purposes. This is a one-time appropriation and shall not become part of the base level funding for the 2004-2005 biennium.

[BUILDING REMODELING.] The commissioner shall use $400,000 from the appropriation for repairs and betterments to remodel building 6 at the Brainerd regional human services center to make the structure suitable for school programs. The Brainerd school district shall reimburse the commissioner $200,000 in fiscal year 2002 and $200,000 in fiscal year 2003 through a lease agreement for these remodeling costs.

Subd. 9. Continuing Care Grants

| | | |
|---|---|---|
| General | 1,363,147,000 | 1,474,989,000 |
| Lottery Cash Flow | 3,850,000 | 3,300,000 |

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) Community Social Services Block Grants

| | |
|---|---|
| 48,910,000 | 49,836,000 |

[CSSA TRADITIONAL APPROPRIATION.] Notwithstanding Minnesota Statutes, section 256E.06, subdivisions 1 and 2, the appropriations available under that section in fiscal years 2002 and 2003 must be distributed to each county proportionately to the aid received by the county in calendar year 2000.

(b) Aging Adult Service Grants

| | |
|---|---|
| 14,117,000 | 13,788,000 |

[AGING AND ADULT SERVICE GRANT CARRYFORWARD AUTHORITY.] (a) Money

appropriated for Senior LinkAge line, community services grants, and access demonstration project grants shall be used by the commissioner to maximize federal reimbursement according to federal law, rule, and regulation.

(b) Unexpended funds appropriated for Senior LinkAge line, community services grants, and access demonstration project grants for fiscal year 2002 do not cancel but are available to the commissioner for these purposes for fiscal year 2003.

[HOME-SHARING GRANTS.] Of this appropriation, $225,000 in fiscal year 2002 and $400,000 in fiscal year 2003 is for the home-sharing grant program under Minnesota Statutes, section 256.973. This appropriation shall become part of the base level funding for the 2004-2005 biennium.

[THE CENTER FOR VICTIMS OF TORTURE.] Of the appropriation for fiscal year 2002, $450,000 is for a grant to the center for victims of torture. The grant is to be used to conduct continuing education and training of health care and human service workers on how to identify torture survivors, provide appropriate care and make referrals, and to establish a network of care providers who will offer pro bono services for survivors of politically motivated torture. This is a one-time appropriation requiring a one-to-one, nonstate, in-kind match, and is available until expended.

(c) Deaf and Hard-of-Hearing Services Grants

2,169,000 1,943,000

[SERVICES TO DEAF PERSONS WITH MENTAL ILLNESS.] (a) Of this appropriation, $125,000 in fiscal year 2002 and $60,000 in fiscal year 2003 is for a grant to a nonprofit agency that currently serves deaf and hard-of-hearing adults with mental illness through residential programs and supportive housing outreach activities. The grant must be used to continue and maintain community support services for deaf and hard-of-hearing adults with mental illness who use or wish to use sign language as their primary means of communication.

(b) The grant for fiscal year 2003 shall be increased by $65,000 minus earnings achieved by the grantee through participation in the

medical assistance rehabilitation option for persons with mental illness under Minnesota Statutes, section 256B.0623. The grant shall not be less than $60,000.

(c) The base level funding for the 2004-2005 biennium shall be $125,000 minus earnings achieved by the grantee through participation in the medical assistance rehabilitation option for persons with mental illness under Minnesota Statutes, section 256B.0623.

[COMMISSION SERVING DEAF AND HARD-OF-HEARING PEOPLE.] Of this appropriation, $5,000 in fiscal year 2002 is to the commissioner for the Minnesota commission serving deaf and hard-of-hearing people to carry out the duties under Minnesota Statutes, section 256C.28.

[DEAF-BLIND SERVICES.] Of this appropriation, $212,000 in fiscal year 2002 and $150,000 in fiscal year 2003 are for grants to providers to provide deaf-blind persons with residential training and self-sufficiency supports.

(d) Mental Health Grants

| | | |
|---|---|---|
| General | 52,694,000 | 54,386,000 |
| Lottery Cash Flow | 3,850,000 | 3,300,000 |

[MENTAL HEALTH COUNSELING FOR FARM FAMILIES.] Of the general fund appropriation, $150,000 in fiscal year 2002 and $150,000 in fiscal year 2003 is to be transferred to the board of trustees of the Minnesota state colleges and universities for mental health counseling support to farm families and business operators through the farm business management program at Central Lakes College and Ridgewater College. This appropriation is available until June 30, 2003.

[COSTS ASSOCIATED WITH STATE INMATES WITH MENTAL ILLNESS.] (a) Of the general fund appropriation, $125,000 in fiscal year 2002 and $185,000 in fiscal year 2003 is for evaluation and support staff to do discharge planning under Minnesota Statutes, section 244.054, for persons with serious and persistent mental illness being discharged from prison. These staff shall be employed by the commissioner but assigned at the direction of the commissioner of corrections.

(b) Of the general fund appropriation, the following amounts shall be transferred to the commissioner of corrections for the purposes indicated:

(1) $258,000 in fiscal year 2002 and $258,000 in fiscal year 2003 for the staff and travel costs associated with discharge planning under Minnesota Statutes, section 244.054, for persons with serious and persistent mental illness;

(2) $769,000 in fiscal year 2002 and $638,000 in fiscal year 2003 for grants to counties under the transitional housing and community support program for former state inmates with serious and persistent mental illness; and

(3) $24,000 in fiscal year 2002 and $24,000 in fiscal year 2003 for the cost of medications for state inmates with serious and persistent mental illness.

[ADULT MENTAL HEALTH EMERGENCY SERVICES.] Of the general fund appropriation, $1,000,000 in fiscal year 2002 and $1,000,000 in fiscal year 2003 is for adult mental health emergency services under Minnesota Statutes, section 245.469.

[COMPULSIVE GAMBLING.] Of the appropriation from the lottery prize fund to the commissioner for the compulsive gambling treatment program:

(1) $1,500,000 in fiscal year 2002 and $1,500,000 in fiscal year 2003 is for treatment of pathological and problem gambling as specified under Minnesota Statutes, section 245.98, subdivision 6;

(2) $100,000 in fiscal year 2002 and $200,000 in fiscal year 2003 is for compulsive gambling treatment for minority groups or persons with disabilities on a grant basis to at least two different providers serving different populations;

(3) $500,000 in fiscal year 2003 is for grants to be used as start-up funding for new treatment programs in underserved areas of the state. This is a one-time appropriation and shall not become part of the base level funding for the 2004-2005 biennium;

(4) $300,000 in fiscal year 2002 is for a prevalence study required by Laws 1998, chapter 407, article 8, section 9, paragraph (a). This is a one-time appropriation and shall not become part of the base appropriation for the 2004-2005 biennium;

(5) $100,000 for fiscal year 2002 is for study on the impact of problem gambling as required by Laws 1998, chapter 407, article 8, section 9, paragraph (b). This is a one-time appropriation

and shall not become part of the base level funding for the 2004-2005 biennium;

(6) $50,000 in fiscal year 2002 and $50,000 in fiscal year 2003 is for the purposes of assessing the results of treatment provided through the compulsive gambling program. This is a one-time appropriation and shall not become part of the base level funding for the 2004-2005 biennium;

(7) $100,000 in fiscal year 2002 and $100,000 in fiscal year 2003 is for a grant to the University of Minnesota medical school for research on the effectiveness of pharmaceutical treatment of pathological gambling. This is a one-time appropriation and shall not become part of the base appropriation for the 2004-2005 biennium;

(8) $600,000 in fiscal year 2002 and $600,000 in fiscal year 2003 is for the state problem gambling help line and for initiatives to increase public awareness of problem and pathological gambling and to assist in its prevention;

(9) $150,000 in fiscal year 2002 and $150,000 in fiscal year 2003 is for grants for educating and training in the the identification of individuals who may need treatment for problem or pathological gambling and counseling individuals or families on treatment options. This is a one-time appropriation and shall not become part of the base level funding for the 2004-2005 biennium;

(10) $50,000 in fiscal year 2002 and $50,000 in fiscal year 2003 is for training of individuals who will provide treatment and prevention for minority or underserved populations. This is a one-time appropriation and shall not become part of the base level funding for the 2004-2005 biennium;

(11) $750,000 in fiscal year 2002 is for a grant to reconstruct project turnabout in Granite Falls that was destroyed by the Granite Falls tornado. This is a one-time appropriation and shall not become part of the base appropriation for the 2004-2005 biennium; and

(12) $150,000 in fiscal year 2002 and $150,000 in fiscal year 2003 is for a grant to a compulsive gambling council located in St. Louis county. The gambling council shall provide a statewide compulsive gambling prevention and education project for adolescents. This is a one-time appropriation and shall not become part of the base appropriation for the 2004-2005 biennium.

The unencumbered balance of the appropriation from the lottery prize fund in the first year of the biennium does not cancel but is available for the second year.

(e) Community Support Grants

12,555,000 12,815,000

(f) Medical Assistance Long-Term Care Waivers and Home Care

452,925,000 536,099,000

[NURSING FACILITY OPERATED BY THE RED LAKE BAND OF CHIPPEWA INDIANS.] (1) The medical assistance payment rates for the 47-bed nursing facility operated by the Red Lake Band of Chippewa Indians must be calculated according to allowable reimbursement costs under the medical assistance program, as specified in Minnesota Statutes, section 246.50, and are subject to the facility-specific Medicare upper limits.

(2) In addition, the commissioner shall make available rate adjustments for the biennium beginning July 1, 2001, on the same basis as the adjustments provided to nursing facilities under Minnesota Statutes, section 256B.431. The commissioner must use the facility's final 2000 and 2001 Medicare cost reports to calculate the adjustments. This rate increase shall become part of the facility's base rate for future rate years.

(g) Medical Assistance Long-Term Care Facilities

574,687,000 575,318,000

[LONG-TERM CARE CONSULTATION SERVICES.] Long-term care consultation services payments to all counties shall continue at the payment amount in effect for preadmission screening in fiscal year 2001, as adjusted for county participation in the access demonstration project.

[MORATORIUM EXCEPTION ADMINISTRATIVE PROCESS.] Of this appropriation, $350,000 in fiscal year 2002 and $650,000 in fiscal year 2003 is for the moratorium exception administrative process under Minnesota Statutes, section 144A.073. The annualized state share of medical assistance costs for projects approved during each year of the biennium must not exceed $1,400,000.

[RATE INCREASE APPLICABILITY.] The nursing facility rate increase provided under

Minnesota Statutes, section 256B.431, subdivision 32, for the first 90 paid days of an admission shall apply only to admissions occurring on or after July 1, 2001.

(h) Alternative Care Grants

| | | |
|---|---|---|
| General | 76,204,000 | 90,680,000 |

[ALTERNATIVE CARE TRANSFER.] Any money allocated to the alternative care program that is not spent for the purposes indicated does not cancel but shall be transferred to the medical assistance account.

[ALTERNATIVE CARE APPROPRIATION.] The commissioner may expend the money appropriated for the alternative care program for that purpose in either year of the biennium.

(i) Group Residential Housing

| | | |
|---|---|---|
| General | 80,228,000 | 88,583,000 |

(j) Chemical Dependency Entitlement Grants

| | | |
|---|---|---|
| General | 42,330,000 | 45,213,000 |

(k) Chemical Dependency Nonentitlement Grants

| | | |
|---|---|---|
| General | 6,328,000 | 6,328,000 |

Subd. 10. Continuing Care Management

| | | |
|---|---|---|
| General | 22,215,000 | 22,421,000 |
| State Government Special Revenue | 117,000 | 119,000 |
| Lottery Cash Flow | 240,000 | 240,000 |

[COUNTY INVOLVEMENT COSTS.] Of the general fund appropriation, up to $384,000 in fiscal year 2002 and up to $514,000 in fiscal year 2003 is for the commissioner to allocate to counties for resident relocation costs resulting from planned closures under Minnesota Statutes, section 256B.437, and resident relocations under Minnesota Statutes, section 144A.161. Unexpended funds for fiscal year 2002 do not cancel but are available to the commissioner for this purpose in fiscal year 2003.

[COMPULSIVE GAMBLING ADMINISTRATION.] Of the lottery cash flow appropriation, $240,000 in fiscal year 2002 and $240,000 in fiscal year 2003 is for administration of the compulsive gambling treatment program.

Subd. 11. Economic Support Grants

| | | |
|---|---|---|
| General | 134,006,000 | 137,928,000 |

| | | |
|---|---|---|
| Federal TANF | 223,257,000 | 232,111,000 |

The amounts that may be spent from this appropriation for each purpose are as follows:

| | | |
|---|---|---|
| (a) Assistance to Families Grants | | |
| General | 69,932,000 | 72,531,000 |
| Federal TANF | 115,732,000 | 107,116,000 |
| (b) Work Grants | | |
| General | 9,844,000 | 9,844,000 |
| Federal TANF | 68,513,000 | 68,513,000 |

[LOCAL INTERVENTION GRANTS FOR SELF-SUFFICIENCY CARRYFORWARD.] Unexpended funds appropriated for local intervention grants under Minnesota Statutes, section 256J.625, for fiscal year 2002 do not cancel but are available to the commissioner for these purposes in fiscal year 2003.

[SOUTHEAST ASIAN TRANSITIONAL EMPLOYMENT TRAINING PROJECT.] (a) Federal TANF funds, as specified in this paragraph, are appropriated to the commissioner for a grant to a nonprofit collaborative in Hennepin county specializing in services to Southeast Asians for an "intensive intervention" transitional employment training project to move refugee and immigrant welfare recipients into unsubsidized employment leading to self-sufficiency. $800,000 in fiscal year 2002 and $800,000 in fiscal year 2003 is appropriated to the commissioner for a grant to a nonprofit collaborative in Hennepin county specializing in services to Southeast Asians. This is a one-time appropriation and shall not become part of the base level funding for the 2004-2005 biennium.

(b) One of the five partners in the collaborative shall be chosen as the fiscal agent by the commissioner. The primary effort must be on intensive employment skills training, including workplace English and overcoming cultural barriers, and on specialized training in fields of work which involve a credit-based curriculum. For recipients without a high school diploma or a GED, extra effort shall be made to help the recipient meet the "ability to benefit test" so the recipient can receive financial aid for further training. During the specialized training, efforts shall be made to involve the recipients with an internship program and retention specialist. Up to ten percent of the grant shall be used for other efforts to make the recipient families more self-sufficient as provided within TANF rules.

| | | |
|---|---|---|
| (c) Economic Support Grants - Other Assistance | | |
| General | 2,907,000 | 3,065,000 |
| Federal TANF | 38,752,000 | 56,222,000 |

[TANF TRANSFER TO CHILD CARE BLOCK GRANT.] $2,009,000 for fiscal year 2002 and $16,097,000 for fiscal year 2003 is appropriated to the commissioner of children, families, and learning for the purposes of Minnesota Statutes, section 119B.05. The commissioner of human services shall authorize a sufficient transfer of funds from the state's federal TANF block grant to the state's child care development fund block grant to meet this appropriation.

[WORKING FAMILY CREDIT.] (a) On a regular basis, the commissioner of revenue, with the assistance of the commissioner of human services, shall calculate the value of the refundable portion of the Minnesota working family credits provided under Minnesota Statutes, section 290.0671, that qualifies for federal reimbursement from the TANF block grant. The commissioner of revenue shall provide the commissioner of human services with such expenditure records and information as are necessary to support draw-down of federal funds.

(b) Federal TANF funds, as specified in this paragraph, are appropriated to the commissioner of human services on calculations under paragraph (a) of working family tax credit expenditures that qualify for reimbursement from the TANF block grant for income tax refunds payable in federal fiscal years beginning October 1, 2001. The draw-down of federal TANF funds shall be made on a regular basis based on calculations of credit expenditures by the commissioner of revenue. $35,743,000 in fiscal year 2002, $39,125,000 in fiscal year 2003, $37,720,000 in fiscal year 2004, and $40,149,000 in fiscal year 2005 are appropriated to the commissioner of human services. These funds shall be transferred to the commissioner of revenue to deposit into the general fund.

[PRIOR YEAR APPROPRIATION REPEALED.] Notwithstanding Laws 2000, chapter 488, article 8, section 2, subdivision 6, as amended by Laws 2000, chapter 499, sections 22 and 39, the commissioner shall not transfer $7,500,000 from the state's federal TANF block

grant to the state's federal Title XX block grant in fiscal year 2002 for purposes of increasing services for families with children whose incomes are at or below 200 percent of the federal poverty guidelines.

[MINNESOTA FOOD ASSISTANCE PROGRAM.] Of the general fund appropriation, $225,000 in fiscal year 2002 and $1,134,000 in fiscal year 2003 is for the Minnesota food assistance program.

(d) Child Support Enforcement

| | | |
|---|---|---|
| General | 4,239,000 | 4,239,000 |
| Federal TANF | 260,000 | 260,000 |

[CHILD SUPPORT PAYMENT CENTER.] Payments to the commissioner from other governmental units, private enterprises, and individuals for services performed by the child support payment center must be deposited in the state systems account authorized under Minnesota Statutes, section 256.014. These payments are appropriated to the commissioner for the operation of the child support payment center or system, according to Minnesota Statutes, section 256.014.

(e) General Assistance

| | | |
|---|---|---|
| General | 17,156,000 | 16,648,000 |

[GENERAL ASSISTANCE STANDARD.] The commissioner shall set the monthly standard of assistance for general assistance units consisting of an adult recipient who is childless and unmarried or living apart from his or her parents or a legal guardian at $203. The commissioner may reduce this amount in accordance with Laws 1997, chapter 85, article 3, section 54.

(f) Minnesota Supplemental Aid

| | | |
|---|---|---|
| General | 29,678,000 | 31,351,000 |

(g) Refugee Services

| | | |
|---|---|---|
| General | 250,000 | 250,000 |

Subd. 12. Economic Support Management

| | | |
|---|---|---|
| General | 45,943,000 | 46,665,000 |
| Health Care Access | 1,333,000 | 1,349,000 |
| Federal TANF | 743,000 | 743,000 |

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) Economic Support Policy Administration

| | | |
|---|---|---|
| General | 8,655,000 | 8,789,000 |
| Federal TANF | 743,000 | 743,000 |

[FOOD STAMP ADMINISTRATIVE REIMBURSEMENT.] The commissioner shall reduce quarterly food stamp administrative reimbursement to counties in fiscal years 2002 and 2003 by the amount that the United States Department of Health and Human Services determines to be the county random moment study share of the food stamp adjustment under Public Law Number 105-185. The reductions shall be allocated to each county in proportion to each county's contribution, if any, to the amount of the adjustment. Any adjustment to medical assistance administrative reimbursement that is based on the United States Department of Health and Human Services' determinations under Public Law Number 105-185 shall be distributed to counties in the same manner.

(b) Economic Support Operations

| | | |
|---|---|---|
| General | 37,288,000 | 37,876,000 |
| Health Care Access | 1,333,000 | 1,349,000 |

[SPENDING AUTHORITY FOR FOOD STAMP ENHANCED FUNDING.] In the event that Minnesota qualifies for United States Department of Agriculture Food and Nutrition Services Food Stamp Program enhanced funding beginning in federal fiscal year 1998, the money is appropriated to the commissioner for the purposes of the program. The commissioner may retain 25 percent of the enhanced funding, with the remaining 75 percent divided among the counties according to a formula that takes into account each county's impact on the statewide food stamp error rate.

[FINANCIAL INSTITUTION DATA MATCH AND PAYMENT OF FEES.] The commissioner is authorized to allocate up to $310,000 in each year of the biennium from the PRISM special revenue account to make payments to financial institutions in exchange for performing data matches between account information held by financial institutions and the public authority's database of child support obligors as authorized by Minnesota Statutes, section 13B.06, subdivision 7.

Sec. 3. COMMISSIONER OF HEALTH

| | | | | |
|---|---|---|---|---|
| Subdivision 1. Total Appropriation | | | 131,062,000 | 130,155,000 |
| | Summary by Fund | | | |
| General | | 83,758,000 | 87,535,000 | |
| State Government Special Revenue | | 26,829,000 | 28,713,000 | |
| Health Care Access | | 13,935,000 | 7,367,000 | |
| Federal TANF | | 6,540,000 | 6,540,000 | |
| Subd. 2. Family and Community Health | | | 68,329,000 | 72,485,000 |
| | Summary by Fund | | | |
| General | | 57,146,000 | 60,246,000 | |
| State Government Special Revenue | | 961,000 | 1,987,000 | |
| Health Care Access | | 3,682,000 | 3,712,000 | |
| Federal TANF | | 6,540,000 | 6,540,000 | |

[HEALTH DISPARITIES.] Of the general fund appropriation, $6,450,000 in fiscal year 2002 and $7,450,000 in fiscal year 2003 is for reducing health disparities to be spent as follows:

(1) $3,400,000 the first year and $4,150,000 the second year for grants to community organizations for prevention services targeted to populations affected by health disparities;

(2) $2,150,000 the first year and $2,350,000 the second year for grants to community health boards.

(3) $500,000 each year for grants to tribal governments to support efforts to identify and implement culturally based community interventions that reduce health disparities for American Indians;

(4) $200,000 the first year and $250,000 the second year for distribution to the community health boards in accordance with Minnesota Statutes, section 145.9269, subdivision 9, for health screening and follow-up services for foreign-born persons; and

(5) $200,000 each year for state administrative costs.

[IMMUNIZATION INFORMATION SERVICE.] Of the general fund appropriation, $1,000,000 the first year and $2,000,000 the second year is available to the commissioner for

grants to community health boards as defined in Minnesota Statutes, section 145A.02, to support the development of a statewide immunization information service and to support maintenance of current registry activities related to tracking medical assistance-eligible children.

[PROMOTING HEALTHY LIFESTYLES.] $6,540,000 from the TANF fund in fiscal years 2002 and 2003 is appropriated to the commissioner to award grants to promote healthy behaviors among youth in accordance with Minnesota Statutes, section 145.9263.

Of this amount, $3,000,000 is for local grants under Minnesota Statutes, section 145.9263, subdivision 2; $3,000,000 is for community youth grants under Minnesota Statutes, section 145.9263, subdivision 3; $480,000 is for a statewide outreach campaign under Minnesota Statutes, section 145.9263, subdivision 4; and $60,000 is for training and technical assistance.

[PROMOTING HEALTHY LIFESTYLES CARRYFORWARD.] Any unexpended balance of the TANF funds appropriated for the promoting healthy lifestyles grant program established under Minnesota Statutes, section 145.9263, in the first fiscal year of the biennium does not cancel but is available for the second year.

[HEALTH WORKFORCE DEVELOPMENT.] Of the general fund appropriation, $1,003,000 in the first year and $1,967,000 in the second year is to expand the health professionals loan program, of which $963,000 in the first year and $1,927,000 in the second year is for direct grants to increase the placement of physicians, dentists, pharmacists, mental health providers, health care technicians in rural communities, and nurses in nursing homes, ICFs/MR, and home health care agencies statewide.

[POISON INFORMATION SYSTEM.] Of the general fund appropriation, $1,360,000 each fiscal year is for poison control system grants under Minnesota Statutes, section 145.93.

[WIC TRANSFERS.] The general fund appropriation for the women, infants, and children (WIC) food supplement program is available for either year of the biennium. Transfers of these funds between fiscal years must be either to maximize federal funds or to minimize fluctuations in the number of program participants.

[MINNESOTA CHILDREN WITH SPECIAL HEALTH NEEDS CARRYFORWARD.] General fund appropriations for treatment services in the services for Minnesota children with special health needs program are available for either year of the biennium.

[HOME VISITING PROGRAM.] Of the general fund appropriation, $7,000,000 each year is for distribution to county boards according to the formula in Minnesota Statutes, section 256J.625, subdivision 3, to be used by county public health boards to serve families with incomes at or below 200 percent of the federal poverty guidelines, in the manner specified by Minnesota Statutes, section 145A.16, subdivision 3, clauses (2), (3), (4), (5), and (6). Training, evaluation, and technical assistance shall be provided in accordance with Minnesota Statutes, section 145A.16, subdivisions 5, 6, and 7. This appropriation shall not become a part of the agency's base funding for the 2004-2005 biennium.

[HOME VISITING TANF BASE REDUCTION.] Notwithstanding Laws 2000, chapter 488, article 8, section 2, subdivision 6, as amended by Laws 2000, chapter 499, sections 22 and 39, base level funding from the state's federal TANF block grant for the home visiting program under Minnesota Statutes, section 145A.16, for fiscal year 2002 and fiscal year 2003 is zero.

[SUICIDE PREVENTION.] Of the general fund appropriation, $1,025,000 each year is to fund community-based suicide prevention programs under Minnesota Statutes, section 145.56, subdivision 2, and $75,000 each year is for the commissioner for suicide prevention activities under Minnesota Statutes, section 145.56, subdivisions 1, 3, 4, and 5.

| | | |
|---|---|---|
| Subd. 3. Access and Quality Improvement | 27,028,000 | 20,480,000 |

Summary by Fund

| | | |
|---|---|---|
| General | 8,263,000 | 8,231,000 |
| State Government Special Revenue | 8,512,000 | 8,594,000 |
| Health Care Access | 10,253,000 | 3,655,000 |

[STOP-LOSS FUND.] Of the health care access fund appropriation, $200,000 the first year and $50,000 the second year is for grants to

organizations developing health care purchasing alliances established under Minnesota Statutes, chapter 62T. Of this appropriation, $50,000 the first year is for a grant to the University of Minnesota-Crookston to support the northwest purchasing alliance; $50,000 the first year is for a grant to the southwest regional development commission to support the southwest purchasing alliance; $50,000 the first year is for a grant to the arrowhead regional development commission to support the development of a northeast Minnesota purchasing alliance; and $50,000 each year is for a grant to the Brainerd lakes area chamber of commerce education association to support the north central purchasing alliance. The state grants must be matched on a one-to-one basis by nonstate funds. This is a one-time appropriation and shall not become part of the base level funding for the 2004-2005 biennium.

[HEALTH CARE SAFETY NET.] Of the health care access fund appropriation, $6,500,000 the first year is to provide financial support to Minnesota health care safety net providers. This appropriation shall not become part of base funding for the agency for the 2004-2005 biennium. Of the amounts available:

(1) $2,000,000 is for a grant program to aid safety net community clinics;

(2) $2,000,000 is to be transferred to the Minnesota comprehensive health association (MCHA); and

(3) $2,500,000 is for a grant program to provide rural hospital capital improvement grants described in Minnesota Statutes, section 144.148.

[GRANTS TO COMMUNITY CLINICS.] Of the general fund appropriation, $2,000,000 each year is for grants to eligible community clinics under Minnesota Statutes, section 145.9268, to improve the ongoing viability of Minnesota's clinic-based safety net providers. This appropriation is contingent on federal approval of the intergovernmental transfers and payments to safety net hospitals authorized under Minnesota Statutes, section 256B.195. This appropriation shall become part of base level funding for the 2004-2005 biennium.

[HOME CARE PROVIDERS FEE WAIVER.] Notwithstanding the provisions of Minnesota Rules, chapter 4669, and Minnesota Statutes,

section 144A.4605, subdivision 5, the commissioner of health may, during the biennium beginning July 1, 2001, waive license fees for all home care providers who hold a current license as of June 30, 2001, for the purpose of reducing surplus home care fees in the state government special revenue fund.

[RURAL AMBULANCE STUDY.] (a) The commissioner shall direct the rural health advisory committee to conduct a study and make recommendations regarding the challenges faced by rural ambulance services related to: personnel shortages for volunteer ambulance services; personnel shortages for full-time, paid ambulance services; funding for ambulance operations; and the impact on rural ambulance services from changes in ambulance reimbursement as a result of the federal Balanced Budget Act of 1997, Public Law Number 105-33.

(b) The advisory committee may also examine and make recommendations on:

(1) whether state law allows adequate flexibility to address operational and staffing problems encountered by rural ambulance services; and

(2) whether current incentive programs, such as the volunteer ambulance recruitment program and state reimbursement for volunteer training, are adequate to ensure ambulance service volunteers will be available in rural areas.

(c) The advisory committee shall identify existing state, regional, and local resources supporting the provision of local ambulance services in rural areas.

(d) The advisory committee shall, if appropriate, make recommendations for addressing alternative delivery models for rural volunteer ambulance services. Such alternatives may include, but are not limited to, multiprovider service coalitions, purchasing cooperatives, regional response strategies, and different utilization of first responder and rescue squads.

(e) In conducting its study, the advisory committee shall consult with groups broadly representative of rural health and emergency medical services. Such groups may include: local elected officials; ambulance and emergency medical services associations; hospitals and nursing homes; physicians, nurses, and mid-level practitioners; rural health groups; the emergency medical services regulatory board and regional

emergency medical services boards; and fire and sheriff's departments.

(f) The advisory committee shall report its findings and recommendations to the commissioner by September 1, 2002.

| | | |
|---|---|---|
| Subd. 4. Health Protection | 30,250,000 | 31,323,000 |
| Summary by Fund | | |
| General | 13,045,000 | 13,346,000 |
| State Government Special Revenue | 17,205,000 | 17,977,000 |

[EMERGING HEALTH THREATS.] (a) Of the general fund appropriation, $750,000 in the first year and $850,000 in the second year is to maintain the state capacity to identify and respond to emerging health threats.

(b) Of these amounts, $450,000 in the first year and $550,000 in the second year is to expand state laboratory capacity to identify infectious disease organisms, evaluate environmental contaminants, and develop new analytical techniques to deal with biological and chemical health threats.

(c) $300,000 each year is to train, consult, and otherwise assist local officials responding to clandestine drug laboratories and minimizing health risks to responders and the public. The commissioner is authorized to bill local governments to reimburse the general fund for the costs incurred.

[SEXUALLY TRANSMITTED INFECTIONS.] Of the general fund appropriation, $150,000 each year is to increase access to free screening for sexually transmitted infections, including efforts to provide screening to members of high-risk communities, and $250,000 each year is for grants to community-based organizations and local public health entities to increase the screening of members of high-risk communities. These appropriations shall become part of the base level funding for the 2004-2005 biennium.

[BASE FUNDING TRANSFER.] $250,000 each fiscal year is transferred from the base appropriation for sexually transmitted disease program operations to the HIV grants program and shall become part of base level funding for the HIV grants program for the 2004-2005 biennium.

[COMMUNITY HEALTH EDUCATION AND PROMOTION PROGRAM ON FOOD

SAFETY.] (a) Of the general fund appropriation, $200,000 each year is for a grant to the city of Minneapolis to establish a community-based health education and promotion program on food safety in the Latino, Somali, and Southeast Asian communities.

(b) The program shall consist of direct training of food industry operators and workers on safe handling of food and proper operation of food establishments and a community consumer awareness campaign to increase community awareness of food safety and access to food regulatory services.

(c) This is a one-time appropriation and shall not become part of the base level funding for the 2004-2005 biennium.

| | | | | |
|---|---|---|---|---|
| Subd. 5. Management and Support Services | | | 5,455,000 | 5,867,000 |
| | Summary by Fund | | | |
| General | 5,304,000 | 5,712,000 | | |
| State Government Special Revenue | 151,000 | 155,000 | | |
| Sec. 4. VETERANS NURSING HOMES BOARD | | | 30,948,000 | 32,030,000 |

[VETERANS HOMES SPECIAL REVENUE ACCOUNT.] The general fund appropriations made to the board may be transferred to a veterans homes special revenue account in the special revenue fund in the same manner as other receipts are deposited according to Minnesota Statutes, section 198.34, and are appropriated to the board for the operation of board facilities and programs.

[SETTING COST OF CARE.] The cost of care for the domiciliary residents at the Minneapolis veterans home for fiscal year 2002 and fiscal year 2003 shall be calculated based on 100 percent occupancy.

[DEFICIENCY FUNDING.] Of the general fund appropriation in fiscal year 2002, $2,000,000 is available with the approval of the commissioner of finance. Approval of the commissioner of finance is contingent upon review of the board's submittal of a report outlining the following:

(1) a long-term revenue outlook for the homes;

(2) a review and recommendation of alternative funding sources for the homes' operations; and

(3) administrative and service options to bring cost growth in line with revenues.

Sec. 5. HEALTH-RELATED BOARDS

| | | |
|---|---|---|
| Subdivision 1. Total Appropriation | 11,199,000 | 11,424,000 |
| [STATE GOVERNMENT SPECIAL REVENUE FUND.] The appropriations in this section are from the state government special revenue fund. | | |
| [NO SPENDING IN EXCESS OF REVENUES.] The commissioner of finance shall not permit the allotment, encumbrance, or expenditure of money appropriated in this section in excess of the anticipated biennial revenues or accumulated surplus revenues from fees collected by the boards. Neither this provision nor Minnesota Statutes, section 214.06, applies to transfers from the general contingent account. | | |
| Subd. 2. Board of Chiropractic Examiners | 372,000 | 384,000 |
| Subd. 3. Board of Dentistry | 946,000 | 855,000 |
| [EXPANDED DUTIES.] Of this appropriation, $115,000 in fiscal year 2002 is to the board for the costs associated with the expanded duties relative to the regulation of dental hygienists and foreign-trained dentists. This is a one-time appropriation and shall not become part of the base level funding for the 2004-2005 biennium. | | |
| Subd. 4. Board of Dietetic and Nutrition Practice | 98,000 | 101,000 |
| Subd. 5. Board of Marriage and Family Therapy | 114,000 | 118,000 |
| [FEE INCREASE.] The board may increase fees to meet the requirements of Minnesota Statutes, section 214.06. | | |
| Subd. 6. Board of Medical Practice | 3,334,000 | 3,400,000 |
| Subd. 7. Board of Nursing | 2,789,000 | 2,902,000 |
| [DEVELOPMENT OF POSTERS.] Of this appropriation, $20,000 in fiscal year 2002 is for the board to develop and distribute posters that may be used by facilities to satisfy the requirements of Minnesota Statutes, section 144.582, subdivision 4. | | |
| [HEALTH PROFESSIONAL SERVICES ACTIVITY.] Of these appropriations, $515,,000 the first year and $546,000 the second year are for the health professional services activity. | | |
| [FEE INCREASE.] The board may increase fees | | |

| | | |
|---|---|---|
| to meet the requirements of Minnesota Statutes, section 214.06. | | |
| Subd. 8. Board of Nursing Home Administrators | 200,000 | 198,000 |
| Subd. 9. Board of Optometry | 93,000 | 96,000 |
| Subd. 10. Board of Pharmacy | 1,336,000 | 1,386,000 |
| [ADMINISTRATIVE SERVICES UNIT.] Of this appropriation, $354,000 the first year and $359,000 the second year are for the health boards administrative services unit. The administrative services unit may receive and expend reimbursements for services performed for other agencies. | | |
| Subd. 11. Board of Physical Therapy | 191,000 | 197,000 |
| Subd. 12. Board of Podiatry | 53,000 | 45,000 |
| Subd. 13. Board of Psychology | 669,000 | 680,000 |
| Subd. 14. Board of Social Work | 846,000 | 873,000 |
| Subd. 15. Board of Veterinary Medicine | 158,000 | 189,000 |
| Sec. 6. EMERGENCY MEDICAL SERVICES BOARD | 2,663,000 | 2,675,000 |
| [COMPREHENSIVE ADVANCED LIFE SUPPORT EDUCATIONAL PROGRAM.] Of this appropriation, $200,000 in fiscal year 2002 and $200,000 in fiscal year 2003 is to increase funding for the comprehensive advanced life support educational program under Minnesota Statutes, section 144E.37. This appropriation shall become part of base level funding for the 2004-2005 biennium. | | |
| [AUTOMATIC DEFIBRILLATOR STUDY.] Of this appropriation, $25,000 in fiscal year 2002 is to the board to study, in consultation with the commissioner of public safety, and report to the legislature by December 15, 2002, regarding the availability of automatic defibrillators outside the seven-county metropolitan area. The report shall include recommendations to make these devices accessible within a reasonable distance through the nonmetropolitan area, including recommendations for funding their acquisition and distribution. | | |
| Sec. 7. COUNCIL ON DISABILITY | 692,000 | 714,000 |
| Sec. 8. OMBUDSMAN FOR MENTAL HEALTH AND MENTAL RETARDATION | 1,752,000 | 1,568,000 |
| [CENTER FOR OMBUDSMAN SERVICES.] (a) Of this appropriation, $250,000 in fiscal year 2002 is for the one-time costs of establishing a | | |

center for Minnesota ombudsman services. Unexpended funds for fiscal year 2002 do not cancel but are available for this purpose in fiscal year 2003.

(b) The following agencies shall colocate to establish the center: the ombudsman for corrections, the crime victims ombudsman, the ombudsman for mental health and mental retardation, the ombudsman for older Minnesotans, the ombudsman for state-managed health care programs, and the ombudsman for families.

(c) Each agency described in paragraph (b) shall retain its statutory authority and funding for the special populations served.

(d) Each agency described in paragraph (b) shall contribute to the shared operational expenses and shall pool administrative capabilities and resources as appropriate in at least the following areas: purchasing, payroll, human resources, information technology, inventory, leasing, contracts, and telecommunications.

(e) The functions described in paragraph (d) shall be administered by a board composed of the six ombudspersons referenced in paragraph (b).

(f) The center shall make a preliminary report to the legislature by January 15, 2003, and a final report by January 15, 2004, on implementation of the colocation requirement.

| | | |
|---|---|---|
| Sec. 9. OMBUDSMAN FOR FAMILIES | 251,000 | 256,000 |

Sec. 10. TRANSFERS

Subdivision 1. Grants

The commissioner of human services, with the approval of the commissioner of finance, and after notification of the chair of the senate health and family security budget division and the chair of the house health and human services finance committee, may transfer unencumbered appropriation balances for the biennium ending June 30, 2003, within fiscal years among the MFIP, general assistance, general assistance medical care, medical assistance, Minnesota supplemental aid, and group residential housing programs, and the entitlement portion of the chemical dependency consolidated treatment fund, and between fiscal years of the biennium.

Subd. 2. Administration

Positions, salary money, and nonsalary administrative money may be transferred within the departments of human services and health and within the programs operated by the veterans nursing homes board as the commissioners and the board consider necessary, with the advance approval of the commissioner of finance. The commissioner or the board shall inform the chairs of the house health and human services finance committee and the senate health and family security budget division quarterly about transfers made under this provision.

Subd. 3. Prohibited Transfers

Grant money shall not be transferred to operations within the departments of human services and health and within the programs operated by the veterans nursing homes board without the approval of the legislature.

Sec. 11. MINNESOTACARE AVAILABILITY

Of the appropriation for MinnesotaCare for fiscal year 2002, an amount sufficient to fund a fiscal year 2001 deficiency is available in fiscal year 2001. This amount shall be determined by the commissioner of human services with the approval of the commissioner of finance.

Sec. 12. INDIRECT COSTS NOT TO FUND PROGRAMS.

The commissioners of health and of human services shall not use indirect cost allocations to pay for the operational costs of any program for which they are responsible.

Sec. 13. CARRYOVER LIMITATION

None of the appropriations in this act which are allowed to be carried forward from fiscal year 2002 to fiscal year 2003 shall become part of the base level funding for the 2004-2005 biennial budget, unless specifically directed by the legislature.

Sec. 14. SUNSET OF UNCODIFIED LANGUAGE

All uncodified language contained in this article expires on June 30, 2003, unless a different expiration date is explicit.

Sec. 15. Minnesota Statutes 2000, section 16A.06, is amended by adding a subdivision to read:

Subd. 10. [TRANSFERS TO HEALTH CARE ACCESS FUND.] For fiscal years beginning on or after July 1, 2002, the commissioner shall transfer from the general fund to the health care access fund an amount equal to the state share of the cost of covering children in families with income under 185 percent of the federal poverty guidelines. In determining the amount of this transfer, the commissioner shall disregard MinnesotaCare program changes enacted after July 1, 2001.

Sec. 16. [246.141] [PROJECT LABOR.]

Wages for project labor may be paid by the commissioner out of repairs and betterments money if the individual is to be engaged in a construction project or a repair project of short-term and nonrecurring nature. Compensation for project labor shall be based on the prevailing wage rates, as defined in section 177.42, subdivision 6. Project laborers are excluded from the provisions of sections 43A.22 to 43A.30, and shall not be eligible for state-paid insurance and benefits.

Sec. 17. Laws 1998, chapter 404, section 18, subdivision 4, is amended to read:

Subd. 4. People, Inc. North Side Community Support Program 375,000

For a grant to ~~Hennepin county~~ People, Inc. to purchase, remodel, and complete accessibility upgrades to an existing building or to acquire land or construct a building to be used by the People, Inc. North Side Community Support Program which may provide office space for state employees.

This appropriation is from the general fund.

Sec. 18. [EFFECTIVE DATE.]

Section 11 is effective the day following final enactment.

ARTICLE 16

CRIMINAL JUSTICE

Section 1. [CRIMINAL JUSTICE APPROPRIATIONS.]

The sums shown in the columns marked "APPROPRIATIONS" are appropriated from the general fund, or another fund named, to the agencies and for the purposes specified in this act, to be available for the fiscal years indicated for each purpose. The figures "2002" and "2003" where used in this article, mean that the appropriation or appropriations listed under them are available for the year ending June 30, 2002, or June 30, 2003, respectively.

SUMMARY BY FUND

| | 2002 | 2003 | TOTAL |
|---|---|---|---|
| General | $ 413,130,000 | $ 428,035,000 | $ 841,165,000 |
| Special Revenue | $ 1,389,000 | $ 1,242,000 | $ 2,631,000 |
| TOTAL | $ 414,519,000 | $ 429,277,000 | $ 843,796,000 |

| | APPROPRIATIONS Available for the Year Ending June 30 2002 | 2003 |
|---|---|---|
| Sec. 2. BOARD OF PUBLIC DEFENSE | | |
| Subdivision 1. Total Appropriation | 51,030,000 | 54,716,000 |

None of this appropriation shall be used to pay for lawsuits against public agencies or public officials to change social or public policy.

During the biennium ending June 30, 2003, the state public defender may, with the approval of the commissioner of finance, transfer funds for

transcript costs from the office of administrative services to the state public defender.

The amounts that may be spent from this appropriation for each program are specified in the following subdivisions.

Subd. 2. State Public Defender

3,450,000 3,734,000

$109,000 the first year and $227,000 the second year are for salary and benefit increases.

Subd. 3. Administrative Services Office

2,467,000 2,553,000

$300,000 the first year and $310,000 the second year are for the statewide corrections information system project.

$32,000 the first year and $68,000 the second year are for salary and benefit increases.

Subd. 4. District Public Defense

45,113,000 48,429,000

$1,326,000 the first year and $1,366,000 the second year are for grants to the five existing public defense corporations under Minnesota Statutes, section 611.216.

$1,315,000 the first year and $3,276,000 the second year are for the part-time public defender viability initiative.

Sec. 3. CORRECTIONS

| | | |
|---|---|---|
| Subdivision 1. Total Appropriation | 362,641,000 | 373,675,000 |
| Summary by Fund | | |
| General | 361,252,000 | 372,433,000 |
| Special Revenue | 1,389,000 | 1,242,000 |

The amounts that may be spent from this appropriation for each program are specified in the following subdivisions.

Any unencumbered balances remaining in the first year do not cancel but are available for the second year of the biennium.

Positions and administrative money may be transferred within the department of corrections as the commissioner considers necessary, upon the advance approval of the commissioner of finance.

For the biennium ending June 30, 2003, the commissioner of corrections may, with the approval of the commissioner of finance, transfer funds to or from salaries.

During the biennium ending June 30, 2003, the commissioner may enter into contracts with private corporations or governmental units of the state of Minnesota to house adult offenders committed to the commissioner of corrections. Every effort shall be made to house individuals committed to the commissioner of corrections in Minnesota correctional facilities.

During the biennium ending June 30, 2003, if it is necessary to reduce services or staffing within a correctional facility, the commissioner or the commissioner's designee shall meet with affected exclusive representatives. The commissioner shall make every reasonable effort to retain correctional officer and prison industry employees should reductions be necessary.

Subd. 2. Correctional Institutions

Summary by Fund

| | | |
|---|---|---|
| General Fund | 225,765,000 | 230,147,000 |
| Special Revenue Fund | 932,000 | 785,000 |

If the commissioner contracts with other states, local units of government, or the federal government to rent beds in the Rush City correctional facility under Minnesota Statutes, section 243.51, subdivision 1, to the extent possible, the commissioner shall charge a per diem under the contract that is equal to or greater than the per diem cost of housing Minnesota inmates in the facility. This per diem cost shall be based on the assumption that the facility is at or near capacity. Notwithstanding any laws to the contrary, the commissioner may use the per diem monies to operate the state correctional institutions.

The commissioner may use any cost savings generated through the implementation of a per diem reduction plan for capital improvements, which will contribute to further per diem reductions at adult correctional facilities.

Subd. 3. Juvenile Services

| | |
|---|---|
| 13,984,000 | 14,283,000 |

In order to maximize federal IV-E funding for state committed juvenile girls, the department of corrections shall make necessary changes to the

Mesabi Academy facility and program in order to be in compliance with IV-E guidelines and requirements. IV-E reimbursement revenue shall be deposited in the state general fund.

Subd. 4. Community Services

Summary by Fund

| | | |
|---|---|---|
| General | 107,923,000 | 114,168,000 |
| Special Revenue | 150,000 | 150,000 |

All money received by the commissioner pursuant to the domestic abuse investigation fee under Minnesota Statutes, section 609.2244, is available for use by the commissioner and is appropriated annually to the commissioner for costs related to conducting the investigations.

$6,125,000 the first year and $7,464,000 the second year are for an increase in community correction act grants under Minnesota Statutes, section 401.10. Counties receiving grants under this appropriation shall continue to spend the local matching funds required in Minnesota Statutes, section 401.12. Counties receiving grants under this appropriation shall consider using a portion of the grant to increase supervision of high risk domestic abuse offenders who are on probation, conditional release, or supervised release by means of caseload reduction so that the number of offenders supervised by officers with specialized caseloads is reduced.

$932,000 the first year and $1,277,000 the second year are for probation and supervised release services.

$621,000 the first year and $851,000 the second year are for county probation officer reimbursements.

$1,265,000 the first year and $1,335,000 the second year are for grants related to restorative justice programs as defined in Minnesota Statutes, section 611A.775. Grant awards must be allocated in a balanced manner among rural, suburban, and urban organizations operating restorative justice programs. Preference must be given to organizations or programs that:

(1) are currently operating and have had successful results;

(2) are community-based; and

(3) are supported by both private and public funding.

$4,283,000 the first year and $8,000,000 the second year are for juvenile residential treatment grants.

Subd. 5. Management Services

| Summary by Fund | | |
|---|---|---|
| General Fund | 13,580,000 | 13,835,000 |
| Special Revenue Fund | 307,000 | 307,000 |

$750,000 the first year and $750,000 the second year are for:

(1) detention grants for the Statewide Supervision System;

(2) out-of-home placement system development;

(3) electronic probation file transfers; and

(4) maintaining and conforming the department's systems to the CriMNet standards and backbone, including the Corrections Operational Management System (COMS), Statewide Supervision System (SSS), Detention Information System (DIS), Court Services Tracking System (CSTS), and the sentencing guidelines worksheet system.

This money may not be used by the commissioner for any other purpose.

$10,000 the first year and $10,000 the second year are for clergy reimbursements under Minnesota Statutes, section 241.052.

| | | |
|---|---|---|
| Sec. 4. CORRECTIONS OMBUDSMAN | 323,000 | 336,000 |
| Sec. 5. SENTENCING GUIDELINES COMMISSION | 525,000 | 550,000 |

Sec. 6. Minnesota Statutes 2000, section 15A.083, subdivision 4, is amended to read:

Subd. 4. [RANGES FOR OTHER JUDICIAL POSITIONS.] Salaries or salary ranges are provided for the following positions in the judicial branch of government. The appointing authority of any position for which a salary range has been provided shall fix the individual salary within the prescribed range, considering the qualifications and overall performance of the employee. The supreme court shall set the salary of the state court administrator and the salaries of district court administrators. The salary of the state court administrator or a district court administrator may not exceed the salary of a district court judge. If district court administrators die, the amounts of their unpaid salaries for the months in which their deaths occur must be paid to their estates. The salary of the state public defender ~~must be 95 percent of the salary of the attorney general~~ shall be fixed by the state board of public defense but must not exceed the salary of a district court judge.

| | Salary or Range Effective July 1, 1994 |
|---|---|
| Board on judicial standards executive director | $44,000-60,000 |

Sec. 7. [241.052] [CLERGY COMPENSATION.]

Subject to the availability of money specifically appropriated for this purpose, the commissioner of corrections shall reimburse, upon request, the instate travel and lodging expenses of members of the clergy of good standing in any church or denomination for imparting religious rites or instruction at correctional facilities under the commissioner's control.

Sec. 8. Minnesota Statutes 2000, section 241.272, subdivision 6, is amended to read:

Subd. 6. [USE OF FEES.] Excluding correctional fees collected from offenders supervised by department agents under the authority of section 244.19, subdivision 1, paragraph (a), clause (3), all correctional fees collected under this section go to the general fund. One-half of the fees collected by agents under the authority of section 244.19, subdivision 1, paragraph (a), clause (3), shall go to the county treasurer in the county where supervision is provided. The remaining one-half of the fees go to the general fund. Fees retained by counties may only be used in accordance with section 244.18, subdivision 6.

Sec. 9. Minnesota Statutes 2000, section 242.192, is amended to read:

242.192 [CHARGES TO COUNTIES.]

(a) Until June 30, ~~2001~~ 2002, the commissioner shall charge counties or other appropriate jurisdictions 65 percent of the per diem cost of confinement, excluding educational costs and nonbillable service, of juveniles at the Minnesota correctional facility-Red Wing and of juvenile females committed to the commissioner of corrections. This charge applies to juveniles committed to the commissioner of corrections and juveniles admitted to the Minnesota correctional facility-Red Wing under established admissions criteria. This charge applies to both counties that participate in the Community Corrections Act and those that do not. The commissioner shall determine the per diem cost of confinement based on projected population, pricing incentives, market conditions, and the requirement that expense and revenue balance out over a period of two years. All money received under this section must be deposited in the state treasury and credited to the general fund.

(b) Until June 30, ~~2001~~ 2002, the department of corrections shall be responsible for 35 percent of the per diem cost of confinement described in this section.

Sec. 10. Minnesota Statutes 2000, section 611.23, is amended to read:

611.23 [OFFICE OF STATE PUBLIC DEFENDER; APPOINTMENT; SALARY.]

The state public defender is responsible to the state board of public defense. The state public defender shall be appointed by the state board of public defense for a term of four years, except as otherwise provided in this section, and until a successor is appointed and qualified. The state public defender shall be a full-time qualified attorney, licensed to practice law in this state, serve in the unclassified service of the state, and be removed only for cause by the appointing authority. Vacancies in the office shall be filled by the appointing authority for the unexpired term. The salary of the state public defender shall be fixed by the state board of public defense but must not exceed the salary of ~~the chief deputy attorney general~~ a district court judge. Terms of the state public defender shall commence on July 1. The state public defender shall devote full time to the performance of duties and shall not engage in the general practice of law.

Sec. 11. Laws 1999, chapter 216, article 1, section 13, subdivision 4, is amended to read:

Subd. 4. Community Services

| Summary by Fund | | |
|---|---|---|
| General | 95,327,000 | 97,416,000 |
| Special Revenue | 90,000 | 90,000 |

All money received by the commissioner of corrections pursuant to the domestic abuse investigation fee under Minnesota Statutes, section 609.2244, is available for use by the

commissioner and is appropriated annually to the commissioner of corrections for costs related to conducting the investigations.

$500,000 the first year and $500,000 the second year are for increased funding for intensive community supervision.

$1,500,000 the first year and $3,500,000 the second year are for a statewide probation and supervised release caseload and workload reduction grant program. Counties that deliver correctional services through Minnesota Statutes, chapter 244, and that qualify for new probation officers under this program shall receive full reimbursement for the officers' salaries and reimbursement for the officers' benefits and support as set forth in the probations standards task force report, not to exceed $70,000 per officer annually. Positions funded by this appropriation may not supplant existing services. Position control numbers for these positions must be annually reported to the commissioner of corrections.

The commissioner shall distribute money appropriated for state and county probation officer caseload and workload reduction, increased supervised release and probation services, and county probation officer reimbursement according to the formula contained in Minnesota Statutes, section 401.10. These appropriations may not be used to supplant existing state or county probation officer positions or existing correctional services or programs. The money appropriated under this provision is intended to reduce state and county probation officer caseload and workload overcrowding and to increase supervision of individuals sentenced to probation at the county level. This increased supervision may be accomplished through a variety of methods, including, but not limited to:

(1) innovative technology services, such as automated probation reporting systems and electronic monitoring;

(2) prevention and diversion programs;

(3) intergovernmental cooperation agreements between local governments and appropriate community resources; and

(4) traditional probation program services.

By January 15, 2001, the commissioner of corrections shall report to the chairs and ranking minority members of the senate and house

committees and divisions having jurisdiction over criminal justice funding on the outcomes achieved through the use of state probation caseload reduction appropriations made since 1995. The commissioner shall, to the extent possible, include an analysis of the ongoing results relating to the measures described in the uniform statewide probation outcome measures workgroup's 1998 report to the legislature.

$150,000 each year is for a grant to the Dodge-Filmore-Olmsted community corrections agency for a pilot project to increase supervision of sex offenders who are on probation, intensive community supervision, supervised release, or intensive supervised release by means of caseload reduction. The grant shall be used to reduce the number of offenders supervised by officers with specialized caseloads to an average of 35 offenders. This is a one-time appropriation. The grant recipient shall report by January 15, 2002, to the House and Senate committees and divisions with jurisdiction over criminal justice policy and funding on the outcomes of the pilot project.

$175,000 the first year and $175,000 the second year are for county probation officer reimbursements.

$50,000 the first year and $50,000 the second year are for the emergency housing initiative. The commissioner of corrections may enter into rental agreements per industry standards for emergency housing.

$150,000 the first year and $150,000 the second year are for probation and supervised release services.

$250,000 the first year and $250,000 the second year are for increased funding of the sentencing to service program and for a housing coordinator for the institution work crews in the sentencing to serve program.

$25,000 the first year and $25,000 the second year are for sex offender transition programming.

$250,000 each year is for increased bed capacity for work release offenders.

$50,000 each year is for programming for adult female offenders.

The following amounts are one-time appropriations for the statewide productive day initiative program defined in Minnesota Statutes, section 241.275:

$472,000 to the Hennepin county community corrections agency;

$472,000 to the Ramsey county community corrections agency;

$590,000 to the Arrowhead regional community corrections agency;

$425,000 to the Dodge-Fillmore-Olmsted community corrections agency;

$283,000 to the Anoka county community corrections agency; and

$118,000 to the Tri-county (Polk, Norman, and Red Lake) community corrections agency.

$250,000 the first year and $250,000 the second year are for grants to Dakota county for the community justice zone pilot project described in article 2, section 24. This is a one-time appropriation.

$230,000 the first year is for grants related to restorative justice programs. The commissioner may make grants to fund new as well as existing programs. This is a one-time appropriation.

The money appropriated for restorative justice program grants under this subdivision may be used to fund the use of restorative justice in domestic abuse cases, except in cases where the restorative justice process that is used includes a meeting at which the offender and victim are both present at the same time. "Domestic abuse" has the meaning given in Minnesota Statutes, section 518B.01, subdivision 2.

$25,000 each year is for the juvenile mentoring project. This is a one-time appropriation.

ARTICLE 17

VITAL STATISTICS"

Amend the title accordingly

## CALL OF THE SENATE

Senator Berglin imposed a call of the Senate for the balance of the proceedings on H.F. No. 1947. The Sergeant at Arms was instructed to bring in the absent members.

Senator Scheevel moved that H.F. No. 1947 be laid on the table.

The question was taken on the adoption of the motion.

The roll was called, and there were yeas 32 and nays 34, as follows:

Those who voted in the affirmative were:

| | | | | |
|---|---|---|---|---|
| Bachmann | Belanger | Berg | Day | Dille |

| | | | | |
|---|---|---|---|---|
| Fischbach | Kierlin | Lessard | Reiter | Stevens |
| Fowler | Kinkel | Limmer | Robling | Stumpf |
| Frederickson | Kleis | Neuville | Sams | Vickerman |
| Johnson, Debbie | Knutson | Olson | Samuelson | |
| Johnson, Doug | Larson | Ourada | Scheevel | |
| Kelly, R.C. | Lesewski | Pariseau | Schwab | |

Those who voted in the negative were:

| | | | | |
|---|---|---|---|---|
| Anderson | Hottinger | Lourey | Pappas | Sabo |
| Berglin | Johnson, Dave | Marty | Pogemiller | Scheid |
| Betzold | Johnson, Dean | Metzen | Price | Terwilliger |
| Chaudhary | Kelley, S.P. | Moe, R.D. | Ranum | Tomassoni |
| Cohen | Kiscaden | Murphy | Rest | Wiener |
| Foley | Krentz | Oliver | Ring | Wiger |
| Higgins | Langseth | Orfield | Robertson | |

The motion did not prevail.

Pursuant to Rule 7.7, Senator Neuville raised a point of order as to whether the Berglin amendment was in order.

The President ruled the point of order not well taken, so the Berglin amendment was in order.

Senator Fischbach moved to amend the Berglin amendment to H.F. No. 1947 as follows:

Page 38, after line 16, insert:

"Sec. 42. [145.4241] [DEFINITIONS.]

Subdivision 1. [APPLICABILITY.] As used in sections 145.4241 to 145.4246, the following terms have the meaning given them.

Subd. 2. [ABORTION.] "Abortion" includes an act, procedure, or use of any instrument, medicine, or drug which is supplied or prescribed for or administered to a woman known to be pregnant with the intention to terminate the pregnancy with an intention other than to increase the probability of live birth, to preserve the life or health of the child after live birth, or to remove a dead fetus.

Subd. 3. [ATTEMPT TO PERFORM AN ABORTION.] "Attempt to perform an abortion" means an act, or an omission of a statutorily required act, that, under the circumstances as the actor believes them to be, constitutes a substantial step in a course of conduct planned to culminate in the performance of an abortion in Minnesota in violation of sections 145.4241 to 145.4246.

Subd. 4. [MEDICAL EMERGENCY.] "Medical emergency" means any condition that, on the basis of the physician's good faith clinical judgment, complicates the medical condition of a pregnant female to the extent that:

(1) an immediate abortion of her pregnancy is necessary to avert her death; or

(2) a 24-hour delay in performing an abortion creates a serious risk of substantial injury or impairment of a major bodily function.

Subd. 5. [PHYSICIAN.] "Physician" means a person licensed under chapter 147.

Subd. 6. [PROBABLE GESTATIONAL AGE OF THE FETUS.] "Probable gestational age of the fetus" means what will, in the judgment of the physician, with reasonable probability, be the gestational age of the fetus at the time the abortion is planned to be performed.

Sec. 43. [145.4242] [INFORMED CONSENT.]

(a) No abortion shall be performed in this state except with the voluntary and informed consent of the female upon whom the abortion is to be performed. Except in the case of a medical emergency, consent to an abortion is voluntary and informed only if the female is told the following, by telephone or in person, by the physician who is to perform the abortion, the referring physician, a registered nurse, or a licensed practical nurse, at least 24 hours prior to the abortion:

(1) the particular medical risks associated with the particular abortion procedure to be employed including, when medically accurate, the risks of infection, hemorrhage, breast cancer, danger to subsequent pregnancies, and infertility;

(2) the probable gestational age of the fetus at the time the abortion is to be performed;

(3) the medical risks associated with carrying to term;

(4) that medical assistance benefits may be available for prenatal care, childbirth, and neonatal care;

(5) that the father is liable to assist in the support of her child except under certain circumstances, even in instances when the father has offered to pay for the abortion;

(6) the availability of a toll-free number and Web site that can provide information on support services during pregnancy and while the child is dependent and offer alternatives to abortion; and

(7) that she has the right to review the printed materials described in section 145.4243, and the printed materials are available on the state Web site.

(b) The physician or the physician's agent shall orally inform the female that the materials have been provided by the state of Minnesota and that they describe the unborn child and list agencies that offer alternatives to abortion.

(c) The physician or the physician's agent shall orally inform the female of the Web site address and toll-free number.

(d) If the female chooses to view the materials, they shall either be given to her at least 24 hours before the abortion or mailed to her at least 72 hours before the abortion by first class mail, or at the woman's request, by certified mail, restricted delivery to addressee, which means the postal employee may only deliver the mail to the addressee. The envelope used by the physician shall not identify the name of the physician or the physician's clinic or business.

(e) If a physical examination, tests, or the availability of other information to the physician subsequently indicates, in the medical judgment of the physician, a revision of the information previously supplied to the patient, that revised information may be communicated to the patient at any time prior to the performance of the abortion.

Sec. 44. [145.4243] [PRINTED INFORMATION.]

Subdivision 1. [MATERIALS.] (a) Within 90 days after the effective date of sections 145.4241 to 145.4246, the department of health shall cause to be published, in English and in each language that is the primary language of two percent or more of the state's population, the printed materials described in paragraphs (b) and (c) in such a way as to ensure that the information is easily comprehensible.

(b) The materials must be designed to inform the female of the probable anatomical and physiological characteristics of the fetus at two-week gestational increments from the time when a female can be known to be pregnant to full term, including any relevant information on the possibility of the fetus' survival and pictures or drawings representing the development of the fetus at two-week gestational increments, provided that any such pictures or drawings must contain the dimensions of the fetus and must be realistic and appropriate for the stage of pregnancy depicted. The materials must be objective, nonjudgmental, and designed to convey only accurate scientific information about the fetus at the various gestational ages.

(c) The materials must contain objective information describing the methods of abortion procedures commonly employed, the medical risks commonly associated with each procedure, the possible detrimental psychological effects of abortion, and the medical risks commonly associated with carrying a child to term.

Subd. 2. [TYPEFACE; AVAILABILITY.] The materials referred to in this section must be

printed in a typeface large enough to be clearly legible. The materials required under this section must be available from the department of health upon request and in appropriate number to any person, facility, or hospital at no cost.

Sec. 45. [145.4244] [PROCEDURE IN CASE OF MEDICAL EMERGENCY.]

When a medical emergency compels the performance of an abortion, the physician shall inform the female, prior to the abortion if possible, of the medical indications supporting the physician's judgment that an abortion is necessary to avert her death or that a 24-hour delay in conformance with section 145.4242 creates a serious risk of substantial injury or impairment of a major bodily function.

Sec. 46. [145.4245] [TOLL-FREE TELEPHONE NUMBER AND WEB SITE.]

Subdivision 1. [RIGHT TO KNOW.] All pregnant women have the right to know information about resources available to assist them and their families. The commissioner of health shall establish and maintain a statewide toll-free telephone number available seven days a week to provide information and referrals to local community resources to assist women and families through pregnancy and childbirth and while the child is dependent.

Subd. 2. [INFORMATION.] The toll-free telephone number must provide information regarding community resources on the following topics:

(1) information regarding avoiding unplanned pregnancies;

(2) prenatal care, including the need for an initial risk screening and assessment;

(3) adoption;

(4) health education, including the importance of good nutrition during pregnancy and the risks associated with alcohol and tobacco use during pregnancy;

(5) available social services, including medical assistance benefits for prenatal care, childbirth, and neonatal care;

(6) legal assistance in obtaining child support; and

(7) community support services and other resources to enhance family strengths and reduce the possibility of family violence.

Subd. 3. [WEB SITE.] The commissioner shall design and maintain a secure Web site to provide the information described under subdivision 2 and section 145.4243 with a minimum resolution of 72 PPI. The Web site shall provide the toll-free information and referral telephone number described under subdivision 2.

Sec. 47. [145.4246] [ENFORCEMENT PENALTIES.]

Subdivision 1. [STANDING.] A person with standing may maintain an action against the performance or attempted performance of abortions in violation of section 145.4242. Those with standing are:

(1) a woman upon whom an abortion in violation of section 145.4242 has been performed or attempted to be performed; and

(2) the parent of an unemancipated minor upon whom an abortion in violation of section 145.4242 has been, is about to be, or was attempted to be performed; and

(3) attorney general of the state of Minnesota.

Subd. 2. [INJUNCTIONS.] Parties bringing actions against the performance or attempted performance of abortions in violation of section 145.4242 may seek temporary restraining orders, preliminary injunctions, and injunctions related only to the physician or facility where the

violation occurred in accordance with the Rules of Civil Procedure. Persons with standing must bring any actions within six months of the date of the performed or attempted performance of abortions in violation of section 145.4242.

Subd. 3. [CONTEMPT.] Any person knowingly violating the terms of an injunction against the performance or attempted performance of abortions in violation of section 145.4242 is subject to civil contempt, and shall be fined no more than $1,000 for the first violation, no more than $5,000 for the second violation, no more than $10,000 for the third violation, and for each successive violation an amount sufficient to deter future violations. The fine shall be the exclusive penalty for a violation. Each performance or attempted performance of abortion in violation of section 145.4242 is a separate violation. No fine shall be assessed against the woman on whom an abortion is performed or attempted.

Subd. 4. [REALLOCATION OF THE FINE.] Any fines collected under this section must be sent to a special account at the Minnesota department of health to be used for materials cited in section 145.4243.

Sec. 48. [145.4247] [CUMULATIVE RIGHTS.]

The provisions of sections 145.4241 to 145.4246 are cumulative with existing law regarding an individual's right to consent to medical treatment and shall not impair any existing right any patient may have under the common law or statutes of this state."

Page 629, after line 39, insert:

"[TRANSFER FOR INFORMED CONSENT COSTS.] (a) The general fund appropriation for electronic government services shall be reduced by $307,000 in fiscal year 2002 and $329,000 in fiscal year 2003.

(b) $172,000 in fiscal year 2002 and $184,000 in fiscal year 2003 are to be transferred to the commissioner of health to implement Minnesota Statutes, sections 145.4241 to 145.4247."

Renumber the sections in sequence and correct the internal references

Correct the subdivision and section totals and the summaries by fund accordingly

The question was taken on the adoption of the Fischbach amendment to the Berglin amendment.

Senator Day moved that those not voting be excused from voting. The motion did not prevail.

The roll was called, and there were yeas 33 and nays 33, as follows:

Those who voted in the affirmative were:

| | | | | |
|---|---|---|---|---|
| Bachmann | Frederickson | Kleis | Olson | Scheevel |
| Belanger | Johnson, Dean | Knutson | Ourada | Schwab |
| Berg | Johnson, Debbie | Larson | Pariseau | Stevens |
| Day | Johnson, Doug | Lesewski | Reiter | Stumpf |
| Dille | Kelly, R.C. | Lessard | Robling | Vickerman |
| Fischbach | Kierlin | Limmer | Sams | |
| Fowler | Kinkel | Neuville | Samuelson | |

Those who voted in the negative were:

| | | | | |
|---|---|---|---|---|
| Anderson | Foley | Kiscaden | Metzen | Pappas |
| Berglin | Higgins | Krentz | Moe, R.D. | Pogemiller |
| Betzold | Hottinger | Langseth | Murphy | Price |
| Chaudhary | Johnson, Dave | Lourey | Oliver | Ranum |
| Cohen | Kelley, S.P. | Marty | Orfield | Rest |

| | | | | |
|---|---|---|---|---|
| Ring | Sabo | Terwilliger | Wiener | Wiger |
| Robertson | Scheid | Tomassoni | | |

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

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

The roll was called, and there were yeas 39 and nays 27, as follows:

Those who voted in the affirmative were:

| | | | | |
|---|---|---|---|---|
| Anderson | Johnson, Dave | Langseth | Pogemiller | Samuelson |
| Berglin | Johnson, Dean | Lourey | Price | Scheid |
| Betzold | Johnson, Doug | Marty | Ranum | Stumpf |
| Chaudhary | Kelley, S.P. | Metzen | Rest | Terwilliger |
| Cohen | Kelly, R.C. | Moe, R.D. | Ring | Tomassoni |
| Foley | Kinkel | Murphy | Robertson | Wiener |
| Higgins | Kiscaden | Orfield | Sabo | Wiger |
| Hottinger | Krentz | Pappas | Sams | |

Those who voted in the negative were:

| | | | | |
|---|---|---|---|---|
| Bachmann | Fowler | Larson | Olson | Schwab |
| Belanger | Frederickson | Lesewski | Ourada | Stevens |
| Berg | Johnson, Debbie | Lessard | Pariseau | Vickerman |
| Day | Kierlin | Limmer | Reiter | |
| Dille | Kleis | Neuville | Robling | |
| Fischbach | Knutson | Oliver | Scheevel | |

The motion prevailed. So the amendment was adopted.

Senator Stevens moved to amend H.F. No. 1947, as amended pursuant to Rule 45, adopted by the Senate May 11, 2001, as follows:

(The text of the amended House File is identical to S.F. No. 1345.)

Delete everything after the enacting clause and insert:

"ARTICLE 1

HEALTH DEPARTMENT

Section 1. Minnesota Statutes 2000, section 103I.101, subdivision 6, is amended to read:

Subd. 6. [FEES FOR VARIANCES.] The commissioner shall charge a nonrefundable application fee of ~~$120~~ $150 to cover the administrative cost of processing a request for a variance or modification of rules adopted by the commissioner under this chapter.

Sec. 2. Minnesota Statutes 2000, section 103I.112, is amended to read:

103I.112 [FEE EXEMPTIONS FOR STATE AND LOCAL GOVERNMENT.]

(a) The commissioner of health may not charge fees required under this chapter to a federal agency, state agency, or a local unit of government or to a subcontractor performing work for the state agency or local unit of government.

(b) "Local unit of government" means a statutory or home rule charter city, town, county, or soil and water conservation district, watershed district, an organization formed for the joint exercise of powers under section 471.59, a board of health or community health board, or other special purpose district or authority with local jurisdiction in water and related land resources management.

Sec. 3. Minnesota Statutes 2000, section 103I.208, subdivision 1, is amended to read:

Subdivision 1. [WELL NOTIFICATION FEE.] The well notification fee to be paid by a property owner is:

(1) for a new well, ~~$120~~ $150, which includes the state core function fee;

(2) for a well sealing, ~~$20~~ $30 for each well, which includes the state core function fee, except that for monitoring wells constructed on a single property, having depths within a 25 foot range, and sealed within 48 hours of start of construction, a single fee of ~~$20~~ $30; and

(3) for construction of a dewatering well, ~~$120~~ $150, which includes the state core function fee, for each well except a dewatering project comprising five or more wells shall be assessed a single fee of ~~$600~~ $750 for the wells recorded on the notification.

Sec. 4. Minnesota Statutes 2000, section 103I.208, subdivision 2, is amended to read:

Subd. 2. [PERMIT FEE.] The permit fee to be paid by a property owner is:

(1) for a well that is not in use under a maintenance permit, ~~$100~~ $125 annually;

(2) for construction of a monitoring well, ~~$120~~ $150, which includes the state core function fee;

(3) for a monitoring well that is unsealed under a maintenance permit, ~~$100~~ $125 annually;

(4) for monitoring wells used as a leak detection device at a single motor fuel retail outlet, a single petroleum bulk storage site excluding tank farms, or a single agricultural chemical facility site, the construction permit fee is ~~$120~~ $150, which includes the state core function fee, per site regardless of the number of wells constructed on the site, and the annual fee for a maintenance permit for unsealed monitoring wells is ~~$100~~ $125 per site regardless of the number of monitoring wells located on site;

(5) for a groundwater thermal exchange device, in addition to the notification fee for wells, ~~$120~~ $150, which includes the state core function fee;

(6) for a vertical heat exchanger, ~~$120~~ $150;

(7) for a dewatering well that is unsealed under a maintenance permit, ~~$100~~ $125 annually for each well, except a dewatering project comprising more than five wells shall be issued a single permit for ~~$500~~ $625 annually for wells recorded on the permit; and

(8) for excavating holes for the purpose of installing elevator shafts, ~~$120~~ $150 for each hole.

Sec. 5. Minnesota Statutes 2000, section 103I.235, subdivision 1, is amended to read:

Subdivision 1. [DISCLOSURE OF WELLS TO BUYER.] (a) Before signing an agreement to sell or transfer real property, the seller must disclose in writing to the buyer information about the status and location of all known wells on the property, by delivering to the buyer either a statement by the seller that the seller does not know of any wells on the property, or a disclosure statement indicating the legal description and county, and a map drawn from available information showing the location of each well to the extent practicable. In the disclosure statement, the seller must indicate, for each well, whether the well is in use, not in use, or sealed.

(b) At the time of closing of the sale, the disclosure statement information, name and mailing address of the buyer, and the quartile, section, township, and range in which each well is located must be provided on a well disclosure certificate signed by the seller or a person authorized to act on behalf of the seller.

(c) A well disclosure certificate need not be provided if the seller does not know of any wells on the property and the deed or other instrument of conveyance contains the statement: "The Seller certifies that the Seller does not know of any wells on the described real property."

(d) If a deed is given pursuant to a contract for deed, the well disclosure certificate required by this subdivision shall be signed by the buyer or a person authorized to act on behalf of the buyer. If the buyer knows of no wells on the property, a well disclosure certificate is not required if the following statement appears on the deed followed by the signature of the grantee or, if there is more than one grantee, the signature of at least one of the grantees: "The Grantee certifies that the

Grantee does not know of any wells on the described real property." The statement and signature of the grantee may be on the front or back of the deed or on an attached sheet and an acknowledgment of the statement by the grantee is not required for the deed to be recordable.

(e) This subdivision does not apply to the sale, exchange, or transfer of real property:

(1) that consists solely of a sale or transfer of severed mineral interests; or

(2) that consists of an individual condominium unit as described in chapters 515 and 515B.

(f) For an area owned in common under chapter 515 or 515B the association or other responsible person must report to the commissioner by July 1, 1992, the location and status of all wells in the common area. The association or other responsible person must notify the commissioner within 30 days of any change in the reported status of wells.

(g) For real property sold by the state under section 92.67, the lessee at the time of the sale is responsible for compliance with this subdivision.

(h) If the seller fails to provide a required well disclosure certificate, the buyer, or a person authorized to act on behalf of the buyer, may sign a well disclosure certificate based on the information provided on the disclosure statement required by this section or based on other available information.

(i) A county recorder or registrar of titles may not record a deed or other instrument of conveyance dated after October 31, 1990, for which a certificate of value is required under section 272.115, or any deed or other instrument of conveyance dated after October 31, 1990, from a governmental body exempt from the payment of state deed tax, unless the deed or other instrument of conveyance contains the statement made in accordance with paragraph (c) or (d) or is accompanied by the well disclosure certificate containing all the information required by paragraph (b) or (d). The county recorder or registrar of titles must not accept a certificate unless it contains all the required information. The county recorder or registrar of titles shall note on each deed or other instrument of conveyance accompanied by a well disclosure certificate that the well disclosure certificate was received. The notation must include the statement "No wells on property" if the disclosure certificate states there are no wells on the property. The well disclosure certificate shall not be filed or recorded in the records maintained by the county recorder or registrar of titles. After noting "No wells on property" on the deed or other instrument of conveyance, the county recorder or registrar of titles shall destroy or return to the buyer the well disclosure certificate. The county recorder or registrar of titles shall collect from the buyer or the person seeking to record a deed or other instrument of conveyance, a fee of ~~$20~~ $30 for receipt of a completed well disclosure certificate. By the tenth day of each month, the county recorder or registrar of titles shall transmit the well disclosure certificates to the commissioner of health. By the tenth day after the end of each calendar quarter, the county recorder or registrar of titles shall transmit to the commissioner of health ~~$17.50~~ $27.50 of the fee for each well disclosure certificate received during the quarter. The commissioner shall maintain the well disclosure certificate for at least six years. The commissioner may store the certificate as an electronic image. A copy of that image shall be as valid as the original.

(j) No new well disclosure certificate is required under this subdivision if the buyer or seller, or a person authorized to act on behalf of the buyer or seller, certifies on the deed or other instrument of conveyance that the status and number of wells on the property have not changed since the last previously filed well disclosure certificate. The following statement, if followed by the signature of the person making the statement, is sufficient to comply with the certification requirement of this paragraph: "I am familiar with the property described in this instrument and I certify that the status and number of wells on the described real property have not changed since the last previously filed well disclosure certificate." The certification and signature may be on the front or back of the deed or on an attached sheet and an acknowledgment of the statement is not required for the deed or other instrument of conveyance to be recordable.

(k) The commissioner in consultation with county recorders shall prescribe the form for a well disclosure certificate and provide well disclosure certificate forms to county recorders and registrars of titles and other interested persons.

(l) Failure to comply with a requirement of this subdivision does not impair:

(1) the validity of a deed or other instrument of conveyance as between the parties to the deed or instrument or as to any other person who otherwise would be bound by the deed or instrument; or

(2) the record, as notice, of any deed or other instrument of conveyance accepted for filing or recording contrary to the provisions of this subdivision.

Sec. 6. Minnesota Statutes 2000, section 103I.525, subdivision 2, is amended to read:

Subd. 2. [APPLICATION FEE.] The application fee for a well contractor's license is ~~$50~~ $75. The commissioner may not act on an application until the application fee is paid.

Sec. 7. Minnesota Statutes 2000, section 103I.525, subdivision 6, is amended to read:

Subd. 6. [LICENSE FEE.] The fee for a well contractor's license is $250, except the fee for an individual well contractor's license is ~~$50~~ $75.

Sec. 8. Minnesota Statutes 2000, section 103I.525, subdivision 8, is amended to read:

Subd. 8. [RENEWAL.] (a) A licensee must file an application and a renewal application fee to renew the license by the date stated in the license.

(b) The renewal application fee ~~shall be set by the commissioner under section 16A.1285~~ for a well contractor's license is $250.

(c) The renewal application must include information that the applicant has met continuing education requirements established by the commissioner by rule.

(d) At the time of the renewal, the commissioner must have on file all properly completed well reports, well sealing reports, reports of excavations to construct elevator shafts, well permits, and well notifications for work conducted by the licensee since the last license renewal.

Sec. 9. Minnesota Statutes 2000, section 103I.525, subdivision 9, is amended to read:

Subd. 9. [INCOMPLETE OR LATE RENEWAL.] If a licensee fails to submit all information required for renewal in subdivision 8 or submits the application and information after the required renewal date:

(1) the licensee must include ~~an additional~~ a late fee ~~set by the commissioner~~ of $75; and

(2) the licensee may not conduct activities authorized by the well contractor's license until the renewal application, renewal application fee, late fee, and all other information required in subdivision 8 are submitted.

Sec. 10. Minnesota Statutes 2000, section 103I.531, subdivision 2, is amended to read:

Subd. 2. [APPLICATION FEE.] The application fee for a limited well/boring contractor's license is ~~$50~~ $75. The commissioner may not act on an application until the application fee is paid.

Sec. 11. Minnesota Statutes 2000, section 103I.531, subdivision 6, is amended to read:

Subd. 6. [LICENSE FEE.] The fee for a limited well/boring contractor's license is ~~$50~~ $75.

Sec. 12. Minnesota Statutes 2000, section 103I.531, subdivision 8, is amended to read:

Subd. 8. [RENEWAL.] (a) A person must file an application and a renewal application fee to renew the limited well/boring contractor's license by the date stated in the license.

(b) The renewal application fee ~~shall be set by the commissioner under section 16A.1285~~ for a limited well/boring contractor's license is $75.

(c) The renewal application must include information that the applicant has met continuing education requirements established by the commissioner by rule.

(d) At the time of the renewal, the commissioner must have on file all properly completed well sealing reports, well permits, vertical heat exchanger permits, and well notifications for work conducted by the licensee since the last license renewal.

Sec. 13. Minnesota Statutes 2000, section 103I.531, subdivision 9, is amended to read:

Subd. 9. [INCOMPLETE OR LATE RENEWAL.] If a licensee fails to submit all information required for renewal in subdivision 8 or submits the application and information after the required renewal date:

(1) the licensee must include ~~an additional~~ a late fee ~~set by the commissioner~~ of $75; and

(2) the licensee may not conduct activities authorized by the limited well/boring contractor's license until the renewal application, renewal application fee, and late fee, and all other information required in subdivision 8 are submitted.

Sec. 14. Minnesota Statutes 2000, section 103I.535, subdivision 2, is amended to read:

Subd. 2. [APPLICATION FEE.] The application fee for an elevator shaft contractor's license is ~~$50~~ $75. The commissioner may not act on an application until the application fee is paid.

Sec. 15. Minnesota Statutes 2000, section 103I.535, subdivision 6, is amended to read:

Subd. 6. [LICENSE FEE.] The fee for an elevator shaft contractor's license is ~~$50~~ $75.

Sec. 16. Minnesota Statutes 2000, section 103I.535, subdivision 8, is amended to read:

Subd. 8. [RENEWAL.] (a) A person must file an application and a renewal application fee to renew the license by the date stated in the license.

(b) The renewal application fee ~~shall be set by the commissioner under section 16A.1285~~ for an elevator shaft contractor's license is $75.

(c) The renewal application must include information that the applicant has met continuing education requirements established by the commissioner by rule.

(d) At the time of renewal, the commissioner must have on file all reports and permits for elevator shaft work conducted by the licensee since the last license renewal.

Sec. 17. Minnesota Statutes 2000, section 103I.535, subdivision 9, is amended to read:

Subd. 9. [INCOMPLETE OR LATE RENEWAL.] If a licensee fails to submit all information required for renewal in subdivision 8 or submits the application and information after the required renewal date:

(1) the licensee must include ~~an additional~~ a late fee ~~set by the commissioner~~ of $75; and

(2) the licensee may not conduct activities authorized by the elevator shaft contractor's license until the renewal application, renewal application fee, and late fee, and all other information required in subdivision 8 are submitted.

Sec. 18. Minnesota Statutes 2000, section 103I.541, subdivision 2b, is amended to read:

Subd. 2b. [APPLICATION FEE.] The application fee for a monitoring well contractor registration is ~~$50~~ $75. The commissioner may not act on an application until the application fee is paid.

Sec. 19. Minnesota Statutes 2000, section 103I.541, subdivision 4, is amended to read:

Subd. 4. [RENEWAL.] (a) A person must file an application and a renewal application fee to renew the registration by the date stated in the registration.

(b) The renewal application fee ~~shall be set by the commissioner under section 16A.1285~~ for a monitoring well contractor's registration is $75.

(c) The renewal application must include information that the applicant has met continuing education requirements established by the commissioner by rule.

(d) At the time of the renewal, the commissioner must have on file all well reports, well sealing reports, well permits, and notifications for work conducted by the registered person since the last registration renewal.

Sec. 20. Minnesota Statutes 2000, section 103I.541, subdivision 5, is amended to read:

Subd. 5. [INCOMPLETE OR LATE RENEWAL.] If a registered person submits a renewal application after the required renewal date:

(1) the registered person must include ~~an additional~~ a late fee ~~set by the commissioner~~ of $75; and

(2) the registered person may not conduct activities authorized by the monitoring well contractor's registration until the renewal application, renewal application fee, late fee, and all other information required in subdivision 4 are submitted.

Sec. 21. Minnesota Statutes 2000, section 103I.545, is amended to read:

103I.545 [REGISTRATION OF DRILLING MACHINES REQUIRED.]

Subdivision 1. [DRILLING MACHINE.] (a) A person may not use a drilling machine such as a cable tool, rotary tool, hollow rod tool, or auger for a drilling activity requiring a license or registration under this chapter unless the drilling machine is registered with the commissioner.

(b) A person must apply for the registration on forms prescribed by the commissioner and submit a ~~$50~~ $75 registration fee.

(c) A registration is valid for one year.

Subd. 2. [PUMP HOIST.] (a) A person may not use a machine such as a pump hoist for an activity requiring a license or registration under this chapter to repair wells or borings, seal wells or borings, or install pumps unless the machine is registered with the commissioner.

(b) A person must apply for the registration on forms prescribed by the commissioner and submit a ~~$50~~ $75 registration fee.

(c) A registration is valid for one year.

**[EFFECTIVE DATE.]** This section is effective July 1, 2002.

Sec. 22. Minnesota Statutes 2000, section 121A.15, subdivision 6, is amended to read:

Subd. 6. [SUSPENSION OF IMMUNIZATION REQUIREMENT; MODIFICATION TO SCHEDULE.] (a) The commissioner of health, on finding that an immunization required pursuant to this section is not necessary to protect the public's health, may suspend for one year the requirement that children receive that immunization.

(b) During portions of the year in which the legislature is not meeting in regular or special session, the commissioner of health may modify the immunization requirements of this section. A modification made under this paragraph must be part of the current immunization recommendations of each of the following organizations: the United States Public Health Service's Advisory Committee on Immunization Practices, the American Academy of Family Physicians, and the American Academy of Pediatrics. The commissioner shall modify the immunization requirements through rulemaking using the expedited process in section 14.389. A rule adopted under this paragraph shall be in effect until the adjournment of the next regular legislative session held after the rule is adopted. The commissioner shall report to the legislature

on any rules adopted under this paragraph during the previous calendar year. Such reports are due by January 15 of the year following the calendar year in which the rule is adopted, except that if a rule is adopted in January, a report on that rule is due by February 15 of that year.

Sec. 23. Minnesota Statutes 2000, section 135A.14, is amended by adding a subdivision to read:

Subd. 7. [MODIFICATIONS TO SCHEDULE.] During portions of the year in which the legislature is not meeting in regular or special session, the commissioner of health may modify the immunization requirements of this section. A modification made under this subdivision must be part of the current immunization recommendations of each of the following organizations: the United States Public Health Service's Advisory Committee on Immunization Practices, the American Academy of Family Physicians, and the American Academy of Pediatrics. The commissioner shall modify the immunization requirements through rulemaking using the expedited process in section 14.389. A rule adopted under this subdivision shall be in effect until the adjournment of the next regular legislative session held after the rule is adopted. The commissioner shall report to the legislature on any rules adopted under this subdivision during the previous calendar year. Such reports are due by January 15 of the year following the calendar year in which the rule is adopted, except that if a rule is adopted in January, a report on that rule is due by February 15 of that year.

Sec. 24. Minnesota Statutes 2000, section 144.1202, subdivision 4, is amended to read:

Subd. 4. [AGREEMENT; CONDITIONS OF IMPLEMENTATION.] (a) An agreement entered into before August 2, ~~2002~~ 2003, must remain in effect until terminated under the Atomic Energy Act of 1954, United States Code, title 42, section 2021, paragraph (j). The governor may not enter into an initial agreement with the Nuclear Regulatory Commission after August 1, ~~2002~~ 2003. If an agreement is not entered into by August 1, ~~2002~~ 2003, any rules adopted under this section are repealed effective August 1, ~~2002~~ 2003.

(b) An agreement authorized under subdivision 1 must be approved by law before it may be implemented.

Sec. 25. [144.1205] [RADIOACTIVE MATERIAL; SOURCE AND SPECIAL NUCLEAR MATERIAL; FEES; INSPECTION.]

Subdivision 1. [APPLICATION AND LICENSE RENEWAL FEE.] When a license is required for radioactive material or source or special nuclear material by a rule adopted under section 144.1202, subdivision 2, an application fee according to subdivision 4 must be paid upon initial application for a license. The licensee must renew the license 60 days before the expiration date of the license by paying a license renewal fee equal to the application fee under subdivision 4. The expiration date of a license is the date set by the United States Nuclear Regulatory Commission before transfer of the licensing program under section 144.1202 and thereafter as specified by rule of the commissioner of health.

Subd. 2. [ANNUAL FEE.] A licensee must pay an annual fee at least 60 days before the anniversary date of the issuance of the license. The annual fee is an amount equal to 80 percent of the application fee under subdivision 4, rounded to the nearest whole dollar.

Subd. 3. [FEE CATEGORIES; INCORPORATION OF FEDERAL LICENSING CATEGORIES.] (a) Fee categories under this section are equivalent to the licensing categories used by the United States Nuclear Regulatory Commission under Code of Federal Regulations, title 10, parts 30 to 36, 39, 40, 70, 71, and 150, except as provided in paragraph (b).

(b) The category of "Academic, small" is the type of license required for the use of radioactive materials in a teaching institution. Radioactive materials are limited to ten radionuclides not to exceed a total activity amount of one curie.

Subd. 4. [APPLICATION FEE.] A licensee must pay an application fee as follows:

| Radioactive material, | Application | U.S. Nuclear Regulatory |
|---|---|---|

| source and special material | fee | Commission licensing category as reference |
|---|---|---|
| Type A broadscope | $20,000 | Medical institution type A |
| Type B broadscope | $15,000 | Research and development type B |
| Type C broadscope | $10,000 | Academic type C |
| Medical use | $4,000 | Medical<br>Medical institution<br>Medical private practice |
| Mobile nuclear medical laboratory | $4,000 | Mobile medical laboratory |
| Medical special use sealed sources | $6,000 | Teletherapy<br>High dose rate remote afterloaders<br>Stereotactic radiosurgery devices |
| In vitro testing | $2,300 | In vitro testing laboratories |
| Measuring gauge, sealed sources | $2,000 | Fixed gauges<br>Portable gauges<br>Analytical instruments<br>Measuring systems - other |
| Gas chromatographs | $1,200 | Gas chromatographs |
| Manufacturing and distribution | $14,700 | Manufacturing and distribution - other |
| Distribution only | $8,800 | Distribution of radioactive material for commercial use only |
| Other services | $1,500 | Other services |
| Nuclear medicine pharmacy | $4,100 | Nuclear pharmacy |
| Waste disposal | $9,400 | Waste disposal service prepackage<br>Waste disposal service processing/repackage |
| Waste storage only | $7,000 | To receive and store radioactive material waste |
| Industrial radiography | $8,400 | Industrial radiography fixed location<br>Industrial radiography portable/temporary sites |
| Irradiator - self-shielded | $4,100 | Irradiators self-shielded less than 10,000 curies |
| Irradiator - less than 10,000 Ci | $7,500 | Irradiators less than 10,000 curies |
| Irradiator - more than 10,000 Ci | $11,500 | Irradiators greater than 10,000 curies |

| | | |
|---|---|---|
| Research and development, no distribution | $4,100 | Research and development |
| Radioactive material possession only | $1,000 | By-product possession only |
| Source material | $1,000 | Source material shielding |
| Special nuclear material, less than 200 grams | $1,000 | Special nuclear material plutonium-neutron sources less than 200 grams |
| Pacemaker manufacturing | $1,000 | Pacemaker by-product and/or special nuclear material - medical institution |
| General license distribution | $2,100 | General license distribution |
| General license distribution, exempt | $1,500 | General license distribution - certain exempt items |
| Academic, small | $1,000 | Possession limit of ten radionuclides, not to exceed a total of one curie of activity |
| Veterinary | $2,000 | Veterinary use |
| Well logging | $5,000 | Well logging |

Subd. 5. [PENALTY FOR LATE PAYMENT.] An annual fee or a license renewal fee submitted to the commissioner after the due date specified by rule must be accompanied by an additional amount equal to 25 percent of the fee due.

Subd. 6. [INSPECTIONS.] The commissioner of health shall make periodic safety inspections of the radioactive material and source and special nuclear material of a licensee. The commissioner shall prescribe the frequency of safety inspections by rule.

Subd. 7. [RECOVERY OF REINSPECTION COST.] If the commissioner finds serious violations of public health standards during an inspection under subdivision 6, the licensee must pay all costs associated with subsequent reinspection of the source. The costs shall be the actual costs incurred by the commissioner and include, but are not limited to, labor, transportation, per diem, materials, legal fees, testing, and monitoring costs.

Subd. 8. [RECIPROCITY FEE.] A licensee submitting an application for reciprocal recognition of a materials license issued by another agreement state or the United States Nuclear Regulatory Commission for a period of 180 days or less during a calendar year must pay one-half of the application fee specified under subdivision 4. For a period of 181 days or more, the licensee must pay the entire application fee under subdivision 4.

Subd. 9. [FEES FOR LICENSE AMENDMENTS.] A licensee must pay a fee to amend a license as follows:

(1) to amend a license requiring no license review including, but not limited to, facility name change or removal of a previously authorized user, no fee;

(2) to amend a license requiring review including, but not limited to, addition of isotopes, procedure changes, new authorized users, or a new radiation safety officer, $200; and

(3) to amend a license requiring review and a site visit including, but not limited to, facility move or addition of processes, $400.

**[EFFECTIVE DATE.]** This section is effective July 1, 2002.

Sec. 26. Minnesota Statutes 2000, section 144.122, is amended to read:

144.122 [LICENSE, PERMIT, AND SURVEY FEES.]

(a) The state commissioner of health, by rule, may prescribe reasonable procedures and fees for filing with the commissioner as prescribed by statute and for the issuance of original and renewal permits, licenses, registrations, and certifications issued under authority of the commissioner. The expiration dates of the various licenses, permits, registrations, and certifications as prescribed by the rules shall be plainly marked thereon. Fees may include application and examination fees and a penalty fee for renewal applications submitted after the expiration date of the previously issued permit, license, registration, and certification. The commissioner may also prescribe, by rule, reduced fees for permits, licenses, registrations, and certifications when the application therefor is submitted during the last three months of the permit, license, registration, or certification period. Fees proposed to be prescribed in the rules shall be first approved by the department of finance. All fees proposed to be prescribed in rules shall be reasonable. The fees shall be in an amount so that the total fees collected by the commissioner will, where practical, approximate the cost to the commissioner in administering the program. All fees collected shall be deposited in the state treasury and credited to the state government special revenue fund unless otherwise specifically appropriated by law for specific purposes.

(b) The commissioner may charge a fee for voluntary certification of medical laboratories and environmental laboratories, and for environmental and medical laboratory services provided by the department, without complying with paragraph (a) or chapter 14. Fees charged for environment and medical laboratory services provided by the department must be approximately equal to the costs of providing the services.

(c) The commissioner may develop a schedule of fees for diagnostic evaluations conducted at clinics held by the services for children with handicaps program. All receipts generated by the program are annually appropriated to the commissioner for use in the maternal and child health program.

(d) The commissioner~~, for fiscal years 1996 and beyond,~~ shall set license fees for hospitals and nursing homes that are not boarding care homes at the following levels:

| | |
|---|---|
| Joint Commission on Accreditation of Healthcare Organizations (JCAHO hospitals) | ~~$1,017~~ $7,055 |
| Non-JCAHO hospitals | ~~$762 plus $34 per bed~~ $4,680 plus $234 per bed |
| Nursing home | ~~$78 plus $19 per bed~~ $183 plus $91 per bed |

~~For fiscal years 1996 and beyond,~~ The commissioner shall set license fees for outpatient surgical centers, boarding care homes, and supervised living facilities at the following levels:

| | |
|---|---|
| Outpatient surgical centers | ~~$517~~ $1,512 |
| Boarding care homes | ~~$78 plus $19 per bed~~ $183 plus $91 per bed |
| Supervised living facilities | ~~$78 plus $19 per bed~~ $183 plus $91 per bed. |

(e) Unless prohibited by federal law, the commissioner of health shall charge applicants the

following fees to cover the cost of any initial certification surveys required to determine a provider's eligibility to participate in the Medicare or Medicaid program:

| | |
|---|---|
| Prospective payment surveys for hospitals | $ 900 |
| Swing bed surveys for nursing homes | $1,200 |
| Psychiatric hospitals | $1,400 |
| Rural health facilities | $1,100 |
| Portable X-ray providers | $ 500 |
| Home health agencies | $1,800 |
| Outpatient therapy agencies | $ 800 |
| End stage renal dialysis providers | $2,100 |
| Independent therapists | $ 800 |
| Comprehensive rehabilitation outpatient facilities | $1,200 |
| Hospice providers | $1,700 |
| Ambulatory surgical providers | $1,800 |
| Hospitals | $4,200 |
| Other provider categories or additional resurveys required to complete initial certification | Actual surveyor costs: average surveyor cost x number of hours for the survey process. |

These fees shall be submitted at the time of the application for federal certification and shall not be refunded. All fees collected after the date that the imposition of fees is not prohibited by federal law shall be deposited in the state treasury and credited to the state government special revenue fund.

Sec. 27. Minnesota Statutes 2000, section 144.148, subdivision 2, is amended to read:

Subd. 2. [PROGRAM.] (a) The commissioner of health shall award rural hospital capital improvement grants to eligible rural hospitals. Except as provided in paragraph (b), A grant shall not exceed $300,000 per hospital. Prior to the receipt of any grant, the hospital must certify to the commissioner that at least one-quarter of the grant amount, which may include in-kind services, is available for the same purposes from nonstate resources.

(b) A grant shall not exceed $1,500,000 per eligible rural hospital that also satisfies the following criteria:

(1) is the only hospital in a county;

(2) has 25 or fewer licensed hospital beds with a net hospital operating margin not greater than an average of two percent over the three fiscal years prior to application;

(3) is located in a medically underserved community (MUC) or a health professional shortage area (HPSA);

(4) is located near a migrant worker employment site and regularly treats significant numbers of migrant workers and their families; and

(5) has not previously received a grant under this section prior to July 1, 1999.

Sec. 28. Minnesota Statutes 2000, section 144.226, subdivision 4, is amended to read:

Subd. 4. [VITAL RECORDS SURCHARGE.] In addition to any fee prescribed under subdivision 1, there is a nonrefundable surcharge of ~~$3~~ $2 for each certified and noncertified birth or death record, and for a certification that the record cannot be found. The local or state registrar shall forward this amount to the state treasurer to be deposited into the state government special revenue fund. This surcharge shall not be charged under those circumstances in which no fee for a birth or death record is permitted under subdivision 1, paragraph (a). ~~This surcharge requirement expires June 30, 2002.~~

Sec. 29. [144.585] [HOSPITAL CHARITY CARE AID.]

Subdivision 1. [PURPOSE.] The purpose of charity care aid is to help offset excess charity care burdens at Minnesota acute care, short-term hospitals.

Subd. 2. [DEFINITIONS.] (a) For purposes of this section, the terms in this subdivision have the meanings given to them.

(b) "Charity care" is the dollar amount of charity care adjustments as determined under subdivision 3.

(c) "Cost-to-charge ratio" means a hospital's total operating expenses over the sum of gross patient revenue and other operating revenue, as reported to the commissioner of health under rules adopted under sections 144.695 to 144.703. The commissioner shall use the most recently available data to calculate the cost-to-charge ratio.

Subd. 3. [CHARITY CARE REPORTING.] (a) For a hospital to report amounts as charity care adjustments, the hospital:

(1) must generate and record a charge;

(2) have a policy on the provision of charity care and must communicate the policy to the public;

(3) have made a reasonable effort to identify a third party payer, encourage the patient to enroll in public programs, and should, to the extent possible, aid the patient in the enrollment process; and

(4) ensure that the patient meets the charity care criteria of this subdivision, which must be consistent with statewide income standards set out in paragraph (c).

(b) In determining whether to classify care as charity care, the hospital must consider the following:

(1) charity care may include services which the provider is obligated to render independently of the ability to collect;

(2) charity care may include care provided to low-income patients who meet the charity care income standards under paragraph (c) and have partial coverage, but are unable to pay the remainder of their medical bills. This does not apply to that portion of the bill which has been determined to be the patient's responsibility after a partial charity care classification;

(3) charity care may include care provided to low-income patients who may qualify for a public health insurance program and meet the statewide eligibility criteria for charity care, but who do not complete the application process for public insurance despite the facility's best efforts;

(4) charity care may include care to individuals whose eligibility for charity care was determined through third party services employed by the hospital for information gathering purposes only;

(5) charity care may not include contractual allowances, which is the difference between gross charges and payments received under contractual arrangements with insurance companies and payers;

(6) charity care may not include bad debt;

(7) charity care may not include what may be perceived as underpayments for operating public programs;

(8) charity care may not include cases which are paid through a charitable contribution through a third party or facility-related foundation;

(9) charity care may not include unreimbursed costs of basic or clinical research and of professional education and training;

(10) charity care may not include professional courtesy discounts;

(11) charity care may not include community service or outreach activities; and

(12) charity care may not include services for patients against whom collection actions where taken which result in a credit report.

(c) The hospital must use the income standards in this paragraph for determining charity care eligibility for reporting purposes. The hospital does not need to make a patient asset determination in order to apply charity care income standards.

(1) Care to a patient with a family income at or below 150 percent of the Federal Poverty Guideline (FPG) may be reported as full charity care or free care.

(2) The hospital's share of discounted charges for care to a patient with family income below 275 percent of the FPG qualifies for classification as charity care. The following sliding fee schedules apply:

| income as % of FPG | charges paid by patient | corresponding charity care |
|---|---|---|
| 151-200% | 20% | 80% |
| 201-225% | 40% | 60% |
| 226-250% | 60% | 40% |
| 251-275% | 80% | 20% |

(3) Care to a patient is considered medical hardship when qualified medical expenses, as defined for the purposes of federal income tax deductibility, exceeds 30 percent of family income. Qualified medical expenses may be counted as charity care in the amount that exceeds 30 percent of family income. This clause applies even if the patient's family income exceeds the charity care income standards in clauses (1) and (2).

Subd. 4. [APPLICATION.] To be eligible for funds under this section, hospitals must submit an application to the commissioner of health by the deadline established by the commissioner. Applications must meet the criteria as established by the commissioner, but must contain:

(1) the dollar amount of charity care in the previous year, as defined in subdivision 3, paragraphs (b) and (c);

(2) a list with the most common diagnoses for which charity care is provided; and

(3) descriptive aggregate statistics of the characteristics of patients who receive charity care.

Subd. 5. [ALLOCATION OF FUNDS.] A hospital's share of the available charity care aid is equal to that hospital's share of charity care relative to the total charity care provided by applicants.

Sec. 30. Minnesota Statutes 2000, section 144.98, subdivision 3, is amended to read:

Subd. 3. [FEES.] (a) An application for certification under subdivision 1 must be accompanied by the biennial fee specified in this subdivision. The fees are for:

(1) nonrefundable base certification fee, ~~$500~~ $1,200; and

(2) test category certification fees:

| Test Category | Certification Fee |
|---|---|

| | |
|---|---|
| Clean water program bacteriology | ~~$200~~ $600 |
| Safe drinking water program bacteriology | $600 |
| Clean water program inorganic chemistry~~,~~ | |
| ~~fewer than four constituents~~ | ~~$100~~ $600 |
| Safe drinking water program inorganic chemistry~~,~~ | |
| ~~four or more constituents~~ | ~~$300~~ $600 |
| Clean water program chemistry metals~~,~~ | |
| ~~fewer than four constituents~~ | ~~$200~~ $800 |
| Safe drinking water program chemistry metals~~,~~ | |
| ~~four or more constituents~~ | ~~$500~~ $800 |
| Resource conservation and recovery program | |
| chemistry metals | $800 |
| Clean water program volatile organic compounds | ~~$600~~ $1,200 |
| Safe drinking water program | |
| volatile organic compounds | $1,200 |
| Resource conservation and recovery program | |
| volatile organic compounds | $1,200 |
| Underground storage tank program | |
| volatile organic compounds | $1,200 |
| Clean water program other organic compounds | ~~$600~~ $1,200 |
| Safe drinking water program other organic compounds | $1,200 |
| Resource conservation and recovery program | |
| other organic compounds | $1,200 |

(b) The total biennial certification fee is the base fee plus the applicable test category fees. ~~The biennial certification fee for a contract laboratory is 1.5 times the total certification fee.~~

(c) Laboratories located outside of this state that require an on-site survey will be assessed an additional ~~$1,200~~ $2,500 fee.

(d) Fees must be set so that the total fees support the laboratory certification program. Direct costs of the certification service include program administration, inspections, the agency's general support costs, and attorney general costs attributable to the fee function.

(e) A change fee shall be assessed if a laboratory requests additional analytes or methods at any time other than when applying for or renewing its certification. The change fee is equal to the test category certification fee for the analyte.

(f) A variance fee shall be assessed if a laboratory requests and is granted a variance from a rule adopted under this section. The variance fee is $500 per variance.

(g) Refunds or credits shall not be made for analytes or methods requested but not approved.

(h) Certification of a laboratory shall not be awarded until all fees are paid.

Sec. 31. Minnesota Statutes 2000, section 144A.44, subdivision 1, is amended to read:

Subdivision 1. [STATEMENT OF RIGHTS.] A person who receives home care services has these rights:

(1) the right to receive written information about rights in advance of receiving care or during the initial evaluation visit before the initiation of treatment, including what to do if rights are violated;

(2) the right to receive care and services according to a suitable and up-to-date plan, and subject to accepted medical or nursing standards, to take an active part in creating and changing the plan and evaluating care and services;

(3) the right to be told in advance of receiving care about the services that will be provided, the disciplines that will furnish care, the frequency of visits proposed to be furnished, other choices that are available, and the consequences of these choices including the consequences of refusing these services;

(4) the right to be told in advance of any change in the plan of care and to take an active part in any change;

(5) the right to refuse services or treatment;

(6) the right to know, in advance, any limits to the services available from a provider, and the provider's grounds for a termination of services;

(7) the right to know in advance of receiving care whether the services are covered by health insurance, medical assistance, or other health programs, the charges for services that will not be covered by Medicare, and the charges that the individual may have to pay;

(8) the right to know what the charges are for services, no matter who will be paying the bill;

(9) the right to know that there may be other services available in the community, including other home care services and providers, and to know where to go for information about these services;

(10) the right to choose freely among available providers and to change providers after services have begun, within the limits of health insurance, medical assistance, or other health programs;

(11) the right to have personal, financial, and medical information kept private, and to be advised of the provider's policies and procedures regarding disclosure of such information;

(12) the right to be allowed access to records and written information from records in accordance with section 144.335;

(13) the right to be served by people who are properly trained and competent to perform their duties;

(14) the right to be treated with courtesy and respect, and to have the patient's property treated with respect;

(15) the right to be free from physical and verbal abuse;

(16) the right to reasonable, advance notice of changes in services or charges, including at least ten days' advance notice of the termination of a service by a provider, except in cases where:

(i) the recipient of services engages in conduct that alters the conditions of employment as specified in the employment contract between the home care provider and the individual providing home care services, or creates an abusive or unsafe work environment for the individual providing home care services; or

(ii) an emergency for the informal caregiver or a significant change in the recipient's condition has resulted in service needs that exceed the current service provider agreement and that cannot be safely met by the home care provider;

(17) the right to a coordinated transfer when there will be a change in the provider of services;

(18) the right to voice grievances regarding treatment or care that is, or fails to be, furnished, or regarding the lack of courtesy or respect to the patient or the patient's property;

(19) the right to know how to contact an individual associated with the provider who is responsible for handling problems and to have the provider investigate and attempt to resolve the grievance or complaint;

(20) the right to know the name and address of the state or county agency to contact for additional information or assistance; and

(21) the right to assert these rights personally, or have them asserted by the patient's family or guardian when the patient has been judged incompetent, without retaliation.

Sec. 32. [145.4241] [DEFINITIONS.]

Subdivision 1. [APPLICABILITY.] As used in sections 145.4241 to 145.4246, the following terms have the meaning given them.

Subd. 2. [ABORTION.] "Abortion" means the use or prescription of any instrument, medicine, drug, or any other substance or device to intentionally terminate the pregnancy of a female known to be pregnant, with an intention other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove a dead fetus.

Subd. 3. [ATTEMPT TO PERFORM AN ABORTION.] "Attempt to perform an abortion" means an act, or an omission of a statutorily required act, that, under the circumstances as the actor believes them to be, constitutes a substantial step in a course of conduct planned to culminate in the performance of an abortion in Minnesota in violation of sections 145.4241 to 145.4246.

Subd. 4. [MEDICAL EMERGENCY.] "Medical emergency" means any condition that, on the basis of the physician's good faith clinical judgment, complicates the medical condition of a pregnant female to the extent that:

(1) an immediate abortion of her pregnancy is necessary to avert her death; or

(2) a 24-hour delay in performing an abortion creates a serious risk of substantial and irreversible impairment of a major bodily function.

Subd. 5. [PHYSICIAN.] "Physician" means a person licensed under chapter 147.

Subd. 6. [PROBABLE GESTATIONAL AGE OF THE UNBORN CHILD.] "Probable gestational age of the unborn child" means what will, in the judgment of the physician, with reasonable probability, be the gestational age of the unborn child at the time the abortion is planned to be performed.

Sec. 33. [145.4242] [INFORMED CONSENT.]

No abortion shall be performed in this state except with the voluntary and informed consent of the female upon whom the abortion is to be performed. Except in the case of a medical emergency, consent to an abortion is voluntary and informed only if:

(1) the female is told the following, by telephone or in person, by the physician who is to perform the abortion or by a referring physician, at least 24 hours before the abortion:

(i) the name of the physician who will perform the abortion;

(ii) the particular medical risks associated with the particular abortion procedure to be employed including, when medically accurate, the risks of infection, hemorrhage, breast cancer, danger to subsequent pregnancies, and infertility;

(iii) the probable gestational age of the unborn child at the time the abortion is to be performed; and

(iv) the medical risks associated with carrying her child to term.

The information required by this clause may be provided by telephone without conducting a physical examination or tests of the patient, in which case the information required to be provided may be based on facts supplied the physician by the female and whatever other relevant information is reasonably available to the physician. It may not be provided by a tape recording, but must be provided during a consultation in which the physician is able to ask questions of the female and the female is able to ask questions of the physician. If a physical examination, tests, or the availability of other information to the physician subsequently indicate, in the medical judgment of the physician, a revision of the information previously supplied to the patient, that revised information may be communicated to the patient at any time prior to the performance of the abortion. Nothing in this section may be construed to preclude provision of required information in a language understood by the patient through a translator;

(2) the female is informed, by telephone or in person, by the physician who is to perform the abortion, by a referring physician, or by an agent of either physician at least 24 hours before the abortion:

(i) that medical assistance benefits may be available for prenatal care, childbirth, and neonatal care;

(ii) that the father is liable to assist in the support of her child, even in instances when the father has offered to pay for the abortion; and

(iii) that she has the right to review the printed materials described in section 145.4243. The physician or the physician's agent shall orally inform the female that the materials have been provided by the state of Minnesota and that they describe the unborn child and list agencies that offer alternatives to abortion. If the female chooses to view the materials, they shall either be given to her at least 24 hours before the abortion or mailed to her at least 72 hours before the abortion by certified mail, restricted delivery to addressee, which means the postal employee can only deliver the mail to the addressee.

The information required by this clause may be provided by a tape recording if provision is made to record or otherwise register specifically whether the female does or does not choose to review the printed materials;

(3) the female certifies in writing, prior to the abortion, that the information described in this section has been furnished her, and that she has been informed of her opportunity to review the information referred to in clause (2); and

(4) prior to the performance of the abortion, the physician who is to perform the abortion or the physician's agent receives a copy of the written certification prescribed by clause (3).

Sec. 34. [145.4243] [PRINTED INFORMATION.]

(a) Within 90 days after the effective date of sections 145.4241 to 145.4246, the department of health shall cause to be published, in English and in each language that is the primary language of two percent or more of the state's population, the following printed materials in such a way as to ensure that the information is easily comprehensible:

(1) geographically indexed materials designed to inform the female of public and private agencies and services available to assist a female through pregnancy, upon childbirth, and while the child is dependent, including adoption agencies, which shall include a comprehensive list of the agencies available, a description of the services they offer, and a description of the manner, including telephone numbers, in which they might be contacted or, at the option of the department of health, printed materials including a toll-free, 24-hours-a-day telephone number that may be called to obtain, orally, such a list and description of agencies in the locality of the caller and of the services they offer; and

(2) materials designed to inform the female of the probable anatomical and physiological characteristics of the unborn child at two-week gestational increments from the time when a

female can be known to be pregnant to full term, including any relevant information on the possibility of the unborn child's survival and pictures or drawings representing the development of unborn children at two-week gestational increments, provided that any such pictures or drawings must contain the dimensions of the fetus and must be realistic and appropriate for the stage of pregnancy depicted. The materials shall be objective, nonjudgmental, and designed to convey only accurate scientific information about the unborn child at the various gestational ages. The material shall also contain objective information describing the methods of abortion procedures commonly employed, the medical risks commonly associated with each procedure, the possible detrimental psychological effects of abortion, the medical risks commonly associated with each procedure, and the medical risks commonly associated with carrying a child to term.

(b) The materials referred to in this section must be printed in a typeface large enough to be clearly legible. The materials required under this section must be available at no cost from the department of health upon request and in appropriate number to any person, facility, or hospital.

Sec. 35. [145.4244] [PROCEDURE IN CASE OF MEDICAL EMERGENCY.]

When a medical emergency compels the performance of an abortion, the physician shall inform the female, prior to the abortion if possible, of the medical indications supporting the physician's judgment that an abortion is necessary to avert her death or that a 24-hour delay in conformance with section 145.4242 creates a serious risk of substantial and irreversible impairment of a major bodily function.

Sec. 36. [145.4245] [REMEDIES.]

Subdivision 1. [CIVIL REMEDIES.] Any person upon whom an abortion has been performed or the parent of a minor upon whom an abortion has been performed may maintain an action against the person who performed the abortion in knowing or reckless violation of sections 145.4241 to 145.4246 for actual and punitive damages. Any person upon whom an abortion has been attempted without complying with sections 145.4241 to 145.4246 may maintain an action against the person who attempted to perform the abortion in knowing or reckless violation of sections 145.4241 to 145.4246 for actual and punitive damages.

Subd. 2. [ATTORNEY FEES.] If judgment is rendered in favor of the plaintiff in any action described in this section, the court shall also render judgment for a reasonable attorney's fee in favor of the plaintiff against the defendant. If judgment is rendered in favor of the defendant and the court finds that the plaintiff's suit was frivolous and brought in bad faith, the court shall also render judgment for a reasonable attorney's fee in favor of the defendant against the plaintiff.

Subd. 3. [PROTECTION OF PRIVACY IN COURT PROCEEDINGS.] In every civil action brought under sections 145.4241 to 145.4246, the court shall rule whether the anonymity of any female upon whom an abortion has been performed or attempted shall be preserved from public disclosure if she does not give her consent to such disclosure. The court, upon motion or sua sponte, shall make such a ruling and, upon determining that her anonymity should be preserved, shall issue orders to the parties, witnesses, and counsel and shall direct the sealing of the record and exclusion of individuals from courtrooms or hearing rooms to the extent necessary to safeguard her identity from public disclosure. Each order must be accompanied by specific written findings explaining why the anonymity of the female should be preserved from public disclosure, why the order is essential to that end, how the order is narrowly tailored to serve that interest, and why no reasonable, less restrictive alternative exists. In the absence of written consent of the female upon whom an abortion has been performed or attempted, anyone, other than a public official, who brings an action under subdivision 1, shall do so under a pseudonym. This section may not be construed to conceal the identity of the plaintiff or of witnesses from the defendant.

Sec. 37. [145.4246] [SEVERABILITY.]

If any one or more provision, section, subsection, sentence, clause, phrase, or word of sections 145.4241 to 145.4246 or the application thereof to any person or circumstance is found to be unconstitutional, the same is hereby declared to be severable and the balance of sections 145.4241 to 145.4246 shall remain effective notwithstanding such unconstitutionality. The legislature

hereby declares that it would have passed sections 145.4241 to 145.4246, and each provision, section, subsection, sentence, clause, phrase, or word thereof, irrespective of the fact that any one or more provision, section, subsection, sentence, clause, phrase, or word be declared unconstitutional.

Sec. 38. Minnesota Statutes 2000, section 145.881, subdivision 2, is amended to read:

Subd. 2. [DUTIES.] The advisory task force shall meet on a regular basis to perform the following duties:

(a) review and report on the health care needs of mothers and children throughout the state of Minnesota;

(b) review and report on the type, frequency and impact of maternal and child health care services provided to mothers and children under existing maternal and child health care programs, including programs administered by the commissioner of health;

(c) establish, review, and report to the commissioner a list of program guidelines and criteria which the advisory task force considers essential to providing an effective maternal and child health care program to low income populations and high risk persons and fulfilling the purposes defined in section 145.88;

(d) review staff recommendations of the department of health regarding maternal and child health grant awards before the awards are made;

(e) make recommendations to the commissioner for the use of other federal and state funds available to meet maternal and child health needs;

(f) make recommendations to the commissioner of health on priorities for funding the following maternal and child health services: (1) prenatal, delivery and postpartum care, (2) comprehensive health care for children, especially from birth through five years of age, (3) adolescent health services, (4) family planning services, (5) preventive dental care, (6) special services for chronically ill and handicapped children and (7) any other services which promote the health of mothers and children; ~~and~~

(g) make recommendations to the commissioner of health on the process to distribute, award and administer the maternal and child health block grant funds; and

(h) review the measures that are used to define the variables of the funding distribution formula in section 145.882, subdivision 4a, every two years and make recommendations to the commissioner of health for changes based upon principles established by the advisory task force for this purpose.

Sec. 39. Minnesota Statutes 2000, section 145.882, is amended by adding a subdivision to read:

Subd. 4a. [ALLOCATION TO COMMUNITY HEALTH BOARDS.] (a) Federal maternal and child health block grant money remaining after distributions made under subdivision 2 and money appropriated for allocation to community health boards must be allocated according to paragraphs (b) to (d) to community health boards as defined in section 145A.02, subdivision 5.

(b) All community health boards must receive 95 percent of the funding awarded to them for the 1998-1999 funding cycle. If the amount of state and federal funding available is less than 95 percent of the amount awarded to community health boards for the 1998-1999 funding cycle, the available funding must be apportioned to reflect a proportional decrease for each recipient.

(c) The federal and state funding remaining after distributions made under paragraph (b) must be allocated to each community health board based on the following three variables:

(1) 25 percent based on the maternal and child population in the area served by the community health board;

(2) 50 percent based on the following factors, as determined by averaging the data available for the three most recent years:

(i) the proportion of infants in the area served by the community health board whose weight at birth was less than 2,500 grams;

(ii) the proportion of mothers in the area served by the community health board who received inadequate or no prenatal care;

(iii) the proportion of births in the area served by the community health board to women under age 19; and

(iv) the proportion of births in the area served by the community health board to American Indian women and women of color; and

(3) 25 percent based on the income of the maternal and child population in the area served by the community health board.

(d) Each variable must be expressed as a city or county score consisting of the city or county frequency of each variable in relation to the statewide frequency of the variable. A total score for each city or county jurisdiction must be computed by totaling the scores of the three variables. Each community health board must be allocated an amount equal to the total score obtained for the city, county, or counties in its area multiplied by the amount of money available.

Sec. 40. Minnesota Statutes 2000, section 145.882, subdivision 7, is amended to read:

Subd. 7. [USE OF BLOCK GRANT MONEY.] ~~(a)~~ Maternal and child health block grant money allocated to a community health board or community health services area under this section must be used for qualified programs for high risk and low-income individuals. Block grant money must be used for programs that:

(1) specifically address the highest risk populations, particularly low-income and minority groups with a high rate of infant mortality and children with low birth weight, by providing services, ~~including~~ excluding prepregnancy family planning services, calculated to produce measurable decreases in infant mortality rates, instances of children with low birth weight, and medical complications associated with pregnancy and childbirth, including infant mortality, low birth rates, and medical complications arising from chemical abuse by a mother during pregnancy;

(2) specifically target pregnant women whose age, medical condition, maternal history, or chemical abuse substantially increases the likelihood of complications associated with pregnancy and childbirth or the birth of a child with an illness, disability, or special medical needs;

(3) specifically address the health needs of young children who have or are likely to have a chronic disease or disability or special medical needs, including physical, neurological, emotional, and developmental problems that arise from chemical abuse by a mother during pregnancy;

(4) provide ~~family planning and~~ preventive medical care, excluding prepregnancy family planning services, for specifically identified target populations, such as minority and low-income teenagers, in a manner calculated to ~~decrease the occurrence of inappropriate pregnancy and~~ minimize the risk of complications associated with pregnancy and childbirth; or

(5) specifically address the frequency and severity of childhood injuries and other child and adolescent health problems in high-risk target populations by providing services, excluding prepregnancy family planning services, calculated to produce measurable decreases in mortality and morbidity. ~~However, money may be used for this purpose only if the community health board's application includes program components for the purposes in clauses (1) to (4) in the proposed geographic service area and the total expenditure for injury-related programs under this clause does not exceed ten percent of the total allocation under subdivision 3.~~

~~(b) Maternal and child health block grant money may be used for purposes other than the purposes listed in this subdivision only under the following conditions:~~

~~(1) the community health board or community health services area can demonstrate that existing programs fully address the needs of the highest risk target populations described in this subdivision; or~~

~~(2) the money is used to continue projects that received funding before creation of the maternal and child health block grant in 1981.~~

~~(c) Projects that received funding before creation of the maternal and child health block grant in 1981, must be allocated at least the amount of maternal and child health special project grant funds received in 1989, unless (1) the local board of health provides equivalent alternative funding for the project from another source; or (2) the local board of health demonstrates that the need for the specific services provided by the project has significantly decreased as a result of changes in the demographic characteristics of the population, or other factors that have a major impact on the demand for services. If the amount of federal funding to the state for the maternal and child health block grant is decreased, these projects must receive a proportional decrease as required in subdivision 1. Increases in allocation amounts to local boards of health under subdivision 4 may be used to increase funding levels for these projects.~~

Sec. 41. Minnesota Statutes 2000, section 145.885, subdivision 2, is amended to read:

Subd. 2. [ADDITIONAL REQUIREMENTS FOR COMMUNITY BOARDS OF HEALTH.] Applications by community health boards as defined in section 145A.02, subdivision 5, under section 145.882, subdivision ~~3~~ 4a, must also contain a summary of the process used to develop the local program, including evidence that the community health board notified local public and private providers of the availability of funding through the community health board for maternal and child health services; a list of all public and private agency requests for grants submitted to the community health board indicating which requests were included in the grant application; and an explanation of how priorities were established for selecting the requests to be included in the grant application. The community health board shall include, with the grant application, a written statement of the criteria to be applied to public and private agency requests for funding.

Sec. 42. Minnesota Statutes 2000, section 145.924, is amended to read:

145.924 [AIDS PREVENTION GRANTS.]

Subdivision 1. [GRANT AWARDS.] (a) The commissioner may award grants to boards of health as defined in section 145A.02, subdivision 2, state agencies, state councils, or nonprofit corporations to provide evaluation and counseling services to populations at risk for acquiring human immunodeficiency virus infection, including, but not limited to, minorities, adolescents, intravenous drug users, and homosexual men.

(b) The commissioner may award grants to agencies experienced in providing services to communities of color, for the design of innovative outreach and education programs for targeted groups within the community who may be at risk of acquiring the human immunodeficiency virus infection, including intravenous drug users and their partners, adolescents, gay and bisexual individuals and women. Grants shall be awarded on a request for proposal basis and shall include funds for administrative costs. Priority for grants shall be given to agencies or organizations that have experience in providing service to the particular community which the grantee proposes to serve; that have policymakers representative of the targeted population; that have experience in dealing with issues relating to HIV/AIDS; and that have the capacity to deal effectively with persons of differing sexual orientations. For purposes of this paragraph, the "communities of color" are: the American-Indian community; the Hispanic community; the African-American community; and the Asian-Pacific community.

(c) All state grants awarded under this ~~section~~ subdivision for programs targeted to adolescents shall include the promotion of abstinence from sexual activity and drug use.

Subd. 2. [OUTCOMES.] The commissioner, in consultation with boards of health, agencies, councils, and nonprofit organizations involved in human immunodeficiency virus infection prevention efforts shall establish measurable outcomes to determine the effectiveness of the grants provided under this section in reducing the number of people who acquire human immunodeficiency virus, the rates of infection, and average numbers of sexual partners for populations served by grants funded under this section.

Subd. 3. [EVALUATION.] (a) Using the outcomes established according to subdivision 2, the commissioner shall conduct a biennial evaluation of activities funded under this section. The evaluation must include:

(1) the effect of these activities on the number of people who acquire human immunodeficiency virus and the rates of infection;

(2) the effect of these activities on average numbers of sexual partners for populations served by grants funded under this section; and

(3) a longitudinal tracking of outcomes for targeted populations who are served under subdivision 1, paragraphs (a) and (b).

(b) Grant recipients shall cooperate with the commissioner in the evaluation and shall provide the commissioner with the information needed to conduct the evaluation. Beginning January 15, 2003, the results of each evaluation must be submitted to the chairs of the policy and finance committees in the house and senate with jurisdiction over health and human services.

Sec. 43. Minnesota Statutes 2000, section 145.925, subdivision 1, is amended to read:

Subdivision 1. [ELIGIBLE ORGANIZATIONS; PURPOSE.] The commissioner of health may make special grants to cities, counties, tribal governments, or groups of cities ~~or~~, counties, ~~or nonprofit corporations~~ or tribal governments to provide prepregnancy family planning services~~.~~ targeted to low-income and minority populations. A city, county, tribal government, or group of cities, counties, or tribal governments that receives a grant is responsible for ensuring that the grant funds are used for services targeted to low-income and minority populations, and must establish a goal for reducing specific pregnancy rates in the service area. In determining populations to serve and services to provide, a city, county, tribal government, or group of cities, counties, or tribal governments must consider the spacing of pregnancies in low-income and minority populations in the service area, teen birth rates in the service area, and the needs of populations of color in the service area. A city, county, tribal government, or group of cities, counties, or tribal governments may contract for the provision of prepregnancy family planning services using grant funds provided under this section only if the contract is specifically authorized by the governing body of the city, county, or tribal government that is contracting for the services.

Any organization or an affiliate of an organization which provides abortions, promotes abortions, or directly refers for abortions, shall be ineligible to receive funds under this subdivision.

Sec. 44. Minnesota Statutes 2000, section 145.925, subdivision 1a, is amended to read:

Subd. 1a. [FAMILY PLANNING SERVICES; DEFINED.] "Family planning services" means counseling by trained personnel regarding family planning; distribution of information relating to family planning, referral to licensed physicians or local health agencies for consultation, examination, medical treatment, genetic counseling, and prescriptions for the purpose of family planning; and the distribution of family planning products, such as charts, thermometers, drugs, medical preparations, and contraceptive devices. Family planning services do not include services that, directly or indirectly, encourage, counsel, refer, or provide abortions or abortion referrals. For purposes of sections 145A.01 to 145A.14, family planning shall mean voluntary action by individuals to prevent or aid conception but does not include ~~the performance, or make referrals for encouragement of voluntary termination of pregnancy~~ services that, directly or indirectly, encourage, counsel, refer, or provide abortions or abortion referrals.

Sec. 45. [145.9257] [TEEN PREGNANCY PREVENTION.]

Subdivision 1. [GOAL.] It is the goal of the state to reduce teen pregnancy rates by 24 percent by 2006. To do so, the commissioner of health shall establish a grant program to reduce the rates of unintended teen pregnancies in the state. If this goal of reducing teen pregnancy rates by 24 percent is not met by December 31, 2006, this section expires June 30, 2007. No funds awarded under this section may be used for medical services or family planning services or for services that, directly or indirectly, encourage, counsel, refer, or provide abortions or abortion referrals.

Any organization or an affiliate of an organization which provides abortions, promotes abortions, or directly refers for abortions, shall be ineligible to receive funds under this section.

Subd. 2. [STATE-COMMUNITY PARTNERSHIPS; PLAN.] The commissioner, in consultation with the commissioner of children, families, and learning; the commissioner of human services; the maternal and child health advisory task force under section 145.881; the Indian affairs council under section 3.922; the council on affairs of Chicano/Latino people under section 3.9223; the council on Black Minnesotans under section 3.9225; the council on Asian-Pacific Minnesotans under section 3.9226; community health boards as defined in section 145A.02; tribal governments; nonprofit community organizations; and others interested in teen pregnancy prevention, shall develop and implement a comprehensive, coordinated plan to reduce the number of teen pregnancies.

Subd. 3. [MEASURABLE OUTCOMES.] The commissioner, in consultation with the commissioners and community partners listed in subdivision 2, shall establish measurable outcomes to achieve the goal specified in subdivision 1 and to determine the effectiveness of the grants provided under this section in reducing teen pregnancies. The development of measurable outcomes must be completed before any funds are distributed under this section.

Subd. 4. [STATEWIDE ASSESSMENT.] The commissioner shall use and enhance current statewide assessments of teen pregnancy risk behaviors and attitudes among youth to establish a baseline to measure the statewide effect of teen pregnancy prevention activities. To the extent feasible, the commissioner shall conduct the assessment so that the results may be compared to national data.

Subd. 5. [PROCESS.] The commissioner, in consultation with the commissioners and community partners listed in subdivision 2, shall develop the criteria and procedures used to allocate grants under this section. In developing the criteria, the commissioner shall establish an administrative cost limit for grant recipients. At the time a grant is awarded, the commissioner shall provide a grant recipient with information on the outcomes established according to subdivision 3.

Subd. 6. [TEEN PREGNANCY PREVENTION DISPARITY GRANTS.] (a) The commissioner shall award competitive grants to eligible applicants for projects to reduce disparities in unintended teen pregnancy rates for American Indians and populations of color, as compared with unintended teen pregnancy rates for whites.

(b) No funds awarded under this subdivision may be used for medical services or family planning services or for services that, directly or indirectly, encourage, counsel, refer, or provide abortions or abortion referrals.

Any organization or an affiliate of an organization which provides abortions, promotes abortions, or directly refers for abortions, shall be ineligible to receive funds under this subdivision.

(c) Eligible applicants may include, but are not limited to, nonprofit organizations, school districts, faith-based organizations, community health boards, and tribal governments. Applicants must submit proposals to the commissioner. A proposal must specify the strategies to be implemented and must take into account the need for a coordinated, statewide teen pregnancy prevention effort. Strategies may include youth development programs, after-school enrichment programs, youth mentoring programs, academic support programs, and abstinence until marriage education programs.

(d) The commissioner shall give priority to applicants who demonstrate that their proposed project:

(1) emphasizes abstinence until marriage;

(2) is research-based or based on proven, effective strategies;

(3) is designed to coordinate with related youth risk behavior reduction activities;

(4) involves youth and parents in the project's development and implementation;

(5) reflects racially and ethnically appropriate approaches; and

(6) will be implemented through or with persons or community-based organizations that reflect the race or ethnicity of the population to be reached.

Subd. 7. [HIGH-RISK COMMUNITY TEEN PREGNANCY PREVENTION GRANTS.] (a) The commissioner shall award grants to communities that have significant risk factors for teen pregnancies, that currently have in place youth development programs, and that are interested in expanding existing efforts to prevent teen pregnancies.

(b) No funds awarded under this subdivision may be used for medical services or family planning services or for services that, directly or indirectly, encourage, counsel, refer, or provide abortions or abortion referrals.

Any organization or an affiliate of an organization which provides abortions, promotes abortions, or directly refers for abortions, shall be ineligible to receive funds under this subdivision.

(c) To be eligible for a grant under this subdivision, an applicant must be a tribal government or a community health board as defined in section 145A.02. Applicants must submit proposals to the commissioner. A proposal must specify the strategies to be implemented. Strategies may include, but are not limited to, youth development programs, youth mentoring programs, academic support programs, and abstinence until marriage education programs. Applicants must demonstrate that a proposed project:

(1) emphasizes abstinence until marriage;

(2) is research-based or based on proven, effective strategies;

(3) is designed to coordinate with related youth risk behavior reduction activities;

(4) involves youth and parents in the project's development and implementation;

(5) reflects racially and ethnically appropriate approaches; and

(6) will be implemented through or with persons or community-based organizations that reflect the race or ethnicity of the population to be reached.

(d) Grants may be awarded to up to 15 community health boards and three tribal governments based on areas having the highest risk factors for teen pregnancies. The commissioner shall award grants based on the following risk factors:

(1) the proportion of teens in the applicant's service area who are sexually active;

(2) the proportion of births to teens in the applicant's service area; and

(3) the proportion of births to teens who are American Indian or of a population of color in the applicant's service area.

Subd. 8. [ADOLESCENT PARENT GRANTS.] The commissioner shall transfer funds to the commissioner of children, families, and learning to increase the number of adolescent parent grants currently provided by the commissioner of children, families, and learning under section 124D.33.

Subd. 9. [COORDINATION.] The commissioner shall coordinate the projects and initiatives funded under this section with other efforts at the local, state, and national levels to avoid duplication and promote complementary efforts.

Subd. 10. [EVALUATION.] Using the outcomes established according to subdivision 3, the commissioner shall conduct a biennial evaluation of the impact of each teen pregnancy prevention

initiative in this section. Grant recipients and the commissioner of children, families, and learning shall cooperate with the commissioner in the evaluation and shall provide the commissioner with the information needed to conduct the evaluation.

Subd. 11. [REPORT.] By January 15, 2002, and January 15 of each even-numbered year thereafter, the commissioner shall submit a report to the legislature on the projects funded under this section and the results of the biennial evaluation.

Sec. 46. [145.9268] [COMMUNITY CLINIC GRANTS.]

Subdivision 1. [DEFINITION.] For purposes of this section, "eligible community clinic" means:

(1) a clinic that provides services under conditions as defined in Minnesota Rules, part 9505.0255 or 9505.0380, and utilizes a sliding fee scale to determine eligibility for charity care;

(2) an Indian tribal government or Indian health service unit; or

(3) a consortium of clinics comprised of entities under clause (1) or (2).

Subd. 2. [GRANTS AUTHORIZED.] The commissioner of health shall award grants to eligible community clinics to improve the ongoing viability of Minnesota's clinic-based safety net providers. Grants shall be awarded to support the capacity of eligible community clinics to serve low-income populations, reduce current or future uncompensated care burdens, or provide for improved care delivery infrastructure.

Subd. 3. [ALLOCATION OF GRANTS.] (a) To receive a grant under this section, an eligible community clinic must submit an application to the commissioner of health by the deadline established by the commissioner. A grant may be awarded upon the signing of a grant contract.

(b) An application must be on a form and contain information as specified by the commissioner but at a minimum must contain:

(1) a description of the project for which grant funds will be used;

(2) a description of the problem the proposed project will address; and

(3) a description of achievable objectives, a workplan, and a timeline for project completion.

(c) The commissioner shall review each application to determine whether the application is complete and whether the applicant and the project are eligible for a grant. In evaluating applications according to paragraph (e), the commissioner shall establish criteria including, but not limited to: the priority level of the project; the applicant's thoroughness and clarity in describing the problem; a description of the applicant's proposed project; the manner in which the applicant will demonstrate the effectiveness of the project; and evidence of efficiencies and effectiveness gained through collaborative efforts. The commissioner may also take into account other relevant factors, including, but not limited to, the percentage for which uninsured patients represent the applicant's patient base. During application review, the commissioner may request additional information about a proposed project, including information on project cost. Failure to provide the information requested disqualifies an applicant.

(d) A grant awarded to an eligible community clinic may not exceed $300,000 per eligible community clinic. For an applicant applying as a consortium of clinics, a grant may not exceed $300,000 per clinic included in the consortium. The commissioner has discretion over the number of grants awarded.

(e) In determining which eligible community clinics will receive grants under this section, the commissioner shall give preference to those grant applications that show evidence of collaboration with other eligible community clinics, hospitals, health care providers, or community organizations. In addition, the commissioner shall give priority, in declining order, to grant applications for projects that:

(1) establish, update, or improve information, data collection, or billing systems;

(2) procure, modernize, remodel, or replace equipment used an the delivery of direct patient care at a clinic;

(3) provide improvements for care delivery, such as increased translation and interpretation services;

(4) provide a direct offset to expenses incurred for charity care services; or

(5) other projects determined by the commissioner to improve the ability of applicants to provide care to the vulnerable populations they serve.

Subd. 4. [EVALUATION.] The commissioner of health shall evaluate the overall effectiveness of the grant program. The commissioner shall collect progress reports to evaluate the grant program from the eligible community clinics receiving grants.

Sec. 47. [145.928] [ELIMINATING HEALTH DISPARITIES.]

Subdivision 1. [GOAL; ESTABLISHMENT.] It is the goal of the state, by 2010, to decrease by 50 percent the disparities in infant mortality rates and adult and child immunization rates for American Indians and populations of color, as compared with rates for whites. To do so and to achieve other measurable outcomes, the commissioner of health shall establish a program to close the gap in the health status of American Indians and populations of color as compared with whites in the following priority areas: infant mortality, breast and cervical cancer screening, HIV/AIDS and sexually transmitted infections, adult and child immunizations, cardiovascular disease, diabetes, and accidental injuries and violence. If this goal of reducing disparities in infant mortality rates and adult and child immunization rates is not met by December 31, 2010, this section expires June 30, 2011.

Subd. 2. [STATE-COMMUNITY PARTNERSHIPS; PLAN.] The commissioner, in partnership with culturally-based community organizations; the Indian affairs council under section 3.922; the council on affairs of Chicano/Latino people under section 3.9223; the council on Black Minnesotans under section 3.9225; the council on Asian-Pacific Minnesotans under section 3.9226; community health boards as defined in section 145A.02; and tribal governments, shall develop and implement a comprehensive, coordinated plan to reduce health disparities in the health disparity priority areas identified in subdivision 1.

Subd. 3. [MEASURABLE OUTCOMES.] The commissioner, in consultation with the community partners listed in subdivision 2, shall establish measurable outcomes to achieve the goal specified in subdivision 1 and to determine the effectiveness of the grants and other activities funded under this section in reducing health disparities in the priority areas identified in subdivision 1. The development of measurable outcomes must be completed before any funds are distributed under this section.

Subd. 4. [STATEWIDE ASSESSMENT.] The commissioner shall enhance current data tools to ensure a statewide assessment of the risk behaviors associated with the health disparity priority areas identified in subdivision 1. The statewide assessment must be used to establish a baseline to measure the effect of activities funded under this section. To the extent feasible, the commissioner shall conduct the assessment so that the results may be compared to national data.

Subd. 5. [TECHNICAL ASSISTANCE.] The commissioner shall provide the necessary expertise to grant applicants to ensure that submitted proposals are likely to be successful in reducing the health disparities identified in subdivision 1. The commissioner shall provide grant recipients with guidance and training on best or most promising strategies to use to reduce the health disparities identified in subdivision 1. The commissioner shall also assist grant recipients in the development of materials and procedures to evaluate local community activities.

Subd. 6. [PROCESS.] (a) The commissioner, in consultation with the community partners listed in subdivision 2, shall develop the criteria and procedures used to allocate grants under this section. In developing the criteria, the commissioner shall establish an administrative cost limit for

grant recipients. At the time a grant is awarded, the commissioner must provide a grant recipient with information on the outcomes established according to subdivision 3.

(b) A grant recipient must coordinate its activities to reduce health disparities with other entities receiving funds under this section that are in the grant recipient's service area.

Subd. 7. [COMMUNITY GRANT PROGRAM; IMMUNIZATION RATES AND INFANT MORTALITY RATES.] (a) The commissioner shall award grants to eligible applicants for local or regional projects and initiatives directed at reducing health disparities in one or both of the following priority areas:

(1) decreasing racial and ethnic disparities in infant mortality rates; or

(2) increasing adult and child immunization rates in nonwhite racial and ethnic populations.

(b) The commissioner may award up to 20 percent of the funds available as planning grants. Planning grants must be used to address such areas as community assessment, coordination activities, and development of community supported strategies.

(c) Eligible applicants may include, but are not limited to, faith-based organizations, social service organizations, community nonprofit organizations, community health boards, tribal governments, and community clinics. Applicants must submit proposals to the commissioner. A proposal must specify the strategies to be implemented to address one or both of the priority areas listed in paragraph (a) and must be targeted to achieve the outcomes established according to subdivision 3.

(d) The commissioner shall give priority to applicants who demonstrate that their proposed project or initiative:

(1) is supported by the community the applicant will serve;

(2) is research-based or based on promising strategies;

(3) is designed to complement other related community activities;

(4) utilizes strategies that positively impact both priority areas;

(5) reflects racially and ethnically appropriate approaches; and

(6) will be implemented through or with community-based organizations that reflect the race or ethnicity of the population to be reached.

Subd. 8. [COMMUNITY GRANT PROGRAM; OTHER HEALTH DISPARITIES.] (a) The commissioner shall award grants to eligible applicants for local or regional projects and initiatives directed at reducing health disparities in one or more of the following priority areas:

(1) decreasing racial and ethnic disparities in morbidity and mortality rates from breast and cervical cancer;

(2) decreasing racial and ethnic disparities in morbidity and mortality rates from HIV/AIDS and sexually transmitted infections;

(3) decreasing racial and ethnic disparities in morbidity and mortality rates from cardiovascular disease;

(4) decreasing racial and ethnic disparities in morbidity and mortality rates from diabetes; or

(5) decreasing racial and ethnic disparities in morbidity and mortality rates from accidental injuries or violence.

(b) The commissioner may award up to 20 percent of the funds available as planning grants. Planning grants must be used to address such areas as community assessment, determining community priority areas, coordination activities, and development of community supported strategies.

(c) Eligible applicants may include, but are not limited to, faith-based organizations, social service organizations, community nonprofit organizations, community health boards, tribal governments, and community clinics. Applicants shall submit proposals to the commissioner. A proposal must specify the strategies to be implemented to address one or more of the priority areas listed in paragraph (a) and must be targeted to achieve the outcomes established according to subdivision 3.

(d) The commissioner shall give priority to applicants who demonstrate that their proposed project or initiative:

(1) is supported by the community the applicant will serve;

(2) is research-based or based on promising strategies;

(3) is designed to complement other related community activities;

(4) utilizes strategies that positively impact more than one priority area;

(5) reflects racially and ethnically appropriate approaches; and

(6) will be implemented through or with community-based organizations that reflect the race or ethnicity of the population to be reached.

Subd. 9. [REFUGEE AND IMMIGRANT HEALTH.] (a) The commissioner shall distribute funds to community health boards for health screening and follow-up services for tuberculosis for refugees. Funds shall be distributed based on the following formula:

(1) $1,500 per refugee with pulmonary tuberculosis in the community health board's service area;

(2) $500 per refugee with extrapulmonary tuberculosis in the community health board's service area;

(3) $500 per month of directly observed therapy provided by the community health board for each uninsured refugee with pulmonary or extrapulmonary tuberculosis; and

(4) $50 per refugee in the community health board's service area.

(b) Payments must be made at the end of each state fiscal year. The amount paid per tuberculosis case, per month of directly observed therapy, and per refugee must be proportionately increased or decreased to fit the actual amount appropriated for that fiscal year.

Subd. 10. [COORDINATION.] The commissioner shall coordinate the projects and initiatives funded under this section with other efforts at the local, state, or national level to avoid duplication and promote complementary efforts.

Subd. 11. [EVALUATION.] Using the outcomes established according to subdivision 3, the commissioner shall conduct a biennial evaluation of the community grant programs under subdivisions 7 and 8. Grant recipients shall cooperate with the commissioner in the evaluation and shall provide the commissioner with the information needed to conduct the evaluation.

Subd. 12. [REPORT.] By January 15, 2002, and January 15 of each even-numbered year thereafter, the commissioner shall submit a report to the legislature on the local community projects and community health board activities funded under this section. The report must include information on grant recipients, activities conducted using grant funds, and evaluation data and outcome measures if available.

Sec. 48. Minnesota Statutes 2000, section 145A.15, subdivision 1, is amended to read:

Subdivision 1. [ESTABLISHMENT.] (a) The commissioner of health shall expand the current grant program to fund additional projects designed to prevent child abuse and neglect and reduce juvenile delinquency by promoting positive parenting, resiliency in children, and a healthy

beginning for children by providing early intervention services for families in need. Grant dollars shall be available to train paraprofessionals to provide in-home intervention services and to allow public health nurses to do case management of services. The grant program shall provide early intervention services for families in need and will include:

(1) expansion of current public health nurse and family aide home visiting programs and public health home visiting projects which prevent child abuse and neglect, prevent juvenile delinquency, and build resiliency in children;

(2) early intervention to promote a healthy and nurturing beginning;

(3) distribution of educational and public information programs and materials in hospital maternity divisions, well-baby clinics, obstetrical clinics, and community clinics; and

(4) training of home visitors in skills necessary for comprehensive home visiting which promotes a healthy and nurturing beginning for the child.

(b) No new grants shall be awarded under this section after June 30, 2001. Grant contracts awarded and in effect under this section as of July 1, 2001, shall continue until their expiration date.

Sec. 49. Minnesota Statutes 2000, section 145A.15, is amended by adding a subdivision to read:

Subd. 5. [EXPIRATION.] This section expires June 30, 2003.

Sec. 50. Minnesota Statutes 2000, section 145A.16, subdivision 1, is amended to read:

Subdivision 1. [ESTABLISHMENT.] The commissioner shall establish a grant program to fund universally offered home visiting programs designed to serve all live births in designated geographic areas. The commissioner shall designate the geographic area to be served by each program. At least one program must provide home visiting services to families within the seven-county metropolitan area, and at least one program must provide home visiting services to families outside the metropolitan area. The purpose of the program is to strengthen families and to promote positive parenting and healthy child development. No new grants shall be awarded under this section after June 30, 2001. Competitive grant contracts awarded and in effect under this section as of July 1, 2001, shall expire December 31, 2003.

Sec. 51. Minnesota Statutes 2000, section 145A.16, is amended by adding a subdivision to read:

Subd. 10. [EXPIRATION.] This section expires December 31, 2003.

Sec. 52. [145A.17] [FAMILY HOME VISITING PROGRAMS.]

Subdivision 1. [ESTABLISHMENT; GOALS.] The commissioner shall establish a program to fund family home visiting programs designed to foster a healthy beginning for children in families at or below 200 percent of the federal poverty guidelines, prevent child abuse and neglect, reduce juvenile delinquency, promote positive parenting and resiliency in children, and promote family health and economic self-sufficiency. A program funded under this section must serve families at or below 200 percent of the federal poverty guidelines, and other families determined to be at risk for child abuse, neglect, or juvenile delinquency. Programs must give priority for services to families considered to be in need of services, including but not limited to families with:

(1) adolescent parents;

(2) a history of alcohol or other drug abuse;

(3) a history of child abuse, domestic abuse, or other types of violence;

(4) a history of domestic abuse, rape, or other forms of victimization;

(5) reduced cognitive functioning;

(6) a lack of knowledge of child growth and development stages;

(7) low resiliency to adversities and environmental stresses; or

(8) insufficient financial resources to meet family needs.

Subd. 2. [ALLOCATION OF FUNDS.] The commissioner shall distribute funds available under this section to community health boards, as defined in section 145A.02, and to tribal governments. Funds shall be distributed to community health boards as follows: (1) each community health board shall receive an allocation of $25,000 per year; and (2) remaining funds available to community health boards shall be distributed according to the formula in section 256J.625, subdivision 3. The commissioner, in consultation with tribal governments, shall establish a formula for distributing funds to tribal governments.

Subd. 3. [REQUIREMENTS FOR PROGRAMS; PROCESS.] (a) Before a community health board or tribal government may receive an allocation under subdivision 2, a community health board or tribal government must submit a proposal to the commissioner that includes identification, based on a community assessment, of the populations at or below 200 percent of the federal poverty guidelines that will be served and the other populations that will be served. Each program that receives funds must:

(1) use either a broad community-based or selective community-based strategy to provide preventive and early intervention home visiting services;

(2) offer a home visit by a trained home visitor. If a home visit is accepted, the first home visit must occur prenatally or as soon after birth as possible and must include a public health nursing assessment by a public health nurse;

(3) offer, at a minimum, information on infant care, child growth and development, positive parenting, preventing diseases, preventing exposure to environmental hazards, and support services available in the community;

(4) provide information on and referrals to health care services, if needed, including information on health care coverage for which the child or family may be eligible; and provide information on preventive services, developmental assessments, and the availability of public assistance programs as appropriate;

(5) recruit home visitors who will represent, to the extent possible, the races, cultures, and languages spoken by families that may be served;

(6) train and supervise home visitors in accordance with the requirements established under subdivision 4;

(7) maximize resources and minimize duplication by coordinating activities with local social and human services organizations, education organizations, and other appropriate governmental entities and community-based organizations and agencies; and

(8) utilize appropriate racial and ethnic approaches to providing home visiting services.

(b) Funds available under this section shall not be used for medical services. The commissioner shall establish an administrative cost limit for recipients of funds. The outcome measures established under subdivision 6 must be specified to recipients of funds at the time the funds are distributed.

Subd. 4. [TRAINING.] The commissioner shall establish training requirements for home visitors and minimum requirements for supervision by a public health nurse. The requirements for nurses must be consistent with chapter 148. Training must include child development, positive parenting techniques, and diverse cultural practices in child rearing and family systems.

Subd. 5. [TECHNICAL ASSISTANCE.] The commissioner shall provide administrative and

technical assistance to each program, including assistance in data collection and other activities related to conducting short- and long-term evaluations of the programs as required under subdivision 7. The commissioner may request research and evaluation support from the University of Minnesota.

Subd. 6. [OUTCOME MEASURES.] The commissioner shall establish outcomes to determine the impact of family home visiting programs funded under this section on the following areas:

(1) appropriate utilization of preventive health care;

(2) rates of substantiated child abuse and neglect;

(3) rates of unintentional child injuries; and

(4) any additional qualitative goals and quantitative measures established by the commissioner.

Subd. 7. [EVALUATION.] Using the qualitative goals and quantitative outcome measures established under subdivisions 1 and 6, the commissioner shall conduct ongoing evaluations of the programs funded under this section. Community health boards and tribal governments shall cooperate with the commissioner in the evaluations and shall provide the commissioner with the information necessary to conduct the evaluations. As part of the ongoing evaluations, the commissioner shall rate the impact of the programs on the outcome measures listed in subdivision 6, and shall periodically determine whether home visiting programs are the best way to achieve the qualitative goals established in subdivision 1 and by the commissioner. If the commissioner determines that home visiting programs are not the best way to achieve these goals, the commissioner shall provide the legislature with alternative methods for achieving them.

Subd. 8. [REPORT.] By January 15, 2002, and January 15 of each even-numbered year thereafter, the commissioner shall submit a report to the legislature on the family home visiting programs funded under this section and on the results of the evaluations conducted under subdivision 7.

Subd. 9. [NO SUPPLANTING OF EXISTING FUNDS.] Funding available under this section may be used only to supplement, not to replace, nonstate funds being used for home visiting services as of July 1, 2001.

Sec. 53. Minnesota Statutes 2000, section 157.16, subdivision 3, is amended to read:

Subd. 3. [ESTABLISHMENT FEES; DEFINITIONS.] (a) The following fees are required for food and beverage service establishments, hotels, motels, lodging establishments, and resorts licensed under this chapter. Food and beverage service establishments must pay the highest applicable fee under paragraph (e), clause (1), (2), (3), or (4), and establishments serving alcohol must pay the highest applicable fee under paragraph (e), clause (6) or (7). The license fee for new operators previously licensed under this chapter for the same calendar year is one-half of the appropriate annual license fee, plus any penalty that may be required. The license fee for operators opening on or after October 1 is one-half of the appropriate annual license fee, plus any penalty that may be required. The fees in paragraphs (b), (c), and (d) effective until June 30, 2001, shall be phased up as specified in section 55 to the fee amounts effective beginning July 1, 2004. Notwithstanding section 16A.1285, in fiscal years 2002, 2003, and 2004, the commissioner shall regulate food and beverage service establishments, hotels, motels, lodging establishments, and resorts with the fees collected for that purpose.

(b) All food and beverage service establishments, except special event food stands, and all hotels, motels, lodging establishments, and resorts shall pay an annual base fee of $100 until June 30, 2001. Effective July 1, 2004, the annual base fee shall be $145.

(c) A special event food stand shall pay a flat fee of $30 annually until June 30, 2001. Effective July 1, 2004, the annual flat fee shall be $35. "Special event food stand" means a fee category where food is prepared or served in conjunction with celebrations, county fairs, or special events from a special event food stand as defined in section 157.15.

(d) In addition to the base fee in paragraph (b), each food and beverage service establishment, other than a special event food stand, and each hotel, motel, lodging establishment, and resort shall pay an additional annual fee for each fee category as specified in this paragraph:

(1) Limited food menu selection, $30 until June 30, 2001. Effective July 1, 2004, the annual fee shall be $40. "Limited food menu selection" means a fee category that provides one or more of the following:

(i) prepackaged food that receives heat treatment and is served in the package;

(ii) frozen pizza that is heated and served;

(iii) a continental breakfast such as rolls, coffee, juice, milk, and cold cereal;

(iv) soft drinks, coffee, or nonalcoholic beverages; or

(v) cleaning for eating, drinking, or cooking utensils, when the only food served is prepared off site.

(2) Small establishment, including boarding establishments, $55 until June 30, 2001. Effective July 1, 2004, the annual fee shall be $75. "Small establishment" means a fee category that has no salad bar and meets one or more of the following:

(i) possesses food service equipment that consists of no more than a deep fat fryer, a grill, two hot holding containers, and one or more microwave ovens;

(ii) serves dipped ice cream or soft serve frozen desserts;

(iii) serves breakfast in an owner-occupied bed and breakfast establishment;

(iv) is a boarding establishment; or

(v) meets the equipment criteria in clause (3), item (i) or (ii), and has a maximum patron seating capacity of not more than 50.

(3) Medium establishment, $150 until June 30, 2001. Effective July 1, 2004, the annual fee shall be $210. "Medium establishment" means a fee category that meets one or more of the following:

(i) possesses food service equipment that includes a range, oven, steam table, salad bar, or salad preparation area;

(ii) possesses food service equipment that includes more than one deep fat fryer, one grill, or two hot holding containers; or

(iii) is an establishment where food is prepared at one location and served at one or more separate locations.

Establishments meeting criteria in clause (2), item (v), are not included in this fee category.

(4) Large establishment, $250 until June 30, 2001. Effective July 1, 2004, the annual fee shall be $350. "Large establishment" means either:

(i) a fee category that (A) meets the criteria in clause (3), items (i) or (ii), for a medium establishment, (B) seats more than 175 people, and (C) offers the full menu selection an average of five or more days a week during the weeks of operation; or

(ii) a fee category that (A) meets the criteria in clause (3), item (iii), for a medium establishment, and (B) prepares and serves 500 or more meals per day.

(5) Other food and beverage service, including food carts, mobile food units, seasonal temporary food stands, and seasonal permanent food stands, $30 until June 30, 2001. Effective July 1, 2004, the annual fee shall be $40.

(6) Beer or wine table service, $30 until June 30, 2001. Effective July 1, 2004, the annual fee shall be $40. "Beer or wine table service" means a fee category where the only alcoholic beverage service is beer or wine, served to customers seated at tables.

(7) Alcoholic beverage service, other than beer or wine table service, $75 until June 30, 2001. Effective July 1, 2004, the annual fee shall be $105.

"Alcohol beverage service, other than beer or wine table service" means a fee category where alcoholic mixed drinks are served or where beer or wine are served from a bar.

(8) Until June 30, 2001, lodging per sleeping accommodation unit, $4, including hotels, motels, lodging establishments, and resorts, up to a maximum of $400. Effective July 1, 2004, lodging per sleeping accommodation unit, $6, including hotels, motels, lodging establishments, and resorts, up to a maximum of $600. "Lodging per sleeping accommodation unit" means a fee category including the number of guest rooms, cottages, or other rental units of a hotel, motel, lodging establishment, or resort; or the number of beds in a dormitory.

(9) First public swimming pool, $100 until June 30, 2001; each additional public swimming pool, $50 until June 30, 2001. Effective July 1, 2004, first public swimming pool, $140; each additional public swimming pool, $80. "Public swimming pool" means a fee category that has the meaning given in Minnesota Rules, part 4717.0250, subpart 8.

(10) First spa, $50 until June 30, 2001; each additional spa, $25 until June 30, 2001. Effective July 1, 2004, first spa, $80; each additional spa, $40. "Spa pool" means a fee category that has the meaning given in Minnesota Rules, part 4717.0250, subpart 9.

(11) Private sewer or water, $30 until June 30, 2001. Effective July 1, 2004, private sewer or water, $40. "Individual private water" means a fee category with a water supply other than a community public water supply as defined in Minnesota Rules, chapter 4720. "Individual private sewer" means a fee category with an individual sewage treatment system which uses subsurface treatment and disposal.

(e) ~~A fee is not required for a food and beverage service establishment operated by a school as defined in sections 120A.05, subdivisions 9, 11, 13, and 17 and 120A.22.~~

~~(f)~~ A fee of $150 for review of the construction plans must accompany the initial license application for food and beverage service establishments, hotels, motels, lodging establishments, or resorts.

~~(g)~~ (f) When existing food and beverage service establishments, hotels, motels, lodging establishments, or resorts are extensively remodeled, a fee of $150 must be submitted with the remodeling plans.

~~(h)~~ (g) Seasonal temporary food stands and special event food stands are not required to submit construction or remodeling plans for review.

Sec. 54. Minnesota Statutes 2000, section 157.22, is amended to read:

157.22 [EXEMPTIONS.]

This chapter shall not be construed to apply to:

(1) interstate carriers under the supervision of the United States Department of Health and Human Services;

(2) any building constructed and primarily used for religious worship;

(3) any building owned, operated, and used by a college or university in accordance with health regulations promulgated by the college or university under chapter 14;

(4) any person, firm, or corporation whose principal mode of business is licensed under sections 28A.04 and 28A.05, is exempt at that premises from licensure as a food or beverage

establishment; provided that the holding of any license pursuant to sections 28A.04 and 28A.05 shall not exempt any person, firm, or corporation from the applicable provisions of this chapter or the rules of the state commissioner of health relating to food and beverage service establishments;

(5) family day care homes and group family day care homes governed by sections 245A.01 to 245A.16;

(6) nonprofit senior citizen centers for the sale of home-baked goods; ~~and~~

(7) food not prepared at an establishment and brought in by individuals attending a potluck event for consumption at the potluck event. An organization sponsoring a potluck event under this clause may advertise the potluck event to the public through any means. Individuals who are not members of an organization sponsoring a potluck event under this clause may attend the potluck event and consume the food at the event. Licensed food establishments cannot be sponsors of potluck events. Potluck event food shall not be brought into a licensed food establishment kitchen; and

(8) a home school in which a child is provided instruction at home.

Sec. 55. [ESTABLISHMENT FEES DURING TRANSITION PERIOD.]

For fiscal years 2002, 2003, and 2004, the following fees shall apply to food and beverage service establishments, hotels, motels, lodging establishments, and resorts for which fees are established under Minnesota Statutes, section 157.16, subdivision 3, paragraphs (b), (c), and (d):

| Fee Category | Fiscal Year 2002 | Fiscal Year 2003 | Fiscal Year 2004 |
|---|---|---|---|
| Annual base fee, all food and beverage service establishments except special event food stands and all hotels, motels, lodging establishments, and resorts | $111.25 | $122.50 | $133.75 |
| Special event food stand | $ 31.25 | $ 32.50 | $ 33.75 |
| Establishment with limited food menu selection | $ 32.50 | $ 35.00 | $ 37.50 |
| Small establishment | $ 60.00 | $ 65.00 | $ 70.00 |
| Medium establishment | $165.00 | $180.00 | $195.00 |
| Large establishment | $275.00 | $300.00 | $325.00 |
| Other food and beverage service | $ 32.50 | $ 35.00 | $ 37.50 |
| Beer or wine table service | $ 32.50 | $ 35.00 | $ 37.50 |
| Alcoholic beverage service other than beer or wine table service | $ 82.50 | $ 90.00 | $ 97.50 |
| Lodging per sleeping accommodation unit, up to a specified maximum | $4.50 per unit, $450 maximum | $5.00 per unit, $500 maximum | $5.50 per unit, $550 maximum |
| First public swimming pool | $110.00 | $120.00 | $130.00 |
| Each additional | $ 57.50 | $ 65.00 | $ 72.50 |

| | | | |
|---|---|---|---|
| public swimming pool | | | |
| First spa | $ 57.50 | $ 65.00 | $ 72.50 |
| Each additional spa | $ 28.75 | $ 32.50 | $ 36.25 |
| Private sewer or water | $ 32.50 | $ 35.00 | $ 37.50 |

Sec. 56. [REPEALER.]

(a) Minnesota Statutes 2000, sections 145.882, subdivisions 3 and 4; and 145.927, are repealed.

(b) Minnesota Statutes 2000, section 144.148, subdivision 8, is repealed.

**[EFFECTIVE DATE.]** Paragraph (b) of this section is effective the day following final enactment.

ARTICLE 2

HEALTH CARE

Section 1. Minnesota Statutes 2000, section 256.01, subdivision 2, is amended to read:

Subd. 2. [SPECIFIC POWERS.] Subject to the provisions of section 241.021, subdivision 2, the commissioner of human services shall:

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

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

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

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

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

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

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

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

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

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

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

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

(6) Act as the agent of and cooperate with the federal government in matters of mutual concern relative to and in conformity with the provisions of Laws 1939, chapter 431, including the administration of any federal funds granted to the state to aid in the performance of any functions of the commissioner as specified in Laws 1939, chapter 431, and including the promulgation of rules making uniformly available medical care benefits to all recipients of public assistance, at such times as the federal government increases its participation in assistance expenditures for medical care to recipients of public assistance, the cost thereof to be borne in the same proportion as are grants of aid to said recipients.

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

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

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

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

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

(12) Have the authority to conduct and administer experimental projects to test methods and procedures of administering assistance and services to recipients or potential recipients of public welfare. To carry out such experimental projects, it is further provided that the commissioner of human services is authorized to waive the enforcement of existing specific statutory program requirements, rules, and standards in one or more counties. The order establishing the waiver shall provide alternative methods and procedures of administration, shall not be in conflict with the basic purposes, coverage, or benefits provided by law, and in no event shall the duration of a project exceed four years. It is further provided that no order establishing an experimental project

as authorized by the provisions of this section shall become effective until the following conditions have been met:

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

(b) A comprehensive plan, including estimated project costs, shall be approved by the legislative advisory commission and filed with the commissioner of administration.

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

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

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

(b) Notwithstanding the provisions of paragraph (a), if the disallowance results from knowing noncompliance by one or more counties with a specific program instruction, and that knowing noncompliance is a matter of official county board record, the commissioner may require payment or recover from the county or counties, in the manner prescribed in paragraph (a), an amount equal to the portion of the total disallowance which resulted from the noncompliance, and may distribute the balance of the disallowance according to paragraph (a).

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

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

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

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

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

(c) If the required reports are not received by the deadlines established in clause (b), the commissioner may delay payments and withhold funds from the county board until the next reporting period. When the report is needed to account for the use of federal funds and the late report results in a reduction in federal funding, the commissioner shall withhold from the county boards with late reports an amount equal to the reduction in federal funding until full federal funding is received.

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

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

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

(g) Counties subject to withholding of funds under paragraph (c) or forfeiture or repayment of funds under paragraph (e) shall not reduce or withhold benefits or services to clients to cover costs incurred due to actions taken by the commissioner under paragraph (c) or (e).

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

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

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

(21) Have the authority to administer a drug rebate program for drugs purchased pursuant to the prescription drug program established under section 256.955 after the beneficiary's satisfaction of any deductible established in the program. The commissioner shall require a rebate agreement from all manufacturers of covered drugs as defined in section 256B.0625, subdivision 13. Rebate agreements for prescription drugs delivered on or after July 1, 2002, must include rebates for individuals covered under the prescription drug program who are under 65 years of age. For each drug, the amount of the rebate shall be equal to the basic rebate as defined for purposes of the federal rebate program in United States Code, title 42, section 1396r-8(c)(1). This basic rebate shall be applied to single-source and multiple-source drugs. The manufacturers must provide full

payment within 30 days of receipt of the state invoice for the rebate within the terms and conditions used for the federal rebate program established pursuant to section 1927 of title XIX of the Social Security Act. The manufacturers must provide the commissioner with any information necessary to verify the rebate determined per drug. The rebate program shall utilize the terms and conditions used for the federal rebate program established pursuant to section 1927 of title XIX of the Social Security Act.

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

~~(22)~~ (23) Operate the department's communication systems account established in Laws 1993, First Special Session chapter 1, article 1, section 2, subdivision 2, to manage shared communication costs necessary for the operation of the programs the commissioner supervises. A communications account may also be established for each regional treatment center which operates communications systems. Each account must be used to manage shared communication costs necessary for the operations of the programs the commissioner supervises. The commissioner may distribute the costs of operating and maintaining communication systems to participants in a manner that reflects actual usage. Costs may include acquisition, licensing, insurance, maintenance, repair, staff time and other costs as determined by the commissioner. Nonprofit organizations and state, county, and local government agencies involved in the operation of programs the commissioner supervises may participate in the use of the department's communications technology and share in the cost of operation. The commissioner may accept on behalf of the state any gift, bequest, devise or personal property of any kind, or money tendered to the state for any lawful purpose pertaining to the communication activities of the department. Any money received for this purpose must be deposited in the department's communication systems accounts. Money collected by the commissioner for the use of communication systems must be deposited in the state communication systems account and is appropriated to the commissioner for purposes of this section.

~~(23)~~ (24) Receive any federal matching money that is made available through the medical assistance program for the consumer satisfaction survey. Any federal money received for the survey is appropriated to the commissioner for this purpose. The commissioner may expend the federal money received for the consumer satisfaction survey in either year of the biennium.

~~(24)~~ (25) Incorporate cost reimbursement claims from First Call Minnesota into the federal cost reimbursement claiming processes of the department according to federal law, rule, and regulations. Any reimbursement received is appropriated to the commissioner and shall be disbursed to First Call Minnesota according to normal department payment schedules.

~~(25)~~ (26) Develop recommended standards for foster care homes that address the components of specialized therapeutic services to be provided by foster care homes with those services.

Sec. 2. Minnesota Statutes 2000, section 256.955, subdivision 2b, is amended to read:

Subd. 2b. [ELIGIBILITY.] Effective July 1, 2002, an individual satisfying the following requirements and the requirements described in subdivision 2, paragraph (d), is eligible for the prescription drug program:

(1) is under 65 years of age; and

(2) is eligible as a qualified Medicare beneficiary according to section 256B.057, subdivision 3 or 3a, or is eligible under section 256B.057, subdivision 3 or 3a, and is also eligible for medical assistance or general assistance medical care with a spenddown as defined in section 256B.056, subdivision 5.

Sec. 3. [256.956] [PURCHASING ALLIANCE STOP-LOSS FUND.]

Subdivision 1. [DEFINITIONS.] For purposes of this section, the following definitions apply:

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

(b) "Health plan" means a policy, contract, or certificate issued by a health plan company to a qualifying purchasing alliance. Any health plan issued to the members of a qualifying purchasing alliance must meet the requirements of chapter 62L.

(c) "Health plan company" means:

(1) a health carrier as defined under section 62A.011, subdivision 2;

(2) a community integrated service network operating under chapter 62N; or

(3) an accountable provider network operating under chapter 62T.

(d) "Qualifying employer" means an employer who:

(1) is a member of a qualifying purchasing alliance;

(2) has at least one employee but no more than ten employees or is a sole proprietor or farmer;

(3) did not offer employer-subsidized health care coverage to its employees for at least 12 months prior to joining the purchasing alliance; and

(4) is offering health coverage through the purchasing alliance to all employees who work at least 20 hours per week unless the employee is eligible for Medicare.

For purposes of this subdivision, "employer-subsidized health coverage" means health coverage for which the employer pays at least 50 percent of the cost of coverage for the employee.

(e) "Qualifying enrollee" means an employee of a qualifying employer or the employee's dependent covered by a health plan.

(f) "Qualifying purchasing alliance" means a purchasing alliance as defined in section 62T.01, subdivision 2, that:

(1) meets the requirements of chapter 62T;

(2) services a geographic area located in outstate Minnesota, excluding the city of Duluth; and

(3) is organized and operating before May 1, 2001.

The criteria used by the qualifying purchasing alliance for membership must be approved by the commissioner of health. A qualifying purchasing alliance may begin enrolling qualifying employers after July 1, 2001, with enrollment ending by December 31, 2003.

Subd. 2. [CREATION OF ACCOUNT.] A purchasing alliance stop-loss fund account is established in the general fund. The commissioner shall use the money to establish a stop-loss fund from which a health plan company may receive reimbursement for claims paid for qualifying enrollees. The account consists of money appropriated by the legislature. Money from the account must be used for the stop-loss fund.

Subd. 3. [REIMBURSEMENT.] (a) A health plan company may receive reimbursement from the fund for 90 percent of the portion of the claim that exceeds $30,000 but not of the portion that exceeds $100,000 in a calendar year for a qualifying enrollee.

(b) Claims shall be reported and funds shall be distributed on a calendar-year basis. Claims shall be eligible for reimbursement only for the calendar year in which the claims were paid.

(c) Once claims paid on behalf of a qualifying enrollee reach $100,000 in a given calendar year, no further claims may be submitted for reimbursement on behalf of that enrollee in that calendar year.

Subd. 4. [REQUEST PROCESS.] (a) Each health plan company must submit a request for reimbursement from the fund on a form prescribed by the commissioner. Requests for payment must be submitted no later than April 1 following the end of the calendar year for which the reimbursement request is being made, beginning April 1, 2002.

(b) The commissioner may require a health plan company to submit claims data as needed in connection with the reimbursement request.

Subd. 5. [DISTRIBUTION.] (a) The commissioner shall calculate the total claims reimbursement amount for all qualifying health plan companies for the calendar year for which claims are being reported and shall distribute the stop-loss funds on an annual basis.

(b) In the event that the total amount requested for reimbursement by the health plan companies for a calendar year exceeds the funds available for distribution for claims paid by all health plan companies during the same calendar year, the commissioner shall provide for the pro rata distribution of the available funds. Each health plan company shall be eligible to receive only a proportionate amount of the available funds as the health plan company's total eligible claims paid compares to the total eligible claims paid by all health plan companies.

(c) In the event that funds available for distribution for claims paid by all health plan companies during a calendar year exceed the total amount requested for reimbursement by all health plan companies during the same calendar year, any excess funds shall be reallocated for distribution in the next calendar year.

Subd. 6. [DATA.] Upon the request of the commissioner, each health plan company shall furnish such data as the commissioner deems necessary to administer the fund. The commissioner may require that such data be submitted on a per enrollee, aggregate, or categorical basis. Any data submitted under this section shall be classified as private data or nonpublic data as defined in section 13.02.

Subd. 7. [DELEGATION.] The commissioner may delegate any or all of the commissioner's administrative duties to another state agency or to a private contractor.

Subd. 8. [REPORT.] The commissioner of commerce, in consultation with the office of rural health and the qualifying purchasing alliances, shall evaluate the extent to which the purchasing alliance stop-loss fund increases the availability of employer-subsidized health care coverage for residents residing in the geographic areas served by the qualifying purchasing alliances. A preliminary report must be submitted to the legislature by February 15, 2003, and a final report must be submitted by February 15, 2004.

Subd. 9. [SUNSET.] This section shall expire January 1, 2005.

Sec. 4. [256.958] [RETIRED DENTIST PROGRAM.]

Subdivision 1. [PROGRAM.] The commissioner of human services shall establish a program to reimburse a retired dentist for the dentist's license fee and for the cost of malpractice insurance in exchange for the dentist providing 100 hours of dental services on a volunteer basis within a 12-month period at a community dental clinic or a dental training clinic located at a Minnesota state college or university.

Subd. 2. [DOCUMENTATION.] Upon completion of the required hours, the retired dentist shall submit to the commissioner the following:

(1) documentation of service provided;

(2) the cost of malpractice insurance for the 12-month period; and

(3) the cost of the license.

Subd. 3. [REIMBURSEMENT.] Upon receipt of the information described in subdivision 2, the commissioner shall provide reimbursement to the retired dentist for the cost of malpractice insurance for the previous 12-month period and the cost of the license.

Sec. 5. Minnesota Statutes 2000, section 256.9657, subdivision 2, is amended to read:

Subd. 2. [HOSPITAL SURCHARGE.] (a) Effective October 1, 1992, each Minnesota hospital except facilities of the federal Indian Health Service and regional treatment centers shall pay to the medical assistance account a surcharge equal to 1.4 percent of net patient revenues excluding net Medicare revenues reported by that provider to the health care cost information system according to the schedule in subdivision 4.

(b) Effective July 1, 1994, the surcharge under paragraph (a) is increased to 1.56 percent.

(c) Notwithstanding the Medicare cost finding and allowable cost principles, the hospital surcharge is not an allowable cost for purposes of rate setting under sections 256.9685 to 256.9695.

Sec. 6. Minnesota Statutes 2000, section 256.969, subdivision 2b, is amended to read:

Subd. 2b. [OPERATING PAYMENT RATES.] In determining operating payment rates for admissions occurring on or after the rate year beginning January 1, 1991, and every two years after, or more frequently as determined by the commissioner, the commissioner shall obtain operating data from an updated base year and, within the limits of available appropriations, establish operating payment rates per admission for each hospital based on the cost-finding methods and allowable costs of the Medicare program in effect during the base year. Rates under the general assistance medical care, medical assistance, and MinnesotaCare programs shall not be rebased to more current data on January 1, 1997. The base year operating payment rate per admission is standardized by the case mix index and adjusted by the hospital cost index, relative values, and disproportionate population adjustment. The cost and charge data used to establish operating rates shall only reflect inpatient services covered by medical assistance and shall not include property cost information and costs recognized in outlier payments.

Sec. 7. Minnesota Statutes 2000, section 256.969, is amended by adding a subdivision to read:

Subd. 26. [GREATER MINNESOTA PAYMENT ADJUSTMENT AFTER JUNE 30, 2001.] (a) For admissions occurring after June 30, 2001, the commissioner shall pay all medical assistance inpatient fee-for-service admissions for the diagnosis-related groups specified in paragraph (b) at hospitals located outside of the seven-county metropolitan area at the higher of:

(1) the hospital's current payment rate for the diagnostic category to which the diagnosis-related group belongs, exclusive of disproportionate population adjustments received under subdivision 9 and hospital payment adjustments received under subdivision 23; or

(2) the rate in clause (1) plus a proportion of the difference between the current average payment rate for that diagnostic category for hospitals located within the seven-county metropolitan area, exclusive of disproportionate population adjustments received under subdivision 9 and hospital payment adjustments received under subdivision 23, and the current rate in clause (1). This proportion shall be 12.5 percent for the fiscal year beginning July 1, 2001, and shall increase by 12.5 percentage points for each of the next seven fiscal years, such that the proportion is 100 percent for the fiscal year beginning July 1, 2008.

(b) The reimbursement increases provided in paragraph (a) apply to the following diagnosis-related groups as they fall within the diagnostic categories:

(1) 370 C-section with complicating diagnosis;

(2) 371 C-section without complicating diagnosis;

(3) 372 vaginal delivery with complicating diagnosis;

(4) 373 vaginal delivery without complicating diagnosis;

(5) 386 extreme immaturity, weight greater than 1,500 grams;

(6) 388 full-term neonates with other problems;

(7) 390 prematurity without major problems;

(8) 391 normal newborn case;

(9) 385 neonate, died or transferred to another health care facility;

(10) 425 acute adjustment reaction and psychosocial dysfunctioning;

(11) 430 psychosis;

(12) 431 childhood mental disorders; and

(13) 164-167 appendectomy.

Sec. 8. Minnesota Statutes 2000, section 256B.04, is amended by adding a subdivision to read:

Subd. 1b. [CONTRACT FOR SERVICES FOR AMERICAN INDIAN CHILDREN.] Notwithstanding subdivision 1, the commissioner may contract with federally recognized Indian tribes with a reservation in Minnesota for the provision of early and periodic screening, diagnosis, and treatment administrative services for American Indian children, according to Code of Federal Regulations, title 42, section 441, subpart B, and Minnesota Rules, part 9505.1693 et seq., when the tribe chooses to provide such services. For purposes of this subdivision, "American Indian" has the meaning given to persons to whom services will be provided for in Code of Federal Regulations, title 42, section 36.12. Notwithstanding Minnesota Rules, part 9505.1748, subpart 1, the commissioner, the local agency, and the tribe may contract with any entity for the provision of early and periodic screening, diagnosis, and treatment administrative services.

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

Sec. 9. Minnesota Statutes 2000, section 256B.055, subdivision 3a, is amended to read:

Subd. 3a. [~~MFIP-S FAMILIES;~~ FAMILIES ELIGIBLE UNDER PRIOR AFDC RULES.] (a) ~~Beginning January 1, 1998, or on the date that MFIP-S is implemented in counties, medical assistance may be paid for a person receiving public assistance under the MFIP-S program.~~ Beginning July 1, 2002, medical assistance may be paid for a person who would have been eligible, but for excess income or assets, under the state's AFDC plan in effect as of July 16, 1996, with the base AFDC standard increased by three percent effective July 1, 2000.

(b) Beginning ~~January 1, 1998,~~ July 1, 2002, medical assistance may be paid for a person who would have been eligible for public assistance under the income and ~~resource~~ assets standards~~, or who would have been eligible but for excess income or assets,~~ under the state's AFDC plan in effect as of July 16, 1996, ~~as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law Number 104-193~~ with the base AFDC rate increased by three percent effective July 1, 2000.

**[EFFECTIVE DATE.]** This section is effective July 1, 2002.

Sec. 10. Minnesota Statutes 2000, section 256B.056, subdivision 1a, is amended to read:

Subd. 1a. [INCOME AND ASSETS GENERALLY.] Unless specifically required by state law or rule or federal law or regulation, the methodologies used in counting income and assets to determine eligibility for medical assistance for persons whose eligibility category is based on blindness, disability, or age of 65 or more years, the methodologies for the supplemental security income program shall be used. Effective upon federal approval, for children eligible under section 256B.055, subdivision 12, or for home and community-based waiver services whose eligibility for medical assistance is determined without regard to parental income, child support payments, including any payments made by an obligor in satisfaction of or in addition to a temporary or permanent order for child support, social security payments, and other benefits for basic needs are not counted as income. For families and children, which includes all other eligibility categories, the methodologies under the state's AFDC plan in effect as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public

Law Number 104-193, shall be used. Effective upon federal approval, in-kind contributions to, and payments made on behalf of, a recipient, by an obligor, in satisfaction of or in addition to a temporary or permanent order for child support or maintenance, shall be considered income to the recipient. For these purposes, a "methodology" does not include an asset or income standard, or accounting method, or method of determining effective dates.

Sec. 11. Minnesota Statutes 2000, section 256B.056, subdivision 3, is amended to read:

Subd. 3. [ASSET LIMITATIONS.] To be eligible for medical assistance, a person must not individually own more than $3,000 in assets, or if a member of a household with two family members, husband and wife, or parent and child, the household must not own more than $6,000 in assets, plus $200 for each additional legal dependent. In addition to these maximum amounts, an eligible individual or family may accrue interest on these amounts, but they must be reduced to the maximum at the time of an eligibility redetermination. The accumulation of the clothing and personal needs allowance according to section 256B.35 must also be reduced to the maximum at the time of the eligibility redetermination. The value of assets that are not considered in determining eligibility for medical assistance is the value of those assets excluded under the AFDC state plan as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law Number 104-193, for families and children, and the supplemental security income program for aged, blind, and disabled persons, with the following exceptions:

(a) Household goods and personal effects are not considered.

(b) Capital and operating assets of a trade or business that the local agency determines are necessary to the person's ability to earn an income are not considered.

(c) Motor vehicles are excluded to the same extent excluded by the supplemental security income program.

(d) Assets designated as burial expenses are excluded to the same extent excluded by the supplemental security income program.

(e) Effective upon federal approval, for a person who no longer qualifies as an employed person with a disability due to loss of earnings, assets allowed while eligible for medical assistance under section 256B.057, subdivision 9, are not considered for 12 months, beginning with the first month of ineligibility as an employed person with a disability, to the extent that the person's total assets remain within the allowed limits of section 256B.057, subdivision 9, paragraph (b).

Sec. 12. Minnesota Statutes 2000, section 256B.056, subdivision 4, is amended to read:

Subd. 4. [INCOME.] (a) To be eligible for medical assistance, a person eligible under section 256B.055, ~~subdivision~~ subdivisions 7, 7a, and 12, ~~not receiving supplemental security income program payments, and~~ may have income up to the following specified percentages of the federal poverty guidelines for the family size effective on April 1 of each year:

(1) 80 percent, effective July 1, 2002;

(2) 90 percent, effective July 1, 2003;

(3) 100 percent, effective July 1, 2004.

Increases in benefits under title II of the Social Security Act shall not be counted as income for purposes of this subdivision until the first day of the second full month following publication of the change in the federal poverty guidelines.

(b) To be eligible for medical assistance, families and children may have an income up to 133-1/3 percent of the AFDC income standard in effect under the July 16, 1996, AFDC state plan. Effective July 1, 2000, the base AFDC standard in effect on July 16, 1996, shall be increased by three percent. Effective January 1, 2000, and each successive January, recipients of supplemental

security income may have an income up to the supplemental security income standard in effect on that date.

(c) Effective July 1, 2002, to be eligible for medical assistance, families and children may have an income up to 100 percent of the federal poverty guidelines for the family size effective on April 1 of each year.

(d) In computing income to determine eligibility of persons under paragraphs (a) to (c) who are not residents of long-term care facilities, the commissioner shall disregard increases in income as required by Public Law Numbers 94-566, section 503; 99-272; and 99-509. Veterans aid and attendance benefits and Veterans Administration unusual medical expense payments are considered income to the recipient.

Sec. 13. Minnesota Statutes 2000, section 256B.056, subdivision 5, is amended to read:

Subd. 5. [EXCESS INCOME.] A person who has excess income is eligible for medical assistance if the person has expenses for medical care that are more than the amount of the person's excess income, computed by deducting incurred medical expenses from the excess income to reduce the excess to the income standard specified in subdivision 4, except that if federal authorization to use the standard in subdivision 4 is not obtained, the medically needy standard for purposes of a spenddown shall be 133 and 1/3 percent of the AFDC income standard in effect under the July 16, 1996, AFDC state plan, increased by three percent. The person shall elect to have the medical expenses deducted at the beginning of a one-month budget period or at the beginning of a six-month budget period. The commissioner shall allow persons eligible for assistance on a one-month spenddown basis under this subdivision to elect to pay the monthly spenddown amount in advance of the month of eligibility to the state agency in order to maintain eligibility on a continuous basis. If the recipient does not pay the spenddown amount on or before the 20th of the month, the recipient is ineligible for this option for the following month. The local agency shall code the Medicaid Management Information System (MMIS) to indicate that the recipient has elected this option. The state agency shall convey recipient eligibility information relative to the collection of the spenddown to providers through the Electronic Verification System (EVS). A recipient electing advance payment must pay the state agency the monthly spenddown amount on or before the 20th of the month in order to be eligible for this option in the following month.

Sec. 14. Minnesota Statutes 2000, section 256B.057, subdivision 9, is amended to read:

Subd. 9. [EMPLOYED PERSONS WITH DISABILITIES.] (a) Medical assistance may be paid for a person who is employed and who:

(1) meets the definition of disabled under the supplemental security income program;

(2) is at least 16 but less than 65 years of age;

(3) meets the asset limits in paragraph (b); and

(4) pays a premium, if required, under paragraph (c).

Any spousal income or assets shall be disregarded for purposes of eligibility and premium determinations.

(b) For purposes of determining eligibility under this subdivision, a person's assets must not exceed $20,000, excluding:

(1) all assets excluded under section 256B.056;

(2) retirement accounts, including individual accounts, 401(k) plans, 403(b) plans, Keogh plans, and pension plans; and

(3) medical expense accounts set up through the person's employer.

(c) A person whose earned and unearned income is equal to or greater than ~~200~~ 100 percent of

federal poverty guidelines for the applicable family size must pay a premium to be eligible for medical assistance under this subdivision. The premium shall be ~~equal to ten percent of~~ based on the person's gross earned and unearned income ~~above 200 percent of federal poverty guidelines for~~ and the applicable family size ~~up to the cost of coverage~~, using a sliding fee scale established by the commissioner which begins at one percent of income at 100 percent of the federal poverty guidelines and gradually increases to 7.5 percent of income for those with incomes at or above 300 percent of the federal poverty guidelines.

(d) A person's eligibility and premium shall be determined by the local county agency. Premiums must be paid to the commissioner. All premiums are dedicated to the commissioner.

(e) Any required premium shall be determined at application and redetermined annually at recertification or when a change in income or family size occurs.

(f) Premium payment is due upon notification from the commissioner of the premium amount required. Premiums may be paid in installments at the discretion of the commissioner.

(g) Nonpayment of the premium shall result in denial or termination of medical assistance unless the person demonstrates good cause for nonpayment. Good cause exists if the requirements specified in Minnesota Rules, part 9506.0040, subpart 7, items B to D, are met. Nonpayment shall include payment with a returned, refused, or dishonored instrument. The commissioner may require a guaranteed form of payment as the only means to replace a returned, refused, or dishonored instrument.

**[EFFECTIVE DATE.]** This section is effective September 1, 2001.

Sec. 15. Minnesota Statutes 2000, section 256B.057, is amended by adding a subdivision to read:

Subd. 10. [CERTAIN PERSONS NEEDING TREATMENT FOR BREAST OR CERVICAL CANCER.] (a) Medical assistance may be paid for a person who:

(1) has been screened for breast or cervical cancer by the Minnesota breast and cervical cancer control program, and program funds have been used to pay for the person's screening;

(2) according to the person's treating health professional, needs treatment, including diagnostic services necessary to determine the extent and proper course of treatment, for breast or cervical cancer, including precancerous conditions and early stage cancer;

(3) meets the income eligibility guidelines for the Minnesota breast and cervical cancer control program;

(4) is under age 65;

(5) is not otherwise eligible for medical assistance under United States Code, title 42, section 1396(a)(10)(A)(i); and

(6) is not otherwise covered under creditable coverage, as defined under United States Code, title 42, section 300gg(c).

(b) Medical assistance provided for an eligible person under this subdivision shall be limited to services provided during the period that the person receives treatment for breast or cervical cancer.

(c) A person meeting the criteria in paragraph (a) is eligible for medical assistance without meeting the eligibility criteria relating to income and assets in section 256B.056, subdivisions 1a to 5b.

Sec. 16. Minnesota Statutes 2000, section 256B.0625, subdivision 3b, is amended to read:

Subd. 3b. [TELEMEDICINE CONSULTATIONS.] ~~(a)~~ Medical assistance covers telemedicine consultations. Telemedicine consultations must be made via two-way, interactive video or store-and-forward technology. Store-and-forward technology includes telemedicine consultations

that do not occur in real time via synchronous transmissions, and that do not require a face-to-face encounter with the patient for all or any part of any such telemedicine consultation. The patient record must include a written opinion from the consulting physician providing the telemedicine consultation. A communication between two physicians that consists solely of a telephone conversation is not a telemedicine consultation. Coverage is limited to three telemedicine consultations per recipient per calendar week. Telemedicine consultations shall be paid at the full allowable rate.

~~(b) This subdivision expires July 1, 2001.~~

Sec. 17. Minnesota Statutes 2000, section 256B.0625, is amended by adding a subdivision to read:

Subd. 5a. [INTENSIVE EARLY INTERVENTION BEHAVIOR THERAPY SERVICES FOR CHILDREN WITH AUTISM SPECTRUM DISORDERS.] (a) [COVERAGE.] Medical assistance covers home-based intensive early intervention behavior therapy for children with autism spectrum disorders. Children with autism spectrum disorder, and their custodial parents or foster parents, may access other covered services to treat autism spectrum disorder, and are not required to receive intensive early intervention behavior therapy services under this subdivision. Intensive early intervention behavior therapy does not include coverage for services to treat developmental disorders of language, early onset psychosis, Rett's disorder, selective mutism, social anxiety disorder, stereotypic movement disorder, dementia, obsessive compulsive disorder, schizoid personality disorder, avoidant personality disorder, or reactive attachment disorder. If a child with autism spectrum disorder is diagnosed to have one or more of these conditions, intensive early intervention behavior therapy includes coverage only for services necessary to treat the autism spectrum disorder.

(b) [PURPOSE OF INTENSIVE EARLY INTERVENTION BEHAVIOR THERAPY SERVICES (IEIBTS).] The purpose of IEIBTS is to improve the child's behavioral functioning, to prevent development of challenging behaviors, to eliminate autistic behaviors, to reduce the risk of out-of-home placement, and to establish independent typical functioning in language and social behavior. The procedures used to accomplish these goals are based upon research in applied behavior analysis.

(c) [ELIGIBLE CHILDREN.] A child is eligible to initiate IEIBTS if, the child meets the additional eligibility criteria in paragraph (d) and in a diagnostic assessment by a mental health professional who is not under the employ of the service provider, the child:

(1) is found to have an autism spectrum disorder;

(2) has a current IQ of either untestable, or at least 30;

(3) if nonverbal, initiated behavior therapy by 42 months of age;

(4) if verbal, initiated behavior therapy by 48 months of age; or

(5) if having an IQ of at least 50, initiated behavior therapy by 84 months of age.

To continue in IEIBTS, at least one of the child's custodial parents or foster parents must participate in an average of at least five hours of documented behavior therapy per week for six months, and consistently implement behavior therapy recommendations 24 hours a day. To continue after six-month individualized treatment plan (ITP) reviews, the child must show documented progress toward mastery of six-month benchmark behavior objectives. The maximum number of months during which services may be billed is 54. If significant progress towards treatment goals has not been achieved after 24 months of treatment, treatment must be discontinued.

(d) [ADDITIONAL ELIGIBLITY CRITERIA.] A child is eligible to initiate IEIBTS if:

(1) in medical and diagnostic assessments by medical and mental health professionals, it is determined that the child does not have severe or profound mental retardation;

(2) an accurate assessment of the child's hearing has been performed, including audiometry if the brain stem auditory evokes response;

(3) a blood lead test has been performed prior to initiation of treatment; and

(4) an EEG or neurologic evaluation is done, prior to initiation of treatment, if the child has a history of staring spells or developmental regression.

(e) [COVERED SERVICES.] The focus of IEIBTS must be to treat the principal diagnostic features of the autism spectrum disorder. All IEIBTS must be delivered by a team of practitioners under the consistent supervision of a single clinical supervisor. A mental health professional must develop the ITP for IEIBTS. The ITP must include six-month benchmark behavior objectives. All behavior therapy must be based upon research in applied behavior analysis, with an emphasis upon positive reinforcement of carefully task-analyzed skills for optimum rates of progress. All behavior therapy must be consistently applied and generalized throughout the 24-hour day and seven-day week by all of the child's regular care providers. When placing the child in school activities, a majority of the peers must have no mental health diagnosis, and the child must have sufficient social skills to succeed with 80 percent of the school activities. Reactive consequences, such as redirection, correction, positive practice, or time-out, must be used only when necessary to improve the child's success when proactive procedures alone have not been effective. IEIBTS must be delivered by a team of behavior therapy practitioners who are employed under the direction of the same agency. The team may deliver up to 200 billable hours per year of direct clinical supervisor services, up to 750 billable hours per year of senior behavior therapist services, and up to 1,800 billable hours per year of direct behavior therapist services. A one-hour clinical review meeting for the child, parents, and staff must be scheduled 50 weeks a year, at which behavior therapy is reviewed and planned. At least one-quarter of the annual clinical supervisor billable hours shall consist of on-site clinical meeting time. At least one-half of the annual senior behavior therapist billable hours shall consist of direct services to the child or parents. All of the behavioral therapist billable hours shall consist of direct on-site services to the child or parents. None of the senior behavior therapist billable hours or behavior therapist billable hours shall consist of clinical meeting time. If there is any regression of the autistic spectrum disorder after 12 months of therapy, a neurologic consultation must be performed.

(f) [PROVIDER QUALIFICATIONS.] The provider agency must be capable of delivering consistent applied behavior analysis (ABA)-based behavior therapy in the home. The site director of the agency must be a mental health professional certified as a behavior analyst by the Association for Behavior Analysis. Each clinical supervisor must be certified as a behavior analyst by the Association for Behavior Analysis.

(g) [SUPERVISION REQUIREMENTS.] (1) Each behavior therapist practitioner must be continuously supervised while in the home until the practitioner has mastered competencies for independent practice. Each behavior therapist must have mastered three credits of academic content and practice in an ABA sequence at an accredited university. A college degree or minimum hours of experience are not required. Each behavior therapist must continue training through weekly direct observation by the senior behavior therapist, through demonstrated performance in clinical meetings with the clinical supervisor, and annual training in ABA.

(2) Each senior behavior therapist practitioner must have mastered the senior behavior therapy competencies, completed one year of practice as a behavior therapist, and six months of co-therapy training with another senior behavior therapist or have an equivalent amount of experience in ABA. Each senior behavior therapist must have mastered 12 credits of academic content and practice in an ABA sequence at an accredited university. Each senior behavior therapist must continue training through demonstrated performance in clinical meetings with the clinical supervisor, and annual training in ABA.

(3) Each clinical supervisor practitioner must have mastered the clinical supervisor and family consultation competencies, completed two years of practice as a senior behavior therapist and one year of co-therapy training with another clinical supervisor, or equivalent experience in ABA. Each clinical supervisor must continue training through annual training in ABA.

(h) [PLACE OF SERVICE.] IEIBTS are provided primarily in the child's home and community. Services may be provided in the child's natural school or preschool classroom, home of a relative, natural recreational setting, or day care.

(i) [PRIOR AUTHORIZATION REQUIREMENTS.] Prior authorization shall be required for services provided after 200 hours of clinical supervisor, 750 hours of senior behavior therapist, or 1,800 hours of behavior therapist services per year.

(j) [PAYMENT RATES.] The following payment rates apply:

(1) for an IEIBTS clinical supervisor practitioner under supervision of a mental health professional, the lower of the submitted charge or $137 per hour unit;

(2) for an IEIBTS senior behavior therapist practitioner under supervision of a mental health professional, the lower of the submitted charge or $56 per hour unit; or

(3) for an IEIBTS behavior therapist practitioner under supervision of a mental health professional, the lower of the submitted charge or $19 per hour unit.

An IEIBTS practitioner may receive payment for travel time which exceeds 50 minutes one-way. The maximum payment allowed will be $0.51 per minute for up to a maximum of 300 hours per year.

For any week during which the above charges are made to medical assistance, payments for the following services are excluded: supervising mental health professional hours and personal care attendant, home-based mental health, family-community support, or mental health behavioral aide hours.

(k) [REPORT.] The commissioner shall collect evidence of the effectiveness of intensive early intervention behavior therapy services and present a report to the legislature by July 1, 2006.

**[EFFECTIVE DATE.]** This section is effective January 1, 2002.

Sec. 18. Minnesota Statutes 2000, section 256B.0625, subdivision 13, is amended to read:

Subd. 13. [DRUGS.] (a) Medical assistance covers drugs, except for fertility drugs when specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed by a licensed pharmacist, by a physician enrolled in the medical assistance program as a dispensing physician, or by a physician or a nurse practitioner employed by or under contract with a community health board as defined in section 145A.02, subdivision 5, for the purposes of communicable disease control. The commissioner, after receiving recommendations from professional medical associations and professional pharmacist associations, shall designate a formulary committee to advise the commissioner on the names of drugs for which payment is made, recommend a system for reimbursing providers on a set fee or charge basis rather than the present system, and develop methods encouraging use of generic drugs when they are less expensive and equally effective as trademark drugs. The formulary committee shall consist of nine members, four of whom shall be physicians who are not employed by the department of human services, and a majority of whose practice is for persons paying privately or through health insurance, three of whom shall be pharmacists who are not employed by the department of human services, and a majority of whose practice is for persons paying privately or through health insurance, a consumer representative, and a nursing home representative. Committee members shall serve three-year terms and shall serve without compensation. Members may be reappointed once.

(b) The commissioner shall establish a drug formulary. Its establishment and publication shall not be subject to the requirements of the Administrative Procedure Act, but the formulary committee shall review and comment on the formulary contents. The formulary committee shall review and recommend drugs which require prior authorization. The formulary committee may recommend drugs for prior authorization directly to the commissioner, as long as opportunity for public input is provided. Prior authorization may be requested by the commissioner based on medical and clinical criteria before certain drugs are eligible for payment. Before a drug may be considered for prior authorization at the request of the commissioner:

(1) the drug formulary committee must develop criteria to be used for identifying drugs; the development of these criteria is not subject to the requirements of chapter 14, but the formulary committee shall provide opportunity for public input in developing criteria;

(2) the drug formulary committee must hold a public forum and receive public comment for an additional 15 days; and

(3) the commissioner must provide information to the formulary committee on the impact that placing the drug on prior authorization will have on the quality of patient care and information regarding whether the drug is subject to clinical abuse or misuse. Prior authorization may be required by the commissioner before certain formulary drugs are eligible for payment. The formulary shall not include:

(i) drugs or products for which there is no federal funding;

(ii) over-the-counter drugs, except for antacids, acetaminophen, family planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults with documented vitamin deficiencies, vitamins for children under the age of seven and pregnant or nursing women, and any other over-the-counter drug identified by the commissioner, in consultation with the drug formulary committee, as necessary, appropriate, and cost-effective for the treatment of certain specified chronic diseases, conditions or disorders, and this determination shall not be subject to the requirements of chapter 14;

(iii) anorectics, except that medically necessary anorectics shall be covered for a recipient previously diagnosed as having pickwickian syndrome and currently diagnosed as having diabetes and being morbidly obese;

(iv) drugs for which medical value has not been established; and

(v) drugs from manufacturers who have not signed a rebate agreement with the Department of Health and Human Services pursuant to section 1927 of title XIX of the Social Security Act.

The commissioner shall publish conditions for prohibiting payment for specific drugs after considering the formulary committee's recommendations. An honorarium of $100 per meeting and reimbursement for mileage shall be paid to each committee member in attendance.

(c) The basis for determining the amount of payment shall be the lower of the actual acquisition costs of the drugs plus a fixed dispensing fee; the maximum allowable cost set by the federal government or by the commissioner plus the fixed dispensing fee; or the usual and customary price charged to the public. The pharmacy dispensing fee shall be $3.65, except that the dispensing fee for intravenous solutions which must be compounded by the pharmacist shall be $8 per bag, $14 per bag for cancer chemotherapy products, and $30 per bag for total parenteral nutritional products dispensed in one liter quantities, or $44 per bag for total parenteral nutritional products dispensed in quantities greater than one liter. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. The actual acquisition cost of a drug shall be estimated by the commissioner, at average wholesale price minus nine percent, except that where a drug has had its wholesale price reduced as a result of the actions of the National Association of Medicaid Fraud Control Units, the estimated actual acquisition cost shall be the reduced average wholesale price, without the nine percent deduction. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to, but no higher than, the maximum amount paid by other third-party payors in this state who have maximum allowable cost programs. The commissioner shall set maximum allowable costs for multisource drugs that are not on the federal upper limit list as described in United States Code, title 42, chapter 7, section 1396r-8(e), the Social Security Act, and Code of Federal Regulations, title 42, part 447, section 447.332. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act. An additional dispensing fee of $.30 may be added to the dispensing fee paid to pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities when a unit dose blister card system, approved by the department, is used. Under this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister

card must be identified on the claim to the department. The unit dose blister card containing the drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider will be required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse. Over-the-counter medications must be dispensed in the manufacturer's unopened package. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply. Whenever a generically equivalent product is available, payment shall be on the basis of the actual acquisition cost of the generic drug, unless the prescriber specifically indicates "dispense as written - brand necessary" on the prescription as required by section 151.21, subdivision 2.

(d) For purposes of this subdivision, "multisource drugs" means covered outpatient drugs, excluding innovator multisource drugs for which there are two or more drug products, which:

(1) are related as therapeutically equivalent under the Food and Drug Administration's most recent publication of "Approved Drug Products with Therapeutic Equivalence Evaluations";

(2) are pharmaceutically equivalent and bioequivalent as determined by the Food and Drug Administration; and

(3) are sold or marketed in Minnesota.

"Innovator multisource drug" means a multisource drug that was originally marketed under an original new drug application approved by the Food and Drug Administration.

(e) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider; the average wholesale price minus five percent; or the maximum allowable cost set by the federal government under United States Code, title 42, chapter 7, section 1396r-8(e) and Code of Federal Regulations, title 42, section 447.332, or by the commissioner under paragraph (c).

Sec. 19. Minnesota Statutes 2000, section 256B.0625, subdivision 13a, is amended to read:

Subd. 13a. [DRUG UTILIZATION REVIEW BOARD.] A nine-member drug utilization review board is established. The board is comprised of at least three but no more than four licensed physicians actively engaged in the practice of medicine in Minnesota; at least three licensed pharmacists actively engaged in the practice of pharmacy in Minnesota; and one consumer representative; the remainder to be made up of health care professionals who are licensed in their field and have recognized knowledge in the clinically appropriate prescribing, dispensing, and monitoring of covered outpatient drugs. The board shall be staffed by an employee of the department who shall serve as an ex officio nonvoting member of the board. The members of the board shall be appointed by the commissioner and shall serve three-year terms. The members shall be selected from lists submitted by professional associations. The commissioner shall appoint the initial members of the board for terms expiring as follows: three members for terms expiring June 30, 1996; three members for terms expiring June 30, 1997; and three members for terms expiring June 30, 1998. Members may be reappointed once. The board shall annually elect a chair from among the members.

The commissioner shall, with the advice of the board:

(1) implement a medical assistance retrospective and prospective drug utilization review program as required by United States Code, title 42, section 1396r-8(g)(3);

(2) develop and implement the predetermined criteria and practice parameters for appropriate prescribing to be used in retrospective and prospective drug utilization review;

(3) develop, select, implement, and assess interventions for physicians, pharmacists, and patients that are educational and not punitive in nature;

(4) establish a grievance and appeals process for physicians and pharmacists under this section;

(5) publish and disseminate educational information to physicians and pharmacists regarding the board and the review program;

(6) adopt and implement procedures designed to ensure the confidentiality of any information collected, stored, retrieved, assessed, or analyzed by the board, staff to the board, or contractors to the review program that identifies individual physicians, pharmacists, or recipients;

(7) establish and implement an ongoing process to (i) receive public comment regarding drug utilization review criteria and standards, and (ii) consider the comments along with other scientific and clinical information in order to revise criteria and standards on a timely basis; and

(8) adopt any rules necessary to carry out this section.

The board may establish advisory committees. The commissioner may contract with appropriate organizations to assist the board in carrying out the board's duties. The commissioner may enter into contracts for services to develop and implement a retrospective and prospective review program.

The board shall report to the commissioner annually on the date the Drug Utilization Review Annual Report is due to the Health Care Financing Administration. This report is to cover the preceding federal fiscal year. The commissioner shall make the report available to the public upon request. The report must include information on the activities of the board and the program; the effectiveness of implemented interventions; administrative costs; and any fiscal impact resulting from the program. An honorarium of ~~$50~~ $100 per meeting and reimbursement for mileage shall be paid to each board member in attendance.

Sec. 20. Minnesota Statutes 2000, section 256B.0625, subdivision 17, is amended to read:

Subd. 17. [TRANSPORTATION COSTS.] (a) Medical assistance covers transportation costs incurred solely for obtaining emergency medical care or transportation costs incurred by nonambulatory persons in obtaining emergency or nonemergency medical care when paid directly to an ambulance company, common carrier, or other recognized providers of transportation services. For the purpose of this subdivision, a person who is incapable of transport by taxicab or bus shall be considered to be nonambulatory.

(b) Medical assistance covers special transportation, as defined in Minnesota Rules, part 9505.0315, subpart 1, item F, if the provider receives and maintains a current physician's order by the recipient's attending physician certifying that the recipient has a physical or mental impairment that would prohibit the recipient from safely accessing and using a bus, taxi, other commercial transportation, or private automobile. Special transportation includes driver-assisted service to eligible individuals. Driver-assisted service includes passenger pickup at and return to the individual's residence or place of business, assistance with admittance of the individual to the medical facility, and assistance in passenger securement or in securing of wheelchairs or stretchers in the vehicle. The commissioner shall establish maximum medical assistance reimbursement rates for special transportation services for persons who need a wheelchair ~~lift~~ accessible van or stretcher-equipped vehicle and for those who do not need a wheelchair ~~lift~~ accessible van or stretcher-equipped vehicle. The average of these two rates per trip must not exceed $15 for the base rate and ~~$1.20~~ $1.50 per mile. Special transportation provided to ~~nonambulatory~~ ambulatory persons who do not need a wheelchair lift van or stretcher-equipped vehicle, may be reimbursed at a lower rate than special transportation provided to persons who need a wheelchair lift van or stretcher-equipped vehicle.

Sec. 21. Minnesota Statutes 2000, section 256B.0625, subdivision 17a, is amended to read:

Subd. 17a. [PAYMENT FOR AMBULANCE SERVICES.] Effective for services rendered on or after July 1, ~~1999~~ 2001, medical assistance payments for ambulance services shall be ~~increased by five percent~~ paid at the greater of: (1) the medical assistance reimbursement rate in effect on June 30, 2000; or (2) the current Medicare reimbursement rate for ambulance services.

Sec. 22. Minnesota Statutes 2000, section 256B.0625, subdivision 18a, is amended to read:

Subd. 18a. [~~PAYMENT FOR MEALS AND LODGING~~ ACCESS TO MEDICAL SERVICES.] (a) Medical assistance reimbursement for meals for persons traveling to receive medical care may not exceed $5.50 for breakfast, $6.50 for lunch, or $8 for dinner.

(b) Medical assistance reimbursement for lodging for persons traveling to receive medical care may not exceed $50 per day unless prior authorized by the local agency.

(c) Medical assistance direct mileage reimbursement to the eligible person or the eligible person's driver may not exceed 20 cents per mile.

(d) Medical assistance covers oral language interpreter services when provided by an enrolled health care provider during the course of providing a direct, person-to-person covered health care service to an enrolled recipient with limited English proficiency.

Sec. 23. Minnesota Statutes 2000, section 256B.0625, subdivision 30, is amended to read:

Subd. 30. [OTHER CLINIC SERVICES.] (a) Medical assistance covers rural health clinic services, federally qualified health center services, nonprofit community health clinic services, public health clinic services, and the services of a clinic meeting the criteria established in rule by the commissioner. Rural health clinic services and federally qualified health center services mean services defined in United States Code, title 42, section 1396d(a)(2)(B) and (C). Payment for rural health clinic and federally qualified health center services shall be made according to applicable federal law and regulation.

(b) A federally qualified health center that is beginning initial operation shall submit an estimate of budgeted costs and visits for the initial reporting period in the form and detail required by the commissioner. A federally qualified health center that is already in operation shall submit an initial report using actual costs and visits for the initial reporting period. Within 90 days of the end of its reporting period, a federally qualified health center shall submit, in the form and detail required by the commissioner, a report of its operations, including allowable costs actually incurred for the period and the actual number of visits for services furnished during the period, and other information required by the commissioner. Federally qualified health centers that file Medicare cost reports shall provide the commissioner with a copy of the most recent Medicare cost report filed with the Medicare program intermediary for the reporting year which support the costs claimed on their cost report to the state.

(c) In order to continue cost-based payment under the medical assistance program according to paragraphs (a) and (b), a federally qualified health center or rural health clinic must apply for designation as an essential community provider within six months of final adoption of rules by the department of health according to section 62Q.19, subdivision 7. For those federally qualified health centers and rural health clinics that have applied for essential community provider status within the six-month time prescribed, medical assistance payments will continue to be made according to paragraphs (a) and (b) for the first three years after application. For federally qualified health centers and rural health clinics that either do not apply within the time specified above or who have had essential community provider status for three years, medical assistance payments for health services provided by these entities shall be according to the same rates and conditions applicable to the same service provided by health care providers that are not federally qualified health centers or rural health clinics.

(d) Effective July 1, 1999, the provisions of paragraph (c) requiring a federally qualified health center or a rural health clinic to make application for an essential community provider designation in order to have cost-based payments made according to paragraphs (a) and (b) no longer apply.

(e) Effective January 1, 2000, payments made according to paragraphs (a) and (b) shall be limited to the cost phase-out schedule of the Balanced Budget Act of 1997.

(f) Effective January 1, 2001, each federally qualified health center and rural health clinic may elect to be paid either under the prospective payment system established in United States Code, title 42, section 1396a, paragraph (a) or under an alternative payment methodology consistent with the requirements of United States Code, title 42, section 1392a, paragraph (a) and approved by the

health care financing administration. The alternative payment methodology shall be 100 percent of cost as determined according to Medicare cost principles.

Sec. 24. Minnesota Statutes 2000, section 256B.0625, subdivision 34, is amended to read:

Subd. 34. [INDIAN HEALTH SERVICES FACILITIES.] Medical assistance payments and MinnesotaCare payments to facilities of the Indian health service and facilities operated by a tribe or tribal organization under funding authorized by United States Code, title 25, sections 450f to 450n, or title III of the Indian Self-Determination and Education Assistance Act, Public Law Number 93-638, for enrollees who are eligible for federal financial participation, shall be at the option of the facility in accordance with the rate published by the United States Assistant Secretary for Health under the authority of United States Code, title 42, sections 248(a) and 249(b). General assistance medical care payments to facilities of the Indian health services and facilities operated by a tribe or tribal organization for the provision of outpatient medical care services billed after June 30, 1990, must be in accordance with the general assistance medical care rates paid for the same services when provided in a facility other than a facility of the Indian health service or a facility operated by a tribe or tribal organization. MinnesotaCare payments for enrollees who are not eligible for federal financial participation at facilities of the Indian Health Service and facilities operated by a tribe or tribal organization for the provision of outpatient medical services must be in accordance with the medical assistance rates paid for the same services when provided in a facility other than a facility of the Indian Health Service or a facility operated by a tribe or tribal organization.

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

Sec. 25. Minnesota Statutes 2000, section 256B.0635, subdivision 1, is amended to read:

Subdivision 1. [INCREASED EMPLOYMENT.] ~~Beginning January 1, 1998~~ (a) Until June 30, 2002, medical assistance may be paid for persons who received MFIP-S or medical assistance for families and children in at least three of six months preceding the month in which the person became ineligible for MFIP-S or medical assistance, if the ineligibility was due to an increase in hours of employment or employment income or due to the loss of an earned income disregard. In addition, to receive continued assistance under this section, persons who received medical assistance for families and children but did not receive MFIP-S must have had income less than or equal to the assistance standard for their family size under the state's AFDC plan in effect as of July 16, 1996, ~~as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law Number 104-193,~~ increased by three percent effective July 1, 2000, at the time medical assistance eligibility began. A person who is eligible for extended medical assistance is entitled to six months of assistance without reapplication, unless the assistance unit ceases to include a dependent child. For a person under 21 years of age, medical assistance may not be discontinued within the six-month period of extended eligibility until it has been determined that the person is not otherwise eligible for medical assistance. Medical assistance may be continued for an additional six months if the person meets all requirements for the additional six months, according to title XIX of the Social Security Act, as amended by section 303 of the Family Support Act of 1988, Public Law Number 100-485.

(b) Beginning July 1, 2002, medical assistance for families and children may be paid for persons who were eligible under section 256B.055, subdivision 3a, paragraph (b), in at least three of six months preceding the month in which the person became ineligible under that section if the ineligibility was due to an increase in hours of employment or employment income or due to the loss of an earned income disregard. A person who is eligible for extended medical assistance is entitled to six months of assistance without reapplication, unless the assistance unit ceases to include a dependent child, except medical assistance may not be discontinued for that dependent child under 21 years of age within the six-month period of extended eligibility until it has been determined that the person is not otherwise eligible for medical assistance. Medical assistance may be continued for an additional six months if the person meets all requirements for the additional six months, according to title XIX of the Social Security Act, as amended by section 303 of the Family Support Act of 1988, Public Law Number 100-485.

**[EFFECTIVE DATE.]** This section is effective July 1, 2001.

Sec. 26. Minnesota Statutes 2000, section 256B.0635, subdivision 2, is amended to read:

Subd. 2. [INCREASED CHILD OR SPOUSAL SUPPORT.] ~~Beginning January 1, 1998~~ (a) Until June 30, 2002, medical assistance may be paid for persons who received MFIP-S or medical assistance for families and children in at least three of the six months preceding the month in which the person became ineligible for MFIP-S or medical assistance, if the ineligibility was the result of the collection of child or spousal support under part D of title IV of the Social Security Act. In addition, to receive continued assistance under this section, persons who received medical assistance for families and children but did not receive MFIP-S must have had income less than or equal to the assistance standard for their family size under the state's AFDC plan in effect as of July 16, 1996, ~~as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law Number 104-193~~ increased by three percent effective July 1, 2000, at the time medical assistance eligibility began. A person who is eligible for extended medical assistance under this subdivision is entitled to four months of assistance without reapplication, unless the assistance unit ceases to include a dependent child~~. For a person under 21 years of age~~, except medical assistance may not be discontinued for that dependent child under 21 years of age within the four-month period of extended eligibility until it has been determined that the person is not otherwise eligible for medical assistance.

(b) Beginning July 1, 2002, medical assistance for families and children may be paid for persons who were eligible under section 256B.055, subdivision 3a, paragraph (b), in at least three of the six months preceding the month in which the person became ineligible under that section if the ineligibility was the result of the collection of child or spousal support under part D of title IV of the Social Security Act. A person who is eligible for extended medical assistance under this subdivision is entitled to four months of assistance without reapplication, unless the assistance unit ceases to include a dependent child, except medical assistance may not be discontinued for that dependent child under 21 years of age within the four-month period of extended eligibility until it has been determined that the person is not otherwise eligible for medical assistance.

**[EFFECTIVE DATE.]** This section is effective July 1, 2001.

Sec. 27. [256B.0637] [PRESUMPTIVE ELIGIBILITY FOR CERTAIN PERSONS NEEDING TREATMENT FOR BREAST OR CERVICAL CANCER.]

Medical assistance is available during a presumptive eligibility period for persons who meet the criteria in section 256B.057, subdivision 10. For purposes of this section, the presumptive eligibility period begins on the date on which an entity designated by the commissioner determines, based on preliminary information, that the person meets the criteria in section 256B.057, subdivision 10. The presumptive eligibility period ends on the day on which a determination is made as to the person's eligibility, except that if an application is not submitted by the last day of the month following the month during which the determination based on preliminary information is made, the presumptive eligibility period ends on that last day of the month.

Sec. 28. [256B.195] [HEALTH CARE SAFETY NET PRESERVATION.]

Subdivision 1. [INTERGOVERNMENTAL TRANSFERS AND RELATED PAYMENTS.] (a) This section is contingent on federal approval of the intergovernmental transfers and payments to safety net hospitals authorized under this section.

(b) In addition to the percentage contribution paid by a county under section 256B.19, subdivision 1, the governmental units designated in this subdivision shall be responsible for an additional portion of the nonfederal share of medical assistance costs attributable to them. For purposes of this section, "designated governmental unit" means Hennepin county, Ramsey county, or the University of Minnesota. For purposes of this section, "nonstate, government hospital" means Hennepin County Medical Center, the successor or assignee to St. Paul-Ramsey Medical Center as described in section 383A.91, or Fairview University Medical Center.

(c) Effective July 1, 2001, the governmental units designated in paragraph (a) shall in total transfer $2,833,333 on a monthly basis to the state Medicaid agency. The commissioner shall

allocate this assessment between the governmental units based on the proportion of the Medicare upper payment limit for each nonstate, government hospital located within the governmental unit to the total Medicare upper payment limit of all participating hospitals in paragraph (b).

(d) The commissioner shall distribute the proceeds of this intergovernmental transfer, including the federal Medicaid match, as follows:

(1) Proceeds may be no less than the amount of the intergovernmental transfer in paragraph (c) multiplied by 1.75.

(2) The remaining proceeds provide funding for hospital charity care aid under section 144.585. The commissioner of human services shall work with the commissioner of health to assure that hospital charity care aid payments are administered in a manner that generates Medicaid matching funds.

(e) The successor or assignee to St. Paul-Ramsey Medical Center shall transfer on a monthly basis to Ramsey county an amount equal to the county assessment under paragraph (c).

Subd. 2. [DETERMINATION OF INTERGOVERNMENTAL TRANSFER AMOUNTS.] Medicaid rate changes, including those required to obtain federal financial participation under section 62J.692, subdivision 8, enacted prior to the effective date of this legislation, shall precede the determination of intergovernmental transfer amounts determined in this section. Participation in the intergovernmental transfer program shall not result in the offset of any nonstate, government hospital's receipt of Medicaid payment increases.

Subd. 3. [STATE PLAN AMENDMENTS.] The commissioner shall amend the state Medicaid plan as necessary to implement this section.

Subd. 4. [PROPORTIONATE ADJUSTMENTS.] (a) The commissioner shall adjust the intergovernmental transfers under subdivision 1, paragraph (c), and the payments under subdivision 1, paragraph (d), upon the approval of the designated governmental unit named in subdivision 1, paragraph (b), based on the commissioner's determination of Medicare upper payment limits, hospital-specific federal limitations on disproportionate share payments or to maximize additional federal reimbursements.

(b) In the event that: (i) federal approval is not received for the total intergovernmental transfer amount specified in subdivision 1, paragraph (d), or, (ii) federal rules regarding the establishment of the 150 percent Medicare upper payment limit, section 1102 of the Social Security Act, United States Code, title 42, section 1302, enacted on March 13, 2001, are rescinded or, (iii) the federal 150 percent Medicare upper payment limit is reduced to 100 percent, the amount of the intergovernmental transfers and Medicaid payments to the nonstate, government hospitals named in subdivision 1, paragraph (b), shall be adjusted for each hospital based on the proportion of each hospital's Medicaid inpatient hospital days to the total Medicaid inpatient hospital days provided by all participating hospitals.

**[EFFECTIVE DATE.]** This section is effective July 1, 2001.

Sec. 29. Minnesota Statutes 2000, section 256B.69, subdivision 4, is amended to read:

Subd. 4. [LIMITATION OF CHOICE.] The commissioner shall develop criteria to determine when limitation of choice may be implemented in the experimental counties. The criteria shall ensure that all eligible individuals in the county have continuing access to the full range of medical assistance services as specified in subdivision 6. The commissioner shall exempt the following persons from participation in the project, in addition to those who do not meet the criteria for limitation of choice:

(1) persons eligible for medical assistance according to section 256B.055, subdivision 1;

(2) persons eligible for medical assistance due to blindness or disability as determined by the social security administration or the state medical review team, unless:

(i) they are 65 years of age or older~~,~~; or

(ii) they reside in Itasca county or they reside in a county in which the commissioner conducts a pilot project under a waiver granted pursuant to section 1115 of the Social Security Act;

(3) recipients who currently have private coverage through a health maintenance organization;

(4) recipients who are eligible for medical assistance by spending down excess income for medical expenses other than the nursing facility per diem expense;

(5) recipients who receive benefits under the Refugee Assistance Program, established under United States Code, title 8, section 1522(e);

(6) children who are both determined to be severely emotionally disturbed and receiving case management services according to section 256B.0625, subdivision 20; ~~and~~

(7) adults who are both determined to be seriously and persistently mentally ill and received case management services according to section 256B.0625, subdivision 20; and

(8) persons eligible for medical assistance according to section 256B.057, subdivision 10.

Children under age 21 who are in foster placement may enroll in the project on an elective basis. Individuals excluded under clauses (6) and (7) may choose to enroll on an elective basis. The commissioner may allow persons with a one-month spenddown who are otherwise eligible to enroll to voluntarily enroll or remain enrolled, if they elect to prepay their monthly spenddown to the state. ~~Beginning on or after July 1, 1997,~~ The commissioner may require those individuals to enroll in the prepaid medical assistance program who otherwise would have been excluded under clauses (1) ~~and~~, (3), and (8), and under Minnesota Rules, part 9500.1452, subpart 2, items H, K, and L. Before limitation of choice is implemented, eligible individuals shall be notified and after notification, shall be allowed to choose only among demonstration providers. The commissioner may assign an individual with private coverage through a health maintenance organization, to the same health maintenance organization for medical assistance coverage, if the health maintenance organization is under contract for medical assistance in the individual's county of residence. After initially choosing a provider, the recipient is allowed to change that choice only at specified times as allowed by the commissioner. If a demonstration provider ends participation in the project for any reason, a recipient enrolled with that provider must select a new provider but may change providers without cause once more within the first 60 days after enrollment with the second provider.

Sec. 30. Minnesota Statutes 2000, section 256B.69, subdivision 5, is amended to read:

Subd. 5. [PROSPECTIVE PER CAPITA PAYMENT.] The commissioner shall establish the method and amount of payments for services. The commissioner shall annually contract with demonstration providers to provide services consistent with these established methods and amounts for payment. Payment rates established by the commissioner must be within the limits of available appropriations.

If allowed by the commissioner, a demonstration provider may contract with an insurer, health care provider, nonprofit health service plan corporation, or the commissioner, to provide insurance or similar protection against the cost of care provided by the demonstration provider or to provide coverage against the risks incurred by demonstration providers under this section. The recipients enrolled with a demonstration provider are a permissible group under group insurance laws and chapter 62C, the Nonprofit Health Service Plan Corporations Act. Under this type of contract, the insurer or corporation may make benefit payments to a demonstration provider for services rendered or to be rendered to a recipient. Any insurer or nonprofit health service plan corporation licensed to do business in this state is authorized to provide this insurance or similar protection.

Payments to providers participating in the project are exempt from the requirements of sections 256.966 and 256B.03, subdivision 2. The commissioner shall complete development of capitation rates for payments before delivery of services under this section is begun. For payments made

during calendar year 1990 and later years, the commissioner shall contract with an independent actuary to establish prepayment rates.

By January 15, 1996, the commissioner shall report to the legislature on the methodology used to allocate to participating counties available administrative reimbursement for advocacy and enrollment costs. The report shall reflect the commissioner's judgment as to the adequacy of the funds made available and of the methodology for equitable distribution of the funds. The commissioner must involve participating counties in the development of the report.

Sec. 31. Minnesota Statutes 2000, section 256B.69, subdivision 5b, is amended to read:

Subd. 5b. [PROSPECTIVE REIMBURSEMENT RATES.] (a) For prepaid medical assistance and general assistance medical care program contract rates set by the commissioner under subdivision 5 and effective on or after January 1, 1998, capitation rates for nonmetropolitan counties shall on a weighted average be no less than 88 percent of the capitation rates for metropolitan counties, excluding Hennepin county. The commissioner shall make a pro rata adjustment in capitation rates paid to counties other than nonmetropolitan counties in order to make this provision budget neutral.

(b) For prepaid medical assistance program contract rates set by the commissioner under subdivision 5 and effective on or after January 1, ~~2001~~ 2002, capitation rates for nonmetropolitan counties shall, on a weighted average, be no less than ~~89~~ 95 percent of the capitation rates for metropolitan counties, excluding Hennepin county. The commissioner shall make a pro rata adjustment in capitation rates paid to Hennepin county in order to make the portion of the increase between 89 and 95 percent budget neutral.

(c) This subdivision shall not affect the nongeographically based risk adjusted rates established under section 62Q.03, subdivision 5a, paragraph (f).

(d) The commissioner shall require prepaid health plans to use all revenue received from the increase in capitation rates for nonmetropolitan counties from 89 to no less than 95 percent of the capitation rate for metropolitan counties, excluding Hennepin county, to increase reimbursement rates, effective January 1, 2002, for providers under contract with the prepaid health plan to serve enrollees from nonmetropolitan counties.

Sec. 32. Minnesota Statutes 2000, section 256B.69, is amended by adding a subdivision to read:

Subd. 6c. [DENTAL SERVICES DEMONSTRATION PROJECT.] The commissioner shall establish a dental services demonstration project in Crow Wing, Todd, Morrison, Wadena, and Cass counties for provision of dental services to medical assistance, general assistance medical care, and MinnesotaCare recipients. The commissioner may contract on a prospective per capita payment basis for these dental services with an organization licensed under chapter 62C, 62D, or 62N in accordance with section 256B.037 or may establish and administer a fee-for-service system for the reimbursement of dental services.

**[EFFECTIVE DATE.]** This section is effective January 1, 2002.

Sec. 33. Minnesota Statutes 2000, section 256B.75, is amended to read:

256B.75 [HOSPITAL OUTPATIENT REIMBURSEMENT.]

(a) For outpatient hospital facility fee payments for services rendered on or after October 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge, or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for which there is a federal maximum allowable payment. Effective for services rendered on or after January 1, 2000, payment rates for nonsurgical outpatient hospital facility fees and emergency room facility fees shall be increased by eight percent over the rates in effect on December 31, 1999, except for those services for which there is a federal maximum allowable payment. Services for which there is a federal maximum allowable payment shall be paid at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare upper limit. If it is determined that a provision of this

section conflicts with existing or future requirements of the United States government with respect to federal financial participation in medical assistance, the federal requirements prevail. The commissioner may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial participation resulting from rates that are in excess of the Medicare upper limitations.

(b) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory surgery hospital facility fee services for critical access hospitals designated under section 144.1483, clause (11), shall be paid on a cost-based payment system that is based on the cost-finding methods and allowable costs of the Medicare program.

(c) Effective for services provided on or after July 1, 2002, rates that are based on the Medicare outpatient prospective payment system shall be replaced by a budget neutral prospective payment system that is derived using medical assistance data. The department shall provide a proposal to the 2002 legislature to define and implement this provision.

Sec. 34. Minnesota Statutes 2000, section 256B.76, is amended to read:

256B.76 [PHYSICIAN AND DENTAL REIMBURSEMENT.]

(a) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for physician services as follows:

(1) payment for level one Health Care Finance Administration's common procedural coding system (HCPCS) codes titled "office and other outpatient services," "preventive medicine new and established patient," "delivery, antepartum, and postpartum care," "critical care," ~~Caesarean~~ cesarean delivery and pharmacologic management provided to psychiatric patients, and HCPCS level three codes for enhanced services for prenatal high risk, shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992. If the rate on any procedure code within these categories is different than the rate that would have been paid under the methodology in section 256B.74, subdivision 2, then the larger rate shall be paid;

(2) payments for all other services shall be paid at the lower of (i) submitted charges, or (ii) 15.4 percent above the rate in effect on June 30, 1992;

(3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases except that payment rates for home health agency services shall be the rates in effect on September 30, 1992;

(4) effective for services rendered on or after January 1, 2000, payment rates for physician and professional services shall be increased by three percent over the rates in effect on December 31, 1999, except for home health agency and family planning agency services; and

(5) the increases in clause (4) shall be implemented January 1, 2000, for managed care.

(b) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for dental services as follows:

(1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992;

(2) dental rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases;

(3) effective for services rendered on or after January 1, 2000, payment rates for dental services shall be increased by three percent over the rates in effect on December 31, 1999;

(4) the commissioner shall award grants to community clinics or other nonprofit community organizations, political subdivisions, professional associations, or other organizations that demonstrate the ability to provide dental services effectively to public program recipients. Grants may be used to fund the costs related to coordinating access for recipients, developing and implementing patient care criteria, upgrading or establishing new facilities, acquiring furnishings

or equipment, recruiting new providers, or other development costs that will improve access to dental care in a region. In awarding grants, the commissioner shall give priority to applicants that plan to serve areas of the state in which the number of dental providers is not currently sufficient to meet the needs of recipients of public programs or uninsured individuals. The commissioner shall consider the following in awarding the grants: (i) potential to successfully increase access to an underserved population; (ii) the ability to raise matching funds; (iii) the long-term viability of the project to improve access beyond the period of initial funding; (iv) the efficiency in the use of the funding; and (v) the experience of the proposers in providing services to the target population.

The commissioner shall monitor the grants and may terminate a grant if the grantee does not increase dental access for public program recipients. The commissioner shall consider grants for the following:

(i) implementation of new programs or continued expansion of current access programs that have demonstrated success in providing dental services in underserved areas;

(ii) a pilot program for utilizing hygienists outside of a traditional dental office to provide dental hygiene services; and

(iii) a program that organizes a network of volunteer dentists, establishes a system to refer eligible individuals to volunteer dentists, and through that network provides donated dental care services to public program recipients or uninsured individuals.

(5) beginning October 1, 1999, the payment for tooth sealants and fluoride treatments shall be the lower of (i) submitted charge, or (ii) 80 percent of median 1997 charges; ~~and~~

(6) the increases listed in clauses (3) and (5) shall be implemented January 1, 2000, for managed care; and

(7) effective for services provided on or after October 1, 2001, payment for diagnostic examinations and dental x-rays provided to children under age 21 shall be the lower of (i) the submitted charge, or (ii) 85 percent of median 1999 charges.

(c) Effective for dental services rendered on or after July 1, 2001, the commissioner may increase reimbursements to dentists and dental clinics deemed by the commissioner to be critical access dental providers. Reimbursement to a critical access dental provider may be increased by not more than 50 percent above the reimbursement rate that would otherwise be paid to the provider. Payments to health plan companies shall be adjusted to reflect increased reimbursements to critical access dental providers as approved by the commissioner. In determining which dentists and dental clinics shall be deemed critical access dental providers, the commissioner shall review:

(1) the utilization rate in the service area in which the dentist or dental clinic operates for dental services to patients covered by medical assistance, general assistance medical care, or MinnesotaCare as their primary source of coverage;

(2) the level of services provided by the dentist or dental clinic to patients covered by medical assistance, general assistance medical care, or MinnesotaCare as their primary source of coverage; and

(3) whether the level of services provided by the dentist or dental clinic is critical to maintaining adequate levels of patient access within the service area.

In the absence of a critical access dental provider in a service area, the commissioner may designate a dentist or dental clinic as a critical access dental provider if the dentist or dental clinic is willing to provide care to patients covered by medical assistance, general assistance medical care, or MinnesotaCare at a level which significantly increases access to dental care in the service area.

(d) An entity that operates both a Medicare certified comprehensive outpatient rehabilitation facility and a facility which was certified prior to January 1, 1993, that is licensed under Minnesota Rules, parts 9570.2000 to 9570.3600, and for whom at least 33 percent of the clients

receiving rehabilitation services in the most recent calendar year are medical assistance recipients, shall be reimbursed by the commissioner for rehabilitation services at rates that are 38 percent greater than the maximum reimbursement rate allowed under paragraph (a), clause (2), when those services are (1) provided within the comprehensive outpatient rehabilitation facility and (2) provided to residents of nursing facilities owned by the entity.

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

Sec. 35. [256B.78] [MEDICAL ASSISTANCE DEMONSTRATION PROJECT FOR FAMILY PLANNING SERVICES.]

(a) The commissioner of human services shall establish a medical assistance demonstration project to determine whether improved access to coverage of prepregnancy family planning services reduces medical assistance and MFIP costs.

(b) This section is effective upon federal approval of the demonstration project.

Sec. 36. Minnesota Statutes 2000, 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-statewide (MFIP-S), who is having a payment made on the person's behalf under sections 256I.01 to 256I.06, or who resides in group residential housing as defined in chapter 256I and can meet a spenddown using the cost of remedial services received through group residential housing; or

(2)(i) who is a resident of Minnesota; and whose equity in assets is not in excess of $1,000 per assistance unit. Exempt assets, the reduction of excess assets, and the waiver of excess assets must conform to the medical assistance program in chapter 256B, 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; and

(ii) who has countable income ~~not in excess of the assistance standards established in section 256B.056, subdivision 4~~ that does not exceed 133 and 1/3 percent of the AFDC income standard in effect under the July 16, 1996, AFDC state plan, increased by three percent, or whose excess income is spent down according to section 256B.056, subdivision 5, using a six-month budget period. The method for calculating earned income disregards and deductions for a person who resides with a dependent child under age 21 shall follow section 256B.056, subdivision 1a. However, if a disregard of $30 and one-third of the remainder has been applied to the wage earner's income, the disregard shall not be applied again until the wage earner's income has not been considered in an eligibility determination for general assistance, general assistance medical care, medical assistance, or MFIP-S for 12 consecutive months. The earned income and work expense deductions for a person who does not reside with a dependent child under age 21 shall be the same as the method used to determine eligibility for a person under section 256D.06, subdivision 1, except the disregard of the first $50 of earned income is not allowed;

(3) who would be eligible for medical assistance except that the person resides in a facility that is determined by the commissioner or the federal Health Care Financing Administration to be an institution for mental diseases; or

(4) who is ineligible for medical assistance under chapter 256B or general assistance medical care under any other provision of this section, and is receiving care and rehabilitation services from a nonprofit center established to serve victims of torture. These individuals are eligible for general assistance medical care only for the period during which they are receiving services from the center. During this period of eligibility, individuals eligible under this clause shall not be required to participate in prepaid general assistance medical care.

(b) Beginning January 1, 2000, applicants or recipients who meet all eligibility requirements of MinnesotaCare as defined in sections 256L.01 to 256L.16, and are:

(i) adults with dependent children under 21 whose gross family income is equal to or less than 275 percent of the federal poverty guidelines; or

(ii) adults without children with earned income and whose family gross income is between 75 percent of the federal poverty guidelines and the amount set by section 256L.04, subdivision 7, shall be terminated from general assistance medical care upon enrollment in MinnesotaCare.

(c) For services rendered on or after July 1, 1997, eligibility is limited to one month prior to application if the person is determined eligible in the prior month. A redetermination of eligibility must occur every 12 months. Beginning January 1, 2000, Minnesota health care program applications completed by recipients and applicants who are persons described in paragraph (b), may be returned to the county agency to be forwarded to the department of human services or sent directly to the department of human services for enrollment in MinnesotaCare. If all other eligibility requirements of this subdivision are met, eligibility for general assistance medical care shall be available in any month during which a MinnesotaCare eligibility determination and enrollment are 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 paragraph (e).

(d) 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 an initial application when health care is delivered due to a medical condition or disability, a health care provider may act on the person's behalf to complete the initial application. 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. On the basis of information provided on the completed application, an applicant who meets the following criteria shall be determined eligible beginning in the month of application:

(1) has gross income less than 90 percent of the applicable income standard;

(2) has liquid assets that total within $300 of the asset standard;

(3) does not reside in a long-term care facility; and

(4) meets all other eligibility requirements.

The applicant must provide all required verifications within 30 days' notice of the eligibility determination or eligibility shall be terminated.

(e) 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.

(f) 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.

(g) 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. General assistance medical care is limited to payment of emergency services only for applicants or

recipients as described in paragraph (b), whose MinnesotaCare coverage is denied or terminated for nonpayment of premiums as required by sections 256L.06 and 256L.07.

(h) In determining the amount of assets of an individual, 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.

(i) 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 Number 104-193, sections 421 and 422, and subsequently set out in federal rules.

(j)(1) An undocumented noncitizen or a nonimmigrant is ineligible for general assistance medical care other than emergency services. 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 Immigration and Naturalization Service.

(2) This paragraph does not apply to a child under age 18, to a Cuban or Haitian entrant as defined in Public Law Number 96-422, section 501(e)(1) or (2)(a), or to a noncitizen who is aged, blind, or disabled as defined in Code of Federal Regulations, title 42, sections 435.520, 435.530, 435.531, 435.540, and 435.541, or effective October 1, 1998, to an individual eligible for general assistance medical care under paragraph (a), clause (4), who cooperates with the Immigration and Naturalization Service to pursue any applicable immigration status, including citizenship, that would qualify the individual for medical assistance with federal financial participation.

(k) For purposes of paragraphs (g) and (j), "emergency services" has the meaning given in Code of Federal Regulations, title 42, section 440.255(b)(1), except that it also means services rendered because of suspected or actual pesticide poisoning.

(l) 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.

Sec. 37. Minnesota Statutes 2000, section 256D.03, subdivision 4, is amended to read:

Subd. 4. [GENERAL ASSISTANCE MEDICAL CARE; SERVICES.] (a) For a person who is eligible under subdivision 3, paragraph (a), clause (3), general assistance medical care covers, except as provided in paragraph (c):

(1) inpatient hospital services;

(2) outpatient hospital services;

(3) services provided by Medicare certified rehabilitation agencies;

(4) prescription drugs and other products recommended through the process established in section 256B.0625, subdivision 13;

(5) equipment necessary to administer insulin and diagnostic supplies and equipment for diabetics to monitor blood sugar level;

(6) eyeglasses and eye examinations provided by a physician or optometrist;

(7) hearing aids;

(8) prosthetic devices;

(9) laboratory and X-ray services;

(10) physician's services;

(11) medical transportation;

(12) chiropractic services as covered under the medical assistance program;

(13) podiatric services;

(14) dental services;

(15) outpatient services provided by a mental health center or clinic that is under contract with the county board and is established under section 245.62;

(16) day treatment services for mental illness provided under contract with the county board;

(17) prescribed medications for persons who have been diagnosed as mentally ill as necessary to prevent more restrictive institutionalization;

(18) psychological services, medical supplies and equipment, and Medicare premiums, coinsurance and deductible payments;

(19) medical equipment not specifically listed in this paragraph when the use of the equipment will prevent the need for costlier services that are reimbursable under this subdivision;

(20) services performed by a certified pediatric nurse practitioner, a certified family nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse practitioner in independent practice, if (1) the service is otherwise covered under this chapter as a physician service, (2) the service provided on an inpatient basis is not included as part of the cost for inpatient services included in the operating payment rate, and (3) the service is within the scope of practice of the nurse practitioner's license as a registered nurse, as defined in section 148.171;

(21) services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic that is a department of, or that operates under the direct authority of, a unit of government, if the service is within the scope of practice of the public health nurse's license as a registered nurse, as defined in section 148.171; and

(22) telemedicine consultations, to the extent they are covered under section 256B.0625, subdivision 3b.

(b) Except as provided in paragraph (c), for a recipient who is eligible under subdivision 3, paragraph (a), clause (1) or (2), general assistance medical care covers the services listed in paragraph (a) with the exception of special transportation services.

(c) Gender reassignment surgery and related services are not covered services under this subdivision unless the individual began receiving gender reassignment services prior to July 1, 1995.

(d) In order to contain costs, the commissioner of human services shall select vendors of

medical care who can provide the most economical care consistent with high medical standards and shall where possible contract with organizations on a prepaid capitation basis to provide these services. The commissioner shall consider proposals by counties and vendors for prepaid health plans, competitive bidding programs, block grants, or other vendor payment mechanisms designed to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided. Before implementing prepaid programs in counties with a county operated or affiliated public teaching hospital or a hospital or clinic operated by the University of Minnesota, the commissioner shall consider the risks the prepaid program creates for the hospital and allow the county or hospital the opportunity to participate in the program in a manner that reflects the risk of adverse selection and the nature of the patients served by the hospital, provided the terms of participation in the program are competitive with the terms of other participants considering the nature of the population served. Payment for services provided pursuant to this subdivision shall be as provided to medical assistance vendors of these services under sections 256B.02, subdivision 8, and 256B.0625. For payments made during fiscal year 1990 and later years, the commissioner shall consult with an independent actuary in establishing prepayment rates, but shall retain final control over the rate methodology. Payment rates established by the commissioner must be within the limits of available appropriations. Notwithstanding the provisions of subdivision 3, an individual who becomes ineligible for general assistance medical care because of failure to submit income reports or recertification forms in a timely manner, shall remain enrolled in the prepaid health plan and shall remain eligible for general assistance medical care coverage through the last day of the month in which the enrollee became ineligible for general assistance medical care.

(e) There shall be no copayment required of any recipient of benefits for any services provided under this subdivision. A hospital receiving a reduced payment as a result of this section may apply the unpaid balance toward satisfaction of the hospital's bad debts.

(f) Any county may, from its own resources, provide medical payments for which state payments are not made.

(g) Chemical dependency services that are reimbursed under chapter 254B must not be reimbursed under general assistance medical care.

(h) The maximum payment for new vendors enrolled in the general assistance medical care program after the base year shall be determined from the average usual and customary charge of the same vendor type enrolled in the base year.

(i) The conditions of payment for services under this subdivision are the same as the conditions specified in rules adopted under chapter 256B governing the medical assistance program, unless otherwise provided by statute or rule.

Sec. 38. Minnesota Statutes 2000, section 256J.31, subdivision 12, is amended to read:

Subd. 12. [RIGHT TO DISCONTINUE CASH ASSISTANCE.] A participant who is not in vendor payment status may discontinue receipt of the cash assistance portion of the MFIP assistance grant and retain eligibility for child care assistance under section 119B.05 ~~and for medical assistance under sections 256B.055, subdivision 3a, and 256B.0635~~. For the months a participant chooses to discontinue the receipt of the cash portion of the MFIP grant, the assistance unit accrues months of eligibility to be applied toward eligibility for child care under section 119B.05 ~~and for medical assistance under sections 256B.055, subdivision 3a, and 256B.0635~~.

**[EFFECTIVE DATE.]** This section is effective July 1, 2002.

Sec. 39. Minnesota Statutes 2000, section 256K.03, subdivision 1, is amended to read:

Subdivision 1. [NOTIFICATION OF PROGRAM.] Except for the provisions in this section, the provisions for the MFIP application process shall be followed. Within two days after receipt of a completed combined application form, the county agency must refer to the provider the applicant who meets the conditions under section 256K.02, and notify the applicant in writing of the program including the following provisions:

(1) notification that, as part of the application process, applicants are required to attend orientation, to be followed immediately by a job search;

(2) the program provider, the date, time, and location of the scheduled program orientation;

(3) the procedures for qualifying for and receiving benefits under the program;

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

(5) the rights, responsibilities, and obligations of participants in the program, including, but not limited to, the grounds for exemptions and deferrals, the consequences for refusing or failing to participate fully, and the appeal process.

**[EFFECTIVE DATE.]** This section is effective July 1, 2002.

Sec. 40. Minnesota Statutes 2000, section 256K.07, is amended to read:

256K.07 [ELIGIBILITY FOR FOOD STAMPS~~, MEDICAL ASSISTANCE,~~ AND CHILD CARE.]

The participant shall be treated as an MFIP recipient for food stamps~~, medical assistance,~~ and child care eligibility purposes. The participant who leaves the program as a result of increased earnings from employment shall be eligible for ~~transitional medical assistance and~~ child care without regard to MFIP receipt in three of the six months preceding ineligibility.

**[EFFECTIVE DATE.]** This section is effective July 1, 2002.

Sec. 41. Minnesota Statutes 2000, section 256L.06, subdivision 3, is amended to read:

Subd. 3. [ADMINISTRATION AND COMMISSIONER'S DUTIES.] (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 changes in enrollee income; 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 annual 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.

(d) Nonpayment of the premium will result in disenrollment from the plan ~~within one calendar month after the due date~~ effective for 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. 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 July 1, 2002.

Sec. 42. Minnesota Statutes 2000, section 256L.12, subdivision 9, is amended to read:

Subd. 9. [RATE SETTING.] Rates will be prospective, per capita, where possible. The commissioner may allow health plans to arrange for inpatient hospital services on a risk or nonrisk basis. The commissioner shall consult with an independent actuary to determine appropriate rates. Rates established by the commissioner must be within the limits of available appropriations.

Sec. 43. Minnesota Statutes 2000, section 256L.12, is amended by adding a subdivision to read:

Subd. 11. [COVERAGE AT INDIAN HEALTH SERVICE FACILITIES.] For American Indian enrollees of MinnesotaCare, MinnesotaCare shall cover health care services provided at Indian Health Service facilities and facilities operated by a tribe or tribal organization under funding authorized by United States Code, title 25, sections 450f to 450n, or title III of the Indian Self-Determination and Education Act, Public Law Number 93-638, if those services would otherwise be covered under section 256L.03. Payments for services provided under this subdivision shall be made on a fee-for-service basis, and may, at the option of the tribe or organization, be made at the rates authorized under sections 256.969, subdivision 16, and 256B.0625, subdivision 34, for those MinnesotaCare enrollees eligible for coverage at medical assistance rates. For purposes of this subdivision, "American Indian" has the meaning given to persons to whom services will be provided for in the Code of Federal Regulations, title 42, section 36.12.

Sec. 44. Minnesota Statutes 2000, section 256L.16, is amended to read:

256L.16 [PAYMENT RATES; SERVICES FOR FAMILIES AND CHILDREN UNDER THE MINNESOTACARE HEALTH CARE REFORM WAIVER.]

Section 256L.11, subdivision 2, shall not apply to services provided to ~~children~~ families with children who are eligible ~~to receive expanded services~~ according to section ~~256L.03, subdivision 1a~~ 256L.04, subdivision 1, paragraph (a).

Sec. 45. Laws 1995, chapter 178, article 2, section 36, is amended to read:

Sec. 36. [EMPOWERMENT ZONES; ADMINISTRATIVE SIMPLIFICATION OF WELFARE LAWS.]

(a) The commissioner of human services shall make recommendations to effectuate the changes in federal laws and regulations, state laws and rules, and the state plan to improve the administrative efficiency of the aid to families with dependent children, general assistance, work readiness, family general assistance, medical assistance, general assistance medical care, and food stamp programs. At a minimum, the following administrative standards and procedures must be changed.

The commissioner shall:

(1) require income or eligibility reviews no more frequently than annually for cases in which income is normally invariant, as in aid to families with dependent children cases where the only source of household income is Supplemental Social Security Income;

(2) permit households to report income annually when the source of income is excluded, such as a minor's earnings;

(3) ~~require income or eligibility reviews no more frequently than annually for extended medical assistance cases;~~

~~(4)~~ require income or eligibility reviews no more frequently than annually for a medical assistance postpartum client, where the client previously had eligibility under a different basis prior to pregnancy or if other household members have eligibility with the same income/basis that applies to the client;

~~(5)~~ (4) permit all income or eligibility reviews for foster care medical assistance cases to use the short application form; and

~~(6)~~ (5) make dependent care expenses declaratory for medical assistance~~; and~~

~~(7) permit households to only report gifts worth $100 or more per month~~.

(b) The county's administrative savings resulting from these changes may be allocated to fund any lawful purpose.

(c) The recommendations must be provided in a report to the chairs of the appropriate legislative committees by August 1, 1995. The recommendations must include a list of the administrative standards and procedures that require approval by the federal government before implementation, and also which administrative simplification standards and procedures may be implemented by a county prior to receiving a federal waiver.

(d) The commissioner shall seek the necessary waivers from the federal government as soon as possible to implement the administrative simplification standards and procedures.

Sec. 46. Laws 1999, chapter 245, article 4, section 110, is amended to read:

Sec. 110. [PROGRAMS FOR SENIOR CITIZENS.]

The commissioner of human services shall study the eligibility criteria of and benefits provided to persons age 65 and over through the array of cash assistance and health care programs administered by the department, and the extent to which these programs can be combined, simplified, or coordinated to reduce administrative costs and improve access. The commissioner shall also study potential barriers to enrollment for low-income seniors who would otherwise deplete resources necessary to maintain independent community living. At a minimum, the study must include an evaluation of asset requirements and enrollment sites. The commissioner shall report study findings and recommendations to the legislature by ~~June~~ September 30, 2001.

Sec. 47. [NOTICE OF NEW PREMIUM SCHEDULE.]

The commissioner of human services shall provide medical assistance enrollees subject to premiums as employed persons with disabilities with prior notice of the new premium schedule established under the section 13 amendment to section 256B.057, subdivision 9, paragraph (c). This notice must be provided at least two months before the month in which the first premium payment under the new schedule is due.

Sec. 48. [MEDICATION THERAPY MANAGEMENT PILOT PROGRAM.]

Subdivision 1. [ESTABLISHMENT.] The commissioner of human services, in consultation with the advisory committee established under subdivision 2, shall implement, beginning July 1, 2001, a two-year medication therapy management pilot program for medical assistance enrollees. Medication therapy management must be provided by teams of physicians and pharmacists working in collaborative practice, as defined in Minnesota Statutes, section 151.01, subdivision 27, clause (5), to help patients use medications safely and effectively. The commissioner may enroll individual pharmacists who participate in the pilot program as medical assistance providers and shall seek to ensure that participating pharmacists represent all geographic regions of the state.

Subd. 2. [ADVISORY COMMITTEE.] The commissioner shall establish a ten-member medication therapy management advisory committee, to advise the commissioner in the implementation and administration of the program and the development of eligibility criteria for enrollees and providers and requirements for collaborative practice agreements. The committee shall be comprised of: two licensed physicians; two licensed pharmacists; two consumer representatives; three members with expertise in the area of medication therapy management, who may be licensed physicians or licensed pharmacists; and a representative of the commissioner, who shall serve as an ex-officio nonvoting member. In appointing members who are not consumer representatives, the commissioner shall consider recommendations of associations representing pharmacy and medical practitioners. The committee is governed by section 15.059, except that committee members do not receive compensation or reimbursement for expenses.

Subd. 3. [EVALUATION.] The commissioner shall evaluate the cost-effectiveness of the pilot

program and its effect on patient outcomes and quality of care, and shall report to the legislature by December 15, 2003. The commissioner may contract with a vendor to conduct the evaluation.

Sec. 49. [REGULATORY SIMPLIFICATION FOR STATE HEALTH CARE PROGRAM PROVIDERS.]

The commissioner of human services, in consultation with providers participating in state health care programs, shall identify nonfinancial barriers to increased provider enrollment and provider retention in state health care programs, and shall implement procedures to address these barriers. Areas to be examined by the commissioner shall include, but are not limited to, regulatory complexity and inconsistencies between state health care programs, provider requirements, provision of technical assistance to providers, responsiveness to provider inquiries and complaints, claims processing turnaround times, and policies for rejecting provider claims. The commissioner shall report to the legislature by February 15, 2002, on any changes to the administration of state health care programs that will be implemented as a result of the study, and present recommendations for any necessary changes in state law.

Sec. 50. [REPEALER.]

(a) Minnesota Statutes 2000, section 256B.037, subdivision 5, is repealed effective January 1, 2002.

(b) Minnesota Statutes 2000, section 256B.0635, subdivision 3, is repealed effective July 1, 2002.

ARTICLE 3

CONTINUING CARE AND HOME CARE

Section 1. Minnesota Statutes 2000, section 245A.13, subdivision 7, is amended to read:

Subd. 7. [RATE RECOMMENDATION.] The commissioner of human services may review rates of a residential program participating in the medical assistance program which is in receivership and that has needs or deficiencies documented by the department of health or the department of human services. If the commissioner of human services determines that a review of the rate established under ~~section 256B.501~~ sections 256B.5012 and 256B.5013 is needed, the commissioner shall:

(1) review the order or determination that cites the deficiencies or needs; and

(2) determine the need for additional staff, additional annual hours by type of employee, and additional consultants, services, supplies, equipment, repairs, or capital assets necessary to satisfy the needs or deficiencies.

Sec. 2. Minnesota Statutes 2000, section 245A.13, subdivision 8, is amended to read:

Subd. 8. [ADJUSTMENT TO THE RATE.] Upon review of rates under subdivision 7, the commissioner may adjust the residential program's payment rate. The commissioner shall review the circumstances, together with the residential ~~program cost report~~ program's most recent income and expense report, to determine whether or not the deficiencies or needs can be corrected or met by reallocating residential program staff, costs, revenues, or any other resources including ~~any~~ investments~~, efficiency incentives, or allowances~~. If the commissioner determines that any deficiency cannot be corrected or the need cannot be met with the payment rate currently being paid, the commissioner shall determine the payment rate adjustment by dividing the additional annual costs established during the commissioner's review by the residential program's actual resident days from the most recent ~~desk-audited cost~~ income and expense report or the estimated resident days in the projected receivership period. The payment rate adjustment ~~must meet the conditions in Minnesota Rules, parts 9553.0010 to 9553.0080, and~~ remains in effect during the period of the receivership or until another date set by the commissioner. Upon the subsequent sale, closure, or transfer of the residential program, the commissioner may recover amounts that were paid as payment rate adjustments under this subdivision. This recovery shall be determined through a review of actual costs and resident days in the receivership period. The costs the

commissioner finds to be allowable shall be divided by the actual resident days for the receivership period. This rate shall be compared to the rate paid throughout the receivership period, with the difference, multiplied by resident days, being the amount to be repaid to the commissioner. Allowable costs shall be determined by the commissioner as those ordinary, necessary, and related to resident care by prudent and cost-conscious management. The buyer or transferee shall repay this amount to the commissioner within 60 days after the commissioner notifies the buyer or transferee of the obligation to repay. This provision does not limit the liability of the seller to the commissioner pursuant to section 256B.0641.

Sec. 3. Minnesota Statutes 2000, section 252.275, subdivision 4b, is amended to read:

Subd. 4b. [GUARANTEED FLOOR.] Each county ~~with an original allocation for the preceding year that is equal to or less than the guaranteed floor minimum index shall have a guaranteed floor equal to its original allocation for the preceding year. Each county with an original allocation for the preceding year that is greater than the guaranteed floor minimum index~~ shall have a guaranteed floor equal to the lesser of clause (1) or (2):

(1) the county's original allocation for the preceding year; or

(2) 70 percent of the county's reported expenditures eligible for reimbursement during the 12 months ending on June 30 of the preceding calendar year.

~~For calendar year 1993, the guaranteed floor minimum index shall be $20,000. For each subsequent year, the index shall be adjusted by the projected change in the average value in the United States Department of Labor Bureau of Labor Statistics consumer price index (all urban) for that year.~~

Notwithstanding this subdivision, no county shall be allocated a guaranteed floor of less than $1,000.

When the amount of funds available for allocation is less than the amount available in the previous year, each county's previous year allocation shall be reduced in proportion to the reduction in the statewide funding, to establish each county's guaranteed floor.

Sec. 4. Minnesota Statutes 2000, section 254B.02, subdivision 3, is amended to read:

Subd. 3. [RESERVE ACCOUNT.] The commissioner shall allocate money from the reserve account to counties that, during the current fiscal year, have met or exceeded the base level of expenditures for eligible chemical dependency services from local money. The commissioner shall establish the base level for fiscal year 1988 as the amount of local money used for eligible services in calendar year 1986. In later years, the base level must be increased in the same proportion as state appropriations to implement Laws 1986, chapter 394, sections 8 to 20, are increased. The base level must be decreased if the fund balance from which allocations are made under section 254B.02, subdivision 1, is decreased in later years. The local match rate for the reserve account is the same rate as applied to the initial allocation. Reserve account payments must not be included when calculating the county adjustments made according to subdivision 2. For counties providing medical assistance or general assistance medical care through managed care plans on January 1, 1996, the base year is fiscal year 1995. For counties beginning provision of managed care after January 1, 1996, the base year is the most recent fiscal year before enrollment in managed care begins. For counties providing managed care, the base level will be increased or decreased in proportion to changes in the fund balance from which allocations are made under subdivision 2, but will be additionally increased or decreased in proportion to the change in county adjusted population made in subdivision 1, paragraphs (b) and (c). Effective July 1, 2001, funds deposited in the reserve account in excess of those needed to meet obligations for services provided during the biennium under this section and sections 254B.06 and 254B.09 shall cancel to the general fund.

Sec. 5. Minnesota Statutes 2000, section 254B.03, subdivision 1, is amended to read:

Subdivision 1. [LOCAL AGENCY DUTIES.] (a) Every local agency shall provide chemical dependency services to persons residing within its jurisdiction who meet criteria established by the

commissioner for placement in a chemical dependency residential or nonresidential treatment service. Chemical dependency money must be administered by the local agencies according to law and rules adopted by the commissioner under sections 14.001 to 14.69.

(b) In order to contain costs, the county board shall, with the approval of the commissioner of human services, select eligible vendors of chemical dependency services who can provide economical and appropriate treatment. Unless the local agency is a social services department directly administered by a county or human services board, the local agency shall not be an eligible vendor under section 254B.05. The commissioner may approve proposals from county boards to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided. If a county implements a demonstration or experimental medical services funding plan, the commissioner shall transfer the money as appropriate. If a county selects a vendor located in another state, the county shall ensure that the vendor is in compliance with the rules governing licensure of programs located in the state.

(c) The calendar year ~~1998~~ 2002 rate for vendors may not increase more than ~~three~~ two percent above the rate approved in effect on January 1, ~~1997~~ 2001. The calendar year ~~1999~~ 2003 rate for vendors may not increase more than ~~three~~ two percent above the rate in effect on January 1, ~~1998~~ 2002. The calendar years 2004 and 2005 rates may not exceed the rate in effect on January 1, 2003.

(d) A culturally specific vendor that provides assessments under a variance under Minnesota Rules, part 9530.6610, shall be allowed to provide assessment services to persons not covered by the variance.

Sec. 6. Minnesota Statutes 2000, section 254B.04, subdivision 1, is amended to read:

Subdivision 1. [ELIGIBILITY.] (a) Persons eligible for benefits under Code of Federal Regulations, title 25, part 20, persons eligible for medical assistance benefits under sections 256B.055, 256B.056, and 256B.057, subdivisions 1, 2, 5, and 6, or who meet the income standards of section 256B.056, subdivision 4, and persons eligible for general assistance medical care under section 256D.03, subdivision 3, are entitled to chemical dependency fund services. State money appropriated for this paragraph must be placed in a separate account established for this purpose.

Persons with dependent children who are determined to be in need of chemical dependency treatment pursuant to an assessment under section 626.556, subdivision 10, or a case plan under section 260C.201, subdivision 6, or 260C.212, shall be assisted by the local agency to access needed treatment services. Treatment services must be appropriate for the individual or family, which may include long-term care treatment or treatment in a facility that allows the dependent children to stay in the treatment facility. The county shall pay for out-of-home placement costs, if applicable.

(b) A person not entitled to services under paragraph (a), but with family income that is less than the 1997 federal poverty guidelines equivalent of 60 percent of the state median income for a family of like size and composition, shall be eligible to receive chemical dependency fund services within the limit of funds ~~available after persons entitled to services under paragraph (a) have been served~~ appropriated for this group for the fiscal year. If notified by the state agency of limited funds, a county must give preferential treatment to persons with dependent children who are in need of chemical dependency treatment pursuant to an assessment under section 626.556, subdivision 10, or a case plan under section 260C.201, subdivision 6, or 260C.212. A county may spend money from its own sources to serve persons under this paragraph. State money appropriated for this paragraph must be placed in a separate account established for this purpose.

(c) Persons whose income is between the 1997 federal poverty guidelines equivalent of 60 percent and 115 percent of the state median income shall be eligible for chemical dependency services on a sliding fee basis, within the limit of funds ~~available, after persons entitled to services under paragraph (a) and persons eligible for services under paragraph (b) have been served~~ appropriated for this group for the fiscal year. Persons eligible under this paragraph must contribute to the cost of services according to the sliding fee scale established under subdivision 3. A county may spend money from its own sources to provide services to persons under this

paragraph. State money appropriated for this paragraph must be placed in a separate account established for this purpose.

Sec. 7. Minnesota Statutes 2000, section 254B.09, is amended by adding a subdivision to read:

Subd. 8. [PAYMENTS TO IMPROVE SERVICES TO AMERICAN INDIANS.] The commissioner may set rates for chemical dependency services according to the American Indian Health Improvement Act, Public Law Number 94-437, for eligible vendors. These rates shall supersede rates set in county purchase of service agreements when payments are made on behalf of clients eligible according to Public Law Number 94-437.

Sec. 8. Minnesota Statutes 2000, section 256.01, is amended by adding a subdivision to read:

Subd. 19. [GRANTS FOR CASE MANAGEMENT SERVICES TO PERSONS WITH HIV OR AIDS.] The commissioner may award grants to eligible vendors for the development, implementation, and evaluation of case management services for individuals infected with the human immunodeficiency virus. HIV/AIDs case management services will be provided to increase access to cost effective health care services, to reduce the risk of HIV transmission, to ensure that basic client needs are met, and to increase client access to needed community supports or services.

Sec. 9. Minnesota Statutes 2000, section 256.476, subdivision 1, is amended to read:

Subdivision 1. [PURPOSE AND GOALS.] The commissioner of human services shall establish a consumer support grant program ~~to assist~~ for individuals with functional limitations and their families ~~in purchasing and securing supports which the individuals need to live as independently and productively in the community as possible~~ who wish to purchase and secure their own supports. The commissioner and local agencies shall jointly develop an implementation plan which must include a way to resolve the issues related to county liability. The program shall:

(1) make support grants available to individuals or families as an effective alternative to existing programs and services, such as the developmental disability family support program, ~~the alternative care program,~~ personal care attendant services, home health aide services, and private duty nursing ~~facility~~ services;

(2) provide consumers more control, flexibility, and responsibility over ~~the needed supports~~ their services and supports;

(3) promote local program management and decision making; and

(4) encourage the use of informal and typical community supports.

Sec. 10. Minnesota Statutes 2000, section 256.476, subdivision 2, is amended to read:

Subd. 2. [DEFINITIONS.] For purposes of this section, the following terms have the meanings given them:

(a) "County board" means the county board of commissioners for the county of financial responsibility as defined in section 256G.02, subdivision 4, or its designated representative. When a human services board has been established under sections 402.01 to 402.10, it shall be considered the county board for the purposes of this section.

(b) "Family" means the person's birth parents, adoptive parents or stepparents, siblings or stepsiblings, children or stepchildren, grandparents, grandchildren, niece, nephew, aunt, uncle, or spouse. For the purposes of this section, a family member is at least 18 years of age.

(c) "Functional limitations" means the long-term inability to perform an activity or task in one or more areas of major life activity, including self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living. For the purpose of this section, the inability to perform an activity or task results from a mental, emotional, psychological, sensory, or physical disability, condition, or illness.

(d) "Informed choice" means a voluntary decision made by the person or the person's legal representative, after becoming familiarized with the alternatives to:

(1) select a preferred alternative from a number of feasible alternatives;

(2) select an alternative which may be developed in the future; and

(3) refuse any or all alternatives.

(e) "Local agency" means the local agency authorized by the county board to carry out the provisions of this section.

(f) "Person" or "persons" means a person or persons meeting the eligibility criteria in subdivision 3.

(g) "Authorized representative" means an individual designated by the person or their legal representative to act on their behalf. This individual may be a family member, guardian, representative payee, or other individual designated by the person or their legal representative, if any, to assist in purchasing and arranging for supports. For the purposes of this section, an authorized representative is at least 18 years of age.

(h) "Screening" means the screening of a person's service needs under sections 256B.0911 and 256B.092.

(i) "Supports" means services, care, aids, ~~home~~ environmental modifications, or assistance purchased by the person or the person's family. Examples of supports include respite care, assistance with daily living, and ~~adaptive aids~~ assistive technology. For the purpose of this section, notwithstanding the provisions of section 144A.43, supports purchased under the consumer support program are not considered home care services.

(j) "Program of origination" means the program the individual transferred from when approved for the consumer support grant program.

Sec. 11. Minnesota Statutes 2000, section 256.476, subdivision 3, is amended to read:

Subd. 3. [ELIGIBILITY TO APPLY FOR GRANTS.] (a) A person is eligible to apply for a consumer support grant if the person meets all of the following criteria:

(1) the person is eligible for and has been approved to receive services under medical assistance as determined under sections 256B.055 and 256B.056 ~~or the person is eligible for and has been approved to receive services under alternative care services as determined under section 256B.0913~~ or the person has been approved to receive a grant under the developmental disability family support program under section 252.32;

(2) the person is able to direct and purchase the person's own care and supports, or the person has a family member, legal representative, or other authorized representative who can purchase and arrange supports on the person's behalf;

(3) the person has functional limitations, requires ongoing supports to live in the community, and is at risk of or would continue institutionalization without such supports; and

(4) the person will live in a home. For the purpose of this section, "home" means the person's own home or home of a person's family member. These homes are natural home settings and are not licensed by the department of health or human services.

(b) Persons may not concurrently receive a consumer support grant if they are:

(1) receiving home and community-based services under United States Code, title 42, section 1396h(c); personal care attendant and home health aide services under section 256B.0625; a developmental disability family support grant; or alternative care services under section 256B.0913; or

(2) residing in an institutional or congregate care setting.

(c) A person or person's family receiving a consumer support grant shall not be charged a fee or premium by a local agency for participating in the program.

(d) The commissioner may limit the participation of ~~nursing facility residents, residents of intermediate care facilities for persons with mental retardation, and the~~ recipients of services from federal waiver programs in the consumer support grant program if the participation of these individuals will result in an increase in the cost to the state.

(e) The commissioner shall establish a budgeted appropriation each fiscal year for the consumer support grant program. The number of individuals participating in the program will be adjusted so the total amount allocated to counties does not exceed the amount of the budgeted appropriation. The budgeted appropriation will be adjusted annually to accommodate changes in demand for the consumer support grants.

Sec. 12. Minnesota Statutes 2000, section 256.476, subdivision 4, is amended to read:

Subd. 4. [SUPPORT GRANTS; CRITERIA AND LIMITATIONS.] (a) A county board may choose to participate in the consumer support grant program. If a county board chooses to participate in the program, the local agency shall establish written procedures and criteria to determine the amount and use of support grants. These procedures must include, at least, the availability of respite care, assistance with daily living, and adaptive aids. The local agency may establish monthly or annual maximum amounts for grants and procedures where exceptional resources may be required to meet the health and safety needs of the person on a time-limited basis, however, the total amount awarded to each individual may not exceed the limits established in subdivision 5, paragraph (f).

(b) Support grants to a person or a person's family will be provided through a monthly subsidy payment and be in the form of cash, voucher, or direct county payment to vendor. Support grant amounts must be determined by the local agency. Each service and item purchased with a support grant must meet all of the following criteria:

(1) it must be over and above the normal cost of caring for the person if the person did not have functional limitations;

(2) it must be directly attributable to the person's functional limitations;

(3) it must enable the person or the person's family to delay or prevent out-of-home placement of the person; and

(4) it must be consistent with the needs identified in the service plan, when applicable.

(c) Items and services purchased with support grants must be those for which there are no other public or private funds available to the person or the person's family. Fees assessed to the person or the person's family for health and human services are not reimbursable through the grant.

(d) In approving or denying applications, the local agency shall consider the following factors:

(1) the extent and areas of the person's functional limitations;

(2) the degree of need in the home environment for additional support; and

(3) the potential effectiveness of the grant to maintain and support the person in the family environment or the person's own home.

(e) At the time of application to the program or screening for other services, the person or the person's family shall be provided sufficient information to ensure an informed choice of alternatives by the person, the person's legal representative, if any, or the person's family. The application shall be made to the local agency and shall specify the needs of the person and family, the form and amount of grant requested, the items and services to be reimbursed, and evidence of eligibility for medical assistance ~~or alternative care program~~.

(f) Upon approval of an application by the local agency and agreement on a support plan for the person or person's family, the local agency shall make grants to the person or the person's family. The grant shall be in an amount for the direct costs of the services or supports outlined in the service agreement.

(g) Reimbursable costs shall not include costs for resources already available, such as special education classes, day training and habilitation, case management, other services to which the person is entitled, medical costs covered by insurance or other health programs, or other resources usually available at no cost to the person or the person's family.

(h) The state of Minnesota, the county boards participating in the consumer support grant program, or the agencies acting on behalf of the county boards in the implementation and administration of the consumer support grant program shall not be liable for damages, injuries, or liabilities sustained through the purchase of support by the individual, the individual's family, or the authorized representative under this section with funds received through the consumer support grant program. Liabilities include but are not limited to: workers' compensation liability, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA). For purposes of this section, participating county boards and agencies acting on behalf of county boards are exempt from the provisions of section 268.04.

Sec. 13. Minnesota Statutes 2000, section 256.476, subdivision 5, is amended to read:

Subd. 5. [REIMBURSEMENT, ALLOCATIONS, AND REPORTING.] (a) For the purpose of transferring persons to the consumer support grant program from specific programs or services, such as the developmental disability family support program and ~~alternative care program,~~ personal care ~~attendant~~ assistant services, home health aide services, or ~~nursing facility~~ private duty nursing services, the amount of funds transferred by the commissioner between the developmental disability family support program account, ~~the alternative care account,~~ the medical assistance account, or the consumer support grant account shall be based on each county's participation in transferring persons to the consumer support grant program from those programs and services.

(b) At the beginning of each fiscal year, county allocations for consumer support grants shall be based on:

(1) the number of persons to whom the county board expects to provide consumer supports grants;

(2) their eligibility for current program and services;

(3) the amount of nonfederal dollars expended on those individuals for those programs and services or, in situations where an individual is unable to obtain the support needed from the program of origination due to the unavailability of service providers at the time or the location where the supports are needed, the allocation will be based on the county's best estimate of the nonfederal dollars that would have been expended if the services had been available; and

(4) projected dates when persons will start receiving grants. County allocations shall be adjusted periodically by the commissioner based on the actual transfer of persons or service openings, and the nonfederal dollars associated with those persons or service openings, to the consumer support grant program.

(c) The amount of funds transferred by the commissioner from ~~the alternative care account and~~ the medical assistance account for an individual may be changed if it is determined by the county or its agent that the individual's need for support has changed.

(d) The authority to utilize funds transferred to the consumer support grant account for the purposes of implementing and administering the consumer support grant program will not be limited or constrained by the spending authority provided to the program of origination.

(e) The commissioner ~~shall~~ may use up to five percent of each county's allocation, as adjusted, for payments to that county for administrative expenses, to be paid as a proportionate addition to reported direct service expenditures.

(f) Except as provided in this paragraph, the county allocation for each individual or individual's family cannot exceed 80 percent of the total nonfederal dollars expended on the individual by the program of origination except for the developmental disabilities family support grant program which can be approved up to 100 percent of the nonfederal dollars and in situations as described in paragraph (b), clause (3). In situations where exceptional need exists or the individual's need for support increases, up to 100 percent of the nonfederal dollars expended by the consumer's program of origination may be allocated to the county. Allocations that exceed 80 percent of the nonfederal dollars expended on the individual by the program of origination must be approved by the commissioner. The remainder of the amount expended on the individual by the program of origination will be used in the following proportions: half will be made available to the consumer support grant program and participating counties for consumer training, resource development, and other costs, and half will be returned to the state general fund.

(g) The commissioner may recover, suspend, or withhold payments if the county board, local agency, or grantee does not comply with the requirements of this section.

(h) Grant funds unexpended by consumers shall return to the state once a year. The annual return of unexpended grant funds shall occur in the quarter following the end of the state fiscal year.

Sec. 14. Minnesota Statutes 2000, section 256.476, subdivision 8, is amended to read:

Subd. 8. [COMMISSIONER RESPONSIBILITIES.] The commissioner shall:

(1) transfer and allocate funds pursuant to this section;

(2) determine allocations based on projected and actual local agency use;

(3) monitor and oversee overall program spending;

(4) evaluate the effectiveness of the program;

(5) provide training and technical assistance for local agencies and consumers to help identify potential applicants to the program; and

(6) develop guidelines for local agency program administration and consumer information~~; and~~.

~~(7) apply for a federal waiver or take any other action necessary to maximize federal funding for the program by September 1, 1999.~~

Sec. 15. Minnesota Statutes 2000, section 256B.0625, subdivision 7, is amended to read:

Subd. 7. [PRIVATE DUTY NURSING.] Medical assistance covers private duty nursing services in a recipient's home. Recipients who are authorized to receive private duty nursing services in their home may use approved hours outside of the home during hours when normal life activities take them outside of their home ~~and when, without the provision of private duty nursing, their health and safety would be jeopardized~~. To use private duty nursing services at school, the recipient or responsible party must provide written authorization in the care plan identifying the chosen provider and the daily amount of services to be used at school. Medical assistance does not cover private duty nursing services for residents of a hospital, nursing facility, intermediate care facility, or a health care facility licensed by the commissioner of health, except as authorized in section 256B.64 for ventilator-dependent recipients in hospitals or unless a resident who is otherwise eligible is on leave from the facility and the facility either pays for the private duty nursing services or forgoes the facility per diem for the leave days that private duty nursing services are used. Total hours of service and payment allowed for services outside the home cannot exceed that which is otherwise allowed in an in-home setting according to section 256B.0627. All private duty nursing services must be provided according to the limits established under section 256B.0627. Private duty nursing services may not be reimbursed if the nurse is the ~~spouse of the recipient or the parent or~~ foster care provider of a recipient who is under age 18~~, or the recipient's legal guardian~~.

Sec. 16. Minnesota Statutes 2000, section 256B.0625, subdivision 19a, is amended to read:

Subd. 19a. [PERSONAL CARE ASSISTANT SERVICES.] Medical assistance covers personal care assistant services in a recipient's home. To qualify for personal care assistant services, recipients or responsible parties must be able to identify the recipient's needs, direct and evaluate task accomplishment, and provide for health and safety. Approved hours may be used outside the home when normal life activities take them outside the home ~~and when, without the provision of personal care, their health and safety would be jeopardized~~. To use personal care assistant services at school, the recipient or responsible party must provide written authorization in the care plan identifying the chosen provider and the daily amount of services to be used at school. Total hours for services, whether actually performed inside or outside the recipient's home, cannot exceed that which is otherwise allowed for personal care assistant services in an in-home setting according to section 256B.0627. Medical assistance does not cover personal care assistant services for residents of a hospital, nursing facility, intermediate care facility, health care facility licensed by the commissioner of health, or unless a resident who is otherwise eligible is on leave from the facility and the facility either pays for the personal care assistant services or forgoes the facility per diem for the leave days that personal care assistant services are used. All personal care services must be provided according to section 256B.0627. Personal care assistant services may not be reimbursed if the personal care assistant is the spouse or legal guardian of the recipient or the parent of a recipient under age 18, or the responsible party or the foster care provider of a recipient who cannot direct the recipient's own care unless, in the case of a foster care provider, a county or state case manager visits the recipient as needed, but not less than every six months, to monitor the health and safety of the recipient and to ensure the goals of the care plan are met. Parents of adult recipients, adult children of the recipient or adult siblings of the recipient may be reimbursed for personal care assistant services ~~if they are not the recipient's legal guardian and~~, if they are granted a waiver under section 256B.0627. ~~Until July 1, 2001, and~~ Notwithstanding the provisions of section 256B.0627, subdivision 4, paragraph (b), clause (4), the noncorporate legal guardian or conservator of an adult, who is not the responsible party and not the personal care provider organization, may be granted a hardship waiver under section 256B.0627, to be reimbursed to provide personal care assistant services to the recipient, and shall not be considered to have a service provider interest for purposes of participation on the screening team under section 256B.092, subdivision 7.

Sec. 17. Minnesota Statutes 2000, section 256B.0625, subdivision 19c, is amended to read:

Subd. 19c. [PERSONAL CARE.] Medical assistance covers personal care assistant services provided by an individual who is qualified to provide the services according to subdivision 19a and section 256B.0627, where the services are prescribed by a physician in accordance with a plan of treatment and are supervised by the recipient ~~under the fiscal agent option according to section 256B.0627, subdivision 10,~~ or a qualified professional. "Qualified professional" means a mental health professional as defined in section 245.462, subdivision 18, or 245.4871, subdivision 27; or a registered nurse as defined in sections 148.171 to 148.285. As part of the assessment, the county public health nurse will ~~consult with~~ assist the recipient or responsible party ~~and~~ to identify the most appropriate person to provide supervision of the personal care assistant. The qualified professional shall perform the duties described in Minnesota Rules, part 9505.0335, subpart 4.

Sec. 18. Minnesota Statutes 2000, section 256B.0625, subdivision 20, is amended to read:

Subd. 20. [MENTAL HEALTH CASE MANAGEMENT.] (a) To the extent authorized by rule of the state agency, medical assistance covers case management services to persons with serious and persistent mental illness and children with severe emotional disturbance. Services provided under this section must meet the relevant standards in sections 245.461 to 245.4888, the Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

(b) Entities meeting program standards set out in rules governing family community support services as defined in section 245.4871, subdivision 17, are eligible for medical assistance reimbursement for case management services for children with severe emotional disturbance when these services meet the program standards in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

(c) Medical assistance and MinnesotaCare payment for mental health case management shall be made on a monthly basis. In order to receive payment for an eligible child, the provider must document at least a face-to-face contact with the child, the child's parents, or the child's legal representative. To receive payment for an eligible adult, the provider must document:

(1) at least a face-to-face contact with the adult or the adult's legal representative; or

(2) at least a telephone contact with the adult or the adult's legal representative and document a face-to-face contact with the adult or the adult's legal representative within the preceding two months.

(d) Payment for mental health case management provided by county or state staff shall be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph (b), with separate rates calculated for child welfare and mental health, and within mental health, separate rates for children and adults.

(e) Payment for mental health case management provided by county-contracted vendors shall be based on a monthly rate negotiated by the host county. The negotiated rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the county may negotiate a team rate with a vendor who is a member of the team. The team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county, except to reimburse the county for advance funding provided by the county to the vendor.

(f) If the service is provided by a team which includes contracted vendors and county or state staff, the costs for county or state staff participation in the team shall be included in the rate for county-provided services. In this case, the contracted vendor and the county may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services, the county must document, in the recipient's file, the need for team case management and a description of the roles of the team members.

(g) The commissioner shall calculate the nonfederal share of actual medical assistance and general assistance medical care payments for each county, based on the higher of calendar year 1995 or 1996, by service date, project that amount forward to 1999, and transfer one-half of the result from medical assistance and general assistance medical care to each county's mental health grants under sections 245.4886 and 256E.12 for calendar year 1999. The annualized minimum amount added to each county's mental health grant shall be $3,000 per year for children and $5,000 per year for adults. The commissioner may reduce the statewide growth factor in order to fund these minimums. The annualized total amount transferred shall become part of the base for future mental health grants for each county.

(h) Any net increase in revenue to the county as a result of the change in this section must be used to provide expanded mental health services as defined in sections 245.461 to 245.4888, the Comprehensive Adult and Children's Mental Health Acts, excluding inpatient and residential treatment. For adults, increased revenue may also be used for services and consumer supports which are part of adult mental health projects approved under Laws 1997, chapter 203, article 7, section 25. For children, increased revenue may also be used for respite care and nonresidential individualized rehabilitation services as defined in section 245.492, subdivisions 17 and 23. "Increased revenue" has the meaning given in Minnesota Rules, part 9520.0903, subpart 3.

(i) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for mental health case management shall be provided by the recipient's county of responsibility, as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds used to match other federal funds.

(j) The commissioner may suspend, reduce, or terminate the reimbursement to a provider that does not meet the reporting or other requirements of this section. The county of responsibility, as defined in sections 256G.01 to 256G.12, is responsible for any federal disallowances. The county may share this responsibility with its contracted vendors.

(k) The commissioner shall set aside a portion of the federal funds earned under this section to repay the special revenue maximization account under section 256.01, subdivision 2, clause (15). The repayment is limited to:

(1) the costs of developing and implementing this section; and

(2) programming the information systems.

(l) Notwithstanding section 256.025, subdivision 2, payments to counties for case management expenditures under this section shall only be made from federal earnings from services provided under this section. Payments to contracted vendors shall include both the federal earnings and the county share.

(m) Notwithstanding section 256B.041, county payments for the cost of mental health case management services provided by county or state staff shall not be made to the state treasurer. For the purposes of mental health case management services provided by county or state staff under this section, the centralized disbursement of payments to counties under section 256B.041 consists only of federal earnings from services provided under this section.

(n) Case management services under this subdivision do not include therapy, treatment, legal, or outreach services.

(o) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital, and the recipient's institutional care is paid by medical assistance, payment for case management services under this subdivision is limited to the last ~~30~~ 180 days of the recipient's residency in that facility and may not exceed more than ~~two~~ six months in a calendar year.

(p) Payment for case management services under this subdivision shall not duplicate payments made under other program authorities for the same purpose.

(q) By July 1, 2000, the commissioner shall evaluate the effectiveness of the changes required by this section, including changes in number of persons receiving mental health case management, changes in hours of service per person, and changes in caseload size.

(r) For each calendar year beginning with the calendar year 2001, the annualized amount of state funds for each county determined under paragraph (g) shall be adjusted by the county's percentage change in the average number of clients per month who received case management under this section during the fiscal year that ended six months prior to the calendar year in question, in comparison to the prior fiscal year.

(s) For counties receiving the minimum allocation of $3,000 or $5,000 described in paragraph (g), the adjustment in paragraph (r) shall be determined so that the county receives the higher of the following amounts:

(1) a continuation of the minimum allocation in paragraph (g); or

(2) an amount based on that county's average number of clients per month who received case management under this section during the fiscal year that ended six months prior to the calendar year in question, in comparison to the prior fiscal year, times the average statewide grant per person per month for counties not receiving the minimum allocation.

(t) The adjustments in paragraphs (r) and (s) shall be calculated separately for children and adults.

Sec. 19. Minnesota Statutes 2000, section 256B.0625, is amended by adding a subdivision to read:

Subd. 43. [TARGETED CASE MANAGEMENT.] For purposes of subdivisions 43a to 43h, the following terms have the meanings given them:

(1) "Home care service recipients" means those individuals receiving the following services under section 256B.0627: skilled nursing visits, home health aide visits, private duty nursing, personal care assistants, or therapies provided through a home health agency.

(2) "Home care targeted case management" means the provision of targeted case management services for the purpose of assisting home care service recipients to gain access to needed services and supports so that they may remain in the community.

(3) "Institutions" means hospitals, consistent with Code of Federal Regulations, title 42, section 440.10; regional treatment center inpatient services, consistent with section 245.474; nursing facilities; and intermediate care facilities for persons with mental retardation.

(4) "Relocation targeted case management" means the provision of targeted case management services for the purpose of assisting recipients to gain access to needed services and supports if they choose to move from an institution to the community. Relocation targeted case management may be provided during the last 180 consecutive days of an eligible recipient's institutional stay.

(5) "Targeted case management" means case management services provided to help recipients gain access to needed medical, social, educational, and other services and supports.

Sec. 20. Minnesota Statutes 2000, section 256B.0625, is amended by adding a subdivision to read:

Subd. 43a. [ELIGIBILITY.] The following persons are eligible for relocation targeted case management or home care targeted case management:

(1) medical assistance eligible persons residing in institutions who choose to move into the community are eligible for relocation targeted case management services; and

(2) medical assistance eligible persons receiving home care services, who are not eligible for any other medical assistance reimbursable case management service, are eligible for home care targeted case management services beginning January 1, 2003.

Sec. 21. Minnesota Statutes 2000, section 256B.0625, is amended by adding a subdivision to read:

Subd. 43b. [RELOCATION TARGETED CASE MANAGEMENT PROVIDER QUALIFICATIONS.] The following qualifications and certification standards must be met by providers of relocation targeted case management:

(a) The commissioner must certify each provider of relocation targeted case management before enrollment. The certification process shall examine the provider's ability to meet the requirements in this subdivision and other federal and state requirements of this service. A certified relocation targeted case management provider may subcontract with another provider to deliver relocation targeted case management services. Subcontracted providers must demonstrate the ability to provide the services outlined in subdivision 43d.

(b) A relocation targeted case management provider is an enrolled medical assistance provider who is determined by the commissioner to have all of the following characteristics:

(1) the legal authority to provide public welfare under sections 393.01, subdivision 7; and 393.07, or a federally recognized Indian tribe;

(2) the demonstrated capacity and experience to provide the components of case management to coordinate and link community resources needed by the eligible population;

(3) the administrative capacity and experience to serve the target population for whom it will provide services and ensure quality of services under state and federal requirements;

(4) the legal authority to provide complete investigative and protective services under section 626.556, subdivision 10, and child welfare and foster care services under section 393.07, subdivisions 1 and 2, or a federally recognized Indian tribe;

(5) a financial management system that provides accurate documentation of services and costs under state and federal requirements; and

(6) the capacity to document and maintain individual case records under state and federal requirements.

A provider of targeted case management under subdivision 20 may be deemed a certified provider of relocation targeted case management.

Sec. 22. Minnesota Statutes 2000, section 256B.0625, is amended by adding a subdivision to read:

Subd. 43c. [HOME CARE TARGETED CASE MANAGEMENT PROVIDER QUALIFICATIONS.] The following qualifications and certification standards must be met by providers of home care targeted case management.

(a) The commissioner must certify each provider of home care targeted case management before enrollment. The certification process shall examine the provider's ability to meet the requirements in this subdivision and other state and federal requirements of this service.

(b) A home care targeted case management provider is an enrolled medical assistance provider who has a minimum of a bachelor's degree or a license in a health or human services field, and is determined by the commissioner to have all of the following characteristics:

(1) the demonstrated capacity and experience to provide the components of case management to coordinate and link community resources needed by the eligible population;

(2) the administrative capacity and experience to serve the target population for whom it will provide services and ensure quality of services under state and federal requirements;

(3) a financial management system that provides accurate documentation of services and costs under state and federal requirements;

(4) the capacity to document and maintain individual case records under state and federal requirements; and

(5) the capacity to coordinate with county administrative functions.

Sec. 23. Minnesota Statutes 2000, section 256B.0625, is amended by adding a subdivision to read:

Subd. 43d. [ELIGIBLE SERVICES.] Services eligible for medical assistance reimbursement as targeted case management include:

(1) assessment of the recipient's need for targeted case management services;

(2) development, completion, and regular review of a written individual service plan, which is based upon the assessment of the recipient's needs and choices, and which will ensure access to medical, social, educational, and other related services and supports;

(3) routine contact or communication with the recipient, recipient's family, primary caregiver, legal representative, substitute care provider, service providers, or other relevant persons identified as necessary to the development or implementation of the goals of the individual service plan;

(4) coordinating referrals for, and the provision of, case management services for the recipient with appropriate service providers, consistent with section 1902(a)(23) of the Social Security Act;

(5) coordinating and monitoring the overall service delivery to ensure quality of services, appropriateness, and continued need;

(6) completing and maintaining necessary documentation that supports and verifies the activities in this subdivision;

(7) traveling to conduct a visit with the recipient or other relevant person necessary to develop or implement the goals of the individual service plan; and

(8) coordinating with the institution discharge planner in the 180-day period before the recipient's discharge.

Sec. 24. Minnesota Statutes 2000, section 256B.0625, is amended by adding a subdivision to read:

Subd. 43e. [TIME LINES.] The following time lines must be met for assigning a case manager:

(1) for relocation targeted case management, an eligible recipient must be assigned a case manager who visits the person within 20 working days of requesting a case manager from their county of financial responsibility as determined under chapter 256G. If a county agency does not provide case management services as required, the recipient may, after written notice to the county agency, obtain targeted relocation case management services from a home care targeted case management provider, as defined in subdivision 43c; and

(2) for home care targeted case management, an eligible recipient must be assigned a case manager within 20 working days of requesting a case manager from a home care targeted case management provider, as defined in subdivision 43c.

Sec. 25. Minnesota Statutes 2000, section 256B.0625, is amended by adding a subdivision to read:

Subd. 43f. [EVALUATION.] The commissioner shall evaluate the delivery of targeted case management, including, but not limited to, access to case management services, consumer satisfaction with case management services, and quality of case management services.

Sec. 26. Minnesota Statutes 2000, section 256B.0625, is amended by adding a subdivision to read:

Subd. 43g. [CONTACT DOCUMENTATION.] The case manager must document each face-to-face and telephone contact with the recipient and others involved in the recipient's individual service plan.

Sec. 27. Minnesota Statutes 2000, section 256B.0625, is amended by adding a subdivision to read:

Subd. 43h. [PAYMENT RATES.] The commissioner shall set payment rates for targeted case management under this subdivision. Case managers may bill according to the following criteria:

(1) for relocation targeted case management, case managers may bill for direct case management activities, including face-to-face and telephone contacts, in the 180 days preceding an eligible recipient's discharge from an institution;

(2) for home care targeted case management, case managers may bill for direct case management activities, including face-to-face and telephone contacts; and

(3) billings for targeted case management services under this subdivision shall not duplicate payments made under other program authorities for the same purpose.

Sec. 28. Minnesota Statutes 2000, section 256B.0627, subdivision 1, is amended to read:

Subdivision 1. [DEFINITION.] (a) "Activities of daily living" includes eating, toileting, grooming, dressing, bathing, transferring, mobility, and positioning.

(b) "Assessment" means a review and evaluation of a recipient's need for home care services conducted in person. Assessments for private duty nursing shall be conducted by a registered private duty nurse. Assessments for home health agency services shall be conducted by a home health agency nurse. Assessments for personal care assistant services shall be conducted by the county public health nurse or a certified public health nurse under contract with the county. A face-to-face assessment must include: documentation of health status, determination of need, evaluation of service effectiveness, identification of appropriate services, service plan development or modification, coordination of services, referrals and follow-up to appropriate

payers and community resources, completion of required reports, recommendation of service authorization, and consumer education. Once the need for personal care assistant services is determined under this section, the county public health nurse or certified public health nurse under contract with the county is responsible for communicating this recommendation to the commissioner and the recipient. A face-to-face assessment for personal care assistant services is conducted on those recipients who have never had a county public health nurse assessment. A face-to-face assessment must occur at least annually or when there is a significant change in the recipient's condition or when there is a change in the need for personal care assistant services. A service update may substitute for the annual face-to-face assessment when there is not a significant change in recipient condition or a change in the need for personal care assistant service. A service update or review for temporary increase includes a review of initial baseline data, evaluation of service effectiveness, redetermination of service need, modification of service plan and appropriate referrals, update of initial forms, obtaining service authorization, and on going consumer education. Assessments for medical assistance home care services for mental retardation or related conditions and alternative care services for developmentally disabled home and community-based waivered recipients may be conducted by the county public health nurse to ensure coordination and avoid duplication. Assessments must be completed on forms provided by the commissioner within 30 days of a request for home care services by a recipient or responsible party.

~~(b)~~ (c) "Care plan" means a written description of personal care assistant services developed by the qualified professional or the recipient's physician with the recipient or responsible party to be used by the personal care assistant with a copy provided to the recipient or responsible party.

(d) "Complex and regular private duty nursing care" means, effective July 1, 2001:

(1) complex care is private duty nursing provided to recipients who are ventilator dependent or for whom a physician has certified that were it not for private duty nursing the recipient would meet the criteria for inpatient hospital intensive care unit (ICU) level of care; and

(2) regular care is private duty nursing provided to all other recipients.

(e) "Health-related functions" means functions that can be delegated or assigned by a licensed health care professional under state law to be performed by a personal care attendant.

~~(c)~~ (f) "Home care services" means a health service, determined by the commissioner as medically necessary, that is ordered by a physician and documented in a service plan that is reviewed by the physician at least once every ~~62~~ 60 days for the provision of home health services, or private duty nursing, or at least once every 365 days for personal care. Home care services are provided to the recipient at the recipient's residence that is a place other than a hospital or long-term care facility or as specified in section 256B.0625.

(g) "Instrumental activities of daily living" includes meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communication by telephone and other media, and getting around and participating in the community.

~~(d)~~ (h) "Medically necessary" has the meaning given in Minnesota Rules, parts 9505.0170 to 9505.0475.

~~(e)~~ (i) "Personal care assistant" means a person who:

(1) is at least 18 years old, except for persons 16 to 18 years of age who participated in a related school-based job training program or have completed a certified home health aide competency evaluation;

(2) is able to effectively communicate with the recipient and personal care provider organization;

(3) effective July 1, 1996, has completed one of the training requirements as specified in Minnesota Rules, part 9505.0335, subpart 3, items A to D;

(4) has the ability to, and provides covered personal care assistant services according to the recipient's care plan, responds appropriately to recipient needs, and reports changes in the recipient's condition to the supervising qualified professional or physician;

(5) is not a consumer of personal care assistant services; and

(6) is subject to criminal background checks and procedures specified in section 245A.04.

~~(f)~~ (j) "Personal care provider organization" means an organization enrolled to provide personal care assistant services under the medical assistance program that complies with the following: (1) owners who have a five percent interest or more, and managerial officials are subject to a background study as provided in section 245A.04. This applies to currently enrolled personal care provider organizations and those agencies seeking enrollment as a personal care provider organization. An organization will be barred from enrollment if an owner or managerial official of the organization has been convicted of a crime specified in section 245A.04, or a comparable crime in another jurisdiction, unless the owner or managerial official meets the reconsideration criteria specified in section 245A.04; (2) the organization must maintain a surety bond and liability insurance throughout the duration of enrollment and provides proof thereof. The insurer must notify the department of human services of the cancellation or lapse of policy; and (3) the organization must maintain documentation of services as specified in Minnesota Rules, part 9505.2175, subpart 7, as well as evidence of compliance with personal care assistant training requirements.

~~(g)~~ (k) "Responsible party" means an individual residing with a recipient of personal care assistant services who is capable of providing the supportive care necessary to assist the recipient to live in the community, is at least 18 years old, and is not a personal care assistant. Responsible parties who are parents of minors or guardians of minors or incapacitated persons may delegate the responsibility to another adult during a temporary absence of at least 24 hours but not more than six months. The person delegated as a responsible party must be able to meet the definition of responsible party, except that the delegated responsible party is required to reside with the recipient only while serving as the responsible party. Foster care license holders may be designated the responsible party for residents of the foster care home if case management is provided as required in section 256B.0625, subdivision 19a. For persons who, as of April 1, 1992, are sharing personal care assistant services in order to obtain the availability of 24-hour coverage, an employee of the personal care provider organization may be designated as the responsible party if case management is provided as required in section 256B.0625, subdivision 19a.

~~(h)~~ (l) "Service plan" means a written description of the services needed based on the assessment developed by the nurse who conducts the assessment together with the recipient or responsible party. The service plan shall include a description of the covered home care services, frequency and duration of services, and expected outcomes and goals. The recipient and the provider chosen by the recipient or responsible party must be given a copy of the completed service plan within 30 calendar days of the request for home care services by the recipient or responsible party.

~~(i)~~ (m) "Skilled nurse visits" are provided in a recipient's residence under a plan of care or service plan that specifies a level of care which the nurse is qualified to provide. These services are:

(1) nursing services according to the written plan of care or service plan and accepted standards of medical and nursing practice in accordance with chapter 148;

(2) services which due to the recipient's medical condition may only be safely and effectively provided by a registered nurse or a licensed practical nurse;

(3) assessments performed only by a registered nurse; and

(4) teaching and training the recipient, the recipient's family, or other caregivers requiring the skills of a registered nurse or licensed practical nurse.

(n) "Telehomecare" means the use of telecommunications technology by a home health care

professional to deliver home health care services, within the professional's scope of practice, to a patient located at a site other than the site where the practitioner is located.

Sec. 29. Minnesota Statutes 2000, section 256B.0627, subdivision 2, is amended to read:

Subd. 2. [SERVICES COVERED.] Home care services covered under this section include:

(1) nursing services under section 256B.0625, subdivision 6a;

(2) private duty nursing services under section 256B.0625, subdivision 7;

(3) home health ~~aide~~ services under section 256B.0625, subdivision 6a;

(4) personal care assistant services under section 256B.0625, subdivision 19a;

(5) supervision of personal care assistant services provided by a qualified professional under section 256B.0625, subdivision 19a;

(6) ~~consulting~~ qualified professional of personal care assistant services under the fiscal ~~agent~~ intermediary option as specified in subdivision 10;

(7) face-to-face assessments by county public health nurses for services under section 256B.0625, subdivision 19a; and

(8) service updates and review of temporary increases for personal care assistant services by the county public health nurse for services under section 256B.0625, subdivision 19a.

Sec. 30. Minnesota Statutes 2000, section 256B.0627, subdivision 4, is amended to read:

Subd. 4. [PERSONAL CARE ASSISTANT SERVICES.] (a) The personal care assistant services that are eligible for payment are ~~the following:~~ services and supports furnished to an individual, as needed, to assist in accomplishing activities of daily living; instrumental activities of daily living; health-related functions through hands-on assistance, supervision, and cuing; and redirection and intervention for behavior including observation and monitoring.

(b) Payment for services will be made within the limits approved using the prior authorized process established in subdivision 5.

(c) The amount and type of services authorized shall be based on an assessment of the recipient's needs in these areas:

(1) bowel and bladder care;

(2) skin care to maintain the health of the skin;

(3) repetitive maintenance range of motion, muscle strengthening exercises, and other tasks specific to maintaining a recipient's optimal level of function;

(4) respiratory assistance;

(5) transfers and ambulation;

(6) bathing, grooming, and hairwashing necessary for personal hygiene;

(7) turning and positioning;

(8) assistance with furnishing medication that is self-administered;

(9) application and maintenance of prosthetics and orthotics;

(10) cleaning medical equipment;

(11) dressing or undressing;

(12) assistance with eating and meal preparation and necessary grocery shopping;

(13) accompanying a recipient to obtain medical diagnosis or treatment;

(14) assisting, monitoring, or prompting the recipient to complete the services in clauses (1) to (13);

(15) redirection, monitoring, and observation that are medically necessary and an integral part of completing the personal care assistant services described in clauses (1) to (14);

(16) redirection and intervention for behavior, including observation and monitoring;

(17) interventions for seizure disorders, including monitoring and observation if the recipient has had a seizure that requires intervention within the past three months;

(18) tracheostomy suctioning using a clean procedure if the procedure is properly delegated by a registered nurse. Before this procedure can be delegated to a personal care assistant, a registered nurse must determine that the tracheostomy suctioning can be accomplished utilizing a clean rather than a sterile procedure and must ensure that the personal care assistant has been taught the proper procedure; and

(19) incidental household services that are an integral part of a personal care service described in clauses (1) to (18).

For purposes of this subdivision, monitoring and observation means watching for outward visible signs that are likely to occur and for which there is a covered personal care service or an appropriate personal care intervention. For purposes of this subdivision, a clean procedure refers to a procedure that reduces the numbers of microorganisms or prevents or reduces the transmission of microorganisms from one person or place to another. A clean procedure may be used beginning 14 days after insertion.

~~(b)~~ (d) The personal care assistant services that are not eligible for payment are the following:

(1) services not ordered by the physician;

(2) assessments by personal care assistant provider organizations or by independently enrolled registered nurses;

(3) services that are not in the service plan;

(4) services provided by the recipient's spouse, legal guardian for an adult or child recipient, or parent of a recipient under age 18;

(5) services provided by a foster care provider of a recipient who cannot direct the recipient's own care, unless monitored by a county or state case manager under section 256B.0625, subdivision 19a;

(6) services provided by the residential or program license holder in a residence for more than four persons;

(7) services that are the responsibility of a residential or program license holder under the terms of a service agreement and administrative rules;

(8) sterile procedures;

(9) injections of fluids into veins, muscles, or skin;

(10) services provided by parents of adult recipients, adult children, or siblings of the recipient, unless these relatives meet one of the following hardship criteria and the commissioner waives this requirement:

(i) the relative resigns from a part-time or full-time job to provide personal care for the recipient;

(ii) the relative goes from a full-time to a part-time job with less compensation to provide personal care for the recipient;

(iii) the relative takes a leave of absence without pay to provide personal care for the recipient;

(iv) the relative incurs substantial expenses by providing personal care for the recipient; or

(v) because of labor conditions, special language needs, or intermittent hours of care needed, the relative is needed in order to provide an adequate number of qualified personal care assistants to meet the medical needs of the recipient;

(11) homemaker services that are not an integral part of a personal care assistant services;

(12) home maintenance, or chore services;

(13) services not specified under paragraph (a); and

(14) services not authorized by the commissioner or the commissioner's designee.

(e) The recipient or responsible party may choose to supervise the personal care assistant or to have a qualified professional, as defined in section 256B.0625, subdivision 19c, provide the supervision. As required under section 256B.0625, subdivision 19c, the county public health nurse, as a part of the assessment, will assist the recipient or responsible party to identify the most appropriate person to provide supervision of the personal care assistant. Health-related delegated tasks performed by the personal care assistant will be under the supervision of a qualified professional or the direction of the recipient's physician. If the recipient has a qualified professional, Minnesota Rules, part 9505.0335, subpart 4, applies.

Sec. 31. Minnesota Statutes 2000, section 256B.0627, subdivision 5, is amended to read:

Subd. 5. [LIMITATION ON PAYMENTS.] Medical assistance payments for home care services shall be limited according to this subdivision.

(a) [LIMITS ON SERVICES WITHOUT PRIOR AUTHORIZATION.] A recipient may receive the following home care services during a calendar year:

(1) up to two face-to-face assessments to determine a recipient's need for personal care assistant services;

(2) one service update done to determine a recipient's need for personal care assistant services; and

(3) up to ~~five~~ nine skilled nurse visits.

(b) [PRIOR AUTHORIZATION; EXCEPTIONS.] All home care services above the limits in paragraph (a) must receive the commissioner's prior authorization, except when:

(1) the home care services were required to treat an emergency medical condition that if not immediately treated could cause a recipient serious physical or mental disability, continuation of severe pain, or death. The provider must request retroactive authorization no later than five working days after giving the initial service. The provider must be able to substantiate the emergency by documentation such as reports, notes, and admission or discharge histories;

(2) the home care services were provided on or after the date on which the recipient's eligibility began, but before the date on which the recipient was notified that the case was opened. Authorization will be considered if the request is submitted by the provider within 20 working days of the date the recipient was notified that the case was opened;

(3) a third-party payor for home care services has denied or adjusted a payment. Authorization requests must be submitted by the provider within 20 working days of the notice of denial or adjustment. A copy of the notice must be included with the request;

(4) the commissioner has determined that a county or state human services agency has made an error; or

(5) the professional nurse determines an immediate need for up to 40 skilled nursing or home health aide visits per calendar year and submits a request for authorization within 20 working days of the initial service date, and medical assistance is determined to be the appropriate payer.

(c) [RETROACTIVE AUTHORIZATION.] A request for retroactive authorization will be evaluated according to the same criteria applied to prior authorization requests.

(d) [ASSESSMENT AND SERVICE PLAN.] Assessments under section 256B.0627, subdivision 1, paragraph (a), shall be conducted initially, and at least annually thereafter, in person with the recipient and result in a completed service plan using forms specified by the commissioner. Within 30 days of recipient or responsible party request for home care services, the assessment, the service plan, and other information necessary to determine medical necessity such as diagnostic or testing information, social or medical histories, and hospital or facility discharge summaries shall be submitted to the commissioner. For personal care assistant services:

(1) The amount and type of service authorized based upon the assessment and service plan will follow the recipient if the recipient chooses to change providers.

(2) If the recipient's medical need changes, the recipient's provider may assess the need for a change in service authorization and request the change from the county public health nurse. Within 30 days of the request, the public health nurse will determine whether to request the change in services based upon the provider assessment, or conduct a home visit to assess the need and determine whether the change is appropriate.

(3) To continue to receive personal care assistant services after the first year, the recipient or the responsible party, in conjunction with the public health nurse, may complete a service update on forms developed by the commissioner according to criteria and procedures in subdivision 1.

(e) [PRIOR AUTHORIZATION.] The commissioner, or the commissioner's designee, shall review the assessment, service update, request for temporary services, service plan, and any additional information that is submitted. The commissioner shall, within 30 days after receiving a complete request, assessment, and service plan, authorize home care services as follows:

(1) [HOME HEALTH SERVICES.] All home health services provided by a ~~licensed nurse or a~~ home health aide must be prior authorized by the commissioner or the commissioner's designee. Prior authorization must be based on medical necessity and cost-effectiveness when compared with other care options. When home health services are used in combination with personal care and private duty nursing, the cost of all home care services shall be considered for cost-effectiveness. The commissioner shall limit ~~nurse and~~ home health aide visits to no more than one visit each per day. The commissioner, or the commissioner's designee, may authorize up to two skilled nurse visits per day.

(2) [PERSONAL CARE ASSISTANT SERVICES.] (i) All personal care assistant services and supervision by a qualified professional, if requested by the recipient, must be prior authorized by the commissioner or the commissioner's designee except for the assessments established in paragraph (a). The amount of personal care assistant services authorized must be based on the recipient's home care rating. A child may not be found to be dependent in an activity of daily living if because of the child's age an adult would either perform the activity for the child or assist the child with the activity and the amount of assistance needed is similar to the assistance appropriate for a typical child of the same age. Based on medical necessity, the commissioner may authorize:

(A) up to two times the average number of direct care hours provided in nursing facilities for the recipient's comparable case mix level; or

(B) up to three times the average number of direct care hours provided in nursing facilities for recipients who have complex medical needs or are dependent in at least seven activities of daily living and need physical assistance with eating or have a neurological diagnosis; or

(C) up to 60 percent of the average reimbursement rate, as of July 1, 1991, for care provided in a regional treatment center for recipients who have Level I behavior, plus any inflation adjustment as provided by the legislature for personal care service; or

(D) up to the amount the commissioner would pay, as of July 1, 1991, plus any inflation adjustment provided for home care services, for care provided in a regional treatment center for recipients referred to the commissioner by a regional treatment center preadmission evaluation team. For purposes of this clause, home care services means all services provided in the home or community that would be included in the payment to a regional treatment center; or

(E) up to the amount medical assistance would reimburse for facility care for recipients referred to the commissioner by a preadmission screening team established under section 256B.0911 or 256B.092; and

(F) a reasonable amount of time for the provision of supervision by a qualified professional of personal care assistant services, if a qualified professional is requested by the recipient or responsible party.

(ii) The number of direct care hours shall be determined according to the annual cost report submitted to the department by nursing facilities. The average number of direct care hours, as established by May 1, 1992, shall be calculated and incorporated into the home care limits on July 1, 1992. These limits shall be calculated to the nearest quarter hour.

(iii) The home care rating shall be determined by the commissioner or the commissioner's designee based on information submitted to the commissioner by the county public health nurse on forms specified by the commissioner. The home care rating shall be a combination of current assessment tools developed under sections 256B.0911 and 256B.501 with an addition for seizure activity that will assess the frequency and severity of seizure activity and with adjustments, additions, and clarifications that are necessary to reflect the needs and conditions of recipients who need home care including children and adults under 65 years of age. The commissioner shall establish these forms and protocols under this section and shall use an advisory group, including representatives of recipients, providers, and counties, for consultation in establishing and revising the forms and protocols.

(iv) A recipient shall qualify as having complex medical needs if the care required is difficult to perform and because of recipient's medical condition requires more time than community-based standards allow or requires more skill than would ordinarily be required and the recipient needs or has one or more of the following:

(A) daily tube feedings;

(B) daily parenteral therapy;

(C) wound or decubiti care;

(D) postural drainage, percussion, nebulizer treatments, suctioning, tracheotomy care, oxygen, mechanical ventilation;

(E) catheterization;

(F) ostomy care;

(G) quadriplegia; or

(H) other comparable medical conditions or treatments the commissioner determines would otherwise require institutional care.

(v) A recipient shall qualify as having Level I behavior if there is reasonable supporting evidence that the recipient exhibits, or that without supervision, observation, or redirection would exhibit, one or more of the following behaviors that cause, or have the potential to cause:

(A) injury to the recipient's own body;

(B) physical injury to other people; or

(C) destruction of property.

(vi) Time authorized for personal care relating to Level I behavior in subclause (v), items (A) to (C), shall be based on the predictability, frequency, and amount of intervention required.

(vii) A recipient shall qualify as having Level II behavior if the recipient exhibits on a daily basis one or more of the following behaviors that interfere with the completion of personal care assistant services under subdivision 4, paragraph (a):

(A) unusual or repetitive habits;

(B) withdrawn behavior; or

(C) offensive behavior.

(viii) A recipient with a home care rating of Level II behavior in subclause (vii), items (A) to (C), shall be rated as comparable to a recipient with complex medical needs under subclause (iv). If a recipient has both complex medical needs and Level II behavior, the home care rating shall be the next complex category up to the maximum rating under subclause (i), item (B).

(3) [PRIVATE DUTY NURSING SERVICES.] All private duty nursing services shall be prior authorized by the commissioner or the commissioner's designee. Prior authorization for private duty nursing services shall be based on medical necessity and cost-effectiveness when compared with alternative care options. The commissioner may authorize medically necessary private duty nursing services in quarter-hour units when:

(i) the recipient requires more individual and continuous care than can be provided during a nurse visit; or

(ii) the cares are outside of the scope of services that can be provided by a home health aide or personal care assistant.

The commissioner may authorize:

(A) up to two times the average amount of direct care hours provided in nursing facilities statewide for case mix classification "K" as established by the annual cost report submitted to the department by nursing facilities in May 1992;

(B) private duty nursing in combination with other home care services up to the total cost allowed under clause (2);

(C) up to 16 hours per day if the recipient requires more nursing than the maximum number of direct care hours as established in item (A) and the recipient meets the hospital admission criteria established under Minnesota Rules, parts ~~9505.0500~~ 9505.0501 to 9505.0540.

The commissioner may authorize up to 16 hours per day of medically necessary private duty nursing services or up to 24 hours per day of medically necessary private duty nursing services until such time as the commissioner is able to make a determination of eligibility for recipients who are cooperatively applying for home care services under the community alternative care program developed under section 256B.49, or until it is determined by the appropriate regulatory agency that a health benefit plan is or is not required to pay for appropriate medically necessary health care services. Recipients or their representatives must cooperatively assist the commissioner in obtaining this determination. Recipients who are eligible for the community alternative care program may not receive more hours of nursing under this section than would otherwise be authorized under section 256B.49.

Beginning July 1, 2001, private duty nursing services shall be authorized for complex and regular care according to subdivision 1.

(4) [VENTILATOR-DEPENDENT RECIPIENTS.] If the recipient is ventilator-dependent, the

monthly medical assistance authorization for home care services shall not exceed what the commissioner would pay for care at the highest cost hospital designated as a long-term hospital under the Medicare program. For purposes of this clause, home care services means all services provided in the home that would be included in the payment for care at the long-term hospital. "Ventilator-dependent" means an individual who receives mechanical ventilation for life support at least six hours per day and is expected to be or has been dependent for at least 30 consecutive days.

(f) [PRIOR AUTHORIZATION; TIME LIMITS.] The commissioner or the commissioner's designee shall determine the time period for which a prior authorization shall be effective. If the recipient continues to require home care services beyond the duration of the prior authorization, the home care provider must request a new prior authorization. Under no circumstances, other than the exceptions in paragraph (b), shall a prior authorization be valid prior to the date the commissioner receives the request or for more than 12 months. A recipient who appeals a reduction in previously authorized home care services may continue previously authorized services, other than temporary services under paragraph (h), pending an appeal under section 256.045. The commissioner must provide a detailed explanation of why the authorized services are reduced in amount from those requested by the home care provider.

(g) [APPROVAL OF HOME CARE SERVICES.] The commissioner or the commissioner's designee shall determine the medical necessity of home care services, the level of caregiver according to subdivision 2, and the institutional comparison according to this subdivision, the cost-effectiveness of services, and the amount, scope, and duration of home care services reimbursable by medical assistance, based on the assessment, primary payer coverage determination information as required, the service plan, the recipient's age, the cost of services, the recipient's medical condition, and diagnosis or disability. The commissioner may publish additional criteria for determining medical necessity according to section 256B.04.

(h) [PRIOR AUTHORIZATION REQUESTS; TEMPORARY SERVICES.] The agency nurse, the independently enrolled private duty nurse, or county public health nurse may request a temporary authorization for home care services by telephone. The commissioner may approve a temporary level of home care services based on the assessment, and service or care plan information, and primary payer coverage determination information as required. Authorization for a temporary level of home care services including nurse supervision is limited to the time specified by the commissioner, but shall not exceed 45 days, unless extended because the county public health nurse has not completed the required assessment and service plan, or the commissioner's determination has not been made. The level of services authorized under this provision shall have no bearing on a future prior authorization.

(i) [PRIOR AUTHORIZATION REQUIRED IN FOSTER CARE SETTING.] Home care services provided in an adult or child foster care setting must receive prior authorization by the department according to the limits established in paragraph (a).

The commissioner may not authorize:

(1) home care services that are the responsibility of the foster care provider under the terms of the foster care placement agreement and administrative rules;

(2) personal care assistant services when the foster care license holder is also the personal care provider or personal care assistant unless the recipient can direct the recipient's own care, or case management is provided as required in section 256B.0625, subdivision 19a;

(3) personal care assistant services when the responsible party is an employee of, or under contract with, or has any direct or indirect financial relationship with the personal care provider or personal care assistant, unless case management is provided as required in section 256B.0625, subdivision 19a; or

(4) personal care assistant and private duty nursing services when the number of foster care residents is greater than four unless the county responsible for the recipient's foster placement made the placement prior to April 1, 1992, requests that personal care assistant and private duty

nursing services be provided, and case management is provided as required in section 256B.0625, subdivision 19a.

Sec. 32. Minnesota Statutes 2000, section 256B.0627, subdivision 7, is amended to read:

Subd. 7. [NONCOVERED HOME CARE SERVICES.] The following home care services are not eligible for payment under medical assistance:

(1) skilled nurse visits for the sole purpose of supervision of the home health aide;

(2) a skilled nursing visit:

(i) only for the purpose of monitoring medication compliance with an established medication program for a recipient; or

(ii) to administer or assist with medication administration, including injections, prefilling syringes for injections, or oral medication set-up of an adult recipient, when as determined and documented by the registered nurse, the need can be met by an available pharmacy or the recipient is physically and mentally able to self-administer or prefill a medication;

(3) home care services to a recipient who is eligible for covered services ~~including hospice, if elected by the recipient,~~ under the Medicare program or any other insurance held by the recipient;

(4) services to other members of the recipient's household;

(5) a visit made by a skilled nurse solely to train other home health agency workers;

(6) any home care service included in the daily rate of the community-based residential facility where the recipient is residing;

(7) nursing and rehabilitation therapy services that are reasonably accessible to a recipient outside the recipient's place of residence, excluding the assessment, counseling and education, and personal assistant care;

(8) any home health agency service, excluding personal care assistant services and private duty nursing services, which are performed in a place other than the recipient's residence; and

(9) Medicare evaluation or administrative nursing visits on dual-eligible recipients that do not qualify for Medicare visit billing.

Sec. 33. Minnesota Statutes 2000, section 256B.0627, subdivision 8, is amended to read:

Subd. 8. [SHARED PERSONAL CARE ASSISTANT SERVICES.] (a) Medical assistance payments for shared personal care assistance services shall be limited according to this subdivision.

(b) Recipients of personal care assistant services may share staff and the commissioner shall provide a rate system for shared personal care assistant services. For two persons sharing services, the rate paid to a provider shall not exceed 1-1/2 times the rate paid for serving a single individual, and for three persons sharing services, the rate paid to a provider shall not exceed twice the rate paid for serving a single individual. These rates apply only to situations in which all recipients were present and received shared services on the date for which the service is billed. No more than three persons may receive shared services from a personal care assistant in a single setting.

(c) Shared service is the provision of personal care assistant services by a personal care assistant to two or three recipients at the same time and in the same setting. For the purposes of this subdivision, "setting" means:

(1) the home or foster care home of one of the individual recipients; or

(2) a child care program in which all recipients served by one personal care assistant are participating, which is licensed under chapter 245A or operated by a local school district or private school; or

(3) outside the home or foster care home of one of the recipients when normal life activities take the recipients outside the home.

The provisions of this subdivision do not apply when a personal care assistant is caring for multiple recipients in more than one setting.

(d) The recipient or the recipient's responsible party, in conjunction with the county public health nurse, shall determine:

(1) whether shared personal care assistant services is an appropriate option based on the individual needs and preferences of the recipient; and

(2) the amount of shared services allocated as part of the overall authorization of personal care assistant services.

The recipient or the responsible party, in conjunction with the supervising qualified professional, if a qualified professional is requested by any one of the recipients or responsible parties, shall arrange the setting and grouping of shared services based on the individual needs and preferences of the recipients. Decisions on the selection of recipients to share services must be based on the ages of the recipients, compatibility, and coordination of their care needs.

(e) The following items must be considered by the recipient or the responsible party and the supervising qualified professional, if a qualified professional has been requested by any one of the recipients or responsible parties, and documented in the recipient's health service record:

(1) the additional qualifications needed by the personal care assistant to provide care to several recipients in the same setting;

(2) the additional training and supervision needed by the personal care assistant to ensure that the needs of the recipient are met appropriately and safely. The provider must provide on-site supervision by a qualified professional within the first 14 days of shared services, and monthly thereafter, if supervision by a qualified provider has been requested by any one of the recipients or responsible parties;

(3) the setting in which the shared services will be provided;

(4) the ongoing monitoring and evaluation of the effectiveness and appropriateness of the service and process used to make changes in service or setting; and

(5) a contingency plan which accounts for absence of the recipient in a shared services setting due to illness or other circumstances and staffing contingencies.

(f) The provider must offer the recipient or the responsible party the option of shared or one-on-one personal care assistant services. The recipient or the responsible party can withdraw from participating in a shared services arrangement at any time.

(g) In addition to documentation requirements under Minnesota Rules, part 9505.2175, a personal care provider must meet documentation requirements for shared personal care assistant services and must document the following in the health service record for each individual recipient sharing services:

(1) permission by the recipient or the recipient's responsible party, if any, for the maximum number of shared services hours per week chosen by the recipient;

(2) permission by the recipient or the recipient's responsible party, if any, for personal care assistant services provided outside the recipient's residence;

(3) permission by the recipient or the recipient's responsible party, if any, for others to receive shared services in the recipient's residence;

(4) revocation by the recipient or the recipient's responsible party, if any, of the shared service authorization, or the shared service to be provided to others in the recipient's residence, or the shared service to be provided outside the recipient's residence;

(5) supervision of the shared personal care assistant services by the qualified professional, if a qualified professional is requested by one of the recipients or responsible parties, including the date, time of day, number of hours spent supervising the provision of shared services, whether the supervision was face-to-face or another method of supervision, changes in the recipient's condition, shared services scheduling issues and recommendations;

(6) documentation by the qualified professional, if a qualified professional is requested by one of the recipients or responsible parties, of telephone calls or other discussions with the personal care assistant regarding services being provided to the recipient who has requested the supervision; and

(7) daily documentation of the shared services provided by each identified personal care assistant including:

(i) the names of each recipient receiving shared services together;

(ii) the setting for the shared services, including the starting and ending times that the recipient received shared services; and

(iii) notes by the personal care assistant regarding changes in the recipient's condition, problems that may arise from the sharing of services, scheduling issues, care issues, and other notes as required by the qualified professional, if a qualified professional is requested by one of the recipients or responsible parties.

(h) Unless otherwise provided in this subdivision, all other statutory and regulatory provisions relating to personal care assistant services apply to shared services.

(i) In the event that supervision by a qualified professional has been requested by one or more recipients, but not by all of the recipients, the supervision duties of the qualified professional shall be limited to only those recipients who have requested the supervision.

Nothing in this subdivision shall be construed to reduce the total number of hours authorized for an individual recipient.

Sec. 34. Minnesota Statutes 2000, section 256B.0627, subdivision 10, is amended to read:

Subd. 10. [FISCAL ~~AGENT~~ INTERMEDIARY OPTION AVAILABLE FOR PERSONAL CARE ASSISTANT SERVICES.] (a) ~~"Fiscal agent option" is an option that allows the recipient to:~~

~~(1) use a fiscal agent instead of a personal care provider organization;~~

~~(2) supervise the personal care assistant; and~~

~~(3) use a consulting professional.~~

The commissioner may allow a recipient of personal care assistant services to use a fiscal ~~agent~~ intermediary to assist the recipient in paying and accounting for medically necessary covered personal care assistant services authorized in subdivision 4 and within the payment parameters of subdivision 5. Unless otherwise provided in this subdivision, all other statutory and regulatory provisions relating to personal care assistant services apply to a recipient using the fiscal ~~agent~~ intermediary option.

(b) The recipient or responsible party shall:

(1) ~~hire, and terminate the personal care assistant and consulting professional, with the fiscal agent~~ recruit, hire, and terminate a qualified professional, if a qualified professional is requested by the recipient or responsible party;

(2) ~~recruit the personal care assistant and consulting professional and orient and train the personal care assistant in areas that do not require professional delegation as determined by the county public health nurse~~ verify and document the credentials of the qualified professional, if a qualified professional is requested by the recipient or responsible party;

(3) ~~supervise and evaluate the personal care assistant in areas that do not require professional delegation as determined in the assessment;~~

~~(4) cooperate with a consulting~~ develop a service plan based on physician orders and public health nurse assessment with the assistance of a qualified professional ~~and implement recommendations pertaining to the health and safety of the recipient~~, if a qualified professional is requested by the recipient or responsible party, that addresses the health and safety of the recipient;

~~(5) hire a qualified professional to train and supervise the performance of delegated tasks done by~~ (4) recruit, hire, and terminate the personal care assistant;

~~(6) monitor services and verify in writing the hours worked by the personal care assistant and the consulting~~ (5) orient and train the personal care assistant with assistance as needed from the qualified professional;

~~(7) develop and revise a care plan with assistance from a consulting~~ (6) supervise and evaluate the personal care assistant with assistance as needed from the recipient's physician or the qualified professional;

~~(8) verify and document the credentials of the consulting~~ (7) monitor and verify in writing and report to the fiscal intermediary the number of hours worked by the personal care assistant and the qualified professional; and

~~(9)~~ (8) enter into a written agreement, as specified in paragraph (f).

(c) The duties of the fiscal ~~agent~~ intermediary shall be to:

(1) bill the medical assistance program for personal care assistant and ~~consulting~~ qualified professional services;

(2) request and secure background checks on personal care assistants and ~~consulting~~ qualified professionals according to section 245A.04;

(3) pay the personal care assistant and ~~consulting~~ qualified professional based on actual hours of services provided;

(4) withhold and pay all applicable federal and state taxes;

(5) verify and ~~document~~ keep records of hours worked by the personal care assistant and ~~consulting~~ qualified professional;

(6) make the arrangements and pay unemployment insurance, taxes, workers' compensation, liability insurance, and other benefits, if any;

(7) enroll in the medical assistance program as a fiscal ~~agent~~ intermediary; and

(8) enter into a written agreement as specified in paragraph (f) before services are provided.

(d) The fiscal ~~agent~~ intermediary:

(1) may not be related to the recipient, ~~consulting~~ qualified professional, or the personal care assistant;

(2) must ensure arm's length transactions with the recipient and personal care assistant; and

(3) shall be considered a joint employer of the personal care assistant and ~~consulting~~ qualified professional to the extent specified in this section.

The fiscal ~~agent~~ intermediary or owners of the entity that provides fiscal ~~agent~~ intermediary services under this subdivision must pass a criminal background check as required in section 256B.0627, subdivision 1, paragraph (e).

(e) If the recipient or responsible party requests a qualified professional, the ~~consulting~~ qualified professional providing assistance to the recipient shall meet the qualifications specified in section 256B.0625, subdivision 19c. The ~~consulting~~ qualified professional shall assist the recipient in developing and revising a plan to meet the recipient's ~~assessed~~ needs, ~~and supervise the performance of delegated tasks, as determined by the public health nurse~~ as assessed by the public health nurse. In performing this function, the ~~consulting~~ qualified professional must visit the recipient in the recipient's home at least once annually. The ~~consulting~~ qualified professional must report ~~to the local county public health nurse concerns relating to the health and safety of the recipient, and~~ any suspected abuse, neglect, or financial exploitation of the recipient to the appropriate authorities.

(f) The fiscal ~~agent~~ intermediary, recipient or responsible party, personal care assistant, and ~~consulting~~ qualified professional shall enter into a written agreement before services are started. The agreement shall include:

(1) the duties of the recipient, qualified professional, personal care assistant, and fiscal agent based on paragraphs (a) to (e);

(2) the salary and benefits for the personal care assistant and ~~those providing professional consultation~~ the qualified professional;

(3) the administrative fee of the fiscal ~~agent~~ intermediary and services paid for with that fee, including background check fees;

(4) procedures to respond to billing or payment complaints; and

(5) procedures for hiring and terminating the personal care assistant and ~~those providing professional consultation~~ the qualified professional.

(g) The rates paid for personal care assistant services, qualified professional ~~assistance~~ services, and fiscal ~~agency~~ intermediary services under this subdivision shall be the same rates paid for personal care assistant services and qualified professional services under subdivision 2 respectively. Except for the administrative fee of the fiscal ~~agent~~ intermediary specified in paragraph (f), the remainder of the rates paid to the fiscal ~~agent~~ intermediary must be used to pay for the salary and benefits for the personal care assistant or ~~those providing professional consultation~~ the qualified professional.

(h) As part of the assessment defined in subdivision 1, the following conditions must be met to use or continue use of a fiscal ~~agent~~ intermediary:

(1) the recipient must be able to direct the recipient's own care, or the responsible party for the recipient must be readily available to direct the care of the personal care assistant;

(2) the recipient or responsible party must be knowledgeable of the health care needs of the recipient and be able to effectively communicate those needs;

(3) a face-to-face assessment must be conducted by the local county public health nurse at least annually, or when there is a significant change in the recipient's condition or change in the need for personal care assistant services~~. The county public health nurse shall determine the services that require professional delegation, if any, and the amount and frequency of related supervision~~;

(4) the recipient cannot select the shared services option as specified in subdivision 8; and

(5) parties must be in compliance with the written agreement specified in paragraph (f).

(i) The commissioner shall deny, revoke, or suspend the authorization to use the fiscal ~~agent~~ intermediary option if:

(1) it has been determined by the ~~consulting~~ qualified professional or local county public health nurse that the use of this option jeopardizes the recipient's health and safety;

(2) the parties have failed to comply with the written agreement specified in paragraph (f); or

(3) the use of the option has led to abusive or fraudulent billing for personal care assistant services.

The recipient or responsible party may appeal the commissioner's action according to section 256.045. The denial, revocation, or suspension to use the fiscal ~~agent~~ intermediary option shall not affect the recipient's authorized level of personal care assistant services as determined in subdivision 5.

Sec. 35. Minnesota Statutes 2000, section 256B.0627, subdivision 11, is amended to read:

Subd. 11. [SHARED PRIVATE DUTY NURSING CARE OPTION.] (a) Medical assistance payments for shared private duty nursing services by a private duty nurse shall be limited according to this subdivision. For the purposes of this section, "private duty nursing agency" means an agency licensed under chapter 144A to provide private duty nursing services.

(b) Recipients of private duty nursing services may share nursing staff and the commissioner shall provide a rate methodology for shared private duty nursing. For two persons sharing nursing care, the rate paid to a provider shall not exceed 1.5 times the ~~nonwaivered~~ regular private duty nursing rates paid for serving a single individual ~~who is not ventilator dependent,~~ by a registered nurse or licensed practical nurse. These rates apply only to situations in which both recipients are present and receive shared private duty nursing care on the date for which the service is billed. No more than two persons may receive shared private duty nursing services from a private duty nurse in a single setting.

(c) Shared private duty nursing care is the provision of nursing services by a private duty nurse to two recipients at the same time and in the same setting. For the purposes of this subdivision, "setting" means:

(1) the home or foster care home of one of the individual recipients; or

(2) a child care program licensed under chapter 245A or operated by a local school district or private school; or

(3) an adult day care service licensed under chapter 245A; or

(4) outside the home or foster care home of one of the recipients when normal life activities take the recipients outside the home.

This subdivision does not apply when a private duty nurse is caring for multiple recipients in more than one setting.

(d) The recipient or the recipient's legal representative, and the recipient's physician, in conjunction with the home health care agency, shall determine:

(1) whether shared private duty nursing care is an appropriate option based on the individual needs and preferences of the recipient; and

(2) the amount of shared private duty nursing services authorized as part of the overall authorization of nursing services.

(e) The recipient or the recipient's legal representative, in conjunction with the private duty nursing agency, shall approve the setting, grouping, and arrangement of shared private duty nursing care based on the individual needs and preferences of the recipients. Decisions on the selection of recipients to share services must be based on the ages of the recipients, compatibility, and coordination of their care needs.

(f) The following items must be considered by the recipient or the recipient's legal representative and the private duty nursing agency, and documented in the recipient's health service record:

(1) the additional training needed by the private duty nurse to provide care to two recipients in the same setting and to ensure that the needs of the recipients are met appropriately and safely;

(2) the setting in which the shared private duty nursing care will be provided;

(3) the ongoing monitoring and evaluation of the effectiveness and appropriateness of the service and process used to make changes in service or setting;

(4) a contingency plan which accounts for absence of the recipient in a shared private duty nursing setting due to illness or other circumstances;

(5) staffing backup contingencies in the event of employee illness or absence; and

(6) arrangements for additional assistance to respond to urgent or emergency care needs of the recipients.

(g) The provider must offer the recipient or responsible party the option of shared or one-on-one private duty nursing services. The recipient or responsible party can withdraw from participating in a shared service arrangement at any time.

(h) The private duty nursing agency must document the following in the health service record for each individual recipient sharing private duty nursing care:

(1) permission by the recipient or the recipient's legal representative for the maximum number of shared nursing care hours per week chosen by the recipient;

(2) permission by the recipient or the recipient's legal representative for shared private duty nursing services provided outside the recipient's residence;

(3) permission by the recipient or the recipient's legal representative for others to receive shared private duty nursing services in the recipient's residence;

(4) revocation by the recipient or the recipient's legal representative of the shared private duty nursing care authorization, or the shared care to be provided to others in the recipient's residence, or the shared private duty nursing services to be provided outside the recipient's residence; and

(5) daily documentation of the shared private duty nursing services provided by each identified private duty nurse, including:

(i) the names of each recipient receiving shared private duty nursing services together;

(ii) the setting for the shared services, including the starting and ending times that the recipient received shared private duty nursing care; and

(iii) notes by the private duty nurse regarding changes in the recipient's condition, problems that may arise from the sharing of private duty nursing services, and scheduling and care issues.

(i) Unless otherwise provided in this subdivision, all other statutory and regulatory provisions relating to private duty nursing services apply to shared private duty nursing services.

Nothing in this subdivision shall be construed to reduce the total number of private duty nursing hours authorized for an individual recipient under subdivision 5.

Sec. 36. Minnesota Statutes 2000, section 256B.0627, is amended by adding a subdivision to read:

Subd. 13. [CONSUMER-DIRECTED HOME CARE DEMONSTRATION PROJECT.] (a) Upon the receipt of federal waiver authority, the commissioner shall implement a consumer-directed home care demonstration project. The consumer-directed home care demonstration project must demonstrate and evaluate the outcomes of a consumer-directed service delivery alternative to improve access, increase consumer control and accountability over available resources, and enable the use of supports that are more individualized and cost-effective for eligible medical assistance recipients receiving certain medical assistance home care services. The consumer-directed home care demonstration project will be administered locally by county agencies, tribal governments, or administrative entities under contract with the state in regions where counties choose not to provide this service.

(b) Grant awards for persons who have been receiving medical assistance covered personal care, home health aide, or private duty nursing services for a period of 12 consecutive months or more prior to enrollment in the consumer-directed home care demonstration project will be established on a case-by-case basis using historical service expenditure data. An average monthly expenditure for each continuing enrollee will be calculated based on historical expenditures made on behalf of the enrollee for personal care, home health aide, or private duty nursing services during the 12 month period directly prior to enrollment in the project. The grant award will equal 90 percent of the average monthly expenditure.

(c) Grant awards for project enrollees who have been receiving medical assistance covered personal care, home health aide, or private duty nursing services for a period of less than 12 consecutive months prior to project enrollment will be calculated on a case-by-case basis using the service authorization in place at the time of enrollment. The total number of units of personal care, home health aide, or private duty nursing services the enrollee has been authorized to receive will be converted to the total cost of the authorized services in a given month using the statewide average service payment rates. To determine an estimated monthly expenditure, the total authorized monthly personal care, home health aide or private duty nursing service costs will be reduced by a percentage rate equivalent to the difference between the statewide average service authorization and the statewide average utilization rate for each of the services by medical assistance eligibles during the most recent fiscal year for which 12 months of data is available. The grant award will equal 90 percent of the estimated monthly expenditure.

(d) The state of Minnesota, county agencies, tribal governments, or administrative entities under contract with the state that participate in the implementation and administration of the consumer-directed home care demonstration project, shall not be liable for damages, injuries, or liabilities sustained through the purchase of support by the individual, the individual's family, or the authorized representative under this section with funds received through the consumer-directed home care demonstration project. Liabilities include but are not limited to: workers' compensation liability, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA).

Sec. 37. Minnesota Statutes 2000, section 256B.0627, is amended by adding a subdivision to read:

Subd. 14. [TELEHOMECARE; SKILLED NURSE VISITS.] Medical assistance covers skilled nurse visits according to section 256B.0625, subdivision 6a, provided via telehomecare, for services which do not require hands-on care between the home care nurse and recipient. The provision of telehomecare must be made via live, two-way interactive audiovisual technology and may be augmented by utilizing store-and-forward technologies. Store-and-forward technology includes telehomecare services that do not occur in real time via synchronous transmissions, and that do not require a face-to-face encounter with the recipient for all or any part of any such telehomecare visit. A communication between the home care nurse and recipient that consists solely of a telephone conversation, facsimile, electronic mail, or a consultation between two health care practitioners, is not to be considered a telehomecare visit. Multiple daily skilled nurse visits provided via telehomecare are allowed. Coverage of telehomecare is limited to two visits per day. All skilled nurse visits provided via telehomecare must be prior authorized by the commissioner or the commissioner's designee and will be covered at the same allowable rate as skilled nurse visits provided in-person.

Sec. 38. Minnesota Statutes 2000, section 256B.0627, is amended by adding a subdivision to read:

Subd. 15. [THERAPIES THROUGH HOME HEALTH AGENCIES.] (a) [PHYSICAL THERAPY.] Medical assistance covers physical therapy and related services, including specialized maintenance therapy. Services provided by a physical therapy assistant shall be reimbursed at the same rate as services performed by a physical therapist when the services of the physical therapy assistant are provided under the direction of a physical therapist who is on the premises. Services provided by a physical therapy assistant that are provided under the direction of a physical therapist who is not on the premises shall be reimbursed at 65 percent of the physical

therapist rate. Direction of the physical therapy assistant must be provided by the physical therapist as described in Minnesota Rules, part 9505.0390, subpart 1, item B. The physical therapist and physical therapist assistant may not both bill for services provided to a recipient on the same day.

(b) [OCCUPATIONAL THERAPY.] Medical assistance covers occupational therapy and related services, including specialized maintenance therapy. Services provided by an occupational therapy assistant shall be reimbursed at the same rate as services performed by an occupational therapist when the services of the occupational therapy assistant are provided under the direction of the occupational therapist who is on the premises. Services provided by an occupational therapy assistant under the direction of an occupational therapist who is not on the premises shall be reimbursed at 65 percent of the occupational therapist rate. Direction of the occupational therapy assistant must be provided by the occupational therapist as described in Minnesota Rules, part 9505.0390, subpart 1, item B. The occupational therapist and occupational therapist assistant may not both bill for services provided to a recipient on the same day.

Sec. 39. Minnesota Statutes 2000, section 256B.0627, is amended by adding a subdivision to read:

Subd. 16. [HARDSHIP CRITERIA; PRIVATE DUTY NURSING.] (a) Payment is allowed for extraordinary services that require specialized nursing skills and are provided by parents of minor children, spouses, and legal guardians who are providing private duty nursing care under the following conditions:

(1) the provision of these services is not legally required of the parents, spouses, or legal guardians;

(2) the services are necessary to prevent hospitalization of the recipient; and

(3) the recipient is eligible for state plan home care or a home and community-based waiver and one of the following hardship criteria are met:

(i) the parent, spouse, or legal guardian resigns from a part-time or full-time job to provide nursing care for the recipient; or

(ii) the parent, spouse, or legal guardian goes from a full-time to a part-time job with less compensation to provide nursing care for the recipient; or

(iii) the parent, spouse, or legal guardian takes a leave of absence without pay to provide nursing care for the recipient; or

(iv) because of labor conditions, special language needs, or intermittent hours of care needed, the parent, spouse, or legal guardian is needed in order to provide adequate private duty nursing services to meet the medical needs of the recipient.

(b) Private duty nursing may be provided by a parent, spouse, or legal guardian who is a nurse licensed in Minnesota. Private duty nursing services provided by a parent, spouse, or legal guardian cannot be used in lieu of nursing services covered and available under liable third-party payers, including Medicare. The private duty nursing provided by a parent, spouse, or legal guardian must be included in the service plan. Authorized skilled nursing services provided by the parent, spouse, or legal guardian may not exceed 50 percent of the total approved nursing hours, or eight hours per day, whichever is less, up to a maximum of 40 hours per week. Nothing in this subdivision precludes the parent's, spouse's, or legal guardian's obligation of assuming the nonreimbursed family responsibilities of emergency backup caregiver and primary caregiver.

(c) A parent or a spouse may not be paid to provide private duty nursing care if the parent or spouse fails to pass a criminal background check according to section 245A.04, or if it has been determined by the home health agency, the case manager, or the physician that the private duty nursing care provided by the parent, spouse, or legal guardian is unsafe.

Sec. 40. Minnesota Statutes 2000, section 256B.0627, is amended by adding a subdivision to read:

Subd. 17. [QUALITY ASSURANCE PLAN FOR PERSONAL CARE ASSISTANT SERVICES.] The commissioner shall establish a quality assurance plan for personal care assistant services that includes:

(1) performance-based provider agreements;

(2) meaningful consumer input, which may include consumer surveys, that measure the extent to which participants receive the services and supports described in the individual plan and participant satisfaction with such services and supports;

(3) ongoing monitoring of the health and well-being of consumers; and

(4) an ongoing public process for development, implementation, and review of the quality assurance plan.

Sec. 41. Minnesota Statutes 2000, section 256B.0911, is amended by adding a subdivision to read:

Subd. 4a. [PREADMISSION SCREENING OF INDIVIDUALS UNDER 65 YEARS OF AGE.] (a) It is the policy of the state of Minnesota to ensure that individuals with disabilities or chronic illness are served in the most integrated setting appropriate to their needs and have the necessary information to make informed choices about home and community-based service options.

(b) Individuals under 65 years of age who are admitted to a nursing facility from a hospital must be screened prior to admission as outlined in subdivision 4.

(c) Individuals under 65 years of age who are admitted to nursing facilities with only a telephone screening must receive a face-to-face assessment from the long-term care consultation team member of the county in which the facility is located or from the recipient's county case manager within 20 working days of admission.

(d) At the face-to-face assessment, the long-term care consultation team member or county case manager must perform the activities required under subdivision 3.

(e) For individuals under 21 years of age, the screening or assessment which recommends nursing facility admission must be approved by the commissioner before the individual is admitted to the nursing facility.

(f) In the event that an individual under 65 years of age is admitted to a nursing facility on an emergency basis, the county must be notified of the admission on the next working day, and a face-to-face assessment as described in paragraph (c) must be conducted within 20 working days of admission.

(g) At the face-to-face assessment, the long-term care consultation team member or the case manager must present information about home and community-based options so the individual can make informed choices. If the individual chooses home and community-based services, the long-term care consultation team member or case manager must complete a written relocation plan within 20 working days of the visit. The plan shall describe the services needed to move out of the facility and a time line for the move which is designed to ensure a smooth transition to the individual's home and community.

(h) An individual under 65 years of age residing in a nursing facility shall receive a face-to-face assessment at least every 12 months to review the person's service choices and available alternatives unless the individual indicates, in writing, that annual visits are not desired. In this case, the individual must receive a face-to-face assessment at least once every 36 months for the same purposes.

(i) Notwithstanding the provisions of subdivision 6, the commissioner may pay county agencies directly for face-to-face assessments for individuals who are eligible for medical assistance, under 65 years of age, and being considered for placement or residing in a nursing facility.

Sec. 42. Minnesota Statutes 2000, section 256B.0916, subdivision 1, is amended to read:

Subdivision 1. [REDUCTION OF WAITING LIST.] (a) The legislature recognizes that as of January 1, 1999, 3,300 persons with mental retardation or related conditions have been screened and determined eligible for the home and community-based waiver services program for persons with mental retardation or related conditions. Many wait for several years before receiving service.

(b) The waiting list for this program shall be reduced or eliminated by June 30, 2003. In order to reduce the number of eligible persons waiting for identified services provided through the home and community-based waiver for persons with mental retardation or related conditions, during the period from July 1, 1999, to June 30, 2003, funding shall be increased to add 100 additional eligible persons each year beyond the February 1999 medical assistance forecast.

(c) The commissioner shall allocate resources in such a manner as to use all resources budgeted during a biennium for the home and community-based waiver for persons with mental retardation or related conditions according to the priorities listed in subdivision 2, paragraph (b), and then to serve other persons on the waiting list. Resources allocated for a fiscal year to serve persons affected by public and private sector ICF/MR closures, but not expected to be expended for that purpose, must be reallocated within that fiscal year to serve other persons on the waiting list, and the number of waiver diversion slots shall be adjusted accordingly.

(d) For fiscal year 2001, at least one-half of the increase in funding over the previous year provided in the February 1999 medical assistance forecast for the home and community-based waiver for persons with mental retardation and related conditions, including changes made by the 1999 legislature, must be used to serve persons who are not affected by public and private sector ICF/MR closures.

(e) The commissioner of finance shall not reduce the expenditure forecast for a biennium for which appropriations have been made, if at the time of the forecast there is a waiting list for waiver services for persons with mental retardation or related conditions who need services within the next 30 months. Funds that would have resulted from a projected reduction in expenditures must be used by the commissioner of human services to serve persons with developmental disabilities through the home and community-based waiver for persons with mental retardation or related conditions.

Sec. 43. Minnesota Statutes 2000, section 256B.0916, is amended by adding a subdivision to read:

Subd. 6a. [STATEWIDE AVAILABILITY OF CONSUMER-DIRECTED COMMUNITY SUPPORT SERVICES.] (a) The commissioner shall submit to the federal Health Care Financing Administration by August 1, 2001, an amendment to the home and community-based waiver for persons with mental retardation or related conditions to make consumer-directed community support services available in every county of the state by January 1, 2002.

(b) If a county declines to meet the requirements for provision of consumer-directed community supports, the commissioner shall contract with another county, a group of counties, or a private agency to plan for and administer consumer-directed community supports in that county.

(c) The state of Minnesota, county agencies, tribal governments, or administrative entities under contract to participate in the implementation and administration of the home and community-based waiver for persons with mental retardation or a related condition, shall not be liable for damages, injuries, or liabilities sustained through the purchase of support by the individual, the individual's family, or the authorized representative with funds received through the consumer-directed community support service under this section. Liabilities include but are not limited to: workers' compensation liability, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA).

Sec. 44. Minnesota Statutes 2000, section 256B.0916, subdivision 7, is amended to read:

Subd. 7. [ANNUAL REPORT BY COMMISSIONER.] Beginning ~~October 1, 1999, and each October 1~~ November 1, 2001, and each November 1 thereafter, the commissioner shall issue an

annual report on county and state use of available resources for the home and community-based waiver for persons with mental retardation or related conditions. For each county or county partnership, the report shall include:

(1) the amount of funds allocated but not used;

(2) the county specific allowed reserve amount approved and used;

(3) the number, ages, and living situations of individuals screened and waiting for services;

(4) the urgency of need for services to begin within one, two, or more than two years for each individual;

(5) the services needed;

(6) the number of additional persons served by approval of increased capacity within existing allocations;

(7) results of action by the commissioner to streamline administrative requirements and improve county resource management; and

(8) additional action that would decrease the number of those eligible and waiting for waivered services.

The commissioner shall specify intended outcomes for the program and the degree to which these specified outcomes are attained.

Sec. 45. Minnesota Statutes 2000, section 256B.0916, subdivision 9, is amended to read:

Subd. 9. [LEGAL REPRESENTATIVE PARTICIPATION EXCEPTION.] The commissioner, in cooperation with representatives of counties, service providers, service recipients, family members, legal representatives and advocates, shall develop criteria to allow legal representatives to be reimbursed for providing specific support services to meet the person's needs when a plan which assures health and safety has been agreed upon and carried out by the legal representative, the person, and the county. Legal representatives providing support under ~~consumer-directed community support services pursuant to section 256B.092, subdivision 4,~~ the home and community-based waiver for persons with mental retardation or related conditions or the consumer support grant program pursuant to section ~~256B.092, subdivision 7~~ 256.476, shall not be considered to have a direct or indirect service provider interest under section 256B.092, subdivision 7, if a health and safety plan which meets the criteria established has been agreed upon and implemented. By ~~October 1, 1999~~ August 1, 2001, the commissioner shall submit, for federal approval, amendments to allow legal representatives to provide support and receive reimbursement under the ~~consumer-directed community support services section of the~~ home and community-based waiver plan.

Sec. 46. Minnesota Statutes 2000, section 256B.092, subdivision 2a, is amended to read:

Subd. 2a. [MEDICAL ASSISTANCE FOR CASE MANAGEMENT ACTIVITIES UNDER THE STATE PLAN MEDICAID OPTION.] (a) Upon receipt of federal approval, the commissioner shall make payments to ~~approved vendors~~ counties, private individuals, and agencies enrolled as providers of case management services participating in the medical assistance program to reimburse costs for providing case management service activities to medical assistance eligible persons with mental retardation or a related condition, in accordance with the state Medicaid plan, the home and community-based waiver for persons with mental retardation and related conditions plan, and federal requirements ~~and limitations~~.

(b) The commissioner shall ensure that each eligible person is given a choice of county and private agency case management service providers. Case management service providers are prohibited from providing any other service to the person receiving case management services.

Sec. 47. Minnesota Statutes 2000, section 256B.092, subdivision 5, is amended to read:

Subd. 5. [FEDERAL WAIVERS.] (a) The commissioner shall apply for any federal waivers necessary to secure, to the extent allowed by law, federal financial participation under United States Code, title 42, sections 1396 et seq., as amended, for the provision of services to persons who, in the absence of the services, would need the level of care provided in a regional treatment center or a community intermediate care facility for persons with mental retardation or related conditions. The commissioner may seek amendments to the waivers or apply for additional waivers under United States Code, title 42, sections 1396 et seq., as amended, to contain costs. The commissioner shall ensure that payment for the cost of providing home and community-based alternative services under the federal waiver plan shall not exceed the cost of intermediate care services including day training and habilitation services that would have been provided without the waivered services.

(b) The commissioner, in administering home and community-based waivers for persons with mental retardation and related conditions, shall ensure that day services for eligible persons are not provided by the person's residential service provider, unless the person or the person's legal representative is offered a choice of providers and agrees in writing to provision of day services by the residential service provider. The individual service plan for individuals who choose to have their residential service provider provide their day services must describe how health, safety, and protection needs will be met by frequent and regular contact with persons other than the residential service provider.

Sec. 48. Minnesota Statutes 2000, section 256B.093, subdivision 3, is amended to read:

Subd. 3. [TRAUMATIC BRAIN INJURY PROGRAM DUTIES.] The department shall fund administrative case management under this subdivision using medical assistance administrative funds. The traumatic brain injury program duties include:

(1) recommending to the commissioner in consultation with the medical review agent according to Minnesota Rules, parts 9505.0500 to 9505.0540, the approval or denial of medical assistance funds to pay for out-of-state placements for traumatic brain injury services and in-state traumatic brain injury services provided by designated Medicare long-term care hospitals;

(2) coordinating the traumatic brain injury home and community-based waiver;

(3) ~~approving traumatic brain injury waiver eligibility or care plans or both;~~

~~(4)~~ providing ongoing technical assistance and consultation to county and facility case managers to facilitate care plan development for appropriate, accessible, and cost-effective medical assistance services;

~~(5)~~ (4) providing technical assistance to promote statewide development of appropriate, accessible, and cost-effective medical assistance services and related policy;

~~(6)~~ (5) providing training and outreach to facilitate access to appropriate home and community-based services to prevent institutionalization;

~~(7)~~ (6) facilitating appropriate admissions, continued stay review, discharges, and utilization review for neurobehavioral hospitals and other specialized institutions;

~~(8)~~ (7) providing technical assistance on the use of prior authorization of home care services and coordination of these services with other medical assistance services;

~~(9)~~ (8) developing a system for identification of nursing facility and hospital residents with traumatic brain injury to assist in long-term planning for medical assistance services. Factors will include, but are not limited to, number of individuals served, length of stay, services received, and barriers to community placement; and

~~(10)~~ (9) providing information, referral, and case consultation to access medical assistance services for recipients without a county or facility case manager. Direct access to this assistance may be limited due to the structure of the program.

Sec. 49. Minnesota Statutes 2000, section 256B.095, is amended to read:

256B.095 [~~THREE-YEAR~~ QUALITY ASSURANCE ~~PILOT~~ PROJECT ESTABLISHED.]

Effective July 1, 1998, an alternative quality assurance licensing system ~~pilot~~ project for programs for persons with developmental disabilities is established in Dodge, Fillmore, Freeborn, Goodhue, Houston, Mower, Olmsted, Rice, Steele, Wabasha, and Winona counties for the purpose of improving the quality of services provided to persons with developmental disabilities. A county, at its option, may choose to have all programs for persons with developmental disabilities located within the county licensed under chapter 245A using standards determined under the alternative quality assurance licensing system ~~pilot~~ project or may continue regulation of these programs under the licensing system operated by the commissioner. The ~~pilot~~ project expires on June 30, ~~2001~~ 2005.

Sec. 50. Minnesota Statutes 2000, section 256B.0951, subdivision 1, is amended to read:

Subdivision 1. [MEMBERSHIP.] The region 10 quality assurance commission is established. The commission consists of at least 14 but not more than 21 members as follows: at least three but not more than five members representing advocacy organizations; at least three but not more than five members representing consumers, families, and their legal representatives; at least three but not more than five members representing service providers; at least three but not more than five members representing counties; and the commissioner of human services or the commissioner's designee. Initial membership of the commission shall be recruited and approved by the region 10 stakeholders group. Prior to approving the commission's membership, the stakeholders group shall provide to the commissioner a list of the membership in the stakeholders group, as of February 1, 1997, a brief summary of meetings held by the group since July 1, 1996, and copies of any materials prepared by the group for public distribution. The first commission shall establish membership guidelines for the transition and recruitment of membership for the commission's ongoing existence. Members of the commission who do not receive a salary or wages from an employer for time spent on commission duties may receive a per diem payment when performing commission duties and functions. All members may be reimbursed for expenses related to commission activities. Notwithstanding the provisions of section 15.059, subdivision 5, the commission expires on June 30, ~~2001~~ 2005.

Sec. 51. Minnesota Statutes 2000, section 256B.0951, subdivision 3, is amended to read:

Subd. 3. [COMMISSION DUTIES.] (a) By October 1, 1997, the commission, in cooperation with the commissioners of human services and health, shall do the following: (1) approve an alternative quality assurance licensing system based on the evaluation of outcomes; (2) approve measurable outcomes in the areas of health and safety, consumer evaluation, education and training, providers, and systems that shall be evaluated during the alternative licensing process; and (3) establish variable licensure periods not to exceed three years based on outcomes achieved. For purposes of this subdivision, "outcome" means the behavior, action, or status of a person that can be observed or measured and can be reliably and validly determined.

(b) By January 15, 1998, the commission shall approve, in cooperation with the commissioner of human services, a training program for members of the quality assurance teams established under section 256B.0952, subdivision 4.

(c) The commission and the commissioner shall establish an ongoing review process for the alternative quality assurance licensing system. The review shall take into account the comprehensive nature of the alternative system, which is designed to evaluate the broad spectrum of licensed and unlicensed entities that provide services to clients, as compared to the current licensing system.

(d) The commission shall contract with an independent entity to conduct a financial review of the alternative quality assurance ~~pilot~~ project. The review shall take into account the comprehensive nature of the alternative system, which is designed to evaluate the broad spectrum of licensed and unlicensed entities that provide services to clients, as compared to the current licensing system. The review shall include an evaluation of possible budgetary savings within the

department of human services as a result of implementation of the alternative quality assurance ~~pilot~~ project. If a federal waiver is approved under subdivision 7, the financial review shall also evaluate possible savings within the department of health. This review must be completed by December 15, 2000.

(e) The commission shall submit a report to the legislature by January 15, 2001, on the results of the review process for the alternative quality assurance ~~pilot~~ project, a summary of the results of the independent financial review, and a recommendation on whether the ~~pilot~~ project should be extended beyond June 30, 2001.

(f) The commissioner, in consultation with the commission, shall examine the feasibility of expanding the project to other populations or geographic areas and identify barriers to expansion. The commissioner shall report findings and recommendations to the legislature by December 15, 2004.

Sec. 52. Minnesota Statutes 2000, section 256B.0951, subdivision 4, is amended to read:

Subd. 4. [COMMISSION'S AUTHORITY TO RECOMMEND VARIANCES OF LICENSING STANDARDS.] The commission may recommend to the commissioners of human services and health variances from the standards governing licensure of programs for persons with developmental disabilities in order to improve the quality of services by implementing an alternative developmental disabilities licensing system if the commission determines that the alternative licensing system does not adversely affect the health or safety of persons being served by the licensed program nor compromise the qualifications of staff to provide services.

Sec. 53. Minnesota Statutes 2000, section 256B.0951, subdivision 5, is amended to read:

Subd. 5. [VARIANCE OF CERTAIN STANDARDS PROHIBITED.] The safety standards, rights, or procedural protections under sections 245.825; 245.91 to 245.97; 245A.04, subdivisions 3, 3a, 3b, and 3c; 245A.09, subdivision 2, paragraph (c), clauses (2) and (5); 245A.12; 245A.13; 252.41, subdivision 9; 256B.092, subdivisions 1b, clause (7), and 10; 626.556; 626.557, and procedures for the monitoring of psychotropic medications shall not be varied under the alternative licensing system ~~pilot~~ project. The commission may make recommendations to the commissioners of human services and health or to the legislature regarding alternatives to or modifications of the rules and procedures referenced in this subdivision.

Sec. 54. Minnesota Statutes 2000, section 256B.0951, subdivision 7, is amended to read:

Subd. 7. [WAIVER OF RULES.] The commissioner of health may exempt residents of intermediate care facilities for persons with mental retardation (ICFs/MR) who participate in the three-year quality assurance pilot project established in section 256B.095 from the requirements of Minnesota Rules, chapter 4665, upon approval by the federal government of a waiver of federal certification requirements for ICFs/MR. ~~The commissioners of health and human services shall apply for any necessary waivers as soon as practicable and shall submit the concept paper to the federal government by June 1, 1998.~~

Sec. 55. Minnesota Statutes 2000, section 256B.0951, is amended by adding a subdivision to read:

Subd. 8. [FEDERAL WAIVER.] The commissioner of human services shall seek federal authority to waive provisions of intermediate care facilities for persons with mental retardation (ICFs/MR) regulations to enable the demonstration and evaluation of the alternative quality assurance system for ICFs/MR under the project. The commissioner of human services shall apply for any necessary waivers as soon as practicable.

Sec. 56. Minnesota Statutes 2000, section 256B.0951, is amended by adding a subdivision to read:

Subd. 9. [EVALUATION.] The commission, in consultation with the commissioner of human services, shall conduct an evaluation of the alternative quality assurance system, and present a report to the commissioner by June 30, 2004.

Sec. 57. Minnesota Statutes 2000, section 256B.0952, subdivision 1, is amended to read:

Subdivision 1. [NOTIFICATION.] ~~By January 15, 1998, each affected county shall notify the commission and the commissioners of human services and health as to whether it chooses to implement on July 1, 1998, the alternative licensing system for the pilot project. A county that does not implement the alternative licensing system on July 1, 1998, may give notice to the commission and the commissioners by January 15, 1999, or January 15, 2000, that it will implement the alternative licensing system on the following July 1. A county that implements the alternative licensing system commits to participate until June 30, 2001.~~ For each year of the project, region 10 counties shall give notice to the commission and commissioners of human services and health by March 15 of intent to join the quality assurance alternative licensing system, effective July 1 of that year. A county choosing to participate in the alternative licensing system commits to participate until June 30, 2005. Counties participating in the quality assurance alternative licensing system as of January 1, 2001, shall notify the commission and the commissioners of human services and health by March 15, 2001, of intent to continue participation. Counties that elect to continue participation must participate in the alternative licensing system until June 30, 2005.

Sec. 58. Minnesota Statutes 2000, section 256B.0952, subdivision 4, is amended to read:

Subd. 4. [APPOINTMENT OF QUALITY ASSURANCE MANAGER.] (a) A county or group of counties that chooses to participate in the alternative licensing system shall designate a quality assurance manager and shall establish quality assurance teams in accordance with subdivision 5. The manager shall recruit, train, and assign duties to the quality assurance team members. In assigning team members to conduct the quality assurance process at a facility, program, or service, the manager shall take into account the size of the service provider, the number of services to be reviewed, the skills necessary for team members to complete the process, and other relevant factors. The manager shall ensure that no team member has a financial, personal, or family relationship with the facility, program, or service being reviewed or with any clients of the facility, program, or service.

(b) Quality assurance teams shall report the findings of their quality assurance reviews to the quality assurance manager. The quality assurance manager shall provide the report from the quality assurance team to the county and, upon request, to the commissioners of human services and health, and shall provide a summary of the report to the quality assurance review council.

Sec. 59. Minnesota Statutes 2000, section 256B.49, is amended by adding a subdivision to read:

Subd. 11. [AUTHORITY.] (a) The commissioner is authorized to apply for home and community-based service waivers, as authorized under section 1915(c) of the Social Security Act to serve persons under the age of 65 who are determined to require the level of care provided in a nursing home and persons who require the level of care provided in a hospital. The commissioner shall apply for the home and community-based waivers in order to: (i) promote the support of persons with disabilities in the most integrated settings; (ii) expand the availability of services for persons who are eligible for medical assistance; (iii) promote cost-effective options to institutional care; and (iv) obtain federal financial participation.

(b) The provision of waivered services to medical assistance recipients with disabilities shall comply with the requirements outlined in the federally approved applications for home and community-based services and subsequent amendments, including provision of services according to a service plan designed to meet the needs of the individual. For purposes of this section, the approved home and community-based application is considered the necessary federal requirement.

(c) The commissioner shall provide interested persons serving on agency advisory committees and task forces, and others upon request, with notice of, and an opportunity to comment on, any changes or amendments to the federally approved applications for home and community-based waivers, prior to their submission to the federal health care financing administration.

(d) The commissioner shall seek approval, as authorized under section 1915(c) of the Social Security Act, to allow medical assistance eligibility under this section for children under age 21 without deeming of parental income or assets.

(e) The commissioner shall seek approval, as authorized under section 1915(c) of the Social Act, to allow medical assistance eligibility under this section for individuals under age 65 without deeming the spouse's income or assets.

Sec. 60. Minnesota Statutes 2000, section 256B.49, is amended by adding a subdivision to read:

Subd. 12. [INFORMED CHOICE.] Persons who are determined likely to require the level of care provided in a nursing facility or hospital shall be informed of the home and community-based support alternatives to the provision of inpatient hospital services or nursing facility services. Each person must be given the choice of either institutional or home and community-based services, using the provisions described in section 256B.77, subdivision 2, paragraph (p).

Sec. 61. Minnesota Statutes 2000, section 256B.49, is amended by adding a subdivision to read:

Subd. 13. [CASE MANAGEMENT.] (a) Each recipient of a home and community-based waiver shall be provided case management services by qualified vendors as described in the federally approved waiver application. The case management service activities provided will include:

(1) assessing the needs of the individual within 20 working days of a recipient's request;

(2) developing the written individual service plan within ten working days after the assessment is completed;

(3) informing the recipient or the recipient's legal guardian or conservator of service options;

(4) assisting the recipient in the identification of potential service providers;

(5) assisting the recipient to access services;

(6) coordinating, evaluating, and monitoring of the services identified in the service plan;

(7) completing the annual reviews of the service plan; and

(8) informing the recipient or legal representative of the right to have assessments completed and service plans developed within specified time periods, and to appeal county action or inaction under section 256.045, subdivision 3.

(b) The case manager may delegate certain aspects of the case management service activities to another individual provided there is oversight by the case manager. The case manager may not delegate those aspects which require professional judgment including assessments, reassessments, and care plan development.

Sec. 62. Minnesota Statutes 2000, section 256B.49, is amended by adding a subdivision to read:

Subd. 14. [ASSESSMENT AND REASSESSMENT.] (a) Assessments of each recipient's strengths, informal support systems, and need for services shall be completed within 20 working days of the recipient's request. Reassessment of each recipient's strengths, support systems, and need for services shall be conducted at least every 12 months and at other times when there has been a significant change in the recipient's functioning.

(b) Persons with mental retardation or a related condition who apply for services under the nursing facility level waiver programs shall be screened for the appropriate level of care according to section 256B.092.

(c) Recipients who are found eligible for home and community-based services under this section before their 65th birthday may remain eligible for these services after their 65th birthday if they continue to meet all other eligibility factors.

Sec. 63. Minnesota Statutes 2000, section 256B.49, is amended by adding a subdivision to read:

Subd. 15. [INDIVIDUALIZED SERVICE PLAN.] Each recipient of home and community-based waivered services shall be provided a copy of the written service plan which:

(1) is developed and signed by the recipient within ten working days of the completion of the assessment;

(2) meets the assessed needs of the recipient;

(3) reasonably ensures the health and safety of the recipient;

(4) promotes independence;

(5) allows for services to be provided in the most integrated settings; and

(6) provides for an informed choice, as defined in section 256B.77, subdivision 2, paragraph (p), of service and support providers.

Sec. 64. Minnesota Statutes 2000, section 256B.49, is amended by adding a subdivision to read:

Subd. 16. [SERVICES AND SUPPORTS.] (a) Services and supports included in the home and community-based waivers for persons with disabilities shall meet the requirements set out in United States Code, title 42, section 1396n. The services and supports, which are offered as alternatives to institutional care, shall promote consumer choice, community inclusion, self-sufficiency, and self-determination.

(b) Beginning January 1, 2003, the commissioner shall simplify and improve access to home and community-based waivered services, to the extent possible, through the establishment of a common service menu that is available to eligible recipients regardless of age, disability type, or waiver program.

(c) Consumer directed community support services shall be offered as an option to all persons eligible for services under section 256B.49, subdivision 11, by January 1, 2002.

(d) Services and supports shall be arranged and provided consistent with individualized written plans of care for eligible waiver recipients.

(e) The state of Minnesota and county agencies that administer home and community-based waivered services for persons with disabilities, shall not be liable for damages, injuries, or liabilities sustained through the purchase of supports by the individual, the individual's family, or the authorized representative with funds received through the consumer-directed community support service under this section. Liabilities include but are not limited to: workers' compensation liability, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA).

Sec. 65. Minnesota Statutes 2000, section 256B.49, is amended by adding a subdivision to read:

Subd. 17. [COST OF SERVICES AND SUPPORTS.] (a) The commissioner shall ensure that the average per capita expenditures estimated in any fiscal year for home and community-based waiver recipients does not exceed the average per capita expenditures that would have been made to provide institutional services for recipients in the absence of the waiver.

(b) The commissioner shall implement on January 1, 2002, one or more aggregate, need-based methods for allocating to local agencies the home and community-based waivered service resources available to support recipients with disabilities in need of the level of care provided in a nursing facility or a hospital. The commissioner shall allocate resources to single counties and county partnerships in a manner that reflects consideration of:

(1) an incentive-based payment process for achieving outcomes;

(2) the need for a state-level risk pool;

(3) the need for retention of management responsibility at the state agency level; and

(4) a phase-in strategy as appropriate.

(c) Until the allocation methods described in paragraph (b) are implemented, the annual allowable reimbursement level of home and community-based waiver services shall be the greater of:

(1) the statewide average payment amount which the recipient is assigned under the waiver reimbursement system in place on June 30, 2001, modified by the percentage of any provider rate increase appropriated for home and community-based services; or

(2) an amount approved by the commissioner based on the recipient's extraordinary needs that cannot be met within the current allowable reimbursement level. The increased reimbursement level must be necessary to allow the recipient to be discharged from an institution or to prevent imminent placement in an institution. The additional reimbursement may be used to secure environmental modifications; assistive technology and equipment; and increased costs for supervision, training, and support services necessary to address the recipient's extraordinary needs. The commissioner may approve an increased reimbursement level for up to one year of the recipient's relocation from an institution or up to six months of a determination that a current waiver recipient is at imminent risk of being placed in an institution.

(d) Beginning July 1, 2001, medically necessary private duty nursing services will be authorized under this section as complex and regular care according to section 256B.0627.

Sec. 66. Minnesota Statutes 2000, section 256B.49, is amended by adding a subdivision to read:

Subd. 18. [PAYMENTS.] The commissioner shall reimburse approved vendors from the medical assistance account for the costs of providing home and community-based services to eligible recipients using the invoice processing procedures of the Medicaid management information system (MMIS). Recipients will be screened and authorized for services according to the federally approved waiver application and its subsequent amendments.

Sec. 67. Minnesota Statutes 2000, section 256B.49, is amended by adding a subdivision to read:

Subd. 19. [HEALTH AND WELFARE.] The commissioner of human services shall take the necessary safeguards to protect the health and welfare of individuals provided services under the waiver.

Sec. 68. Minnesota Statutes 2000, section 256B.49, is amended by adding a subdivision to read:

Subd. 20. [TRAUMATIC BRAIN INJURY AND RELATED CONDITIONS.] The commissioner shall seek to amend the traumatic brain injury waiver to include, as eligible persons, individuals with an acquired or degenerative disease diagnosis where cognitive impairment is present, such as multiple sclerosis.

Sec. 69. Minnesota Statutes 2000, section 256B.69, subdivision 23, is amended to read:

Subd. 23. [ALTERNATIVE INTEGRATED LONG-TERM CARE SERVICES; ELDERLY AND DISABLED PERSONS.] (a) The commissioner may implement demonstration projects to create alternative integrated delivery systems for acute and long-term care services to elderly persons and persons with disabilities as defined in section 256B.77, subdivision 7a, that provide increased coordination, improve access to quality services, and mitigate future cost increases. The commissioner may seek federal authority to combine Medicare and Medicaid capitation payments for the purpose of such demonstrations. Medicare funds and services shall be administered according to the terms and conditions of the federal waiver and demonstration provisions. For the purpose of administering medical assistance funds, demonstrations under this subdivision are subject to subdivisions 1 to 22. The provisions of Minnesota Rules, parts 9500.1450 to 9500.1464, apply to these demonstrations, with the exceptions of parts 9500.1452, subpart 2, item B; and 9500.1457, subpart 1, items B and C, which do not apply to persons enrolling in demonstrations under this section. An initial open enrollment period may be provided. Persons who disenroll from demonstrations under this subdivision remain subject to Minnesota Rules, parts 9500.1450 to 9500.1464. When a person is enrolled in a health plan under these demonstrations and the health plan's participation is subsequently terminated for any reason, the person shall be provided an opportunity to select a new health plan and shall have the right to change health plans within the

first 60 days of enrollment in the second health plan. Persons required to participate in health plans under this section who fail to make a choice of health plan shall not be randomly assigned to health plans under these demonstrations. Notwithstanding section 256L.12, subdivision 5, and Minnesota Rules, part 9505.5220, subpart 1, item A, if adopted, for the purpose of demonstrations under this subdivision, the commissioner may contract with managed care organizations, including counties, to serve only elderly persons eligible for medical assistance, elderly and disabled persons, or disabled persons only. For persons with primary diagnoses of mental retardation or a related condition, serious and persistent mental illness, or serious emotional disturbance, the commissioner must ensure that the county authority has approved the demonstration and contracting design. Enrollment in these projects for persons with disabilities shall be voluntary ~~until July 1, 2001~~. The commissioner shall not implement any demonstration project under this subdivision for persons with primary diagnoses of mental retardation or a related condition, serious and persistent mental illness, or serious emotional disturbance, without approval of the county board of the county in which the demonstration is being implemented.

Before implementation of a demonstration project for disabled persons, the commissioner must provide information to appropriate committees of the house of representatives and senate and must involve representatives of affected disability groups in the design of the demonstration projects.

(b) A nursing facility reimbursed under the alternative reimbursement methodology in section 256B.434 may, in collaboration with a hospital, clinic, or other health care entity provide services under paragraph (a). The commissioner shall amend the state plan and seek any federal waivers necessary to implement this paragraph.

Sec. 70. Minnesota Statutes 2000, section 256D.35, is amended by adding a subdivision to read:

Subd. 11a. [INSTITUTION.] "Institution" means: a hospital, consistent with Code of Federal Regulations, title 42, section 440.10; regional treatment center inpatient services; a nursing facility; and an intermediate care facility for persons with mental retardation.

Sec. 71. Minnesota Statutes 2000, section 256D.35, is amended by adding a subdivision to read:

Subd. 18a. [SHELTER COSTS.] "Shelter costs" means: rent, manufactured home lot rentals; monthly principal, interest, insurance premiums, and property taxes due for mortgages or contract for deed costs; costs for utilities, including heating, cooling, electricity, water, and sewerage; garbage collection fees; and the basic service fee for one telephone.

Sec. 72. Minnesota Statutes 2000, section 256D.44, subdivision 5, is amended to read:

Subd. 5. [SPECIAL NEEDS.] In addition to the state standards of assistance established in subdivisions 1 to 4, payments are allowed for the following special needs of recipients of Minnesota supplemental aid who are not residents of a nursing home, a regional treatment center, or a group residential housing facility.

(a) The county agency shall pay a monthly allowance for medically prescribed diets payable under the Minnesota family investment program if the cost of those additional dietary needs cannot be met through some other maintenance benefit.

(b) Payment for nonrecurring special needs must be allowed for necessary home repairs or necessary repairs or replacement of household furniture and appliances using the payment standard of the AFDC program in effect on July 16, 1996, for these expenses, as long as other funding sources are not available.

(c) A fee for guardian or conservator service is allowed at a reasonable rate negotiated by the county or approved by the court. This rate shall not exceed five percent of the assistance unit's gross monthly income up to a maximum of $100 per month. If the guardian or conservator is a member of the county agency staff, no fee is allowed.

(d) The county agency shall continue to pay a monthly allowance of $68 for restaurant meals

for a person who was receiving a restaurant meal allowance on June 1, 1990, and who eats two or more meals in a restaurant daily. The allowance must continue until the person has not received Minnesota supplemental aid for one full calendar month or until the person's living arrangement changes and the person no longer meets the criteria for the restaurant meal allowance, whichever occurs first.

(e) A fee of ten percent of the recipient's gross income or $25, whichever is less, is allowed for representative payee services provided by an agency that meets the requirements under SSI regulations to charge a fee for representative payee services. This special need is available to all recipients of Minnesota supplemental aid regardless of their living arrangement.

(f) Notwithstanding the language in this subdivision, an amount equal to the maximum allotment authorized by the federal Food Stamp Program for a single individual which is in effect on the first day of January of the previous year will be added to the standards of assistance established in subdivisions 1 to 4 for individuals under the age of 65 who are relocating from an institution and who are shelter needy. An eligible individual who receives this benefit prior to age 65 may continue to receive the benefit after the age of 65.

"Shelter needy" means that the assistance unit incurs monthly shelter costs that exceed 40 percent of the assistance unit's gross income before the application of this special needs standard. "Gross income" for the purposes of this section is the applicant's or recipient's income as defined in section 256D.35, subdivision 10, or the standard specified in subdivision 3, whichever is greater. A recipient of a federal or state housing subsidy, that limits shelter costs to a percentage of gross income, shall not be considered shelter needy for purposes of this paragraph.

Sec. 73. Minnesota Statutes 2000, section 256I.05, subdivision 1e, is amended to read:

Subd. 1e. [SUPPLEMENTARY RATE FOR CERTAIN FACILITIES.] Notwithstanding the provisions of subdivisions 1a and 1c, beginning July 1, ~~1999~~ 2001, a county agency shall negotiate a supplementary rate in addition to the rate specified in subdivision 1, equal to ~~25~~ 125 percent of the amount specified in subdivision 1a, including any legislatively authorized inflationary adjustments, for a group residential housing provider that:

(1) is located in Hennepin county and has had a group residential housing contract with the county since June 1996;

(2) operates in three separate locations a ~~56-bed~~ 71-bed facility, ~~a~~ and two 40-bed ~~facility, and a 30-bed facility~~ facilities; and

(3) serves a chemically dependent clientele, providing 24 hours per day supervision and limiting a resident's maximum length of stay to 13 months out of a consecutive 24-month period.

Sec. 74. [256I.07] [RESPITE CARE PILOT PROJECT FOR FAMILY ADULT FOSTER CARE PROVIDERS.]

Subdivision 1. [PROGRAM ESTABLISHED.] The state recognizes the importance of developing and maintaining quality family foster care resources. In order to accomplish that goal, the commissioner shall establish a two-year respite care pilot project for family adult foster care providers in three counties. This pilot project is intended to provide support to caregivers of adult foster care residents. The commissioner shall establish a pilot project to accomplish the provisions in subdivisions 2 to 4.

Subd. 2. [ELIGIBILITY.] A family adult foster care home provider as defined under section 144D.01, subdivision 7, who has been licensed for six months is eligible for 30 days of respite care per calendar year. In cases of emergency, a county social services agency may waive the six-month licensing requirement. In order to be eligible to receive respite payment from group residential housing and alternative care, a provider must take time off away from their foster care residents.

Subd. 3. [PAYMENT STRUCTURE.] (a) The payment for respite care for an adult foster care resident eligible for only group residential housing shall be based on the current monthly group

residential housing base room and board rate and the current maximum monthly group residential housing difficulty of care rate.

(b) The payment for respite care for an adult foster care resident eligible for alternative care funds shall be based on the resident's alternative care foster care rate.

(c) The payment for respite care for an adult foster care resident eligible for Medicaid home and community-based services waiver funds shall be based on the group residential housing base room and board rate.

(d) The total amount available to pay for respite care for a family adult foster care provider shall be based on the number of residents currently served in the foster care home and the source of funding used to pay for each resident's foster care. Respite care must be paid for on a per diem basis and for a full day.

Subd. 4. [PRIVATE PAY RESIDENTS.] Payment for respite care for private pay foster care residents must be arranged between the provider and the resident or the resident's family.

Sec. 75. Laws 1999, chapter 152, section 1, is amended to read:

Section 1. [TASK FORCE.]

A day training and habilitation task force is established. Task force membership shall consist of representatives of the commissioner of human services, counties, service consumers, and vendors of day training and habilitation as defined in Minnesota Statutes, section 252.41, subdivision 9, including at least one representative from each association representing day training and habilitation vendors. Appointments to the task force shall be made by the commissioner of human services and technical assistance shall be provided by the department of human services.

Sec. 76. Laws 1999, chapter 152, section 4, is amended to read:

Sec. 4. [REPORT.]

The task force shall present a report recommending a new payment rate structure to the legislature by January 15, 2000, and shall make recommendations to the commissioner of human services regarding the implementation of the pilot project for the individualized payment rate structure, so the pilot project can be implemented by July 1, 2002, as required in section 3. The task force expires on ~~March 15, 2000~~ December 30, 2003.

Sec. 77. [DAY TRAINING AND HABILITATION PAYMENT STRUCTURE PILOT PROJECT.]

Subdivision 1. [INDIVIDUALIZED PAYMENT RATE STRUCTURE.] Notwithstanding Minnesota Statutes, sections 252.451, subdivision 5; and 252.46; and Minnesota Rules, part 9525.1290, subpart 1, items A and B, the commissioner of human services shall initiate a pilot project and phase-in for the individualized payment rate structure described in this section and section 74. The pilot project shall include actual transfers of funds, not simulated transfers. The pilot project may include all or some of the vendors in up to eight counties, with no more than two counties from the seven-county Minneapolis-St. Paul metropolitan area. Following initiation of the pilot project, the commissioner shall phase in implementation of the individualized payment rate structure to the remaining counties and vendors according to the implementation plan developed by the task force. The pilot and phase-in shall not extend over more than 18 months and shall be completed by December 31, 2003.

Subd. 2. [SUNSET.] The pilot project shall sunset upon implementation of a new statewide rate structure according to the implementation plan developed by the task force described in subdivision 3, in its report to the legislature on December 1, 2001. The rates of vendors participating in the pilot project must be modified to be consistent with the new statewide rate structure, as implemented.

Subd. 3. [TASK FORCE RESPONSIBILITIES.] The day training and habilitation task force

established under Laws 1999, chapter 152, section 4, shall evaluate the pilot project authorized under subdivision 1, and by December 1, 2001, shall report to the legislature with an implementation plan, which shall address how and when the pilot project individualized payment rate structure will be implemented statewide, shall ensure that vendors that wish to maintain their current per diem rate may do so within the new payment system, and shall identify criteria that would halt statewide implementation if vendors or clients were adversely affected by the new payment rate structure, and with recommendations for any amendments that should be made before statewide implementation. These recommendations shall be made in a report to the chairs of the house health and human services policy and finance committees and the senate health and family security committee and finance division.

Subd. 4. [RATE SETTING.] (a) The rate structure under this section is intended to allow a county to authorize an individual rate for each client in the vendor's program based on the needs and expected outcomes of the individual client. Rates shall be based on an authorized package of services for each individual over a typical time frame. Rates may be established across multiple sites run by a single vendor.

(b) With county concurrence, a vendor shall establish up to four levels of service, A through D, based on the intensity of services provided to an individual client of day training and habilitation services. Service level A shall be the highest intensity of services, marked primarily, but not exclusively, by a one-to-one client-to-staff ratio. Service level D shall be the lowest intensity of services. The county shall document the vendor's description of the type and amount of services associated with each service level.

(c) For each vendor, a county board shall establish a dollar value for one hour of service at each of the service levels defined in paragraph (b). In establishing these values for existing vendors transitioning from the payment rate structure under Minnesota Statutes, section 252.46, subdivision 1, the county board shall follow the formula and guidelines developed by the day training and habilitation task force under paragraph (e).

(d) A vendor may elect to maintain a single transportation rate or may elect to establish up to five types of transportation services: public transportation, public special transportation, nonambulatory transportation, out-of-service area transportation, and ambulatory transportation. For vendors that elect to establish multiple transportation services, the county board shall establish a dollar value for a round trip on each type of transportation service offered through the vendor. With vendor concurrence, the county may also establish a uniform one-way trip value for some or all of the transportation service types.

(e) The county board shall ensure that the vendor translates the vendor's existing program and transportation rates to the rates and values in the pilot project by using the conversion calculations for services and transportation approved by the day training and habilitation task force established under Laws 1999, chapter 152, and included in the task force's recommendations to the legislature. The conversion calculation may be amended by the task force with the approval of the commissioner and any amendments shall become effective upon notification to the pilot project counties from the commissioner. The calculation shall take the total reimbursement dollars available to the vendor and divide by the units of service expected at each service level and of each transportation type. In determining the total reimbursement dollars available to a vendor, the vendor shall multiply the vendor's current per diem rate for both services and transportation, including any new rate increases, by the vendor's actual utilization for the year prior to implementation of the pilot project. Vendors shall be allowed to allocate available reimbursement dollars between service and transportation before the vendor's service level and transportation values are calculated. After translating its existing service and transportation rates to the service level and transportation values under the pilot, the vendor shall project its expected reimbursement income using the expected service and transportation packages for its existing clients, based on current service authorizations. If the projected reimbursement income is less than the vendor would have received under the payment structure of Minnesota Statutes, section 252.46, the vendor and the county, with the approval of the commissioner, shall adjust the vendor's service level and transportation values to eliminate the shortfall. The commissioner shall report all adjustments to the day training and habilitation task force for consideration of possible modifications to the pilot project individualized payment rate structure.

Subd. 5. [INDIVIDUAL RATE AUTHORIZATION.] (a) As part of its annual authorization of services for each client under Minnesota Statutes, section 252.44, paragraph (a), clause (1), and Minnesota Rules, part 9525.0016, subpart 12, the county shall authorize and document a service package and a transportation package as follows:

(1) the service package shall include the amount and type of services at each applicable service level to be provided to the client over a package period. An individual client may receive services at multiple service levels over the course of the package period. The service package rate shall be the sum of the amount of services at each level over the package period, multiplied by the dollar value for each service level;

(2) the transportation package shall include the amount and type of transportation services to be provided to the client over the package period. The transportation package rate shall be the sum of the amount of transportation services, multiplied by the dollar value associated with the type of transportation service authorized for the client;

(3) the package period shall be established by the county, and may be one week, two weeks, or one month; and

(4) the individual rate authorization may be reviewed and modified by the county at any time and must be reviewed and reauthorized by the county at least annually.

(b) For vendors with rates established under this section, a service day under Minnesota Statutes, sections 245B.06 and 252.44, includes any day in which a client receives any reimbursable service from a vendor or attends employment arranged by the vendor.

Subd. 6. [BILLING FOR SERVICES.] The vendor shall bill for, and shall be reimbursed for, the service package rate and transportation package rate for the package period as authorized by the county for each client in the vendor's program. The length of the package period shall not affect the timing or frequency of vendors' submissions of claims for payment under the Medicaid Management Information System II (MMIS) or its successors.

Subd. 7. [NOTIFICATION OF CHANGE IN CLIENT NEEDS.] The vendor shall notify an individual client's case manager if the vendor has knowledge of a material change in the client's needs that may indicate a need for a change in service authorization. Factors that would require such notice include, but are not limited to, significant changes in medical status, residential placement, attendance patterns, behavioral needs, or skill functioning. The vendor shall notify the case manager as soon as possible but no later than 30 calendar days after becoming aware of the change in needs. The service authorization for the client shall not change until the county authorizes a new service and transportation package for the client in accordance with the provisions in Minnesota Statutes, section 256B.092.

Sec. 78. [COUNTY BOARD RESPONSIBILITIES.]

For each vendor with rates established under section 73, the county board shall document the vendor's description of the type and amount of services associated with each service level, the vendor's service level values, the vendor's transportation values, and the package period that will be used to determine the rate for each individual client. The county shall establish a package period of one week, two weeks, or one month.

Sec. 79. [STUDY OF DAY TRAINING AND HABILITATION VENDOR RATES.]

The commissioner shall identify the vendors with the lowest rates or underfunded programs in the state and make recommendations to reconcile the discrepancies prior to the implementation of the individualized payment rate structure described in sections 73 and 74.

Sec. 80. [FEDERAL APPROVAL.]

The commissioner shall seek any amendments to the state Medicaid plan and any waivers necessary to permit implementation of section 74 within the timelines specified.

Sec. 81. [SEMI-INDEPENDENT LIVING SERVICES (SILS) STUDY.]

The commissioner of human services, in consultation with county representatives and other interested persons, shall develop recommendations revising the funding methodology for SILS as defined in Minnesota Statutes, section 252.275, subdivisions 3, 4, 4a, 4b, and 4c, and report by January 15, 2002, to the chair of the house of representatives health and human services finance committee and the chairs of the senate health, human services, and corrections budget division.

Sec. 82. [WAIVER REQUEST REGARDING SPOUSAL INCOME.]

By September 1, 2001, the commissioner of human services shall seek federal approval to allow recipients of home and community-based waivers authorized under Minnesota Statutes, section 256B.49, to choose either a waiver of deeming of spousal income or the spousal impoverishment protections authorized under United States Code, title 42, section 1396r-5, with the addition of the group residential housing rate set according to Minnesota Statutes, section 256I.03, subdivision 5, to the personal needs allowance authorized by Minnesota Statutes, section 256B.0575.

Sec. 83. [PROGRAM OPTIONS FOR CERTAIN PERSONS WITH DEVELOPMENTAL DISABILITIES.]

(a) The commissioner of human services shall ensure that services continue to be available to persons with developmental disabilities who were covered by social services supplemental grants prior to July 1, 2001. Services shall be provided in priority order as follows:

(1) to the extent possible, the commissioner shall establish for these persons targeted slots under the home and community-based waivered services program for persons with mental retardation or related conditions;

(2) persons accommodated under clause (1) shall, if eligible, receive room and board services through group residential housing under Minnesota Statutes, chapter 256I; and

(3) any remaining persons shall continue to receive services through community social services supplemental grants to the affected counties.

(b) This section applies only to individuals receiving services under social services supplemental grants as of June 30, 2001.

Sec. 84. [FEDERAL APPROVAL.]

The commissioner of human services, by September 1, 2001, shall request any federal approval and plan amendments necessary to implement the choice of case manager provision in section 256B.092, subdivision 2a, paragraph (b).

Sec. 85. [FEDERAL WAIVER REQUESTS.]

The commissioner of human services shall submit to the federal Health Care Financing Administration by September 1, 2001, a request for a home and community-based services waiver for day services, including: community inclusion, supported employment, and day training and habilitation services defined in Minnesota Statutes, section 252.41, subdivision 3, clause (1), for persons eligible for the waiver under Minnesota Statutes, section 256B.092.

Sec. 86. [REPEALER.]

(a) Minnesota Statutes 2000, sections 256B.0951, subdivision 6; and 256E.06, subdivision 2b, are repealed.

(b) Minnesota Statutes 2000, sections 145.9245; 256.476, subdivision 7; 256B.0912; 256B.0915, subdivisions 3a, 3b, and 3c; and 256B.49, subdivisions 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10, are repealed.

(c) Laws 1995, chapter 178, article 2, section 48, subdivision 6, is repealed.

(d) Minnesota Rules, parts 9505.2455; 9505.2458; 9505.2460; 9505.2465; 9505.2470; 9505.2473; 9505.2475; 9505.2480; 9505.2485; 9505.2486; 9505.2490; 9505.2495; 9505.2496; 9505.2500; 9505.3010; 9505.3015; 9505.3020; 9505.3025; 9505.3030; 9505.3035; 9505.3040; 9505.3065; 9505.3085; 9505.3135; 9505.3500; 9505.3510; 9505.3520; 9505.3530; 9505.3535; 9505.3540; 9505.3545; 9505.3550; 9505.3560; 9505.3570; 9505.3575; 9505.3580; 9505.3585; 9505.3600; 9505.3610; 9505.3620; 9505.3622; 9505.3624; 9505.3626; 9505.3630; 9505.3635; 9505.3640; 9505.3645; 9505.3650; 9505.3660; and 9505.3670, are repealed.

ARTICLE 4

CONSUMER INFORMATION AND ASSISTANCE

AND COMMUNITY-BASED CARE

Section 1. [144A.35] [EXPANSION OF BED DISTRIBUTION STUDY AND CREATION OF CRITICAL ACCESS SITES.]

Subdivision 1. [OLDER ADULT SERVICES DISTRIBUTION STUDY.] The commissioner of health, in coordination with the commissioner of human services, shall monitor and analyze the distribution of older adult services, including, but not limited to, nursing home beds, senior housing, housing with services units, and home and community-based services in the different geographic areas of the state. The study shall include an analysis of the impact of amendments to the nursing home moratorium law which would allow for transfers of nursing home beds within the state. The commissioner of health shall submit to the legislature, beginning January 15, 2002, and each January 15 thereafter, an assessment of the distribution of long-term health care services by geographic area, with particular attention to service deficits or problems, the designation of critical access service sites, and corrective action plans.

Subd. 2. [CRITICAL ACCESS SERVICE SITE.] "Critical access service site" shall include nursing homes, senior housing, housing with services, and home and community-based services that are certified by the state as necessary providers of health care services to a specific geographic area. For purposes of this requirement, a "necessary provider of health care services" is a provider that is:

(1) located more than 20 miles, defined as official mileage as reported by the Minnesota department of transportation, from the next nearest long-term health care provider;

(2) the sole long-term health care provider in the county; or

(3) a long-term health care provider located in a medically underserved area or health professional shortage area.

Subd. 3. [IDENTIFICATION OF CRITICAL ACCESS SERVICE SITES.] Based on the results of the analysis completed in subdivision 1, the commissioners of health and human services shall identify and designate long-term health care providers as critical access service sites.

Subd. 4. [CRITICAL ACCESS SERVICE SITES.] The commissioner of health, in consultation with the commissioner of human services, shall:

(1) develop and implement specific waivers to regulations governing health care personnel scope of duties, physical plant requirements, and location of community-based services, to address critical access service site older adult service needs;

(2) identify payment barriers to the continued operation of older adult services in critical access service sites, and provide recommendations on changes to reimbursement rates to facilitate the continued operation of these services.

Sec. 2. Minnesota Statutes 2000, section 256.973, is amended by adding a subdivision to read:

Subd. 6. [GRANTS FOR HOME-SHARING PROGRAMS.] Grants awarded for home-sharing programs under this section shall be awarded through a request for proposals process every two years according to criteria developed by the commissioner. In awarding grants, the commissioner

shall not give priority to an applicant solely because the applicant has previously received a grant under this section. Nothing under this subdivision shall prohibit the commissioner from evaluating the performance of a home-sharing program receiving a grant under this section and allocating funds based on the evaluation.

Sec. 3. Minnesota Statutes 2000, section 256.975, is amended by adding a subdivision to read:

Subd. 7. [CONSUMER INFORMATION AND ASSISTANCE; SENIOR LINKAGE.] (a) The Minnesota board on aging shall operate a statewide information and assistance service to aid older Minnesotans and their families in making informed choices about long-term care options and health care benefits. Language services to persons with limited English language skills may be made available. The service, known as Senior LinkAge Line, must be available during business hours through a statewide toll-free number and must also be available through the Internet.

(b) The service must assist older adults, caregivers, and providers in accessing information about choices in long-term care services that are purchased through private providers or available through public options. The service must:

(1) develop a comprehensive database that includes detailed listings in both consumer- and provider-oriented formats;

(2) make the database accessible on the Internet and through other telecommunication and media-related tools;

(3) link callers to interactive long-term care screening tools and make these tools available through the Internet by integrating the tools with the database;

(4) develop community education materials with a focus on planning for long-term care and evaluating independent living, housing, and service options;

(5) conduct an outreach campaign to assist older adults and their caregivers in finding information on the Internet and through other means of communication;

(6) implement a messaging system for overflow callers and respond to these callers by the next business day;

(7) link callers with county human services and other providers to receive more in-depth assistance and consultation related to long-term care options; and

(8) link callers with quality profiles for nursing facilities and other providers developed by the commissioner of health.

(c) The Minnesota board on aging shall conduct an evaluation of the effectiveness of the statewide information and assistance, and submit this evaluation to the legislature by December 1, 2002. The evaluation must include an analysis of funding adequacy, gaps in service delivery, continuity in information between the service and identified linkages, and potential use of private funding to enhance the service.

Sec. 4. [256.9754] [COMMUNITY SERVICES DEVELOPMENT GRANTS PROGRAM.]

Subdivision 1. [DEFINITIONS.] For purposes of this section, the following terms have the meanings given.

(a) "Community" means a town, township, city, or targeted neighborhood within a city, or a consortium of towns, townships, cities, or targeted neighborhoods within cities.

(b) "Older adult services" means any services available under the elderly waiver program or alternative care grant programs; nursing facility services; transportation services; respite services; and other community-based services identified as necessary either to maintain lifestyle choices for older Minnesotans, or to promote independence.

(c) "Older adult" refers to individuals 65 years of age and older.

Subd. 2. [CREATION.] The community services development grants program is created under the administration of the commissioner of human services.

Subd. 3. [PROVISION OF GRANTS.] The commissioner shall make grants available to communities, providers of older adult services identified in subdivision 1, or to a consortium of providers of older adult services, to establish older adult services. Grants may be provided for capital and other costs including, but not limited to, start-up and training costs, equipment, and supplies related to older adult services or other residential or service alternatives to nursing facility care. Grants may also be made to renovate current buildings, provide transportation services, fund programs that would allow older adults or disabled individuals to stay in their own homes by sharing a home, fund programs that coordinate and manage formal and informal services to older adults in their homes to enable them to live as independently as possible in their own homes as an alternative to nursing home care, or expand state-funded programs in the area.

Subd. 4. [ELIGIBILITY.] Grants may be awarded only to communities and providers or to a consortium of providers that have a local match of 50 percent of the costs for the project in the form of donations, local tax dollars, in-kind donations, fundraising, or other local matches.

Subd. 5. [GRANT PREFERENCE.] The commissioner of human services may award grants to the extent grant funds are available and to the extent applications are approved by the commissioner. Denial of approval of an application in one year does not preclude submission of an application in a subsequent year. The maximum grant amount is limited to $750,000.

Sec. 5. Minnesota Statutes 2000, section 256B.0911, subdivision 1, is amended to read:

Subdivision 1. [PURPOSE AND GOAL.] (a) The purpose of ~~the preadmission screening program~~ long-term care consultation services is to assist persons with long-term or chronic care needs in making long-term care decisions and selecting options that meet their needs and reflect their preferences. The availability of, and access to, information and other types of assistance is also intended to prevent or delay certified nursing facility placements ~~by assessing applicants and residents and offering cost-effective alternatives appropriate for the person's needs~~ and to provide transition assistance after admission. Further, the goal of ~~the program~~ these services is to contain costs associated with unnecessary certified nursing facility admissions. The commissioners of human services and health shall seek to maximize use of available federal and state funds and establish the broadest program possible within the funding available.

(b) These services must be coordinated with services provided under sections 256.975, subdivision 7, and 256.9772, and with services provided by other public and private agencies in the community to offer a variety of cost-effective alternatives to persons with disabilities and elderly persons. The county agency providing long-term care consultation services shall encourage the use of volunteers from families, religious organizations, social clubs, and similar civic and service organizations to provide community-based services.

Sec. 6. Minnesota Statutes 2000, section 256B.0911, is amended by adding a subdivision to read:

Subd. 1a. [DEFINITIONS.] For purposes of this section, the following definitions apply:

(a) "Long-term care consultation services" means:

(1) providing information and education to the general public regarding availability of the services authorized under this section;

(2) an intake process that provides access to the services described in this section;

(3) assessment of the health, psychological, and social needs of referred individuals;

(4) assistance in identifying services needed to maintain an individual in the least restrictive environment;

(5) providing recommendations on cost-effective community services that are available to the individual;

(6) development of an individual's community support plan;

(7) providing information regarding eligibility for Minnesota health care programs;

(8) preadmission screening to determine the need for a nursing facility level of care;

(9) preliminary determination of Minnesota health care programs eligibility for individuals who need a nursing facility level of care, with appropriate referrals for final determination;

(10) providing recommendations for nursing facility placement when there are no cost-effective community services available; and

(11) assistance to transition people back to community settings after facility admission.

(b) "Minnesota health care programs" means the medical assistance program under chapter 256B, the alternative care program under section 256B.0913, and the prescription drug program under section 256.955.

Sec. 7. Minnesota Statutes 2000, section 256B.0911, subdivision 3, is amended to read:

Subd. 3. [~~PERSONS RESPONSIBLE FOR CONDUCTING THE PREADMISSION SCREENING~~ LONG-TERM CARE CONSULTATION TEAM.] (a) A ~~local screening~~ long-term care consultation team shall be established by the county board of commissioners. Each local ~~screening~~ consultation team shall consist of ~~screeners who are a~~ at least one social worker and ~~a~~ at least one public health nurse from their respective county agencies. The board may designate public health or social services as the lead agency for long-term care consultation services. If a county does not have a public health nurse available, it may request approval from the commissioner to assign a county registered nurse with at least one year experience in home care to participate on the team. ~~The screening team members must confer regarding the most appropriate care for each individual screened.~~ Two or more counties may collaborate to establish a joint local ~~screening~~ consultation team or teams.

(b) ~~In assessing a person's needs, screeners shall have a physician available for consultation and shall consider the assessment of the individual's attending physician, if any. The individual's physician shall be included if the physician chooses to participate. Other personnel may be included on the team as deemed appropriate by the county agencies.~~ The team is responsible for providing long-term care consultation services to all persons located in the county who request the services, regardless of eligibility for Minnesota health care programs.

Sec. 8. Minnesota Statutes 2000, section 256B.0911, is amended by adding a subdivision to read:

Subd. 3a. [ASSESSMENT AND SUPPORT PLANNING.] (a) Persons requesting assessment, services planning, or other assistance intended to support community-based living must be visited by a long-term care consultation team within ten working days after the date on which an assessment was requested or recommended. Assessments must be conducted according to paragraphs (b) to (g).

(b) The county may utilize a team of either the social worker or public health nurse, or both, to conduct the assessment in a face-to-face interview. The consultation team members must confer regarding the most appropriate care for each individual screened or assessed.

(c) The long-term care consultation team must assess the health and social needs of the person, using an assessment form provided by the commissioner of human services.

(d) The team must conduct the assessment in a face-to-face interview with the person being assessed and the person's legal representative, if applicable.

(e) The team must provide the person, or the person's legal representative, with written recommendations for facility- or community-based services. The team must document that the most cost-effective alternatives available were offered to the individual. For purposes of this

requirement, "cost-effective alternatives" means community services and living arrangements that cost the same as or less than nursing facility care.

(f) If the person chooses to use community-based services, the team must provide the person or the person's legal representative with a written community support plan, regardless of whether the individual is eligible for Minnesota health care programs. The person may request assistance in developing a community support plan without participating in a complete assessment.

(g) The team must give the person receiving assessment or support planning, or the person's legal representative, materials supplied by the commissioner of human services containing the following information:

(1) the purpose of preadmission screening and assessment;

(2) information about Minnesota health care programs;

(3) the person's freedom to accept or reject the recommendations of the team;

(4) the person's right to confidentiality under the Minnesota Government Data Practices Act, chapter 13; and

(5) the person's right to appeal the decision regarding the need for nursing facility level of care or the county's final decisions regarding public programs eligibility according to section 256.045, subdivision 3.

Sec. 9. Minnesota Statutes 2000, section 256B.0911, is amended by adding a subdivision to read:

Subd. 3b. [TRANSITION ASSISTANCE.] (a) A long-term care consultation team shall provide assistance to persons residing in a nursing facility, hospital, regional treatment center, or intermediate care facility for persons with mental retardation who request or are referred for such assistance. Transition assistance must include assessment, community support plan development, referrals to Minnesota health care programs, and referrals to programs that provide assistance with housing.

(b) The county shall develop transition processes with institutional social workers and discharge planners to ensure that:

(1) persons admitted to facilities receive information about transition assistance that is available;

(2) the assessment is completed for persons within ten working days of the date of request or recommendation for assessment; and

(3) there is a plan for transition and follow-up for the individual's return to the community. The plan must require notification of other local agencies when a person who may require assistance is screened by one county for admission to a facility located in another county.

(c) If a person who is eligible for a Minnesota health care program is admitted to a nursing facility, the nursing facility must include a consultation team member or the case manager in the discharge planning process.

Sec. 10. Minnesota Statutes 2000, section 256B.0911, is amended by adding a subdivision to read:

Subd. 4a. [PREADMISSION SCREENING ACTIVITIES RELATED TO NURSING FACILITY ADMISSIONS.] (a) All applicants to Medicaid certified nursing facilities, including certified boarding care facilities, must be screened prior to admission regardless of income, assets, or funding sources for nursing facility care, except as described in subdivision 4b. The purpose of the screening is to determine the need for nursing facility level of care as described in paragraph (d) and to complete activities required under federal law related to mental illness and mental retardation as outlined in paragraph (b).

(b) A person who has a diagnosis or possible diagnosis of mental illness, mental retardation, or a related condition must receive a preadmission screening before admission regardless of the exemptions outlined in subdivision 4b, paragraph (b), to identify the need for further evaluation and specialized services, unless the admission prior to screening is authorized by the local mental health authority or the local developmental disabilities case manager, or unless authorized by the county agency according to Public Law Number 100-508.

The following criteria apply to the preadmission screening:

(1) the county must use forms and criteria developed by the commissioner of human services to identify persons who require referral for further evaluation and determination of the need for specialized services; and

(2) the evaluation and determination of the need for specialized services must be done by:

(i) a qualified independent mental health professional, for persons with a primary or secondary diagnosis of a serious mental illness; or

(ii) a qualified mental retardation professional, for persons with a primary or secondary diagnosis of mental retardation or related conditions. For purposes of this requirement, a qualified mental retardation professional must meet the standards for a qualified mental retardation professional under Code of Federal Regulations, title 42, section 483.430.

(c) The local county mental health authority or the state mental retardation authority under Public Laws Numbers 100-203 and 101-508 may prohibit admission to a nursing facility if the individual does not meet the nursing facility level of care criteria or needs specialized services as defined in Public Laws Numbers 100-203 and 101-508. For purposes of this section, "specialized services" for a person with mental retardation or a related condition means active treatment as that term is defined under Code of Federal Regulations, title 42, section 483.440, paragraph (a), clause (1).

(d) The determination of the need for nursing facility level of care must be made according to criteria developed by the commissioner of human services. In assessing a person's needs, consultation team members shall have a physician available for consultation and shall consider the assessment of the individual's attending physician, if any. The individual's physician must be included if the physician chooses to participate. Other personnel may be included on the team as deemed appropriate by the county.

Sec. 11. Minnesota Statutes 2000, section 256B.0911, is amended by adding a subdivision to read:

Subd. 4b. [EXEMPTIONS AND EMERGENCY ADMISSIONS.] (a) Exemptions from the federal screening requirements outlined in subdivision 4a, paragraphs (b) and (c), are limited to:

(1) a person who, having entered an acute care facility from a certified nursing facility, is returning to a certified nursing facility; and

(2) a person transferring from one certified nursing facility in Minnesota to another certified nursing facility in Minnesota.

(b) Persons who are exempt from preadmission screening for purposes of level of care determination include:

(1) persons described in paragraph (a);

(2) an individual who has a contractual right to have nursing facility care paid for indefinitely by the veterans' administration;

(3) an individual enrolled in a demonstration project under section 256B.69, subdivision 8, at the time of application to a nursing facility;

(4) an individual currently being served under the alternative care program or under a home and

community-based services waiver authorized under section 1915(c) of the federal Social Security Act; and

(5) individuals admitted to a certified nursing facility for a short-term stay, which is expected to be 14 days or less in duration based upon a physician's certification, and who have been assessed and approved for nursing facility admission within the previous six months. This exemption applies only if the consultation team member determines at the time of the initial assessment of the six-month period that it is appropriate to use the nursing facility for short-term stays and that there is an adequate plan of care for return to the home or community-based setting. If a stay exceeds 14 days, the individual must be referred no later than the first county working day following the 14th resident day for a screening, which must be completed within five working days of the referral. The payment limitations in subdivision 7 apply to an individual found at screening to not meet the level of care criteria for admission to a certified nursing facility.

(c) Persons admitted to a Medicaid-certified nursing facility from the community on an emergency basis as described in paragraph (d) or from an acute care facility on a nonworking day must be screened the first working day after admission.

(d) Emergency admission to a nursing facility prior to screening is permitted when all of the following conditions are met:

(1) a person is admitted from the community to a certified nursing or certified boarding care facility during county nonworking hours;

(2) a physician has determined that delaying admission until preadmission screening is completed would adversely affect the person's health and safety;

(3) there is a recent precipitating event that precludes the client from living safely in the community, such as sustaining an injury, sudden onset of acute illness, or a caregiver's inability to continue to provide care;

(4) the attending physician has authorized the emergency placement and has documented the reason that the emergency placement is recommended; and

(5) the county is contacted on the first working day following the emergency admission.

Transfer of a patient from an acute care hospital to a nursing facility is not considered an emergency except for a person who has received hospital services in the following situations: hospital admission for observation, care in an emergency room without hospital admission, or following hospital 24-hour bed care.

Sec. 12. Minnesota Statutes 2000, section 256B.0911, is amended by adding a subdivision to read:

Subd. 4c. [SCREENING REQUIREMENTS.] (a) A person may be screened for nursing facility admission by telephone or in a face-to-face screening interview. Consultation team members shall identify each individual's needs using the following categories:

(1) the person needs no face-to-face screening interview to determine the need for nursing facility level of care based on information obtained from other health care professionals;

(2) the person needs an immediate face-to-face screening interview to determine the need for nursing facility level of care and complete activities required under subdivision 4a; or

(3) the person may be exempt from screening requirements as outlined in subdivision 4b, but will need transitional assistance after admission or in-person follow-along after a return home.

(b) Persons admitted on a nonemergency basis to a Medicaid-certified nursing facility must be screened prior to admission.

(c) The long-term care consultation team shall recommend a case mix classification for persons admitted to a certified nursing facility when sufficient information is received to make that

classification. The nursing facility is authorized to conduct all case mix assessments for persons who have been screened prior to admission for whom the county did not recommend a case mix classification. The nursing facility is authorized to conduct all case mix assessments for persons admitted to the facility prior to a preadmission screening. The county retains the responsibility of distributing appropriate case mix forms to the nursing facility.

(d) The county screening or intake activity must include processes to identify persons who may require transition assistance as described in subdivision 3b.

Sec. 13. Minnesota Statutes 2000, section 256B.0911, subdivision 5, is amended to read:

Subd. 5. [~~SIMPLIFICATION OF FORMS~~ ADMINISTRATIVE ACTIVITY.] The commissioner shall minimize the number of forms required in the ~~preadmission screening process~~ provision of long-term care consultation services and shall limit the screening document to items necessary for ~~care~~ community support plan approval, reimbursement, program planning, evaluation, and policy development.

Sec. 14. Minnesota Statutes 2000, section 256B.0911, subdivision 6, is amended to read:

Subd. 6. [PAYMENT FOR ~~PREADMISSION SCREENING~~ LONG-TERM CARE CONSULTATION SERVICES.] (a) The total ~~screening~~ payment for each county must be paid monthly by certified nursing facilities in the county. The monthly amount to be paid by each nursing facility for each fiscal year must be determined by dividing the county's annual allocation for ~~screenings~~ long-term care consultation services by 12 to determine the monthly payment and allocating the monthly payment to each nursing facility based on the number of licensed beds in the nursing facility. Payments to counties in which there is no certified nursing facility must be made by increasing the payment rate of the two facilities located nearest to the county seat.

(b) The commissioner shall include the total annual payment ~~for screening~~ determined under paragraph (a) for each nursing facility according to section 256B.431, subdivision 2b, paragraph (g), 256B.434, or 256B.435.

(c) Payments for ~~screening activities~~ long-term care consultation services are available to the county or counties to cover staff salaries and expenses to provide the ~~screening function~~ services described in subdivision 1a. The ~~lead agency~~ county shall employ, or contract with other agencies to employ, within the limits of available funding, sufficient personnel to ~~conduct the preadmission screening activity~~ provide long-term care consultation services while meeting the state's long-term care outcomes and objectives as defined in section 256B.0917, subdivision 1. The ~~local agency~~ county shall be accountable for meeting local objectives as approved by the commissioner in the CSSA biennial plan.

(d) Notwithstanding section 256B.0641, overpayments attributable to payment of the screening costs under the medical assistance program may not be recovered from a facility.

(e) The commissioner of human services shall amend the Minnesota medical assistance plan to include reimbursement for the local ~~screening~~ consultation teams.

(f) The county may bill, as case management services, assessments, support planning, and follow-along provided to persons determined to be eligible for case management under Minnesota health care programs. No individual or family member shall be charged for an initial assessment or initial support plan development provided under subdivision 3a or 3b.

Sec. 15. Minnesota Statutes 2000, section 256B.0911, subdivision 7, is amended to read:

Subd. 7. [REIMBURSEMENT FOR CERTIFIED NURSING FACILITIES.] (a) Medical assistance reimbursement for nursing facilities shall be authorized for a medical assistance recipient only if a preadmission screening has been conducted prior to admission or the ~~local~~ county ~~agency~~ has authorized an exemption. Medical assistance reimbursement for nursing facilities shall not be provided for any recipient who the local screener has determined does not meet the level of care criteria for nursing facility placement or, if indicated, has not had a level II ~~PASARR~~ OBRA evaluation as required under the federal Omnibus Reconciliation Act of 1987

completed unless an admission for a recipient with mental illness is approved by the local mental health authority or an admission for a recipient with mental retardation or related condition is approved by the state mental retardation authority.

(b) The nursing facility must not bill a person who is not a medical assistance recipient for resident days that preceded the date of completion of screening activities as required under subdivisions 4a, 4b, and 4c. The nursing facility must include unreimbursed resident days in the nursing facility resident day totals reported to the commissioner.

(c) The commissioner shall make a request to the health care financing administration for a waiver allowing screening team approval of Medicaid payments for certified nursing facility care. An individual has a choice and makes the final decision between nursing facility placement and community placement after the screening team's recommendation, except as provided in ~~paragraphs (b) and (c)~~ subdivision 4a, paragraph (c).

~~(c) The local county mental health authority or the state mental retardation authority under Public Law Numbers 100-203 and 101-508 may prohibit admission to a nursing facility, if the individual does not meet the nursing facility level of care criteria or needs specialized services as defined in Public Law Numbers 100-203 and 101-508. For purposes of this section, "specialized services" for a person with mental retardation or a related condition means "active treatment" as that term is defined in Code of Federal Regulations, title 42, section 483.440(a)(1).~~

~~(e) Appeals from the screening team's recommendation or the county agency's final decision shall be made according to section 256.045, subdivision 3.~~

Sec. 16. Minnesota Statutes 2000, section 256B.0913, subdivision 1, is amended to read:

Subdivision 1. [PURPOSE AND GOALS.] The purpose of the alternative care program is to provide funding for ~~or access to~~ home and community-based services for ~~frail~~ elderly persons, in order to limit nursing facility placements. The program is designed to support ~~frail~~ elderly persons in their desire to remain in the community as independently and as long as possible and to support informal caregivers in their efforts to provide care for ~~frail~~ elderly people. Further, the goals of the program are:

(1) to contain medical assistance expenditures by ~~providing~~ funding care in the community ~~at a cost the same or less than nursing facility costs~~; and

(2) to maintain the moratorium on new construction of nursing home beds.

Sec. 17. Minnesota Statutes 2000, section 256B.0913, subdivision 2, is amended to read:

Subd. 2. [ELIGIBILITY FOR SERVICES.] Alternative care services are available to ~~all frail older~~ Minnesotans~~. This includes:~~

~~(1) persons who are receiving medical assistance and served under the medical assistance program or the Medicaid waiver program;~~

~~(2) persons~~ age 65 or older who are not eligible for medical assistance without a spenddown or waiver obligation but who would be eligible for medical assistance within 180 days of admission to a nursing facility and ~~served under~~ subject to subdivisions 4 to 13~~; and~~

~~(3) persons who are paying for their services out-of-pocket~~.

Sec. 18. Minnesota Statutes 2000, section 256B.0913, subdivision 4, is amended to read:

Subd. 4. [ELIGIBILITY FOR FUNDING FOR SERVICES FOR NONMEDICAL ASSISTANCE RECIPIENTS.] (a) Funding for services under the alternative care program is available to persons who meet the following criteria:

(1) the person has been ~~screened by the county screening team or, if previously screened and served under the alternative care program, assessed by the local county social worker or public health nurse~~ determined by a community assessment under section 256B.0911, to be a person who

would require the level of care provided in a nursing facility, but for the provision of services under the alternative care program;

(2) the person is age 65 or older;

(3) the person would be ~~financially~~ eligible for medical assistance within 180 days of admission to a nursing facility;

(4) the person ~~meets the asset transfer requirements of~~ is not ineligible for the medical assistance program due to an asset transfer penalty;

(5) ~~the screening team would recommend nursing facility admission or continued stay for the person if alternative care services were not available;~~

~~(6)~~ the person needs services that are not ~~available at that time in the county~~ funded through other ~~county,~~ state~~,~~ or federal funding ~~sources~~; and

~~(7)~~ (6) the monthly cost of the alternative care services funded by the program for this person does not exceed 75 percent of the statewide ~~average monthly medical assistance payment for nursing facility care at the individual's case mix classification~~ weighted average monthly nursing facility rate of the case mix resident class to which the individual alternative care client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, less the recipient's maintenance needs allowance as described in section 256B.0915, subdivision 1d, paragraph (a), until the first day of the state fiscal year in which the resident assessment system, under section 256B.437, for nursing home rate determination is implemented. Effective on the first day of the state fiscal year in which a resident assessment system, under section 256B.437, for nursing home rate determination is implemented and the first day of each subsequent state fiscal year, the monthly cost of alternative care services for this person shall not exceed the alternative care monthly cap for the case mix resident class to which the alternative care client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, which was in effect on the last day of the previous state fiscal year, and adjusted by the greater of any legislatively adopted home and community-based services cost-of-living percentage increase or any legislatively adopted statewide percent rate increase for nursing facilities. This monthly limit does not prohibit the alternative care client from payment for additional services, but in no case may the cost of additional services purchased under this section exceed the difference between the client's monthly service limit defined under section 256B.0915, subdivision 3, and the alternative care program monthly service limit defined in this paragraph. If medical supplies and equipment or ~~adaptations~~ environmental modifications are or will be purchased for an alternative care services recipient, the costs may be prorated on a monthly basis ~~throughout the year in which they are purchased~~ for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's other alternative care services exceeds the monthly limit established in this paragraph, the annual cost of the alternative care services shall be determined. In this event, the annual cost of alternative care services shall not exceed 12 times the monthly limit ~~calculated~~ described in this paragraph.

(b) ~~Individuals who meet the criteria in paragraph (a) and who have been approved for alternative care funding are called 180-day eligible clients.~~

~~(c) The statewide average payment for nursing facility care is the statewide average monthly nursing facility rate in effect on July 1 of the fiscal year in which the cost is incurred, less the statewide average monthly income of nursing facility residents who are age 65 or older and who are medical assistance recipients in the month of March of the previous fiscal year. This monthly limit does not prohibit the 180-day eligible client from paying for additional services needed or desired.~~

~~(d) In determining the total costs of alternative care services for one month, the costs of all services funded by the alternative care program, including supplies and equipment, must be included.~~

~~(e)~~ Alternative care funding under this subdivision is not available for a person who is a

medical assistance recipient or who would be eligible for medical assistance without a spenddown~~, unless authorized by the commissioner~~ or waiver obligation. A person whose initial application for medical assistance is being processed may be served under the alternative care program for a period up to 60 days. If the individual is found to be eligible for medical assistance, ~~the county must bill~~ medical assistance must be billed for services payable under the federally approved elderly waiver plan and delivered from the date the individual was found eligible for ~~services reimbursable under~~ the federally approved elderly waiver ~~program~~ plan. Notwithstanding this provision, upon federal approval, alternative care funds may not be used to pay for any service the cost of which is payable by medical assistance or which is used by a recipient to meet a medical assistance income spenddown or waiver obligation.

~~(f)~~ (c) Alternative care funding is not available for a person who resides in a licensed nursing home ~~or~~, certified boarding care home, hospital, or intermediate care facility, except for case management services which are ~~being~~ provided in support of the discharge planning process to a nursing home resident or certified boarding care home resident who is ineligible for case management funded by medical assistance.

Sec. 19. Minnesota Statutes 2000, section 256B.0913, subdivision 5, is amended to read:

Subd. 5. [SERVICES COVERED UNDER ALTERNATIVE CARE.] (a) Alternative care funding may be used for payment of costs of:

(1) adult foster care;

(2) adult day care;

(3) home health aide;

(4) homemaker services;

(5) personal care;

(6) case management;

(7) respite care;

(8) assisted living;

(9) residential care services;

(10) care-related supplies and equipment;

(11) meals delivered to the home;

(12) transportation;

(13) skilled nursing;

(14) chore services;

(15) companion services;

(16) nutrition services;

(17) training for direct informal caregivers;

(18) telemedicine devices to monitor recipients in their own homes as an alternative to hospital care, nursing home care, or home visits; ~~and~~

(19) other services ~~including~~ which includes discretionary funds and direct cash payments to clients, ~~approved by the county agency~~ following approval by the commissioner, subject to the provisions of paragraph ~~(m)~~ (j). Total annual payments for " other services" for all clients within a county may not exceed either ten percent of that county's annual alternative care program base

allocation or $5,000, whichever is greater. In no case shall this amount exceed the county's total annual alternative care program base allocation; and

(20) environmental modifications.

(b) The county agency must ensure that the funds are not used ~~only to supplement and not~~ to supplant services available through other public assistance or services programs.

(c) Unless specified in statute, the service definitions and standards for alternative care services shall be the same as the service definitions and standards ~~defined~~ specified in the federally approved elderly waiver plan. Except for the county agencies' approval of direct cash payments to clients as described in paragraph (j) or for a provider of supplies and equipment when the monthly cost of the supplies and equipment is less than $250, persons or agencies must be employed by or under a contract with the county agency or the public health nursing agency of the local board of health in order to receive funding under the alternative care program. Supplies and equipment may be purchased from a non-Medicaid certified vendor if the cost for the item is less than that of a Medicaid vendor.

(d) The adult foster care rate shall be considered a difficulty of care payment and shall not include room and board. The adult foster care ~~daily~~ rate shall be negotiated between the county agency and the foster care provider. ~~The rate established under this section shall not exceed 75 percent of the state average monthly nursing home payment for the case mix classification to which the individual receiving foster care is assigned, and it must allow for other alternative care services to be authorized by the case manager.~~ The alternative care payment for the foster care service in combination with the payment for other alternative care services, including case management, must not exceed the limit specified in subdivision 4, paragraph (a), clause (6).

(e) Personal care services ~~may be provided by a personal care provider organization.~~ must meet the service standards defined in the federally approved elderly waiver plan, except that a county agency may contract with a client's relative ~~of the client~~ who meets the relative hardship waiver requirement as defined in section 256B.0627, subdivision 4, paragraph (b), clause (10), to provide personal care services~~, but must ensure nursing~~ if the county agency ensures supervision of this service by a registered nurse or mental health practitioner. ~~Covered personal care services defined in section 256B.0627, subdivision 4, must meet applicable standards in Minnesota Rules, part 9505.0335.~~

(f) ~~A county may use alternative care funds to purchase medical supplies and equipment without prior approval from the commissioner when: (1) there is no other funding source; (2) the supplies and equipment are specified in the individual's care plan as medically necessary to enable the individual to remain in the community according to the criteria in Minnesota Rules, part 9505.0210, item A; and (3) the supplies and equipment represent an effective and appropriate use of alternative care funds. A county may use alternative care funds to purchase supplies and equipment from a non-Medicaid certified vendor if the cost for the items is less than that of a Medicaid vendor. A county is not required to contract with a provider of supplies and equipment if the monthly cost of the supplies and equipment is less than $250.~~

~~(g)~~ For purposes of this section, residential care services are services which are provided to individuals living in residential care homes. Residential care homes are currently licensed as board and lodging establishments and are registered with the department of health as providing special services under section 157.17 and are not subject to registration under chapter 144D. Residential care services are defined as "supportive services" and "health-related services." "Supportive services" means the provision of up to 24-hour supervision and oversight. Supportive services includes: (1) transportation, when provided by the residential care ~~center~~ home only; (2) socialization, when socialization is part of the plan of care, has specific goals and outcomes established, and is not diversional or recreational in nature; (3) assisting clients in setting up meetings and appointments; (4) assisting clients in setting up medical and social services; (5) providing assistance with personal laundry, such as carrying the client's laundry to the laundry room. Assistance with personal laundry does not include any laundry, such as bed linen, that is included in the room and board rate. "Health-related services" are limited to minimal assistance with dressing, grooming, and bathing and providing reminders to residents to take medications

that are self-administered or providing storage for medications, if requested. Individuals receiving residential care services cannot receive homemaking services funded under this section.

~~(h)~~ (g) For the purposes of this section, "assisted living" refers to supportive services provided by a single vendor to clients who reside in the same apartment building of three or more units which are not subject to registration under chapter 144D and are licensed by the department of health as a class A home care provider or a class E home care provider. Assisted living services are defined as up to 24-hour supervision, and oversight, supportive services as defined in clause (1), individualized home care aide tasks as defined in clause (2), and individualized home management tasks as defined in clause (3) provided to residents of a residential center living in their units or apartments with a full kitchen and bathroom. A full kitchen includes a stove, oven, refrigerator, food preparation counter space, and a kitchen utensil storage compartment. Assisted living services must be provided by the management of the residential center or by providers under contract with the management or with the county.

(1) Supportive services include:

(i) socialization, when socialization is part of the plan of care, has specific goals and outcomes established, and is not diversional or recreational in nature;

(ii) assisting clients in setting up meetings and appointments; and

(iii) providing transportation, when provided by the residential center only.

~~Individuals receiving assisted living services will not receive both assisted living services and homemaking services. Individualized means services are chosen and designed specifically for each resident's needs, rather than provided or offered to all residents regardless of their illnesses, disabilities, or physical conditions.~~

(2) Home care aide tasks means:

(i) preparing modified diets, such as diabetic or low sodium diets;

(ii) reminding residents to take regularly scheduled medications or to perform exercises;

(iii) household chores in the presence of technically sophisticated medical equipment or episodes of acute illness or infectious disease;

(iv) household chores when the resident's care requires the prevention of exposure to infectious disease or containment of infectious disease; and

(v) assisting with dressing, oral hygiene, hair care, grooming, and bathing, if the resident is ambulatory, and if the resident has no serious acute illness or infectious disease. Oral hygiene means care of teeth, gums, and oral prosthetic devices.

(3) Home management tasks means:

(i) housekeeping;

(ii) laundry;

(iii) preparation of regular snacks and meals; and

(iv) shopping.

Individuals receiving assisted living services shall not receive both assisted living services and homemaking services. Individualized means services are chosen and designed specifically for each resident's needs, rather than provided or offered to all residents regardless of their illnesses, disabilities, or physical conditions. Assisted living services as defined in this section shall not be authorized in boarding and lodging establishments licensed according to sections 157.011 and 157.15 to 157.22.

~~(i)~~ (h) For establishments registered under chapter 144D, assisted living services under this section means either the services described ~~and licensed~~ in paragraph (g) and delivered by a class E home care provider licensed by the department of health or the services described under section 144A.4605 and delivered by an assisted living home care provider or a class A home care provider licensed by the commissioner of health.

~~(j) For the purposes of this section, reimbursement~~ (i) Payment for assisted living services and residential care services shall be a monthly rate negotiated and authorized by the county agency based on an individualized service plan for each resident and may not cover direct rent or food costs. ~~The rate~~

(1) The individualized monthly negotiated payment for assisted living services as described in paragraph (g) or (h), and residential care services as described in paragraph (f), shall not exceed the nonfederal share in effect on July 1 of the state fiscal year for which the rate limit is being calculated of the greater of either the statewide or any of the geographic groups' weighted average monthly ~~medical assistance~~ nursing facility payment rate of the case mix resident class to which the ~~180-day~~ alternative care eligible client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, ~~unless the~~ less the maintenance needs allowance as described in subdivision 1d, paragraph (a), until the first day of the state fiscal year in which a resident assessment system, under section 256B.437, of nursing home rate determination is implemented. Effective on the first day of the state fiscal year in which a resident assessment system, under section 256B.437, of nursing home rate determination is implemented and the first day of each subsequent state fiscal year, the individualized monthly negotiated payment for the services described in this clause shall not exceed the limit described in this clause which was in effect on the last day of the previous state fiscal year and which has been adjusted by the greater of any legislatively adopted home and community-based services cost-of-living percentage increase or any legislatively adopted statewide percent rate increase for nursing facilities.

(2) The individualized monthly negotiated payment for assisted living services ~~are provided by a home care~~ described under section 144A.4605 and delivered by a provider licensed by the department of health as a class A home care provider or an assisted living home care provider and ~~are~~ provided in a building that is registered as a housing with services establishment under chapter 144D and that provides 24-hour supervision in combination with the payment for other alternative care services, including case management, must not exceed the limit specified in subdivision 4, paragraph (a), clause (6).

~~(k) For purposes of this section, companion services are defined as nonmedical care, supervision and oversight, provided to a functionally impaired adult. Companions may assist the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on medical care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the recipient. This service must be approved by the case manager as part of the care plan. Companion services must be provided by individuals or organizations who are under contract with the local agency to provide the service. Any person related to the waiver recipient by blood, marriage or adoption cannot be reimbursed under this service. Persons providing companion services will be monitored by the case manager.~~

~~(l) For purposes of this section, training for direct informal caregivers is defined as a classroom or home course of instruction which may include: transfer and lifting skills, nutrition, personal and physical cares, home safety in a home environment, stress reduction and management, behavioral management, long-term care decision making, care coordination and family dynamics. The training is provided to an informal unpaid caregiver of a 180-day eligible client which enables the caregiver to deliver care in a home setting with high levels of quality. The training must be approved by the case manager as part of the individual care plan. Individuals, agencies, and educational facilities which provide caregiver training and education will be monitored by the case manager.~~

~~(m)~~ (j) A county agency may make payment from their alternative care program allocation for "other services" ~~provided to an alternative care program recipient if those services prevent,~~

~~shorten, or delay institutionalization. These services may~~ which include use of "discretionary funds" for services that are not otherwise defined in this section and direct cash payments to the ~~recipient~~ client for the purpose of purchasing the ~~recipient's~~ services. The following provisions apply to payments under this paragraph:

(1) a cash payment to a client under this provision cannot exceed 80 percent of the monthly payment limit for that client as specified in subdivision 4, paragraph (a), clause ~~(7)~~ (6);

(2) a county may not approve any cash payment for a client who meets either of the following:

(i) has been assessed as having a dependency in orientation, unless the client has an authorized representative ~~under section 256.476, subdivision 2, paragraph (g), or for a client who~~. An "authorized representative" means an individual who is at least 18 years of age and is designated by the person or the person's legal representative to act on the person's behalf. This individual may be a family member, guardian, representative payee, or other individual designated by the person or the person's legal representative, if any, to assist in purchasing and arranging for supports; or

(ii) is concurrently receiving adult foster care, residential care, or assisted living services;

(3) ~~any service approved under this section must be a service which meets the purpose and goals of the program as listed in subdivision 1;~~

~~(4) cash payments must also meet the criteria of and are governed by the procedures and liability protection established in section 256.476, subdivision 4, paragraphs (b) through (h), and recipients of cash grants must meet the requirements in section 256.476, subdivision 10; and~~ cash payments to a person or a person's family will be provided through a monthly payment and be in the form of cash, voucher, or direct county payment to vendor. Fees or premiums assessed to the person for eligibility for health and human services are not reimbursable through this service option. Services and goods purchased through cash payments must be identified in the person's individualized care plan and must meet all of the following criteria:

(i) they must be over and above the normal cost of caring for the person if the person did not have functional limitations;

(ii) they must be directly attributable to the person's functional limitations;

(iii) they must have the potential to be effective at meeting the goals of the program;

(iv) they must be consistent with the needs identified in the individualized service plan. The service plan shall specify the needs of the person and family, the form and amount of payment, the items and services to be reimbursed, and the arrangements for management of the individual grant; and

(v) the person, the person's family, or the legal representative shall be provided sufficient information to ensure an informed choice of alternatives. The local agency shall document this information in the person's care plan, including the type and level of expenditures to be reimbursed;

(4) the county, lead agency under contract, or tribal government under contract to administer the alternative care program shall not be liable for damages, injuries, or liabilities sustained through the purchase of direct supports or goods by the person, the person's family, or the authorized representative with funds received through the cash payments under this section. Liabilities include, but are not limited to, workers' compensation, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA);

(5) persons receiving grants under this section shall have the following responsibilities:

(i) spend the grant money in a manner consistent with their individualized service plan with the local agency;

(ii) notify the local agency of any necessary changes in the grant-expenditures;

(iii) arrange and pay for supports; and

(iv) inform the local agency of areas where they have experienced difficulty securing or maintaining supports; and

~~(5)~~ (6) the county shall report client outcomes, services, and costs under this paragraph in a manner prescribed by the commissioner.

(k) Upon implementation of direct cash payments to clients under this section, any person determined eligible for the alternative care program who chooses a cash payment approved by the county agency shall receive the cash payment under this section and not under section 256.476 unless the person was receiving a consumer support grant under section 256.476 before implementation of direct cash payments under this section.

Sec. 20. Minnesota Statutes 2000, section 256B.0913, subdivision 6, is amended to read:

Subd. 6. [ALTERNATIVE CARE PROGRAM ADMINISTRATION.] The alternative care program is administered by the county agency. This agency is the lead agency responsible for the local administration of the alternative care program as described in this section. However, it may contract with the public health nursing service to be the lead agency. The commissioner may contract with federally recognized Indian tribes with a reservation in Minnesota to serve as the lead agency responsible for the local administration of the alternative care program as described in the contract.

Sec. 21. Minnesota Statutes 2000, section 256B.0913, subdivision 7, is amended to read:

Subd. 7. [CASE MANAGEMENT.] Providers of case management services for persons receiving services funded by the alternative care program must meet the qualification requirements and standards specified in section 256B.0915, subdivision 1b. The case manager must ~~ensure the health and safety of the individual client and~~ not approve alternative care funding for a client in any setting in which the case manager cannot reasonably ensure the client's health and safety. The case manager is responsible for the cost-effectiveness of the alternative care individual care plan and must not approve any care plan in which the cost of services funded by alternative care and client contributions exceeds the limit specified in section 256B.0915, subdivision 3, paragraph (b). The county may allow a case manager employed by the county to delegate certain aspects of the case management activity to another individual employed by the county provided there is oversight of the individual by the case manager. The case manager may not delegate those aspects which require professional judgment including assessments, reassessments, and care plan development.

Sec. 22. Minnesota Statutes 2000, section 256B.0913, subdivision 8, is amended to read:

Subd. 8. [REQUIREMENTS FOR INDIVIDUAL CARE PLAN.] (a) The case manager shall implement the plan of care for each ~~180-day eligible~~ alternative care client and ensure that a client's service needs and eligibility are reassessed at least every 12 months. The plan shall include any services prescribed by the individual's attending physician as necessary to allow the individual to remain in a community setting. In developing the individual's care plan, the case manager should include the use of volunteers from families and neighbors, religious organizations, social clubs, and civic and service organizations to support the formal home care services. The county shall be held harmless for damages or injuries sustained through the use of volunteers under this subdivision including workers' compensation liability. ~~The lead agency shall provide documentation to the commissioner verifying that the individual's alternative care is not available at that time through any other public assistance or service program.~~ The lead agency shall provide documentation in each individual's plan of care and, if requested, to the commissioner that the most cost-effective alternatives available have been offered to the individual and that the individual was free to choose among available qualified providers, both public and private. The case manager must give the individual a ten-day written notice of any decrease in or termination of alternative care services.

(b) If the county administering alternative care services is different than the county of financial responsibility, the care plan may be implemented without the approval of the county of financial responsibility.

Sec. 23. Minnesota Statutes 2000, section 256B.0913, subdivision 9, is amended to read:

Subd. 9. [CONTRACTING PROVISIONS FOR PROVIDERS.] ~~The lead agency shall document to the commissioner that the agency made reasonable efforts to inform potential providers of the anticipated need for services under the alternative care program or waiver programs under sections 256B.0915 and 256B.49, including a minimum of 14 days' written advance notice of the opportunity to be selected as a service provider and an annual public meeting with providers to explain and review the criteria for selection. The lead agency shall also document to the commissioner that the agency allowed potential providers an opportunity to be selected to contract with the county agency. Funds reimbursed to counties under this subdivision~~ Alternative care funds paid to service providers are subject to audit by the commissioner for fiscal and utilization control.

The lead agency must select providers for contracts or agreements using the following criteria and other criteria established by the county:

(1) the need for the particular services offered by the provider;

(2) the population to be served, including the number of clients, the length of time services will be provided, and the medical condition of clients;

(3) the geographic area to be served;

(4) quality assurance methods, including appropriate licensure, certification, or standards, and supervision of employees when needed;

(5) rates for each service and unit of service exclusive of county administrative costs;

(6) evaluation of services previously delivered by the provider; and

(7) contract or agreement conditions, including billing requirements, cancellation, and indemnification.

The county must evaluate its own agency services under the criteria established for other providers. ~~The county shall provide a written statement of the reasons for not selecting providers.~~

Sec. 24. Minnesota Statutes 2000, section 256B.0913, subdivision 10, is amended to read:

Subd. 10. [ALLOCATION FORMULA.] (a) The alternative care appropriation for fiscal years 1992 and beyond shall cover only ~~180-day~~ alternative care eligible clients. Prior to July 1 of each year, the commissioner shall allocate to county agencies the state funds available for alternative care for persons eligible under subdivision 2.

(b) ~~Prior to July 1 of each year, the commissioner shall allocate to county agencies the state funds available for alternative care for persons eligible under subdivision 2. The allocation for fiscal year 1992 shall be calculated using a base that is adjusted to exclude the medical assistance share of alternative care expenditures. The adjusted base is calculated by multiplying each county's allocation for fiscal year 1991 by the percentage of county alternative care expenditures for 180-day eligible clients. The percentage is determined based on expenditures for services rendered in fiscal year 1989 or calendar year 1989, whichever is greater.~~ The adjusted base for each county is the county's current fiscal year base allocation plus any targeted funds approved during the current fiscal year. Calculations for paragraphs (c) and (d) are to be made as follows: for each county, the determination of alternative care program expenditures shall be based on payments for services rendered from April 1 through March 31 in the base year, to the extent that claims have been submitted and paid by June 1 of that year.

(c) If the ~~county~~ alternative care program expenditures ~~for 180-day eligible clients~~ as defined in

paragraph (b) are 95 percent or more of ~~its~~ the county's adjusted base allocation, the allocation for the next fiscal year is 100 percent of the adjusted base, plus inflation to the extent that inflation is included in the state budget.

(d) If the ~~county~~ alternative care program expenditures ~~for 180-day eligible clients~~ as defined in paragraph (b) are less than 95 percent of ~~its~~ the county's adjusted base allocation, the allocation for the next fiscal year is the adjusted base allocation less the amount of unspent funds below the 95 percent level.

(e) ~~For fiscal year 1992 only, a county may receive an increased allocation if annualized service costs for the month of May 1991 for 180-day eligible clients are greater than the allocation otherwise determined. A county may apply for this increase by reporting projected expenditures for May to the commissioner by June 1, 1991. The amount of the allocation may exceed the amount calculated in paragraph (b). The projected expenditures for May must be based on actual 180-day eligible client caseload and the individual cost of clients' care plans. If a county does not report its expenditures for May, the amount in paragraph (c) or (d) shall be used.~~

~~(f) Calculations for paragraphs (c) and (d) are to be made as follows: for each county, the determination of expenditures shall be based on payments for services rendered from April 1 through March 31 in the base year, to the extent that claims have been submitted by June 1 of that year. Calculations for paragraphs (c) and (d) must also include the funds transferred to the consumer support grant program for clients who have transferred to that program from April 1 through March 31 in the base year.~~

~~(g) For the biennium ending June 30, 2001, the allocation of state funds to county agencies shall be calculated as described in paragraphs (c) and (d).~~ If the annual legislative appropriation for the alternative care program is inadequate to fund the combined county allocations for ~~fiscal year 2000 or 2001~~ a biennium, the commissioner shall distribute to each county the entire annual appropriation as that county's percentage of the computed base as calculated in ~~paragraph (f)~~ paragraphs (c) and (d).

Sec. 25. Minnesota Statutes 2000, section 256B.0913, subdivision 11, is amended to read:

Subd. 11. [TARGETED FUNDING.] (a) The purpose of targeted funding is to make additional money available to counties with the greatest need. Targeted funds are not intended to be distributed equitably among all counties, but rather, allocated to those with long-term care strategies that meet state goals.

(b) The funds available for targeted funding shall be the total appropriation for each fiscal year minus county allocations determined under subdivision 10 as adjusted for any inflation increases provided in appropriations for the biennium.

(c) The commissioner shall allocate targeted funds to counties that demonstrate to the satisfaction of the commissioner that they have developed feasible plans to increase alternative care spending. In making targeted funding allocations, the commissioner shall use the following priorities:

(1) counties that received a lower allocation in fiscal year 1991 than in fiscal year 1990. Counties remain in this priority until they have been restored to their fiscal year 1990 level plus inflation;

(2) counties that sustain a base allocation reduction for failure to spend 95 percent of the allocation if they demonstrate that the base reduction should be restored;

(3) counties that propose projects to divert community residents from nursing home placement or convert nursing home residents to community living; and

(4) counties that can otherwise justify program growth by demonstrating the existence of waiting lists, demographically justified needs, or other unmet needs.

(d) Counties that would receive targeted funds according to paragraph (c) must demonstrate to

the commissioner's satisfaction that the funds would be appropriately spent by showing how the funds would be used to further the state's alternative care goals as described in subdivision 1, and that the county has the administrative and service delivery capability to use them.

(e) The commissioner shall request applications ~~by June 1 each year, for county agencies to apply~~ for targeted funds by November 1 of each year. The counties selected for targeted funds shall be notified of the amount of their additional funding ~~by August 1 of each year~~. Targeted funds allocated to a county agency in one year shall be treated as part of the county's base allocation for that year in determining allocations for subsequent years. No reallocations between counties shall be made.

~~(f) The allocation for each year after fiscal year 1992 shall be determined using the previous fiscal year's allocation, including any targeted funds, as the base and then applying the criteria under subdivision 10, paragraphs (c), (d), and (f), to the current year's expenditures.~~

Sec. 26. Minnesota Statutes 2000, section 256B.0913, subdivision 12, is amended to read:

Subd. 12. [CLIENT PREMIUMS.] (a) A premium is required for all ~~180-day~~ alternative care eligible clients to help pay for the cost of participating in the program. The amount of the premium for the alternative care client shall be determined as follows:

(1) when the alternative care client's income less recurring and predictable medical expenses is greater than the ~~medical assistance income standard~~ recipient's maintenance needs allowance as defined in section 256B.0915, subdivision 1d, paragraph (a), but less than 150 percent of the federal poverty guideline effective on July 1 of the state fiscal year in which the premium is being computed, and total assets are less than $10,000, the fee is zero;

(2) when the alternative care client's income less recurring and predictable medical expenses is greater than 150 percent of the federal poverty guideline effective on July 1 of the state fiscal year in which the premium is being computed, and total assets are less than $10,000, the fee is 25 percent of the cost of alternative care services or the difference between 150 percent of the federal poverty guideline effective on July 1 of the state fiscal year in which the premium is being computed and the client's income less recurring and predictable medical expenses, whichever is less; and

(3) when the alternative care client's total assets are greater than $10,000, the fee is 25 percent of the cost of alternative care services.

For married persons, total assets are defined as the total marital assets less the estimated community spouse asset allowance, under section 256B.059, if applicable. For married persons, total income is defined as the client's income less the monthly spousal allotment, under section 256B.058.

All alternative care services except case management shall be included in the estimated costs for the purpose of determining 25 percent of the costs.

The monthly premium shall be calculated based on the cost of the first full month of alternative care services and shall continue unaltered until the next reassessment is completed or at the end of 12 months, whichever comes first. Premiums are due and payable each month alternative care services are received unless the actual cost of the services is less than the premium.

(b) The fee shall be waived by the commissioner when:

(1) a person who is residing in a nursing facility is receiving case management only;

(2) a person is applying for medical assistance;

(3) a married couple is requesting an asset assessment under the spousal impoverishment provisions;

(4) ~~a person is a medical assistance recipient, but has been approved for alternative care-funded assisted living services;~~

~~(5)~~ a person is found eligible for alternative care, but is not yet receiving alternative care services; or

~~(6)~~ (5) a person's fee under paragraph (a) is less than $25.

(c) The county agency must record in the state's receivable system the client's assessed premium amount or the reason the premium has been waived. The commissioner will bill and collect the premium from the client ~~and forward the amounts collected to the commissioner in the manner and at the times prescribed by the commissioner~~. Money collected must be deposited in the general fund and is appropriated to the commissioner for the alternative care program. The client must supply the county with the client's social security number at the time of application. ~~If a client fails or refuses to pay the premium due,~~ The county shall supply the commissioner with the client's social security number and other information the commissioner requires to collect the premium from the client. The commissioner shall collect unpaid premiums using the Revenue Recapture Act in chapter 270A and other methods available to the commissioner. The commissioner may require counties to inform clients of the collection procedures that may be used by the state if a premium is not paid.

(d) The commissioner shall begin to adopt emergency or permanent rules governing client premiums within 30 days after July 1, 1991, including criteria for determining when services to a client must be terminated due to failure to pay a premium.

Sec. 27. Minnesota Statutes 2000, section 256B.0913, subdivision 13, is amended to read:

Subd. 13. [COUNTY BIENNIAL PLAN.] The county biennial plan for ~~the preadmission screening program~~ long-term care consultation under section 256B.0911, the alternative care program under this section, and waivers for the elderly under section 256B.0915, ~~and waivers for the disabled under section 256B.49,~~ shall be incorporated into the biennial Community Social Services Act plan and shall meet the regulations and timelines of that plan. ~~This county biennial plan shall include:~~

~~(1) information on the administration of the preadmission screening program;~~

~~(2) information on the administration of the home and community-based services waivers for the elderly under section 256B.0915, and for the disabled under section 256B.49; and~~

~~(3) information on the administration of the alternative care program.~~

Sec. 28. Minnesota Statutes 2000, section 256B.0913, subdivision 14, is amended to read:

Subd. 14. [~~REIMBURSEMENT~~ PAYMENT AND RATE ADJUSTMENTS.] (a) ~~Reimbursement~~ Payment for ~~expenditures for the~~ provided alternative care services as approved by the client's case manager shall be through the invoice processing procedures of the department's Medicaid Management Information System (MMIS). To receive ~~reimbursement~~ payment, the county or vendor must submit invoices within 12 months following the date of service. The county agency and its vendors under contract shall not be reimbursed for services which exceed the county allocation.

(b) ~~If a county collects less than 50 percent of the client premiums due under subdivision 12, the commissioner may withhold up to three percent of the county's final alternative care program allocation determined under subdivisions 10 and 11.~~

~~(c)~~ The county shall negotiate individual rates with vendors and may ~~be reimbursed~~ authorize service payment for actual costs up to ~~the greater of~~ the county's current approved rate ~~or 60 percent of the maximum rate in fiscal year 1994 and 65 percent of the maximum rate in fiscal year 1995 for each alternative care service~~. Notwithstanding any other rule or statutory provision to the contrary, the commissioner shall not be authorized to increase rates by an annual inflation factor, unless so authorized by the legislature.

~~(d)~~ (c) ~~On July 1, 1993, the commissioner shall increase the maximum rate for home delivered meals to $4.50 per meal.~~ To improve access to community services and eliminate payment

disparities between the alternative care program and the elderly waiver program, the commissioner shall establish statewide maximum service rate limits and eliminate county-specific service rate limits.

(1) Effective July 1, 2001, for service rate limits, except those in subdivision 5, paragraphs (d) and (j), the rate limit for each service shall be the greater of the alternative care statewide maximum rate or the elderly waiver statewide maximum rate.

(2) Counties may negotiate individual service rates with vendors for actual costs up to the statewide maximum service rate limit.

Sec. 29. Minnesota Statutes 2000, section 256B.0915, subdivision 1d, is amended to read:

Subd. 1d. [POSTELIGIBILITY TREATMENT OF INCOME AND RESOURCES FOR ELDERLY WAIVER.] ~~(a)~~ Notwithstanding the provisions of section 256B.056, the commissioner shall make the following amendment to the medical assistance elderly waiver program effective July 1, 1999, or upon federal approval, whichever is later.

A recipient's maintenance needs will be an amount equal to the Minnesota supplemental aid equivalent rate as defined in section 256I.03, subdivision 5, plus the medical assistance personal needs allowance as defined in section 256B.35, subdivision 1, paragraph (a), when applying posteligibility treatment of income rules to the gross income of elderly waiver recipients, except for individuals whose income is in excess of the special income standard according to Code of Federal Regulations, title 42, section 435.236. Recipient maintenance needs shall be adjusted under this provision each July 1.

~~(b) The commissioner of human services shall secure approval of additional elderly waiver slots sufficient to serve persons who will qualify under the revised income standard described in paragraph (a) before implementing section 256B.0913, subdivision 16.~~

~~(c) In implementing this subdivision, the commissioner shall consider allowing persons who would otherwise be eligible for the alternative care program but would qualify for the elderly waiver with a spenddown to remain on the alternative care program.~~

Sec. 30. Minnesota Statutes 2000, section 256B.0915, subdivision 3, is amended to read:

Subd. 3. [LIMITS OF CASES, RATES, ~~REIMBURSEMENT~~ PAYMENTS, AND FORECASTING.] (a) The number of medical assistance waiver recipients that a county may serve must be allocated according to the number of medical assistance waiver cases open on July 1 of each fiscal year. Additional recipients may be served with the approval of the commissioner.

(b) The monthly limit for the cost of waivered services to an individual elderly waiver client shall be the ~~statewide average payment~~ weighted average monthly nursing facility rate of the case mix resident class to which the elderly waiver client would be assigned under ~~the medical assistance case mix reimbursement system.~~ Minnesota Rules, parts 9549.0050 to 9549.0059, less the recipient's maintenance needs allowance as described in subdivision 1d, paragraph (a), until the first day of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented. Effective on the first day of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented and the first day of each subsequent state fiscal year, the monthly limit for the cost of waivered services to an individual elderly waiver client shall be the rate of the case mix resident class to which the waiver client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, in effect on the last day of the previous state fiscal year, adjusted by the greater of any legislatively adopted home and community-based services cost-of-living percentage increase or any legislatively adopted statewide percent rate increase for nursing facilities.

(c) If extended medical supplies and equipment or ~~adaptations~~ environmental modifications are or will be purchased for an elderly waiver ~~services recipient~~ client, the costs may be prorated ~~on a monthly basis throughout the year in which they are purchased~~ for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's ~~other~~ waivered services

exceeds the monthly limit established in ~~this~~ paragraph (b), the annual cost of ~~the~~ all waivered services shall be determined. In this event, the annual cost of all waivered services shall not exceed 12 times the monthly limit ~~calculated in this paragraph. The statewide average payment rate is calculated by determining the statewide average monthly nursing home rate, effective July 1 of the fiscal year in which the cost is incurred, less the statewide average monthly income of nursing home residents who are age 65 or older, and who are medical assistance recipients in the month of March of the previous state fiscal year. The annual cost divided by 12 of elderly or disabled waivered services~~ of waivered services as described in paragraph (b).

(d) For a person who is a nursing facility resident at the time of requesting a determination of eligibility for elderly ~~or disabled~~ waivered services ~~shall be the greater of the monthly payment for: (i)~~, a monthly conversion limit for the cost of elderly waivered services may be requested. The monthly conversion limit for the cost of elderly waiver services shall be the resident class assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, for that resident in the nursing facility where the resident currently resides~~; or (ii) the statewide average payment of the case mix resident class to which the resident would be assigned under the medical assistance case mix reimbursement system, provided that~~ until July 1 of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented. Effective on July 1 of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented, the monthly conversion limit for the cost of elderly waiver services shall be the per diem nursing facility rate as determined by the resident assessment system as described in section 256B.437 for that resident in the nursing facility where the resident currently resides multiplied by 365 and divided by 12, less the recipient's maintenance needs allowance as described in subdivision 1d. The limit under this clause only applies to persons discharged from a nursing facility after a minimum 30-day stay and found eligible for waivered services on or after July 1, 1997. The following costs must be included in determining the total monthly costs for the waiver client:

(1) cost of all waivered services, including extended medical supplies and equipment and environmental modifications; and

(2) cost of skilled nursing, home health aide, and personal care services reimbursable by medical assistance.

~~(c)~~ (e) Medical assistance funding for skilled nursing services, private duty nursing, home health aide, and personal care services for waiver recipients must be approved by the case manager and included in the individual care plan.

~~(d) For both the elderly waiver and the nursing facility disabled waiver, a county may purchase extended supplies and equipment without prior approval from the commissioner when there is no other funding source and the supplies and equipment are specified in the individual's care plan as medically necessary to enable the individual to remain in the community according to the criteria in Minnesota Rules, part 9505.0210, items A and B.~~ (f) A county is not required to contract with a provider of supplies and equipment if the monthly cost of the supplies and equipment is less than $250.

~~(e)~~ (g) The adult foster care ~~daily~~ rate ~~for the elderly and disabled waivers~~ shall be considered a difficulty of care payment and shall not include room and board. The adult foster care service rate shall be negotiated between the county agency and the foster care provider. ~~The rate established under this section shall not exceed the state average monthly nursing home payment for the case mix classification to which the individual receiving foster care is assigned; the rate must allow for other waiver and medical assistance home care services to be authorized by the case manager.~~ The elderly waiver payment for the foster care service in combination with the payment for all other elderly waiver services, including case management, must not exceed the limit specified in paragraph (b).

~~(f) The assisted living and residential care service rates for elderly and community alternatives for disabled individuals (CADI) waivers shall be made to the vendor as a monthly rate negotiated with the county agency based on an individualized service plan for each resident. The rate shall not exceed the nonfederal share of the greater of either the statewide or any of the geographic~~

~~groups' weighted average monthly medical assistance nursing facility payment rate of the case mix resident class to which the elderly or disabled client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, unless the services are provided by a home care provider licensed by the department of health and are provided in a building that is registered as a housing with services establishment under chapter 144D and that provides 24-hour supervision. For alternative care assisted living projects established under Laws 1988, chapter 689, article 2, section 256, monthly rates may not exceed 65 percent of the greater of either the statewide or any of the geographic groups' weighted average monthly medical assistance nursing facility payment rate for the case mix resident class to which the elderly or disabled client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059. The rate may not cover direct rent or food costs.~~

(h) Payment for assisted living service shall be a monthly rate negotiated and authorized by the county agency based on an individualized service plan for each resident and may not cover direct rent or food costs.

(1) The individualized monthly negotiated payment for assisted living services as described in section 256B.0913, subdivision 5, paragraph (g) or (h), and residential care services as described in section 256B.0913, subdivision 5, paragraph (f), shall not exceed the nonfederal share, in effect on July 1 of the state fiscal year for which the rate limit is being calculated, of the greater of either the statewide or any of the geographic groups' weighted average monthly nursing facility rate of the case mix resident class to which the elderly waiver eligible client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, less the maintenance needs allowance as described in subdivision 1d, paragraph (a), until the July 1 of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented. Effective on July 1 of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented and July 1 of each subsequent state fiscal year, the individualized monthly negotiated payment for the services described in this clause shall not exceed the limit described in this clause which was in effect on June 30 of the previous state fiscal year and which has been adjusted by the greater of any legislatively adopted home and community-based services cost-of-living percentage increase or any legislatively adopted statewide percent rate increase for nursing facilities.

(2) The individualized monthly negotiated payment for assisted living services described in section 144A.4605 and delivered by a provider licensed by the department of health as a class A home care provider or an assisted living home care provider and provided in a building that is registered as a housing with services establishment under chapter 144D and that provides 24-hour supervision in combination with the payment for other elderly waiver services, including case management, must not exceed the limit specified in paragraph (b).

~~(g)~~ (i) The county shall negotiate individual service rates with vendors and may ~~be reimbursed~~ authorize payment for actual costs up to the ~~greater of the~~ county's current approved rate ~~or 60 percent of the maximum rate in fiscal year 1994 and 65 percent of the maximum rate in fiscal year 1995 for each service within each program~~. Persons or agencies must be employed by or under a contract with the county agency or the public health nursing agency of the local board of health in order to receive funding under the elderly waiver program, except as a provider of supplies and equipment when the monthly cost of the supplies and equipment is less than $250.

~~(h) On July 1, 1993, the commissioner shall increase the maximum rate for home-delivered meals to $4.50 per meal.~~

~~(i)~~ (j) Reimbursement for the medical assistance recipients under the approved waiver shall be made from the medical assistance account through the invoice processing procedures of the department's Medicaid Management Information System (MMIS), only with the approval of the client's case manager. The budget for the state share of the Medicaid expenditures shall be forecasted with the medical assistance budget, and shall be consistent with the approved waiver.

(k) To improve access to community services and eliminate payment disparities between the alternative care program and the elderly waiver, the commissioner shall establish statewide maximum service rate limits and eliminate county-specific service rate limits.

(1) Effective July 1, 2001, for service rate limits, except those described or defined in paragraphs (g) and (h), the rate limit for each service shall be the greater of the alternative care statewide maximum rate or the elderly waiver statewide maximum rate.

(2) Counties may negotiate individual service rates with vendors for actual costs up to the statewide maximum service rate limit.

~~(j)~~ (l) Beginning July 1, 1991, the state shall reimburse counties according to the payment schedule in section 256.025 for the county share of costs incurred under this subdivision on or after January 1, 1991, for individuals who are receiving medical assistance.

~~(k) For the community alternatives for disabled individuals waiver, and nursing facility disabled waivers, county may use waiver funds for the cost of minor adaptations to a client's residence or vehicle without prior approval from the commissioner if there is no other source of funding and the adaptation:~~

~~(1) is necessary to avoid institutionalization;~~

~~(2) has no utility apart from the needs of the client; and~~

~~(3) meets the criteria in Minnesota Rules, part 9505.0210, items A and B.~~

~~For purposes of this subdivision, "residence" means the client's own home, the client's family residence, or a family foster home. For purposes of this subdivision, "vehicle" means the client's vehicle, the client's family vehicle, or the client's family foster home vehicle.~~

~~(l) The commissioner shall establish a maximum rate unit for baths provided by an adult day care provider that are not included in the provider's contractual daily or hourly rate. This maximum rate must equal the home health aide extended rate and shall be paid for baths provided to clients served under the elderly and disabled waivers.~~

Sec. 31. Minnesota Statutes 2000, section 256B.0915, subdivision 5, is amended to read:

Subd. 5. [REASSESSMENTS FOR WAIVER CLIENTS.] A reassessment of a client served under the elderly ~~or disabled~~ waiver must be conducted at least every 12 months and at other times when the case manager determines that there has been significant change in the client's functioning. This may include instances where the client is discharged from the hospital.

Sec. 32. Minnesota Statutes 2000, section 256B.0917, subdivision 7, is amended to read:

Subd. 7. [CONTRACT.] (a) The commissioner of human services shall execute a contract with Living at Home/Block Nurse Program, Inc. (LAH/BN, Inc.). The contract shall require LAH/BN, Inc. to:

(1) develop criteria for and award grants to establish community-based organizations that will implement living-at-home/block nurse programs throughout the state;

(2) award grants to enable ~~current~~ living-at-home/block nurse programs to continue to implement the combined living-at-home/block nurse program model;

(3) serve as a state technical assistance center to assist and coordinate the living-at-home/block nurse programs established; and

(4) manage contracts with individual living-at-home/block nurse programs.

(b) The contract shall be effective July 1, 1997, and section 16B.17 shall not apply.

Sec. 33. [256B.0918] [DEVELOPMENT AND PURPOSE OF MEDICAL ASSISTANCE PILOT PROJECT ON SENIOR SERVICES.]

Subdivision 1. [DEVELOPMENT AND PURPOSE.] The commissioner of human services shall develop a medical assistance pilot project on senior services to determine how converting the

delivery of housing, supportive services, and health care for seniors into a flexible voucher program will impact public expenditures for older adult service care and provide an alternative way to purchase services based on consumer choice.

Subd. 2. [FEDERAL WAIVER AUTHORITY.] The commissioner shall apply for any necessary federal waivers or approvals to implement this pilot project. The commissioner shall submit the waiver request no later than April 15, 2002.

Subd. 3. [REPORT.] The commissioner shall report to the legislature by January 15, 2003, on approval of waivers requested. Upon federal approval, the commissioner shall seek legislative authorization to implement the pilot project. Once the pilot project is implemented, participating communities and the commissioner of human services shall collaborate to prepare and issue an annual report each December 1 to the appropriate committee chairs in the senate and house on: (1) the use of state resources, including other funds leveraged for this initiative; (2) the status of individuals being served in the pilot project; and (3) the cost-effectiveness of the pilot project. The commissioner shall provide data that may be needed to evaluate the pilot project to communities that request the data.

Subd. 4. [SUNSET.] This section sunsets June 30, 2008.

Sec. 34. [SERVICE ACCESS STUDY.]

By February 15, 2002, the commissioner of human services shall submit to the legislature recommendations for creating coordinated service access at the county agency level for both publicly subsidized and nonsubsidized long-term care services and housing options. The report must:

(1) include a plan to coordinate public funding streams to allow low-income, privately paying consumers to purchase services through a sliding fee scale; and

(2) evaluate the feasibility of statewide implementation, based upon an evaluation of public cost, consumer preferences and satisfaction, and other relevant factors.

Sec. 35. [RESPITE CARE.]

The Minnesota board on aging shall report to the legislature by February 1, 2002, on the provision of in-home and out-of-home respite care services on a sliding scale basis under the federal Older Americans Act.

Sec. 36. [REPEALER.]

Minnesota Statutes 2000, sections 256B.0911, subdivisions 2, 2a, 4, 8, and 9; and 256B.0913, subdivisions 3, 15a, 15b, 15c, and 16; Minnesota Rules, parts 9505.2390; 9505.2395; 9505.2396; 9505.2400; 9505.2405; 9505.2410; 9505.2413; 9505.2415; 9505.2420; 9505.2425; 9505.2426; 9505.2430; 9505.2435; 9505.2440; 9505.2445; 9505.2450; 9505.2455; 9505.2458; 9505.2460; 9505.2465; 9505.2470; 9505.2473; 9505.2475; 9505.2480; 9505.2485; 9505.2486; 9505.2490; 9505.2495; 9505.2496; and 9505.2500, are repealed.

ARTICLE 5

LONG-TERM CARE REFORM AND REIMBURSEMENT

Section 1. [144.0724] [RESIDENT REIMBURSEMENT CLASSIFICATION.]

Subdivision 1. [RESIDENT REIMBURSEMENT CLASSIFICATIONS.] The commissioner of health shall establish resident reimbursement classifications based upon the assessments of residents of nursing homes and boarding care homes conducted under this section and according to section 256B.437. The reimbursement classifications established under this section shall be implemented after June 30, 2002, but no later than January 1, 2003.

Subd. 2. [DEFINITIONS.] For purposes of this section, the following terms have the meanings given.

(a) [ASSESSMENT REFERENCE DATE.] "Assessment reference date" means the last day of the minimum data set observation period. The date sets the designated endpoint of the common observation period, and all minimum data set items refer back in time from that point.

(b) [CASE MIX INDEX.] "Case mix index" means the weighting factors assigned to the RUG-III classifications.

(c) [INDEX MAXIMIZATION.] "Index maximization" means classifying a resident who could be assigned to more than one category, to the category with the highest case mix index.

(d) [MINIMUM DATA SET.] "Minimum data set" means the assessment instrument specified by the Health Care Financing Administration and designated by the Minnesota department of health.

(e) [REPRESENTATIVE.] "Representative" means a person who is the resident's guardian or conservator, the person authorized to pay the nursing home expenses of the resident, a representative of the nursing home ombudsman's office whose assistance has been requested, or any other individual designated by the resident.

(f) [RESOURCE UTILIZATION GROUPS OR RUG.] "Resource utilization groups" or "RUG" means the system for grouping a nursing facility's residents according to their clinical and functional status identified in data supplied by the facility's minimum data set.

Subd. 3. [RESIDENT REIMBURSEMENT CLASSIFICATIONS.] (a) Resident reimbursement classifications shall be based on the minimum data set, version 2.0 assessment instrument, or its successor version mandated by the Health Care Financing Administration that nursing facilities are required to complete for all residents. The commissioner of health shall establish resident classes according to the 34 group, resource utilization groups, version III or RUG-III model. Resident classes must be established based on the individual items on the minimum data set and must be completed according to the facility manual for case mix classification issued by the Minnesota department of health. The facility manual for case mix classification shall be drafted by the Minnesota department of health and presented to the chairs of health and human services legislative committees by December 31, 2001.

(b) Each resident must be classified based on the information from the minimum data set according to general domains in clauses (1) to (7):

(1) extensive services where a resident requires intravenous feeding or medications, suctioning, tracheostomy care, or is on a ventilator or respirator;

(2) rehabilitation where a resident requires physical, occupational, or speech therapy;

(3) special care where a resident has cerebral palsy; quadriplegia; multiple sclerosis; pressure ulcers; fever with vomiting, weight loss, or dehydration; tube feeding and aphasia; or is receiving radiation therapy;

(4) clinically complex status where a resident has burns, coma, septicemia, pneumonia, internal bleeding, chemotherapy, wounds, kidney failure, urinary tract infections, oxygen, or transfusions;

(5) impaired cognition where a resident has poor cognitive performance;

(6) behavior problems where a resident exhibits wandering, has hallucinations, or is physically or verbally abusive toward others, unless the resident's other condition would place the resident in other categories; and

(7) reduced physical functioning where a resident has no special clinical conditions.

(c) The commissioner of health shall establish resident classification according to a 34 group model based on the information on the minimum data set and within the general domains listed in paragraph (b), clauses (1) to (7). Detailed descriptions of each resource utilization group shall be defined in the facility manual for case mix classification issued by the Minnesota department of health. The 34 groups are described as follows:

(1) SE3: requires four or five extensive services;

(2) SE2: requires two or three extensive services;

(3) SE1: requires one extensive service;

(4) RAD: requires rehabilitation services and is dependent in activity of daily living (ADL) at a count of 17 or 18;

(5) RAC: requires rehabilitation services and ADL count is 14 to 16;

(6) RAB: requires rehabilitation services and ADL count is ten to 13;

(7) RAA: requires rehabilitation services and ADL count is four to nine;

(8) SSC: requires special care and ADL count is 17 or 18;

(9) SSB: requires special care and ADL count is 15 or 16;

(10) SSA: requires special care and ADL count is seven to 14;

(11) CC2: clinically complex with depression and ADL count is 17 or 18;

(12) CC1: clinically complex with no depression and ADL count is 17 or 18;

(13) CB2: clinically complex with depression and ADL count is 12 to 16;

(14) CB1: clinically complex with no depression and ADL count is 12 to 16;

(15) CA2: clinically complex with depression and ADL count is four to 11;

(16) CA1: clinically complex with no depression and ADL count is four to 11;

(17) IB2: impaired cognition with nursing rehabilitation and ADL count is six to ten;

(18) IB1: impaired cognition with no nursing rehabilitation and ADL count is six to ten;

(19) IA2: impaired cognition with nursing rehabilitation and ADL count is four or five;

(20) IA1: impaired cognition with no nursing rehabilitation and ADL count is four or five;

(21) BB2: behavior problems with nursing rehabilitation and ADL count is six to ten;

(22) BB1: behavior problems with no nursing rehabilitation and ADL count is six to ten;

(23) BA2: behavior problems with nursing rehabilitation and ADL count is four to five;

(24) BA1: behavior problems with no nursing rehabilitation and ADL count is four to five;

(25) PE2: reduced physical functioning with nursing rehabilitation and ADL count is 16 to 18;

(26) PE1: reduced physical functioning with no nursing rehabilitation and ADL count is 16 to 18;

(27) PD2: reduced physical functioning with nursing rehabilitation and ADL count is 11 to 15;

(28) PD1: reduced physical functioning with no nursing rehabilitation and ADL count is 11 to 15;

(29) PC2: reduced physical functioning with nursing rehabilitation and ADL count is nine or ten;

(30) PC1: reduced physical functioning with no nursing rehabilitation and ADL count is nine or ten;

(31) PB2: reduced physical functioning with nursing rehabilitation and ADL count is six to eight;

(32) PB1: reduced physical functioning with no nursing rehabilitation and ADL count is six to eight;

(33) PA2: reduced physical functioning with nursing rehabilitation and ADL count is four or five; and

(34) PA1: reduced physical functioning with no nursing rehabilitation and ADL count is four or five.

Subd. 4. [RESIDENT ASSESSMENT SCHEDULE.] (a) A facility must conduct and electronically submit to the commissioner of health case mix assessments that conform with the assessment schedule defined by the Code of Federal Regulations, title 42, section 483.20, and published by the United States Department of Health and Human Services, Health Care Financing Administration, in the Long Term Care Assessment Instrument User's Manual, version 2.0, October 1995, and subsequent clarifications made in the Long-Term Care Assessment Instrument Questions and Answers, version 2.0, August 1996. The commissioner of health may substitute successor manuals or question and answer documents published by the United States Department of Health and Human Services, Health Care Financing Administration, to replace or supplement the current version of the manual or document.

(b) The assessments used to determine a case mix classification for reimbursement include the following:

(1) a new admission assessment must be completed by day 14 following admission;

(2) an annual assessment must be completed within 366 days of the last comprehensive assessment;

(3) a significant change assessment must be completed within 14 days of the identification of a significant change; and

(4) the second quarterly assessment following either a new admission assessment, an annual assessment, or a significant change assessment. Each quarterly assessment must be completed within 92 days of the previous assessment.

Subd. 5. [SHORT STAYS.] (a) A facility must submit to the commissioner of health an initial admission assessment for all residents who stay in the facility less than 14 days.

(b) Notwithstanding the admission assessment requirements of paragraph (a), a facility may elect to accept a default rate with a case mix index of 1.0 for all facility residents who stay less than 14 days in lieu of submitting an initial assessment. Facilities may make this election to be effective on the day of implementation of the revised case mix system.

(c) After implementation of the revised case mix system, nursing facilities must elect one of the options described in paragraphs (a) and (b) on the annual report to the commissioner of human services filed for each report year ending September 30. The election shall be effective on the following July 1.

(d) For residents who are admitted or readmitted and leave the facility on a frequent basis and for whom readmission is expected, the resident may be discharged on an extended leave status. This status does not require reassessment each time the resident returns to the facility unless a significant change in the resident's status has occurred since the last assessment. The case mix classification for these residents is determined by the facility election made in paragraphs (a) and (b).

Subd. 6. [PENALTIES FOR LATE OR NONSUBMISSION.] A facility that fails to complete or submit an assessment for a RUG-III classification within seven days of the time requirements in subdivisions 4 and 5 is subject to a reduced rate for that resident. The reduced rate shall be the

lowest rate for that facility. The reduced rate is effective on the day of admission for new admission assessments or on the day that the assessment was due for all other assessments and continues in effect until the first day of the month following the date of submission of the resident's assessment.

Subd. 7. [NOTICE OF RESIDENT REIMBURSEMENT CLASSIFICATION.] (a) A facility must elect between the options in clauses (1) and (2) to provide notice to a resident of the resident's case mix classification.

(1) The commissioner of health shall provide to a nursing facility a notice for each resident of the reimbursement classification established under subdivision 1. The notice must inform the resident of the classification that was assigned, the opportunity to review the documentation supporting the classification, the opportunity to obtain clarification from the commissioner, and the opportunity to request a reconsideration of the classification. The commissioner must send notice of resident classification by first class mail. A nursing facility is responsible for the distribution of the notice to each resident, to the person responsible for the payment of the resident's nursing home expenses, or to another person designated by the resident. This notice must be distributed within three working days after the facility's receipt of the notice from the commissioner of health.

(2) A facility may choose to provide a classification notice, as prescribed by the commissioner of health, to a resident upon receipt of the confirmation of the case mix classification calculated by a facility or a corrected case mix classification as indicated on the final validation report from the commissioner. A nursing facility is responsible for the distribution of the notice to each resident, to the person responsible for the payment of the resident's nursing home expenses, or to another person designated by the resident. This notice must be distributed within three working days after the facility's receipt of the validation report from the commissioner. If a facility elects this option, the commissioner of health shall provide the facility with a list of residents and their case mix classifications as determined by the commissioner. A nursing facility may make this election to be effective on the day of implementation of the revised case mix system.

(3) After implementation of the revised case mix system, a nursing facility shall elect a notice of resident reimbursement classification procedure as described in clause (1) or (2) on the annual report to the commissioner of human services filed for each report year ending September 30. The election will be effective the following July 1.

(b) If a facility submits a correction to an assessment conducted under subdivision 3 that results in a change in case mix classification, the facility shall give written notice to the resident or the resident's representative about the item that was corrected and the reason for the correction. The notice of corrected assessment may be provided at the same time that the resident or resident's representative is provided the resident's corrected notice of classification.

Subd. 8. [REQUEST FOR RECONSIDERATION OF RESIDENT CLASSIFICATIONS.] (a) The resident, or resident's representative, or the nursing facility or boarding care home may request that the commissioner of health reconsider the assigned reimbursement classification. The request for reconsideration must be submitted in writing to the commissioner within 30 days of the day the resident or the resident's representative receives the resident classification notice. The request for reconsideration must include the name of the resident, the name and address of the facility in which the resident resides, the reasons for the reconsideration, the requested classification changes, and documentation supporting the requested classification. The documentation accompanying the reconsideration request is limited to documentation which establishes that the needs of the resident at the time of the assessment justify a classification which is different than the classification established by the commissioner of health.

(b) Upon request, the nursing facility must give the resident or the resident's representative a copy of the assessment form and the other documentation that was given to the commissioner of health to support the assessment findings. The nursing facility shall also provide access to and a copy of other information from the resident's record that has been requested by or on behalf of the resident to support a resident's reconsideration request. A copy of any requested material must be provided within three working days of receipt of a written request for the information. If a facility

fails to provide the material within this time, it is subject to the issuance of a correction order and penalty assessment under sections 144.653 and 144A.10. Notwithstanding those sections, any correction order issued under this subdivision must require that the nursing facility immediately comply with the request for information and that as of the date of the issuance of the correction order, the facility shall forfeit to the state a $100 fine for the first day of noncompliance, and an increase in the $100 fine by $50 increments for each day the noncompliance continues.

(c) In addition to the information required under paragraphs (a) and (b), a reconsideration request from a nursing facility must contain the following information: (i) the date the reimbursement classification notices were received by the facility; (ii) the date the classification notices were distributed to the resident or the resident's representative; and (iii) a copy of a notice sent to the resident or to the resident's representative. This notice must inform the resident or the resident's representative that a reconsideration of the resident's classification is being requested, the reason for the request, that the resident's rate will change if the request is approved by the commissioner, the extent of the change, that copies of the facility's request and supporting documentation are available for review, and that the resident also has the right to request a reconsideration. If the facility fails to provide the required information with the reconsideration request, the request must be denied, and the facility may not make further reconsideration requests on that specific reimbursement classification.

(d) Reconsideration by the commissioner must be made by individuals not involved in reviewing the assessment, audit, or reconsideration that established the disputed classification. The reconsideration must be based upon the initial assessment and upon the information provided to the commissioner under paragraphs (a) and (b). If necessary for evaluating the reconsideration request, the commissioner may conduct on-site reviews. Within 15 working days of receiving the request for reconsideration, the commissioner shall affirm or modify the original resident classification. The original classification must be modified if the commissioner determines that the assessment resulting in the classification did not accurately reflect the needs or assessment characteristics of the resident at the time of the assessment. The resident and the nursing facility or boarding care home shall be notified within five working days after the decision is made. A decision by the commissioner under this subdivision is the final administrative decision of the agency for the party requesting reconsideration.

(e) The resident classification established by the commissioner shall be the classification that applies to the resident while the request for reconsideration is pending.

(f) The commissioner may request additional documentation regarding a reconsideration necessary to make an accurate reconsideration determination.

Subd. 9. [AUDIT AUTHORITY.] (a) The commissioner shall audit the accuracy of resident assessments performed under section 256B.437 through desk audits, on-site review of residents and their records, and interviews with staff and families. The commissioner shall reclassify a resident if the commissioner determines that the resident was incorrectly classified.

(b) The commissioner is authorized to conduct on-site audits on an unannounced basis.

(c) A facility must grant the commissioner access to examine the medical records relating to the resident assessments selected for audit under this subdivision. The commissioner may also observe and speak to facility staff and residents.

(d) The commissioner shall consider documentation under the time frames for coding items on the minimum data set as set out in the Resident Assessment Instrument Manual published by the Health Care Financing Administration.

(e) The commissioner shall develop an audit selection procedure that includes the following factors:

(1) The commissioner may target facilities that demonstrate an atypical pattern of scoring minimum data set items, nonsubmission of assessments, late submission of assessments, or a previous history of audit changes of greater than 35 percent. The commissioner shall select at least

20 percent of the most current assessments submitted to the state for audit. Audits of assessments selected in the targeted facilities must focus on the factors leading to the audit. If the number of targeted assessments selected does not meet the threshold of 20 percent of the facility residents, then a stratified sample of the remainder of assessments shall be drawn to meet the quota. If the total change exceeds 35 percent, the commissioner may conduct an expanded audit up to 100 percent of the remaining current assessments.

(2) Facilities that are not a part of the targeted group shall be placed in a general pool from which facilities will be selected on a random basis for audit. Every facility shall be audited annually. If a facility has two successive audits in which the percentage of change is five percent or less and the facility has not been the subject of a targeted audit in the past 36 months, the facility may be audited biannually. A stratified sample of 15 percent of the most current assessments shall be selected for audit. If more than 20 percent of the RUGS-III classifications after the audit are changed, the audit shall be expanded to a second 15 percent sample. If the total change between the first and second samples exceed 35 percent, the commissioner may expand the audit to all of the remaining assessments.

(3) If a facility qualifies for an expanded audit, the commissioner may audit the facility again within six months. If a facility has two expanded audits within a 24-month period, that facility will be audited at least every six months for the next 18 months.

(4) The commissioner may conduct special audits if the commissioner determines that circumstances exist that could alter or affect the validity of case mix classifications of residents. These circumstances include, but are not limited to, the following:

(i) frequent changes in the administration or management of the facility;

(ii) an unusually high percentage of residents in a specific case mix classification;

(iii) a high frequency in the number of reconsideration requests received from a facility;

(iv) frequent adjustments of case mix classifications as the result of reconsiderations or audits;

(v) a criminal indictment alleging provider fraud; or

(vi) other similar factors that relate to a facility's ability to conduct accurate assessments.

(f) Within 15 working days of completing the audit process, the commissioner shall mail the written results of the audit to the facility, along with a written notice for each resident affected to be forwarded by the facility. The notice must contain the resident's classification and a statement informing the resident, the resident's authorized representative, and the facility of their right to review the commissioner's documents supporting the classification and to request a reconsideration of the classification. This notice must also include the address and telephone number of the area nursing home ombudsman.

Subd. 10. [TRANSITION.] After implementation of this section, reconsiderations requested for classifications made under section 144.0722, subdivision 1, shall be determined under section 144.0722, subdivision 3.

Sec. 2. Minnesota Statutes 2000, section 144A.071, subdivision 1, is amended to read:

Subdivision 1. [FINDINGS.] The legislature declares that a moratorium on the licensure and medical assistance certification of new nursing home beds and construction projects that exceed ~~$750,000~~ $1,000,000 is necessary to control nursing home expenditure growth and enable the state to meet the needs of its elderly by providing high quality services in the most appropriate manner along a continuum of care.

Sec. 3. Minnesota Statutes 2000, section 144A.071, subdivision 1a, is amended to read:

Subd. 1a. [DEFINITIONS.] For purposes of sections 144A.071 to 144A.073, the following terms have the meanings given them:

(a) "attached fixtures" has the meaning given in Minnesota Rules, part 9549.0020, subpart 6.

(b) "buildings" has the meaning given in Minnesota Rules, part 9549.0020, subpart 7.

(c) "capital assets" has the meaning given in section 256B.421, subdivision 16.

(d) "commenced construction" means that all of the following conditions were met: the final working drawings and specifications were approved by the commissioner of health; the construction contracts were let; a timely construction schedule was developed, stipulating dates for beginning, achieving various stages, and completing construction; and all zoning and building permits were applied for.

(e) "completion date" means the date on which a certificate of occupancy is issued for a construction project, or if a certificate of occupancy is not required, the date on which the construction project is available for facility use.

(f) "construction" means any erection, building, alteration, reconstruction, modernization, or improvement necessary to comply with the nursing home licensure rules.

(g) "construction project" means:

(1) a capital asset addition to, or replacement of a nursing home or certified boarding care home that results in new space or the remodeling of or renovations to existing facility space;

(2) the remodeling or renovation of existing facility space the use of which is modified as a result of the project described in clause (1). This existing space and the project described in clause (1) must be used for the functions as designated on the construction plans on completion of the project described in clause (1) for a period of not less than 24 months; or

(3) capital asset additions or replacements that are completed within 12 months before or after the completion date of the project described in clause (1).

(h) "new licensed" or "new certified beds" means:

(1) newly constructed beds in a facility or the construction of a new facility that would increase the total number of licensed nursing home beds or certified boarding care or nursing home beds in the state; or

(2) newly licensed nursing home beds or newly certified boarding care or nursing home beds that result from remodeling of the facility that involves relocation of beds but does not result in an increase in the total number of beds, except when the project involves the upgrade of boarding care beds to nursing home beds, as defined in section 144A.073, subdivision 1. "Remodeling" includes any of the type of conversion, renovation, replacement, or upgrading projects as defined in section 144A.073, subdivision 1.

(i) "project construction costs" means the cost of the facility capital asset additions, replacements, renovations, or remodeling projects, construction site preparation costs, and related soft costs. Project construction costs ~~also~~ include the cost of any remodeling or renovation of existing facility space which is modified as a result of the construction project. Project construction costs also includes the cost of new technology implemented as part of the construction project.

(j) "technology" means information systems or devices that make documentation, charting, and staff time more efficient or encourage and allow for care through alternative settings including, but not limited to, touch screens, monitors, hand-helds, swipe cards, motion detectors, pagers, telemedicine, medication dispensers, and equipment to monitor vital signs and self-injections, and to observe skin and other conditions.

Sec. 4. Minnesota Statutes 2000, section 144A.071, subdivision 2, is amended to read:

Subd. 2. [MORATORIUM.] The commissioner of health, in coordination with the commissioner of human services, shall deny each request for new licensed or certified nursing

home or certified boarding care beds except as provided in subdivision 3 or 4a, or section 144A.073. "Certified bed" means a nursing home bed or a boarding care bed certified by the commissioner of health for the purposes of the medical assistance program, under United States Code, title 42, sections 1396 et seq.

The commissioner of human services, in coordination with the commissioner of health, shall deny any request to issue a license under section 252.28 and chapter 245A to a nursing home or boarding care home, if that license would result in an increase in the medical assistance reimbursement amount.

In addition, the commissioner of health must not approve any construction project whose cost exceeds ~~$750,000~~ $1,000,000 unless:

(a) any construction costs exceeding ~~$750,000~~ $1,000,000 are not added to the facility's appraised value and are not included in the facility's payment rate for reimbursement under the medical assistance program; or

(b) the project:

(1) has been approved through the process described in section 144A.073;

(2) meets an exception in subdivision 3 or 4a;

(3) is necessary to correct violations of state or federal law issued by the commissioner of health;

(4) is necessary to repair or replace a portion of the facility that was damaged by fire, lightning, groundshifts, or other such hazards, including environmental hazards, provided that the provisions of subdivision 4a, clause (a), are met;

(5) as of May 1, 1992, the facility has submitted to the commissioner of health written documentation evidencing that the facility meets the "commenced construction" definition as specified in subdivision 1a, clause (d), or that substantial steps have been taken prior to April 1, 1992, relating to the construction project. "Substantial steps" require that the facility has made arrangements with outside parties relating to the construction project and include the hiring of an architect or construction firm, submission of preliminary plans to the department of health or documentation from a financial institution that financing arrangements for the construction project have been made; or

(6) is being proposed by a licensed nursing facility that is not certified to participate in the medical assistance program and will not result in new licensed or certified beds.

Prior to the final plan approval of any construction project, the commissioner of health shall be provided with an itemized cost estimate for the project construction costs. If a construction project is anticipated to be completed in phases, the total estimated cost of all phases of the project shall be submitted to the commissioner and shall be considered as one construction project. Once the construction project is completed and prior to the final clearance by the commissioner, the total project construction costs for the construction project shall be submitted to the commissioner. If the final project construction cost exceeds the dollar threshold in this subdivision, the commissioner of human services shall not recognize any of the project construction costs or the related financing costs in excess of this threshold in establishing the facility's property-related payment rate.

The dollar thresholds for construction projects are as follows: for construction projects other than those authorized in clauses (1) to (6), the dollar threshold is ~~$750,000~~ $1,000,000. For projects authorized after July 1, 1993, under clause (1), the dollar threshold is the cost estimate submitted with a proposal for an exception under section 144A.073, plus inflation as calculated according to section 256B.431, subdivision 3f, paragraph (a). For projects authorized under clauses (2) to (4), the dollar threshold is the itemized estimate project construction costs submitted to the commissioner of health at the time of final plan approval, plus inflation as calculated according to section 256B.431, subdivision 3f, paragraph (a).

The commissioner of health shall adopt rules to implement this section or to amend the emergency rules for granting exceptions to the moratorium on nursing homes under section 144A.073.

Sec. 5. Minnesota Statutes 2000, section 144A.071, subdivision 4a, is amended to read:

Subd. 4a. [EXCEPTIONS FOR REPLACEMENT BEDS.] It is in the best interest of the state to ensure that nursing homes and boarding care homes continue to meet the physical plant licensing and certification requirements by permitting certain construction projects. Facilities should be maintained in condition to satisfy the physical and emotional needs of residents while allowing the state to maintain control over nursing home expenditure growth.

The commissioner of health in coordination with the commissioner of human services, may approve the renovation, replacement, upgrading, or relocation of a nursing home or boarding care home, under the following conditions:

(a) to license or certify beds in a new facility constructed to replace a facility or to make repairs in an existing facility that was destroyed or damaged after June 30, 1987, by fire, lightning, or other hazard provided:

(i) destruction was not caused by the intentional act of or at the direction of a controlling person of the facility;

(ii) at the time the facility was destroyed or damaged the controlling persons of the facility maintained insurance coverage for the type of hazard that occurred in an amount that a reasonable person would conclude was adequate;

(iii) the net proceeds from an insurance settlement for the damages caused by the hazard are applied to the cost of the new facility or repairs;

(iv) the new facility is constructed on the same site as the destroyed facility or on another site subject to the restrictions in section 144A.073, subdivision 5;

(v) the number of licensed and certified beds in the new facility does not exceed the number of licensed and certified beds in the destroyed facility; and

(vi) the commissioner determines that the replacement beds are needed to prevent an inadequate supply of beds.

Project construction costs incurred for repairs authorized under this clause shall not be considered in the dollar threshold amount defined in subdivision 2;

(b) to license or certify beds that are moved from one location to another within a nursing home facility, provided the total costs of remodeling performed in conjunction with the relocation of beds does not exceed ~~$750,000~~ $1,000,000;

(c) to license or certify beds in a project recommended for approval under section 144A.073;

(d) to license or certify beds that are moved from an existing state nursing home to a different state facility, provided there is no net increase in the number of state nursing home beds;

(e) to certify and license as nursing home beds boarding care beds in a certified boarding care facility if the beds meet the standards for nursing home licensure, or in a facility that was granted an exception to the moratorium under section 144A.073, and if the cost of any remodeling of the facility does not exceed ~~$750,000~~ $1,000,000. If boarding care beds are licensed as nursing home beds, the number of boarding care beds in the facility must not increase beyond the number remaining at the time of the upgrade in licensure. The provisions contained in section 144A.073 regarding the upgrading of the facilities do not apply to facilities that satisfy these requirements;

(f) to license and certify up to 40 beds transferred from an existing facility owned and operated by the Amherst H. Wilder Foundation in the city of St. Paul to a new unit at the same location as the existing facility that will serve persons with Alzheimer's disease and other related disorders.

The transfer of beds may occur gradually or in stages, provided the total number of beds transferred does not exceed 40. At the time of licensure and certification of a bed or beds in the new unit, the commissioner of health shall delicense and decertify the same number of beds in the existing facility. As a condition of receiving a license or certification under this clause, the facility must make a written commitment to the commissioner of human services that it will not seek to receive an increase in its property-related payment rate as a result of the transfers allowed under this paragraph;

(g) to license and certify nursing home beds to replace currently licensed and certified boarding care beds which may be located either in a remodeled or renovated boarding care or nursing home facility or in a remodeled, renovated, newly constructed, or replacement nursing home facility within the identifiable complex of health care facilities in which the currently licensed boarding care beds are presently located, provided that the number of boarding care beds in the facility or complex are decreased by the number to be licensed as nursing home beds and further provided that, if the total costs of new construction, replacement, remodeling, or renovation exceed ten percent of the appraised value of the facility or $200,000, whichever is less, the facility makes a written commitment to the commissioner of human services that it will not seek to receive an increase in its property-related payment rate by reason of the new construction, replacement, remodeling, or renovation. The provisions contained in section 144A.073 regarding the upgrading of facilities do not apply to facilities that satisfy these requirements;

(h) to license as a nursing home and certify as a nursing facility a facility that is licensed as a boarding care facility but not certified under the medical assistance program, but only if the commissioner of human services certifies to the commissioner of health that licensing the facility as a nursing home and certifying the facility as a nursing facility will result in a net annual savings to the state general fund of $200,000 or more;

(i) to certify, after September 30, 1992, and prior to July 1, 1993, existing nursing home beds in a facility that was licensed and in operation prior to January 1, 1992;

(j) to license and certify new nursing home beds to replace beds in a facility acquired by the Minneapolis community development agency as part of redevelopment activities in a city of the first class, provided the new facility is located within three miles of the site of the old facility. Operating and property costs for the new facility must be determined and allowed under section 256B.431 or 256B.434;

(k) to license and certify up to 20 new nursing home beds in a community-operated hospital and attached convalescent and nursing care facility with 40 beds on April 21, 1991, that suspended operation of the hospital in April 1986. The commissioner of human services shall provide the facility with the same per diem property-related payment rate for each additional licensed and certified bed as it will receive for its existing 40 beds;

(l) to license or certify beds in renovation, replacement, or upgrading projects as defined in section 144A.073, subdivision 1, so long as the cumulative total costs of the facility's remodeling projects do not exceed ~~$750,000~~ $1,000,000;

(m) to license and certify beds that are moved from one location to another for the purposes of converting up to five four-bed wards to single or double occupancy rooms in a nursing home that, as of January 1, 1993, was county-owned and had a licensed capacity of 115 beds;

(n) to allow a facility that on April 16, 1993, was a 106-bed licensed and certified nursing facility located in Minneapolis to layaway all of its licensed and certified nursing home beds. These beds may be relicensed and recertified in a newly-constructed teaching nursing home facility affiliated with a teaching hospital upon approval by the legislature. The proposal must be developed in consultation with the interagency committee on long-term care planning. The beds on layaway status shall have the same status as voluntarily delicensed and decertified beds, except that beds on layaway status remain subject to the surcharge in section 256.9657. This layaway provision expires July 1, 1998;

(o) to allow a project which will be completed in conjunction with an approved moratorium

exception project for a nursing home in southern Cass county and which is directly related to that portion of the facility that must be repaired, renovated, or replaced, to correct an emergency plumbing problem for which a state correction order has been issued and which must be corrected by August 31, 1993;

(p) to allow a facility that on April 16, 1993, was a 368-bed licensed and certified nursing facility located in Minneapolis to layaway, upon 30 days prior written notice to the commissioner, up to 30 of the facility's licensed and certified beds by converting three-bed wards to single or double occupancy. Beds on layaway status shall have the same status as voluntarily delicensed and decertified beds except that beds on layaway status remain subject to the surcharge in section 256.9657, remain subject to the license application and renewal fees under section 144A.07 and shall be subject to a $100 per bed reactivation fee. In addition, at any time within three years of the effective date of the layaway, the beds on layaway status may be:

(1) relicensed and recertified upon relocation and reactivation of some or all of the beds to an existing licensed and certified facility or facilities located in Pine River, Brainerd, or International Falls; provided that the total project construction costs related to the relocation of beds from layaway status for any facility receiving relocated beds may not exceed the dollar threshold provided in subdivision 2 unless the construction project has been approved through the moratorium exception process under section 144A.073;

(2) relicensed and recertified, upon reactivation of some or all of the beds within the facility which placed the beds in layaway status, if the commissioner has determined a need for the reactivation of the beds on layaway status.

The property-related payment rate of a facility placing beds on layaway status must be adjusted by the incremental change in its rental per diem after recalculating the rental per diem as provided in section 256B.431, subdivision 3a, paragraph (c). The property-related payment rate for a facility relicensing and recertifying beds from layaway status must be adjusted by the incremental change in its rental per diem after recalculating its rental per diem using the number of beds after the relicensing to establish the facility's capacity day divisor, which shall be effective the first day of the month following the month in which the relicensing and recertification became effective. Any beds remaining on layaway status more than three years after the date the layaway status became effective must be removed from layaway status and immediately delicensed and decertified;

(q) to license and certify beds in a renovation and remodeling project to convert 12 four-bed wards into 24 two-bed rooms, expand space, and add improvements in a nursing home that, as of January 1, 1994, met the following conditions: the nursing home was located in Ramsey county; had a licensed capacity of 154 beds; and had been ranked among the top 15 applicants by the 1993 moratorium exceptions advisory review panel. The total project construction cost estimate for this project must not exceed the cost estimate submitted in connection with the 1993 moratorium exception process;

(r) to license and certify up to 117 beds that are relocated from a licensed and certified 138-bed nursing facility located in St. Paul to a hospital with 130 licensed hospital beds located in South St. Paul, provided that the nursing facility and hospital are owned by the same or a related organization and that prior to the date the relocation is completed the hospital ceases operation of its inpatient hospital services at that hospital. After relocation, the nursing facility's status under section 256B.431, subdivision 2j, shall be the same as it was prior to relocation. The nursing facility's property-related payment rate resulting from the project authorized in this paragraph shall become effective no earlier than April 1, 1996. For purposes of calculating the incremental change in the facility's rental per diem resulting from this project, the allowable appraised value of the nursing facility portion of the existing health care facility physical plant prior to the renovation and relocation may not exceed $2,490,000;

(s) to license and certify two beds in a facility to replace beds that were voluntarily delicensed and decertified on June 28, 1991;

(t) to allow 16 licensed and certified beds located on July 1, 1994, in a 142-bed nursing home and 21-bed boarding care home facility in Minneapolis, notwithstanding the licensure and

certification after July 1, 1995, of the Minneapolis facility as a 147-bed nursing home facility after completion of a construction project approved in 1993 under section 144A.073, to be laid away upon 30 days' prior written notice to the commissioner. Beds on layaway status shall have the same status as voluntarily delicensed or decertified beds except that they shall remain subject to the surcharge in section 256.9657. The 16 beds on layaway status may be relicensed as nursing home beds and recertified at any time within five years of the effective date of the layaway upon relocation of some or all of the beds to a licensed and certified facility located in Watertown, provided that the total project construction costs related to the relocation of beds from layaway status for the Watertown facility may not exceed the dollar threshold provided in subdivision 2 unless the construction project has been approved through the moratorium exception process under section 144A.073.

The property-related payment rate of the facility placing beds on layaway status must be adjusted by the incremental change in its rental per diem after recalculating the rental per diem as provided in section 256B.431, subdivision 3a, paragraph (c). The property-related payment rate for the facility relicensing and recertifying beds from layaway status must be adjusted by the incremental change in its rental per diem after recalculating its rental per diem using the number of beds after the relicensing to establish the facility's capacity day divisor, which shall be effective the first day of the month following the month in which the relicensing and recertification became effective. Any beds remaining on layaway status more than five years after the date the layaway status became effective must be removed from layaway status and immediately delicensed and decertified;

(u) to license and certify beds that are moved within an existing area of a facility or to a newly constructed addition which is built for the purpose of eliminating three- and four-bed rooms and adding space for dining, lounge areas, bathing rooms, and ancillary service areas in a nursing home that, as of January 1, 1995, was located in Fridley and had a licensed capacity of 129 beds;

(v) to relocate 36 beds in Crow Wing county and four beds from Hennepin county to a 160-bed facility in Crow Wing county, provided all the affected beds are under common ownership;

(w) to license and certify a total replacement project of up to 49 beds located in Norman county that are relocated from a nursing home destroyed by flood and whose residents were relocated to other nursing homes. The operating cost payment rates for the new nursing facility shall be determined based on the interim and settle-up payment provisions of Minnesota Rules, part 9549.0057, and the reimbursement provisions of section 256B.431, except that subdivision 26, paragraphs (a) and (b), shall not apply until the second rate year after the settle-up cost report is filed. Property-related reimbursement rates shall be determined under section 256B.431, taking into account any federal or state flood-related loans or grants provided to the facility;

(x) to license and certify a total replacement project of up to 129 beds located in Polk county that are relocated from a nursing home destroyed by flood and whose residents were relocated to other nursing homes. The operating cost payment rates for the new nursing facility shall be determined based on the interim and settle-up payment provisions of Minnesota Rules, part 9549.0057, and the reimbursement provisions of section 256B.431, except that subdivision 26, paragraphs (a) and (b), shall not apply until the second rate year after the settle-up cost report is filed. Property-related reimbursement rates shall be determined under section 256B.431, taking into account any federal or state flood-related loans or grants provided to the facility;

(y) to license and certify beds in a renovation and remodeling project to convert 13 three-bed wards into 13 two-bed rooms and 13 single-bed rooms, expand space, and add improvements in a nursing home that, as of January 1, 1994, met the following conditions: the nursing home was located in Ramsey county, was not owned by a hospital corporation, had a licensed capacity of 64 beds, and had been ranked among the top 15 applicants by the 1993 moratorium exceptions advisory review panel. The total project construction cost estimate for this project must not exceed the cost estimate submitted in connection with the 1993 moratorium exception process;

(z) to license and certify up to 150 nursing home beds to replace an existing 285 bed nursing facility located in St. Paul. The replacement project shall include both the renovation of existing buildings and the construction of new facilities at the existing site. The reduction in the licensed

capacity of the existing facility shall occur during the construction project as beds are taken out of service due to the construction process. Prior to the start of the construction process, the facility shall provide written information to the commissioner of health describing the process for bed reduction, plans for the relocation of residents, and the estimated construction schedule. The relocation of residents shall be in accordance with the provisions of law and rule;

(aa) to allow the commissioner of human services to license an additional 36 beds to provide residential services for the physically handicapped under Minnesota Rules, parts 9570.2000 to 9570.3400, in a 198-bed nursing home located in Red Wing, provided that the total number of licensed and certified beds at the facility does not increase;

(bb) to license and certify a new facility in St. Louis county with 44 beds constructed to replace an existing facility in St. Louis county with 31 beds, which has resident rooms on two separate floors and an antiquated elevator that creates safety concerns for residents and prevents nonambulatory residents from residing on the second floor. The project shall include the elimination of three- and four-bed rooms;

(cc) to license and certify four beds in a 16-bed certified boarding care home in Minneapolis to replace beds that were voluntarily delicensed and decertified on or before March 31, 1992. The licensure and certification is conditional upon the facility periodically assessing and adjusting its resident mix and other factors which may contribute to a potential institution for mental disease declaration. The commissioner of human services shall retain the authority to audit the facility at any time and shall require the facility to comply with any requirements necessary to prevent an institution for mental disease declaration, including delicensure and decertification of beds, if necessary; ~~or~~

(dd) to license and certify 72 beds in an existing facility in Mille Lacs county with 80 beds as part of a renovation project. The renovation must include construction of an addition to accommodate ten residents with beginning and midstage dementia in a self-contained living unit; creation of three resident households where dining, activities, and support spaces are located near resident living quarters; designation of four beds for rehabilitation in a self-contained area; designation of 30 private rooms; and other improvements~~.~~;

(ee) to license and certify beds in a facility that has undergone replacement or remodeling as part of a planned closure under section 256B.437;

(ff) to license and certify a total replacement project of up to 124 beds located in Wilkin county that are in need of relocation from a nursing home substantially destroyed by flood. The operating cost payment rates for the new nursing facility shall be determined based on the interim and settle-up payment provisions of Minnesota Rules, part 9549.0057, and the reimbursement provisions of section 256B.431, except that section 256B.431, subdivision 26, paragraphs (a) and (b), shall not apply until the second rate year after the settle-up cost report is filed. Property-related reimbursement rates shall be determined under section 256B.431, taking into account any federal or state flood-related loans or grants provided to the facility;

(gg) to allow the commissioner of human services to license an additional nine beds to provide residential services for the physically handicapped under Minnesota Rules, parts 9570.2000 to 9570.3400, in a 215-bed nursing home located in Duluth, provided that the total number of licensed and certified beds at the facility does not increase;

(hh) to license and certify up to 120 new nursing facility beds to replace beds in a facility in Anoka county, which was licensed for 98 beds as of July 1, 2000, provided the new facility is located within four miles of the existing facility and is in Anoka county. Operating and property rates shall be determined and allowed under section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, or section 256B.434 or 256B.435. The provisions of section 256B.431, subdivision 26, paragraphs (a) and (b), do not apply until the second rate year following settle-up; or

(ii) to transfer up to 98 beds of a 129-licensed bed facility located in Anoka county that, as of March 25, 2001, is in the active process of closing, to a 122-licensed bed nonprofit nursing facility

located in the city of Columbia Heights or its affiliate. The transfer is effective when the receiving facility notifies the commissioner in writing of the number of beds accepted. The commissioner shall place all transferred beds on layaway status held in the name of the receiving facility. The layaway adjustment provisions of section 256B.431, subdivision 30, do not apply to this layaway. The receiving facility may only remove the beds from layaway for recertification and relicensure at the receiving facility's current site, or at a newly constructed facility located in Anoka county. The receiving facility must receive statutory authorization before removing these beds from layaway.

Sec. 6. Minnesota Statutes 2000, section 144A.073, subdivision 2, is amended to read:

Subd. 2. [REQUEST FOR PROPOSALS.] At the authorization by the legislature of additional medical assistance expenditures for exceptions to the moratorium on nursing homes, the interagency committee shall publish in the State Register a request for proposals for nursing home projects to be licensed or certified under section 144A.071, subdivision 4a, clause (c). The public notice of this funding and the request for proposals must specify how the approval criteria will be prioritized by the advisory review panel, the interagency long-term care planning committee, and the commissioner. The notice must describe the information that must accompany a request and state that proposals must be submitted to the interagency committee within 90 days of the date of publication. The notice must include the amount of the legislative appropriation available for the additional costs to the medical assistance program of projects approved under this section. If no money is appropriated for a year, the interagency committee shall publish a notice to that effect, and no proposals shall be requested. If money is appropriated, the interagency committee shall initiate the application and review process described in this section at least twice each biennium and up to four times each biennium, according to dates established by rule. Authorized funds shall be allocated proportionally to the number of processes. Funds not encumbered by an earlier process within a biennium shall carry forward to subsequent iterations of the process. Authorization for expenditures does not carry forward into the following biennium. To be considered for approval, a proposal must include the following information:

(1) whether the request is for renovation, replacement, upgrading, conversion, or relocation;

(2) a description of the problem the project is designed to address;

(3) a description of the proposed project;

(4) an analysis of projected costs of the nursing facility proposal, which are not required to exceed the cost threshold referred to in section 144A.071, subdivision 1, to be considered under this section, including initial construction and remodeling costs; site preparation costs; technology costs; financing costs, including the current estimated long-term financing costs of the proposal, which consists of estimates of the amount and sources of money, reserves if required under the proposed funding mechanism, annual payments schedule, interest rates, length of term, closing costs and fees, insurance costs, and any completed marketing study or underwriting review; and estimated operating costs during the first two years after completion of the project;

(5) for proposals involving replacement of all or part of a facility, the proposed location of the replacement facility and an estimate of the cost of addressing the problem through renovation;

(6) for proposals involving renovation, an estimate of the cost of addressing the problem through replacement;

(7) the proposed timetable for commencing construction and completing the project;

(8) a statement of any licensure or certification issues, such as certification survey deficiencies;

(9) the proposed relocation plan for current residents if beds are to be closed so that the department of human services can estimate the total costs of a proposal; and

(10) other information required by permanent rule of the commissioner of health in accordance with subdivisions 4 and 8.

Sec. 7. Minnesota Statutes 2000, section 144A.073, subdivision 4, is amended to read:

Subd. 4. [CRITERIA FOR REVIEW.] The following criteria shall be used in a consistent manner to compare, evaluate, and rank all proposals submitted. Except for the criteria specified in clause (3), the application of criteria listed under this subdivision shall not reflect any distinction based on the geographic location of the proposed project:

(1) the extent to which the proposal furthers state long-term care goals, ~~including the goals stated in section 144A.31, and~~ including the goal of enhancing the availability and use of alternative care services and the goal of reducing the number of long-term care resident rooms with more than two beds;

(2) the proposal's long-term effects on state costs including the cost estimate of the project according to section 144A.071, subdivision 5a;

(3) the extent to which the proposal promotes equitable access to long-term care services in nursing homes through redistribution of the nursing home bed supply, as measured by the number of beds relative to the population 85 or older, projected to the year 2000 by the state demographer, and according to items (i) to (iv):

(i) reduce beds in counties where the supply is high, relative to the statewide mean, and increase beds in counties where the supply is low, relative to the statewide mean;

(ii) adjust the bed supply so as to create the greatest benefits in improving the distribution of beds;

(iii) adjust the existing bed supply in counties so that the bed supply in a county moves toward the statewide mean; and

(iv) adjust the existing bed supply so that the distribution of beds as projected for the year 2020 would be consistent with projected need, based on the methodology outlined in the interagency long-term care committee's ~~1993~~ nursing home bed distribution study;

(4) the extent to which the project improves conditions that affect the health or safety of residents, such as narrow corridors, narrow door frames, unenclosed fire exits, and wood frame construction, and similar provisions contained in fire and life safety codes and licensure and certification rules;

(5) the extent to which the project improves conditions that affect the comfort or quality of life of residents in a facility or the ability of the facility to provide efficient care, such as a relatively high number of residents in a room; inadequate lighting or ventilation; poor access to bathing or toilet facilities; a lack of available ancillary space for dining rooms, day rooms, or rooms used for other activities; problems relating to heating, cooling, or energy efficiency; inefficient location of nursing stations; narrow corridors; or other provisions contained in the licensure and certification rules;

(6) the extent to which the applicant demonstrates the delivery of quality care, as defined in state and federal statutes and rules, to residents as evidenced by the two most recent state agency certification surveys and the applicants' response to those surveys;

(7) the extent to which the project removes the need for waivers or variances previously granted by either the licensing agency, certifying agency, fire marshal, or local government entity; ~~and~~

(8) the extent to which the project increases the number of private or single bed rooms; and

(9) other factors that may be developed in permanent rule by the commissioner of health that evaluate and assess how the proposed project will further promote or protect the health, safety, comfort, treatment, or well-being of the facility's residents.

Sec. 8. [144A.185] [DEFINITIONS.]

Subdivision 1. [APPLICABILITY.] For purposes of sections 144A.185 to 144A.1887, the terms defined in this section have the meanings given them.

Subd. 2. [CLOSURE.] "Closure" means the cessation of operations of a nursing home and the delicensure or decertification of all beds within the facility.

Subd. 3. [CURTAILMENT, REDUCTION, OR CHANGE IN OPERATIONS.] "Curtailment, reduction, or change in operations" means any change in operations or services that would result in or encourage the relocation of residents.

Subd. 4. [FACILITY.] "Facility" means a licensed nursing home or a certified boarding care home licensed according to sections 144.50 to 144.56.

Subd. 5. [LICENSEE.] "Licensee" means the owner of the facility or the owner's designee or the commissioner of health for a facility in receivership.

Subd. 6. [LOCAL AGENCY.] "Local agency" means a county or a multicounty social service agency authorized under section 393.01 as the agency responsible for providing social services for the county in which the facility is located.

Subd. 7. [PLAN.] "Plan" means a process developed under section 144A.186 for the closure or curtailment, reduction, or change in operations of a facility and for the subsequent relocation of residents.

Subd. 8. [RELOCATION.] "Relocation" means the discharge of a resident and movement of the resident to another facility or living arrangement as a result of a closure or curtailment, reduction, or change in operations of a facility.

Sec. 9. [144A.1855] [INITIAL NOTICE.]

Subdivision 1. [NOTIFICATION; PARTIES.] A licensee shall notify the following parties in writing when there is an intent to close or curtail, reduce, or change operations which would result in or encourage the relocation of residents:

(1) the commissioner of health;

(2) the commissioner of human services;

(3) the local agency;

(4) the office of the ombudsman for older Minnesotans; and

(5) the office of the ombudsman for mental health and mental retardation.

Subd. 2. [NOTICE REQUIREMENTS.] The written notice shall include the names, telephone numbers, fax numbers, and e-mail addresses of the persons in the facility who are responsible for coordinating the facility's efforts in the planning process and the number of residents potentially affected by the closure or curtailment, reduction, or change in operations.

Sec. 10. [144A.186] [PLANNING PROCESS.]

Subdivision 1. [LOCAL AGENCY REQUIREMENTS.] (a) A local agency, within five working days of receiving an initial notice from a licensee according to section 144A.1855, shall provide all parties identified in section 144A.1855, subdivision 1, with the names, telephone numbers, fax numbers, and e-mail addresses of those persons who are responsible for coordinating local agency efforts in the planning process.

(b) Within ten working days of receipt of the notice under paragraph (a), the local agency and licensee shall meet to develop the relocation plan under subdivision 2. The local agency shall inform the departments of health and human services, the office of the ombudsman for older Minnesotans, and the office of the ombudsman for mental health and mental retardation of the date, time, and location of the meeting so that their representatives may attend. The relocation plan

must be completed within 45 days, but may be completed earlier according to a schedule agreed to by all parties.

Subd. 2. [RELOCATION PLAN.] (a) The plan shall:

(1) identify the expected date of closure or curtailment, reduction, or change in operations;

(2) outline the process for public notification of the closure or curtailment, reduction, or change in operations;

(3) outline the process to ensure 60-day advance written notice to residents, family members, and designated representatives of residents;

(4) present an aggregate description of the resident population remaining to be relocated and the population's needs;

(5) outline the individual resident assessment process to be used;

(6) identify an inventory of available relocation options, including home and community-based services;

(7) identify a timeline for submission of the list required under section 144A.1865, subdivision 3; and

(8) identify a schedule for each element of the plan.

(b) All parties to the plan shall refrain from any public notification of the intent to close or curtail, reduce, or change operations until a relocation plan has been established.

Sec. 11. [144A.1865] [REQUIREMENTS OF LICENSEE.]

Subdivision 1. [RELOCATION.] The licensee shall provide for the safe, orderly, and appropriate relocation of residents. The licensee and facility staff shall cooperate with representatives from the local agency, the departments of health and human services, the office of the ombudsman for older Minnesotans, and the office of the ombudsman for mental health and mental retardation in planning for and implementing the relocation of residents.

Subd. 2. [INTERDISCIPLINARY TEAM.] The licensee shall establish an interdisciplinary team responsible for coordinating and implementing the plan under section 144A.186, subdivision 2. The interdisciplinary team shall include representatives from the local agency, the office of the ombudsman for older Minnesotans, facility staff who provide direct care services to the residents, and the facility administration.

Subd. 3. [RESIDENT LISTS.] The licensee shall provide a list to the local agency that includes the following information on each resident to be relocated:

(1) name;

(2) date of birth;

(3) social security number;

(4) medical assistance ID number;

(5) all diagnoses; and

(6) name of and contact information for the resident's family or other designated representative.

Subd. 4. [CONSULTATION WITH LOCAL AGENCY.] The licensee shall consult with the local agency on the availability and development of resources and in the resident relocation process.

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

Sec. 12. [144A.187] [RESIDENT AND PHYSICIAN NOTICE.]

Subdivision 1. [RESIDENT NOTICE REQUIRED.] (a) At least 60 days before the proposed date of closure or curtailment, reduction, or change in operations as agreed to in the plan under section 144A.186, the licensee shall send a written notice of closure or curtailment, reduction, or change in operations to each resident being relocated, the resident's family member or designated representative, and the resident's attending physician.

(b) The notice must include:

(1) the date of the proposed closure or curtailment, reduction, or change in operations;

(2) the name, address, telephone number, fax number, and e-mail address of the individuals in the facility responsible for providing assistance and information;

(3) a notice of upcoming meetings for residents, families and designated representatives, and resident and family councils to discuss the relocation of residents;

(4) the name, address, and telephone number of the local agency contact person;

(5) the name, address, and telephone number of the office of the ombudsman for older Minnesotans and the office of the ombudsman for mental health and mental retardation; and

(6) a notice of resident rights during discharge and relocation.

(c) The notice to residents must comply with all applicable state and federal requirements for notice of transfer or discharge of nursing home residents.

Subd. 2. [MEDICAL INFORMATION REQUEST.] The licensee shall request the attending physician to furnish the licensee with, or arrange for the release of, any medical information needed to update a resident's medical records and to prepare transfer forms and discharge summaries.

Sec. 13. [144A.1875] [RELOCATION OF RESIDENTS.]

Subdivision 1. [PREPARATION; PLACEMENT INFORMATION.] A licensee shall provide sufficient preparation to residents to ensure safe, orderly, and appropriate discharge and relocation. The facility is responsible for assisting residents in finding placement within the resident's desired geographic location using the Senior LinkAge database of the department of human services. By January 1, 2002, Senior LinkAge line shall make available via a Web site the name, address, and telephone and fax numbers of each facility with available beds, the certification level of the available beds, the types of services available, and the number of beds that are available as updated daily by the licensee. The Web site shall include the information required by section 256.975, subdivision 7, paragraph (b), clause (1), and home and community-based services and other options for individuals with special needs. The licensee must provide residents, their families or designated representatives, the office of the ombudsman for older Minnesotans, the office of the ombudsman for mental health and mental retardation, and the local agency with the toll-free number and Web site address for the Senior LinkAge line.

Subd. 2. [RESIDENT AND FAMILY MEETINGS.] After preparing the plan according to section 144A.186, the licensee shall conduct meetings with residents, families and designated representatives, and resident and family councils to notify them of the process for resident relocation. Representatives from the local agency, the office of the ombudsman for older Minnesotans, the office of the ombudsman for mental health and mental retardation, the departments of health and human services shall receive advance notice of these meetings.

Subd. 3. [PERSONAL PROPERTY.] (a) The licensee shall update the inventory of residents' personal possessions and provide a copy of the final inventory to each resident and the resident's family or designated representative prior to the relocation of the resident. The licensee is responsible for the timely transfer of a resident's possessions for all relocations within the state and within a 50-mile radius of the facility for relocations outside the state.

(b) The licensee shall complete a final accounting of personal funds held in trust by the licensee and provide a copy of the accounting to each resident and the resident's family or designated representative. The licensee is responsible for the timely transfer of all personal funds held in trust by the licensee.

Subd. 4. [SITE VISITS.] The licensee is responsible for assisting residents desiring to make site visits to facilities or other placements to which the resident may be relocated, unless it is medically inadvisable, as documented by the attending physician in the resident's care record. The licensee shall provide, or make arrangements for, transportation for site visits to facilities or other placements within a 50-mile radius.

Subd. 5. [FINAL NOTICE OF RELOCATION.] (a) Before relocating a resident, the licensee shall provide a final written notice to the resident, the resident's family or designated representative, and the resident's attending physician.

(b) The final written notice shall:

(1) be provided seven days before the relocation of a resident, unless the resident agrees to waive the resident's right to advance notice; and

(2) identify the date of the anticipated relocation and the location to which the resident is being relocated.

Subd. 6. [ADMINISTRATIVE DUTIES.] (a) All administrative duties of the licensee under subdivisions 1, 2, 4, and 5 must be completed before relocation of a resident.

(b) The licensee is responsible for providing the receiving facility or other health, housing, or care entity with a complete and accurate resident record, including information on family members, designated representatives, guardians, social service caseworkers, and other contact information. The record must also include all information necessary to provide appropriate medical care and social services, including, but not limited to, information on preadmission screening, Level I and Level II screening, minimum data set and all other assessments, resident diagnosis, behavior, and medication.

(c) For residents with special care needs, the licensee shall consult with the receiving facility or other placement entity and provide staff training or other preparation as needed to assist in providing for the special needs.

(d) The licensee shall assist residents with the transfer or reconnection of telephone service. The licensee shall bear all costs associated with reestablishing telephone service.

Subd. 7. [TRANSPORTATION; CONTINUITY OF CARE.] The licensee shall make arrangements or provide for the transportation of residents to the new facility or placement within the state or within a 50-mile radius for relocations outside the state. The licensee shall provide a staff person to accompany the resident during transportation, upon request of the resident, the resident's family, or designated representative. The discharge and relocation of residents must comply with all applicable state and federal requirements and must be conducted in a safe, orderly, and appropriate manner. The licensee must ensure that there is no disruption in providing meals, medications, or treatments of a resident during the relocation process.

Sec. 14. [144A.1885] [RELOCATION REPORTS.]

(a) Beginning the week following development of the initial relocation plan under section 144A.186, the licensee shall submit weekly status reports to the commissioners of health and human services, or their designees, and to the local agency.

(b) The first status report must identify the relocation plan developed under section 144A.186, the interdisciplinary team members, and the number of residents to be relocated.

(c) Subsequent status reports must note any modifications to the relocation plan, any change of interdisciplinary team members or number of residents relocated, the placement destination to

which residents have been relocated, and the number of residents remaining to be relocated. Subsequent status reports must also identify issues or problems encountered during the relocation process and the resolution of these issues.

Sec. 15. [144A.1886] [REQUIREMENTS OF LOCAL AGENCY.]

Subdivision 1. [MEETING; REPRESENTATION.] (a) The local agency with the licensee shall convene a meeting to develop a plan according to section 144A.186, subdivision 1, paragraph (b).

(b) The local agency shall designate a representative to the interdisciplinary team established by the licensee responsible for coordinating the relocation efforts.

Subd. 2. [RESOURCE.] (a) The local agency shall serve as a resource in the relocation process.

(b) Concurrent with the notice sent to residents from the licensee according to section 144A.187, subdivision 1, the local agency shall provide written notice to residents, family members, and designated representatives describing:

(1) the local agency's role in the relocation process and in the follow-up to relocation;

(2) a local agency contact name, address, and telephone number; and

(3) the name, address, and telephone number of the office of the ombudsman for older Minnesotans and the office of the ombudsman for mental health and mental retardation.

(c) The local agency is responsible for the safe and orderly relocation of residents in cases where an emergent need arises or when the licensee has abrogated the licensee's responsibilities under the relocation plan.

Subd. 3. [COORDINATION; OVERSIGHT.] (a) The local agency shall meet with appropriate facility staff to coordinate any assistance. Coordination shall include participating in group meetings with residents, family members, and designated representatives to explain the transfer or relocation process.

(b) The local agency shall monitor compliance with all components of the relocation plan. When the licensee is not in compliance, the local agency shall notify the commissioners of health and human services.

(c) Except as requested by the resident, family member, or designated representative and within the parameters of the Vulnerable Adults Act, the local agency may halt a relocation that it deems inappropriate or dangerous to the health or safety of a resident.

Subd. 4. [FOLLOW-UP REVIEW.] (a) A member of the local agency staff shall visit residents relocated within 100 miles of the county within 30 days after a relocation. Local agency staff shall interview the resident and family member or designated representative or shall observe the resident on-site, or both, and review and discuss pertinent medical or social records with appropriate facility staff to assess the adjustment of the resident to the new placement, recommend services or methods to meet any special needs of the resident, and identify residents at risk.

(b) The local agency may conduct subsequent follow-up visits in cases where the adjustment of the resident to the new placement is in question.

(c) Within 60 days of the completion of the follow-up visits, the local agency shall submit a written summary of the follow-up work to the commissioners of health and human services, in a manner approved by the commissioners.

(d) The local agency shall submit a report of any issues that may require further review or monitoring to the commissioner of health.

Sec. 16. [144A.1887] [FUNDING.]

(a) Within 60 days of a nursing home ceasing operations, the commissioner of human services

shall reimburse nursing homes that are reimbursed under sections 256B.431, 256B.434, and 256B.435 for operating costs incurred by the nursing home during the closure process. The amount to be reimbursed to the nursing home shall be determined by applying paragraphs (b) to (f).

(b) The facility shall provide the commissioner of human services with the nursing home's operating costs for the time period of 30 days prior to the notice specified under section 144A.16, to 30 days after the nursing home's closure.

(c) The nursing home shall provide the commissioner of human services with the number of medical assistance, Medicare, private pay, and other resident days for the period referenced in paragraph (b) by the 11 case mix categories.

(d) The commissioner of human services shall calculate a nursing home closure rate by dividing the facility operating costs in paragraph (b) by the total resident days in paragraph (c).

(e) The total closure costs attributable to medical assistance shall be determined by multiplying the nursing home closure rate in paragraph (d) by the medical assistance days provided by the nursing facility in paragraph (c).

(f) The amount to be reimbursed to the nursing home is equal to the total closure costs in paragraph (e) minus the sum of the nursing facility's 11 operating rates times their respective number of medical assistance days by case mix as referenced in paragraph (c).

Sec. 17. [144A.36] [TRANSITION PLANNING GRANTS.]

Subdivision 1. [DEFINITIONS.] "Eligible nursing home" means any nursing home licensed under sections 144A.01 to 144A.16 and certified by the appropriate authority under United States Code, title 42, sections 1396-1396p, to participate as a vendor in the medical assistance program established under chapter 256B.

Subd. 2. [GRANTS AUTHORIZED.] (a) The commissioner shall establish a program of transition planning grants to assist eligible nursing homes in implementing the provisions in paragraphs (b) and (c).

(b) Transition planning grants may be used by nursing homes to develop strategic plans which identify the appropriate institutional and noninstitutional settings necessary to meet the older adult service needs of the community.

(c) At a minimum, a strategic plan must consist of:

(1) a needs assessment to determine what older adult services are needed and desired by the community;

(2) an assessment of the appropriate settings in which to provide needed older adult services;

(3) an assessment identifying currently available services and their settings in the community; and

(4) a transition plan to achieve the needed outcome identified by the assessment.

Subd. 3. [ALLOCATION OF GRANTS.] (a) Eligible nursing homes must apply to the commissioner no later than September 1 of each fiscal year for grants awarded in that fiscal year. A grant shall be awarded upon signing of a grant contract.

(b) The commissioner must make a final decision on the funding of each application within 60 days of the deadline for receiving applications.

Subd. 4. [EVALUATION.] The commissioner shall evaluate the overall effectiveness of the grant program. The commissioner may collect, from the nursing homes receiving grants, the information necessary to evaluate the grant program. Information related to the financial condition of individual nursing homes shall be classified as nonpublic data.

Sec. 18. [144A.37] [ALTERNATIVE NURSING HOME SURVEY PROCESS.]

Subdivision 1. [ALTERNATIVE NURSING HOME SURVEY SCHEDULES.] (a) The commissioner of health shall implement alternative procedures for the nursing home survey process as authorized under this section.

(b) These alternative survey process procedures seek to: (1) use department resources more effectively and efficiently to target problem areas; (2) use other existing or new mechanisms to provide objective assessments of quality and to measure quality improvement; (3) provide for frequent collaborative interaction of facility staff and surveyors rather than a punitive approach; and (4) reward a nursing home that has performed very well by extending intervals between full surveys.

(c) The commissioner shall pursue changes in federal law necessary to accomplish this process and shall apply for any necessary federal waivers or approval. If a federal waiver is approved, the commissioner shall promptly submit, to the house and senate committees with jurisdiction over health and human services policy and finance, fiscal estimates for implementing the alternative survey process waiver. The commissioner shall also pursue any necessary federal law changes during the 107th Congress.

(d) The alternative nursing home survey schedule and related educational activities shall not be implemented until funding is appropriated by the legislature.

Subd. 2. [SURVEY INTERVALS.] The commissioner of health must extend the time period between standard surveys up to 30 months based on the criteria established in subdivision 4. In using the alternative survey schedule, the requirement for the statewide average to not exceed 12 months does not apply.

Subd. 3. [COMPLIANCE HISTORY.] The commissioner shall develop a process for identifying the survey cycles for skilled nursing facilities based upon the compliance history of the facility. This process can use a range of months for survey intervals. At a minimum, the process must be based on information from the last two survey cycles and shall take into consideration any deficiencies issued as the result of a survey or a complaint investigation during the interval. A skilled nursing facility with a finding of substandard quality of care or a finding of immediate jeopardy is not entitled to a survey interval greater than 12 months. The commissioner shall alter the survey cycle for a specific skilled nursing facility based on findings identified through the completion of a survey, a monitoring visit, or a complaint investigation. The commissioner must also take into consideration information other than the facility's compliance history.

Subd. 4. [CRITERIA FOR SURVEY INTERVAL CLASSIFICATION.] (a) The commissioner shall provide public notice of the classification process and shall identify the selected survey cycles for each skilled nursing facility. The classification system must be based on an analysis of the findings made during the past two standard survey intervals, but it only takes one survey or complaint finding to modify the interval.

(b) The commissioner shall also take into consideration information obtained from residents and family members in each skilled nursing facility and from other sources such as employees and ombudsmen in determining the appropriate survey intervals for facilities.

Subd. 5. [REQUIRED MONITORING.] (a) The commissioner shall conduct at least one monitoring visit on an annual basis for every skilled nursing facility which has been selected for a survey cycle greater than 12 months. The commissioner shall develop protocols for the monitoring visits which shall be less extensive than the requirements for a standard survey. The commissioner shall use the criteria in paragraph (b) to determine whether additional monitoring visits to a facility will be required.

(b) The criteria shall include, but not be limited to, the following:

(1) changes in ownership, administration of the facility, or direction of the facility's nursing service;

(2) changes in the facility's quality indicators which might evidence a decline in the facility's quality of care;

(3) reductions in staffing or an increase in the utilization of temporary nursing personnel; and

(4) complaint information or other information that identifies potential concerns for the quality of the care and services provided in the skilled nursing facility.

Subd. 6. [SURVEY REQUIREMENTS FOR FACILITIES NOT APPROVED FOR EXTENDED SURVEY INTERVALS.] The commissioner shall establish a process for surveying and monitoring of facilities which require a survey interval of less than 15 months. This information shall identify the steps that the commissioner must take to monitor the facility in addition to the standard survey.

Subd. 7. [IMPACT ON SURVEY AGENCY'S BUDGET.] The implementation of an alternative survey process for the state must not result in any reduction of funding that would have been provided to the state survey agency for survey and enforcement activity based upon the completion of full standard surveys for each skilled nursing facility in the state.

Subd. 8. [EDUCATIONAL ACTIVITIES.] The commissioner shall expand the state survey agency's ability to conduct training and educational efforts for skilled nursing facilities, residents and family members, residents and family councils, long-term care ombudsman programs, and the general public.

Subd. 9. [EVALUATION.] The commissioner shall develop a process for the evaluation of the effectiveness of an alternative survey process conducted under this section.

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

Sec. 19. [144A.38] [INNOVATIONS IN QUALITY DEMONSTRATION GRANTS.]

Subdivision 1. [PROGRAM ESTABLISHED.] The commissioner of health and the commissioner of human services shall establish a long-term care grant program that demonstrates best practices and innovation for long-term care service delivery and housing. The grants must fund demonstrations that create new means and models for serving the elderly or demonstrate creativity in service provision through the scope of their program or service.

Subd. 2. [ELIGIBILITY.] Grants may only be made to those who provide direct service or housing to the elderly within the state. Grants may only be made for projects that show innovations and measurable improvement in resident care, quality of life, use of technology, or customer satisfaction.

Subd. 3. [AWARDING OF GRANTS.] (a) Applications for grants must be made to the commissioners on forms prescribed by the commissioners.

(b) The commissioners shall review applications and award grants based on the following criteria:

(1) improvement in direct care to residents;

(2) increase in efficiency through the use of technology;

(3) increase in quality of care through the use of technology;

(4) increase in the access and delivery of service;

(5) enhancement of nursing staff training;

(6) the effectiveness of the project as a demonstration; and

(7) the immediate transferability of the project to scale.

(c) In reviewing applications and awarding grants, the commissioners shall consult with

long-term care providers, consumers of long-term care, long-term care researchers, and staff of other state agencies.

(d) Grants for eligible projects may not exceed $100,000.

Sec. 20. [144A.39] [LONG-TERM CARE QUALITY PROFILES.]

Subdivision l. [DEVELOPMENT AND IMPLEMENTATION OF QUALITY PROFILES.] (a) The commissioner of health and the commissioner of human services shall develop and implement a quality profile system for nursing facilities and, beginning not later than July 1, 2003, other providers of long-term care services, except when the quality profile system would duplicate requirements under sections 256B.5011 and 256B.5013. The system must be developed and implemented to the extent possible without the collection of new data. To the extent possible, the system must incorporate or be coordinated with information on quality maintained by area agencies on aging, long-term care trade associations, and other entities. The system must be designed to provide information on quality:

(1) to consumers and their families to facilitate informed choices of service providers;

(2) to providers to enable them to measure the results of their quality improvement efforts and compare quality achievements with other service providers; and

(3) to public and private purchasers of long-term care services to enable them to purchase high-quality care.

(b) The system must be developed in consultation with the long-term care task force, area agencies on aging, and representatives of consumers, providers, and labor unions. Within the limits of available appropriations, the commissioners may employ consultants to assist with this project.

Subd. 2. [QUALITY MEASUREMENT TOOLS.] The commissioners shall identify and apply existing quality measurement tools to:

(1) emphasize quality of care and its relationship to quality of life; and

(2) address the needs of various users of long-term care services, including, but not limited to, short-stay residents, persons with behavioral problems, persons with dementia, and persons who are members of minority groups.

The tools must be identified and applied, to the extent possible, without requiring providers to supply information beyond current state and federal requirements.

Subd. 3. [CONSUMER SURVEYS.] Following identification of the quality measurement tool, the commissioners shall conduct surveys of long-term care service consumers to develop quality profiles of providers. To the extent possible, surveys must be conducted face-to-face by state employees or contractors. At the discretion of the commissioners, surveys may be conducted by telephone or by provider staff. Surveys must be conducted periodically to update quality profiles of individual service providers.

Subd. 4. [DISSEMINATION OF QUALITY PROFILES.] By July 1, 2002, the commissioners shall implement a system to disseminate the quality profiles developed from consumer surveys using the quality measurement tool. Profiles must be disseminated to the Senior LinkAge line and to consumers, providers, and purchasers of long-term care services through all feasible printed and electronic outlets. The commissioners shall conduct a public awareness campaign to inform potential users regarding profile contents and potential uses.

Sec. 21. Minnesota Statutes 2000, section 256B.431, subdivision 17, is amended to read:

Subd. 17. [SPECIAL PROVISIONS FOR MORATORIUM EXCEPTIONS.] (a) Notwithstanding Minnesota Rules, part 9549.0060, subpart 3, for rate periods beginning on October 1, 1992, and for rate years beginning after June 30, 1993, a nursing facility that (1) has completed a construction project approved under section 144A.071, subdivision 4a, clause (m); (2)

has completed a construction project approved under section 144A.071, subdivision 4a, and effective after June 30, 1995; or (3) has completed a renovation, replacement, or upgrading project approved under the moratorium exception process in section 144A.073 shall be reimbursed for costs directly identified to that project as provided in subdivision 16 and this subdivision.

(b) Notwithstanding Minnesota Rules, part 9549.0060, subparts 5, item A, subitems (1) and (3), and 7, item D, allowable interest expense on debt shall include:

(1) interest expense on debt related to the cost of purchasing or replacing depreciable equipment, excluding vehicles, not to exceed six percent of the total historical cost of the project; and

(2) interest expense on debt related to financing or refinancing costs, including costs related to points, loan origination fees, financing charges, legal fees, and title searches; and issuance costs including bond discounts, bond counsel, underwriter's counsel, corporate counsel, printing, and financial forecasts. Allowable debt related to items in this clause shall not exceed seven percent of the total historical cost of the project. To the extent these costs are financed, the straight-line amortization of the costs in this clause is not an allowable cost; and

(3) interest on debt incurred for the establishment of a debt reserve fund, net of the interest earned on the debt reserve fund.

(c) Debt incurred for costs under paragraph (b) is not subject to Minnesota Rules, part 9549.0060, subpart 5, item A, subitem (5) or (6).

(d) The incremental increase in a nursing facility's rental rate, determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section, resulting from the acquisition of allowable capital assets, and allowable debt and interest expense under this subdivision shall be added to its property-related payment rate and shall be effective on the first day of the month following the month in which the moratorium project was completed.

(e) Notwithstanding subdivision 3f, paragraph (a), for rate periods beginning on October 1, 1992, and for rate years beginning after June 30, 1993, the replacement-costs-new per bed limit to be used in Minnesota Rules, part 9549.0060, subpart 4, item B, for a nursing facility that has completed a renovation, replacement, or upgrading project that has been approved under the moratorium exception process in section 144A.073, or that has completed an addition to or replacement of buildings, attached fixtures, or land improvements for which the total historical cost exceeds the lesser of $150,000 or ten percent of the most recent appraised value, must be $47,500 per licensed bed in multiple-bed rooms and $71,250 per licensed bed in a single-bed room. These amounts must be adjusted annually as specified in subdivision 3f, paragraph (a), beginning January 1, 1993.

(f) For purposes of this paragraph, a total replacement means the complete replacement of the nursing facility's physical plant through the construction of a new physical plant, the transfer of the nursing facility's license from one physical plant location to another, or a new building addition to relocate beds from three- and four-bed wards. For total replacement projects completed on or after July 1, 1992, the commissioner shall compute the incremental change in the nursing facility's rental per diem, for rate years beginning on or after July 1, 1995, by replacing its appraised value, including the historical capital asset costs, and the capital debt and interest costs with the new nursing facility's allowable capital asset costs and the related allowable capital debt and interest costs. If the new nursing facility has decreased its licensed capacity, the aggregate investment per bed limit in subdivision 3a, paragraph (c), shall apply. If the new nursing facility has retained a portion of the original physical plant for nursing facility usage, then a portion of the appraised value prior to the replacement must be retained and included in the calculation of the incremental change in the nursing facility's rental per diem. For purposes of this part, the original nursing facility means the nursing facility prior to the total replacement project. The portion of the appraised value to be retained shall be calculated according to clauses (1) to (3):

(1) The numerator of the allocation ratio shall be the square footage of the area in the original physical plant which is being retained for nursing facility usage.

(2) The denominator of the allocation ratio shall be the total square footage of the original nursing facility physical plant.

(3) Each component of the nursing facility's allowable appraised value prior to the total replacement project shall be multiplied by the allocation ratio developed by dividing clause (1) by clause (2).

In the case of either type of total replacement as authorized under section 144A.071 or 144A.073, the provisions of this subdivision shall also apply. For purposes of the moratorium exception authorized under section 144A.071, subdivision 4a, paragraph (s), if the total replacement involves the renovation and use of an existing health care facility physical plant, the new allowable capital asset costs and related debt and interest costs shall include first the allowable capital asset costs and related debt and interest costs of the renovation, to which shall be added the allowable capital asset costs of the existing physical plant prior to the renovation, and if reported by the facility, the related allowable capital debt and interest costs.

(g) Notwithstanding Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2), for a total replacement, as defined in paragraph (f), authorized under section 144A.071 or 144A.073 after July 1, 1999, or any building project that is a relocation, renovation, upgrading, or conversion ~~authorized under section 144A.073,~~ completed on or after July 1, 2001, the replacement-costs-new per bed limit shall be $74,280 per licensed bed in multiple-bed rooms, $92,850 per licensed bed in semiprivate rooms with a fixed partition separating the resident beds, and $111,420 per licensed bed in single rooms. Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2), does not apply. These amounts must be adjusted annually as specified in subdivision 3f, paragraph (a), beginning January 1, 2000.

(h) For a total replacement, as defined in paragraph (f), authorized under section 144A.073 for a 96-bed nursing home in Carlton county, the replacement-costs-new per bed limit shall be $74,280 per licensed bed in multiple-bed rooms, $92,850 per licensed bed in semiprivate rooms with a fixed partition separating the resident's beds, and $111,420 per licensed bed in a single room. Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2), does not apply. The resulting maximum allowable replacement-costs-new multiplied by 1.25 shall constitute the project's dollar threshold for purposes of application of the limit set forth in section 144A.071, subdivision 2. The commissioner of health may waive the requirements of section 144A.073, subdivision 3b, paragraph (b), clause (2), on the condition that the other requirements of that paragraph are met.

(i) For a renovation authorized under section 144A.073 for a 65-bed nursing home in St. Louis county, the incremental increase in rental rate for purposes of paragraph (d) shall be $8.16, and the total replacement cost, allowable appraised value, allowable debt, and allowable interest shall be increased according to the incremental increase.

(j) For a total replacement, as defined in paragraph (f), authorized under section 144A.073 involving a new building addition that relocates beds from three-bed wards for an 80-bed nursing home in Redwood county, the replacement-costs-new per bed limit shall be $74,280 per licensed bed for multiple-bed rooms; $92,850 per licensed bed for semiprivate rooms with a fixed partition separating the beds; and $111,420 per licensed bed for single rooms. These amounts shall be adjusted annually, beginning January 1, 2001. Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2), does not apply. The resulting maximum allowable replacement-costs-new multiplied by 1.25 shall constitute the project's dollar threshold for purposes of application of the limit set forth in section 144A.071, subdivision 2. The commissioner of health may waive the requirements of section 144A.073, subdivision 3b, paragraph (b), clause (2), on the condition that the other requirements of that paragraph are met.

Sec. 22. Minnesota Statutes 2000, section 256B.431, is amended by adding a subdivision to read:

Subd. 31. [PAYMENT DURING FIRST 90 DAYS.] (a) For rate years beginning on or after July 1, 2001, the total payment rate for a facility reimbursed under this section, section 256B.434, or any other section for the first 90 days after admission shall be:

(1) for the first 30 paid days, the rate shall be 120 percent of the facility's medical assistance rate for each case mix class; and

(2) for the next 60 days after the first 30 paid days, the rate shall be 110 percent of the facility's medical assistance rate for each case mix class.

(b) Beginning with the 91st paid day after admission, the payment rate shall be the rate otherwise determined under this section, section 256B.434, or any other section.

(c) This subdivision applies to admissions occurring on or after July 1, 2001.

Sec. 23. Minnesota Statutes 2000, section 256B.431, is amended by adding a subdivision to read:

Subd. 32. [NURSING FACILITY RATE INCREASES BEGINNING JULY 1, 2001, AND JULY 1, 2002.] For the rate years beginning July 1, 2001, and July 1, 2002, the commissioner shall make available to each nursing facility reimbursed under this section or section 256B.434 an adjustment equal to 3.0 percent of the total operating payment rate. The operating payment rates in effect on June 30, 2001, and June 30, 2002, respectively, shall include the adjustment in subdivision 2i, paragraph (c).

Sec. 24. Minnesota Statutes 2000, section 256B.431, is amended by adding a subdivision to read:

Subd. 33. [ADDITIONAL INCREASES FOR LOW RATE METROPOLITAN AREA FACILITIES.] After the calculation of the increase for the rate year beginning July 1, 2001, in subdivision 31, the commissioner must provide for special increases to facilities determined to be the lowest rate facilities in state development region 11, as defined in section 462.385. Within this region, the commissioner shall identify the median nursing facility rate by case mix category for all nursing facilities under section 256B.431 or 256B.434. Nursing home rates that are below the median for case mix class A must be adjusted to the set of case mix rates for the facility at the median for case mix class A.

Sec. 25. Minnesota Statutes 2000, section 256B.431, is amended by adding a subdivision to read:

Subd. 34. [RATE FLOOR FOR FACILITIES LOCATED OUTSIDE THE METROPOLITAN AREA.] (a) For the rate year beginning July 1, 2001, the commissioner shall adjust operating costs per diem for nursing facilities located outside of state development region 11, as defined in section 462.385, reimbursed under this section and sections 256B.434 and 256B.435, as provided in this subdivision.

(b) For each nursing facility, the commissioner shall compare the operating costs per diem listed in this paragraph to the operating costs per diem the facility would otherwise receive for the July 1, 2001, rate year after provision of any other rate increases required by this chapter.

| Case mix classification | Operating costs per diem |
|---|---|
| A | $ 67.02 |
| B | $ 73.00 |
| C | $ 79.77 |
| D | $ 85.94 |
| E | $ 92.32 |
| F | $ 92.72 |
| G | $ 98.13 |
| H | $108.40 |
| I | $112.03 |
| J | $117.67 |
| K | $129.55 |

(c) If a facility's total reimbursement for operating costs, using the case mix classification

operating costs per diem listed in paragraph (b), is greater than the total reimbursement for operating costs the facility would otherwise receive, the commissioner shall calculate operating costs per diem for that facility for the rate year beginning July 1, 2001, using the case mix classification operating costs per diem listed in paragraph (b).

(d) If a facility's total reimbursement for operating costs, using the case mix classification costs per diem listed in paragraph (b), is less than the total reimbursement for operating costs the facility would otherwise receive, the commissioner shall reimburse that facility for the rate year beginning July 1, 2001, as provided in this section, section 256B.434, or 256B.435, whichever is applicable, and shall not calculate operating costs per diem for that facility using the case mix classification operating costs per diem listed in paragraph (b).

Sec. 26. Minnesota Statutes 2000, section 256B.431, is amended by adding a subdivision to read:

Subd. 35. [EXCLUSION OF RAW FOOD COST ADJUSTMENT.] For rate years beginning on or after July 1, 2001, in calculating a nursing facility's operating cost per diem for the purposes of constructing an array of nursing facility payment rates to be used to determine future rate increases under this section, section 256B.434, or any other section, the commissioner shall exclude adjustments for raw food costs under subdivision 2b, paragraph (h), that are related to providing special diets based on religious beliefs.

Sec. 27. Minnesota Statutes 2000, section 256B.434, subdivision 4, is amended to read:

Subd. 4. [ALTERNATE RATES FOR NURSING FACILITIES.] (a) For nursing facilities which have their payment rates determined under this section rather than section 256B.431, the commissioner shall establish a rate under this subdivision. The nursing facility must enter into a written contract with the commissioner.

(b) A nursing facility's case mix payment rate for the first rate year of a facility's contract under this section is the payment rate the facility would have received under section 256B.431.

(c) A nursing facility's case mix payment rates for the second and subsequent years of a facility's contract under this section are the previous rate year's contract payment rates plus an inflation adjustment and an adjustment to include the cost of any increase in health department licensing fees for the facility taking effect on or after July 1, 2001. The index for the inflation adjustment must be based on the change in the Consumer Price Index-All Items (United States City average) (CPI-U) forecasted by Data Resources, Inc., as forecasted in the fourth quarter of the calendar year preceding the rate year. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined. For the rate years beginning on July 1, 1999, ~~and~~ July 1, 2000, July 1, 2001, and July 1, 2002, this paragraph shall apply only to the property-related payment rate, except that adjustments to include the cost of any increase in health department licensing fees taking effect on or after July 1, 2001, shall be provided. In determining the amount of the property-related payment rate adjustment under this paragraph, the commissioner shall determine the proportion of the facility's rates that are property-related based on the facility's most recent cost report.

(d) The commissioner shall develop additional incentive-based payments of up to five percent above the standard contract rate for achieving outcomes specified in each contract. The specified facility-specific outcomes must be measurable and approved by the commissioner. The commissioner may establish, for each contract, various levels of achievement within an outcome. After the outcomes have been specified the commissioner shall assign various levels of payment associated with achieving the outcome. Any incentive-based payment cancels if there is a termination of the contract. In establishing the specified outcomes and related criteria the commissioner shall consider the following state policy objectives:

(1) improved cost effectiveness and quality of life as measured by improved clinical outcomes;

(2) successful diversion or discharge to community alternatives;

(3) decreased acute care costs;

(4) improved consumer satisfaction;

(5) the achievement of quality; or

(6) any additional outcomes proposed by a nursing facility that the commissioner finds desirable.

Sec. 28. Minnesota Statutes 2000, section 256B.434, is amended by adding a subdivision to read:

Subd. 4c. [FACILITY RATE INCREASES EFFECTIVE JANUARY 1, 2002.] For the rate period beginning January 1, 2002, and for the rate year beginning July 1, 2002, a nursing facility in Morrison county licensed for 83 beds shall receive an increase of $2.54 in each case mix payment rate to offset property tax payments due as a result of the facility's conversion from nonprofit to for-profit status. The increases under this subdivision shall be added following the determination under this chapter of the payment rate for the rate year beginning July 1, 2001, and shall be included in the facility's total payment rates for the purposes of determining future rates under this section or any other section.

Sec. 29. Minnesota Statutes 2000, section 256B.434, is amended by adding a subdivision to read:

Subd. 4d. [FACILITY RATE INCREASES EFFECTIVE JULY 1, 2001.] For the rate year beginning July 1, 2001, a nursing facility in Hennepin county licensed for 302 beds shall receive an increase of 29 cents in each case mix payment rate to correct an error in the cost-reporting system that occurred prior to the date that the facility entered the alternative payment demonstration project. The increases under this subdivision shall be added following the determination under this chapter of the payment rate for the rate year beginning July 1, 2001, and shall be included in the facility's total payment rates for the purposes of determining future rates under this section or any other section.

Sec. 30. Minnesota Statutes 2000, section 256B.434, is amended by adding a subdivision to read:

Subd. 4e. [RATE INCREASE EFFECTIVE JULY 1, 2001.] A nursing facility in Anoka county licensed for 98 beds as of July 1, 2000, shall receive an increase of $10 in each case mix rate for the rate year beginning July 1, 2001. This increase shall be included in the facility's total payment rate for purposes of determining future rates under this section or any other section through June 30, 2004.

Sec. 31. Minnesota Statutes 2000, section 256B.434, subdivision 10, is amended to read:

Subd. 10. [EXEMPTIONS.] (a) To the extent permitted by federal law, (1) a facility that has entered into a contract under this section is not required to file a cost report, as defined in Minnesota Rules, part 9549.0020, subpart 13, for any year after the base year that is the basis for the calculation of the contract payment rate for the first rate year of the alternative payment demonstration project contract; and (2) a facility under contract is not subject to audits of historical costs or revenues, or paybacks or retroactive adjustments based on these costs or revenues, except audits, paybacks, or adjustments relating to the cost report that is the basis for calculation of the first rate year under the contract.

(b) ~~A facility that is under contract with the commissioner under this section is not subject to the moratorium on licensure or certification of new nursing home beds in section 144A.071, unless the project results in a net increase in bed capacity or involves relocation of beds from one site to another. Contract payment rates must not be adjusted to reflect any additional costs that a nursing facility incurs as a result of a construction project undertaken under this paragraph. In addition, as a condition of entering into a contract under this section, a nursing facility must agree that any future medical assistance payments for nursing facility services will not reflect any additional costs attributable to the sale of a nursing facility under this section and to construction~~

~~undertaken under this paragraph that otherwise would not be authorized under the moratorium in section 144A.073. Nothing in this section prevents a nursing facility participating in the alternative payment demonstration project under this section from seeking approval of an exception to the moratorium through the process established in section 144A.073, and if approved the facility's rates shall be adjusted to reflect the cost of the project. Nothing in this section prevents a nursing facility participating in the alternative payment demonstration project from seeking legislative approval of an exception to the moratorium under section 144A.071, and, if enacted, the facility's rates shall be adjusted to reflect the cost of the project.~~

~~(c)~~ Notwithstanding section 256B.48, subdivision 6, paragraphs (c), (d), and (e), and pursuant to any terms and conditions contained in the facility's contract, a nursing facility that is under contract with the commissioner under this section is in compliance with section 256B.48, subdivision 6, paragraph (b), if the facility is Medicare certified.

~~(d)~~ (c) Notwithstanding paragraph (a), if by April 1, 1996, the health care financing administration has not approved a required waiver, or the health care financing administration otherwise requires cost reports to be filed prior to the waiver's approval, the commissioner shall require a cost report for the rate year.

~~(e)~~ (d) A facility that is under contract with the commissioner under this section shall be allowed to change therapy arrangements from an unrelated vendor to a related vendor during the term of the contract. The commissioner may develop reasonable requirements designed to prevent an increase in therapy utilization for residents enrolled in the medical assistance program.

Sec. 32. [256B.437] [IMPLEMENTATION OF A CASE MIX SYSTEM FOR NURSING FACILITIES BASED ON THE MINIMUM DATA SET.]

Subdivision 1. [SCOPE.] This section establishes the method and criteria used to determine resident reimbursement classifications based upon the assessments of residents of nursing homes and boarding care homes whose payment rates are established under section 256B.431, 256B.434, or 256B.435. Resident reimbursement classifications shall be established according to the 34 group, resource utilization groups, version III or RUG-III model as described in section 144.0724. Reimbursement classifications established under this section shall be implemented after June 30, 2002, but no later than January 1, 2003.

Subd. 2. [DEFINITIONS.] For purposes of this section, the following terms have the meanings given.

(a) [ASSESSMENT REFERENCE DATE.] "Assessment reference date" has the meaning given in section 144.0724, subdivision 2, paragraph (a).

(b) [CASE MIX INDEX.] "Case mix index" has the meaning given in section 144.0724, subdivision 2, paragraph (b).

(c) [INDEX MAXIMIZATION.] "Index maximization" has the meaning given in section 144.0724, subdivision 2, paragraph (c).

(d) [MINIMUM DATA SET.] "Minimum data set" has the meaning given in section 144.0724, subdivision 2, paragraph (d).

(e) [REPRESENTATIVE.] "Representative" has the meaning given in section 144.0724, subdivision 2, paragraph (e).

(f) [RESOURCE UTILIZATION GROUPS OR RUG.] "Resource utilization groups" or "RUG" has the meaning given in section 144.0724, subdivision 2, paragraph (f).

Subd. 3. [CASE MIX INDICES.] (a) The commissioner of human services shall assign a case mix index to each resident class based on the Health Care Financing Administration's staff time measurement study and adjusted for Minnesota-specific wage indices. The case mix indices assigned to each resident class shall be published in the Minnesota State Register at least 120 days prior to the implementation of the 34 group, RUG-III resident classification system.

(b) An index maximization approach shall be used to classify residents.

(c) After implementation of the revised case mix system, the commissioner of human services may annually rebase case mix indices and base rates using more current data on average wage rates and staff time measurement studies. This rebasing shall be calculated under subdivision 7, paragraph (b). The commissioner shall publish in the Minnesota State Register adjusted case mix indices at least 45 days prior to the effective date of the adjusted case mix indices.

Subd. 4. [RESIDENT ASSESSMENT SCHEDULE.] (a) Nursing facilities shall conduct and submit case mix assessments according to the schedule established by the commissioner of health under section 144.0724, subdivisions 4 and 5.

(b) The resident reimbursement classifications established under section 144.0724, subdivision 3, shall be effective the day of admission for new admission assessments. The effective date for significant change assessments shall be the assessment reference date. The effective date for annual and second quarterly assessments shall be the first day of the month following assessment reference date.

Subd. 5. [NOTICE OF RESIDENT REIMBURSEMENT CLASSIFICATION.] Nursing facilities shall provide notice to a resident of the resident's case mix classification according to procedures established by the commissioner of health under section 144.0724, subdivision 7.

Subd. 6. [RECONSIDERATION OF RESIDENT CLASSIFICATION.] Any request for reconsideration of a resident classification must be made under section 144.0724, subdivision 8.

Subd. 7. [RATE DETERMINATION UPON TRANSITION TO RUG-III PAYMENT RATES.] (a) The commissioner of human services shall determine payment rates at the time of transition to the RUG based payment model in a facility-specific, budget-neutral manner. The case mix indices as defined in subdivision 3 shall be used to allocate the case mix adjusted component of total payment across all case mix groups. To transition from the current calculation methodology to the RUG based methodology, the commissioner of health shall report to the commissioner of human services the resident days classified according to the categories defined in subdivision 3 for the 12-month reporting period ending September 30, 2001, for each nursing facility. The commissioner of human services shall use this data to compute the standardized days for the reporting period under the RUG system.

(b) The commissioner of human services shall determine the case mix adjusted component of the rate as follows:

(1) determine the case mix portion of the 11 case mix rates in effect on June 30, 2002, or the 34 case mix rates in effect on or after June 30, 2003;

(2) multiply each amount in clause (1) by the number of resident days assigned to each group for the reporting period ending September 30, 2001, or the most recent year for which data is available;

(3) compute the sum of the amounts in clause (2);

(4) determine the total RUG standardized days for the reporting period ending September 30, 2001, or the most recent year for which data is available using new indices calculated under subdivision 3, paragraph (c);

(5) divide the amount in clause (3) by the amount in clause (4) which shall be the average case mix adjusted component of the rate under the RUG method; and

(6) multiply this average rate by the case mix weight in subdivision 3 for each RUG group.

(c) The noncase mix component will be allocated to each RUG group as a constant amount to determine the transition payment rate. Any other rate adjustments that are effective on or after July 1, 2002, shall be applied to the transition rates determined under this section.

Sec. 33. [256B.4371] [NURSING FACILITY VOLUNTARY CLOSURES AND PLANNING AND DEVELOPMENT OF COMMUNITY-BASED ALTERNATIVES.]

Subdivision 1. [DEFINITIONS.] (a) The definitions in this subdivision apply to subdivisions 2 to 9.

(b) "Closure" means the cessation of operations of a nursing facility and delicensure and decertification of all beds within the facility.

(c) "Commencement of closure" means the date on which residents and designated representatives are notified of a planned closure according to sections 144A.185 to 144A.1887 as part of an approved closure plan.

(d) "Completion of closure" means the date on which the final resident of the nursing facility or nursing facilities designated for closure in an approved closure plan is discharged from the facility or facilities.

(e) "Closure plan" means a plan to close a nursing facility and reallocate the resulting savings to provide planned closure rate adjustments at other facilities.

(f) "Partial closure" means the delicensure and decertification of a portion of the beds within the facility.

(g) "Planned closure rate adjustment" means an increase in a nursing facility's operating rates resulting from a partial planned closure of a facility or a planned closure of another facility.

Subd. 2. [PLANNING AND DEVELOPMENT OF COMMUNITY BASED SERVICES.]

(a) The commissioner of human services shall establish a process to adjust the capacity and distribution of long-term care services to equalize the supply and demand for different types of services. This process must include community planning, expansion or establishment of needed services, and analysis of voluntary nursing facility closures.

(b) The purpose of this process is to support the planning and development of community-based services. This process must support early intervention, advocacy, and consumer protection while providing resources and incentives for expanded county planning and for nursing facilities to transition to meet community needs.

(c) The process shall support and facilitate expansion of community-based services under the county-administered alternative care program under section 256B.0913 and waivers for elderly under section 256B.0915, including the development of supportive services such as housing and transportation. The process shall utilize community assessments and planning developed for the community health services plan and plan update and for the community social services act plan.

(d) The addendum to the biennial plan shall be submitted annually, beginning in 2001, and shall include recommendations for development of community-based services. Both planning and implementation shall be implemented within the amount of funding made available to the county board for these purposes.

(e) The commissioner of health and the commissioner of human services, as appropriate, shall provide available data necessary for the county, including but not limited to data on nursing facility bed distribution, housing with services options, the closure of nursing facilities that occur outside of the planned closure process, and approval of planned closures in the county and contiguous counties.

(f) The plan, within the funding allocated, shall:

(1) identify the need for services based on demographic data, service availability, caseload information, and provider information;

(2) involve providers, consumers, cities, townships, businesses, and area agencies on aging in the planning process;

(3) address the availability of alternative care and elderly waiver services for eligible recipients;

(4) address the development of other supportive services, such as transit, housing, and workforce and economic development; and

(5) estimate the cost and timelines for development.

(g) The biennial plan addendum shall be coordinated with the county mental health plan for inclusion in the community health services plan and included as an addendum to the community social services plan.

(h) The county board having financial responsibility for persons present in another county shall cooperate with that county for planning and development of services.

(i) The county board shall cooperate in planning and development of community based services with other counties, as necessary, and coordinate planning for long-term care services that involve more than one county, within the funding allocated for these purposes.

(j) The commissioners of health and human services, in cooperation with county boards, shall report to the legislature by February 1 of each year, beginning February 1, 2002, regarding the development of community based services, transition or closure of nursing facilities, and consumer outcomes achieved, as documented by each county and reported to the commissioner by December 31 of each year.

(k) The process established by the commissioner of human services shall ensure:

(1) that counties consider multicounty service areas in developing services that may impact delivery efficiencies; and

(2) review and comment by the area agencies on aging, regional development commissions, where they exist, and other planning agencies of the biennial plan addendum.

Subd. 3. [REQUEST FOR APPLICATIONS FOR PLANNED CLOSURE OF NURSING FACILITIES.] (a) By July 15, 2001, the commissioner of human services shall implement and announce a program for closure or partial closure of nursing facilities. Names and identifying information provided in response to the announcement shall remain private unless approved, according to the timelines established in the plan. The announcement must specify:

(1) the criteria that will be used by the interagency long-term care planning committee established under section 144A.31 and the commissioner to approve or reject applications;

(2) a requirement for the submission of a letter of intent before the submission of an application;

(3) the information that must accompany an application;

(4) a schedule for letters of intent, applications, and consideration of applications for a minimum of four review processes to be conducted before June 30, 2003; and

(5) that applications may combine planned closure rate adjustments with moratorium exception funding, in which case a single application may serve both purposes.

Between October 1, 2001, and June 30, 2003, the commissioner shall approve planned closures of at least 5,140 nursing facility beds, with no more than 2,070 approved for closure prior to July 1, 2002, less the number of licensed beds in facilities that close during the same time period without approved closure plans or have notified the commissioner of health of their intent to close without an approved closure plan.

(b) A facility or facilities reimbursed under section 256B.431, 256B.434, or 256B.435 with a closure plan approved by the commissioner under subdivision 6 may assign a planned closure rate adjustment to another facility that is not closing or facilities that are not closing, or in the case of a partial closure, to the facility undertaking the partial closure. A facility may also elect to have a

planned closure rate adjustment shared equally by the five nursing facilities with the lowest total operating payment rates in the state development region, designated under section 462.385, in which the facility receiving the planned closure rate adjustment is located. The planned closure rate adjustment must be calculated under subdivision 7. A planned closure rate adjustment under this section is effective on the first day of the month following completion of closure of all facilities designated for closure in the application and becomes part of the nursing facility's total operating payment rate.

Applicants may use the planned closure rate adjustment to allow for a property payment for a new nursing facility or an addition to an existing nursing facility. Applications approved under this paragraph are exempt from other requirements for moratorium exceptions under section 144A.073, subdivisions 2 and 3.

Facilities without a closure plan, or whose closure plan is not approved by the commissioner, are not eligible for a planned closure rate adjustment under subdivision 7. However, the commissioner shall calculate the amount the facility would have received under subdivision 7 and shall use this amount to provide equal rate adjustments to the five nursing facilities with the lowest total operating payment rates in the state development region, designated under section 462.385, in which the facility is located.

(c) To be considered for approval, an application must include:

(1) a description of the proposed closure plan, which must include identification of the facility or facilities to receive a planned closure rate adjustment and the amount and timing of a planned closure rate adjustment proposed for each facility;

(2) the proposed timetable for any proposed closure, including the proposed dates for announcement to residents, commencement of closure, and completion of closure;

(3) the proposed relocation plan for current residents of any facility designated for closure. The proposed relocation plan must be designed to comply with all applicable state and federal statutes and regulations, including, but not limited to, section 144A.16 and Minnesota Rules, parts 4655.6810 to 4655.6830, 4658.1600 to 4658.1690, and 9546.0010 to 9546.0060;

(4) a description of the relationship between the nursing facility that is proposed for closure and the nursing facility or facilities proposed to receive the planned closure rate adjustment. If these facilities are not under common ownership, copies of any contracts, purchase agreements, or other documents establishing a relationship or proposed relationship must be provided;

(5) documentation, in a format approved by the commissioner, that all the nursing facilities receiving a planned closure rate adjustment under the plan have accepted joint and several liability for recovery of overpayments under section 256B.0641, subdivision 2, for the facilities designated for closure under the plan; and

(6) an explanation of how the application coordinates with planning efforts under subdivision 2.

(d) The application must address the criteria listed in subdivision 4.

Subd. 4. [CRITERIA FOR REVIEW OF APPLICATION.] In reviewing and approving closure proposals, the commissioner shall consider, but not be limited to, the following criteria:

(1) improved quality of care and quality of life for consumers;

(2) closure of a nursing facility that has a poor physical plant;

(3) the existence of excess nursing facility beds, measured in terms of beds per thousand persons aged 85 or older. The excess must be measured in reference to:

(i) the county in which the facility is located;

(ii) the county and all contiguous counties;

(iii) the region in which the facility is located; or

(iv) the facility's service area.

The facility shall indicate in its proposal the area it believes is appropriate for this measurement. A facility in a county that is in the lowest quartile of counties with reference to beds per thousand persons aged 85 or older is not in an area of excess capacity;

(4) low-occupancy rates, provided that the unoccupied beds are not the result of a personnel shortage. In analyzing occupancy rates, the commissioner shall examine waiting lists in the applicant facility and at facilities in the surrounding area, as determined under clause (3);

(5) evidence of a community planning process to determine what services are needed and ensure that needed services are established;

(6) innovative use of reinvestment funds;

(7) innovative use planned for the closed facility's physical plant;

(8) evidence that the proposal serves the interests of the state; and

(9) evidence of other factors that affect the viability of the facility, including excessive nursing pool costs.

Subd. 5. [REVIEW AND APPROVAL OF PROPOSALS.] (a) The interagency long-term care planning committee may recommend that the commissioner of human services grant approval, within the limits established in subdivision 3, paragraph (a), to applications that satisfy the requirements of this section. The interagency committee may appoint an advisory review panel composed of representatives of counties, SAIL projects, consumers, and providers to review proposals and provide comments and recommendations to the committee. The commissioners of human services and health shall provide staff and technical assistance to the committee for the review and analysis of proposals. The commissioners of human services and health shall jointly approve or disapprove an application within 30 days after receiving the committee's recommendations.

(b) Approval of a planned closure expires 18 months after approval by the commissioner of human services, unless commencement of closure has begun.

(c) The commissioner of human services may change any provision of the application to which all parties agree.

Subd. 6. [PLANNED CLOSURE RATE ADJUSTMENT.] The commissioner of human services shall calculate the amount of the planned closure rate adjustment available under subdivision 3, paragraph (b), according to clauses (1) to (4):

(1) the amount available is the net reduction of nursing facility beds multiplied by $2,080;

(2) the total number of beds in the nursing facility receiving the planned closure rate adjustment must be identified;

(3) capacity days are determined by multiplying the number determined under clause (2) by 365; and

(4) the planned closure rate adjustment is the amount available in clause (1), divided by capacity days determined under clause (3).

Subd. 7. [OTHER RATE ADJUSTMENTS.] Facilities receiving planned closure rate adjustments remain eligible for any applicable rate adjustments provided under section 256B.431, 256B.434, or any other section.

Subd. 8. [COUNTY COSTS.] The commissioner of human services shall allocate up to $500 per nursing facility bed that is closing, within the limits of the appropriation specified for this

purpose, to be used for relocation costs incurred by counties for planned closures under this section or resident relocation under sections 144A.185 to 144A.1887. To be eligible for this allocation, a county in which a nursing facility closes must provide to the commissioner a detailed statement in a form provided by the commissioner of additional costs, not to exceed $500 per bed closed, that are directly incurred related to the county's required role in the relocation process.

Sec. 34. Minnesota Statutes 2000, section 256B.501, is amended by adding a subdivision to read:

Subd. 14. [ICF/MR RATE INCREASES BEGINNING JULY 1, 2001, AND JULY 1, 2002.] (a) For the rate periods beginning July 1, 2001, and July 1, 2002, the commissioner shall make available to each facility reimbursed under this section, section 256B.5011, and Laws 1993, First Special Session chapter 1, article 4, section 11, an adjustment to the total operating payment rate of 3.0 percent.

(b) For each facility, the commissioner shall determine the payment rate adjustment using the percentage specified in paragraph (a) multiplied by the total operating payment rate in effect on the last day of the prior rate year, and dividing the resulting amount by the facility's actual resident days. The total operating payment rate shall include the adjustment provided in subdivision 12.

(c) Any facility whose payment rates are governed by closure agreements, receivership agreements, or Minnesota Rules, part 9553.0075, is not eligible for an adjustment otherwise granted under this subdivision.

Sec. 35. Minnesota Statutes 2000, section 256B.76, is amended to read:

256B.76 [PHYSICIAN AND DENTAL REIMBURSEMENT.]

(a) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for physician services as follows:

(1) payment for level one Health Care Finance Administration's common procedural coding system (HCPCS) codes titled "office and other outpatient services," "preventive medicine new and established patient," "delivery, antepartum, and postpartum care," "critical care," ~~Caesarean~~ cesarean delivery and pharmacologic management provided to psychiatric patients, and HCPCS level three codes for enhanced services for prenatal high risk, shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992. If the rate on any procedure code within these categories is different than the rate that would have been paid under the methodology in section 256B.74, subdivision 2, then the larger rate shall be paid;

(2) payments for all other services shall be paid at the lower of (i) submitted charges, or (ii) 15.4 percent above the rate in effect on June 30, 1992;

(3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases except that payment rates for home health agency services shall be the rates in effect on September 30, 1992;

(4) effective for services rendered on or after January 1, 2000, payment rates for physician and professional services shall be increased by three percent over the rates in effect on December 31, 1999, except for home health agency and family planning agency services; and

(5) the increases in clause (4) shall be implemented January 1, 2000, for managed care.

(b) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for dental services as follows:

(1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992;

(2) dental rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases;

(3) effective for services rendered on or after January 1, 2000, payment rates for dental services shall be increased by three percent over the rates in effect on December 31, 1999;

(4) the commissioner shall award grants to community clinics or other nonprofit community organizations, political subdivisions, professional associations, or other organizations that demonstrate the ability to provide dental services effectively to public program recipients. Grants may be used to fund the costs related to coordinating access for recipients, developing and implementing patient care criteria, upgrading or establishing new facilities, acquiring furnishings or equipment, recruiting new providers, or other development costs that will improve access to dental care in a region. In awarding grants, the commissioner shall give priority to applicants that plan to serve areas of the state in which the number of dental providers is not currently sufficient to meet the needs of recipients of public programs or uninsured individuals. The commissioner shall consider the following in awarding the grants: (i) potential to successfully increase access to an underserved population; (ii) the ability to raise matching funds; (iii) the long-term viability of the project to improve access beyond the period of initial funding; (iv) the efficiency in the use of the funding; and (v) the experience of the proposers in providing services to the target population.

The commissioner shall monitor the grants and may terminate a grant if the grantee does not increase dental access for public program recipients. The commissioner shall consider grants for the following:

(i) implementation of new programs or continued expansion of current access programs that have demonstrated success in providing dental services in underserved areas;

(ii) a pilot program for utilizing hygienists outside of a traditional dental office to provide dental hygiene services; and

(iii) a program that organizes a network of volunteer dentists, establishes a system to refer eligible individuals to volunteer dentists, and through that network provides donated dental care services to public program recipients or uninsured individuals.

(5) beginning October 1, 1999, the payment for tooth sealants and fluoride treatments shall be the lower of (i) submitted charge, or (ii) 80 percent of median 1997 charges; and

(6) the increases listed in clauses (3) and (5) shall be implemented January 1, 2000, for managed care.

(c) An entity that operates both a Medicare certified comprehensive outpatient rehabilitation facility and a facility which was certified prior to January 1, 1993, that is licensed under Minnesota Rules, parts 9570.2000 to 9570.3600, and for whom at least 33 percent of the clients receiving rehabilitation services and mental health services in the most recent calendar year are medical assistance recipients, shall be reimbursed by the commissioner for rehabilitation services and mental health services at rates that are 38 percent greater than the maximum reimbursement rate allowed under paragraph (a), clause (2), when those services are (1) provided within the comprehensive outpatient rehabilitation facility and (2) provided to residents of nursing facilities owned by the entity.

Sec. 36. Laws 1995, chapter 207, article 3, section 21, as amended by Laws 1999, chapter 245, article 3, section 43, is amended to read:

Sec. 21. [FACILITY CERTIFICATION.]

(a) Notwithstanding Minnesota Statutes, section 252.291, subdivisions 1 and 2, the commissioner of health shall inspect to certify a large community-based facility currently licensed under Minnesota Rules, parts 9525.0215 to 9525.0355, for more than 16 beds and located in Northfield. The facility may be certified for up to 44 beds. The commissioner of health must inspect to certify the facility as soon as possible after the effective date of this section. The commissioner of human services shall work with the facility and affected counties to relocate any current residents of the facility who do not meet the admission criteria for an ICF/MR. Until January 1, 1999, in order to fund the ICF/MR services and relocations of current residents authorized, the commissioner of human services may transfer on a quarterly basis to the medical

assistance account from each affected county's community social service allocation, an amount equal to the state share of medical assistance reimbursement for the residential and day habilitation services funded by medical assistance and provided to clients for whom the county is financially responsible.

(b) After January 1, 1999, the commissioner of human services shall fund the services under the state medical assistance program and may transfer on a quarterly basis to the medical assistance account from each affected county's community social service allocation, an amount equal to one-half of the state share of medical assistance reimbursement for the residential and day habilitation services funded by medical assistance and provided to clients for whom the county is financially responsible.

(c) Effective July 1, 2001, the commissioner of human services shall fund the entire state share of medical assistance reimbursement for the residential and day habilitation services funded by medical assistance and provided to clients for whom counties are financially responsible from the medical assistance account, and shall not make any transfer from the community social service allocations of affected counties.

(d) For nonresidents of Minnesota seeking admission to the facility, Rice county shall be notified in order to assure that appropriate funding is guaranteed from their state or country of residence.

Sec. 37. Laws 1999, chapter 245, article 3, section 45, as amended by Laws 2000, chapter 312, section 3, is amended to read:

Sec. 45. [STATE LICENSURE CONFLICTS WITH FEDERAL REGULATIONS.]

(a) Notwithstanding the provisions of Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval.

(b) This section expires July 1, ~~2001~~ 2003.

Sec. 38. [DEVELOPMENT OF NEW NURSING FACILITY REIMBURSEMENT SYSTEM.]

(a) The commissioner of human services shall develop and report to the legislature by January 15, 2003, a system to replace the current nursing facility reimbursement system established under Minnesota Statutes, sections 256B.431, 256B.434, and 256B.435.

(b) The system must be developed in consultation with the long-term care task force and with representatives of consumers, providers, and labor unions. Within the limits of available appropriations, the commissioner may employ consultants to assist with this project.

(c) The new reimbursement system must:

(1) provide incentives to enhance quality of life and quality of care;

(2) recognize cost differences in the care of different types of populations, including subacute care and dementia care;

(3) establish rates that are sufficient without being excessive;

(4) be affordable for the state and for private-pay residents;

(5) be sensitive to changing conditions in the long-term care environment;

(6) avoid creating access problems related to insufficient funding;

(7) allow providers maximum flexibility in their business operations;

(8) recognize the need for capital investment to improve physical plants; and

(9) provide incentives for the development and use of private rooms.

(d) Notwithstanding Minnesota Statutes, section 256B.435, the commissioner must not implement a performance-based contracting system for nursing facilities prior to July 1, 2003. The commissioner shall continue to reimburse nursing facilities under Minnesota Statutes, section 256B.431 or 256B.434, until otherwise directed by law.

(e) The commissioner of human services, in consultation with the commissioner of health, shall conduct or contract for a time study to determine staff time being spent on various case mix categories; recommend adjustments to the case mix weights based on the time study data; and determine whether current staffing standards are adequate for providing quality care based on professional best practice and consumer experience. If the commissioner determines the current standards are inadequate, the commissioner shall determine an appropriate staffing standard for the various case mix categories and the financial implications of phasing into this standard over the next four years.

Sec. 39. [REPORT ON STANDARDS FOR SUBACUTE CARE FACILITY LICENSURE.]

By January 15, 2003, the commissioner of health shall submit a report to the legislature on implementation of a licensure program for subacute care. This report must include:

(1) definitions of subacute care and applicability of the proposed licensure program to various types of licensed facilities;

(2) an analysis of whether specific standards for subacute levels of care need to be developed and the potential for increased costs for existing providers of subacute care;

(3) recommendations on the applicability of the nursing home moratorium law to the licensure of subacute care facilities or programs;

(4) identification of federal regulations guiding the provision of subacute care and whether further state standards are needed; and

(5) identification of current and potential reimbursement for subacute care under Medicare, Medicaid, or managed care programs.

Sec. 40. [REGULATORY FLEXIBILITY.]

(a) By July 1, 2001, the commissioners of health and human services shall:

(1) develop a summary of federal nursing facility and community long-term care regulations that hamper state flexibility and place burdens on the goal of achieving high-quality care and optimum outcomes for consumers of services; and

(2) share this summary with the legislature, other states, national groups that advocate for state interests with Congress, and the Minnesota congressional delegation.

(b) The commissioners shall conduct ongoing follow-up with the entities to which this summary is provided and with the health care financing administration to achieve maximum regulatory flexibility, including the possibility of pilot projects to demonstrate regulatory flexibility on less than a statewide basis.

Sec. 41. [REPORT.]

By January 15, 2003, the commissioner of health and the commissioner of human services shall report to the senate health and family security committee and the house health and human services policy committee on the number of closures that have taken place under Minnesota Statutes, section 256B.437, and any other nursing facility closures that may have taken place, alternatives to

nursing facility care that have been developed, any problems with access to long-term care services that have resulted, and any recommendations for continuation of the regional long-term care planning process and the closure process after June 30, 2003.

Sec. 42. [NURSING ASSISTANT; HOME HEALTH AIDE CURRICULUM.]

By January 1, 2003, the commissioner of health, in consultation with long-term care consumers, advocates, unions, and trade associations, shall present to the chairs of the legislative committees dealing with health care policy recommendations for updating the nursing assistant and home health aide curriculum (1998 edition) to help students learn front-line survival skills that support job motivation and satisfaction. These skills include, but are not limited to, working with challenging behaviors, communication skills, stress management including the impact of personal life stress in the work setting, building relationships with families, cultural competencies, and working with death and dying.

Sec. 43. [EVALUATION OF REPORTING REQUIREMENTS.]

The commissioners of human services and health, in consultation with interested parties, shall evaluate long-term care provider reporting requirements, balancing the need for public accountability with the need to reduce unnecessary paperwork, and shall eliminate unnecessary reporting requirements, seeking any necessary changes in federal and state law. The commissioners shall present a progress report by February 1, 2002, to the chairs of the house and senate committees with jurisdiction over health and human services policy and finance.

Sec. 44. [NURSING FACILITY MULTIPLE SCLEROSIS PILOT PROJECT.]

(a) For the period from July 1, 2001, to June 30, 2003, the commissioner of human services shall establish and implement a pilot project to contract with nursing facilities eligible to receive medical assistance payments that, at the time of enrollment in the pilot project, serve ten or more persons with a diagnosis of multiple sclerosis. The commissioner shall negotiate a payment rate with eligible facilities to provide services to persons with multiple sclerosis that must not exceed 150 percent of the person's case mix classification payment rate for that facility. The commissioner may contract with up to six nursing facilities.

(b) Facilities may enroll in the pilot project between July 1, 2001, and December 31, 2001.

(c) The commissioner shall evaluate the additional payments made under the pilot project to determine if the adjustment enables participating facilities to adequately meet the needs for individual care and specialized programming, including programs to meet psychosocial, physiological, and case management needs, without incurring financial losses. The commissioner of human services, in consultation with the commissioner of health, shall report to the legislature by January 15, 2003, on the results of the project and with a recommendation on whether the project should be made permanent.

(d) The negotiated adjustment shall not affect the payment rate charged to private paying residents under the provisions of Minnesota Statutes, section 256B.48, subdivision 1.

Sec. 45. [MINIMUM STAFFING STANDARDS REPORT.]

By January 15, 2002, the commissioner of health and the commissioner of human services shall report to the legislature on whether they should translate the minimum nurse staffing requirement in Minnesota Statutes, section 144A.04, subdivision 7, paragraph (a), upon the transition to the RUG-III classification system, or whether they should establish different time-based standards, and how to accomplish either.

Sec. 46. [REPEALER.]

Minnesota Statutes 2000, sections 144.0721, subdivision 1, and 256B.434, subdivision 5, are repealed.

ARTICLE 6

WORK FORCE

Section 1. Minnesota Statutes 2000, section 144.1464, is amended to read:

144.1464 [SUMMER HEALTH CARE INTERNS.]

Subdivision 1. [SUMMER INTERNSHIPS.] The commissioner of health, through a contract with a nonprofit organization as required by subdivision 4, shall award grants to hospitals ~~and~~, clinics, nursing facilities, and home care providers to establish a secondary and post-secondary summer health care intern program. The purpose of the program is to expose interested secondary and post-secondary pupils to various careers within the health care profession.

Subd. 2. [CRITERIA.] (a) The commissioner, through the organization under contract, shall award grants to hospitals ~~and~~, clinics, nursing facilities, and home care providers that agree to:

(1) provide secondary and post-secondary summer health care interns with formal exposure to the health care profession;

(2) provide an orientation for the secondary and post-secondary summer health care interns;

(3) pay one-half the costs of employing the secondary and post-secondary summer health care intern~~, based on an overall hourly wage that is at least the minimum wage but does not exceed $6 an hour~~;

(4) interview and hire secondary and post-secondary pupils for a minimum of six weeks and a maximum of 12 weeks; and

(5) employ at least one secondary student for each post-secondary student employed, to the extent that there are sufficient qualifying secondary student applicants.

(b) In order to be eligible to be hired as a secondary summer health intern by a hospital ~~or~~, clinic, nursing facility, or home care provider, a pupil must:

(1) intend to complete high school graduation requirements and be between the junior and senior year of high school; and

(2) be from a school district in proximity to the facility~~; and~~

~~(3) provide the facility with a letter of recommendation from a health occupations or science educator~~.

(c) In order to be eligible to be hired as a post-secondary summer health care intern by a hospital or clinic, a pupil must:

(1) intend to complete a health care training program or a two-year or four-year degree program and be planning on enrolling in or be enrolled in that training program or degree program; and

(2) be enrolled in a Minnesota educational institution or be a resident of the state of Minnesota; priority must be given to applicants from a school district or an educational institution in proximity to the facility~~; and~~

~~(3) provide the facility with a letter of recommendation from a health occupations or science educator~~.

(d) Hospitals ~~and~~, clinics, nursing facilities, and home care providers awarded grants may employ pupils as secondary and post-secondary summer health care interns beginning on or after June 15, 1993, if they agree to pay the intern, during the period before disbursement of state grant money, with money designated as the facility's 50 percent contribution towards internship costs.

Subd. 3. [GRANTS.] The commissioner, through the organization under contract, shall award separate grants to hospitals ~~and~~, clinics, nursing facilities, and home care providers meeting the requirements of subdivision 2. The grants must be used to pay one-half of the costs of employing

secondary and post-secondary pupils in a hospital ~~or~~, clinic, nursing facility, or home care setting during the course of the program. No more than 50 percent of the participants may be post-secondary students, unless the program does not receive enough qualified secondary applicants per fiscal year. No more than five pupils may be selected from any secondary or post-secondary institution to participate in the program and no more than one-half of the number of pupils selected may be from the seven-county metropolitan area.

Subd. 4. [CONTRACT.] The commissioner shall contract with a statewide, nonprofit organization representing facilities at which secondary and post-secondary summer health care interns will serve, to administer the grant program established by this section. Grant funds that are not used in one fiscal year may be carried over to the next fiscal year. The organization awarded the grant shall provide the commissioner with any information needed by the commissioner to evaluate the program, in the form and at the times specified by the commissioner.

Sec. 2. [144.1499] [PROMOTION OF HEALTH CARE AND LONG-TERM CARE CAREERS.]

The commissioner of health, in consultation with an organization representing health care employers, long-term care employers, and educational institutions, may make grants to qualifying consortia as defined in section 116L.11, subdivision 4, for intergenerational programs to encourage middle and high school students to work and volunteer in health care and long-term care settings. To qualify for a grant under this section, a consortium shall:

(1) develop a health and long-term care careers curriculum that provides career exploration and training in national skill standards for health care and long-term care and that is consistent with Minnesota graduation standards and other related requirements;

(2) offer programs for high school students that provide training in health and long-term care careers with credits that articulate into post-secondary programs; and

(3) provide technical support to the participating health care and long-term care employer to enable the use of the employer's facilities and programs for K-12 health and long-term care careers education.

Sec. 3. Minnesota Statutes 2000, section 144A.62, subdivision 1, is amended to read:

Subdivision 1. [ASSISTANCE WITH EATING AND DRINKING.] (a) Upon federal approval, a nursing home may employ resident attendants to assist with the activities authorized under subdivision 2. The resident attendant ~~will not~~ shall be counted in the minimum staffing requirements under section 144A.04, subdivision 7.

(b) The commissioner shall submit by ~~May~~ July 15, ~~2000~~ 2001, a new request for a federal waiver necessary to implement this section.

Sec. 4. Minnesota Statutes 2000, section 144A.62, subdivision 2, is amended to read:

Subd. 2. [DEFINITION.] (a) "Resident attendant" means an individual who assists residents ~~in a nursing home~~ with ~~the~~ one or more of the following activities ~~of eating and drinking~~:

(1) eating and drinking; and

(2) transporting.

(b) A resident attendant does not include an individual who:

(1) is a licensed health professional or a registered dietitian;

(2) volunteers without monetary compensation; or

(3) is a registered nursing assistant.

Sec. 5. Minnesota Statutes 2000, section 144A.62, subdivision 3, is amended to read:

Subd. 3. [REQUIREMENTS.] (a) A nursing home may not use on a full-time or other paid basis any individual as a resident attendant in the nursing home unless the individual:

(1) has completed a training and competency evaluation program encompassing the ~~tasks~~ activities in subdivision 2 that the individual provides;

(2) is competent to provide ~~feeding and hydration services~~ those activities; and

(3) is under the supervision of the director of nursing.

(b) A nursing home may not use a current employee as a resident attendant unless the employee satisfies the requirements of paragraph (a) and volunteers to be used in that capacity.

Sec. 6. Minnesota Statutes 2000, section 144A.62, subdivision 4, is amended to read:

Subd. 4. [EVALUATION.] The training and competency evaluation program may be facility based. It must include, at a minimum, the training and competency standards for ~~eating and drinking assistance~~ the specific activities the attendant will be conducting contained in the nursing assistant training curriculum.

Sec. 7. Minnesota Statutes 2000, section 148.212, is amended to read:

148.212 [TEMPORARY PERMIT.]

Upon receipt of the applicable licensure or reregistration fee and permit fee, and in accordance with rules of the board, the board may issue a nonrenewable temporary permit to practice professional or practical nursing to an applicant for licensure or reregistration who is not the subject of a pending investigation or disciplinary action, nor disqualified for any other reason, under the following circumstances:

(a) The applicant for licensure by examination under section 148.211, subdivision 1, has graduated from an approved nursing program within the 60 days preceding board receipt of an affidavit of graduation or transcript and has been authorized by the board to write the licensure examination for the first time in the United States. The permit holder must practice professional or practical nursing under the direct supervision of a registered nurse. The permit is valid from the date of issue until the date the board takes action on the application or for 60 days whichever occurs first.

(b) The applicant for licensure by endorsement under section 148.211, subdivision 2, is currently licensed to practice professional or practical nursing in another state, territory, or Canadian province. The permit is valid from submission of a proper request until the date of board action on the application.

(c) The applicant for licensure by endorsement under section 148.211, subdivision 2, or for reregistration under section 148.231, subdivision 5, is currently registered in a formal, structured refresher course or its equivalent for nurses that includes clinical practice.

(d) The applicant for licensure by examination under section 148.211, subdivision 1, as a registered nurse has been issued a commission on graduates of foreign nurse schools certificate, has completed all requirements for licensure except the licensing examination, and has been authorized by the board to write the licensure examination for the first time in the United States. The permit holder must practice professional nursing under the direct supervision of a registered nurse. The permit is valid from the date of issue until the date the board takes action on the application or for 60 days, whichever occurs first.

ARTICLE 7

REGULATION OF SUPPLEMENTAL
NURSING SERVICES AGENCIES

Section 1. [144A.70] [REGISTRATION OF SUPPLEMENTAL NURSING SERVICES AGENCIES; DEFINITIONS.]

Subdivision 1. [SCOPE.] As used in sections 144A.70 to 144A.74, the terms defined in this section have the meanings given them.

Subd. 2. [COMMISSIONER.] "Commissioner" means the commissioner of health.

Subd. 3. [CONTROLLING PERSON.] "Controlling person" means a business entity, officer, program administrator, or director whose responsibilities include the direction of the management or policies of a supplemental nursing services agency. Controlling person also means an individual who, directly or indirectly, beneficially owns an interest in a corporation, partnership, or other business association that is a controlling person.

Subd. 4. [HEALTH CARE FACILITY.] "Health care facility" means a hospital, boarding care home, or outpatient surgical center licensed under sections 144.50 to 144.58, a nursing home or home care agency licensed under this chapter, a residential care home, or a board and lodging establishment that is registered to provide supportive or health supervision services under section 157.17.

Subd. 5. [PERSON.] "Person" includes an individual, firm, corporation, partnership, or association.

Subd. 6. [SUPPLEMENTAL NURSING SERVICES AGENCY.] "Supplemental nursing services agency" means a person, firm, corporation, partnership, or association engaged for hire in the business of providing or procuring temporary employment in health care facilities for nurses, nursing assistants, nurse aides, and orderlies. Supplemental nursing services agency does not include an individual who only engages in providing the individual's services on a temporary basis to health care facilities. Supplemental nursing services agency also does not include any nursing services agency that is limited to providing temporary nursing personnel solely to one or more health care facilities owned or operated by the same person, firm, corporation, or partnership.

Sec. 2. [144A.71] [SUPPLEMENTAL NURSING SERVICES AGENCY REGISTRATION.]

Subdivision 1. [DUTY TO REGISTER.] A person who operates a supplemental nursing services agency shall register the agency with the commissioner. Each separate location of the business of a supplemental nursing services agency shall register the agency with the commissioner. Each separate location of the business of a supplemental nursing services agency shall have a separate registration.

Subd. 2. [APPLICATION INFORMATION AND FEE.] The commissioner shall establish forms and procedures for processing each supplemental nursing services agency registration application. An application for a supplemental nursing services agency registration must include at least the following:

(1) the names and addresses of the owner or owners of the supplemental nursing services agency;

(2) if the owner is a corporation, copies of its articles of incorporation and current bylaws, together with the names and addresses of its officers and directors;

(3) any other relevant information that the commissioner determines is necessary to properly evaluate an application for registration; and

(4) the annual registration fee for a supplemental nursing services agency, which is $891.

Subd. 3. [REGISTRATION NOT TRANSFERABLE.] A registration issued by the commissioner according to this section is effective for a period of one year from the date of its issuance unless the registration is revoked or suspended under section 144A.72, subdivision 2, or unless the supplemental nursing services agency is sold or ownership or management is transferred. When a supplemental nursing services agency is sold or ownership or management is transferred, the registration of the agency must be voided and the new owner or operator may apply for a new registration.

Sec. 3. [144A.72] [REGISTRATION REQUIREMENTS.]

The commissioner shall require that, as a condition of registration:

(1) the supplemental nursing services agency shall document that each temporary employee provided to health care facilities currently meets the minimum licensing, training, and continuing education standards for the position in which the employee will be working;

(2) the supplemental nursing services agency shall comply with all pertinent requirements relating to the health and other qualifications of personnel employed in health care facilities;

(3) the supplemental nursing services agency must not restrict in any manner the employment opportunities of its employees;

(4) the supplemental nursing services agency, when supplying temporary employees to a health care facility, and when requested by the facility to do so, shall agree that at least 30 percent of the total personnel hours supplied are during night, holiday, or weekend shifts;

(5) the supplemental nursing services agency shall carry medical malpractice insurance to insure against the loss, damage, or expense incident to a claim arising out of the death or injury of any person as the result of negligence or malpractice in the provision of health care services by the supplemental nursing services agency or by any employee of the agency; and

(6) the supplemental nursing services agency must not, in any contract with any employee or health care facility, require the payment of liquidated damages, employment fees, or other compensation should the employee be hired as a permanent employee of a health care facility.

Sec. 4. [144A.73] [COMPLAINT SYSTEM.]

The commissioner shall establish a system for reporting complaints against a supplemental nursing services agency or its employees. Complaints may be made by any member of the public. Written complaints must be forwarded to the employer of each person against whom a complaint is made. The employer shall promptly report to the commissioner any corrective action taken.

Sec. 5. [144A.74] [MAXIMUM CHARGES.]

A supplemental nursing services agency must not bill or receive payments from a nursing home licensed under this chapter at a rate higher than 150 percent of the weighted average wage rate for the applicable employee classification for the geographic group to which the nursing home is assigned under chapter 256B. The weighted average wage rates must be determined by the commissioner of human services and reported to the commissioner of health on an annual basis. Facilities shall provide information necessary to determine weighted average wage rates to the commissioner of human services in a format requested by the commissioner. The maximum rate must include all charges for administrative fees, contract fees, or other special charges in addition to the hourly rates for the temporary nursing pool personnel supplied to a nursing home.

Sec. 6. Minnesota Statutes 2000, section 245A.04, subdivision 3, is amended to read:

Subd. 3. [BACKGROUND STUDY OF THE APPLICANT; DEFINITIONS.] (a) Before the commissioner issues a license, the commissioner shall conduct a study of the individuals specified in paragraph ~~(c)~~ (d), clauses (1) to (5), according to rules of the commissioner.

Beginning January 1, 1997, the commissioner shall also conduct a study of employees providing direct contact services for nonlicensed personal care provider organizations described in paragraph ~~(c)~~ (d), clause (5).

The commissioner shall recover the cost of these background studies through a fee of no more than $12 per study charged to the personal care provider organization. The fees collected under this paragraph are appropriated to the commissioner for the purpose of conducting background studies.

Beginning August 1, 1997, the commissioner shall conduct all background studies required

under this chapter for adult foster care providers who are licensed by the commissioner of human services and registered under chapter 144D. The commissioner shall conduct these background studies in accordance with this chapter. The commissioner shall initiate a pilot project to conduct up to 5,000 background studies under this chapter in programs with joint licensure as home and community-based services and adult foster care for people with developmental disabilities when the license holder does not reside in the foster care residence.

(b) Beginning July 1, 1998, the commissioner shall conduct a background study on individuals specified in paragraph ~~(c)~~ (d), clauses (1) to (5), who perform direct contact services in a nursing home or a home care agency licensed under chapter 144A or a boarding care home licensed under sections 144.50 to 144.58, when the subject of the study resides outside Minnesota; the study must be at least as comprehensive as that of a Minnesota resident and include a search of information from the criminal justice data communications network in the state where the subject of the study resides.

(c) Beginning August 1, 2001, the commissioner shall conduct all background studies required under this chapter and initiated by supplemental nursing services agencies registered under chapter 144A. Studies for the agencies must be initiated annually by each agency. The commissioner shall conduct the background studies according to this chapter. The commissioner shall recover the cost of the background studies through a fee of no more than $8 per study, charged to the supplemental nursing services agency. The fees collected under this paragraph are appropriated to the commissioner for the purpose of conducting background studies.

(d) The applicant, license holder, ~~the~~ registrant, bureau of criminal apprehension, ~~the~~ commissioner of health, and county agencies, after written notice to the individual who is the subject of the study, shall help with the study by giving the commissioner criminal conviction data and reports about the maltreatment of adults substantiated under section 626.557 and the maltreatment of minors in licensed programs substantiated under section 626.556. The individuals to be studied shall include:

(1) the applicant;

(2) persons over the age of 13 living in the household where the licensed program will be provided;

(3) current employees or contractors of the applicant who will have direct contact with persons served by the facility, agency, or program;

(4) volunteers or student volunteers who have direct contact with persons served by the program to provide program services, if the contact is not directly supervised by the individuals listed in clause (1) or (3); and

(5) any person who, as an individual or as a member of an organization, exclusively offers, provides, or arranges for personal care assistant services under the medical assistance program as authorized under sections 256B.04, subdivision 16, and 256B.0625, subdivision 19a.

The juvenile courts shall also help with the study by giving the commissioner existing juvenile court records on individuals described in clause (2) relating to delinquency proceedings held within either the five years immediately preceding the application or the five years immediately preceding the individual's 18th birthday, whichever time period is longer. The commissioner shall destroy juvenile records obtained pursuant to this subdivision when the subject of the records reaches age 23.

For purposes of this section and Minnesota Rules, part 9543.3070, a finding that a delinquency petition is proven in juvenile court shall be considered a conviction in state district court.

For purposes of this subdivision, "direct contact" means providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by a program. For purposes of this subdivision, "directly supervised" means an individual listed in clause (1), (3), or (5) is within sight or hearing of a volunteer to the extent that the individual listed in clause (1), (3), or (5) is capable at all times of intervening to protect the health and safety of the persons served by the program who have direct contact with the volunteer.

A study of an individual in clauses (1) to (5) shall be conducted at least upon application for initial license or registration and reapplication for a license or registration. The commissioner is not required to conduct a study of an individual at the time of reapplication for a license or if the individual has been continuously affiliated with a foster care provider licensed by the commissioner of human services and registered under chapter 144D, other than a family day care or foster care license, if: (i) a study of the individual was conducted either at the time of initial licensure or when the individual became affiliated with the license holder; (ii) the individual has been continuously affiliated with the license holder since the last study was conducted; and (iii) the procedure described in paragraph ~~(d)~~ (e) has been implemented and was in effect continuously since the last study was conducted. For the purposes of this section, a physician licensed under chapter 147 is considered to be continuously affiliated upon the license holder's receipt from the commissioner of health or human services of the physician's background study results. For individuals who are required to have background studies under clauses (1) to (5) and who have been continuously affiliated with a foster care provider that is licensed in more than one county, criminal conviction data may be shared among those counties in which the foster care programs are licensed. A county agency's receipt of criminal conviction data from another county agency shall meet the criminal data background study requirements of this section.

The commissioner may also conduct studies on individuals specified in clauses (3) and (4) when the studies are initiated by:

(i) personnel pool agencies;

(ii) temporary personnel agencies;

(iii) educational programs that train persons by providing direct contact services in licensed programs; and

(iv) professional services agencies that are not licensed and which contract with licensed programs to provide direct contact services or individuals who provide direct contact services.

Studies on individuals in items (i) to (iv) must be initiated annually by these agencies, programs, and individuals. Except for personal care provider organizations and supplemental nursing services agencies, no applicant, license holder, or individual who is the subject of the study shall pay any fees required to conduct the study.

(1) At the option of the licensed facility, rather than initiating another background study on an individual required to be studied who has indicated to the licensed facility that a background study by the commissioner was previously completed, the facility may make a request to the commissioner for documentation of the individual's background study status, provided that:

(i) the facility makes this request using a form provided by the commissioner;

(ii) in making the request the facility informs the commissioner that either:

(A) the individual has been continuously affiliated with a licensed facility since the individual's previous background study was completed, or since October 1, 1995, whichever is shorter; or

(B) the individual is affiliated only with a personnel pool agency, a temporary personnel agency, an educational program that trains persons by providing direct contact services in licensed programs, or a professional services agency that is not licensed and which contracts with licensed programs to provide direct contact services or individuals who provide direct contact services; and

(iii) the facility provides notices to the individual as required in paragraphs (a) to ~~(d)~~ (e), and that the facility is requesting written notification of the individual's background study status from the commissioner.

(2) The commissioner shall respond to each request under paragraph (1) with a written or electronic notice to the facility and the study subject. If the commissioner determines that a background study is necessary, the study shall be completed without further request from a licensed agency or notifications to the study subject.

(3) When a background study is being initiated by a licensed facility or a foster care provider that is also registered under chapter 144D, a study subject affiliated with multiple licensed facilities may attach to the background study form a cover letter indicating the additional facilities' names, addresses, and background study identification numbers. When the commissioner receives such notices, each facility identified by the background study subject shall be notified of the study results. The background study notice sent to the subsequent agencies shall satisfy those facilities' responsibilities for initiating a background study on that individual.

~~(d)~~ (e) If an individual who is affiliated with a program or facility regulated by the department of human services or department of health or who is affiliated with a nonlicensed personal care provider organization, is convicted of a crime constituting a disqualification under subdivision 3d, the probation officer or corrections agent shall notify the commissioner of the conviction. The commissioner, in consultation with the commissioner of corrections, shall develop forms and information necessary to implement this paragraph and shall provide the forms and information to the commissioner of corrections for distribution to local probation officers and corrections agents. The commissioner shall inform individuals subject to a background study that criminal convictions for disqualifying crimes will be reported to the commissioner by the corrections system. A probation officer, corrections agent, or corrections agency is not civilly or criminally liable for disclosing or failing to disclose the information required by this paragraph. Upon receipt of disqualifying information, the commissioner shall provide the notifications required in subdivision 3a, as appropriate to agencies on record as having initiated a background study or making a request for documentation of the background study status of the individual. This paragraph does not apply to family day care and child foster care programs.

~~(e)~~ (f) The individual who is the subject of the study must provide the applicant or license holder with sufficient information to ensure an accurate study including the individual's first, middle, and last name; home address, city, county, and state of residence for the past five years; zip code; sex; date of birth; and driver's license number. The applicant or license holder shall provide this information about an individual in paragraph ~~(c)~~ (d), clauses (1) to (5), on forms prescribed by the commissioner. By January 1, 2000, for background studies conducted by the department of human services, the commissioner shall implement a system for the electronic transmission of: (1) background study information to the commissioner; and (2) background study results to the license holder. The commissioner may request additional information of the individual, which shall be optional for the individual to provide, such as the individual's social security number or race.

~~(f)~~ (g) Except for child foster care, adult foster care, and family day care homes, a study must include information related to names of substantiated perpetrators of maltreatment of vulnerable adults that has been received by the commissioner as required under section 626.557, subdivision 9c, paragraph (i), and the commissioner's records relating to the maltreatment of minors in licensed programs, information from juvenile courts as required in paragraph ~~(c)~~ (d) for persons listed in paragraph ~~(c)~~ (d), clause (2), and information from the bureau of criminal apprehension. For child foster care, adult foster care, and family day care homes, the study must include information from the county agency's record of substantiated maltreatment of adults, and the maltreatment of minors, information from juvenile courts as required in paragraph ~~(c)~~ (d) for persons listed in paragraph ~~(c)~~ (d), clause (2), and information from the bureau of criminal apprehension. The commissioner may also review arrest and investigative information from the bureau of criminal apprehension, the commissioner of health, a county attorney, county sheriff, county agency, local chief of police, other states, the courts, or the Federal Bureau of Investigation if the commissioner has reasonable cause to believe the information is pertinent to the disqualification of an individual listed in paragraph ~~(c)~~ (d), clauses (1) to (5). The commissioner is not required to conduct more than one review of a subject's records from the Federal Bureau of Investigation if a review of the subject's criminal history with the Federal Bureau of Investigation has already been completed by the commissioner and there has been no break in the subject's affiliation with the license holder who initiated the background studies.

When the commissioner has reasonable cause to believe that further pertinent information may exist on the subject, the subject shall provide a set of classifiable fingerprints obtained from an authorized law enforcement agency. For purposes of requiring fingerprints, the commissioner shall be considered to have reasonable cause under, but not limited to, the following circumstances:

(1) information from the bureau of criminal apprehension indicates that the subject is a multistate offender;

(2) information from the bureau of criminal apprehension indicates that multistate offender status is undetermined; or

(3) the commissioner has received a report from the subject or a third party indicating that the subject has a criminal history in a jurisdiction other than Minnesota.

~~(g)~~ (h) An applicant's ~~or~~, license holder's, or registrant's failure or refusal to cooperate with the commissioner is reasonable cause to disqualify a subject, deny a license application or immediately suspend, suspend, or revoke a license or registration. Failure or refusal of an individual to cooperate with the study is just cause for denying or terminating employment of the individual if the individual's failure or refusal to cooperate could cause the applicant's application to be denied or the license holder's license to be immediately suspended, suspended, or revoked.

~~(h)~~ (i) The commissioner shall not consider an application to be complete until all of the information required to be provided under this subdivision has been received.

~~(i)~~ (j) No person in paragraph ~~(c)~~ (d), clause (1), (2), (3), (4), or (5), who is disqualified as a result of this section may be retained by the agency in a position involving direct contact with persons served by the program.

~~(j)~~ (k) Termination of persons in paragraph ~~(c)~~ (d), clause (1), (2), (3), (4), or (5), made in good faith reliance on a notice of disqualification provided by the commissioner shall not subject the applicant or license holder to civil liability.

~~(k)~~ (l) The commissioner may establish records to fulfill the requirements of this section.

~~(l)~~ (m) The commissioner may not disqualify an individual subject to a study under this section because that person has, or has had, a mental illness as defined in section 245.462, subdivision 20.

~~(m)~~ (n) An individual subject to disqualification under this subdivision has the applicable rights in subdivision 3a, 3b, or 3c.

~~(n)~~ (o) For the purposes of background studies completed by tribal organizations performing licensing activities otherwise required of the commissioner under this chapter, after obtaining consent from the background study subject, tribal licensing agencies shall have access to criminal history data in the same manner as county licensing agencies and private licensing agencies under this chapter.

Sec. 7. [REPORT ON SUPPLEMENTAL NURSING SERVICES AGENCY USE.]

Beginning July 1, 2001, through June 30, 2003, the commissioner of human services shall require nursing facilities and other providers of long-term care services to report semiannually on the use of supplemental nursing services, in the form and manner specified by the commissioner. The information reported must include, but is not limited to:

(1) number of hours worked by supplemental nursing services personnel, by job classification, for each month;

(2) payments to supplemental nursing services agencies, on a per hour worked basis, by job classification, for each month; and

(3) percentage of total monthly work hours provided by supplemental nursing services agency personnel, by job classification, for each shift and for weekdays and weekends.

ARTICLE 8

LONG-TERM CARE INSURANCE

Section 1. Minnesota Statutes 2000, section 62A.48, subdivision 4, is amended to read:

Subd. 4. [LOSS RATIO.] The anticipated loss ratio for long-term care policies must not be less than 65 percent for policies issued on a group basis or 60 percent for policies issued on an individual or mass-market basis. This subdivision does not apply to policies issued on or after January 1, 2002, that comply with sections 62S.021 and 62S.081.

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

Sec. 2. Minnesota Statutes 2000, section 62A.48, is amended by adding a subdivision to read:

Subd. 10. [REGULATION OF PREMIUMS AND PREMIUM INCREASES.] Policies issued under sections 62A.46 to 62A.56 on or after January 1, 2002, must comply with sections 62S.021, 62S.081, 62S.265, and 62S.266 to the same extent as policies issued under chapter 62S.

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

Sec. 3. Minnesota Statutes 2000, section 62A.48, is amended by adding a subdivision to read:

Subd. 11. [NONFORFEITURE BENEFITS.] Policies issued under sections 62A.46 to 62A.56 on or after January 1, 2002, must comply with section 62S.02, subdivision 2, to the same extent as policies issued under chapter 62S.

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

Sec. 4. Minnesota Statutes 2000, section 62S.01, is amended by adding a subdivision to read:

Subd. 13a. [EXCEPTIONAL INCREASE.] (a) "Exceptional increase" means only those premium rate increases filed by an insurer as exceptional for which the commissioner determines that the need for the premium rate increase is justified due to changes in laws or rules applicable to long-term care coverage in this state, or due to increased and unexpected utilization that affects the majority of insurers of similar products.

(b) Except as provided in section 62S.265, exceptional increases are subject to the same requirements as other premium rate schedule increases. The commissioner may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase. The commissioner, in determining that the necessary basis for an exceptional increase exists, shall also determine any potential offsets to higher claims costs.

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

Sec. 5. Minnesota Statutes 2000, section 62S.01, is amended by adding a subdivision to read:

Subd. 17a. [INCIDENTAL.] "Incidental," as used in section 62S.265, subdivision 10, means that the value of the long-term care benefits provided is less than ten percent of the total value of the benefits provided over the life of the policy. These values must be measured as of the date of issue.

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

Sec. 6. Minnesota Statutes 2000, section 62S.01, is amended by adding a subdivision to read:

Subd. 23a. [QUALIFIED ACTUARY.] "Qualified actuary" means a member in good standing of the American Academy of Actuaries.

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

Sec. 7. Minnesota Statutes 2000, section 62S.01, is amended by adding a subdivision to read:

Subd. 25a. [SIMILAR POLICY FORMS.] "Similar policy forms" means all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition in section 62S.01, subdivision 15, clause (1), are not considered similar to certificates or policies

otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: institutional long-term care benefits only, noninstitutional long-term care benefits only, or comprehensive long-term care benefits.

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

Sec. 8. [62S.021] [LONG-TERM CARE INSURANCE; INITIAL FILING.]

Subdivision 1. [APPLICABILITY.] This section applies to any long-term care policy issued in this state on or after January 1, 2002, under this chapter or sections 62A.46 to 62A.56.

Subd. 2. [REQUIRED SUBMISSION TO COMMISSIONER.] An insurer shall provide the following information to the commissioner 30 days prior to making a long-term care insurance form available for sale:

(1) a copy of the disclosure documents required in section 62S.081; and

(2) an actuarial certification consisting of at least the following:

(i) a statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;

(ii) a statement that the policy design and coverage provided have been reviewed and taken into consideration;

(iii) a statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration; and

(iv) a complete description of the basis for contract reserves that are anticipated to be held under the form, to include:

(A) sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;

(B) a statement that the assumptions used for reserves contain reasonable margins for adverse experience;

(C) a statement that the net valuation premium for renewal years does not increase, except for attained-age rating where permitted;

(D) a statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses, or if such a statement cannot be made, a complete description of the situations in which this does not occur. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship. If the gross premiums for certain age groups appear to be inconsistent with this requirement, the commissioner may request a demonstration under item (i) based on a standard age distribution; and

(E) either a statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits, or a comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.

Subd. 3. [ACTUARIAL DEMONSTRATION.] The commissioner may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration must include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both. If the commissioner asks for additional information under this subdivision, the 30-day time limit in subdivision 2 does not include the time during which the insurer is preparing the requested information.

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

Sec. 9. [62S.081] [REQUIRED DISCLOSURE OF RATING PRACTICES TO CONSUMERS.]

Subdivision 1. [APPLICATION.] This section applies as follows:

(a) Except as provided in paragraph (b), this section applies to any long-term care policy or certificate issued in this state on or after January 1, 2002.

(b) For certificates issued on or after the effective date of this section under a policy of group long-term care insurance as defined in section 62S.01, subdivision 15, that was in force on the effective date of this section, this section applies on the policy anniversary following June 30, 2002.

Subd. 2. [REQUIRED DISCLOSURES.] Other than policies for which no applicable premium rate or rate schedule increases can be made, insurers shall provide all of the information listed in this subdivision to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that time; in this case, an insurer shall provide all of the information listed in this subdivision to the applicant no later than at the time of delivery of the policy or certificate:

(1) a statement that the policy may be subject to rate increases in the future;

(2) an explanation of potential future premium rate revisions and the policyholder's or certificate holder's option in the event of a premium rate revision;

(3) the premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase;

(4) a general explanation of applying premium rate or rate schedule adjustments that must include:

(i) a description of when premium rate or rate schedule adjustments will be effective, for example the next anniversary date or the next billing date; and

(ii) the right to a revised premium rate or rate schedule as provided in clause (3) if the premium rate or rate schedule is changed; and

(5)(i) information regarding each premium rate increase on this policy form or similar policy forms over the past ten years for this state or any other state that, at a minimum, identifies:

(A) the policy forms for which premium rates have been increased;

(B) the calendar years when the form was available for purchase; and

(C) the amount or percent of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics;

(ii) the insurer may, in a fair manner, provide additional explanatory information related to the rate increases;

(iii) an insurer has the right to exclude from the disclosure premium rate increases that apply only to blocks of business acquired from other nonaffiliated insurers or the long-term care policies acquired from other nonaffiliated insurers when those increases occurred prior to the acquisition;

(iv) if an acquiring insurer files for a rate increase on a long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers on or before the later of the effective date of this section, or the end of a 24-month period following the acquisition of the block of policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling company must include the disclosure of that rate increase according to item (i); and

(v) if the acquiring insurer in item (iv) files for a subsequent rate increase, even within the 24-month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers referenced in item (iv), the acquiring insurer shall make all disclosures required by this subdivision, including disclosure of the earlier rate increase referenced in item (iv).

Subd. 3. [ACKNOWLEDGMENT.] An applicant shall sign an acknowledgment at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required under subdivision 2. If, due to the method of application, the applicant cannot sign an acknowledgment at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

Subd. 4. [FORMS.] An insurer shall use the forms in Appendices B and F of the Long-term Care Insurance Model Regulation adopted by the National Association of Insurance Commissioners to comply with the requirements of subdivisions 1 and 2.

Subd. 5. [NOTICE OF INCREASE.] An insurer shall provide notice of an upcoming premium rate schedule increase, after the increase has been approved by the commissioner, to all policyholders or certificate holders, if applicable, at least 45 days prior to the implementation of the premium rate schedule increase by the insurer. The notice must include the information required by subdivision 2 when the rate increase is implemented.

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

Sec. 10. Minnesota Statutes 2000, section 62S.26, is amended to read:

62S.26 [LOSS RATIO.]

(a) The minimum loss ratio must be at least 60 percent, calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, the commissioner shall give consideration to all relevant factors, including:

(1) statistical credibility of incurred claims experience and earned premiums;

(2) the period for which rates are computed to provide coverage;

(3) experienced and projected trends;

(4) concentration of experience within early policy duration;

(5) expected claim fluctuation;

(6) experience refunds, adjustments, or dividends;

(7) renewability features;

(8) all appropriate expense factors;

(9) interest;

(10) experimental nature of the coverage;

(11) policy reserves;

(12) mix of business by risk classification; and

(13) product features such as long elimination periods, high deductibles, and high maximum limits.

(b) This section does not apply to policies or certificates that are subject to sections 62S.021, 62S.081, and 62S.265, and that comply with those sections.

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

Sec. 11. [62S.265] [PREMIUM RATE SCHEDULE INCREASES.]

Subdivision 1. [APPLICABILITY.] (a) Except as provided in paragraph (b), this section applies to any long-term care policy or certificate issued in this state on or after January 1, 2002, under this chapter or sections 62A.46 to 62A.56.

(b) For certificates issued on or after the effective date of this section under a group long-term care insurance policy as defined in section 62S.01, subdivision 15, issued under this chapter, that was in force on the effective date of this section, this section applies on the policy anniversary following June 30, 2002.

Subd. 2. [NOTICE.] An insurer shall file a requested premium rate schedule increase, including an exceptional increase, to the commissioner for prior approval at least 60 days prior to the notice to the policyholders and shall include:

(1) all information required by section 62S.081;

(2) certification by a qualified actuary that:

(i) if the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated; and

(ii) the premium rate filing complies with this section;

(3) an actuarial memorandum justifying the rate schedule change request that includes:

(i) lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale;

(A) annual values for the five years preceding and the three years following the valuation date must be provided separately;

(B) the projections must include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;

(C) the projections must demonstrate compliance with subdivision 3; and

(D) for exceptional increases, the projected experience must be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase and, if the commissioner determines that offsets to higher claim costs may exist, the insurer shall use appropriate net projected experience;

(ii) disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;

(iii) disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied upon by the actuary;

(iv) a statement that policy design, underwriting, and claims adjudication practices have been taken into consideration; and

(v) if it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer shall file composite rates reflecting projections of new certificates;

(4) a statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commissioner; and

(5) sufficient information for review and approval of the premium rate schedule increase by the commissioner.

Subd. 3. [REQUIREMENTS PERTAINING TO RATE INCREASES.] All premium rate schedule increases must be determined according to the following requirements:

(1) exceptional increases must provide that 70 percent of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

(2) premium rate schedule increases must be calculated so that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

(i) the accumulated value of the initial earned premium times 58 percent;

(ii) 85 percent of the accumulated value of prior premium rate schedule increases on an earned basis;

(iii) the present value of future projected initial earned premiums times 58 percent; and

(iv) 85 percent of the present value of future projected premiums not in item (iii) on an earned basis;

(3) if a policy form has both exceptional and other increases, the values in clause (2), items (ii) and (iv), must also include 70 percent for exceptional rate increase amounts; and

(4) all present and accumulated values used to determine rate increases must use the maximum valuation interest rate for contract reserves permitted for valuation of whole life insurance policies issued in this state on the same date. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

Subd. 4. [PROJECTIONS.] For each rate increase that is implemented, the insurer shall file for approval by the commissioner updated projections, as described in subdivision 2, clause (3), item (i), annually for the next three years and include a comparison of actual results to projected values. The commissioner may extend the period to greater than three years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in subdivision 11, the projections required by this subdivision must be provided to the policyholder in lieu of filing with the commissioner.

Subd. 5. [LIFETIME PROJECTIONS.] If any premium rate in the revised premium rate schedule is greater than 200 percent of the comparable rate in the initial premium schedule, lifetime projections, as described in subdivision 2, clause (3), item (i), must be filed for approval by the commissioner every five years following the end of the required period in subdivision 4. For group insurance policies that meet the conditions in subdivision 11, the projections required by this subdivision must be provided to the policyholder in lieu of filing with the commissioner.

Subd. 6. [EFFECT OF ACTUAL EXPERIENCE.] (a) If the commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in subdivision 3, the commissioner may require the insurer to implement any of the following:

(1) premium rate schedule adjustments; or

(2) other measures to reduce the difference between the projected and actual experience.

(b) In determining whether the actual experience adequately matches the projected experience, consideration must be given to subdivision 2, clause (3), item (v), if applicable.

Subd. 7. [CONTINGENT BENEFIT UPON LAPSE.] If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:

(1) a plan, subject to commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or a demonstration that appropriate administration and claims processing have been implemented or are in effect; otherwise, the commissioner may impose the condition in subdivision 8, paragraph (b); and

(2) the original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to subdivision 3 had the greater of the original anticipated lifetime loss ratio or 58 percent been used in the calculations described in subdivision 3, clause (2), items (i) and (iii).

Subd. 8. [PROJECTED LAPSE RATES.] (a) For a rate increase filing that meets the following criteria, the commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the 12 months following each increase to determine if significant adverse lapsation has occurred or is anticipated:

(1) the rate increase is not the first rate increase requested for the specific policy form or forms;

(2) the rate increase is not an exceptional increase; and

(3) the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

(b) If significant adverse lapsation has occurred, is anticipated in the filing, or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the commissioner may determine that a rate spiral exists. Following the determination that a rate spiral exists, the commissioner may require the insurer to offer, without underwriting, to all in-force insureds subject to the rate increase, the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates. The offer must:

(1) be subject to the approval of the commissioner;

(2) be based upon actuarially sound principles, but not be based upon attained age; and

(3) provide that maximum benefits under any new policy accepted by an insured will be reduced by comparable benefits already paid under the existing policy.

(c) The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase must be limited to the lesser of the maximum rate increase determined based on the combined experience and the maximum rate increase determined based only upon the experience of the insureds originally issued the form plus ten percent.

Subd. 9. [PERSISTENT PRACTICE OF INADEQUATE INITIAL RATES.] If the commissioner determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the commissioner may, in addition to the provisions of subdivision 8, take either of the following actions:

(1) prohibit the insurer from filing and marketing comparable coverage for a period of up to five years; or

(2) prohibit the insurer from offering all other similar coverages and limit the insurer's marketing of new applications for the products that are subject to recent premium rate schedule increases.

Subd. 10. [INCIDENTAL LONG-TERM CARE BENEFITS.] Subdivisions 1 to 9 do not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in section 62S.01, subdivision 17a, if the policy complies with all of the following provisions:

(1) the interest credited internally to determine cash value accumulations, including long-term

care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

(2) the portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following:

(i) for life insurance, section 61A.25;

(ii) for individual deferred annuities, section 61A.245; and

(iii) for variable annuities, section 61A.21;

(3) the policy meets the disclosure requirements of sections 62S.10 and 62S.11 if the policy is governed by chapter 62S and of section 62A.50 if the policy is governed by sections 62A.46 to 62A.56;

(4) the portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements as applicable in the following:

(i) policy illustrations to the extent required by state law applicable to life insurance;

(ii) disclosure requirements in state law applicable to annuities; and

(iii) disclosure requirements applicable to variable annuities; and

(5) an actuarial memorandum is filed with the commissioner that includes:

(i) a description of the basis on which the long-term care rates were determined;

(ii) a description of the basis for the reserves;

(iii) a summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(iv) a description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

(v) a description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(vi) the estimated average annual premium per policy and the average issue age;

(vii) a statement as to whether underwriting is performed at the time of application. The statement must indicate whether underwriting is used and, if used, the statement must include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement must indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(viii) a description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values, and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

Subd. 11. [LARGE GROUP POLICIES.] Subdivisions 6 and 9 do not apply to group long-term care insurance policies as defined in section 62S.01, subdivision 15, where:

(1) the policies insure 250 or more persons, and the policyholder has 5,000 or more eligible employees of a single employer; or

(2) the policyholder, and not the certificate holders, pays a material portion of the premium, which is not less than 20 percent of the total premium for the group in the calendar year prior to the year in which a rate increase is filed.

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

Sec. 12. [62S.266] [NONFORFEITURE BENEFIT REQUIREMENT.]

Subdivision 1. [APPLICABILITY.] This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

Subd. 2. [REQUIREMENT.] An insurer must offer each prospective policyholder a nonforfeiture benefit in compliance with the following requirements:

(1) a policy or certificate offered with nonforfeiture benefits must have coverage elements, eligibility, benefit triggers, and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer must be the benefit described in subdivision 5; and

(2) the offer must be in writing if the nonforfeiture benefit is not otherwise described in the outline of coverage or other materials given to the prospective policyholder.

Subd. 3. [EFFECT OF REJECTION OF OFFER.] If the offer required to be made under subdivision 2 is rejected, the insurer shall provide the contingent benefit upon lapse described in this section.

Subd. 4. [CONTINGENT BENEFIT UPON LAPSE.] (a) After rejection of the offer required under subdivision 2, for individual and group policies without nonforfeiture benefits issued after the effective date of this section, the insurer shall provide a contingent benefit upon lapse.

(b) If a group policyholder elects to make the nonforfeiture benefit an option to the certificate holder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

(c) The contingent benefit on lapse must be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium based on the insured's issue age provided in this paragraph, and the policy or certificate lapses within 120 days of the due date of the premium increase. Unless otherwise required, policyholders shall be notified at least 30 days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase

| Issue Age | Percent Increase Over Initial Premium |
|---|---|
| 29 and Under | 200 |
| 30-34 | 190 |
| 35-39 | 170 |
| 40-44 | 150 |
| 45-49 | 130 |
| 50-54 | 110 |
| 55-59 | 90 |
| 60 | 70 |
| 61 | 66 |
| 62 | 62 |
| 63 | 58 |
| 64 | 54 |
| 65 | 50 |
| 66 | 48 |
| 67 | 46 |
| 68 | 44 |
| 69 | 42 |
| 70 | 40 |
| 71 | 38 |
| 72 | 36 |

| | |
|---|---|
| 73 | 34 |
| 74 | 32 |
| 75 | 30 |
| 76 | 28 |
| 77 | 26 |
| 78 | 24 |
| 79 | 22 |
| 80 | 20 |
| 81 | 19 |
| 82 | 18 |
| 83 | 17 |
| 84 | 16 |
| 85 | 15 |
| 86 | 14 |
| 87 | 13 |
| 88 | 12 |
| 89 | 11 |
| 90 and over | 10 |

(d) On or before the effective date of a substantial premium increase as defined in paragraph (c), the insurer shall:

(1) offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(2) offer to convert the coverage to a paid-up status with a shortened benefit period according to the terms of subdivision 5. This option may be elected at any time during the 120-day period referenced in paragraph (c); and

(3) notify the policyholder or certificate holder that a default or lapse at any time during the 120-day period referenced in paragraph (c) is deemed to be the election of the offer to convert in clause (2).

Subd. 5. [NONFORFEITURE BENEFITS; REQUIREMENTS.] (a) Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse, must be as described in this subdivision.

(b) For purposes of this subdivision, "attained age rating" is defined as a schedule of premiums starting from the issue date which increases with age at least one percent per year prior to age 50, and at least three percent per year beyond age 50.

(c) For purposes of this subdivision, the nonforfeiture benefit must be of a shortened benefit period providing paid-up, long-term care insurance coverage after lapse. The same benefits, amounts, and frequency in effect at the time of lapse, but not increased thereafter, will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits must be determined as specified in paragraph (d).

(d) The standard nonforfeiture credit is equal to 100 percent of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, so long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit must not be less than 30 times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of this subdivision.

(e) The nonforfeiture benefit must begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse must be effective during the first three years as well as thereafter.

(f) Notwithstanding paragraph (e), for a policy or certificate with attained age rating, the nonforfeiture benefit must begin on the earlier of:

(1) the end of the tenth year following the policy or certificate issue date; or

(2) the end of the second year following the date the policy or certificate is no longer subject to attained age rating.

(g) Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

Subd. 6. [BENEFIT LIMIT.] All benefits paid by the insurer while the policy or certificate is in premium-paying status and in the paid-up status will not exceed the maximum benefits which would be payable if the policy or certificate had remained in premium-paying status.

Subd. 7. [MINIMUM BENEFITS; INDIVIDUAL AND GROUP POLICIES.] There must be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.

Subd. 8. [APPLICATION; EFFECTIVE DATES.] This section becomes effective January 1, 2002, and applies as follows:

(a) Except as provided in paragraph (b), this section applies to any long-term care policy issued in this state on or after the effective date of this section.

(b) For certificates issued on or after the effective date of this section, under a group long-term care insurance policy that was in force on the effective date of this section, the provisions of this section do not apply.

Subd. 9. [EFFECT ON LOSS RATIO.] Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse are subject to the loss ratio requirements of section 62A.48, subdivision 4, or 62S.26, treating the policy as a whole, except for policies or certificates that are subject to sections 62S.021, 62S.081, and 62S.265 and that comply with those sections.

Subd. 10. [PURCHASED BLOCKS OF BUSINESS.] To determine whether contingent nonforfeiture upon lapse provisions are triggered under subdivision 4, paragraph (c), a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

Subd. 11. [LEVEL PREMIUM CONTRACTS.] A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts must be offered that meets the following requirements:

(1) the nonforfeiture provision must be appropriately captioned;

(2) the nonforfeiture provision must provide a benefit available in the event of a default in the payment of any premiums and must state that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying contracts approved by the commissioner for the same contract form; and

(3) the nonforfeiture provision must provide at least one of the following:

(i) reduced paid-up insurance;

(ii) extended term insurance;

(iii) shortened benefit period; or

(iv) other similar offerings approved by the commissioner.

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

Sec. 13. Minnesota Statutes 2000, section 256.975, is amended by adding a subdivision to read:

Subd. 8. [PROMOTION OF LONG-TERM CARE INSURANCE.] The Minnesota board on aging, either directly or through contract, shall promote the provision of employer-sponsored, long-term care insurance. The board shall encourage private and public sector employers to make long-term care insurance available to employees, provide interested employers with information on the long-term care insurance product offered to state employees, and provide technical assistance to employers in designing long-term care insurance products and contacting companies offering long-term care insurance products.

Sec. 14. [256B.0571] [LONG-TERM CARE PARTNERSHIP.]

Subdivision 1. [DEFINITIONS.] For purposes of this section, the following terms have the meanings given them.

(a) "Home care service" means care described in section 144A.43.

(b) "Long-term care insurance" means a policy described in section 62S.01.

(c) "Medical assistance" means the program of medical assistance established under section 256B.01.

(d) "Nursing home" means nursing home as described in section 144A.01.

(e) "Partnership policy" means a long-term care insurance policy that meets the requirements under chapter 62S.

(f) "Partnership program" means the Minnesota partnership for long-term care program established under this section.

Subd. 2. [PARTNERSHIP PROGRAM.] (a) Subject to federal waiver approval, the commissioner of human services, along 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 paragraph (c) is eligible to participate in the partnership program.

(c) The individual must:

(1) be a Minnesota resident;

(2) purchase a partnership policy that is delivered, issued for delivery, or renewed on or after the effective date of this section, and maintains the partnership policy in effect throughout the period of participation in the partnership program; and

(3) exhaust the minimum benefits under the partnership policy as described in this section. Benefits received under a long-term care insurance policy before the effective date of this section do not count toward the exhaustion of benefits required in this subdivision.

Subd. 3. [MEDICAL ASSISTANCE ELIGIBILITY.] (a) Upon application of an individual who meets the requirements described in subdivision 2, the commissioner of human services shall determine the individual's eligibility for medical assistance according to paragraphs (b) and (c).

(b) After disregarding financial assets exempted under medical assistance eligibility requirements, the department shall disregard an additional amount of financial assets equal to the dollar amount of coverage under the partnership policy.

(c) The department shall consider the individual's income according to medical assistance eligibility requirements.

Subd. 4. [FEDERAL APPROVAL.] (a) The commissioner of human services shall seek

appropriate amendments to the medical assistance state plan and shall apply for any necessary waiver of medical assistance requirements by the federal Health Care Financing Administration to implement the partnership program. The state shall not implement the partnership program unless the provisions in paragraphs (b) and (c) apply.

(b) The commissioner shall seek any necessary federal waiver of medical assistance requirements.

(c) Individuals who receive medical assistance under this section are exempt from estate recovery requirements under section 1917, title XIX of the federal Social Security Act, United States Code, title 42, section 1396p.

Subd. 5. [APPROVED POLICIES.] (a) A partnership policy must meet all of the requirements in paragraphs (b) to (h).

(b) Minimum coverage shall be for a period of not less than three years and for a dollar amount equal to 36 months of nursing home care at the minimum daily benefit rate determined and adjusted under paragraph (c). The policy shall provide for home health care benefits to be substituted for nursing home care benefits on the basis of two home health care days for one nursing home care day.

(c) Minimum daily benefits shall be $130 for nursing home care or $65 for home care. These minimum daily benefit amounts shall be adjusted by the department on October 1 of each year, based on the health care index used under medical assistance for nursing home rate setting. Adjusted minimum daily benefit amounts shall be rounded to the nearest whole dollar.

(d) The insured shall be entitled to designate a third party to receive notice if the policy is about to lapse for nonpayment of premium, and an additional 30-day grace period for payment of premium shall be granted following notification to that person.

(e) The policy must cover all of the following services:

(1) nursing home stay;

(2) home care service;

(3) care management; and

(4) up to 14 days of nursing care in a hospital while the individual is waiting for long-term care placement.

(f) Payment for service under paragraph (e), clause (4), must not exceed the daily benefit amount for nursing home care.

(g) A partnership policy must offer both options in paragraph (h) for an adjusted premium.

(h) The options are:

(1) an elimination period of not more than 100 days; and

(2) nonforfeiture benefits for applicants between the ages of 18 and 75.

ARTICLE 9

MENTAL HEALTH AND CIVIL COMMITMENT

Section 1. [145.56] [SUICIDE PREVENTION.]

Subdivision 1. [PUBLIC HEALTH GOAL; SUICIDE PREVENTION PLAN.] The commissioner of health shall make suicide prevention an important public health goal of the state and shall conduct suicide prevention activities to accomplish that goal using an evidence-based, public health approach focused on prevention. The commissioner shall refine, coordinate, and implement the state's suicide prevention plan, in collaboration with assigned staff from the

department of human services; the department of public safety; the department of children, families, and learning; and appropriate agencies, organizations, and institutions in the community.

Subd. 2. [COMMUNITY-BASED PROGRAMS.] (a) The commissioner shall establish a grant program consistent with the policy goals of this section to fund:

(1) community-based programs to provide education, outreach, and advocacy services to populations who may be at risk for suicide;

(2) community-based programs that educate natural community helpers and gatekeepers, such as family members, spiritual leaders, coaches, and business owners, employers, and coworkers, on how to prevent suicide by encouraging help-seeking behaviors; and

(3) community-based programs to provide evidence-based suicide prevention and intervention education to school staff, parents, and students in kindergarten through grade 12.

(b) Education to populations at risk for suicide and to community helpers and gatekeepers must include information on the symptoms of depression and other psychiatric illnesses, the warning signs of suicide, skills for preventing suicides, and making or seeking effective referrals to intervention and community resources.

Subd. 3. [WORKPLACE AND PROFESSIONAL EDUCATION.] (a) The commissioner shall promote the use of employee assistance and workplace programs to support employees with depression and other psychiatric illnesses and substance abuse disorders, and refer them to services. In promoting these programs, the commissioner shall collaborate with employer and professional associations, unions, and safety councils.

(b) The commissioner shall provide training and technical assistance to local public health and other community-based professionals to provide for integrated implementation of best practices for preventing suicides.

Subd. 4. [COLLECTING AND REPORTING SUICIDE DATA.] The commissioner shall coordinate with federal, regional, local, and other state agencies to collect, analyze, and annually issue a public report on Minnesota-specific data on suicide and suicidal behaviors.

Subd. 5. [PERIODIC EVALUATIONS; BIENNIAL REPORTS.] The commissioner shall conduct periodic evaluations of the impact of and outcomes from implementation of the state's suicide prevention plan and each of the activities specified in this section. By July 1, 2002, and July 1 of each even-numbered year thereafter, the commissioner shall report the results of these evaluations to the chairs of the policy and finance committees in the house and senate with jurisdiction over health and human services issues.

Sec. 2. Minnesota Statutes 2000, section 245.462, subdivision 8, is amended to read:

Subd. 8. [DAY TREATMENT SERVICES.] "Day treatment," "day treatment services," or "day treatment program" means a structured program of treatment and care provided to an adult in or by: (1) a hospital accredited by the joint commission on accreditation of health organizations and licensed under sections 144.50 to 144.55; (2) a community mental health center under section 245.62; or (3) an entity that is under contract with the county board to operate a program that meets the requirements of section 245.4712, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475. Day treatment consists of group psychotherapy and other intensive therapeutic services that are provided at least one day a week by a multidisciplinary staff under the clinical supervision of a mental health professional. Day treatment may include education and consultation provided to families and other individuals as part of the treatment process. The services are aimed at stabilizing the adult's mental health status, providing mental health services, and developing and improving the adult's independent living and socialization skills. The goal of day treatment is to reduce or relieve mental illness and to enable the adult to live in the community. Day treatment services are not a part of inpatient or residential treatment services. Day treatment services are distinguished from day care by their structured therapeutic program of psychotherapy services. The commissioner may limit medical assistance reimbursement for day treatment to 15 hours per week per person instead of the three hours per day per person specified in Minnesota Rules, part 9505.0323, subpart 15.

Sec. 3. Minnesota Statutes 2000, section 245.462, subdivision 18, is amended to read:

Subd. 18. [MENTAL HEALTH PROFESSIONAL.] "Mental health professional" means a person providing clinical services in the treatment of mental illness who is qualified in at least one of the following ways:

(1) in psychiatric nursing: a registered nurse who is licensed under sections 148.171 to 148.285, and who is certified as a clinical specialist in adult psychiatric and mental health nursing by a national nurse certification organization or who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;

(2) in clinical social work: a person licensed as an independent clinical social worker under section 148B.21, subdivision 6, or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;

(3) in psychology: ~~a psychologist~~ an individual licensed by the board of psychology under sections 148.88 to 148.98 who has stated to the board of psychology competencies in the diagnosis and treatment of mental illness;

(4) in psychiatry: a physician licensed under chapter 147 and certified by the American board of psychiatry and neurology or eligible for board certification in psychiatry;

(5) in marriage and family therapy: the mental health professional must be a marriage and family therapist licensed under sections 148B.29 to 148B.39 with at least two years of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness; or

(6) in allied fields: a person with a master's degree from an accredited college or university in one of the behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness.

Sec. 4. Minnesota Statutes 2000, section 245.462, is amended by adding a subdivision to read:

Subd. 25a. [SIGNIFICANT IMPAIRMENT IN FUNCTIONING.] "Significant impairment in functioning" means a condition, including significant suicidal ideation or thoughts of harming self or others, which harmfully affects, recurrently or consistently, a person's activities of daily living in employment, housing, family, and social relationships, or education.

Sec. 5. Minnesota Statutes 2000, section 245.4871, subdivision 10, is amended to read:

Subd. 10. [DAY TREATMENT SERVICES.] "Day treatment," "day treatment services," or "day treatment program" means a structured program of treatment and care provided to a child in:

(1) an outpatient hospital accredited by the joint commission on accreditation of health organizations and licensed under sections 144.50 to 144.55;

(2) a community mental health center under section 245.62;

(3) an entity that is under contract with the county board to operate a program that meets the requirements of section 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475; or

(4) an entity that operates a program that meets the requirements of section 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475, that is under contract with an entity that is under contract with a county board.

Day treatment consists of group psychotherapy and other intensive therapeutic services that are provided for a minimum three-hour time block by a multidisciplinary staff under the clinical supervision of a mental health professional. Day treatment may include education and consultation

provided to families and other individuals as an extension of the treatment process. The services are aimed at stabilizing the child's mental health status, and developing and improving the child's daily independent living and socialization skills. Day treatment services are distinguished from day care by their structured therapeutic program of psychotherapy services. Day treatment services are not a part of inpatient hospital or residential treatment services. Day treatment services for a child are an integrated set of education, therapy, and family interventions.

A day treatment service must be available to a child at least five days a week throughout the year and must be coordinated with, integrated with, or part of an education program offered by the child's school.

Sec. 6. Minnesota Statutes 2000, section 245.4871, subdivision 27, is amended to read:

Subd. 27. [MENTAL HEALTH PROFESSIONAL.] "Mental health professional" means a person providing clinical services in the diagnosis and treatment of children's emotional disorders. A mental health professional must have training and experience in working with children consistent with the age group to which the mental health professional is assigned. A mental health professional must be qualified in at least one of the following ways:

(1) in psychiatric nursing, the mental health professional must be a registered nurse who is licensed under sections 148.171 to 148.285 and who is certified as a clinical specialist in child and adolescent psychiatric or mental health nursing by a national nurse certification organization or who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;

(2) in clinical social work, the mental health professional must be a person licensed as an independent clinical social worker under section 148B.21, subdivision 6, or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental disorders;

(3) in psychology, the mental health professional must be ~~a psychologist~~ an individual licensed by the board of psychology under sections 148.88 to 148.98 who has stated to the board of psychology competencies in the diagnosis and treatment of mental disorders;

(4) in psychiatry, the mental health professional must be a physician licensed under chapter 147 and certified by the American board of psychiatry and neurology or eligible for board certification in psychiatry;

(5) in marriage and family therapy, the mental health professional must be a marriage and family therapist licensed under sections 148B.29 to 148B.39 with at least two years of post-master's supervised experience in the delivery of clinical services in the treatment of mental disorders or emotional disturbances; or

(6) in allied fields, the mental health professional must be a person with a master's degree from an accredited college or university in one of the behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of emotional disturbances.

Sec. 7. Minnesota Statutes 2000, section 245.4876, subdivision 1, is amended to read:

Subdivision 1. [CRITERIA.] Children's mental health services required by sections 245.487 to 245.4888 must be:

(1) based, when feasible, on research findings;

(2) based on individual clinical, cultural, and ethnic needs, and other special needs of the children being served;

(3) delivered in a manner that improves family functioning when clinically appropriate;

(4) provided in the most appropriate, least restrictive setting that meets the requirements in subdivision 1a, and that is available to the county board to meet the child's treatment needs;

(5) accessible to all age groups of children;

(6) appropriate to the developmental age of the child being served;

(7) delivered in a manner that provides accountability to the child for the quality of service delivered and continuity of services to the child during the years the child needs services from the local system of care;

(8) provided by qualified individuals as required in sections 245.487 to 245.4888;

(9) coordinated with children's mental health services offered by other providers;

(10) provided under conditions that protect the rights and dignity of the individuals being served; and

(11) provided in a manner and setting most likely to facilitate progress toward treatment goals.

Sec. 8. Minnesota Statutes 2000, section 245.4876, is amended by adding a subdivision to read:

Subd. 1a. [APPROPRIATE SETTING TO RECEIVE SERVICES.] A child must be provided with mental health services in the least restrictive setting that is appropriate to the needs and current condition of the individual child. For a child to receive mental health services in a residential treatment or acute care hospital inpatient setting, the family may not be required to demonstrate that services were first provided in a less restrictive setting and that the child failed to make progress toward or meet treatment goals in the less restrictive setting.

Sec. 9. Minnesota Statutes 2000, section 245.4885, subdivision 1, is amended to read:

Subdivision 1. [SCREENING REQUIRED.] The county board shall, prior to admission, except in the case of emergency admission, screen all children referred for treatment of severe emotional disturbance to a residential treatment facility or informally admitted to a regional treatment center if public funds are used to pay for the services. The county board shall also screen all children admitted to an acute care hospital for treatment of severe emotional disturbance if public funds other than reimbursement under chapters 256B and 256D are used to pay for the services. If a child is admitted to a residential treatment facility or acute care hospital for emergency treatment or held for emergency care by a regional treatment center under section 253B.05, subdivision 1, screening must occur within three working days of admission. Screening shall determine whether the proposed treatment:

(1) is necessary;

(2) is appropriate to the child's individual treatment needs;

(3) cannot be effectively provided in the child's home; and

(4) provides a length of stay as short as possible consistent with the individual child's need.

When a screening is conducted, the county board may not determine that referral or admission to a residential treatment facility or acute care hospital is not appropriate solely because services were not first provided to the child in a less restrictive setting and the child failed to make progress toward or meet treatment goals in the less restrictive setting. Screening shall include both a diagnostic assessment and a functional assessment which evaluates family, school, and community living situations. If a diagnostic assessment or functional assessment has been completed by a mental health professional within 180 days, a new diagnostic or functional assessment need not be completed unless in the opinion of the current treating mental health professional the child's mental health status has changed markedly since the assessment was completed. The child's parent shall be notified if an assessment will not be completed and of the reasons. A copy of the notice shall be placed in the child's file. Recommendations developed as part of the screening process shall include specific community services needed by the child and, if appropriate, the

child's family, and shall indicate whether or not these services are available and accessible to the child and family.

During the screening process, the child, child's family, or child's legal representative, as appropriate, must be informed of the child's eligibility for case management services and family community support services and that an individual family community support plan is being developed by the case manager, if assigned.

Screening shall be in compliance with section 256F.07 or 260C.212, whichever applies. Wherever possible, the parent shall be consulted in the screening process, unless clinically inappropriate.

The screening process, and placement decision, and recommendations for mental health services must be documented in the child's record.

An alternate review process may be approved by the commissioner if the county board demonstrates that an alternate review process has been established by the county board and the times of review, persons responsible for the review, and review criteria are comparable to the standards in clauses (1) to (4).

Sec. 10. Minnesota Statutes 2000, section 245.4886, subdivision 1, is amended to read:

Subdivision 1. [STATEWIDE PROGRAM; ESTABLISHMENT.] The commissioner shall establish a statewide program to assist counties in providing services to children with severe emotional disturbance as defined in section 245.4871, subdivision 15, and their families; and to young adults meeting the criteria for transition services in section 245.4875, subdivision 8, and their families. Services must be designed to help each child to function and remain with the child's family in the community. Transition services to eligible young adults must be designed to foster independent living in the community. The commissioner shall make grants to counties to establish, operate, or contract with private providers to provide the following services in the following order of priority when these cannot be reimbursed under section 256B.0625:

(1) family community support services including crisis placement and crisis respite care as specified in section 245.4871, subdivision 17;

(2) case management services as specified in section 245.4871, subdivision 3;

(3) day treatment services as specified in section 245.4871, subdivision 10;

(4) professional home-based family treatment as specified in section 245.4871, subdivision 31; and

(5) therapeutic support of foster care as specified in section 245.4871, subdivision 34.

Funding appropriated beginning July 1, 1991, must be used by county boards to provide family community support services and case management services. Additional services shall be provided in the order of priority as identified in this subdivision.

Sec. 11. Minnesota Statutes 2000, section 245.99, subdivision 4, is amended to read:

Subd. 4. [ADMINISTRATION OF CRISIS HOUSING ASSISTANCE.] The commissioner may contract with organizations or government units experienced in housing assistance to operate the program under this section. This program is not an entitlement. The commissioner may take any of the following steps whenever the commissioner projects that funds will be inadequate to meet demand in a given fiscal year:

(1) transfer funds from mental health grants in the same appropriation; and

(2) impose statewide restrictions as to the type and amount of assistance available to each recipient under this program including reducing the income eligibility level, limiting reimbursement to a percentage of each recipient's costs, limiting housing assistance to 60 days per recipient, or closing the program for the remainder of the fiscal year.

Sec. 12. Minnesota Statutes 2000, section 256.969, subdivision 3a, is amended to read:

Subd. 3a. [PAYMENTS.] Acute care hospital billings under the medical assistance program must not be submitted until the recipient is discharged. However, the commissioner shall establish monthly interim payments for inpatient hospitals that have individual patient lengths of stay over 30 days regardless of diagnostic category. Except as provided in section 256.9693, medical assistance reimbursement for treatment of mental illness shall be reimbursed based on diagnostic classifications. ~~The commissioner may selectively contract with hospitals for services within the diagnostic categories relating to mental illness and chemical dependency under competitive bidding when reasonable geographic access by recipients can be assured. No physician shall be denied the privilege of treating a recipient required to use a hospital under contract with the commissioner, as long as the physician meets credentialing standards of the individual hospital.~~ Individual hospital payments established under this section and sections 256.9685, 256.9686, and 256.9695, in addition to third party and recipient liability, for discharges occurring during the rate year shall not exceed, in aggregate, the charges for the medical assistance covered inpatient services paid for the same period of time to the hospital. This payment limitation shall be calculated separately for medical assistance and general assistance medical care services. The limitation on general assistance medical care shall be effective for admissions occurring on or after July 1, 1991. Services that have rates established under subdivision 11 or 12, must be limited separately from other services. After consulting with the affected hospitals, the commissioner may consider related hospitals one entity and may merge the payment rates while maintaining separate provider numbers. The operating and property base rates per admission or per day shall be derived from the best Medicare and claims data available when rates are established. The commissioner shall determine the best Medicare and claims data, taking into consideration variables of recency of the data, audit disposition, settlement status, and the ability to set rates in a timely manner. The commissioner shall notify hospitals of payment rates by December 1 of the year preceding the rate year. The rate setting data must reflect the admissions data used to establish relative values. Base year changes from 1981 to the base year established for the rate year beginning January 1, 1991, and for subsequent rate years, shall not be limited to the limits ending June 30, 1987, on the maximum rate of increase under subdivision 1. The commissioner may adjust base year cost, relative value, and case mix index data to exclude the costs of services that have been discontinued by the October 1 of the year preceding the rate year or that are paid separately from inpatient services. Inpatient stays that encompass portions of two or more rate years shall have payments established based on payment rates in effect at the time of admission unless the date of admission preceded the rate year in effect by six months or more. In this case, operating payment rates for services rendered during the rate year in effect and established based on the date of admission shall be adjusted to the rate year in effect by the hospital cost index.

**[EFFECTIVE DATE.]** This section is effective July 1, 2002.

Sec. 13. [256.9693] [CONTINUING CARE PROGRAM FOR PERSONS WITH MENTAL ILLNESS.]

The commissioner shall establish a continuing care benefit program for persons with mental illness, in which persons with mental illness may obtain acute care hospital inpatient treatment for mental illness for up to 45 days beyond that allowed by section 256.969. Persons with mental illness who are eligible for medical assistance may obtain inpatient treatment under this program in hospital beds for which the commissioner contracts under this section. The commissioner may selectively contract with hospitals to provide this benefit through competitive bidding when reasonable geographic access by recipients can be assured. Payments under this section shall not affect payments under section 256.969. The commissioner may contract externally with a utilization review organization to authorize persons with mental illness to access the continuing care benefit program. The commissioner, as part of the contracts with hospitals, shall establish admission criteria to allow persons with mental illness to access the continuing care benefit program. If a court orders acute care hospital inpatient treatment for mental illness for a person, the person may obtain the treatment under the continuing care benefit program. The commissioner shall not require, as part of the admission criteria, any commitment or petition under chapter 253B as a condition of accessing the program. This benefit is not available for people who are also eligible for Medicare and who have not exhausted their annual or lifetime inpatient psychiatric

benefit under Medicare. If a recipient is enrolled in a prepaid plan, this program is included in the plan's coverage.

**[EFFECTIVE DATE.]** This section is effective July 1, 2002.

Sec. 14. [256B.0623] [ADULT REHABILITATIVE MENTAL HEALTH SERVICES.]

Subdivision 1. [SCOPE.] Medical assistance covers adult rehabilitative mental health services as defined in subdivision 2, subject to federal approval, if provided to recipients as defined in subdivision 3 and provided by a qualified provider entity meeting the standards in this section and by a qualified individual provider working within the provider's scope of practice and identified in the recipient's individual treatment plan as defined in section 245.462, subdivision 14, and if determined to be medically necessary according to section 62Q.53.

Subd. 2. [DEFINITIONS.] For purposes of this section, the following terms have the meanings given them.

(a) "Adult rehabilitative mental health services" means mental health services which are rehabilitative and enable the recipient to develop and enhance psychiatric stability, social competencies, personal and emotional adjustment, and independent living and community skills, when these abilities are impaired by the symptoms of mental illness. Adult rehabilitative mental health services are also appropriate when provided to enable a recipient to retain stability and functioning, if the recipient would be at risk of significant functional decompensation or more restrictive service settings without these services.

(1) Adult rehabilitative mental health services instruct, assist, and support the recipient in areas such as: interpersonal communication skills, community resource utilization and integration skills, crisis assistance, relapse prevention skills, health care directives, budgeting and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills, transportation skills, medication education and monitoring, mental illness symptom management skills, household management skills, employment-related skills, and transition to community living services.

(2) These services shall be provided to the recipient on a one-to-one basis in the recipient's home or another community setting or in groups.

(b) "Medication education services" means services provided individually or in groups which focus on educating the recipient about mental illness and symptoms; the role and effects of medications in treating symptoms of mental illness; and the side effects of medications. Medication education is coordinated with medication management services, and does not duplicate it. Medication education services are provided by physicians, pharmacists, or registered nurses.

(c) "Transition to community living services" means services which maintain continuity of contact between the rehabilitation services provider and the recipient and which facilitate discharge from a hospital, residential treatment program under Minnesota Rules, chapter 9505, board and lodging facility, or nursing home. Transition to community living services are not intended to provide other areas of adult rehabilitative mental health services.

Subd. 3. [ELIGIBILITY.] An eligible recipient is an individual who:

(1) is age 18 or older;

(2) is diagnosed with a medical condition, such as mental illness or traumatic brain injury, for which adult rehabilitative mental health services are needed;

(3) has substantial disability and functional impairment in three or more of the areas listed in section 245.462, subdivision 11a, so that self-sufficiency is markedly reduced; and

(4) has had a recent diagnostic assessment by a qualified professional that documents adult rehabilitative mental health services are medically necessary to address identified disability and functional impairments and individual recipient goals.

Subd. 4. [PROVIDER ENTITY STANDARDS.] (a) The provider entity must be:

(1) a county operated entity certified by the state; or

(2) a noncounty entity certified by the entity's host county.

(b) The certification process is a determination as to whether the entity meets the standards in this subdivision. The certification must specify which adult rehabilitative mental health services the entity is qualified to provide.

(c) If an entity seeks to provide services outside its host county, it must obtain additional certification from each county in which it will provide services. The additional certification must be based on the adequacy of the entity's knowledge of that county's local health and human service system, and the ability of the entity to coordinate its services with the other services available in that county.

(d) Recertification must occur at least every two years.

(e) The commissioner may intervene at any time and decertify providers with cause. The decertification is subject to appeal to the state. A county board may recommend that the state decertify a provider for cause.

(f) The adult rehabilitative mental health services provider entity must meet the following standards:

(1) have capacity to recruit, hire, manage, and train mental health professionals, mental health practitioners, and mental health rehabilitation workers;

(2) have adequate administrative ability to ensure availability of services;

(3) ensure adequate preservice and inservice training for staff;

(4) ensure that mental health professionals, mental health practitioners, and mental health rehabilitation workers are skilled in the delivery of the specific adult rehabilitative mental health services provided to the individual eligible recipient;

(5) ensure that staff is capable of implementing culturally specific services that are culturally competent and appropriate as determined by the recipient's culture, beliefs, values, and language as identified in the individual treatment plan;

(6) ensure enough flexibility in service delivery to respond to the changing and intermittent care needs of a recipient as identified by the recipient and the individual treatment plan;

(7) ensure that the mental health professional or mental health practitioner, who is under the clinical supervision of a mental health professional, involved in a recipient's services participates in the development of the individual treatment plan;

(8) assist the recipient in arranging needed crisis assessment, intervention, and stabilization services;

(9) ensure that services are coordinated with other recipient mental health services providers and the county mental health authority and the federally recognized American Indian authority and necessary others after obtaining the consent of the recipient. Services must also be coordinated with the recipient's case manager or care coordinator, if the recipient is receiving case management or care coordination services;

(10) develop and maintain recipient files, individual treatment plans, and contact charting;

(11) develop and maintain staff training and personnel files;

(12) submit information as required by the state;

(13) establish and maintain a quality assurance plan to evaluate the outcome of services provided;

(14) keep all necessary records required by law;

(15) deliver services as required by section 245.461;

(16) comply with all applicable laws;

(17) be an enrolled Medicaid provider;

(18) maintain a quality assurance plan to determine specific service outcomes and the recipient's satisfaction with services; and

(19) develop and maintain written policies and procedures regarding service provision and administration of the provider entity.

(g) The commissioner shall develop statewide procedures for provider certification, including timelines for counties to certify qualified providers.

Subd. 5. [QUALIFICATIONS OF PROVIDER STAFF.] Adult rehabilitative mental health services must be provided by qualified individual provider staff of a certified provider entity. Individual provider staff must be qualified under one of the following criteria:

(1) a mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (5);

(2) a mental health practitioner as defined in section 245.462, subdivision 17. The mental health practitioner must work under the clinical supervision of a mental health professional; or

(3) a mental health rehabilitation worker. A mental health rehabilitation worker means a staff person working under the direction of a mental health practitioner or mental health professional, and under the clinical supervision of a mental health professional in the implementation of rehabilitative mental health services as identified in the recipient's individual treatment plan; and who:

(i) is at least 21 years of age;

(ii) has a high school diploma or equivalent;

(iii) has successfully completed 30 hours of training during the past two years in all of the following areas: recipient rights, recipient-centered individual treatment planning, behavioral terminology, mental illness, co-occurring mental illness and substance abuse, psychotropic medications and side effects, functional assessment, local community resources, adult vulnerability, recipient confidentiality; and

(iv) meets the qualifications in (A) or (B):

(A) has an associate of arts degree in one of the behavioral sciences or human services, or is a registered nurse without a bachelor's degree, or who within the previous ten years has:

(1) three years of personal life experience with serious and persistent mental illness;

(2) three years of life experience as a primary caregiver to an adult with a serious mental illness or traumatic brain injury; or

(3) 4,000 hours of supervised paid work experience in the delivery of mental health services to adults with a serious mental illness or traumatic brain injury; or

(B)(1) be fluent in the non-English language or competent in the culture of the ethnic group to which at least 50 percent of the mental health rehabilitation worker's clients belong;

(2) receives during the first 2,000 hours of work, monthly documented individual clinical supervision by a mental health professional;

(3) has 18 hours of documented field supervision by a mental health professional or practitioner

during the first 160 hours of contact work with recipients, and at least six hours of field supervision quarterly during the following year;

(4) has review and cosignature of charting of recipient contacts during field supervision by a mental health professional or practitioner; and

(5) has 40 hours of additional continuing education on mental health topics during the first year of employment.

Subd. 6. [REQUIRED TRAINING AND SUPERVISION.] (a) Mental health rehabilitation workers must receive ongoing continuing education training of at least 30 hours every two years in areas of mental illness and mental health services and other areas specific to the population being served. Mental health rehabilitation workers must also be subject to the ongoing direction and clinical supervision standards in paragraphs (c) and (d).

(b) Mental health practitioners must receive ongoing continuing education training as required by their professional license; or if the practitioner is not licensed, the practitioner must receive ongoing continuing education training of at least 30 hours every two years in areas of mental illness and mental health services. Mental health practitioners must meet the ongoing clinical supervision standards in paragraph (c).

(c) A mental health professional providing clinical supervision of staff delivering adult rehabilitative mental health services must provide the following guidance:

(1) review the information in the recipient's file;

(2) review and approve initial and updates of individual treatment plans;

(3) meet with mental health rehabilitation workers and practitioners, individually or in small groups, at least monthly to discuss treatment topics of interest to the workers and practitioners;

(4) meet with mental health rehabilitation workers and practitioners, individually or in small groups, at least monthly to discuss treatment plans of recipients, and approve by signature and document in the recipient's file any resulting plan updates;

(5) meet at least twice a month with the directing mental health practitioner, if there is one, to review needs of the adult rehabilitative mental health services program, review staff on-site observations and evaluate mental health rehabilitation workers, plan staff training, review program evaluation and development, and consult with the directing practitioner;

(6) be available for urgent consultation as the individual recipient needs or the situation necessitates; and

(7) provide clinical supervision by full- or part-time mental health professionals employed by or under contract with the provider entity.

(d) An adult rehabilitative mental health services provider entity must have a treatment director who is a mental health practitioner or mental health professional. The treatment director must ensure the following:

(1) while delivering direct services to recipients, a newly hired mental health rehabilitation worker must be directly observed delivering services to recipients by the mental health practitioner or mental health professional for at least six hours per 40 hours worked during the first 160 hours that the mental health rehabilitation worker works;

(2) the mental health rehabilitation worker must receive ongoing on-site direct service observation by a mental health professional or mental health practitioner for at least six hours for every six months of employment;

(3) progress notes are reviewed from on-site service observation prepared by the mental health rehabilitation worker and mental health practitioner for accuracy and consistency with actual recipient contact and the individual treatment plan and goals;

(4) immediate availability by phone or in person for consultation by a mental health professional or a mental health practitioner to the mental health rehabilitation services worker during service provision;

(5) oversee the identification of changes in individual recipient treatment strategies, revise the plan and communicate treatment instructions and methodologies as appropriate to ensure that treatment is implemented correctly;

(6) model service practices which: respect the recipient, include the recipient in planning and implementation of the individual treatment plan, recognize the recipient's strengths, collaborate and coordinate with other involved parties and providers;

(7) ensure that mental health practitioners and mental health rehabilitation workers are able to effectively communicate with the recipients, significant others, and providers; and

(8) oversee the record of the results of on-site observation and charting evaluation and corrective actions taken to modify the work of the mental health practitioners and mental health rehabilitation workers.

(e) A mental health practitioner who is providing treatment direction for a provider entity must receive supervision at least monthly from a mental health professional to:

(1) identify and plan for general needs of the recipient population served;

(2) identify and plan to address provider entity program needs and effectiveness;

(3) identify and plan provider entity staff training and personnel needs and issues; and

(4) plan, implement, and evaluate provider entity quality improvement programs.

Subd. 7. [PERSONNEL FILE.] The adult rehabilitative mental health services provider entity must maintain a personnel file on each staff. Each file must contain:

(1) an annual performance review;

(2) a summary of on-site service observations and charting review;

(3) a criminal background check of all direct service staff;

(4) evidence of academic degree and qualifications;

(5) a copy of professional license;

(6) any job performance recognition and disciplinary actions;

(7) any individual staff written input into own personnel file;

(8) all clinical supervision provided; and

(9) documentation of compliance with continuing education requirements.

Subd. 8. [DIAGNOSTIC ASSESSMENT.] Providers of adult rehabilitative mental health services must complete a diagnostic assessment as defined in section 245.462, subdivision 9, within five days after the recipient's second visit or within 30 days after intake, whichever occurs first. In cases where a diagnostic assessment is available that reflects the recipient's current status, and has been completed within 180 days preceding admission, an update must be completed. An update shall include a written summary by a mental health professional of the recipient's current mental health status and service needs. If the recipient's mental health status has changed significantly since the adult's most recent diagnostic assessment, a new diagnostic assessment is required.

Subd. 9. [FUNCTIONAL ASSESSMENT.] Providers of adult rehabilitative mental health services must complete a written functional assessment as defined in section 245.462, subdivision

11a, for each recipient. The functional assessment must be completed within 30 days of intake, and reviewed and updated at least every six months after it is developed, unless there is a significant change in the functioning of the recipient. If there is a significant change in functioning, the assessment must be updated. A single functional assessment can meet case management and adult rehabilitative mental health services requirements, if agreed to by the recipient. Unless the recipient refuses, the recipient must have significant participation in the development of the functional assessment.

Subd. 10. [INDIVIDUAL TREATMENT PLAN.] All providers of adult rehabilitative mental health services must develop and implement an individual treatment plan for each recipient. The provisions in clauses (1) and (2) apply:

(1) Individual treatment plan means a plan of intervention, treatment, and services for an individual recipient written by a mental health professional or by a mental health practitioner under the clinical supervision of a mental health professional. The individual treatment plan must be based on diagnostic and functional assessments. To the extent possible, the development and implementation of a treatment plan must be a collaborative process involving the recipient, and with the permission of the recipient, the recipient's family and others in the recipient's support system. Providers of adult rehabilitative mental health services must develop the individual treatment plan within 30 calendar days of intake. The treatment plan must be updated at least every six months thereafter, or more often when there is significant change in the recipient's situation or functioning, or in services or service methods to be used, or at the request of the recipient or the recipient's legal guardian.

(2) The individual treatment plan must include:

(i) a list of problems identified in the assessment;

(ii) the recipient's strengths and resources;

(iii) concrete, measurable goals to be achieved, including time frames for achievement;

(iv) specific objectives directed toward the achievement of each one of the goals;

(v) documentation of participants in the treatment planning. The recipient, if possible, must be a participant. The recipient or the recipient's legal guardian must sign the treatment plan, or documentation must be provided why this was not possible. A copy of the plan must be given to the recipient or legal guardian. Referral to formal services must be arranged, including specific providers where applicable;

(vi) cultural considerations, resources, and needs of the recipient must be included;

(vii) planned frequency and type of services must be initiated; and

(viii) clear progress notes on outcome of goals.

(3) The individual community support plan defined in section 245.462, subdivision 12, may serve as the individual treatment plan if there is involvement of a mental health case manager, and with the approval of the recipient. The individual community support plan must include the criteria in clause (2).

Subd. 11. [RECIPIENT FILE.] Providers of adult rehabilitative mental health services must maintain a file for each recipient that contains the following information:

(1) diagnostic assessment or verification of its location, that is current and that was reviewed by a mental health professional who is employed by or under contract with the provider entity;

(2) functional assessments;

(3) individual treatment plans signed by the recipient and the mental health professional, or if the recipient refused to sign the plan, the date and reason stated by the recipient as to why the recipient would not sign the plan;

(4) recipient history;

(5) signed release forms;

(6) recipient health information and current medications;

(7) emergency contacts for the recipient;

(8) case records which document the date of service, the place of service delivery, signature of the person providing the service, nature, extent and units of service, and place of service delivery;

(9) contacts, direct or by telephone, with recipient's family or others, other providers, or other resources for service coordination;

(10) summary of recipient case reviews by staff; and

(11) written information by the recipient that the recipient requests be included in the file.

Subd. 12. [ADDITIONAL REQUIREMENTS.] (a) Providers of adult rehabilitative mental health services must comply with the requirements relating to referrals for case management in section 245.467, subdivision 4.

(b) Adult rehabilitative mental health services are provided for most recipients in the recipient's home and community. Services may also be provided at the home of a relative or significant other, job site, psychosocial clubhouse, drop-in center, social setting, classroom, or other places in the community. Except for "transition to community services," the place of service does not include a regional treatment center, nursing home, residential treatment facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0670 (Rule 36), or an acute care hospital.

(c) Adult rehabilitative mental health services may be provided in group settings if appropriate to each participating recipient's needs and treatment plan. A group is defined as two to ten clients, at least one of whom is a recipient, who is concurrently receiving a service which is identified in this section. The service and group must be specified in the recipient's treatment plan. No more than two qualified staff may bill Medicaid for services provided to the same group of recipients. If two adult rehabilitative mental health workers bill for recipients in the same group session, they must each bill for different recipients.

Subd. 13. [EXCLUDED SERVICES.] The following services are excluded from reimbursement as adult rehabilitative mental health services:

(1) recipient transportation services;

(2) a service provided and billed by a provider who is not enrolled to provide adult rehabilitative mental health service;

(3) adult rehabilitative mental health services performed by volunteers;

(4) provider performance of household tasks, chores, or related activities, such as laundering clothes, moving the recipient's household, housekeeping, and grocery shopping for the recipient;

(5) direct billing of time spent "on call" when not delivering services to recipients;

(6) activities which are primarily social or recreational in nature, rather than rehabilitative, for the individual recipient, as determined by the individual's needs and treatment plan;

(7) job-specific skills services, such as on-the-job training;

(8) provider service time included in case management reimbursement;

(9) outreach services to potential recipients;

(10) a mental health service that is not medically necessary; and

(11) any services provided by a hospital, board and lodging, or residential facility to an individual who is a patient in or resident of that facility.

Subd. 14. [BILLING WHEN SERVICES ARE PROVIDED BY QUALIFIED STATE STAFF.] When rehabilitative services are provided by qualified state staff who are assigned to pilot projects under section 245.4661, the county or other local entity to which the qualified state staff are assigned may consider these staff part of the local provider entity for which certification is sought under this section, and may bill the medical assistance program for qualifying services provided by the qualified state staff. Notwithstanding section 256.025, subdivision 2, payments for services provided by state staff who are assigned to adult mental health initiatives shall only be made from federal funds.

Sec. 15. [256B.0624] [ADULT MENTAL HEALTH CRISIS RESPONSE SERVICES.]

Subdivision 1. [SCOPE.] Medical assistance covers adult mental health crisis response services as defined in subdivision 2, paragraphs (c) to (e), subject to federal approval, if provided to a recipient as defined in subdivision 3 and provided by a qualified provider entity as defined in this section and by a qualified individual provider working within the provider's scope of practice and as defined in this subdivision and identified in the recipient's individual crisis treatment plan as defined in subdivision 10 and if determined to be medically necessary.

Subd. 2. [DEFINITIONS.] For purposes of this section, the following terms have the meanings given them.

(a) "Mental health crisis" is an adult behavioral, emotional, or psychiatric situation which, but for the provision of crisis response services, would likely result in significantly reduced levels of functioning in primary activities of daily living, or in an emergency situation, or in the placement of the recipient in a more restrictive setting, including, but not limited to, inpatient hospitalization.

(b) "Mental health emergency" is an adult behavioral, emotional, or psychiatric situation which causes an immediate need for mental health services and is consistent with section 62Q.55.

A mental health crisis or emergency is determined for medical assistance service reimbursement by a physician, a mental health professional, or crisis mental health practitioner with input from the recipient whenever possible.

(c) "Mental health crisis assessment" means an immediate face-to-face assessment by a physician, a mental health professional, or mental health practitioner under the clinical supervision of a mental health professional, following a screening that suggests that the adult may be experiencing a mental health crisis or mental health emergency situation.

(d) "Mental health mobile crisis intervention services" means face-to-face, short-term intensive mental health services initiated during a mental health crisis or mental health emergency to help the recipient cope with immediate stressors, identify and utilize available resources and strengths, and begin to return to the recipient's baseline level of functioning.

(1) This service is provided on-site by a mobile crisis intervention team outside of an inpatient hospital setting. Mental health mobile crisis intervention services must be available 24 hours a day, seven days a week.

(2) The initial screening must consider other available services to determine which service intervention would best address the recipient's needs and circumstances.

(3) The mobile crisis intervention team must be available to meet promptly face-to-face with a person in mental health crisis or emergency in a community setting.

(4) The intervention must consist of a mental health crisis assessment and a crisis treatment plan.

(5) The treatment plan must include recommendations for any needed crisis stabilization services for the recipient.

(e) "Mental health crisis stabilization services" means individualized mental health services provided to a recipient following crisis intervention services which are designed to restore the recipient to the recipient's prior functional level. Mental health crisis stabilization services may be provided in the recipient's home, the home of a family member or friend of the recipient, another community setting, or a short-term supervised, licensed residential program. Mental health crisis stabilization does not include partial hospitalization or day treatment.

Subd. 3. [ELIGIBILITY.] An eligible recipient is an individual who:

(1) is age 18 or older;

(2) is screened as possibly experiencing a mental health crisis or emergency where a mental health crisis assessment is needed; and

(3) is assessed as experiencing a mental health crisis or emergency, and mental health crisis intervention or crisis intervention and stabilization services are determined to be medically necessary.

Subd. 4. [PROVIDER ENTITY STANDARDS.] (a) A provider entity is an entity that meets the standards listed in paragraph (b) and:

(1) is a county board operated entity; or

(2) is a provider entity that is under contract with the county board in the county where the potential crisis or emergency is occurring. To provide services under this section, the provider entity must directly provide the services; or if services are subcontracted, the provider entity must maintain responsibility for services and billing.

(b) The adult mental health crisis response services provider entity must meet the following standards:

(1) has the capacity to recruit, hire, and manage and train mental health professionals, practitioners, and rehabilitation workers;

(2) has adequate administrative ability to ensure availability of services;

(3) is able to ensure adequate preservice and in-service training;

(4) is able to ensure that staff providing these services are skilled in the delivery of mental health crisis response services to recipients;

(5) is able to ensure that staff are capable of implementing culturally specific treatment identified in the individual treatment plan that is meaningful and appropriate as determined by the recipient's culture, beliefs, values, and language;

(6) is able to ensure enough flexibility to respond to the changing intervention and care needs of a recipient as identified by the recipient during the service partnership between the recipient and providers;

(7) is able to ensure that mental health professionals and mental health practitioners have the communication tools and procedures to communicate and consult promptly about crisis assessment and interventions as services occur;

(8) is able to coordinate these services with county emergency services and mental health crisis services;

(9) is able to ensure that mental health crisis assessment and mobile crisis intervention services are available 24 hours a day, seven days a week;

(10) is able to ensure that services are coordinated with other mental health service providers, county mental health authorities, or federally recognized American Indian authorities and others as necessary, with the consent of the adult. Services must also be coordinated with the recipient's case manager if the adult is receiving case management services;

(11) is able to ensure that crisis intervention services are provided in a manner consistent with sections 245.461 to 245.486;

(12) is able to submit information as required by the state;

(13) maintains staff training and personnel files;

(14) is able to establish and maintain a quality assurance and evaluation plan to evaluate the outcomes of services and recipient satisfaction;

(15) is able to keep records as required by applicable laws;

(16) is able to comply with all applicable laws and statutes;

(17) is an enrolled medical assistance provider; and

(18) develops and maintains written policies and procedures regarding service provision and administration of the provider entity including safety of staff and recipients in high risk situations.

Subd. 5. [MOBILE CRISIS INTERVENTION STAFF QUALIFICATIONS.] For provision of adult mental health mobile crisis intervention services, a mobile crisis intervention team is comprised of at least two mental health professionals as defined in section 245.462, subdivision 18, clauses (1) to (5), or a combination of at least one mental health professional and one mental health practitioner as defined in section 245.462, subdivision 17, with the required mental health crisis training and under the clinical supervision of a mental health professional on the team. The team must have at least two people with at least one member providing on-site crisis intervention services when needed. Team members must be experienced in mental health assessment, crisis intervention techniques, and clinical decision-making under emergency conditions and have knowledge of local services and resources. The team must recommend and coordinate the team's services with appropriate local resources such as the county social services agency, mental health services, and local law enforcement when necessary.

Subd. 6. [INITIAL SCREENING, CRISIS ASSESSMENT, AND MOBILE INTERVENTION TREATMENT PLANNING.] (a) Prior to initiating mobile crisis intervention services, a screening of the potential crisis situation must be conducted. The screening may use the resources of crisis assistance and emergency services as defined in sections 245.462, subdivision 6, and 245.469, subdivisions 1 and 2. The screening must gather information, determine whether a crisis situation exists, identify parties involved, and determine an appropriate response.

(b) If a crisis exists, a crisis assessment must be completed. A crisis assessment evaluates any immediate needs for which emergency services are needed and, as time permits, the recipient's current life situation, sources of stress, mental health problems and symptoms, strengths, cultural considerations, support network, vulnerabilities, and current functioning.

(c) If the crisis assessment determines mobile crisis intervention services are needed, the intervention services must be provided promptly. As opportunity presents during the intervention, at least two members of the mobile crisis intervention team must confer directly or by telephone about the assessment, treatment plan, and actions taken and needed. At least one of the team members must be on-site providing crisis intervention services. If providing on-site crisis intervention services, a mental health practitioner must seek clinical supervision as required in subdivision 8.

(d) The mobile crisis intervention team must develop an initial, brief crisis treatment plan as soon as appropriate but no later than 24 hours after the initial face-to-face intervention. The plan must address the needs and problems noted in the crisis assessment and include measurable short-term goals, cultural considerations, and frequency and type of services to be provided to achieve the goals and reduce or eliminate the crisis. The treatment plan must be updated as needed to reflect current goals and services.

(e) The team must document which short-term goals have been met, and when no further crisis intervention services are required.

(f) If the recipient's crisis is stabilized, but the recipient needs a referral to other services, the team must provide referrals to these services. If the recipient has a case manager, planning for other services must be coordinated with the case manager.

Subd. 7. [CRISIS STABILIZATION SERVICES.] (a) Crisis stabilization services must be provided by qualified staff of a crisis stabilization services provider entity and must meet the following standards:

(1) a crisis stabilization treatment plan must be developed which meets the criteria in subdivision 11;

(2) staff must be qualified as defined in subdivision 8; and

(3) services must be delivered according to the treatment plan and include face-to-face contact with the recipient by qualified staff for further assessment, help with referrals, updating of the crisis stabilization treatment plan, supportive counseling, skills training, and collaboration with other service providers in the community.

(b) If crisis stabilization services are provided in a supervised, licensed residential setting, the recipient must be contacted face-to-face daily by a qualified mental health practitioner or mental health professional. The program must have 24-hour-a-day residential staffing which may include staff who do not meet the qualifications in subdivision 8. The residential staff must have 24-hour-a-day immediate direct or telephone access to a qualified mental health professional or practitioner.

(c) If crisis stabilization services are provided in a supervised, licensed residential setting that serves no more than four adult residents, and no more than two are recipients of crisis stabilization services, the residential staff must include, for at least eight hours per day, at least one individual who meets the qualifications in subdivision 8.

(d) If crisis stabilization services are provided in a supervised, licensed residential setting that serves more than four adult residents, and one or more are recipients of crisis stabilization services, the residential staff must include, for 24 hours a day, at least one individual who meets the qualifications in subdivision 8. During the first 48 hours that a recipient is in the residential program, the residential program must have at least two staff working 24 hours a day. Staffing levels may be adjusted thereafter according to the needs of the recipient as specified in the crisis stabilization treatment plan.

Subd. 8. [ADULT CRISIS STABILIZATION STAFF QUALIFICATIONS.] (a) Adult mental health crisis stabilization services must be provided by qualified individual staff of a qualified provider entity. Individual provider staff must have the following qualifications:

(1) be a mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (5);

(2) be a mental health practitioner as defined in section 245.462, subdivision 17. The mental health practitioner must work under the clinical supervision of a mental health professional; or

(3) be a mental health rehabilitation worker who meets the criteria in section 256B.0623, subdivision 5, clause (3); works under the direction of a mental health practitioner as defined in section 245.462, subdivision 17, or under direction of a mental health professional; and works under the clinical supervision of a mental health professional.

(b) Mental health practitioners and mental health rehabilitation workers must have completed at least 30 hours of training in crisis intervention and stabilization during the past two years.

Subd. 9. [SUPERVISION.] Mental health practitioners may provide crisis assessment and mobile crisis intervention services if the following clinical supervision requirements are met:

(1) the mental health provider entity must accept full responsibility for the services provided;

(2) the mental health professional of the provider entity, who is an employee or under contract with the provider entity, must be available by phone or in person for clinical supervision;

(3) the mental health professional is consulted, in person or by phone, during the first three hours when a mental health practitioner provides on-site service;

(4) the mental health professional must:

(i) review and approve of the tentative crisis assessment and crisis treatment plan;

(ii) document the consultation; and

(iii) sign the crisis assessment and treatment plan within the next business day;

(5) if the mobile crisis intervention services continue into a second calendar day, a mental health professional must contact the recipient face-to-face on the second day to provide services and update the crisis treatment plan; and

(6) the on-site observation must be documented in the recipient's record and signed by the mental health professional.

Subd. 10. [RECIPIENT FILE.] Providers of mobile crisis intervention or crisis stabilization services must maintain a file for each recipient containing the following information:

(1) individual crisis treatment plans signed by the recipient, mental health professional, and mental health practitioner who developed the crisis treatment plan, or if the recipient refused to sign the plan, the date and reason stated by the recipient as to why the recipient would not sign the plan;

(2) signed release forms;

(3) recipient health information and current medications;

(4) emergency contacts for the recipient;

(5) case records which document the date of service, place of service delivery, signature of the person providing the service, and the nature, extent, and units of service. Direct or telephone contact with the recipient's family or others should be documented;

(6) required clinical supervision by mental health professionals;

(7) summary of the recipient's case reviews by staff; and

(8) any written information by the recipient that the recipient wants in the file.

Documentation in the file must comply with all requirements of the commissioner.

Subd. 11. [TREATMENT PLAN.] The individual crisis stabilization treatment plan must include, at a minimum:

(1) a list of problems identified in the assessment;

(2) a list of the recipient's strengths and resources;

(3) concrete, measurable short-term goals and tasks to be achieved, including time frames for achievement;

(4) specific objectives directed toward the achievement of each one of the goals;

(5) documentation of the participants involved in the service planning. The recipient, if possible, must be a participant. The recipient or the recipient's legal guardian must sign the service plan or documentation must be provided why this was not possible. A copy of the plan must be given to the recipient and the recipient's legal guardian. The plan should include services arranged, including specific providers where applicable;

(6) planned frequency and type of services initiated;

(7) a crisis response action plan if a crisis should occur;

(8) clear progress notes on outcome of goals;

(9) a written plan must be completed within 24 hours of beginning services with the recipient; and

(10) a treatment plan must be developed by a mental health professional or mental health practitioner under the clinical supervision of a mental health professional. The mental health professional must approve and sign all treatment plans.

Subd. 12. [EXCLUDED SERVICES.] The following services are excluded from reimbursement under this section:

(1) room and board services;

(2) services delivered to a recipient while admitted to an inpatient hospital;

(3) recipient transportation costs may be covered under other medical assistance provisions, but transportation services are not an adult mental health crisis response service;

(4) services provided and billed by a provider who is not enrolled under medical assistance to provide adult mental health crisis response services;

(5) services performed by volunteers;

(6) direct billing of time spent "on call" when not delivering services to a recipient;

(7) provider service time included in case management reimbursement. When a provider is eligible to provide more than one type of medical assistance service, the recipient must have a choice of provider for each service, unless otherwise provided for by law;

(8) outreach services to potential recipients; and

(9) a mental health service that is not medically necessary.

Sec. 16. Minnesota Statutes 2000, section 256B.0625, subdivision 20, is amended to read:

Subd. 20. [MENTAL HEALTH CASE MANAGEMENT.] (a) To the extent authorized by rule of the state agency, medical assistance covers case management services to persons with serious and persistent mental illness and children with severe emotional disturbance. Services provided under this section must meet the relevant standards in sections 245.461 to 245.4888, the Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

(b) Entities meeting program standards set out in rules governing family community support services as defined in section 245.4871, subdivision 17, are eligible for medical assistance reimbursement for case management services for children with severe emotional disturbance when these services meet the program standards in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

(c) Medical assistance and MinnesotaCare payment for mental health case management shall be made on a monthly basis. In order to receive payment for an eligible child, the provider must document at least a face-to-face contact with the child, the child's parents, or the child's legal representative. To receive payment for an eligible adult, the provider must document:

(1) at least a face-to-face contact with the adult or the adult's legal representative; or

(2) at least a telephone contact with the adult or the adult's legal representative and document a face-to-face contact with the adult or the adult's legal representative within the preceding two months.

(d) Payment for mental health case management provided by county or state staff shall be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph (b), with separate rates calculated for child welfare and mental health, and within mental health, separate rates for children and adults.

(e) Payment for mental health case management provided by Indian health services or by agencies operated by Indian tribes may be made according to this section or other relevant federally approved rate setting methodology.

(f) Payment for mental health case management provided by ~~county-contracted~~ vendors who contract with a county or Indian tribe shall be based on a monthly rate negotiated by the host county or tribe. The negotiated rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the county or tribe may negotiate a team rate with a vendor who is a member of the team. The team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county or tribe, except to reimburse the county or tribe for advance funding provided by the county or tribe to the vendor.

~~(f)~~ (g) If the service is provided by a team which includes contracted vendors, tribal staff, and county or state staff, the costs for county or state staff participation in the team shall be included in the rate for county-provided services. In this case, the contracted vendor, the tribal agency, and the county may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services, ~~the county~~ each entity must document, in the recipient's file, the need for team case management and a description of the roles of the team members.

~~(g)~~ (h) The commissioner shall calculate the nonfederal share of actual medical assistance and general assistance medical care payments for each county, based on the higher of calendar year 1995 or 1996, by service date, project that amount forward to 1999, and transfer one-half of the result from medical assistance and general assistance medical care to each county's mental health grants under sections 245.4886 and 256E.12 for calendar year 1999. The annualized minimum amount added to each county's mental health grant shall be $3,000 per year for children and $5,000 per year for adults. The commissioner may reduce the statewide growth factor in order to fund these minimums. The annualized total amount transferred shall become part of the base for future mental health grants for each county.

~~(h)~~ (i) Any net increase in revenue to the county or tribe as a result of the change in this section must be used to provide expanded mental health services as defined in sections 245.461 to 245.4888, the Comprehensive Adult and Children's Mental Health Acts, excluding inpatient and residential treatment. For adults, increased revenue may also be used for services and consumer supports which are part of adult mental health projects approved under Laws 1997, chapter 203, article 7, section 25. For children, increased revenue may also be used for respite care and nonresidential individualized rehabilitation services as defined in section 245.492, subdivisions 17 and 23. "Increased revenue" has the meaning given in Minnesota Rules, part 9520.0903, subpart 3.

~~(i)~~ (j) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for mental health case management shall be provided by the recipient's county of responsibility, as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds used to match other federal funds. If the service is provided by a tribal agency, the nonfederal share, if any, shall be provided by the recipient's tribe.

~~(j)~~ (k) The commissioner may suspend, reduce, or terminate the reimbursement to a provider that does not meet the reporting or other requirements of this section. The county of responsibility, as defined in sections 256G.01 to 256G.12, or, if applicable, the tribal agency, is responsible for any federal disallowances. The county or tribe may share this responsibility with its contracted vendors.

~~(k)~~ (l) The commissioner shall set aside a portion of the federal funds earned under this section to repay the special revenue maximization account under section 256.01, subdivision 2, clause (15). The repayment is limited to:

(1) the costs of developing and implementing this section; and

(2) programming the information systems.

~~(l)~~ (m) Notwithstanding section 256.025, subdivision 2, payments to counties and tribal agencies for case management expenditures under this section shall only be made from federal earnings from services provided under this section. Payments to ~~contracted~~ county-contracted vendors shall include both the federal earnings and the county share.

~~(m)~~ (n) Notwithstanding section 256B.041, county payments for the cost of mental health case management services provided by county or state staff shall not be made to the state treasurer. For the purposes of mental health case management services provided by county or state staff under this section, the centralized disbursement of payments to counties under section 256B.041 consists only of federal earnings from services provided under this section.

~~(n)~~ (o) Case management services under this subdivision do not include therapy, treatment, legal, or outreach services.

~~(o)~~ (p) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital, and the recipient's institutional care is paid by medical assistance, payment for case management services under this subdivision is limited to the last 30 days of the recipient's residency in that facility and may not exceed more than two months in a calendar year.

~~(p)~~ (q) Payment for case management services under this subdivision shall not duplicate payments made under other program authorities for the same purpose.

~~(q)~~ (r) By July 1, 2000, the commissioner shall evaluate the effectiveness of the changes required by this section, including changes in number of persons receiving mental health case management, changes in hours of service per person, and changes in caseload size.

~~(r)~~ (s) For each calendar year beginning with the calendar year 2001, the annualized amount of state funds for each county determined under paragraph ~~(g)~~ (h) shall be adjusted by the county's percentage change in the average number of clients per month who received case management under this section during the fiscal year that ended six months prior to the calendar year in question, in comparison to the prior fiscal year.

~~(s)~~ (t) For counties receiving the minimum allocation of $3,000 or $5,000 described in paragraph ~~(g)~~ (h), the adjustment in paragraph ~~(r)~~ (s) shall be determined so that the county receives the higher of the following amounts:

(1) a continuation of the minimum allocation in paragraph ~~(g)~~ (h); or

(2) an amount based on that county's average number of clients per month who received case management under this section during the fiscal year that ended six months prior to the calendar year in question, ~~in comparison to the prior fiscal year,~~ times the average statewide grant per person per month for counties not receiving the minimum allocation.

~~(t)~~ (u) The adjustments in paragraphs ~~(r) and~~ (s) and (t) shall be calculated separately for children and adults.

Sec. 17. Minnesota Statutes 2000, section 256B.0625, is amended by adding a subdivision to read:

Subd. 43. [APPEAL PROCESS.] If a county contract or certification is required to enroll as an authorized provider of mental health services under medical assistance, and if a county refuses to grant the necessary contract or certification, the provider may appeal the county decision to the commissioner. A recipient may initiate an appeal on behalf of a provider who has been denied certification. The commissioner shall determine whether the provider meets applicable standards under state laws and rules based on an independent review of the facts, including comments from the county review. If the commissioner finds that the provider meets the applicable standards, the commissioner shall enroll the provider as an authorized provider. The commissioner shall develop

procedures for providers and recipients to appeal a county decision to refuse to enroll a provider. After the commissioner makes a decision regarding an appeal, the county, provider, or recipient may request that the commissioner reconsider the commissioner's initial decision. The commissioner's reconsideration decision is final and not subject to further appeal.

Sec. 18. Minnesota Statutes 2000, section 256B.0625, is amended by adding a subdivision to read:

Subd. 44. [MENTAL HEALTH PROVIDER TRAVEL TIME.] Medical assistance covers provider travel time if a recipient's individual treatment plan requires the provision of mental health services outside of the provider's normal place of business. This does not include any travel time which is included in other billable services, and is only covered when the mental health service being provided to a recipient is covered under medical assistance.

Sec. 19. [256B.761] [REIMBURSEMENT FOR MENTAL HEALTH SERVICES.]

Payment for medication management provided to psychiatric patients, outpatient mental health services, day treatment services, home-based mental health services, and family community support services shall be paid at:

(1) for services rendered on or after July 1, 2001, and before July 1, 2002, the lower of (i) submitted charges, or (ii) the 73rd percentile of the 50th percentile of 1999 charges; and

(2) for services rendered on or after July 1, 2002, the lower of (i) submitted charges, or (ii) the 75th percentile of the 50th percentile of 1999 charges.

Sec. 20. [299A.76] [SUICIDE STATISTICS.]

(a) The commissioner of public safety shall not:

(1) include any statistics on committing suicide or attempting suicide in any compilation of crime statistics published by the commissioner; or

(2) label as a crime statistic, any data on committing suicide or attempting suicide.

(b) This section does not apply to the crimes of aiding suicide under section 609.215, subdivision 1, or aiding attempted suicide under section 609.215, subdivision 2, or to statistics directly related to the commission of a crime.

Sec. 21. [NOTICE REGARDING ESTABLISHMENT OF CONTINUING CARE BENEFIT PROGRAM.]

When the continuing care benefit program for persons with mental illness under Minnesota Statutes, section 256.9693 is established, the commissioner of human services shall notify counties, health plan companies with prepaid medical assistance contracts, health care providers, and enrollees of the benefit program through bulletins, workshops, and other meetings.

**[EFFECTIVE DATE.]** This section is effective July 1, 2002.

Sec. 22. [STUDY; LENGTH OF STAY FOR MEDICARE-ELIGIBLE PERSONS.]

The commissioner of human services shall study and make recommendations on how Medicare-eligible persons with mental illness may obtain acute care hospital inpatient treatment for mental illness for a length of stay beyond that allowed by the diagnostic classifications for mental illness according to Minnesota Statutes, section 256.969, subdivision 3a. The study and recommendations shall be reported to the legislature by January 15, 2002.

Sec. 23. [DEVELOPMENT OF PAYMENT SYSTEM FOR ADULT RESIDENTIAL SERVICES GRANTS.]

The commissioner of human services shall review funding methods for adult residential services grants under Minnesota Rules, parts 9535.2000 to 9535.3000, and shall develop a

payment system that takes into account client difficulty of care as manifested by client physical, mental, or behavioral conditions. The payment system must provide reimbursement for education, consultation, and support services provided to families and other individuals as an extension of the treatment process. The commissioner shall present recommendations and draft legislation for an adult residential services payment system to the legislature by January 15, 2002. The recommendations must address whether additional funding for adult residential services grants is necessary for the provision of high quality services under a payment reimbursement system.

ARTICLE 10

ASSISTANCE PROGRAMS

Section 1. Minnesota Statutes 2000, section 256.01, subdivision 18, is amended to read:

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

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

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

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

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

~~The commissioner shall report to the Immigration and Naturalization Service all undocumented persons who have been identified through application verification procedures or by the self-admission of an applicant for assistance. Reports made under this subdivision must comply with the requirements of section 411A of the Social Security Act, as amended, and United States Code, title 8, section 1644.~~

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

Sec. 2. Minnesota Statutes 2000, section 256D.053, subdivision 1, is amended to read:

Subdivision 1. [PROGRAM ESTABLISHED.] The Minnesota food assistance program is established to provide food assistance to legal noncitizens residing in this state who are ineligible to participate in the federal Food Stamp Program solely due to the provisions of section 402 or 403 of Public Law Number 104-193, as authorized by Title VII of the 1997 Emergency Supplemental Appropriations Act, Public Law Number 105-18, and as amended by Public Law Number 105-185.

Beginning July 1, ~~2002~~ 2003, the Minnesota food assistance program is limited to those noncitizens described in this subdivision who are 50 years of age or older.

Sec. 3. [256J.021] [SEPARATE STATE PROGRAM FOR USE OF STATE MONEY.]

Beginning October 1, 2001, and each year thereafter, the commissioner of human services must treat financial assistance expenditures made to or on behalf of any minor child under section 256J.02, subdivision 2, clause (1), who is a resident of this state under section 256J.12, and who is part of a two-parent eligible household as expenditures under a separately funded state program and report those expenditures to the federal Department of Health and Human Services as separate state program expenditures under Code of Federal Regulations, title 45, section 263.5.

Sec. 4. Minnesota Statutes 2000, section 256J.09, subdivision 1, is amended to read:

Subdivision 1. [WHERE TO APPLY.] To apply for assistance a person must ~~apply for assistance at~~ submit a signed application to the county agency in the county where that person lives.

Sec. 5. Minnesota Statutes 2000, section 256J.09, subdivision 2, is amended to read:

Subd. 2. [COUNTY AGENCY RESPONSIBILITY TO PROVIDE INFORMATION.] When a person inquires about assistance, a county agency must ~~inform a person who inquires about assistance about~~:

(1) explain the eligibility requirements ~~for assistance~~ of, and how to apply for, diversionary assistance~~, including diversionary assistance and~~ as provided in section 256J.47; emergency assistance~~.~~ as provided in section 256J.48; MFIP as provided in section 256J.10; or any other assistance for which the person may be eligible; and

~~A county agency must~~ (2) offer the person brochures developed or approved by the commissioner that describe how to apply for assistance.

Sec. 6. Minnesota Statutes 2000, section 256J.09, subdivision 3, is amended to read:

Subd. 3. [SUBMITTING THE APPLICATION FORM.] (a) A county agency must offer, in person or by mail, the application forms prescribed by the commissioner as soon as a person makes a written or oral inquiry. At that time, the county agency must:

(1) inform the person that assistance begins with the date the signed application is received by the county agency or the date all eligibility criteria are met, whichever is later~~. The county agency must~~;

(2) inform the ~~applicant~~ person that any delay in submitting the application will reduce the amount of assistance paid for the month of application~~. A county agency must~~;

(3) inform a person that the person may submit the application before an interview ~~appointment. To apply for assistance, a person must submit a signed application to the county agency.~~;

(4) explain the information that will be verified during the application process by the county agency as provided in section 256J.32;

(5) inform a person about the county agency's average application processing time and explain how the application will be processed under subdivision 5;

(6) explain how to contact the county agency if a person's application information changes and how to withdraw the application;

(7) inform a person that the next step in the application process is an interview and what a person must do if the application is approved including, but not limited to, attending orientation under section 256J.45 and complying with employment and training services requirements in sections 256J.52 to 256J.55;

(8) explain the child care and transportation services that are available under paragraph (c) to enable caregivers to attend the interview, screening, and orientation; and

(9) identify any language barriers and arrange for translation assistance during appointments, including, but not limited to, screening under subdivision 3a, orientation under section 256J.45, and the initial assessment under section 256J.52.

(b) Upon receipt of a signed application, the county agency must stamp the date of receipt on the face of the application. The county agency must process the application within the time period required under subdivision 5. An applicant may withdraw the application at any time by giving written or oral notice to the county agency. The county agency must issue a written notice

confirming the withdrawal. The notice must inform the applicant of the county agency's understanding that the applicant has withdrawn the application and no longer wants to pursue it. When, within ten days of the date of the agency's notice, an applicant informs a county agency, in writing, that the applicant does not wish to withdraw the application, the county agency must reinstate the application and finish processing the application.

(c) Upon a participant's request, the county agency must arrange for transportation and child care or reimburse the participant for transportation and child care expenses necessary to enable participants to attend the screening under subdivision 3a and orientation under section 256J.45.

Sec. 7. Minnesota Statutes 2000, section 256J.09, is amended by adding a subdivision to read:

Subd. 3a. [SCREENING.] The county agency, or at county option, the county's employment and training service provider as defined in section 256J.49, must screen each applicant to determine immediate needs and to determine if the applicant may be eligible for:

(1) another program that is not partially funded through the federal temporary assistance to needy families block grant under Title I of Public Law Number 104-193, including the expedited issuance of food stamps under section 256J.28, subdivision 1. If the applicant may be eligible for another program, a county caseworker must provide the appropriate referral to the program;

(2) the diversionary assistance program under section 256J.47; or

(3) the emergency assistance program under section 256J.48.

Sec. 8. Minnesota Statutes 2000, section 256J.09, is amended by adding a subdivision to read:

Subd. 3b. [INTERVIEW TO DETERMINE REFERRALS AND SERVICES.] If the applicant is not diverted from applying for MFIP, and if the applicant meets the MFIP eligibility requirements, then a county agency must:

(1) identify an applicant who is under the age of 20 and explain to the applicant the assessment procedures and employment plan requirements for minor parents under section 256J.54;

(2) explain to the applicant the eligibility criteria for an exemption under the family violence provisions in section 256J.52, subdivision 6, and explain what an applicant should do to develop an alternative employment plan;

(3) determine if an applicant qualifies for an exemption under section 256J.56 from employment and training services requirements, explain how a person should report to the county agency any status changes, and explain that an applicant who is exempt may volunteer to participate in employment and training services;

(4) for applicants who are not exempt from the requirement to attend orientation, arrange for an orientation under section 256J.45 and an initial assessment under section 256J.52;

(5) inform an applicant who is not exempt from the requirement to attend orientation that failure to attend the orientation is considered an occurrence of noncompliance with program requirements and will result in an imposition of a sanction under section 256J.46; and

(6) explain how to contact the county agency if an applicant has questions about compliance with program requirements.

Sec. 9. Minnesota Statutes 2000, section 256J.15, is amended by adding a subdivision to read:

Subd. 3. [ELIGIBILITY AFTER DISQUALIFICATION DUE TO NONCOMPLIANCE.] (a) An applicant who is a member of an assistance unit that was disqualified from receiving MFIP under section 256J.46, subdivision 1, paragraph (d), clause (3), and who applies for MFIP assistance within six months of the date of the disqualification is considered to be a new applicant for purposes of the property limitations under section 256J.20 and, at county option, the payment of assistance provisions under section 256J.24, subdivision 8. The county agency must also use the initial income test under section 256J.21, subdivision 3, in determining the applicant's eligibility for assistance.

(b) Notwithstanding section 256J.24, subdivisions 5 to 7 and 9, for an applicant who is eligible for MFIP under this subdivision, the residual amount of the grant, after making any applicable vendor payments for shelter and utility costs, if any, must be reduced by ten percent of the applicable MFIP standard of need for an assistance unit of the same size for each of the first six months on MFIP before the residual amount of the grant is paid to the assistance unit.

(c) A participant who is disqualified from MFIP a second or subsequent time and who is eligible for MFIP under this subdivision is considered to have a third occurrence of noncompliance and must be sanctioned under section 256J.46, subdivision 1, paragraph (d), clause (2), for the first six months on MFIP under this subdivision.

Sec. 10. Minnesota Statutes 2000, section 256J.24, subdivision 10, is amended to read:

Subd. 10. [MFIP EXIT LEVEL.] ~~(a) In state fiscal years 2000 and 2001,~~ The commissioner shall adjust the MFIP earned income disregard to ensure that most participants do not lose eligibility for MFIP until their income reaches at least 120 percent of the federal poverty guidelines in effect in October of each fiscal year. The adjustment to the disregard shall be based on a household size of three, and the resulting earned income disregard percentage must be applied to all household sizes. The adjustment under this subdivision must be implemented at the same time as the October food stamp cost-of-living adjustment is reflected in the food portion of MFIP transitional standard as required under subdivision 5a.

~~(b) In state fiscal year 2002 and thereafter, the earned income disregard percentage must be the same as the percentage implemented in October 2000.~~

Sec. 11. Minnesota Statutes 2000, section 256J.26, subdivision 1, is amended to read:

Subdivision 1. [PERSON CONVICTED OF DRUG OFFENSES.] (a) Applicants or participants who have been convicted of a drug offense committed after July 1, 1997, may, if otherwise eligible, receive MFIP benefits subject to the following conditions:

(1) Benefits for the entire assistance unit must be paid in vendor form for shelter and utilities during any time the applicant is part of the assistance unit.

(2) The convicted applicant or participant shall be subject to random drug testing as a condition of continued eligibility and following any positive test for an illegal controlled substance is subject to the following sanctions:

(i) for failing a drug test the first time, the ~~participant's grant shall be reduced by ten percent of the MFIP standard of need, prior to making vendor payments for shelter and utility costs; or~~

~~(ii) for failing a drug test two or more times, the~~ residual amount of the participant's grant after making vendor payments for shelter and utility costs, if any, must be reduced by an amount equal to 30 percent of the MFIP standard of need for an assistance unit of the same size. When a sanction under this subdivision is in effect, the job counselor must attempt to meet with the person face-to-face. During the face-to-face meeting, the job counselor must explain the consequences of a subsequent drug test failure and inform the participant of the right to appeal the sanction under section 256J.40. If a face-to-face meeting is not possible, the county agency must send the participant a notice of adverse action as provided in section 256J.31, subdivisions 4 and 5, and must include the information required in the face-to-face meeting; or

(ii) for failing a drug test two times, the participant is permanently disqualified from receiving MFIP assistance, both the cash and food portions. The assistance unit's MFIP grant must be reduced by the amount which would have otherwise been made available to the disqualified participant. Disqualification under this item does not make a participant ineligible for food stamps. Before a disqualification under this provision is imposed, the job counselor must attempt to meet with the participant face-to-face. During the face-to-face meeting, the job counselor must identify other resources that may be available to the participant to meet the needs of the family and inform the participant of the right to appeal the disqualification under section 256J.40. If a face-to-face meeting is not possible, the county agency must send the participant a notice of adverse action as provided in section 256J.31, subdivisions 4 and 5, and must include the information required in the face-to-face meeting.

(3) A participant who fails ~~an initial~~ a drug test the first time and is under a sanction due to other MFIP program requirements is considered to have more than one occurrence of noncompliance and is subject to the applicable level of sanction ~~in clause (2)(ii)~~ as specified under section 256J.46, subdivision 1, paragraph (d).

(b) Applicants requesting only food stamps or participants receiving only food stamps, who have been convicted of a drug offense that occurred after July 1, 1997, may, if otherwise eligible, receive food stamps if the convicted applicant or participant is subject to random drug testing as a condition of continued eligibility. Following a positive test for an illegal controlled substance, the applicant is subject to the following sanctions:

(1) for failing a drug test the first time, ~~food stamps shall be reduced by ten percent of the applicable food stamp allotment; and~~

~~(2) for failing a drug test two or more times,~~ food stamps shall be reduced by an amount equal to 30 percent of the applicable food stamp allotment. When a sanction under this clause is in effect, a job counselor must attempt to meet with the person face-to-face. During the face-to-face meeting, a job counselor must explain the consequences of a subsequent drug test failure and inform the participant of the right to appeal the sanction under section 256J.40. If a face-to-face meeting is not possible, a county agency must send the participant a notice of adverse action as provided in section 256J.31, subdivisions 4 and 5, and must include the information required in the face-to-face meeting; and

(2) for failing a drug test two times, the participant is permanently disqualified from receiving food stamps. Before a disqualification under this provision is imposed, a job counselor must attempt to meet with the participant face-to-face. During the face-to-face meeting, the job counselor must identify other resources that may be available to the participant to meet the needs of the family and inform the participant of the right to appeal the disqualification under section 256J.40. If a face-to-face meeting is not possible, a county agency must send the participant a notice of adverse action as provided in section 256J.31, subdivisions 4 and 5, and must include the information required in the face-to-face meeting.

(c) For the purposes of this subdivision, "drug offense" means an offense that occurred after July 1, 1997, of sections 152.021 to 152.025, 152.0261, or 152.096. Drug offense also means a conviction in another jurisdiction of the possession, use, or distribution of a controlled substance, or conspiracy to commit any of these offenses, if the offense occurred after July 1, 1997, and the conviction is a felony offense in that jurisdiction, or in the case of New Jersey, a high misdemeanor.

Sec. 12. Minnesota Statutes 2000, section 256J.31, subdivision 4, is amended to read:

Subd. 4. [PARTICIPANT'S RIGHT TO NOTICE.] A county agency must give a participant written notice of all adverse actions affecting the participant including payment reductions, suspensions, terminations, and use of protective, vendor, or two-party payments. The notice of adverse action must be on a form prescribed or approved by the commissioner, must be understandable at a seventh grade reading level, and must be mailed to the last known mailing address provided by the participant. A notice written in English must include the department of human services language block and must be sent to every applicable participant. The county agency must state on the notice of adverse action the action it intends to take, the reasons for the action, the participant's right to appeal the action, the conditions under which assistance can be continued pending an appeal decision, and the related consequences of the action.

Sec. 13. Minnesota Statutes 2000, section 256J.32, subdivision 7a, is amended to read:

Subd. 7a. [REQUIREMENT TO REPORT TO IMMIGRATION AND NATURALIZATION SERVICES.] ~~Notwithstanding subdivision 7, effective July 1, 2001, the commissioner shall report to the Immigration and Naturalization Services all undocumented persons who have been identified through application verification procedures or by the self-admission of an applicant for assistance. Reports made under this subdivision must comply with the requirements of section 411A of the Social Security Act, as amended, and United States Code, title 8, section 1644.~~ The

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

Sec. 14. Minnesota Statutes 2000, section 256J.42, is amended by adding a subdivision to read:

Subd. 6. [CASE REVIEW.] (a) Within 180 days before the end of the participant's 60th month on MFIP, the county agency or job counselor must review the participant's case to determine if the employment plan is still appropriate, or if the participant is exempt under section 256J.56 from the employment and training services component, and attempt to meet with the participant face-to-face.

(b) During the face-to-face meeting, a county agency or the job counselor must:

(1) inform the participant how many months of counted assistance the participant has accrued and when the participant is expected to reach the 60th month;

(2) explain the hardship extension criteria under section 256J.425 and what the participant should do if the participant thinks a hardship extension applies;

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

(4) inform the participant of the right to appeal the case closure under section 256J.40.

(c) If a face-to-face meeting is not possible, the county agency must send the participant a notice of adverse action as provided in section 256J.31, subdivisions 4 and 5.

(d) Before a participant's case is closed under this section, the county must ensure that:

(1) the case has been reviewed by the job counselor's supervisor or the review team designated in the county's approved local service unit plan to determine if the criteria for a hardship extension, if requested, were applied appropriately; and

(2) the county agency or the job counselor attempted to meet with the participant face-to-face.

Sec. 15. [256J.425] [HARDSHIP EXTENSIONS.]

Subdivision 1. [ELIGIBILITY.] An assistance unit subject to the time limit under section 256J.42, subdivision 1, in which any participant has received 60 counted months of assistance is not eligible to receive months of assistance beyond the first 60 months under a hardship extension, if the participant is not in compliance. If there is more than one participant in the household, each participant must be in compliance to be eligible for a hardship extension. For purposes of determining eligibility for a hardship extension, a participant is in compliance in any month that the participant has not been sanctioned under section 256J.46, subdivision 1, or under 256J.26, subdivision 1.

Subd. 2. [ILL OR INCAPACITATED PARTICIPANTS; DEPENDENT HOUSEHOLD MEMBER.] (a) An assistance unit subject to the time limit in section 256J.42, subdivision 1, in which any participant has received 60 counted months of assistance, is eligible to receive months of assistance under a hardship extension if the participant belongs to any of the following groups:

(1) participants who are suffering from a professionally certified illness, injury, or incapacity which is expected to continue for more than 30 days and which prevents the person from obtaining or retaining employment and who are following the treatment recommendations of the health care provider certifying the illness, injury, or incapacity;

(2) participants whose presence in the home is required because of the professionally certified illness or incapacity of another member in the assistance unit, a relative in the household, or a foster child in the household and the illness or incapacity is expected to continue for more than 30 days; or

(3) caregivers with a child or an adult in the household who meets the disability or medical

criteria for home care services under section 256B.0627, subdivision 1, paragraph (c), or a home and community-based waiver services program under chapter 256B, or meets the criteria for severe emotional disturbance under section 245.4871, subdivision 6, or for serious and persistent mental illness under section 245.462, subdivision 20, paragraph (c). Caregivers in this category are presumed to be prevented from obtaining or retaining employment.

(b) An assistance unit receiving assistance under a hardship extension under this subdivision may continue to receive assistance under MFIP as long as the participant meets the criteria in paragraph (a), clause (1), (2), or (3). A county agency or job counselor must, on a quarterly basis, review the case file of an assistance unit receiving assistance under this subdivision to determine if the participant still meets the criteria in paragraph (a), clause (1), (2), or (3).

Subd. 3. [CERTAIN HARD-TO-EMPLOY PARTICIPANTS.] (a) An assistance unit subject to the time limit in section 256J.42, subdivision 1, in which any participant has received 60 counted months of assistance, is eligible to receive months of assistance under a hardship extension if the participant belongs to any of the following groups:

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

(2) a person who has been assessed by a vocational specialist, job counselor, or the county agency to be unemployable for purposes of this subdivision; a person is considered employable if positions of employment in the local labor market exist, regardless of the current availability of openings for those positions, that the person is capable of performing. The person's eligibility under this category must be reassessed at least annually; or

(3) a person who is determined by the county agency, according to Minnesota Rules, part 9500.1251, subpart 2, item I, to be learning disabled, provided that if a rehabilitation plan for the person is developed or approved by the county agency, the person is following the plan. A rehabilitation plan does not replace the requirement to develop and comply with an employment plan under section 256J.52.

(b) An assistance unit receiving assistance under a hardship extension under this subdivision may continue to receive assistance under MFIP as long as the participant meets the criteria in paragraph (a), clause (1), (2), or (3), and all participants in the assistance unit remain in compliance with, or are exempt from, the employment and training services requirements in sections 256J.52 to 256J.55.

Subd. 4. [VICTIMS OF FAMILY VIOLENCE.] A participant who received TANF assistance that counted towards the federal 60-month time limit while the participant complied with a safety plan or, after October 1, 2001, an alternative employment plan under the MFIP employment and training component is eligible for assistance under a hardship extension for a period of time equal to the number of months that were counted toward the federal 60-month time limit while the participant complied with a safety plan or, after October 1, 2001, an alternative employment plan under the MFIP employment and training component.

Subd. 5. [ACCRUAL OF CERTAIN EXEMPT MONTHS.] (a) A participant who received TANF assistance that counted towards the federal 60-month time limit while the participant was or would have been exempt under section 256J.56, paragraph (a), clause (7), from employment and training services requirements and who is no longer eligible for assistance under a hardship extension under subdivision 2, paragraph (a), clause (3), is eligible for assistance under a hardship extension for a period of time equal to the number of months that were counted toward the federal 60-month time limit while the participant was or would have been exempt under section 256J.56, paragraph (a), clause (7), from the employment and training services requirements.

(b) A participant who received TANF assistance that counted towards the federal 60-month time limit while the participant met the state time limit exemption criteria under section 256J.42, subdivision 5, is eligible for assistance under a hardship extension for a period of time equal to the number of months that were counted toward the federal 60-month time limit while the participant met the state time limit exemption criteria under section 256J.42, subdivision 5.

Sec. 16. Minnesota Statutes 2000, section 256J.45, subdivision 1, is amended to read:

Subdivision 1. [COUNTY AGENCY TO PROVIDE ORIENTATION.] A county agency must provide a face-to-face orientation to each MFIP caregiver ~~who is not exempt under section 256J.56, paragraph (a), clause (6) or (8), with a face-to-face orientation~~ unless the caregiver is:

(1) a single parent, or one parent in a two-parent family, employed at least 35 hours per week; or

(2) a second parent in a two-parent family who is employed for 20 or more hours per week provided the first parent is employed at least 35 hours per week.

The county agency must inform caregivers who are not exempt under ~~section 256J.56, paragraph (a), clause (6) or (8),~~ clause (1) or (2) that failure to attend the orientation is considered an occurrence of noncompliance with program requirements, and will result in the imposition of a sanction under section 256J.46. If the client complies with the orientation requirement prior to the first day of the month in which the grant reduction is proposed to occur, the orientation sanction shall be lifted.

Sec. 17. Minnesota Statutes 2000, section 256J.46, subdivision 1, is amended to read:

Subdivision 1. [~~SANCTIONS FOR~~ PARTICIPANTS NOT COMPLYING WITH PROGRAM REQUIREMENTS.] (a) A participant who fails without good cause to comply with the requirements of this chapter, and who is not subject to a sanction under subdivision 2, shall be subject to a sanction as provided in this subdivision. Prior to the imposition of a sanction, a county agency shall provide a notice of intent to sanction under section 256J.57, subdivision 2, and, when applicable, a notice of adverse action as provided in section 256J.31.

(b) A participant who fails to comply with an alternative employment plan must have the plan reviewed by a person trained in domestic violence and a job counselor to determine if components of the alternative employment plan are still appropriate. If the activities are no longer appropriate, the plan must be revised with a person trained in domestic violence and approved by a job counselor. A participant who fails to comply with a plan that is determined not to need revision will lose their exemption and be required to comply with regular employment services activities.

(c) A sanction under this subdivision becomes effective the month following the month in which a required notice is given. A sanction must not be imposed when a participant comes into compliance with the requirements for orientation under section 256J.45 or third-party liability for medical services under section 256J.30, subdivision 10, prior to the effective date of the sanction. A sanction must not be imposed when a participant comes into compliance with the requirements for employment and training services under sections 256J.49 to ~~256J.72~~ 256J.55 ten days prior to the effective date of the sanction. For purposes of this subdivision, each month that a participant fails to comply with a requirement of this chapter shall be considered a separate occurrence of noncompliance. A participant who has had one or more sanctions imposed must remain in compliance with the provisions of this chapter for six months in order for a subsequent occurrence of noncompliance to be considered a first occurrence.

~~(b)~~ (d) Sanctions for noncompliance shall be imposed as follows:

(1) For the first occurrence of noncompliance by a participant in ~~a single-parent household or by one participant in a two-parent household~~ an assistance unit, the assistance unit's grant shall be reduced by ten percent of the MFIP standard of need for an assistance unit of the same size with the residual grant paid to the participant. The reduction in the grant amount must be in effect for a minimum of one month and shall be removed in the month following the month that the participant returns to compliance.

(2) For a second ~~or subsequent~~ and third occurrence of noncompliance by a participant in an assistance unit, or when ~~both~~ each of the participants in a two-parent ~~household are out of compliance~~ assistance unit have a first occurrence of noncompliance at the same time, the assistance unit's shelter costs shall be vendor paid up to the amount of the cash portion of the

MFIP grant for which the ~~participant's~~ assistance unit is eligible. At county option, the assistance unit's utilities may also be vendor paid up to the amount of the cash portion of the MFIP grant remaining after vendor payment of the assistance unit's shelter costs. The residual amount of the grant after vendor payment, if any, must be reduced by an amount equal to 30 percent of the MFIP standard of need for an assistance unit of the same size before the residual grant is paid to the assistance unit. The reduction in the grant amount must be in effect for a minimum of one month and shall be removed in the month following the month that ~~a~~ the participant in a one-parent ~~household~~ assistance unit returns to compliance. In a two-parent ~~household~~ assistance unit, the grant reduction must be in effect for a minimum of one month and shall be removed in the month following the month both participants return to compliance. The vendor payment of shelter costs and, if applicable, utilities shall be removed six months after the month in which the participant or participants return to compliance. If an assistance unit is sanctioned under this clause, the participant's case file must be reviewed as required under paragraph (e).

(3) For a fourth occurrence of noncompliance, the assistance unit is disqualified from receiving MFIP assistance, both the cash and food portions. This disqualification must be in effect for a minimum of one full month. Disqualification under this clause does not make a participant ineligible for food stamps. Before an assistance unit is disqualified under this clause, the county must ensure that:

(i) the case has been reviewed by the job counselor's supervisor or the review team designated in the county's approved local service unit plan to determine if the review required under paragraph (e) has occurred; and

(ii) the job counselor attempted to meet with the participant face-to-face.

~~(c) No later than during the second month that~~ (e) When a sanction under paragraph ~~(b)~~ (d), clause (2), is in effect ~~due to noncompliance with employment services, the participant's case file must be reviewed to determine if~~, the county agency or job counselor must review the participant's case to determine if the employment plan is still appropriate and attempt to meet with the participant face-to-face. If a face-to-face meeting is not possible, the county agency must send the participant a notice of adverse action as provided in section 256J.31, subdivisions 4 and 5.

(1) During the face-to-face meeting, the job counselor must:

(i) determine whether the continued noncompliance can be explained and mitigated by providing a needed preemployment activity, as defined in section 256J.49, subdivision 13, clause (16), or services under a local intervention grant for self-sufficiency under section 256J.625;

(ii) determine whether the participant qualifies for a good cause exception under section 256J.57; ~~or~~

(iii) determine whether the participant qualifies for an exemption under section 256J.56;

(iv) determine whether the participant qualifies for an exemption for victims of family violence under section 256J.52, subdivision 6;

(v) inform the participant of the participant's sanction status and explain the consequences of continuing noncompliance;

(vi) identify other resources that may be available to the participant to meet the needs of the family if the participant is sanctioned and disqualified from MFIP under paragraph (d), clause (3); and

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

(2) If the lack of an identified activity can explain the noncompliance, the county must work with the participant to provide the identified activity, and the county must restore the participant's grant amount to the full amount for which the assistance unit is eligible. The grant must be restored retroactively to the first day of the month in which the participant was found to lack preemployment activities or to qualify for an exemption ~~or~~ under section 256J.56, a good cause

exception under section 256J.57, or an exemption for victims of family violence under section 256J.52, subdivision 6.

(3) If the participant is found to qualify for a good cause exception or an exemption, the county must restore the participant's grant to the full amount for which the assistance unit is eligible.

**[EFFECTIVE DATE.]** The family violence provisions in paragraph (e) are effective October 1, 2001, if the alternative employment plan and family violence provisions in section 256J.52, subdivision 6, are enacted during the 2001 session.

Sec. 18. Minnesota Statutes 2000, section 256J.46, subdivision 2a, is amended to read:

Subd. 2a. [DUAL SANCTIONS.] (a) Notwithstanding the provisions of subdivisions 1 and 2, for a participant subject to a sanction for refusal to comply with child support requirements under subdivision 2 and subject to a concurrent sanction for refusal to cooperate with other program requirements under subdivision 1, sanctions shall be imposed in the manner prescribed in this subdivision.

A participant who has had one or more sanctions imposed under this subdivision must remain in compliance with the provisions of this chapter for six months in order for a subsequent occurrence of noncompliance to be considered a first occurrence. Any vendor payment of shelter costs or utilities under this subdivision must remain in effect for six months after the month in which the participant is no longer subject to sanction under subdivision 1.

(b) If the participant was subject to sanction ~~for:~~

~~(i) noncompliance under subdivision 1 before being subject to sanction for noncooperation under subdivision 2; or~~

~~(ii) noncooperation under subdivision 2 before being subject to sanction for noncompliance under subdivision 1;~~ under subdivision 1 or 2 before being subject to sanction under the other of those subdivisions, the participant shall be sanctioned as provided in subdivision 1, paragraph ~~(b)~~ (d), ~~clause~~ clauses (2) and (3), and the requirement that the county conduct a review as specified in subdivision 1, paragraph ~~(c)~~ (e), remains in effect.

(c) A participant who first becomes subject to sanction under both subdivisions 1 and 2 in the same month is subject to sanction as follows:

(i) in the first month of noncompliance and noncooperation, the participant's grant must be reduced by 25 percent of the applicable MFIP standard of need, with any residual amount paid to the participant;

(ii) in the second and subsequent months of noncompliance and noncooperation, the participant shall be sanctioned as provided in subdivision 1, paragraph ~~(b)~~ (d), ~~clause~~ clauses (2) and (3).

The requirement that the county conduct a review as specified in subdivision 1, paragraph ~~(c)~~ (e), remains in effect.

(d) A participant remains subject to sanction under subdivision 2 if the participant:

(i) returns to compliance and is no longer subject to sanction under subdivision 1; or

(ii) has the sanction under subdivision 1, paragraph ~~(b)~~ (d), removed upon completion of the review under subdivision 1, paragraph ~~(c)~~ (e).

A participant remains subject to sanction under subdivision 1, paragraph ~~(b)~~ (d), if the participant cooperates and is no longer subject to sanction under subdivision 2.

Sec. 19. Minnesota Statutes 2000, section 256J.46, is amended by adding a subdivision to read:

Subd. 3. [SANCTION STATUS AFTER DISQUALIFICATION.] An applicant who is a member of an assistance unit that was disqualified from receiving MFIP under subdivision 1,

paragraph (d), clause (3), who applies for MFIP assistance within six months of the date of the disqualification, and who is determined to be eligible for MFIP assistance, is considered to have a first occurrence of noncompliance. An applicant who is a member of an assistance unit that was disqualified from MFIP under subdivision 1, paragraph (d), clause (3), a second or subsequent time, who applies for assistance within six months of the date of disqualification, and who is determined to be eligible for MFIP assistance, is considered to have a third occurrence of noncompliance. The applicant must remain in compliance with the provisions of this chapter for six months in order for a subsequent occurrence of noncompliance to be considered a first occurrence.

Sec. 20. Minnesota Statutes 2000, section 256J.50, subdivision 1, is amended to read:

Subdivision 1. [EMPLOYMENT AND TRAINING SERVICES COMPONENT OF MFIP.] (a) By January 1, 1998, each county must develop and implement an employment and training services component of MFIP which is designed to put participants on the most direct path to unsubsidized employment. Participation in these services is mandatory for all MFIP caregivers, unless the caregiver is exempt under section 256J.56.

(b) A county must provide employment and training services under sections 256J.515 to 256J.74 within 30 days after the caregiver's participation becomes mandatory under subdivision 5 or within 30 days of receipt of a request for services from a caregiver who under section 256J.42 is no longer eligible to receive MFIP but whose income is below 120 percent of the federal poverty guidelines for a family of the same size. The request must be made within 12 months of the date the caregivers' MFIP case was closed.

Sec. 21. Minnesota Statutes 2000, section 256J.50, subdivision 7, is amended to read:

Subd. 7. [LOCAL SERVICE UNIT PLAN.] (a) Each local or county service unit shall prepare and submit a plan as specified in section 268.88.

(b) The plan must include a description of how projects funded under the local intervention grants for self-sufficiency in section 256J.625, subdivisions 2 and 3, operate in the local service unit, including:

(1) the target populations of hard-to-employ participants ~~and~~, working participants in need of job retention and wage advancement services, and caregivers who, within the last 12 months, have been determined under section 256J.42 to no longer be eligible to receive MFIP and whose income is below 120 percent of the federal poverty guidelines for a family of the same size, with a description of how individual participant needs will be met;

(2) services that will be provided which may include paid work experience, enhanced mental health services, outreach to sanctioned families and to caregivers who, within the last 12 months, have been determined under section 256J.42 to no longer be eligible to receive MFIP but whose income is below 120 percent of the federal poverty guidelines for a family of the same size, child care for social services, child care transition year set-aside, homeless and housing advocacy, and transportation;

(3) projected expenditures by activity;

(4) anticipated program outcomes including the anticipated impact the intervention efforts will have on performance measures under section 256J.751 and on reducing the number of MFIP participants expected to reach their 60-month time limit; and

(5) a description of services that are provided or will be provided to MFIP participants affected by chemical dependency, mental health issues, learning disabilities, or family violence.

Each plan must demonstrate how the county or tribe is working within its organization and with other organizations in the community to serve hard-to-employ populations, including how organizations in the community were engaged in planning for use of these funds, services other entities will provide under the plan, and whether multicounty or regional strategies are being implemented as part of this plan.

(c) Activities and expenditures in the plan must enhance or supplement MFIP activities without supplanting existing activities and expenditures. However, this paragraph does not require a county to maintain either:

(1) its current provision of child care assistance to MFIP families through the expenditure of county resources under chapter 256E for social services child care assistance if funds are appropriated by another law for an MFIP social services child care pool;

(2) its current provision of transition-year child care assistance through the expenditure of county resources if funds are appropriated by another law for this purpose; or

(3) its current provision of intensive ESL programs through the expenditure of county resources if funds are appropriated by another law for intensive ESL grants.

(d) The plan required under this subdivision must be approved before the local or county service unit is eligible to receive funds under section 256J.625, subdivisions 2 and 3.

Sec. 22. Minnesota Statutes 2000, section 256J.56, is amended to read:

256J.56 [EMPLOYMENT AND TRAINING SERVICES COMPONENT; EXEMPTIONS.]

(a) An MFIP ~~caregiver~~ participant is exempt from the requirements of sections 256J.52 to 256J.55 if the ~~caregiver~~ participant belongs to any of the following groups:

(1) ~~individuals~~ participants who are age 60 or older;

(2) ~~individuals~~ participants who are suffering from a professionally certified permanent or temporary illness, injury, or incapacity which is expected to continue for more than 30 days and which prevents the person from obtaining or retaining employment. Persons in this category with a temporary illness, injury, or incapacity must be reevaluated at least quarterly;

(3) ~~caregivers~~ participants whose presence in the home is required because of the professionally certified illness or incapacity of another member in the assistance unit, a relative in the household, or a foster child in the household and the illness or incapacity is expected to continue for more than 30 days;

(4) women who are pregnant, if the pregnancy has resulted in a professionally certified incapacity that prevents the woman from obtaining or retaining employment;

(5) caregivers of a child under the age of one year who personally provide full-time care for the child. This exemption may be used for only 12 months in a lifetime. In two-parent households, only one parent or other relative may qualify for this exemption;

~~(6) individuals who are single parents, or one parent in a two-parent family, employed at least 35 hours per week;~~

~~(7) individuals~~ (6) participants experiencing a personal or family crisis that makes them incapable of participating in the program, as determined by the county agency. If the participant does not agree with the county agency's determination, the participant may seek professional certification, as defined in section 256J.08, that the participant is incapable of participating in the program.

Persons in this exemption category must be reevaluated every 60 days; or

~~(8) second parents in two-parent families employed for 20 or more hours per week, provided the first parent is employed at least 35 hours per week; or~~

~~(9)~~ (7) caregivers with a child or an adult in the household who meets the disability or medical criteria for home care services under section 256B.0627, subdivision 1, paragraph (c), or a home and community-based waiver services program under chapter 256B, or meets the criteria for severe emotional disturbance under section 245.4871, subdivision 6, or for serious and persistent mental illness under section 245.462, subdivision 20, paragraph (c). Caregivers in this exemption category are presumed to be prevented from obtaining or retaining employment.

A caregiver who is exempt under clause (5) must enroll in and attend an early childhood and family education class, a parenting class, or some similar activity, if available, during the period of time the caregiver is exempt under this section. Notwithstanding section 256J.46, failure to attend the required activity shall not result in the imposition of a sanction.

(b) The county agency must provide employment and training services to MFIP ~~caregivers~~ participants who are exempt under this section, but who volunteer to participate. Exempt volunteers may request approval for any work activity under section 256J.49, subdivision 13. The hourly participation requirements for nonexempt ~~caregivers~~ participants under section 256J.50, subdivision 5, do not apply to exempt ~~caregivers~~ participants who volunteer to participate.

Sec. 23. Minnesota Statutes 2000, section 256J.57, subdivision 2, is amended to read:

Subd. 2. [NOTICE OF INTENT TO SANCTION.] (a) When a participant fails without good cause to comply with the requirements of sections 256J.52 to 256J.55, the job counselor or the county agency must provide a notice of intent to sanction to the participant specifying the program requirements that were not complied with, informing the participant that the county agency will impose the sanctions specified in section 256J.46, and informing the participant of the opportunity to request a conciliation conference as specified in paragraph (b). The notice must also state that the participant's continuing noncompliance with the specified requirements will result in additional sanctions under section 256J.46, without the need for additional notices or conciliation conferences under this subdivision. The notice, written in English, must include the department of human services language block, and must be sent to every applicable participant. If the participant does not request a conciliation conference within ten calendar days of the mailing of the notice of intent to sanction, the job counselor must notify the county agency that the assistance payment should be reduced. The county must then send a notice of adverse action to the participant informing the participant of the sanction that will be imposed, the reasons for the sanction, the effective date of the sanction, and the participant's right to have a fair hearing under section 256J.40.

(b) The participant may request a conciliation conference by sending a written request, by making a telephone request, or by making an in-person request. The request must be received within ten calendar days of the date the county agency mailed the ten-day notice of intent to sanction. If a timely request for a conciliation is received, the county agency's service provider must conduct the conference within five days of the request. The job counselor's supervisor, or a designee of the supervisor, must review the outcome of the conciliation conference. If the conciliation conference resolves the noncompliance, the job counselor must promptly inform the county agency and request withdrawal of the sanction notice.

(c) Upon receiving a sanction notice, the participant may request a fair hearing under section 256J.40, without exercising the option of a conciliation conference. In such cases, the county agency shall not require the participant to engage in a conciliation conference prior to the fair hearing.

(d) If the participant requests a fair hearing or a conciliation conference, sanctions will not be imposed until there is a determination of noncompliance. Sanctions must be imposed as provided in section 256J.46.

Sec. 24. Minnesota Statutes 2000, section 256J.62, subdivision 9, is amended to read:

Subd. 9. [CONTINUATION OF CERTAIN SERVICES.] At the request of the ~~caregiver~~ participant, the county may continue to provide case management, counseling, or other support services to a participant ~~following the participant's achievement of~~:

(a) who has achieved the employment goal~~,~~; or

(b) who under section 256J.42 is no longer eligible to receive MFIP.

These services may be provided for up to 12 months following termination of the participant's eligibility for MFIP.

~~A county may expend funds for a specific employment and training service for the duration of that service to a participant if the funds are obligated or expended prior to the participant losing MFIP eligibility.~~

Sec. 25. Minnesota Statutes 2000, section 256J.625, subdivision 1, is amended to read:

Subdivision 1. [ESTABLISHMENT; GUARANTEED MINIMUM ALLOCATION.] (a) The commissioner shall make grants under this subdivision to assist county and tribal TANF programs to more effectively serve hard-to-employ MFIP participants and participants who, within the last 12 months, have been determined under section 256J.42 to no longer be eligible to receive MFIP but whose income is below 120 percent of the federal poverty guidelines for a family of the same size. Funds appropriated for local intervention grants for self-sufficiency must be allocated first in amounts equal to the guaranteed minimum in paragraph (b), and second according to the provisions of subdivision 2. Any remaining funds must be allocated according to the formula in subdivision 3. Counties or tribes must have an approved local service unit plan under section 256J.50, subdivision 7, paragraph (b), in order to receive and expend funds under subdivisions 2 and 3.

(b) Each county or tribal program shall receive a guaranteed minimum annual allocation of $25,000.

Sec. 26. Minnesota Statutes 2000, section 256J.625, subdivision 2, is amended to read:

Subd. 2. [SET-ASIDE FUNDS.] (a) Of the funds appropriated for grants under this section, after the allocation in subdivision 1, paragraph (b), is made, 20 percent of the remaining funds each year shall be retained by the commissioner and awarded to counties or tribes whose approved plans demonstrate additional need based on their identification of hard-to-employ families ~~and~~, working participants in need of job retention and wage advancement services, and participants who within the last 12 months, have been determined under section 256J.42 to no longer be eligible to receive MFIP but whose income is below 120 percent of the federal poverty guidelines for a family of same size, strong anticipated outcomes for families and an effective plan for monitoring performance, or, use of a multicounty, multi-entity or regional approach to serve hard-to-employ families ~~and~~, working participants in need of job retention and wage advancement services, and participants who, within the last 12 months, have been determined under section 256J.42 to no longer be eligible to receive MFIP but whose income is below 120 percent of the federal poverty guidelines for a family of the same size, who are identified as a target population to be served in the plan submitted under section 256J.50, subdivision 7, paragraph (b). In distributing funds under this paragraph, the commissioner must achieve a geographic balance. The commissioner may award funds under this paragraph to other public, private, or nonprofit entities to deliver services in a county or region where the entity or entities submit a plan that demonstrates a strong capability to fulfill the terms of the plan and where the plan shows an innovative or multi-entity approach.

(b) For fiscal year 2001 only, of the funds available under this subdivision the commissioner must allocate funding in the amounts specified in article 1, section 2, subdivision 7, for an intensive intervention transitional employment training project and for nontraditional career assistance and training programs. These allocations must occur before any set-aside funds are allocated under paragraph (a).

Sec. 27. Minnesota Statutes 2000, section 256J.625, subdivision 4, is amended to read:

Subd. 4. [USE OF FUNDS.] (a) A county or tribal program may use funds allocated under this subdivision to provide services to MFIP participants who are hard-to-employ and their families. Services provided must be intended to reduce the number of MFIP participants who are expected to reach the 60-month time limit under section 256J.42. Counties, tribes, and other entities receiving funds under subdivision 2 or 3 must submit semiannual progress reports to the commissioner which detail program outcomes.

(b) Funds allocated under this section may not be used to provide benefits that are defined as "assistance" in Code of Federal Regulations, title 45, section 260.31, to an assistance unit that is

only receiving the food portion of MFIP benefits or under section 256J.42 is no longer eligible to receive MFIP.

(c) A county may use funds allocated under this section for that part of the match for federal access to jobs transportation funds that is TANF-eligible. A county may also use funds allocated under this section to enhance transportation choices for eligible recipients up to 150 percent of the federal poverty guidelines.

Sec. 28. Minnesota Statutes 2000, section 256J.751, is amended to read:

256J.751 [COUNTY PERFORMANCE MANAGEMENT.]

~~(a)~~ Subdivision 1. [QUARTERLY COUNTY CASELOAD REPORT.] The commissioner shall report quarterly to ~~all counties~~ each county on the county's performance on the following measures:

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

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

(2) number of child-only cases;

(3) number of minor caregivers;

(4) number of cases that are exempt from the 60-month time limit by the exemption category under section 256J.42;

(5) number of participants who are exempt from employment and training services requirements by the exemption category under section 256J.56;

(6) number of assistance units receiving assistance under a hardship extension under section 256J.425;

(7) number of participants and number of months spent in each level of sanction under section 256J.46, subdivision 1;

~~(3)~~ (8) number of MFIP cases that have left assistance;

~~(4)~~ (9) federal participation requirements as specified in title 1 of Public Law Number 104-193; ~~and~~

~~(5)~~ (10) median placement wage rate.; and

~~(b)~~ (11) of each county's total MFIP caseload less the number of cases in clauses (1) to (6):

(i) number of one-parent cases;

(ii) number of two-parent cases;

(iii) percent of one-parent cases that are working more than 20 hours per week;

(iv) percent of two-parent cases that are working more than 20 hours per week; and

(v) percent of cases that have received more than 36 months of assistance.

Subd. 2. [QUARTERLY COMPARISON REPORT.] The commissioner shall report quarterly to all counties on each county's performance on the following measures:

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

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

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

(4) federal participation requirements as specified in Title 1 of Public Law Number 104-193;

(5) median placement wage rate; and

(6) caseload by months of TANF assistance.

Subd. 3. [ANNUAL REPORT.] The commissioner must report to all counties and to the legislature on each county's annual performance on the measures required under subdivision 1 by racial and ethnic group and, to the extent consistent with state and federal law, must include each county's performance on:

(1) the number of out-of-wedlock births and births to teen mothers; and

(2) number of cases by racial and ethnic group.

The report must be completed by January 1, 2002, and January 1 of each year thereafter and must comply with sections 3.195 and 3.197.

Subd. 4. [DEVELOPMENT OF PERFORMANCE MEASURES.] By January 1, 2002, the commissioner shall, in consultation with counties, develop measures for county performance in addition to those in ~~paragraph (a)~~ subdivision 1 and 2. In developing these measures, the commissioner must consider:

(1) a measure for MFIP cases that leave assistance due to employment;

(2) job retention after participants leave MFIP; and

(3) participant's earnings at a follow-up point after the participant has left MFIP; and

(4) the appropriateness of services provided to minority groups.

~~(c)~~ Subd. 5. [FAILURE TO MEET FEDERAL PERFORMANCE STANDARDS.] (a) If sanctions occur for failure to meet the performance standards specified in title 1 of Public Law Number 104-193 of the Personal Responsibility and Work Opportunity Act of 1996, the state shall pay 88 percent of the sanction. The remaining 12 percent of the sanction will be paid by the counties. The county portion of the sanction will be distributed across all counties in proportion to each county's percentage of the MFIP average monthly caseload during the period for which the sanction was applied.

~~(d)~~ (b) If a county fails to meet the performance standards specified in title 1 of Public Law Number 104-193 of the Personal Responsibility and Work Opportunity Act of 1996 for any year, the commissioner shall work with counties to organize a joint state-county technical assistance team to work with the county. The commissioner shall coordinate any technical assistance with other departments and agencies including the departments of economic security and children, families, and learning as necessary to achieve the purpose of this paragraph.

Sec. 29. Minnesota Statutes 2000, section 256K.25, subdivision 1, is amended to read:

Subdivision 1. [ESTABLISHMENT AND PURPOSE.] (a) The commissioner shall establish a supportive housing and managed care pilot project ~~in two counties, one within the seven-county metropolitan area and one outside of that area,~~ to determine whether the integrated delivery of employment services, supportive services, housing, and health care into a single, flexible program will:

(1) reduce public expenditures on homeless families with minor children, homeless noncustodial parents, and other homeless individuals;

(2) increase the employment rates of these persons; and

(3) provide a new alternative to providing services to this hard-to-serve population.

(b) The commissioner shall create a program for counties for the purpose of providing

integrated intensive and individualized case management services, employment services, health care services, rent subsidies or other short- or medium-term housing assistance, and other supportive services to eligible families and individuals. Minimum project and application requirements shall be developed by the commissioner in cooperation with counties and their nonprofit partners with the goal to provide the maximum flexibility in program design.

(c) Services available under this project must be coordinated with available health care services for an eligible project participant.

Sec. 30. Minnesota Statutes 2000, section 256K.25, subdivision 3, is amended to read:

Subd. 3. [COUNTY ELIGIBILITY.] (a) A county may request funding under this pilot project if the county:

(1) agrees to develop, in cooperation with nonprofit partners, a supportive housing and managed care pilot project that integrates the delivery of employment services, supportive services, housing and health care for eligible families and individuals, or agrees to contract with an existing integrated program;

(2) for eligible participants who are also MFIP recipients, agrees to develop, in cooperation with nonprofit partners, procedures to ensure that the services provided under the pilot project are closely coordinated with the services provided under MFIP; ~~and~~

(3) develops a method for evaluating the quality of the integrated services provided and the amount of any resulting cost savings to the county and state~~.~~; and

(4) addresses in the pilot design the prevalence in the homeless population served those individuals with mental illness, a history of substance abuse, or HIV.

(b) Preference may be given to counties that cooperate with other counties participating in the pilot project for purposes of evaluation and counties that provide additional funding.

Sec. 31. Minnesota Statutes 2000, section 256K.25, subdivision 4, is amended to read:

Subd. 4. [PARTICIPANT ELIGIBILITY.] (a) In order to ~~be eligible~~ meet initial eligibility criteria for the pilot project, the county must determine that a participant is homeless or is at risk of homelessness~~; has a mental illness, a history of substance abuse, or HIV;~~ and is a family that meets the criteria in paragraph (b) or is an individual who meets the criteria in paragraph (c).

(b) An eligible family must include a minor child or a pregnant woman, and:

(1) be receiving or be eligible for MFIP assistance under chapter 256J; or

(2) include an adult caregiver who is employed or is receiving employment and training services, and have household income below the MFIP exit level in section 256J.24, subdivision 10.

(c) An eligible individual must:

(1) meet the eligibility requirements of the group residential housing program under section 256I.04, subdivision 1; or

(2) be a noncustodial parent who is employed or is receiving employment and training services, and have household income below the MFIP exit level in section 256J.24, subdivision 10.

(d) Counties participating in the pilot project may develop and initiate disenrollment criteria, subject to approval by the commissioner of human services.

Sec. 32. Minnesota Statutes 2000, section 256K.25, subdivision 5, is amended to read:

Subd. 5. [FUNDING.] A county may request funding from the commissioner for a specified number of ~~TANF-eligible~~ project participants. The commissioner shall review the request for

compliance with subdivisions 1 to 4 and may approve or disapprove the request. If other funds are available, the commissioner may allocate funding for project participants who meet the eligibility requirements of subdivision 4, paragraph (c). The commissioner may also redirect funds to the pilot project.

Sec. 33. Minnesota Statutes 2000, section 256K.25, subdivision 6, is amended to read:

Subd. 6. [REPORT.] Participating counties and the commissioner shall collaborate to prepare and issue an annual report, beginning December 1, 2001, to the chairs of the appropriate legislative committees on the pilot project's use of public resources, including other funds leveraged for this initiative, and an assessment of the feasibility of financing the pilot through other health and human services programs, the employment and housing status of the families and individuals served in the project, and the cost-effectiveness of the project. The annual report must also evaluate the pilot project with respect to the following project goals: that participants will lead more productive, healthier, more stable and better quality lives; that the teams created under the project to deliver services for each project participant will be accountable for ensuring that services are more appropriate, cost-effective and well-coordinated; and that the system-wide costs of serving this population, and the inappropriate use of emergency, crisis-oriented or institutional services, will be materially reduced. The commissioner shall provide data that may be needed to evaluate the project to participating counties that request the data.

Sec. 34. Minnesota Statutes 2000, section 268.0122, subdivision 2, is amended to read:

Subd. 2. [SPECIFIC POWERS.] The commissioner of economic security shall:

(1) administer and supervise all forms of unemployment benefits provided for under federal and state laws that are vested in the commissioner, including make investigations and audits, secure and transmit information, and make available services and facilities as the commissioner considers necessary or appropriate to facilitate the administration of any other states, or the federal Economic Security Law, and accept and use information, services, and facilities made available by other states or the federal government;

(2) administer and supervise all employment and training services assigned to the department under federal or state law;

(3) review and comment on local service unit plans and community investment program plans and approve or disapprove the plans;

(4) establish and maintain administrative units necessary to perform administrative functions common to all divisions of the department;

(5) supervise the county boards of commissioners, local service units, and any other units of government designated in federal or state law as responsible for employment and training programs;

(6) establish administrative standards and payment conditions for providers of employment and training services;

(7) act as the agent of, and cooperate with, the federal government in matters of mutual concern, including the administration of any federal funds granted to the state to aid in the performance of functions of the commissioner;

(8) obtain reports from local service units and service providers for the purpose of evaluating the performance of employment and training services; and

(9) review and comment on plans for Indian tribe employment and training services and approve or disapprove the plans; and

(10) require all general employment and training programs that receive state funds to make available information about opportunities for women in nontraditional careers in the trades and technical occupations.

Sec. 35. Laws 1997, chapter 203, article 9, section 21, as amended by Laws 1998, chapter 407, article 6, section 111, and Laws 2000, chapter 488, article 10, section 28, is amended to read:

Sec. 21. [INELIGIBILITY FOR STATE FUNDED PROGRAMS.]

(a) Effective on the date specified, the following persons will be ineligible for general assistance and general assistance medical care under Minnesota Statutes, chapter 256D, group residential housing under Minnesota Statutes, chapter 256I, and MFIP assistance under Minnesota Statutes, chapter 256J, funded with state money:

(1) Beginning July 1, 2002, persons who are terminated from or denied Supplemental Security Income due to the 1996 changes in the federal law making persons whose alcohol or drug addiction is a material factor contributing to the person's disability ineligible for Supplemental Security Income, and are eligible for general assistance under Minnesota Statutes, section 256D.05, subdivision 1, paragraph (a), clause (15), general assistance medical care under Minnesota Statutes, chapter 256D, or group residential housing under Minnesota Statutes, chapter 256I;

(2) Beginning July 1, 2002, legal noncitizens who are ineligible for Supplemental Security Income due to the 1996 changes in federal law making certain noncitizens ineligible for these programs due to their noncitizen status; and

(3) Beginning July 1, ~~2001~~ 2002, legal noncitizens who are eligible for MFIP assistance, either the cash assistance portion or the food assistance portion, funded entirely with state money.

(b) State money that remains unspent due to changes in federal law enacted after May 12, 1997, that reduce state spending for legal noncitizens or for persons whose alcohol or drug addiction is a material factor contributing to the person's disability, or enacted after February 1, 1998, that reduce state spending for food benefits for legal noncitizens shall not cancel and shall be deposited in the TANF reserve account.

Sec. 36. [REPORT ON ASSESSMENT OF COUNTY PERFORMANCE.]

By January 15, 2003, the commissioner, in consultation with counties, must report to the chairs of the house and senate committees having jurisdiction over human services, on a proposal for assessing county performance using a methodology that controls for demographic, economic, and other variables that may impact county achievement of MFIP performance outcomes. The proposal must recommend how state and federal funds may be allocated to counties to encourage and reward high performance.

Sec. 37. [REPEALER.]

Minnesota Statutes 2000, sections 256J.42, subdivision 4; 256J.44; and 256J.46, subdivision 1a, are repealed.

ARTICLE 11

DHS LICENSING

Section 1. Minnesota Statutes 2000, section 13.46, subdivision 4, is amended to read:

Subd. 4. [LICENSING DATA.] (a) As used in this subdivision:

(1) "licensing data" means all data collected, maintained, used, or disseminated by the welfare system pertaining to persons licensed or registered or who apply for licensure or registration or who formerly were licensed or registered under the authority of the commissioner of human services;

(2) "client" means a person who is receiving services from a licensee or from an applicant for licensure; and

(3) "personal and personal financial data" means social security numbers, identity of and letters

of reference, insurance information, reports from the bureau of criminal apprehension, health examination reports, and social/home studies.

(b)(1) Except as provided in paragraph (c), the following data on current and former licensees are public: name, address, telephone number of licensees, licensed capacity, type of client preferred, variances granted, type of dwelling, name and relationship of other family members, previous license history, class of license, and the existence and status of complaints. When disciplinary action has been taken against a licensee or the complaint is resolved, the following data are public: the substance of the complaint, the findings of the investigation of the complaint, the record of informal resolution of a licensing violation, orders of hearing, findings of fact, conclusions of law, and specifications of the final disciplinary action contained in the record of disciplinary action.

(2) The following data on persons subject to disqualification under section 245A.04 in connection with a license to provide family day care for children, child care center services, foster care for children in the provider's home, or foster care or day care services for adults in the provider's home, are public: the nature of any disqualification set aside under section 245A.04, subdivision 3b, and the reasons for setting aside the disqualification; and the reasons for granting any variance under section 245A.04, subdivision 9.

(3) When maltreatment is substantiated under section 626.556 or 626.557 and the victim and the substantiated perpetrator are affiliated with a program licensed under chapter 245A, the commissioner of human services, local social services agency, or county welfare agency may inform the license holder where the maltreatment occurred of the identity of the substantiated perpetrator and the victim.

(c) The following are private data on individuals under section 13.02, subdivision 12, or nonpublic data under section 13.02, subdivision 9: personal and personal financial data on family day care program and family foster care program applicants and licensees and their family members who provide services under the license.

(d) The following are private data on individuals: the identity of persons who have made reports concerning licensees or applicants that appear in inactive investigative data, and the records of clients or employees of the licensee or applicant for licensure whose records are received by the licensing agency for purposes of review or in anticipation of a contested matter. The names of reporters under sections 626.556 and 626.557 may be disclosed only as provided in section 626.556, subdivision 11, or 626.557, subdivision 12b.

(e) Data classified as private, confidential, nonpublic, or protected nonpublic under this subdivision become public data if submitted to a court or administrative law judge as part of a disciplinary proceeding in which there is a public hearing concerning the disciplinary action.

(f) Data generated in the course of licensing investigations that relate to an alleged violation of law are investigative data under subdivision 3.

(g) Data that are not public data collected, maintained, used, or disseminated under this subdivision that relate to or are derived from a report as defined in section 626.556, subdivision 2, are subject to the destruction provisions of section 626.556, subdivision 11.

(h) Upon request, not public data collected, maintained, used, or disseminated under this subdivision that relate to or are derived from a report of substantiated maltreatment as defined in section 626.556 or 626.557 may be exchanged with the department of health for purposes of completing background studies pursuant to section 144.057.

(i) Data on individuals collected according to licensing activities under chapter 245A, and data on individuals collected by the commissioner of human services according to maltreatment investigations under sections 626.556 and 626.557, may be shared with the department of human rights, the department of health, the department of corrections, the ombudsman for mental health and retardation, and the individual's professional regulatory board when there is reason to believe that laws or standards under the jurisdiction of those agencies may have been violated.

(j) In addition to the notice of determinations required under section 626.556, subdivision 10f, if the commissioner or the local social services agency has determined that an individual is a substantiated perpetrator of maltreatment of a child based on sexual abuse, as defined in section 626.556, subdivision 2, and the commissioner or local social services agency knows that the individual is a person responsible for a child's care in another facility, the commissioner or local social services agency shall notify the head of that facility of this determination. The notification must include an explanation of the individual's available appeal rights and the status of any appeal. If a notice is given under this paragraph, the government entity making the notification shall provide a copy of the notice to the individual who is the subject of the notice.

**[EFFECTIVE DATE.]** This section is effective July 1, 2001.

Sec. 2. Minnesota Statutes 2000, section 144.057, is amended to read:

144.057 [BACKGROUND STUDIES ON LICENSEES AND SUPPLEMENTAL NURSING SERVICES AGENCY PERSONNEL.]

Subdivision 1. [BACKGROUND STUDIES REQUIRED.] The commissioner of health shall contract with the commissioner of human services to conduct background studies of:

(1) individuals providing services which have direct contact, as defined under section 245A.04, subdivision 3, with patients and residents in hospitals, boarding care homes, outpatient surgical centers licensed under sections 144.50 to 144.58; nursing homes and home care agencies licensed under chapter 144A; residential care homes licensed under chapter 144B, and board and lodging establishments that are registered to provide supportive or health supervision services under section 157.17; ~~and~~

(2) beginning July 1, 1999, all other employees in nursing homes licensed under chapter 144A, and boarding care homes licensed under sections 144.50 to 144.58. A disqualification of an individual in this section shall disqualify the individual from positions allowing direct contact or access to patients or residents receiving services;

(3) individuals employed by a supplemental nursing services agency, as defined under section 144A.70, who are providing services in health care facilities; and

(4) controlling persons of a supplemental nursing services agency, as defined under section 144A.70.

If a facility or program is licensed by the department of human services and subject to the background study provisions of chapter 245A and is also licensed by the department of health, the department of human services is solely responsible for the background studies of individuals in the jointly licensed programs.

Subd. 2. [RESPONSIBILITIES OF DEPARTMENT OF HUMAN SERVICES.] The department of human services shall conduct the background studies required by subdivision 1 in compliance with the provisions of chapter 245A and Minnesota Rules, parts 9543.3000 to 9543.3090. For the purpose of this section, the term "residential program" shall include all facilities described in subdivision 1. The department of human services shall provide necessary forms and instructions, shall conduct the necessary background studies of individuals, and shall provide notification of the results of the studies to the facilities, supplemental nursing services agencies, individuals, and the commissioner of health. Individuals shall be disqualified under the provisions of chapter 245A and Minnesota Rules, parts 9543.3000 to 9543.3090. If an individual is disqualified, the department of human services shall notify the facility, the supplemental nursing services agency, and the individual and shall inform the individual of the right to request a reconsideration of the disqualification by submitting the request to the department of health.

Subd. 3. [RECONSIDERATIONS.] The commissioner of health shall review and decide reconsideration requests, including the granting of variances, in accordance with the procedures and criteria contained in chapter 245A and Minnesota Rules, parts 9543.3000 to 9543.3090. The commissioner's decision shall be provided to the individual and to the department of human services. The commissioner's decision to grant or deny a reconsideration of disqualification is the

final administrative agency action, except for the provisions under section 245A.04, subdivisions 3b, paragraphs (e) and (f); and 3c, paragraph (a).

**[EFFECTIVE DATE.]** This subdivision is effective January 1, 2002.

Subd. 4. [RESPONSIBILITIES OF FACILITIES AND AGENCIES.] Facilities and agencies described in subdivision 1 shall be responsible for cooperating with the departments in implementing the provisions of this section. The responsibilities imposed on applicants and licensees under chapter 245A and Minnesota Rules, parts 9543.3000 to 9543.3090, shall apply to these facilities and supplemental nursing services agencies. The provision of section 245A.04, subdivision 3, paragraph (e), shall apply to applicants, licensees, registrants, or an individual's refusal to cooperate with the completion of the background studies. Supplemental nursing services agencies subject to the registration requirements in section 144A.71 must maintain records verifying compliance with the background study requirements under this section.

Sec. 3. Minnesota Statutes 2000, section 214.104, is amended to read:

214.104 [HEALTH-RELATED LICENSING BOARDS; DETERMINATIONS REGARDING ~~DISQUALIFICATIONS FOR~~ MALTREATMENT.]

(a) A health-related licensing board shall make determinations as to whether ~~licensees~~ regulated persons who are under the board's jurisdiction should be ~~disqualified under section 245A.04, subdivision 3d, from positions allowing direct contact with persons receiving services~~ the subject of disciplinary or corrective action because of substantiated maltreatment under section 626.556 or 626.557. ~~A determination under this section may be done as part of an investigation under section 214.103.~~ The board shall make a determination ~~within 90 days of~~ upon receipt, and after the review, of an investigation memorandum or other notice of substantiated maltreatment under section 626.556 or 626.557, or of a notice from the commissioner of human services that a background study of a ~~licensee~~ regulated person shows substantiated maltreatment. ~~The board shall also make a determination under this section upon consideration of the licensure of an individual who was subject to disqualification before licensure because of substantiated maltreatment.~~

~~(b) In making a determination under this section, the board shall consider the nature and extent of any injury or harm resulting from the conduct that would constitute grounds for disqualification, the seriousness of the misconduct, the extent that disqualification is necessary to protect persons receiving services or the public, and other factors specified in section 245A.04, subdivision 3b, paragraph (b).~~

~~(c) The board shall determine the duration and extent of the disqualification or may establish conditions under which the licensee may hold a position allowing direct contact with persons receiving services or in a licensed facility.~~

(b) Upon completion of its review of a report of substantiated maltreatment, the board shall notify the commissioner of human services ~~and the lead agency that conducted an investigation under section 626.556 or 626.557, as applicable,~~ of its determination. The board shall notify the commissioner of human services if, following a review of the report of substantiated maltreatment, the board determines that it does not have jurisdiction in the matter and the commissioner shall make the appropriate disqualification decision regarding the regulated person as otherwise provided in chapter 245A. The board shall also notify the commissioner of health or the commissioner of human services immediately upon receipt of knowledge of a facility or program allowing a regulated person to provide direct contact services at the facility or program while not complying with requirements placed on the regulated person.

(c) In addition to any other remedy provided by law, the board may, through its designated board member, temporarily suspend the license of a licensee; deny a credential to an applicant; or require the regulated person to be continuously supervised, if the board finds there is probable cause to believe the regulated person referred to the board according to paragraph (a) poses an immediate risk of harm to vulnerable persons. The board shall consider all relevant information available, which may include but is not limited to:

(1) the extent the action is needed to protect persons receiving services or the public;

(2) the recency of the maltreatment;

(3) the number of incidents of maltreatment;

(4) the intrusiveness or violence of the maltreatment; and

(5) the vulnerability of the victim of maltreatment.

The action shall take effect upon written notice to the regulated person, served by certified mail, specifying the statute violated. The board shall notify the commissioner of health or the commissioner of human services of the suspension or denial of a credential. The action shall remain in effect until the board issues a temporary stay or a final order in the matter after a hearing or upon agreement between the board and the regulated person. At the time the board issues the notice, the regulated person shall inform the board of all settings in which the regulated person is employed or practices and the board shall inform all known employment and practice settings of the board action and schedule a disciplinary hearing to be held under chapter 14. The board shall provide the regulated person with at least 30 days' notice of the hearing, unless the parties agree to a hearing date that provides less than 30 days notice, and shall schedule the hearing to begin no later than 90 days after issuance of the notice of hearing.

**[EFFECTIVE DATE.]** This section is effective July 1, 2001.

Sec. 4. Minnesota Statutes 2000, section 245A.03, subdivision 2b, is amended to read:

Subd. 2b. [EXCEPTION.] The provision in subdivision 2, clause (2), does not apply to:

(1) a child care provider who as an applicant for licensure or as a license holder has received a license denial under section 245A.05, a ~~fine~~ conditional license under section 245A.06, or a sanction under section 245A.07 from the commissioner that has not been reversed on appeal; or

(2) a child care provider, or a child care provider who has a household member who, as a result of a licensing process, has a disqualification under this chapter that has not been set aside by the commissioner.

**[EFFECTIVE DATE.]** This section is effective January 1, 2002.

Sec. 5. Minnesota Statutes 2000, section 245A.04, subdivision 3a, is amended to read:

Subd. 3a. [NOTIFICATION TO SUBJECT AND LICENSE HOLDER OF STUDY RESULTS; DETERMINATION OF RISK OF HARM.] (a) The commissioner shall notify the applicant ~~or~~, license holder, or registrant and the individual who is the subject of the study, in writing or by electronic transmission, of the results of the study. When the study is completed, a notice that the study was undertaken and completed shall be maintained in the personnel files of the program. For studies on individuals pertaining to a license to provide family day care or group family day care, foster care for children in the provider's own home, or foster care or day care services for adults in the provider's own home, the commissioner is not required to provide a separate notice of the background study results to the individual who is the subject of the study unless the study results in a disqualification of the individual.

The commissioner shall notify the individual studied if the information in the study indicates the individual is disqualified from direct contact with persons served by the program. The commissioner shall disclose the information causing disqualification and instructions on how to request a reconsideration of the disqualification to the individual studied. An applicant or license holder who is not the subject of the study shall be informed that the commissioner has found information that disqualifies the subject from direct contact with persons served by the program. However, only the individual studied must be informed of the information contained in the subject's background study unless the ~~only~~ basis for the disqualification is failure to cooperate, substantiated maltreatment under section 626.556 or 626.557, the Data Practices Act provides for release of the information, or the individual studied authorizes the release of the information.

When a disqualification is based on the subject's failure to cooperate with the background study or substantiated maltreatment under section 626.556 or 626.557, the agency that initiated the study shall be informed by the commissioner of the reason for the disqualification.

(b) Except as provided in subdivision 3d, paragraph (b), if the commissioner determines that the individual studied has a disqualifying characteristic, the commissioner shall review the information immediately available and make a determination as to the subject's immediate risk of harm to persons served by the program where the individual studied will have direct contact. The commissioner shall consider all relevant information available, including the following factors in determining the immediate risk of harm: the recency of the disqualifying characteristic; the recency of discharge from probation for the crimes; the number of disqualifying characteristics; the intrusiveness or violence of the disqualifying characteristic; the vulnerability of the victim involved in the disqualifying characteristic; and the similarity of the victim to the persons served by the program where the individual studied will have direct contact. The commissioner may determine that the evaluation of the information immediately available gives the commissioner reason to believe one of the following:

(1) The individual poses an imminent risk of harm to persons served by the program where the individual studied will have direct contact. If the commissioner determines that an individual studied poses an imminent risk of harm to persons served by the program where the individual studied will have direct contact, the individual and the license holder must be sent a notice of disqualification. The commissioner shall order the license holder to immediately remove the individual studied from direct contact. The notice to the individual studied must include an explanation of the basis of this determination.

(2) The individual poses a risk of harm requiring continuous supervision while providing direct contact services during the period in which the subject may request a reconsideration. If the commissioner determines that an individual studied poses a risk of harm that requires continuous supervision, the individual and the license holder must be sent a notice of disqualification. The commissioner shall order the license holder to immediately remove the individual studied from direct contact services or assure that the individual studied is within sight or hearing of another staff person when providing direct contact services during the period in which the individual may request a reconsideration of the disqualification. If the individual studied does not submit a timely request for reconsideration, or the individual submits a timely request for reconsideration, but the disqualification is not set aside for that license holder, the license holder will be notified of the disqualification and ordered to immediately remove the individual from any position allowing direct contact with persons receiving services from the license holder.

(3) The individual does not pose an imminent risk of harm or a risk of harm requiring continuous supervision while providing direct contact services during the period in which the subject may request a reconsideration. If the commissioner determines that an individual studied does not pose a risk of harm that requires continuous supervision, only the individual must be sent a notice of disqualification. The license holder must be sent a notice that more time is needed to complete the individual's background study. If the individual studied submits a timely request for reconsideration, and if the disqualification is set aside for that license holder, the license holder will receive the same notification received by license holders in cases where the individual studied has no disqualifying characteristic. If the individual studied does not submit a timely request for reconsideration, or the individual submits a timely request for reconsideration, but the disqualification is not set aside for that license holder, the license holder will be notified of the disqualification and ordered to immediately remove the individual from any position allowing direct contact with persons receiving services from the license holder.

(c) County licensing agencies performing duties under this subdivision may develop an alternative system for determining the subject's immediate risk of harm to persons served by the program, providing the notices under paragraph (b), and documenting the action taken by the county licensing agency. Each county licensing agency's implementation of the alternative system is subject to approval by the commissioner. Notwithstanding this alternative system, county licensing agencies shall complete the requirements of paragraph (a).

**[EFFECTIVE DATE.]** This section is effective July 1, 2001.

Sec. 6. Minnesota Statutes 2000, section 245A.04, subdivision 3b, is amended to read:

Subd. 3b. [RECONSIDERATION OF DISQUALIFICATION.] (a) The individual who is the subject of the disqualification may request a reconsideration of the disqualification.

The individual must submit the request for reconsideration to the commissioner in writing. A request for reconsideration for an individual who has been sent a notice of disqualification under subdivision 3a, paragraph (b), clause (1) or (2), must be submitted within 30 calendar days of the disqualified individual's receipt of the notice of disqualification. A request for reconsideration for an individual who has been sent a notice of disqualification under subdivision 3a, paragraph (b), clause (3), must be submitted within 15 calendar days of the disqualified individual's receipt of the notice of disqualification. An individual who was determined to have maltreated a child under section 626.556 or a vulnerable adult under section 626.557, and who was disqualified under this section on the basis of serious or recurring maltreatment, may request reconsideration of both the maltreatment and the disqualification determinations. The request for reconsideration of the maltreatment determination and the disqualification must be submitted within 30 calendar days of the individual's receipt of the notice of disqualification. Removal of a disqualified individual from direct contact shall be ordered if the individual does not request reconsideration within the prescribed time, and for an individual who submits a timely request for reconsideration, if the disqualification is not set aside. The individual must present information showing that:

(1) the information the commissioner relied upon is incorrect or inaccurate. If the basis of a reconsideration request is that a maltreatment determination or disposition under section 626.556 or 626.557 is incorrect, and the commissioner has issued a final order in an appeal of that determination or disposition under section 256.045 or 245A.08, subdivision 5, the commissioner's order is conclusive on the issue of maltreatment. If the individual did not request reconsideration of the maltreatment determination, the maltreatment determination is deemed conclusive; or

(2) the subject of the study does not pose a risk of harm to any person served by the applicant ~~or~~, license holder, or registrant.

(b) The commissioner shall rescind the disqualification if the commissioner finds that the information relied on to disqualify the subject is incorrect. The commissioner may set aside the disqualification under this section if the commissioner finds that the ~~information the commissioner relied upon is incorrect or the~~ individual does not pose a risk of harm to any person served by the applicant ~~or~~, license holder, or registrant. In determining that an individual does not pose a risk of harm, the commissioner shall consider the consequences of the event or events that lead to disqualification, whether there is more than one disqualifying event, the vulnerability of the victim at the time of the event, the time elapsed without a repeat of the same or similar event, documentation of successful completion by the individual studied of training or rehabilitation pertinent to the event, and any other information relevant to reconsideration. In reviewing a disqualification under this section, the commissioner shall give preeminent weight to the safety of each person to be served by the license holder ~~or~~, applicant, or registrant over the interests of the license holder ~~or~~, applicant, or registrant.

(c) Unless the information the commissioner relied on in disqualifying an individual is incorrect, the commissioner may not set aside the disqualification of an individual in connection with a license to provide family day care for children, foster care for children in the provider's own home, or foster care or day care services for adults in the provider's own home if:

(1) less than ten years have passed since the discharge of the sentence imposed for the offense; and the individual has been convicted of a violation of any offense listed in sections 609.20 (manslaughter in the first degree), 609.205 (manslaughter in the second degree), criminal vehicular homicide under 609.21 (criminal vehicular homicide and injury), 609.215 (aiding suicide or aiding attempted suicide), felony violations under 609.221 to 609.2231 (assault in the first, second, third, or fourth degree), 609.713 (terroristic threats), 609.235 (use of drugs to injure or to facilitate crime), 609.24 (simple robbery), 609.245 (aggravated robbery), 609.25 (kidnapping), 609.255 (false imprisonment), 609.561 or 609.562 (arson in the first or second

degree), 609.71 (riot), burglary in the first or second degree under 609.582 (burglary), 609.66 (dangerous weapon), 609.665 (spring guns), 609.67 (machine guns and short-barreled shotguns), 609.749 (harassment; stalking), 152.021 or 152.022 (controlled substance crime in the first or second degree), 152.023, subdivision 1, clause (3) or (4), or subdivision 2, clause (4) (controlled substance crime in the third degree), 152.024, subdivision 1, clause (2), (3), or (4) (controlled substance crime in the fourth degree), 609.224, subdivision 2, paragraph (c) (fifth-degree assault by a caregiver against a vulnerable adult), 609.228 (great bodily harm caused by distribution of drugs), 609.23 (mistreatment of persons confined), 609.231 (mistreatment of residents or patients), 609.2325 (criminal abuse of a vulnerable adult), 609.233 (criminal neglect of a vulnerable adult), 609.2335 (financial exploitation of a vulnerable adult), 609.234 (failure to report), 609.265 (abduction), 609.2664 to 609.2665 (manslaughter of an unborn child in the first or second degree), 609.267 to 609.2672 (assault of an unborn child in the first, second, or third degree), 609.268 (injury or death of an unborn child in the commission of a crime), 617.293 (disseminating or displaying harmful material to minors), a gross misdemeanor offense under 609.324, subdivision 1 (other prohibited acts), a gross misdemeanor offense under 609.378 (neglect or endangerment of a child), a gross misdemeanor offense under 609.377 (malicious punishment of a child), 609.72, subdivision 3 (disorderly conduct against a vulnerable adult); or an attempt or conspiracy to commit any of these offenses, as each of these offenses is defined in Minnesota Statutes; or an offense in any other state, the elements of which are substantially similar to the elements of any of the foregoing offenses;

(2) regardless of how much time has passed since the discharge of the sentence imposed for the offense, the individual was convicted of a violation of any offense listed in sections 609.185 to 609.195 (murder in the first, second, or third degree), 609.2661 to 609.2663 (murder of an unborn child in the first, second, or third degree), a felony offense under 609.377 (malicious punishment of a child), a felony offense under 609.324, subdivision 1 (other prohibited acts), a felony offense under 609.378 (neglect or endangerment of a child), 609.322 (solicitation, inducement, and promotion of prostitution), 609.342 to 609.345 (criminal sexual conduct in the first, second, third, or fourth degree), 609.352 (solicitation of children to engage in sexual conduct), 617.246 (use of minors in a sexual performance), 617.247 (possession of pictorial representations of a minor), 609.365 (incest), a felony offense under sections 609.2242 and 609.2243 (domestic assault), a felony offense of spousal abuse, a felony offense of child abuse or neglect, a felony offense of a crime against children, or an attempt or conspiracy to commit any of these offenses as defined in Minnesota Statutes, or an offense in any other state, the elements of which are substantially similar to any of the foregoing offenses;

(3) within the seven years preceding the study, the individual committed an act that constitutes maltreatment of a child under section 626.556, subdivision 10e, and that resulted in substantial bodily harm as defined in section 609.02, subdivision 7a, or substantial mental or emotional harm as supported by competent psychological or psychiatric evidence; or

(4) within the seven years preceding the study, the individual was determined under section 626.557 to be the perpetrator of a substantiated incident of maltreatment of a vulnerable adult that resulted in substantial bodily harm as defined in section 609.02, subdivision 7a, or substantial mental or emotional harm as supported by competent psychological or psychiatric evidence.

In the case of any ground for disqualification under clauses (1) to (4), if the act was committed by an individual other than the applicant ~~or~~, license holder, or registrant residing in the applicant's ~~or~~, license holder's, or registrant's home, the applicant ~~or~~, license holder, or registrant may seek reconsideration when the individual who committed the act no longer resides in the home.

The disqualification periods provided under clauses (1), (3), and (4) are the minimum applicable disqualification periods. The commissioner may determine that an individual should continue to be disqualified from licensure or registration because the license holder ~~or~~, applicant, or registrant poses a risk of harm to a person served by that individual after the minimum disqualification period has passed.

(d) The commissioner shall respond in writing or by electronic transmission to all reconsideration requests for which the basis for the request is that the information relied upon by

the commissioner to disqualify is incorrect or inaccurate within 30 working days of receipt of a request and all relevant information. If the basis for the request is that the individual does not pose a risk of harm, the commissioner shall respond to the request within 15 working days after receiving the request for reconsideration and all relevant information. If the request is based on both the correctness or accuracy of the information relied on to disqualify the individual and the risk of harm, the commissioner shall respond to the request within 45 working days after receiving the request for reconsideration and all relevant information. If the disqualification is set aside, the commissioner shall notify the applicant or license holder in writing or by electronic transmission of the decision.

(e) Except as provided in subdivision 3c, ~~the commissioner's decision to disqualify an individual, including the decision to grant or deny a rescission or set aside a disqualification under this section, is the final administrative agency action and shall not be subject to further review in a contested case under chapter 14 involving a negative licensing appeal taken in response to the disqualification or involving an accuracy and completeness appeal under section 13.04.~~ if a disqualification is not set aside or is not rescinded, an individual who was disqualified on the basis of a preponderance of evidence that the individual committed an act or acts that meet the definition of any of the crimes lists in subdivision 3d, paragraph (a), clauses (1) to (4); or for failure to make required reports under section 626.556, subdivision 3, or 626.557, subdivision 3, pursuant to subdivision 3d, paragraph (a), clause (4), may request a fair hearing under section 256.045. Except as provided under subdivision 3c, the commissioner's final order for an individual under this paragraph is conclusive on the issue of disqualification, including for purposes of subsequent studies conducted under section 245A.04, subdivision 3, and is the only administrative appeal of the final agency determination, specifically, including a challenge to the accuracy and completeness of data under section 13.04.

(f) Except as provided under subdivision 3c, if an individual was disqualified on the basis of a determination of maltreatment under section 626.556 or 626.557, which was serious or recurring, and the individual has requested reconsideration of the maltreatment determination under section 626.556, subdivision 10i, or 626.557, subdivision 9d, and also requested reconsideration of the disqualification under this subdivision, reconsideration of the maltreatment determination and reconsideration of the disqualification shall be consolidated into a single reconsideration. For maltreatment and disqualification determinations made by county agencies, the consolidated reconsideration shall be conducted by the county agency. Except as provided under subdivision 3c, if an individual who was disqualified on the basis of serious or recurring maltreatment requests a fair hearing on the maltreatment determination under section 626.556, subdivision 10i, or 626.557, subdivision 9d, the scope of the fair hearing under section 256.045 shall include the maltreatment determination and the disqualification. Except as provided under subdivision 3c, the commissioner's final order for an individual under this paragraph is conclusive on the issue of maltreatment and disqualification, including for purposes of subsequent studies conducted under subdivision 3, and is the only administrative appeal of the final agency determination, specifically, including a challenge to the accuracy and completeness of data under section 13.04.

**[EFFECTIVE DATE.]** This section is effective January 1, 2002.

Sec. 7. Minnesota Statutes 2000, section 245A.04, subdivision 3c, is amended to read:

Subd. 3c. [CONTESTED CASE.] (a) Notwithstanding subdivision 3b, paragraphs (e) and (f), if a disqualification is not set aside, a person who is an employee of an employer, as defined in section 179A.03, subdivision 15, may request a contested case hearing under chapter 14. If the disqualification which was not set aside or was not rescinded was based on a maltreatment determination, the scope of the contested case hearing shall include the maltreatment determination and the disqualification. In such cases, a fair hearing shall not be conducted under section 256.045. Rules adopted under this chapter may not preclude an employee in a contested case hearing for disqualification from submitting evidence concerning information gathered under subdivision 3, paragraph (e).

(b) If a disqualification for which reconsideration was requested and which was not set aside or was not rescinded under subdivision 3b is the basis for a denial of a license under section 245A.05

or a licensing sanction under section 245A.07, the license holder has the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8510 to 1400.8612 and successor rules. The appeal must be submitted in accordance with section 245A.05 or 245A.07, subdivision 3. As provided for under section 245A.08, subdivision 2a, the scope of the consolidated contested case hearing shall include the disqualification and the licensing sanction or denial of a license. If the disqualification was based on a determination of substantiated serious or recurring maltreatment under section 626.556 or 626.557, the appeal must be submitted in accordance with sections 245A.07, subdivision 3, and 626.556, subdivision 10i, or 626.557, subdivision 9d. As provided for under section 245A.08, subdivision 2a, the scope of the contested case hearing shall include the maltreatment determination, the disqualification, and the licensing sanction or denial of a license. In such cases, a fair hearing shall not be conducted under section 256.045.

(c) If a maltreatment determination or disqualification, which was not set aside or was not rescinded under subdivision 3b, is the basis for a denial of a license under section 245A.05 or a licensing sanction under section 245A.07, and the disqualified subject is an individual other than the license holder and upon whom a background study must be conducted under subdivision 3, the hearing of all parties may be consolidated into a single contested case hearing upon consent of all parties and the administrative law judge.

(d) The commissioner's final order under section 245A.08, subdivision 5, is conclusive on the issue of maltreatment and disqualification, including for purposes of subsequent background studies. The contested case hearing under this subdivision is the only administrative appeal of the final agency determination, specifically, including a challenge to the accuracy and completeness of data under section 13.04.

**[EFFECTIVE DATE.]** This section is effective January 1, 2002.

Sec. 8. Minnesota Statutes 2000, section 245A.04, subdivision 3d, is amended to read:

Subd. 3d. [DISQUALIFICATION.] (a) Except as provided in paragraph (b), when a background study completed under subdivision 3 shows any of the following: a conviction of one or more crimes listed in clauses (1) to (4); the individual has admitted to or a preponderance of the evidence indicates the individual has committed an act or acts that meet the definition of any of the crimes listed in clauses (1) to (4); or an investigation results in an administrative determination listed under clause (4), the individual shall be disqualified from any position allowing direct contact with persons receiving services from the license holder, registrant and for individuals studied under section 245A.04, subdivision 3, paragraph (c), clauses (2), (6), and (7), in H.F. 1381, if enacted, the individual shall also be disqualified from access to persons receiving services from the license holder:

(1) regardless of how much time has passed since the discharge of the sentence imposed for the offense, and unless otherwise specified, regardless of the level of the conviction, the individual was convicted of any of the following offenses: sections 609.185 (murder in the first degree); 609.19 (murder in the second degree); 609.195 (murder in the third degree); 609.2661 (murder of an unborn child in the first degree); 609.2662 (murder of an unborn child in the second degree); 609.2663 (murder of an unborn child in the third degree); 609.322 (solicitation, inducement, and promotion of prostitution); 609.342 (criminal sexual conduct in the first degree); 609.343 (criminal sexual conduct in the second degree); 609.344 (criminal sexual conduct in the third degree); 609.345 (criminal sexual conduct in the fourth degree); 609.352 (solicitation of children to engage in sexual conduct); 609.365 (incest); felony offense under 609.377 (malicious punishment of a child); a felony offense under 609.378 (neglect or endangerment of a child); a felony offense under 609.324, subdivision 1 (other prohibited acts); 617.246 (use of minors in sexual performance prohibited); 617.247 (possession of pictorial representations of minors); a felony offense under sections 609.2242 and 609.2243 (domestic assault), a felony offense of spousal abuse, a felony offense of child abuse or neglect, a felony offense of a crime against children; or attempt or conspiracy to commit any of these offenses as defined in Minnesota Statutes, or an offense in any other state or country, where the elements are substantially similar to any of the offenses listed in this clause;

(2) if less than 15 years have passed since the discharge of the sentence imposed for the

offense; and the individual has received a felony conviction for a violation of any of these offenses: sections 609.20 (manslaughter in the first degree); 609.205 (manslaughter in the second degree); 609.21 (criminal vehicular homicide and injury); 609.215 (suicide); 609.221 to 609.2231 (assault in the first, second, third, or fourth degree); repeat offenses under 609.224 (assault in the fifth degree); repeat offenses under 609.3451 (criminal sexual conduct in the fifth degree); 609.713 (terroristic threats); 609.235 (use of drugs to injure or facilitate crime); 609.24 (simple robbery); 609.245 (aggravated robbery); 609.25 (kidnapping); 609.255 (false imprisonment); 609.561 (arson in the first degree); 609.562 (arson in the second degree); 609.563 (arson in the third degree); repeat offenses under 617.23 (indecent exposure; penalties); repeat offenses under 617.241 (obscene materials and performances; distribution and exhibition prohibited; penalty); 609.71 (riot); 609.66 (dangerous weapons); 609.67 (machine guns and short-barreled shotguns); 609.749 (harassment; stalking; penalties); 609.228 (great bodily harm caused by distribution of drugs); 609.2325 (criminal abuse of a vulnerable adult); 609.2664 (manslaughter of an unborn child in the first degree); 609.2665 (manslaughter of an unborn child in the second degree); 609.267 (assault of an unborn child in the first degree); 609.2671 (assault of an unborn child in the second degree); 609.268 (injury or death of an unborn child in the commission of a crime); 609.52 (theft); 609.2335 (financial exploitation of a vulnerable adult); 609.521 (possession of shoplifting gear); 609.582 (burglary); 609.625 (aggravated forgery); 609.63 (forgery); 609.631 (check forgery; offering a forged check); 609.635 (obtaining signature by false pretense); 609.27 (coercion); 609.275 (attempt to coerce); 609.687 (adulteration); 260C.301 (grounds for termination of parental rights); and chapter 152 (drugs; controlled substance). An attempt or conspiracy to commit any of these offenses, as each of these offenses is defined in Minnesota Statutes; or an offense in any other state or country, the elements of which are substantially similar to the elements of the offenses in this clause. If the individual studied is convicted of one of the felonies listed in this clause, but the sentence is a gross misdemeanor or misdemeanor disposition, the lookback period for the conviction is the period applicable to the disposition, that is the period for gross misdemeanors or misdemeanors;

(3) if less than ten years have passed since the discharge of the sentence imposed for the offense; and the individual has received a gross misdemeanor conviction for a violation of any of the following offenses: sections 609.224 (assault in the fifth degree); 609.2242 and 609.2243 (domestic assault); violation of an order for protection under 518B.01, subdivision 14; 609.3451 (criminal sexual conduct in the fifth degree); repeat offenses under 609.746 (interference with privacy); repeat offenses under 617.23 (indecent exposure); 617.241 (obscene materials and performances); 617.243 (indecent literature, distribution); 617.293 (harmful materials; dissemination and display to minors prohibited); 609.71 (riot); 609.66 (dangerous weapons); 609.749 (harassment; stalking; penalties); 609.224, subdivision 2, paragraph (c) (assault in the fifth degree by a caregiver against a vulnerable adult); 609.23 (mistreatment of persons confined); 609.231 (mistreatment of residents or patients); 609.2325 (criminal abuse of a vulnerable adult); 609.233 (criminal neglect of a vulnerable adult); 609.2335 (financial exploitation of a vulnerable adult); 609.234 (failure to report maltreatment of a vulnerable adult); 609.72, subdivision 3 (disorderly conduct against a vulnerable adult); 609.265 (abduction); 609.378 (neglect or endangerment of a child); 609.377 (malicious punishment of a child); 609.324, subdivision 1a (other prohibited acts; minor engaged in prostitution); 609.33 (disorderly house); 609.52 (theft); 609.582 (burglary); 609.631 (check forgery; offering a forged check); 609.275 (attempt to coerce); or an attempt or conspiracy to commit any of these offenses, as each of these offenses is defined in Minnesota Statutes; or an offense in any other state or country, the elements of which are substantially similar to the elements of any of the offenses listed in this clause. If the defendant is convicted of one of the gross misdemeanors listed in this clause, but the sentence is a misdemeanor disposition, the lookback period for the conviction is the period applicable to misdemeanors; or

(4) if less than seven years have passed since the discharge of the sentence imposed for the offense; and the individual has received a misdemeanor conviction for a violation of any of the following offenses: sections 609.224 (assault in the fifth degree); 609.2242 (domestic assault); violation of an order for protection under 518B.01 (Domestic Abuse Act); violation of an order for protection under 609.3232 (protective order authorized; procedures; penalties); 609.746 (interference with privacy); 609.79 (obscene or harassing phone calls); 609.795 (letter, telegram, or package; opening; harassment); 617.23 (indecent exposure; penalties); 609.2672 (assault of an

unborn child in the third degree); 617.293 (harmful materials; dissemination and display to minors prohibited); 609.66 (dangerous weapons); 609.665 (spring guns); 609.2335 (financial exploitation of a vulnerable adult); 609.234 (failure to report maltreatment of a vulnerable adult); 609.52 (theft); 609.27 (coercion); or an attempt or conspiracy to commit any of these offenses, as each of these offenses is defined in Minnesota Statutes; or an offense in any other state or country, the elements of which are substantially similar to the elements of any of the offenses listed in this clause; failure to make required reports under section 626.556, subdivision 3, or 626.557, subdivision 3, for incidents in which: (i) the final disposition under section 626.556 or 626.557 was substantiated maltreatment, and (ii) the maltreatment was recurring or serious; or substantiated serious or recurring maltreatment of a minor under section 626.556 or of a vulnerable adult under section 626.557 for which there is a preponderance of evidence that the maltreatment occurred, and that the subject was responsible for the maltreatment.

For the purposes of this section, "serious maltreatment" means sexual abuse; maltreatment resulting in death; or maltreatment resulting in serious injury which reasonably requires the care of a physician whether or not the care of a physician was sought; or abuse resulting in serious injury. For purposes of this section, "abuse resulting in serious injury" means: bruises, bites, skin laceration or tissue damage; fractures; dislocations; evidence of internal injuries; head injuries with loss of consciousness; extensive second-degree or third-degree burns and other burns for which complications are present; extensive second-degree or third-degree frostbite, and others for which complications are present; irreversible mobility or avulsion of teeth; injuries to the eyeball; ingestion of foreign substances and objects that are harmful; near drowning; and heat exhaustion or sunstroke. For purposes of this section, "care of a physician" is treatment received or ordered by a physician, but does not include diagnostic testing, assessment, or observation. For the purposes of this section, "recurring maltreatment" means more than one incident of maltreatment for which there is a preponderance of evidence that the maltreatment occurred, and that the subject was responsible for the maltreatment. For purposes of this section, "access" means physical access to an individual receiving services or the individual's personal property without continuous, direct supervision as defined in section 245A.04, subdivision 3.

(b) ~~If~~ Except for background studies related to child foster care, adult foster care, or family child care licensure, when the subject of a background study is ~~licensed~~ regulated by a health-related licensing board as defined in chapter 214, and the regulated person has been determined to have been responsible for substantiated maltreatment under section 626.556 or 626.557, instead of the commissioner making a decision regarding disqualification, the board shall make ~~the~~ a determination ~~regarding a disqualification under this subdivision based on a finding of substantiated maltreatment under section 626.556 or 626.557. The commissioner shall notify the health-related licensing board if a background study shows that a licensee would be disqualified because of substantiated maltreatment and the board shall make a determination under section 214.104.~~ whether to impose disciplinary or corrective action under chapter 214.

(1) The commissioner shall notify the health-related licensing board:

(i) upon completion of a background study that produces a record showing that the individual was determined to have been responsible for substantiated maltreatment;

(ii) upon the commissioner's completion of an investigation that determined the individual was responsible for substantiated maltreatment; or

(iii) upon receipt from another agency of a finding of substantiated maltreatment for which the individual was responsible.

(2) The commissioner's notice shall indicate whether the individual would have been disqualified by the commissioner for the substantiated maltreatment if the individual were not regulated by the board. The commissioner shall concurrently send a copy of this notice to the individual.

(3) Notwithstanding the exclusion from this subdivision for individuals who provide child foster care, adult foster care, or family child care, when the commissioner or a local agency has reason to believe that the direct contact services provided by the individual may fall within the

jurisdiction of a health-related licensing board, a referral shall be made to the board as provided in this section.

(4) If, upon review of the information provided by the commissioner, a health-related licensing board informs the commissioner that the board does not have jurisdiction to take disciplinary or corrective action, the commissioner shall make the appropriate disqualification decision regarding the individual as otherwise provided in this chapter.

(5) The commissioner has the authority to monitor the facility's compliance with any requirements that the health-related licensing board places on regulated persons practicing in a facility either during the period pending a final decision on a disciplinary or corrective action or as a result of a disciplinary or corrective action. The commissioner has the authority to order the immediate removal of a regulated person from direct contact or access when a board issues an order of temporary suspension based on a determination that the regulated person poses an immediate risk of harm to persons receiving services in a licensed facility.

(6) A facility that allows a regulated person to provide direct contact services while not complying with the requirements imposed by the health-related licensing board is subject to action by the commissioner as specified under sections 245A.06 and 245A.07.

(7) The commissioner shall notify a health-related licensing board immediately upon receipt of knowledge of noncompliance with requirements placed on a facility or upon a person regulated by the board.

**[EFFECTIVE DATE.]** This section is effective July 1, 2001.

Sec. 9. Minnesota Statutes 2000, section 245A.05, is amended to read:

245A.05 [DENIAL OF APPLICATION.]

The commissioner may deny a license if an applicant fails to comply with applicable laws or rules, or knowingly withholds relevant information from or gives false or misleading information to the commissioner in connection with an application for a license or during an investigation. An applicant whose application has been denied by the commissioner must be given notice of the denial. Notice must be given by certified mail. The notice must state the reasons the application was denied and must inform the applicant of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8510 to 1400.8612 and successor rules. The applicant may appeal the denial by notifying the commissioner in writing by certified mail within 20 calendar days after receiving notice that the application was denied. Section 245A.08 applies to hearings held to appeal the commissioner's denial of an application.

**[EFFECTIVE DATE.]** This section is effective January 1, 2002.

Sec. 10. Minnesota Statutes 2000, section 245A.06, is amended to read:

245A.06 [CORRECTION ORDER AND ~~FINES~~ CONDITIONAL LICENSE.]

Subdivision 1. [CONTENTS OF CORRECTION ORDERS ~~OR FINES~~ AND CONDITIONAL LICENSES.] (a) If the commissioner finds that the applicant or license holder has failed to comply with an applicable law or rule and this failure does not imminently endanger the health, safety, or rights of the persons served by the program, the commissioner may issue a correction order and an order of conditional license to ~~or impose a fine on~~ the applicant or license holder. When issuing a conditional license, the commissioner shall consider the nature, chronicity, or severity of the violation of law or rule and the effect of the violation on the health, safety, or rights of persons served by the program. The correction order or ~~fine~~ conditional license must state:

(1) the conditions that constitute a violation of the law or rule;

(2) the specific law or rule violated;

(3) the time allowed to correct each violation; and

(4) if a ~~fine is imposed, the amount of the fine~~ license is made conditional, the length and terms of the conditional license.

(b) Nothing in this section prohibits the commissioner from proposing a sanction as specified in section 245A.07, prior to issuing a correction order or ~~fine~~ conditional license.

Subd. 2. [RECONSIDERATION OF CORRECTION ORDERS.] If the applicant or license holder believes that the contents of the commissioner's correction order are in error, the applicant or license holder may ask the department of human services to reconsider the parts of the correction order that are alleged to be in error. The request for reconsideration must be in writing and received by the commissioner within 20 calendar days after receipt of the correction order by the applicant or license holder, and:

(1) specify the parts of the correction order that are alleged to be in error;

(2) explain why they are in error; and

(3) include documentation to support the allegation of error.

A request for reconsideration does not stay any provisions or requirements of the correction order. The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14.

Subd. 3. [FAILURE TO COMPLY.] If the commissioner finds that the applicant or license holder has not corrected the violations specified in the correction order or conditional license, the commissioner may impose a fine and order other licensing sanctions pursuant to section 245A.07. ~~If a fine was imposed and the violation was not corrected, the commissioner may impose an additional fine. This section does not prohibit the commissioner from seeking a court order, denying an application, or suspending, revoking, or making conditional the license in addition to imposing a fine.~~

Subd. 4. [NOTICE OF ~~FINE~~ CONDITIONAL LICENSE; RECONSIDERATION OF ~~FINE~~ CONDITIONAL LICENSE.] ~~A license holder who is ordered to pay a fine~~ If a license is made conditional, the license holder must be notified of the order by certified mail. The notice must be mailed to the address shown on the application or the last known address of the license holder. The notice must state the reasons the ~~fine~~ conditional license was ordered and must inform the license holder of the ~~responsibility for payment of fines in subdivision 7 and the~~ right to request reconsideration of the ~~fine~~ conditional license by the commissioner. The license holder may request reconsideration of the order ~~to forfeit a fine~~ of conditional license by notifying the commissioner by certified mail ~~within 20 calendar days after receiving the order~~. The request must be in writing and must be received by the commissioner within ten calendar days after the license holder received the order. The license holder may submit with the request for reconsideration written argument or evidence in support of the request for reconsideration. A timely request for reconsideration shall stay ~~forfeiture of the fine~~ imposition of the terms of the conditional license until the commissioner issues a decision on the request for reconsideration. ~~The request for reconsideration must be in writing and:~~

~~(1) specify the parts of the violation that are alleged to be in error;~~

~~(2) explain why they are in error;~~

~~(3) include documentation to support the allegation of error; and~~

~~(4) any other information relevant to the fine or the amount of the fine.~~

The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14.

~~Subd. 5. [FORFEITURE OF FINES.] The license holder shall pay the fines assessed on or before the payment date specified in the commissioner's order. If the license holder fails to fully comply with the order, the commissioner shall issue a second fine or suspend the license until the~~

~~license holder complies. If the license holder receives state funds, the state, county, or municipal agencies or departments responsible for administering the funds shall withhold payments and recover any payments made while the license is suspended for failure to pay a fine.~~

~~Subd. 5a. [ACCRUAL OF FINES.] A license holder shall promptly notify the commissioner of human services, in writing, when a violation specified in an order to forfeit is corrected. If upon reinspection the commissioner determines that a violation has not been corrected as indicated by the order to forfeit, the commissioner may issue a second fine. The commissioner shall notify the license holder by certified mail that a second fine has been assessed. The license holder may request reconsideration of the second fine under the provisions of subdivision 4.~~

~~Subd. 6. [AMOUNT OF FINES.] Fines shall be assessed as follows:~~

~~(1) the license holder shall forfeit $1,000 for each occurrence of violation of law or rule prohibiting the maltreatment of children or the maltreatment of vulnerable adults, including but not limited to corporal punishment, illegal or unauthorized use of physical, mechanical, or chemical restraints, and illegal or unauthorized use of aversive or deprivation procedures;~~

~~(2) the license holder shall forfeit $200 for each occurrence of a violation of law or rule governing matters of health, safety, or supervision, including but not limited to the provision of adequate staff to child or adult ratios; and~~

~~(3) the license holder shall forfeit $100 for each occurrence of a violation of law or rule other than those included in clauses (1) and (2).~~

~~For the purposes of this section, "occurrence" means each violation identified in the commissioner's forfeiture order.~~

~~Subd. 7. [RESPONSIBILITY FOR PAYMENT OF FINES.] When a fine has been assessed, the license holder may not avoid payment by closing, selling, or otherwise transferring the licensed program to a third party. In such an event, the license holder will be personally liable for payment. In the case of a corporation, each controlling individual is personally and jointly liable for payment.~~

~~Fines for child care centers must be assessed according to this section.~~

**[EFFECTIVE DATE.]** This section is effective January 1, 2002.

Sec. 11. Minnesota Statutes 2000, section 245A.07, is amended to read:

245A.07 [SANCTIONS.]

Subdivision 1. [SANCTIONS AVAILABLE.] In addition to ~~ordering forfeiture of fines~~ making a license conditional under section 245A.06, the commissioner may propose to suspend~~,~~ or revoke~~, or make conditional~~ the license, impose a fine, or secure an injunction against the continuing operation of the program of a license holder who does not comply with applicable law or rule. When applying sanctions authorized under this section, the commissioner shall consider the nature, chronicity, or severity of the violation of law or rule and the effect of the violation on the health, safety, or rights of persons served by the program.

Subd. 2. [~~IMMEDIATE SUSPENSION IN CASES OF IMMINENT DANGER TO HEALTH, SAFETY, OR RIGHTS~~ TEMPORARY IMMEDIATE SUSPENSION.] (a) If the license holder's actions or failure to comply with applicable law or rule ~~has placed~~ poses an imminent risk of harm to the health, safety, or rights of persons served by the program ~~in imminent danger~~, the commissioner shall act immediately to temporarily suspend the license. No state funds shall be made available or be expended by any agency or department of state, county, or municipal government for use by a license holder regulated under this chapter while a license is under immediate suspension. A notice stating the reasons for the immediate suspension and informing the license holder of the right to ~~a contested case~~ an expedited hearing under chapter 14 and Minnesota Rules, parts 1400.8510 to 1400.8612 and successor rules, must be delivered by personal service to the address shown on the application or the last known address of the license

holder. The license holder may appeal an order immediately suspending a license. The appeal of an order immediately suspending a license must be made in writing by certified mail and must be received by the commissioner within five calendar days after the license holder receives notice that the license has been immediately suspended. A license holder and any controlling individual shall discontinue operation of the program upon receipt of the commissioner's order to immediately suspend the license.

(b) The commissioner is liable to the license holder for actual damages for days of lost service in an amount not more than $50,000 when:

(1) the commissioner immediately suspends a license under paragraph (a); and

(2) the administrative law judge recommends, after a review of the facts in an expedited hearing under chapter 14 and Minnesota Rules, parts 1400.8510 to 1400.8612 and successor rules, that reasonable cause did not exist at the time the commissioner issued the immediate suspension.

(c) If the commissioner immediately suspends a license under paragraph (a) and the administrative law judge recommends that reasonable cause exists for the immediate suspension, the commissioner is not liable to the license holder.

Subd. 2a. [IMMEDIATE SUSPENSION EXPEDITED HEARING.] (a) Within five working days of receipt of the license holder's timely appeal, the commissioner shall request assignment of an administrative law judge. The request must include a proposed date, time, and place of a hearing. A hearing must be conducted by an administrative law judge within 30 calendar days of the request for assignment, unless an extension is requested by either party and granted by the administrative law judge for good cause. The commissioner shall issue a notice of hearing by certified mail at least ten working days before the hearing. The scope of the hearing shall be limited solely to the issue of whether the temporary immediate suspension should remain in effect pending the commissioner's final order under section 245A.08, regarding a licensing sanction issued under subdivision 3 following the immediate suspension. The burden of proof in expedited hearings under this subdivision shall be limited to the commissioner's demonstration that reasonable cause exists to believe that the license holder's actions or failure to comply with applicable law or rule poses an imminent risk of harm to the health, safety, or rights of persons served by the program.

(b) The administrative law judge shall issue findings of fact, conclusions, and a recommendation within ten working days from the date of hearing. The commissioner's final order shall be issued within ten working days from receipt of the recommendation of the administrative law judge. Within 90 calendar days after a final order affirming an immediate suspension, the commissioner shall make a determination regarding whether a final licensing sanction shall be issued under subdivision 3. The license holder shall continue to be prohibited from operation of the program during this 90-day period.

Subd. 3. [LICENSE SUSPENSION, REVOCATION, ~~DENIAL~~ OR ~~CONDITIONAL LICENSE~~ FINE.] The commissioner may suspend~~,~~ or revoke~~, make conditional, or deny~~ a license, or impose a fine if ~~an applicant or~~ a license holder fails to comply fully with applicable laws or rules, or knowingly withholds relevant information from or gives false or misleading information to the commissioner in connection with an application for a license or during an investigation. A license holder who has had a license suspended, revoked, or ~~made conditional~~ has been ordered to pay a fine must be given notice of the action by certified mail. The notice must be mailed to the address shown on the application or the last known address of the license holder. The notice must state the reasons the license was suspended, revoked, or ~~made conditional~~ a fine was ordered.

(a) If the license was suspended or revoked, the notice must inform the license holder of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8510 to 1400.8612 and successor rules. The license holder may appeal an order suspending or revoking a license. The appeal of an order suspending or revoking a license must be made in writing by certified mail and must be received by the commissioner within ten calendar days after the license holder receives notice that the license has been suspended or revoked.

(b) ~~If the license was made conditional, the notice must inform the license holder of the right to request a reconsideration by the commissioner. The request for reconsideration must be made in writing by certified mail and must be received by the commissioner within ten calendar days after the license holder receives notice that the license has been made conditional. The license holder may submit with the request for reconsideration written argument or evidence in support of the request for reconsideration. The commissioner's disposition of a request for reconsideration is final and is not subject to appeal under chapter 14.~~ (1) If the license holder was ordered to pay a fine, the notice must inform the license holder of the responsibility for payment of fines and the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8510 to 1400.8612 and successor rules. The appeal of an order to pay a fine must be made in writing by certified mail and must be received by the commissioner within ten calendar days after the license holder receives notice that the fine has been ordered.

(2) The license holder shall pay the fines assessed on or before the payment date specified. If the license holder fails to fully comply with the order, the commissioner may issue a second fine or suspend the license until the license holder complies. If the license holder receives state funds, the state, county, or municipal agencies or departments responsible for administering the funds shall withhold payments and recover any payments made while the license is suspended for failure to pay a fine. A timely appeal shall stay payment of the fine until the commissioner issues a final order.

(3) A license holder shall promptly notify the commissioner of human services, in writing, when a violation specified in the order to forfeit a fine is corrected. If upon reinspection the commissioner determines that a violation has not been corrected as indicated by the order to forfeit a fine, the commissioner may issue a second fine. The commissioner shall notify the license holder by certified mail that a second fine has been assessed. The license holder may appeal the second fine as provided under this subdivision.

(4) Fines shall be assessed as follows: the license holder shall forfeit $1,000 for each determination of maltreatment of a child under section 626.556 or the maltreatment of a vulnerable adult under section 626.557; the license holder shall forfeit $200 for each occurrence of a violation of law or rule governing matters of health, safety, or supervision, including but not limited to the provision of adequate staff to child or adult ratios, and failure to submit a background study; and the license holder shall forfeit $100 for each occurrence of a violation of law or rule other than those subject to a $1,000 or $200 fine above. For purposes of this section, "occurrence" means each violation identified in the commissioner's fine order.

(5) When a fine has been assessed, the license holder may not avoid payment by closing, selling, or otherwise transferring the licensed program to a third party. In such an event, the license holder will be personally liable for payment. In the case of a corporation, each controlling individual is personally and jointly liable for payment.

Subd. 4. [ADOPTION AGENCY VIOLATIONS.] If a license holder licensed to place children for adoption fails to provide services as described in the disclosure form required by section 259.37, subdivision 2, the sanctions under this section may be imposed.

**[EFFECTIVE DATE.]** This section is effective January 1, 2002.

Sec. 12. Minnesota Statutes 2000, section 245A.08, is amended to read:

245A.08 [HEARINGS.]

Subdivision 1. [RECEIPT OF APPEAL; CONDUCT OF HEARING.] Upon receiving a timely appeal or petition pursuant to section 245A.04, subdivision 3c, 245A.05, or 245A.07, subdivision 3, the commissioner shall issue a notice of and order for hearing to the appellant under chapter 14 and Minnesota Rules, parts 1400.8510 to 1400.8612 and successor rules.

Subd. 2. [CONDUCT OF HEARINGS.] At any hearing provided for by section 245A.04, subdivision 3c, 245A.05, or 245A.07, subdivision 3, the appellant may be represented by counsel and has the right to call, examine, and cross-examine witnesses. The administrative law judge may require the presence of witnesses and evidence by subpoena on behalf of any party.

Subd. 2a. [CONSOLIDATED CONTESTED CASE HEARINGS FOR SANCTIONS BASED ON MALTREATMENT DETERMINATIONS AND DISQUALIFICATIONS.] (a) When a denial of a license under section 245A.05 or a licensing sanction under section 245A.07, subdivision 3, is based on a disqualification for which reconsideration was requested and which was not set aside or was not rescinded under section 245A.04, subdivision 3b, the scope of the contested case hearing shall include the disqualification and the licensing sanction or denial of a license. When the licensing sanction or denial of a license is based on a determination of maltreatment under section 626.556 or 626.557, or a disqualification for serious or recurring maltreatment which was not set aside or was not rescinded, the scope of the contested case hearing shall include the maltreatment determination, disqualification, and the licensing sanction or denial of a license. In such cases, a fair hearing under section 256.045 shall not be conducted as provided for in sections 626.556, subdivision 10i, and 626.557, subdivision 9d.

(b) In consolidated contested case hearings regarding sanctions issued in family child care, child foster care, and adult foster care, the county attorney shall defend the commissioner's orders in accordance with section 245A.16, subdivision 4.

(c) The commissioner's final order under subdivision 5 is the final agency action on the issue of maltreatment and disqualification, including for purposes of subsequent background studies under section 245A.04, subdivision 3, and is the only administrative appeal of the final agency determination, specifically, including a challenge to the accuracy and completeness of data under section 13.04.

(d) When consolidated hearings under this subdivision involve a licensing sanction based on a previous maltreatment determination for which the commissioner has issued a final order in an appeal of that determination under section 256.045, or the individual failed to exercise the right to appeal the previous maltreatment determination under section 626.556, subdivision 10i, or 626.557, subdivision 9d, the commissioner's order is conclusive on the issue of maltreatment. In such cases, the scope of the administrative law judge's review shall be limited to the disqualification and the licensing sanction or denial of a license. In the case of a denial of a license or a licensing sanction issued to a facility based on a maltreatment determination regarding an individual who is not the license holder or a household member, the scope of the administrative law judge's review includes the maltreatment determination.

(e) If a maltreatment determination or disqualification, which was not set aside or was not rescinded under section 245A.04, subdivision 3b, is the basis for a denial of a license under section 245A.05 or a licensing sanction under section 245A.07, and the disqualified subject is an individual other than the license holder and upon whom a background study must be conducted under section 245A.04, subdivision 3, the hearings of all parties may be consolidated into a single contested case hearing upon consent of all parties and the administrative law judge.

Subd. 3. [BURDEN OF PROOF.] (a) At a hearing regarding ~~suspension, immediate suspension, or revocation of a license for family day care or foster care~~ a licensing sanction under section 245A.07, including consolidated hearings under subdivision 2a, the commissioner may demonstrate reasonable cause for action taken by submitting statements, reports, or affidavits to substantiate the allegations that the license holder failed to comply fully with applicable law or rule. If the commissioner demonstrates that reasonable cause existed, the burden of proof ~~in hearings involving suspension, immediate suspension, or revocation of a family day care or foster care license~~ shifts to the license holder to demonstrate by a preponderance of the evidence that the license holder was in full compliance with those laws or rules that the commissioner alleges the license holder violated, at the time that the commissioner alleges the violations of law or rules occurred.

(b) At a hearing on denial of an application, the applicant bears the burden of proof to demonstrate by a preponderance of the evidence that the appellant has complied fully with ~~sections 245A.01 to 245A.15~~ this chapter and other applicable law or rule and that the application should be approved and a license granted.

~~(c) At all other hearings under this section, the commissioner bears the burden of proof to demonstrate, by a preponderance of the evidence, that the violations of law or rule alleged by the commissioner occurred.~~

Subd. 4. [RECOMMENDATION OF ADMINISTRATIVE LAW JUDGE.] The administrative law judge shall recommend whether or not the commissioner's order should be affirmed. The recommendations must be consistent with this chapter and the rules of the commissioner. The recommendations must be in writing and accompanied by findings of fact and conclusions and must be mailed to the parties by certified mail to their last known addresses as shown on the license or application.

Subd. 5. [NOTICE OF THE COMMISSIONER'S FINAL ORDER.] After considering the findings of fact, conclusions, and recommendations of the administrative law judge, the commissioner shall issue a final order. The commissioner shall consider, but shall not be bound by, the recommendations of the administrative law judge. The appellant must be notified of the commissioner's final order as required by chapter 14 and Minnesota Rules, parts 1400.8510 to 1400.8612 and successor rules. The notice must also contain information about the appellant's rights under chapter 14 and Minnesota Rules, parts 1400.8510 to 1400.8612 and successor rules. The institution of proceedings for judicial review of the commissioner's final order shall not stay the enforcement of the final order except as provided in section 14.65. A license holder and each controlling individual of a license holder whose license has been revoked because of noncompliance with applicable law or rule must not be granted a license for five years following the revocation. An applicant whose application was denied must not be granted a license for two years following a denial, unless the applicant's subsequent application contains new information which constitutes a substantial change in the conditions that caused the previous denial.

**[EFFECTIVE DATE.]** This section is effective January 1, 2002.

Sec. 13. Minnesota Statutes 2000, section 245A.16, subdivision 1, is amended to read:

Subdivision 1. [DELEGATION OF AUTHORITY TO AGENCIES.] (a) County agencies and private agencies that have been designated or licensed by the commissioner to perform licensing functions and activities under section 245A.04, to recommend denial of applicants under section 245A.05, to issue correction orders, to issue variances, and recommend ~~fines~~ a conditional license under section 245A.06, or to recommend suspending~~,~~ or revoking~~, and making licenses probationary~~ a license or issuing a fine under section 245A.07, shall comply with rules and directives of the commissioner governing those functions and with this section.

(b) For family day care programs, the commissioner may authorize licensing reviews every two years after a licensee has had at least one annual review.

**[EFFECTIVE DATE.]** This section is effective January 1, 2002.

Sec. 14. Minnesota Statutes 2000, section 245B.08, subdivision 3, is amended to read:

Subd. 3. [SANCTIONS AVAILABLE.] Nothing in this subdivision shall be construed to limit the commissioner's authority to suspend~~,~~ or revoke a license, or ~~make conditional~~ issue a fine at any time ~~a license~~ under section 245A.07; make correction orders and ~~require fines~~ make a license conditional for failure to comply with applicable laws or rules under section 245A.06; or deny an application for license under section 245A.05.

**[EFFECTIVE DATE.]** This section is effective January 1, 2002.

Sec. 15. Minnesota Statutes 2000, section 256.045, subdivision 3, is amended to read:

Subd. 3. [STATE AGENCY HEARINGS.] (a) State agency hearings are available for the following: (1) any person applying for, receiving or having received public assistance, medical care, or a program of social services granted by the state agency or a county agency or the federal Food Stamp Act whose application for assistance is denied, not acted upon with reasonable promptness, or whose assistance is suspended, reduced, terminated, or claimed to have been incorrectly paid; (2) any patient or relative aggrieved by an order of the commissioner under section 252.27; (3) a party aggrieved by a ruling of a prepaid health plan; (4) except as provided under chapter 245A, any individual or facility determined by a lead agency to have maltreated a vulnerable adult under section 626.557 after they have exercised their right to administrative reconsideration under section 626.557; (5) any person whose claim for foster care payment

according to a placement of the child resulting from a child protection assessment under section 626.556 is denied or not acted upon with reasonable promptness, regardless of funding source; (6) any person to whom a right of appeal according to this section is given by other provision of law; (7) an applicant aggrieved by an adverse decision to an application for a hardship waiver under section 256B.15; ~~or~~ (8) except as provided under chapter 245A, an individual or facility determined to have maltreated a minor under section 626.556, after the individual or facility has exercised the right to administrative reconsideration under section 626.556; or (9) except as provided under chapter 245A, an individual disqualified under section 245A.04, subdivision 3d, on the basis of serious or recurring maltreatment; a preponderance of the evidence that the individual has committed an act or acts that meet the definition of any of the crimes listed in section 245A.04, subdivision 3d, paragraph (a), clauses (1) to (4); or for failing to make reports required under section 626.556, subdivision 3, or 626.557, subdivision 3. Hearings regarding a maltreatment determination under clause (4) or (8) and a disqualification under this clause in which the basis for a disqualification is serious or recurring maltreatment, which has not been set aside or rescinded under section 245A.04, subdivision 3b, shall be consolidated into a single fair hearing. In such cases, the scope of review by the human services referee shall include both the maltreatment determination and the disqualification. The failure to exercise the right to an administrative reconsideration shall not be a bar to a hearing under this section if federal law provides an individual the right to a hearing to dispute a finding of maltreatment. Individuals and organizations specified in this section may contest the specified action, decision, or final disposition before the state agency by submitting a written request for a hearing to the state agency within 30 days after receiving written notice of the action, decision, or final disposition, or within 90 days of such written notice if the applicant, recipient, patient, or relative shows good cause why the request was not submitted within the 30-day time limit.

The hearing for an individual or facility under clause (4) ~~or~~, (8), or (9) is the only administrative appeal to the final agency determination specifically, including a challenge to the accuracy and completeness of data under section 13.04. Hearings requested under clause (4) apply only to incidents of maltreatment that occur on or after October 1, 1995. Hearings requested by nursing assistants in nursing homes alleged to have maltreated a resident prior to October 1, 1995, shall be held as a contested case proceeding under the provisions of chapter 14. Hearings requested under clause (8) apply only to incidents of maltreatment that occur on or after July 1, 1997. A hearing for an individual or facility under clause (8) is only available when there is no juvenile court or adult criminal action pending. If such action is filed in either court while an administrative review is pending, the administrative review must be suspended until the judicial actions are completed. If the juvenile court action or criminal charge is dismissed or the criminal action overturned, the matter may be considered in an administrative hearing.

For purposes of this section, bargaining unit grievance procedures are not an administrative appeal.

The scope of hearings involving claims to foster care payments under clause (5) shall be limited to the issue of whether the county is legally responsible for a child's placement under court order or voluntary placement agreement and, if so, the correct amount of foster care payment to be made on the child's behalf and shall not include review of the propriety of the county's child protection determination or child placement decision.

(b) A vendor of medical care as defined in section 256B.02, subdivision 7, or a vendor under contract with a county agency to provide social services under section 256E.08, subdivision 4, is not a party and may not request a hearing under this section, except if assisting a recipient as provided in subdivision 4.

(c) An applicant or recipient is not entitled to receive social services beyond the services included in the amended community social services plan developed under section 256E.081, subdivision 3, if the county agency has met the requirements in section 256E.081.

(d) The commissioner may summarily affirm the county or state agency's proposed action without a hearing when the sole issue is an automatic change due to a change in state or federal law.

**[EFFECTIVE DATE.]** This section is effective January 1, 2002.

Sec. 16. Minnesota Statutes 2000, section 256.045, subdivision 3b, is amended to read:

Subd. 3b. [STANDARD OF EVIDENCE FOR MALTREATMENT AND DISQUALIFICATION HEARINGS.] The state human services referee shall determine that maltreatment has occurred if a preponderance of evidence exists to support the final disposition under sections 626.556 and 626.557. For purposes of hearings regarding disqualification, the state human services referee shall affirm the proposed disqualification in an appeal under subdivision 3, paragraph (a), clause (9), if a preponderance of the evidence shows the individual has:

(1) committed maltreatment under section 626.556 or 626.557, which is serious or recurring;

(2) committed an act or acts meeting the definition of any of the crimes listed in section 245A.04, subdivision 3d, paragraph (a), clauses (1) to (4); or

(3) failed to make required reports under section 626.556 or 626.557 for incidents in which:

(i) the final disposition under section 626.556 or 626.557 was substantiated maltreatment; and

(ii) the maltreatment was recurring or serious; or substantiated serious or recurring maltreatment of a minor under section 626.556 or of a vulnerable adult under section 626.557 for which there is a preponderance of evidence that the maltreatment occurred, and that the subject was responsible for the maltreatment. If the disqualification is affirmed, the state human services referee shall determine whether the individual poses a risk of harm in accordance with the requirements of section 245A.04, subdivision 3b.

The state human services referee shall recommend an order to the commissioner of health or human services, as applicable, who shall issue a final order. The commissioner shall affirm, reverse, or modify the final disposition. Any order of the commissioner issued in accordance with this subdivision is conclusive upon the parties unless appeal is taken in the manner provided in subdivision 7. Except as provided under section 245A.04, subdivisions 3b, paragraphs (e) and (f); and 3c, in any licensing appeal under chapter 245A and sections 144.50 to 144.58 and 144A.02 to 144A.46, the commissioner's determination as to maltreatment is conclusive.

**[EFFECTIVE DATE.]** This section is effective January 1, 2002.

Sec. 17. Minnesota Statutes 2000, section 256.045, subdivision 4, is amended to read:

Subd. 4. [CONDUCT OF HEARINGS.] (a) All hearings held pursuant to subdivision 3, 3a, 3b, or 4a shall be conducted according to the provisions of the federal Social Security Act and the regulations implemented in accordance with that act to enable this state to qualify for federal grants-in-aid, and according to the rules and written policies of the commissioner of human services. County agencies shall install equipment necessary to conduct telephone hearings. A state human services referee may schedule a telephone conference hearing when the distance or time required to travel to the county agency offices will cause a delay in the issuance of an order, or to promote efficiency, or at the mutual request of the parties. Hearings may be conducted by telephone conferences unless the applicant, recipient, former recipient, person, or facility contesting maltreatment objects. The hearing shall not be held earlier than five days after filing of the required notice with the county or state agency. The state human services referee shall notify all interested persons of the time, date, and location of the hearing at least five days before the date of the hearing. Interested persons may be represented by legal counsel or other representative of their choice, including a provider of therapy services, at the hearing and may appear personally, testify and offer evidence, and examine and cross-examine witnesses. The applicant, recipient, former recipient, person, or facility contesting maltreatment shall have the opportunity to examine the contents of the case file and all documents and records to be used by the county or state agency at the hearing at a reasonable time before the date of the hearing and during the hearing. In hearings under subdivision 3, paragraph (a), clauses (4) ~~and~~, (8), and (9), either party may subpoena the private data relating to the investigation prepared by the agency under section 626.556 or 626.557 that is not otherwise accessible under section 13.04, provided the identity of the reporter may not be disclosed.

(b) The private data obtained by subpoena in a hearing under subdivision 3, paragraph (a), clause (4) ~~or~~, (8), or (9), must be subject to a protective order which prohibits its disclosure for any other purpose outside the hearing provided for in this section without prior order of the district court. Disclosure without court order is punishable by a sentence of not more than 90 days imprisonment or a fine of not more than $700, or both. These restrictions on the use of private data do not prohibit access to the data under section 13.03, subdivision 6. Except for appeals under subdivision 3, paragraph (a), clauses (4), (5), ~~and~~ (8), and (9), upon request, the county agency shall provide reimbursement for transportation, child care, photocopying, medical assessment, witness fee, and other necessary and reasonable costs incurred by the applicant, recipient, or former recipient in connection with the appeal. All evidence, except that privileged by law, commonly accepted by reasonable people in the conduct of their affairs as having probative value with respect to the issues shall be submitted at the hearing and such hearing shall not be "a contested case" within the meaning of section 14.02, subdivision 3. The agency must present its evidence prior to or at the hearing, and may not submit evidence after the hearing except by agreement of the parties at the hearing, provided the petitioner has the opportunity to respond.

**[EFFECTIVE DATE.]** This section is effective January 1, 2002.

Sec. 18. Minnesota Statutes 2000, section 626.556, subdivision 3, is amended to read:

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

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

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

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

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

(c) A person mandated to report physical or sexual child abuse or neglect occurring within a licensed facility shall report the information to the agency specified under subdivisions 3b and 3c as responsible for ~~licensing the~~ assessing or investigating a facility licensed under sections 144.50 to 144.58; a facility licensed under section 241.021; ~~245A.01 to 245A.16; or 245B, or~~ a facility licensed under chapter 245A; a school as defined in ~~sections~~ section 120A.05, subdivisions 9, 11, and 13~~; and~~, or section 124D.10; or a nonlicensed personal care provider organization as defined

in ~~sections~~ section 256B.04, subdivision 16~~; and~~, or section 256B.0625, subdivision 19. ~~A health or corrections~~ An agency receiving a report may request the local welfare agency to provide assistance pursuant to subdivisions 10, 10a, and 10b.

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

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

**[EFFECTIVE DATE.]** This section is effective July 1, 2001.

Sec. 19. Minnesota Statutes 2000, section 626.556, subdivision 3c, is amended to read:

Subd. 3c. [AGENCY RESPONSIBLE FOR ASSESSING OR INVESTIGATING REPORTS OF MALTREATMENT.] The following agencies are the administrative agencies responsible for assessing or investigating reports of alleged child maltreatment in facilities made under this section:

(1) the county local welfare agency is the agency responsible for assessing or investigating allegations of maltreatment in child foster care, family child care, and legally unlicensed child care ~~and~~;

(2) the department of human services is the agency responsible for assessing or investigating allegations of maltreatment in juvenile correctional facilities licensed under section 241.021 ~~located in the local welfare agency's county~~;

~~(2)~~ (3) the department of human services is the agency responsible for assessing or investigating allegations of maltreatment in facilities licensed under chapters 245A and 245B, except for child foster care and family child care; and

~~(3)~~ (4) the department of health is the agency responsible for assessing or investigating allegations of child maltreatment in facilities licensed under sections 144.50 to 144.58, and in unlicensed home health care.

**[EFFECTIVE DATE.]** This section is effective July 1, 2001.

Sec. 20. Minnesota Statutes 2000, section 626.556, subdivision 10b, is amended to read:

Subd. 10b. [DUTIES OF COMMISSIONER; NEGLECT OR ABUSE IN FACILITY.] (a) This section applies to the commissioners of human services, health, and children, families, and learning. The commissioner of the agency responsible for assessing or investigating the report shall immediately investigate if the report alleges that:

(1) a child who is in the care of a facility as defined in subdivision 2 is neglected, physically abused, or sexually abused by an individual in that facility, or has been so neglected or abused by an individual in that facility within the three years preceding the report; or

(2) a child was neglected, physically abused, or sexually abused by an individual in a facility defined in subdivision 2, while in the care of that facility within the three years preceding the report.

The commissioner of the agency responsible for assessing or investigating the report shall arrange for the transmittal to the commissioner of reports received by local agencies and may delegate to a local welfare agency the duty to investigate reports. In conducting an investigation under this section, the commissioner has the powers and duties specified for local welfare agencies under this section. The commissioner of the agency responsible for assessing or investigating the

report or local welfare agency may interview any children who are or have been in the care of a facility under investigation and their parents, guardians, or legal custodians.

(b) Prior to any interview, the commissioner of the agency responsible for assessing or investigating the report or local welfare agency shall notify the parent, guardian, or legal custodian of a child who will be interviewed in the manner provided for in subdivision 10d, paragraph (a). If reasonable efforts to reach the parent, guardian, or legal custodian of a child in an out-of-home placement have failed, the child may be interviewed if there is reason to believe the interview is necessary to protect the child or other children in the facility. The commissioner of the agency responsible for assessing or investigating the report or local agency must provide the information required in this subdivision to the parent, guardian, or legal custodian of a child interviewed without parental notification as soon as possible after the interview. When the investigation is completed, any parent, guardian, or legal custodian notified under this subdivision shall receive the written memorandum provided for in subdivision 10d, paragraph (c).

(c) In conducting investigations under this subdivision the ~~commissioner or local welfare~~ agency responsible for assessing or investigating the report shall ~~obtain~~ be given access to information consistent with subdivision 10, paragraphs (g), (h), (i), and (j), and shall be granted the same access to the facility as the facility's licensing agency under the corresponding facility licensing statute. A facility that denies the investigating agency access to this information shall be subject to a negative licensing action by the appropriate licensing agency. When the agency responsible for assessing or investigating a report under this section and the licensing agency for the facility involved are not the same agency, the investigating agency and the licensing agency may share not public data as necessary to complete the investigation or to determine appropriate licensing action.

(d) Except for foster care and family child care, the commissioner has the primary responsibility for the investigations and notifications required under subdivisions 10d and 10f for reports that allege maltreatment related to the care provided by or in facilities licensed by the commissioner. The commissioner may request assistance from the local social services agency.

**[EFFECTIVE DATE.]** This section is effective July 1, 2001.

Sec. 21. Minnesota Statutes 2000, section 626.556, subdivision 10i, is amended to read:

Subd. 10i. [ADMINISTRATIVE RECONSIDERATION OF FINAL DETERMINATION OF MALTREATMENT AND DISQUALIFICATION BASED ON SERIOUS OR RECURRING MALTREATMENT.] (a) Except as provided under paragraph (e), an individual or facility that the commissioner or a local social service agency determines has maltreated a child, or the child's designee, regardless of the determination, who contests the investigating agency's final determination regarding maltreatment, may request the investigating agency to reconsider its final determination regarding maltreatment. The request for reconsideration must be submitted in writing to the investigating agency within 15 calendar days after receipt of notice of the final determination regarding maltreatment. An individual who was determined to have maltreated a child under this section and who was disqualified on the basis of serious or recurring maltreatment under section 245A.04, subdivision 3d, may request reconsideration of the maltreatment determination and the disqualification. The request for reconsideration of the maltreatment determination and the disqualification must be submitted within 30 calendar days of the individual's receipt of the notice of disqualification under section 245A.04, subdivision 3a.

(b) Except as provided under paragraphs (e) and (f), if the investigating agency denies the request or fails to act upon the request within 15 calendar days after receiving the request for reconsideration, the person or facility entitled to a fair hearing under section 256.045 may submit to the commissioner of human services a written request for a hearing under that section.

(c) If, as a result of the reconsideration, the investigating agency changes the final determination of maltreatment, that agency shall notify the parties specified in subdivisions 10b, 10d, and 10f.

(d) Except as provided under paragraph (f), if an individual or facility contests the investigating

agency's final determination regarding maltreatment by requesting a fair hearing under section 256.045, the commissioner of human services shall assure that the hearing is conducted and a decision is reached within 90 days of receipt of the request for a hearing. The time for action on the decision may be extended for as many days as the hearing is postponed or the record is held open for the benefit of either party.

(e) If an individual was disqualified under section 245A.04, subdivision 3d, on the basis of a determination of maltreatment, which was serious or recurring, and the individual has requested reconsideration of the maltreatment determination under paragraph (a) and requested reconsideration of the disqualification under section 245A.04, subdivision 3b, reconsideration of the maltreatment determination and reconsideration of the disqualification shall be consolidated into a single reconsideration. If an individual disqualified on the basis of a determination of maltreatment, which was serious or recurring requests a fair hearing under paragraph (b), the scope of the fair hearing shall include the maltreatment determination and the disqualification.

(f) If a maltreatment determination or a disqualification based on serious or recurring maltreatment is the basis for a denial of a license under section 245A.05 or a licensing sanction under section 245A.07, the license holder has the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8510 to 1400.8612 and successor rules. As provided for under section 245A.08, subdivision 2a, the scope of the contested case hearing shall include the maltreatment determination, disqualification, and licensing sanction or denial of a license. In such cases, a fair hearing regarding the maltreatment determination shall not be conducted under paragraph (b). If the disqualified subject is an individual other than the license holder and upon whom a background study must be conducted under section 245A.04, subdivision 3, the hearings of all parties may be consolidated into a single contested case hearing upon consent of all parties and the administrative law judge.

**[EFFECTIVE DATE.]** This section is effective January 1, 2002.

Sec. 22. Minnesota Statutes 2000, section 626.557, subdivision 3, is amended to read:

Subd. 3. [TIMING OF REPORT.] (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:

(1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or

(2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4).

(b) A person not required to report under the provisions of this section may voluntarily report as described above.

(c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.

(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.

(e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c.

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

Sec. 23. Minnesota Statutes 2000, section 626.557, subdivision 9d, is amended to read:

Subd. 9d. [ADMINISTRATIVE RECONSIDERATION OF FINAL DISPOSITION OF MALTREATMENT AND DISQUALIFICATION BASED ON SERIOUS OR RECURRING MALTREATMENT; REVIEW PANEL.] (a) Except as provided under paragraph (e), any individual or facility which a lead agency determines has maltreated a vulnerable adult, or the vulnerable adult or an interested person acting on behalf of the vulnerable adult, regardless of the lead agency's determination, who contests the lead agency's final disposition of an allegation of maltreatment, may request the lead agency to reconsider its final disposition. The request for reconsideration must be submitted in writing to the lead agency within 15 calendar days after receipt of notice of final disposition or, if the request is made by an interested person who is not entitled to notice, within 15 days after receipt of the notice by the vulnerable adult or the vulnerable adult's legal guardian. An individual who was determined to have maltreated a vulnerable adult under this section and who was disqualified on the basis of serious or recurring maltreatment under section 245A.04, subdivision 3d, may request reconsideration of the maltreatment determination and the disqualification. The request for reconsideration of the maltreatment determination and the disqualification must be submitted within 30 calendar days of the individual's receipt of the notice of disqualification under section 245A.04, subdivision 3a.

(b) Except as provided under paragraphs (e) and (f), if the lead agency denies the request or fails to act upon the request within 15 calendar days after receiving the request for reconsideration, the person or facility entitled to a fair hearing under section 256.045, may submit to the commissioner of human services a written request for a hearing under that statute. The vulnerable adult, or an interested person acting on behalf of the vulnerable adult, may request a review by the vulnerable adult maltreatment review panel under section 256.021 if the lead agency denies the request or fails to act upon the request, or if the vulnerable adult or interested person contests a reconsidered disposition. The lead agency shall notify persons who request reconsideration of their rights under this paragraph. The request must be submitted in writing to the review panel and a copy sent to the lead agency within 30 calendar days of receipt of notice of a denial of a request for reconsideration or of a reconsidered disposition. The request must specifically identify the aspects of the agency determination with which the person is dissatisfied.

(c) If, as a result of a reconsideration or review, the lead agency changes the final disposition, it shall notify the parties specified in subdivision 9c, paragraph (d).

(d) For purposes of this subdivision, "interested person acting on behalf of the vulnerable adult" means a person designated in writing by the vulnerable adult to act on behalf of the vulnerable adult, or a legal guardian or conservator or other legal representative, a proxy or health care agent appointed under chapter 145B or 145C, or an individual who is related to the vulnerable adult, as defined in section 245A.02, subdivision 13.

(e) If an individual was disqualified under section 245A.04, subdivision 3d, on the basis of a determination of maltreatment, which was serious or recurring, and the individual has requested reconsideration of the maltreatment determination under paragraph (a) and reconsideration of the disqualification under section 245A.04, subdivision 3b, reconsideration of the maltreatment determination and requested reconsideration of the disqualification shall be consolidated into a single reconsideration. If an individual who was disqualified on the basis of serious or recurring maltreatment requests a fair hearing under paragraph (b), the scope of the fair hearing shall include the maltreatment determination and the disqualification.

(f) If a maltreatment determination or a disqualification based on serious or recurring maltreatment is the basis for a denial of a license under section 245A.05 or a licensing sanction under section 245A.07, the license holder has the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8510 to 1400.8612 and successor rules. As provided for under section 245A.08, the scope of the contested case hearing shall include the maltreatment determination, disqualification, and licensing sanction or denial of a license. In such cases, a fair hearing shall not be conducted under paragraph (b). If the disqualified subject is an individual other than the license holder and upon whom a background study must be conducted under section

245A.04, subdivision 3, the hearings of all parties may be consolidated into a single contested case hearing upon consent of all parties and the administrative law judge.

(g) Until August 1, 2002, an individual or facility that was determined by the commissioner of human services or the commissioner of health to be responsible for neglect under section 626.5572, subdivision 17, after October 1, 1995, and before August 1, 2001, that believes that the finding of neglect does not meet an amended definition of neglect may request a reconsideration of the determination of neglect. The commissioner of human services or the commissioner of health shall mail a notice to the last known address of individuals who are eligible to seek this reconsideration. The request for reconsideration must state how the established findings no longer meet the elements of the definition of neglect. The commissioner shall review the request for reconsideration and make a determination within 15 calendar days. The commissioner's decision on this reconsideration is the final agency action.

(1) For purposes of compliance with the data destruction schedule under subdivision 12b, paragraph (d), when a finding of substantiated maltreatment has been changed as a result of a reconsideration under this paragraph, the date of the original finding of a substantiated maltreatment must be used to calculate the destruction date.

(2) For purposes of any background studies under section 245A.04, when a determination of substantiated maltreatment has been changed as a result of a reconsideration under this paragraph, any prior disqualification of the individual under section 245A.04 that was based on this determination of maltreatment shall be rescinded, and for future background studies under section 245A.04 the commissioner must not use the previous determination of substantiated maltreatment as a basis for disqualification or as a basis for referring the individual's maltreatment history to a health-related licensing board under section 245A.04, subdivision 3d, paragraph (b).

**[EFFECTIVE DATE.]** Paragraph (g) of this section is effective the day following final enactment. Paragraphs (a), (b), (e), and (f) are effective January 1, 2002.

Sec. 24. Minnesota Statutes 2000, section 626.5572, subdivision 17, is amended to read:

Subd. 17. [NEGLECT.] "Neglect" means:

(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

(c) For purposes of this section, a vulnerable adult is not neglected for the sole reason that:

(1) the vulnerable adult or a person with authority to make health care decisions for the vulnerable adult under sections 144.651, 144A.44, chapter 145B, 145C, or 252A, or section 253B.03, or 525.539 to 525.6199, refuses consent or withdraws consent, consistent with that authority and within the boundary of reasonable medical practice, to any therapeutic conduct, including any care, service, or procedure to diagnose, maintain, or treat the physical or mental condition of the vulnerable adult, or, where permitted under law, to provide nutrition and hydration parenterally or through intubation; this paragraph does not enlarge or diminish rights otherwise held under law by:

(i) a vulnerable adult or a person acting on behalf of a vulnerable adult, including an involved family member, to consent to or refuse consent for therapeutic conduct; or

(ii) a caregiver to offer or provide or refuse to offer or provide therapeutic conduct; or

(2) the vulnerable adult, a person with authority to make health care decisions for the vulnerable adult, or a caregiver in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the vulnerable adult in lieu of medical care, provided that this is consistent with the prior practice or belief of the vulnerable adult or with the expressed intentions of the vulnerable adult;

(3) the vulnerable adult, who is not impaired in judgment or capacity by mental or emotional dysfunction or undue influence, engages in sexual contact with:

(i) a person including a facility staff person when a consensual sexual personal relationship existed prior to the caregiving relationship; or

(ii) a personal care attendant, regardless of whether the consensual sexual personal relationship existed prior to the caregiving relationship; or

(4) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult which~~: (i)~~ does not result in injury or harm which reasonably requires medical or mental health care; or~~, if it reasonably requires care,~~

(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm which reasonably requires the care of a physician; and:

(i) the necessary care is ~~sought and~~ provided in a timely fashion as dictated by the condition of the vulnerable adult; ~~and~~ (ii) the injury or harm that required care does not result in ~~substantial acute, or~~ chronic injury or illness, or permanent disability above and beyond the vulnerable adult's preexisting condition;

~~(ii) is~~ (iii) the error is not part of a pattern of errors by the individual;

(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally ~~by the employee or person providing services~~ in the facility ~~in order to evaluate and identify corrective action~~;

(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and

~~(iii) is~~ (vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency~~; and~~.

~~(iv) is not part of a pattern of errors by the individual.~~

(d) Nothing in this definition requires a caregiver, if regulated, to provide services in excess of those required by the caregiver's license, certification, registration, or other regulation.

(e) If the findings of an investigation by a lead agency result in a determination of substantiated maltreatment for the sole reason that the actions required of a facility under paragraph (c), clause (5), item (iv), (v), or (vi), were not taken, then the facility is subject to a correction order. This must not alter the lead agency's determination of mitigating factors under section 626.557, subdivision 9c, paragraph (c).

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

Sec. 25. [FEDERAL LAW CHANGE REQUEST OR WAIVER.]

The commissioner of health or human services, whichever is appropriate, shall pursue changes to federal law necessary to allow greater discretion on disciplinary activities of unlicensed health care workers and apply for necessary federal waivers or approval that would allow for a set-aside process related to disqualifications for nurse aides in nursing homes by July 1, 2002.

**[EFFECTIVE DATE.]** This section is effective July 1, 2001.

Sec. 26. [WAIVER FROM FEDERAL RULES AND REGULATIONS.]

By January 2002, the commissioner of health shall work with providers to examine federal rules and regulations prohibiting neglect, abuse, and financial exploitation of residents in licensed nursing facilities and shall apply for federal waivers to:

(1) allow the use of Minnesota Statutes, section 626.5572, to control the identification and prevention of maltreatment of residents in licensed nursing facilities, rather than the definitions under federal rules and regulations; and

(2) allow the use of Minnesota Statutes, sections 214.104, 245A.04, and 626.557 to control the disqualification or discipline of any persons providing services to residents in licensed nursing facilities, rather than the nurse aide registry or other exclusionary provisions of federal rules and regulations.

**[EFFECTIVE DATE.]** This section is effective July 1, 2001.

ARTICLE 12

MISCELLANEOUS

Section 1. Minnesota Statutes 2000, section 144.1222, is amended by adding a subdivision to read:

Subd. 2a. [POOLS AT FAMILY DAY CARE OR GROUP FAMILY DAY CARE HOMES.] Notwithstanding Minnesota Rules, part 4717.0250, subpart 8, a pool that is located at a family day care or group family day care home licensed under Minnesota Rules, chapter 9502, shall not be considered a public pool, and is exempt from the requirements for public pools in Minnesota Rules, parts 4717.0150 to 4717.3975. If the provider chooses to allow children cared for at the family day care or group family day care home to use the pool located at the home, the provider must satisfy the requirements in section 245A.14, subdivision 10.

Sec. 2. Minnesota Statutes 2000, section 148B.21, subdivision 6a, is amended to read:

Subd. 6a. [BACKGROUND CHECKS.] The board shall request a criminal history background check from the superintendent of the bureau of criminal apprehension on all applicants for initial licensure. An application for a license under this section must be accompanied by an executed criminal history consent form and the fee for conducting the criminal history background check. The board shall deposit all fees paid by applicants for criminal history background checks under this subdivision into the miscellaneous special revenue fund and shall reimburse the bureau of criminal apprehension for the cost of the background checks upon their completion.

Sec. 3. Minnesota Statutes 2000, section 148B.22, subdivision 3, is amended to read:

Subd. 3. [BACKGROUND CHECKS.] The board shall request a criminal history background check from the superintendent of the bureau of criminal apprehension on all licensees under its jurisdiction who did not complete a criminal history background check as part of an application for initial licensure. This background check is a one-time requirement. An application for a license under this section must be accompanied by an executed criminal history consent form and the fee for conducting the criminal history background check. The board shall deposit all fees paid by licensees for criminal history background checks under this subdivision into the miscellaneous special revenue fund and shall reimburse the bureau of criminal apprehension for the cost of the background checks upon their completion.

Sec. 4. Minnesota Statutes 2000, section 245A.14, is amended by adding a subdivision to read:

Subd. 10. [SWIMMING POOLS; FAMILY DAY CARE AND GROUP FAMILY DAY CARE PROVIDERS.] (a) This subdivision governs pools located at family day care or group family day care homes licensed under Minnesota Rules, chapter 9502. This subdivision does not apply to portable wading pools or whirlpools located at family day care or group family day care

homes licensed under Minnesota Rules, chapter 9502. For a provider to be eligible to allow a child cared for at the family day care or group family day care home to use the pool located at the home, the provider must not have had a licensing sanction under section 245A.07 or a correction order or fine under section 245A.06 relating to the supervision or health and safety of children substantiated by the county agency during the prior 24 months, and must satisfy the following requirements:

(1) obtain written consent from a child's parent or legal guardian allowing the child to use the pool, and renew the parent's or legal guardian's written consent at least annually. The written consent must include a statement that the parent or legal guardian has received and read materials provided by the department of health to the department of human services for distribution to all family day care or group family day care homes related to the risk of disease transmission as well as other health risks associated with swimming pools. The written consent must also include a statement that the department of health and county agency will not monitor or inspect the provider's swimming pool to ensure compliance with the requirements in this subdivision;

(2) enter into a written contract with a child's parent or legal guardian, and renew the written contract annually. The terms of the written contract must specify that the provider agrees to perform all of the requirements in this subdivision;

(3) attend and successfully complete a pool operator training course once every five years. Acceptable training courses are:

(i) the National Swimming Pool Foundation Certified Pool Operator course;

(ii) the National Spa and Pool Institute Tech I and Tech II courses (both required); or

(iii) the National Recreation and Park Association Aquatic Facility Operator course;

(4) require a caregiver trained in first aid and adult and child cardiopulmonary resuscitation to supervise and be present at the pool with any children in the pool;

(5) toilet all potty-trained children before they enter the pool;

(6) require all children who are not potty-trained to wear swim diapers while in the pool;

(7) if fecal material enters the pool water, add three times the normal shock treatment to the pool water to raise the chlorine level to at least 20 parts per million, and close the pool to swimming for the 24 hours following the entrance of fecal material into the water or until the water pH and disinfectant concentration levels have returned to the standards specified in clause (9), whichever is later;

(8) prevent any child from entering the pool who has an open wound or any child who has or is suspected of having a communicable disease;

(9) maintain the pool water at a pH of not less than 7.2 and not more than 8.0, maintain the disinfectant concentration between two and five parts per million for chlorine or between 2.3 and 4.5 parts per million for bromine, and maintain a daily record of the pool's operation with pH and disinfectant concentration readings on days when children cared for at the family day care or group family day care home are present;

(10) have a disinfectant feeder or feeders;

(11) have a recirculation system that will clarify and disinfect the pool volume of water in ten hours or less;

(12) maintain the pool's water clarity so that an object on the pool floor at the pool's deepest point is easily visible;

(13) have two or more suction lines in the pool;

(14) have in place and enforce written safety rules and pool policies;

(15) prohibit diving;

(16) prohibit pushing or rough play in the pool area;

(17) have in place at all times a safety rope that divides the shallow and deep portions of the pool;

(18) satisfy any existing local ordinances regarding pool installation, decks, and fencing;

(19) maintain a water temperature of not more than 104 degrees Fahrenheit and not less than 70 degrees Fahrenheit; and

(20) for lifesaving equipment, have a United States Coast Guard-approved life ring attached to a rope, an exit ladder, and a shepherd's hook available at all times to the caregiver supervising the pool.

(b) A violation of this subdivision is grounds for a sanction under section 245A.07, or a correction order or fine under section 245A.06. If a provider under this subdivision receives a licensing sanction or a correction order or fine relating to the supervision or health and safety of children, the provider is prohibited from allowing a child cared for at the family day care or group family day care home to continue to use the pool located at the home.

Sec. 5. Minnesota Statutes 2000, section 246.57, is amended by adding a subdivision to read:

Subd. 7. [SHARED SERVICES ACCOUNT.] Notwithstanding subdivision 1, beginning July 1, 2001, $6,000,000 each biennium is transferred from the shared services account into which receipts for shared services under subdivision 1 are deposited to the general fund. This subdivision expires June 30, 2005.

Sec. 6. Minnesota Statutes 2000, section 252A.02, is amended by adding a subdivision to read:

Subd. 3a. [GUARDIANSHIP SERVICE PROVIDERS.] "Guardianship service providers" are individuals or agencies that meet the ethical conduct and best practice standards of the National Guardianship Association, meet the criminal background check requirements of section 245A.04, and do not provide any other services to the individuals for whom guardianship services are provided.

Sec. 7. Minnesota Statutes 2000, section 252A.02, subdivision 12, is amended to read:

Subd. 12. [COMPREHENSIVE EVALUATION.] "Comprehensive evaluation" shall consist of:

(1) a medical report on the health status and physical condition of the proposed ward, prepared under the direction of a licensed physician;

(2) a report on the proposed ward's intellectual capacity and functional abilities, specifying the tests and other data used in reaching its conclusions, prepared by a psychologist who is qualified in the diagnosis of mental retardation; and

(3) a report from the case manager that includes:

(i) the most current assessment of individual service needs as described in rules of the commissioner;

(ii) the most current individual service plan ~~as described in rules of the commissioner~~ under section 256B.092, subdivision 1b; and

(iii) a description of contacts with and responses of near relatives of the proposed ward notifying them that a nomination for public guardianship has been made and advising them that they may seek private guardianship.

Each report shall contain recommendations as to the amount of assistance and supervision

required by the proposed ward to function as independently as possible in society. To be considered part of the comprehensive evaluation, reports must be completed no more than one year before filing the petition under section 252A.05.

Sec. 8. Minnesota Statutes 2000, section 252A.02, subdivision 13, is amended to read:

Subd. 13. [CASE MANAGER.] "Case manager" means the person designated ~~by the county board under rules of the commissioner to provide case management services~~ under section 256B.092.

Sec. 9. Minnesota Statutes 2000, section 252A.111, subdivision 6, is amended to read:

Subd. 6. [SPECIAL DUTIES.] In exercising powers and duties under this chapter, the commissioner shall:

(1) maintain close contact with the ward, visiting at least twice a year;

(2) ~~prohibit filming a ward in any way that would reveal the identity of the ward unless the commissioner determines the filming to be in the best interests of the ward. The commissioner may give written consent for filming of the ward after permitting and encouraging input by the nearest relative~~ protect and exercise the legal rights of the ward;

(3) take actions and make decisions on behalf of the ward that encourage and allow the maximum level of independent functioning in a manner least restrictive of the ward's personal freedom consistent with the need for supervision and protection; and

(4) permit and encourage maximum self-reliance on the part of the ward and permit and encourage input by the nearest relative of the ward in planning and decision making on behalf of the ward.

Sec. 10. Minnesota Statutes 2000, section 252A.16, subdivision 1, is amended to read:

Subdivision 1. [REVIEW REQUIRED.] The commissioner shall ~~provide~~ require an annual review of the physical, mental, and social adjustment and progress of every ward and conservatee. A copy of this review shall be kept on file at the department of human services and may be inspected by the ward or conservatee, the ward's or conservatee's parents, spouse, or relatives and other persons who receive the permission of the commissioner. The review shall contain information required under ~~rules of the commissioner~~ Minnesota Rules, part 9525.3065, subpart 1.

Sec. 11. Minnesota Statutes 2000, section 252A.19, subdivision 2, is amended to read:

Subd. 2. [PETITION.] The commissioner, ward, or any interested person may petition the appointing court or the court to which venue has been transferred for an order to remove the guardianship or to limit or expand the powers of the conservatorship or to appoint a guardian or conservator under sections 525.539 to 525.705 or to restore the ward or conservatee to full legal capacity or to review de novo any decision made by the public guardian or public conservator for or on behalf of a ward or conservatee or for any other order as the court may deem just and equitable. Section 525.61, subdivision 3, does not apply to a petition to remove a public guardian.

Sec. 12. Minnesota Statutes 2000, section 252A.20, subdivision 1, is amended to read:

Subdivision 1. [WITNESS AND ATTORNEY FEES.] In each proceeding under sections 252A.01 to 252A.21, the court shall allow and order paid to each witness subpoenaed the fees and mileage prescribed by law; to each physician, psychologist, or social worker who assists in the preparation of the comprehensive evaluation and who is not in the employ of the local agency~~,~~ or the state department of human services, ~~or area mental health-mental retardation board,~~ a reasonable sum for services and for travel; and to the ward's counsel, when appointed by the court, a reasonable sum for travel and for each day or portion of a day actually employed in court or actually consumed in preparing for the hearing. Upon order the county auditor shall issue a warrant on the county treasurer for payment of the amount allowed.

Sec. 13. Minnesota Statutes 2000, section 256.482, subdivision 8, is amended to read:

Subd. 8. [SUNSET.] Notwithstanding section 15.059, subdivision 5, the council on disability shall not sunset until June 30, ~~2001~~ 2005.

Sec. 14. [PUBLIC GUARDIANSHIP ALTERNATIVES.]

The commissioner of human services shall provide county agencies with funds up to the amount appropriated for public guardianship alternatives based on proposals by the counties to establish private alternatives.

Sec. 15. [AUTOMATIC DEFIBRILLATOR STUDY.]

The emergency medical services regulatory board, in consultation with the department of public safety, shall study and report to the legislature by December 15, 2002, regarding the availability of automatic defibrillators outside the seven-county metropolitan area. The report shall include recommendations to make these devices accessible within a reasonable distance throughout the nonmetropolitan area, including recommendations for funding their acquisition and distribution.

Sec. 16. [REPEALER.]

Minnesota Statutes 2000, section 252A.111, subdivision 3, is repealed.

ARTICLE 13

APPROPRIATIONS

Section 1. [HEALTH AND HUMAN SERVICES APPROPRIATIONS.]

The sums shown in the columns marked "APPROPRIATIONS" are appropriated from the general fund, or any other named fund, to the agencies and for the purposes specified in the following sections of this article, to be available for the fiscal years indicated for each purpose. The figures "2002" and "2003" where used in this article, mean that the appropriation or appropriations listed under them are available for the fiscal year ending June 30, 2002, or June 30, 2003, respectively. Where a dollar amount appears in parentheses, it means a reduction of an appropriation.

SUMMARY BY FUND

| APPROPRIATIONS | 2002 | 2003 | BIENNIAL TOTAL |
|---|---|---|---|
| General | $3,083,417,000 | $3,390,915,000 | $6,474,332,000 |
| State Government Special Revenue | 35,451,000 | 37,127,000 | 72,578,000 |
| Health Care Access | 214,712,000 | 269,923,000 | 484,635,000 |
| Federal TANF | 318,103,000 | 277,420,000 | 595,523,000 |
| Lottery Cash Flow | 1,300,000 | 1,300,000 | 2,600,000 |
| TOTAL | $3,652,983,000 | $3,976,685,000 | $7,629,668,000 |

| | APPROPRIATIONS Available for the Year Ending June 30 2002 | 2003 |
|---|---|---|
| Sec. 2. COMMISSIONER OF HUMAN SERVICES | | |
| Subdivision 1. Total Appropriation | $3,467,982,000 | $3,792,993,000 |

| Summary by Fund | | |
|---|---|---|
| General | 2,960,188,000 | 3,270,671,000 |
| State Government Special Revenue | 507,000 | 507,000 |
| Health Care Access | 207,884,000 | 263,095,000 |
| Federal TANF | 298,103,000 | 257,420,000 |
| Lottery Cash Flow | 1,300,000 | 1,300,000 |

[APPROPRIATION FOR COURT-ORDERED MENTAL HEALTH TREATMENT.] Of the general fund appropriation, $2,289,000 in fiscal year 2002 and $2,289,000 in fiscal year 2003 are for the cost of implementing H.F. 560, if enacted. This appropriation is available only if H.F. 560 is enacted.

[APPROPRIATIONS FOR CIVIL COMMITMENT.] (a) Of the general fund appropriation, $3,386,000 in fiscal year 2003 is for the cost of implementing H.F. 281, if enacted. This appropriation is available only if H.F. 281 is enacted.

(b) Of the general fund appropriation, $155,000 in fiscal year 2003 is appropriated to the commissioner to be transferred to the Minnesota supreme court for costs associated with petitions filed for judicial commitment. This appropriation is available only if H.F. 281 is enacted.

[APPROPRIATIONS FOR CHILD SUPPORT.] (1) Of the general fund appropriation, $32,000 in fiscal year 2002 and $32,000 in fiscal year 2003 are for the cost of implementing H.F. 1807, if enacted. This appropriation is available only if H.F. 1807 is enacted.

(2) Of the general fund appropriation, $435,000 in fiscal year 2002 is for the cost of implementing H.F. 1446, if enacted. This appropriation is available only if H.F. 1446 is enacted.

[APPROPRIATION FOR PATIENT PROTECTIONS.] (a) Of the general fund appropriation, $248,000 in fiscal year 2002 and $591,000 in fiscal year 2003 are for the cost of implementing the patient protection provisions in H.F. 560, if enacted. This appropriation is available only if H.F. 560 is enacted.

(b) Of the health care access fund appropriation, $106,000 in fiscal year 2002 and $255,000 in fiscal year 2003 are for the cost of implementing H.F. 560, if enacted. This appropriation is available only if H.F. 560 is enacted.

[RECEIPTS FOR SYSTEMS PROJECTS.] Appropriations and federal receipts for information system projects for MAXIS, PRISM, MMIS, and SSIS must be deposited in the state system account authorized in Minnesota Statutes, section 256.014. Money appropriated for computer projects approved by the Minnesota office of technology, funded by the legislature, and approved by the commissioner of finance may be transferred from one project to another and from development to operations as the commissioner of human services considers necessary. Any unexpended balance in the appropriation for these projects does not cancel but is available for ongoing development and operations.

[GIFTS.] Notwithstanding Minnesota Statutes, chapter 7, the commissioner may accept on behalf of the state additional funding from sources other than state funds for the purpose of financing the cost of assistance program grants or nongrant administration. All additional funding is appropriated to the commissioner for use as designated by the grantor of funding.

[SYSTEMS CONTINUITY.] In the event of disruption of technical systems or computer operations, the commissioner may use available grant appropriations to ensure continuity of payments for maintaining the health, safety, and well-being of clients served by programs administered by the department of human services. Grant funds must be used in a manner consistent with the original intent of the appropriation.

[SPECIAL REVENUE FUND INFORMATION.] On December 1, 2001, and December 1, 2002, the commissioner shall provide the chairs of the house health and human services finance committee and the senate health, human services, and corrections budget division with detailed fund balance information for each special revenue fund account.

[FEDERAL ADMINISTRATIVE REIMBURSEMENT.] Federal administrative reimbursement resulting from MinnesotaCare outreach grants and the Minnesota senior health options project are appropriated to the commissioner for these activities. Any balance from this appropriation remaining at the end of the biennium shall be transferred to the general fund.

[NONFEDERAL SHARE TRANSFERS.] The

nonfederal share of activities for which federal administrative reimbursement is appropriated to the commissioner may be transferred to the special revenue fund. Any balance from this appropriation remaining at the end of the biennium shall be transferred to the general fund.

[MAJOR SYSTEMS TRANSFER.] (1) $21,550,000 of funds available in the state systems account authorized in Minnesota Statutes, section 256.014, is transferred to the general fund for the biennium ending June 30, 2003.

(2) $2,450,000 of funds available in the state systems account authorized in Minnesota Statutes, section 256.014, is transferred to the general fund for the biennium ending June 30, 2005. Notwithstanding section 13 of this article, this rider does not expire on June 30, 2003.

[TANF FUNDS APPROPRIATED TO OTHER ENTITIES.] Any expenditures from the TANF block grant shall be expended in accordance with the requirements and limitations of part A of title IV of the Social Security Act, as amended, and any other applicable federal requirement or limitation. Prior to any expenditure of these funds, the commissioner shall assure that funds are expended in compliance with the requirements and limitations of federal law and that any reporting requirements of federal law are met. It shall be the responsibility of any entity to which these funds are appropriated to implement a memorandum of understanding with the commissioner that provides the necessary assurance of compliance prior to any expenditure of funds. The commissioner shall receipt TANF funds appropriated to other state agencies and coordinate all related interagency accounting transactions necessary to implement these appropriations. Unexpended TANF funds appropriated to any state, local, or nonprofit entity cancel at the end of the state fiscal year unless appropriating language permits otherwise.

[TANF FUNDS TRANSFERRED TO OTHER FEDERAL GRANTS.] The commissioner must authorize transfers from TANF to other federal block grants so that funds are available to meet the annual expenditure needs as appropriated. Transfers may be authorized prior to the expenditure year with the agreement of the receiving entity. Transferred funds must be expended in the year for which the funds were appropriated unless appropriation language

permits otherwise. In accelerating transfer authorizations, the commissioner must aim to preserve the future potential transfer capacity from TANF to other block grants.

[TANF MAINTENANCE OF EFFORT.] (a) In order to meet the basic maintenance of effort (MOE) requirements of the TANF block grant specified under Code of Federal Regulations, title 45, section 263.1, the commissioner may only report nonfederal money expended for allowable activities listed in the following clauses as TANF MOE expenditures:

(1) MFIP cash and food assistance benefits under Minnesota Statutes, chapter 256J;

(2) the child care assistance programs under Minnesota Statutes, sections 119B.03 and 119B.05, and county child care administrative costs under Minnesota Statutes, section 119B.15;

(3) state and county MFIP administrative costs under Minnesota Statutes, chapters 256J and 256K;

(4) state, county, and tribal MFIP employment services under Minnesota Statutes, chapters 256J and 256K; and

(5) expenditures made on behalf of noncitizen MFIP recipients who qualify for the medical assistance without federal financial participation program under Minnesota Statutes, section 256B.06, subdivision 4, paragraphs (d), (e), and (j).

(b) The commissioner shall ensure that sufficient qualified nonfederal expenditures are made each year to meet the state's TANF MOE requirements. For the activities listed in paragraph (a), clauses (2) to (5), the commissioner may only report expenditures that are excluded from the definition of assistance under Code of Federal Regulations, title 45, section 260.31.

(c) If nonfederal expenditures for the programs and purposes listed in paragraph (a) are insufficient to meet the state's TANF MOE requirements, the commissioner shall recommend additional allowable sources of nonfederal expenditures to the legislature, if the legislature is or will be in session to take action to specify additional sources of nonfederal expenditures for TANF MOE before a federal penalty is imposed. The commissioner shall otherwise provide notice to the legislative commission on planning and fiscal policy under paragraph (e).

(d) If the commissioner uses authority granted under Laws 1999, chapter 245, article 1, section 10, or similar authority granted by a subsequent legislature, to meet the state's TANF MOE requirements in a reporting period, the commissioner shall inform the chairs of the appropriate legislative committees about all transfers made under that authority for this purpose.

(e) If the commissioner determines that nonfederal expenditures under paragraph (a) are insufficient to meet TANF MOE expenditure requirements, and if the legislature is not or will not be in session to take timely action to avoid a federal penalty, the commissioner may report nonfederal expenditures from other allowable sources as TANF MOE expenditures after the requirements of this paragraph are met. The commissioner may report nonfederal expenditures in addition to those specified under paragraph (a) as nonfederal TANF MOE expenditures, but only ten days after the commissioner of finance has first submitted the commissioner's recommendations for additional allowable sources of nonfederal TANF MOE expenditures to the members of the legislative commission on planning and fiscal policy for their review.

(f) The commissioner of finance shall not incorporate any changes in federal TANF expenditures or nonfederal expenditures for TANF MOE that may result from reporting additional allowable sources of nonfederal TANF MOE expenditures under the interim procedures in paragraph (e) into the February or November forecasts required under Minnesota Statutes, section 16A.103, unless the commissioner of finance has approved the additional sources of expenditures under paragraph (e).

(g) The provisions of Minnesota Statutes, section 256.011, subdivision 3, which require that federal grants or aids secured or obtained under that subdivision be used to reduce any direct appropriations provided by law, do not apply if the grants or aids are federal TANF funds.

(h) Notwithstanding section 14 of this article, paragraphs (a) to (h) expire June 30, 2005.

Subd. 2. Agency Management

| | | |
|---|---|---|
| General | 34,500,000 | 32,971,000 |
| State Government Special Revenue | 392,000 | 392,000 |

| | | |
|---|---|---|
| Health Care Access | 3,591,000 | 3,602,000 |
| Federal TANF | 546,000 | 454,000 |

The amounts that may be spent from the appropriation for each purpose are as follows:

(a) Financial Operations

| | | |
|---|---|---|
| General | 6,708,000 | 6,708,000 |
| Health Care Access | 803,000 | 803,000 |
| Federal TANF | 546,000 | 454,000 |

(b) Legal and Regulation Operations

| | | |
|---|---|---|
| General | 8,682,000 | 8,305,000 |
| State Government Special Revenue | 392,000 | 392,000 |
| Health Care Access | 233,000 | 244,000 |

[CORE LICENSING ACTIVITIES.] Of the general fund appropriation, $1,138,000 in fiscal year 2002 and $923,000 in fiscal year 2003 is to support 14 new licensor positions. Of this amount, $72,000 in fiscal year 2002 and $107,000 in fiscal year 2003 is to cover maintenance and operational costs for a new computer system, which will provide public access to licensing information. In order to receive continued appropriations for these purposes, by January 1, 2003, the commissioner shall:

(1) reduce the average length of time to complete investigations of licensing complaints within 75 days;

(2) complete all licensing reviews within the one-year and two-year intervals set forth in statutes; and

(3) complete negative licensing action decisions within 45 days of county recommendations.

[EXPEDITED MALTREATMENT INVESTIGATIONS.] Of the general fund appropriation, $359,000 in fiscal year 2002 and $277,000 in fiscal year 2003 are for one senior investigator position, three investigator positions, and one-half of a clerical position to achieve the goals for expedited maltreatment investigations. In order to receive continued appropriations for this purpose, by January 1, 2003, the commissioner shall reduce the average length of time to complete maltreatment investigations to 60 days.

[PUBLIC GUARDIANSHIP INCENTIVES.] Of the general fund appropriation, $250,000 in fiscal year 2002 and $250,000 in fiscal year 2003 is to be used for the purposes of providing fiscal incentives to encourage counties to establish private alternatives.

(c) Management Operations

| | | |
|---|---|---|
| General | 19,110,000 | 17,958,000 |
| Health Care Access | 2,555,000 | 2,555,000 |

Subd. 3. Administrative Reimbursement/ Pass Through

| | | |
|---|---|---|
| Federal TANF | 60,565 | 51,992 |

Subd. 4. Children's Services Grants

| | | |
|---|---|---|
| General | 59,320,000 | 59,833,000 |
| Federal TANF | 6,290,000 | 6,290,000 |

[ADOPTION ASSISTANCE INCENTIVE GRANTS.] Federal funds available during fiscal year 2002 and fiscal year 2003, for adoption incentive grants are appropriated to the commissioner for these purposes.

[TANF TRANSFER TO SOCIAL SERVICES.] $4,650,000 is appropriated to the commissioner in fiscal year 2002 and in fiscal year 2003 for purposes of increasing services for families with children whose incomes are at or below 200 percent of the federal poverty guidelines. The commissioner shall authorize a sufficient transfer of funds from the state's federal TANF block grant to the state's federal social services block grant to meet this appropriation.

[SOCIAL SERVICES BLOCK GRANT FUNDS FOR CONCURRENT PERMANENCY PLANNING.] Notwithstanding Minnesota Statutes, section 256E.07, $4,650,000 in fiscal year 2002 and $4,650,000 in fiscal year 2003 in social services block grant funds allocated to the commissioner under title XX of the Social Security Act are available for distribution to counties under the formula in Minnesota Statutes, section 260C.213, for the purposes of concurrent permanency planning.

Subd. 5. Children's Services Management

| | | |
|---|---|---|
| General | 5,487,000 | 5,487,000 |

Subd. 6. Basic Health Care Grants

Summary by Fund

| | | |
|---|---|---|
| General | 1,114,020,000 | 1,317,641,000 |

| | | |
|---|---|---|
| Health Care Access | 189,392,000 | 244,592,000 |

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) MinnesotaCare Grants

| | | |
|---|---|---|
| Health Care Access | 188,642,000 | 243,842,000 |

[MINNESOTACARE FEDERAL RECEIPTS.] Receipts received as a result of federal participation pertaining to administrative costs of the Minnesota health care reform waiver shall be deposited as nondedicated revenue in the health care access fund. Receipts received as a result of federal participation pertaining to grants shall be deposited in the federal fund and shall offset health care access funds for payments to providers.

[MINNESOTACARE FUNDING.] The commissioner may expend money appropriated from the health care access fund for MinnesotaCare in either fiscal year of the biennium.

(b) MA Basic Health Care Grants - Families and Children

| | | |
|---|---|---|
| General | 433,298,000 | 517,563,000 |

(c) MA Basic Health Care Grants - Elderly and Disabled

| | | |
|---|---|---|
| General | 511,946,000 | 604,451,000 |

[MEDICALLY NEEDY STANDARD AND FEDERAL AUTHORIZATION.] If federal authorization to use the medical assistance income standard in Minnesota Statutes, section 256B.056, subdivision 4, as the medically needy standard is not obtained, the commissioner shall use all resulting savings to provide services under the home and community-based waiver for persons with mental retardation and related conditions.

(d) General Assistance Medical Care

| | | |
|---|---|---|
| General | 155,744,000 | 176,748,000 |

(e) Health Care Grants - Other Assistance

| | | |
|---|---|---|
| General | 13,032,000 | 18,879,000 |
| Health Care Access | 750,000 | 750,000 |

[PURCHASING ALLIANCE STOP-LOSS FUNDING.] Of the general fund appropriation, $150,000 in fiscal year 2002 and $500,000 in

fiscal year 2003 are appropriated to the commissioner for the cost of establishing the Purchasing Alliance Stop-loss fund under Minnesota Statutes, section 256.956.

Subd. 7. Basic Health Care Management

| | | |
|---|---|---|
| General | 20,730,000 | 20,715,000 |
| Health Care Access | 13,583,000 | 13,583,000 |

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) Health Care Policy Administration

| | | |
|---|---|---|
| General | 2,822,000 | 2,862,000 |
| Health Care Access | 562,000 | 562,000 |

(b) Health Care Operations

| | | |
|---|---|---|
| General | 17,908,000 | 17,853,000 |
| Health Care Access | 13,021,000 | 13,021,000 |

[PREPAID MEDICAL PROGRAMS.] The nonfederal share of the prepaid medical assistance program fund, which has been appropriated to fund county managed care advocacy and enrollment operating costs, shall be disbursed as grants using either a reimbursement or block grant mechanism.

Subd. 8. State-Operated Services

| | | |
|---|---|---|
| General | 205,868,000 | 199,287,000 |

The amounts that may be spent from this appropriation for each purpose are as follows:

[MITIGATION RELATED TO STATE-OPERATED SERVICES RESTRUCTURING.] Money appropriated to finance mitigation expenses related to restructuring state-operated services programs and administrative services may be transferred between fiscal years within the biennium.

[STATE-OPERATED SERVICES CHEMICAL DEPENDENCY PROGRAMS.] When the operations of the state-operated services chemical dependency fund created in Minnesota Statutes, section 246.18, subdivision 2, are impeded by projected cash deficiencies resulting from delays in the receipt of grants, dedicated income, or other similar receivables, and when the deficiencies would be corrected within the budget period involved, the commissioner of finance may transfer general fund cash reserves

into this account as necessary to meet cash demands. The cash flow transfers must be returned to the general fund in the fiscal year that the transfer was made. Any interest earned on general fund cash flow transfers accrues to the general fund and not the state-operated services chemical dependency fund.

[STATE-OPERATED SERVICES RESTRUCTURING.] For purposes of restructuring state-operated services, any state-operated services employee whose position is to be eliminated shall be afforded the options provided in applicable collective bargaining agreements. All salary and mitigation allocations from fiscal year 2002 shall be carried forward into fiscal year 2003. Provided there is no conflict with any collective bargaining agreement, any state-operated services position reduction must only be accomplished through mitigation, attrition, transfer, and other measures as provided in state or applicable collective bargaining agreements and in Minnesota Statutes, section 252.50, subdivision 11, and not through layoff.

[REPAIRS AND BETTERMENTS.] The commissioner may transfer unencumbered appropriation balances between fiscal years within the biennium for the state residential facilities repairs and betterments account and special equipment.

Subd. 9. Continuing Care Grants

| | | |
|---|---|---|
| General | 1,366,856,000 | 1,483,268,000 |
| Lottery Cash Flow | 1,158,000 | 1,158,000 |

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) Community Social Services Block Grants

| | |
|---|---|
| 48,718,000 | 49,695,000 |

[CSSA TRADITIONAL APPROPRIATION.] Notwithstanding Minnesota Statutes, section 256E.06, subdivisions 1 and 2, the appropriations available under that section in fiscal years 2002 and 2003 must be distributed to each county proportionately to the aid received by the county in calendar year 2000.

(b) Aging Adult Service Grants

| | |
|---|---|
| 10,300,000 | 10,532,000 |

[COUNTY PLANNING AND SERVICE DEVELOPMENT.] Of this appropriation,

$1,200,000 in fiscal year 2002 and $1,600,000 in fiscal year 2003 are for distribution to county boards for planning and development of community services for the elderly as required under Minnesota Statutes, section 256B.437, subdivision 2. For Phase I funding to develop the initial biennial plan addendum, the commissioner shall distribute a minimum of $10,000 to each county on July 1, 2001. In a county with more than 10,000 persons over 65 years, the funding allocation shall be $15,000; with more than 30,000 persons over 65 years - $20,000; with more than 50,000 persons over 65 years - $25,000; and with more than 100,000 persons over 65 years - $30,000. Upon submission of the completed biennial plan addendum, the commissioner shall distribute Phase II funding to each county for development of community-based services no later than January 1, 2002. For counties with less than 4,500 persons under 65 years, the Phase II allocation shall be $10,000. For counties with more than 4,500 persons over 65 years, the Phase II allocation shall be $2.23 per person over 65 years. Any remaining funds shall be available as targeted funds distributed to counties with designated critical access sites. Phase I funding may be carried over by the county into 2002 and 2003 for the development of services.

(c) Deaf and Hard-of-Hearing Services Grants

1,923,000 1,825,000

[SERVICES TO DEAF PERSONS WITH MENTAL ILLNESS.] Of this appropriation, $100,000 in fiscal year 2002 and $100,000 in fiscal year 2003 is for a grant to a nonprofit agency that currently serves deaf and hard-of-hearing adults with mental illness through residential programs and supportive housing outreach activities. The grant must be used to continue and maintain community support services for deaf and hard-of-hearing adults with mental illness who use or wish to use sign language as their primary means of communication.

(d) Mental Health Grants

| | | |
|---|---|---|
| General | 50,014,000 | 51,525,000 |
| Lottery Cash Flow | 1,158,000 | 1,158,000 |

(e) Community Support Grants

12,698,000 12,920,000

(f) Medical Assistance Long-Term Care Waivers and Home Care

452,689,000 533,489,000

[PROVIDER RATE INCREASES.] (1) The commissioner shall increase reimbursement rates by 3.0 percent the first year of the biennium and by 3.0 percent the second year for the providers listed in paragraph (2). The increases shall be effective for services rendered on or after July 1 of each year.

(2) The rate increases described in this section shall be provided to home and community-based waivered services for persons with mental retardation or related conditions under Minnesota Statutes, section 256B.501; home and community-based waivered services for the elderly under Minnesota Statutes, section 256B.0915; waivered services under community alternatives for disabled individuals under Minnesota Statutes, section 256B.49; community alternative care waivered services under Minnesota Statutes, section 256B.49; traumatic brain injury waivered services under Minnesota Statutes, section 256B.49; nursing services and home health services under Minnesota Statutes, section 256B.0625, subdivision 6a; personal care services and nursing supervision of personal care services under Minnesota Statutes, section 256B.0625, subdivision 19a; private-duty nursing services under Minnesota Statutes, section 256B.0625, subdivision 7; day training and habilitation services for adults with mental retardation or related conditions under Minnesota Statutes, sections 252.40 to 252.46; alternative care services under Minnesota Statutes, section 256B.0913; adult residential program grants under Minnesota Rules, parts 9535.2000 to 9535.3000; adult and family community support grants under Minnesota Rules, parts 9535.1700 to 9535.1760; semi-independent living services under Minnesota Statutes, section 252.275, including SILS funding under county social services grants formerly funded under Minnesota Statutes, chapter 256I; community support services for deaf and hard-of-hearing adults with mental illness who use or wish to use sign language as their primary means of communication; and living skills training programs for persons with intractable epilepsy who need assistance in the transition to independent living; and group residential housing supplementary service rate under Minnesota Statutes, section 256I.05, subdivision 1a.

(g) Medical Assistance Long-Term Care Facilities

590,638,000 599,866,000

[MORATORIUM EXCEPTIONS.] During each year of the biennium beginning July 1, 2001, the commissioner of health may approve moratorium exception projects under Minnesota Statutes, section 144A.073, for which the full annualized state share of medical assistance costs does not exceed $2,000,000.

[NURSING FACILITY OPERATED BY THE RED LAKE BAND OF CHIPPEWA INDIANS.] (1) The medical assistance payment rates for the 47-bed nursing facility operated by the Red Lake Band of Chippewa Indians must be calculated according to allowable reimbursement costs under the medical assistance program, as specified in Minnesota Statutes, section 246.50, and are subject to the facility-specific Medicare upper limits.

(2) In addition, the commissioner shall make available rate adjustments for the biennium beginning July 1, 2001, on the same basis as the adjustments provided to nursing facilities under Minnesota Statutes, section 256B.431. The commissioner must use the facility's final 2000 and 2001 Medicare cost reports to calculate the adjustments. This rate increase shall become part of the facility's base rate for future rate years.

[ICF/MR DISALLOWANCES.] Of this appropriation, $65,000 in each fiscal year is to reimburse a four-bed ICF/MR in Ramsey county for disallowance resulting from field audit findings. The commissioner shall exempt these facilities from the provisions of Minnesota Statutes, section 256B.501, subdivision 5b, paragraph (d), clause (6), for the rate years beginning October 1, 1996, and October 1, 1997.

[COMMUNITY SERVICES DEVELOPMENT GRANTS PROGRAM.] Of this appropriation, $18,000,000 for the biennium ending June 30, 2003, is to the commissioner for grants under Minnesota Statutes, section 256.9754. Unexpended appropriations in fiscal year 2002 do not cancel but are available to the commissioner for these purposes in fiscal year 2003. This is a one-time appropriation and shall not become part of the base-level funding for the 2004-2005 biennium.

[LONG-TERM CARE CONSULTATION SERVICES.] Long-term care consultation

services payments to all counties shall continue at the payment amount in effect for preadmission screening in fiscal year 2001.

(h) Alternative Care Grants

| | | |
|---|---|---|
| General | 75,764,000 | 89,646,000 |

[ALTERNATIVE CARE TRANSFER.] Any money allocated to the alternative care program that is not spent for the purposes indicated does not cancel but shall be transferred to the medical assistance account.

[ALTERNATIVE CARE APPROPRIATION.] The commissioner may expend the money appropriated for the alternative care program for that purpose in either year of the biennium.

(i) Group Residential Housing

| | | |
|---|---|---|
| General | 78,712,000 | 86,807,000 |

(j) Chemical Dependency Entitlement Grants

| | | |
|---|---|---|
| General | 39,459,000 | 41,045,000 |

(k) Chemical Dependency Nonentitlement Grants

| | | |
|---|---|---|
| General | 5,941,000 | 5,918,000 |

[CONSOLIDATED CHEMICAL DEPENDENCY TREATMENT FUND ONE-TIME TRANSFER.] $9,367,000 of funds available in the consolidated chemical dependency treatment fund general reserve account is transferred in fiscal year 2002 to the general fund.

Subd. 10. Continuing Care Management

| | | |
|---|---|---|
| General | 24,546,000 | 23,928,000 |
| State Government Special Revenue | 115,000 | 115,000 |
| Lottery Cash Flow | 142,000 | 142,000 |

[COUNTY INVOLVEMENT COSTS.] Of this appropriation, up to $481,000 in fiscal year 2002 and up to $642,000 in fiscal year 2003 are for the commissioner to allocate to counties for resident relocation costs resulting from planned closures under Minnesota Statutes, section 256B.437, and resident relocations under Minnesota Statutes, section 144A.161. Unexpended funds for fiscal year 2002 do not cancel but are available to the commissioner for this purpose in fiscal year 2003.

[REGION 10 QUALITY ASSURANCE COMMISSION.] (1) Of the appropriation from

the general fund for the biennium ending June 30, 2003, $548,000 is to the commissioner of human services to be allocated to the region 10 quality assurance commission for operating costs of the alternative quality assurance licensing project and for grants to counties participating in that project.

(2) $50,000 is appropriated from the general fund to the commissioner of human services for the biennium ending June 30, 2003, for the region 10 quality assurance commission to conduct the evaluation required under Minnesota Statutes, section 256B.0951, subdivision 9.

(3) $150,000 is appropriated from the general fund to the commissioner of human services for the biennium ending June 30, 2003, for the commissioner to conduct the project evaluation required for the federal 1115 waiver of ICF/MR regulations.

Subd. 11. Economic Support Grants

| | | |
|---|---|---|
| General | 91,086,000 | 90,136,000 |
| Federal TANF | 228,209,000 | 197,741,000 |

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) Assistance to Families Grants

| | | |
|---|---|---|
| General | 25,237,000 | 21,821,000 |
| Federal TANF | 164,745,000 | 133,553,000 |

(b) Work Grants

| | | |
|---|---|---|
| General | 9,844,000 | 9,844,000 |
| Federal TANF | 62,203,000 | 61,403,000 |

[NONTRADITIONAL CAREER ASSISTANCE.] Of the federal TANF appropriation, $500,000 for fiscal year 2002 and $500,000 for fiscal year 2003 is for grants for nontraditional career assistance training programs under Minnesota Statutes, section 256K.30. This is a one-time appropriation and shall not be added to the base-level funding in the 2004-2005 biennium.

[SUPPORTIVE HOUSING AND MANAGED CARE PILOT PROJECT.] Of the general fund appropriation, $2,000,000 in fiscal year 2002 and $5,000,000 in fiscal year 2003 is for the supportive housing and managed care pilot project under Minnesota Statutes, section 256K.25. This appropriation may be transferred between fiscal years within the biennium.

[INTENSIVE INTERVENTION

TRANSITIONAL EMPLOYMENT TRAINING PROJECT.] Of the federal TANF appropriation, $800,000 for the biennium ending June 30, 2003, is for the Southeast Asian collaborative in Hennepin county for an intensive intervention transitional employment training project, which serves TANF-eligible recipients, and which moves refugee and immigrant welfare recipients into unsubsidized employment leading to self-sufficiency. The commissioner must select one of the five partners in the collaborative as the fiscal agent for the project. The primary effort of the project must be on intensive employment skills training, including workplace English and overcoming cultural barriers, and on specialized training in fields of work which involve a credit-based curriculum. For recipients without a high school diploma or a GED, extra effort shall be made to help the recipient meet the "ability to benefit test" so the recipient can receive financial aid for further training. During the specialized training, efforts should be made to involve the recipients with an internship program and retention specialist. A minor amount of the grant may be used for other efforts to make the recipient families more self-sufficient as provided within TANF rules. This is a one-time appropriation and shall not be added to the base-level funding for the 2004-2005 biennium.

[LOCAL INTERVENTION GRANTS FOR SELF-SUFFICIENCY CARRYFORWARD.] Unexpended funds appropriated for local intervention grants under Minnesota Statutes, section 256J.625, for fiscal year 2002 do not cancel but are available to the commissioner for these purposes in fiscal year 2003.

(c) Economic Support Grants - Other Assistance

| | | |
|---|---|---|
| General | 4,682,000 | 6,931,000 |
| Federal TANF | 1,001,000 | 2,525,000 |

[TANF TRANSFER TO CHILD CARE AND DEVELOPMENT BLOCK GRANT.] $1,526,000 for fiscal year 2003 is appropriated to the commissioner of children, families, and learning for the purposes of Minnesota Statutes, section 119B.05. The commissioner of human services shall authorize a sufficient transfer of funds from the state’s federal TANF block grant to the state’s child care and development fund block grant to meet this appropriation.

[WORKING FAMILY TAX CREDITS.] (1) On

a regular basis, the commissioner of revenue, with the assistance of the commissioner of human services, shall calculate the value of the refundable portion of the Minnesota working family credits provided under Minnesota Statutes, section 290.0671, that qualifies for federal reimbursement from the temporary assistance for needy families block grant. The commissioner of revenue shall provide the commissioner of human services with such expenditure records and information as are necessary to support draws of federal funds.

(2) Federal TANF funds, as specified in this paragraph, are appropriated to the commissioner of human services based on calculations under paragraph (a) of working family tax credit expenditures that qualify for reimbursement from the TANF block grant for income tax refunds payable in federal fiscal years beginning October 1, 2001. The draws of federal TANF funds shall be made on a regular basis based on calculations of credit expenditures by the commissioner of revenue. Up to the following amounts of federal TANF draws are appropriated to the commissioner of human services to deposit in the general fund: in fiscal year 2002, $25,000,000; and in fiscal year 2003, $16,000,000.

(d) Child Support Enforcement

| | | |
|---|---|---|
| General | 4,239,000 | 4,239,000 |
| Federal TANF | 260,000 | 260,000 |

[CHILD SUPPORT PAYMENT CENTER.] Payments to the commissioner from other governmental units, private enterprises, and individuals for services performed by the child support payment center must be deposited in the state systems account authorized under Minnesota Statutes, section 256.014. These payments are appropriated to the commissioner for the operation of the child support payment center or system, according to Minnesota Statutes, section 256.014.

(e) General Assistance

| | | |
|---|---|---|
| General | 17,156,000 | 15,700,000 |

[GENERAL ASSISTANCE STANDARD.] The commissioner shall set the monthly standard of assistance for general assistance units consisting of an adult recipient who is childless and unmarried or living apart from his or her parents or a legal guardian at $203. The commissioner may reduce this amount in accordance with Laws 1997, chapter 85, article 3, section 54.

| | | |
|---|---|---|
| (f) Minnesota Supplemental Aid | | |
| General | 29,678,000 | 31,351,000 |
| (g) Refugee Services | | |
| General | 250,000 | 250,000 |
| Subd. 12. Economic Support Management | | |
| General | 37,775,000 | 37,405,000 |
| Health Care Access | 1,318,000 | 1,318,000 |
| Federal TANF | 2,493,000 | 943,000 |

The amounts that may be spent from this appropriation for each purpose are as follows:

| | | |
|---|---|---|
| (a) Economic Support Policy Administration | | |
| General | 6,528,000 | 6,191,000 |
| Federal TANF | 2,493,000 | 943,000 |

[FOOD STAMP ADMINISTRATIVE REIMBURSEMENT.] The commissioner shall reduce quarterly food stamp administrative reimbursement to counties in fiscal years 2002 and 2003 by the amount that the United States Department of Health and Human Services determines to be the county random moment study share of the food stamp adjustment under Public Law Number 105-185. The reductions shall be allocated to each county in proportion to each county's contribution, if any, to the amount of the adjustment. Any adjustment to medical assistance administrative reimbursement that is based on the United States Department of Health and Human Services' determinations under Public Law Number 105-185 shall be distributed to counties in the same manner.

[EMPLOYMENT SERVICES TRACKING SYSTEM.] Of the federal TANF appropriation, $1,750,000 in fiscal year 2002 and $200,000 in fiscal year 2003 are for development of an employment tracking system in collaboration with the department of economic security. Unexpended funds in fiscal year 2002 do not cancel but are available to the commissioner for these purposes in fiscal year 2003. This is a one-time appropriation and shall not be added to the base-level funding for the 2004-2005 biennium.

| | | |
|---|---|---|
| (b) Economic Support Operations | | |
| General | 31,247,000 | 31,214,000 |

| | | |
|---|---|---|
| Health Care Access | 1,318,000 | 1,318,000 |
| Federal TANF | ...,-0-,... | ...,-0-,... |

[SPENDING AUTHORITY FOR FOOD STAMP ENHANCED FUNDING.] In the event that Minnesota qualifies for United States Department of Agriculture Food and Nutrition Services Food Stamp Program enhanced funding beginning in federal fiscal year 1998, the money is appropriated to the commissioner for the purposes of the program. The commissioner shall retain 25 percent of the enhanced funding for the Minnesota food assistance program, with the remaining 75 percent divided among the counties according to a formula that takes into account each county's impact on the statewide food stamp error rate.

[FINANCIAL INSTITUTION DATA MATCH AND PAYMENT OF FEES.] The commissioner is authorized to allocate up to $310,000 each year in fiscal year 2002 and fiscal year 2003 from the PRISM special revenue account to make payments to financial institutions in exchange for performing data matches between account information held by financial institutions and the public authority's database of child support obligors as authorized by Minnesota Statutes, section 13B.06, subdivision 7.

Sec. 3. COMMISSIONER OF HEALTH

| | | |
|---|---|---|
| Subdivision 1. Total Appropriation | 138,591,000 | 138,716,000 |
| Summary by Fund | | |
| General | 87,619,000 | 86,160,000 |
| State Government Special Revenue | 24,144,000 | 25,728,000 |
| Health Care Access | 6,828,000 | 6,828,000 |
| Federal TANF | 20,000,000 | 20,000,000 |
| Subd. 2. Family and Community Health | 72,535,000 | 72,847,000 |
| Summary by Fund | | |
| General | 47,943,000 | 47,256,000 |
| State Government Special Revenue | 936,000 | 1,935,000 |
| Health Care Access | 3,656,000 | 3,656,000 |
| Federal TANF | 20,000,000 | 20,000,000 |

[ELIMINATING HEALTH DISPARITIES.] Of the general fund appropriation, $6,000,000 each year is for reducing health disparities. Of the amounts available:

(1) $1,500,000 each year is for competitive grants under Minnesota Statutes, section 145.928, subdivision 7, to eligible applicants to reduce health disparities in infant mortality rates and adult and child immunization rates.

(2) $2,000,000 each year is for competitive grants under Minnesota Statutes, section 145.928, subdivision 8, to eligible applicants to reduce health disparities in breast and cervical cancer screening rates, HIV/AIDS and sexually transmitted infection rates, cardiovascular disease rates, diabetes rates, and rates of accidental injuries and violence.

(3) $500,000 each year is for grants under Minnesota Statutes, section 145.928, subdivision 9, to community health boards as defined in Minnesota Statutes, section 145A.02, to improve access to health screening and follow-up services for refugee populations.

(4) $2,000,000 each year is for grants to community health boards as defined in Minnesota Statutes, section 145A.02, according to the formula in Minnesota Statutes, section 145.882, subdivision 4a, to provide services targeted at reducing maternal and child health disparities.

[TEEN PREGNANCY PREVENTION.] $20,000,000 from the TANF fund for the 2002-2003 biennium is appropriated to the commissioner of health for a teen pregnancy prevention program. Of the amounts available:

(1) $3,500,000 in fiscal year 2002 and $5,000,000 in fiscal year 2003 are for teen pregnancy prevention disparity grants under Minnesota Statutes, section 145.9257, subdivision 6.

(2) $3,000,000 in fiscal year 2002 and $3,000,000 in fiscal year 2003 are for high-risk community teen pregnancy prevention grants under Minnesota Statutes, section 145.9257, subdivision 7.

(3) $2,000,000 in fiscal year 2002 and $2,000,000 in fiscal year 2003 are for transfer to the commissioner of children, families, and learning to increase the number of adolescent parenting grants.

(4) $1,500,000 in fiscal year 2002 is for one-time grants to public school districts to implement an abstinence until marriage curriculum and to train staff to implement the curriculum. The curriculum shall educate adolescents that abstinence from sexual activity outside of marriage is the expected standard and that sexual activity outside the context of marriage is likely to have harmful emotional, physical, and social effects; and shall provide an explanation of the value of the institution of marriage and a discussion of the historical purpose and significance of marriage. The commissioner of health, in consultation with the commissioner of children, families, and learning, shall make school districts aware of the availability of funds for this purpose. This appropriation shall not become part of the base-level funding for this activity.

[POISON INFORMATION SYSTEM.] Of the general fund appropriation, $1,360,000 each fiscal year is for poison control system grants under Minnesota Statutes, section 145.93. This is a one-time appropriation that shall not become part of base-level funding in 2004-2005.

[SUICIDE PREVENTION.] Of the general fund appropriation, $1,100,000 each fiscal year is for suicide prevention activities under Minnesota Statutes, section 145.56. Of the amounts available:

(1) $275,000 each fiscal year is for refining, coordinating, and implementing the suicide prevention plan according to Minnesota Statutes, section 145.56, subdivisions 1, 3, 4, and 5.

(2) $825,000 each fiscal year is to fund community-based programs under Minnesota Statutes, section 145.56, subdivision 2.

[TANF HOME VISITING PROGRAM.] Of the federal TANF appropriation, $10,000,000 in fiscal year 2002 and $10,000,000 in fiscal year 2003 are for family home visiting programs under Minnesota Statutes, section 145A.17. These amounts include $7,000,000 in fiscal year 2002 and $7,000,000 in fiscal year 2003 of appropriations to the commissioner of human services for transfer to the commissioner of health authorized in Laws 2000, chapter 488, article 13, section 15, subdivision 6, clause (3), as amended by Laws 2000, chapter 499, sections 22 and 39.

[TANF HOME VISITING

CARRYFORWARD.] Any unexpended balance of the TANF funds appropriated for family home visiting in the first year of the biennium does not cancel but is available for the second year.

[TEEN PREGNANCY PREVENTION CARRYFORWARD.] Any unexpended balance of the TANF funds appropriated for teen pregnancy prevention in the first fiscal year of the biennium does not cancel but is available for the second year.

[WIC TRANSFERS.] The general fund appropriation for the women, infants, and children (WIC) food supplement program is available for either year of the biennium. Transfers of these funds between fiscal years must be either to maximize federal funds or to minimize fluctuations in the number of program participants.

[MINNESOTA CHILDREN WITH SPECIAL HEALTH NEEDS CARRYFORWARD.] General fund appropriations for treatment services in the services for Minnesota children with special health needs program are available for either year of the biennium.

[ONE-TIME REDUCTION FOR FAMILY PLANNING SPECIAL PROJECT GRANTS.] For fiscal year 2003, base-level funding for the Family Planning Special Project Grants under Minnesota Statutes, section 145.925, shall be reduced by $690,000.

| | | | |
|---|---|---|---|
| Subd. 3. Access and Quality Improvement | | 31,284,000 | 30,268,000 |
| Summary by Fund | | | |
| General | 21,160,000 | 20,194,000 | |
| State Government Special Revenue | 6,952,000 | 6,902,000 | |
| Health Care Access | 3,172,000 | 3,172,000 | |

[HEALTH CARE SAFETY NET.] (1) Of the general fund appropriation, $5,000,000 each year is for a grant program to aid safety net community clinics.

(2) $5,000,000 each year is for a grant program to provide rural hospital capital improvement grants described in Minnesota Statutes, section 144.148.

| | | | |
|---|---|---|---|
| Subd. 4. Health Protection | | 29,808,000 | 30,639,000 |
| Summary by Fund | | | |

| | | |
|---|---|---|
| General | 13,699,000 | 13,895,000 |
| State Government Special Revenue | 16,109,000 | 16,744,000 |

[EMERGING HEALTH THREATS.] (a) Of the general fund appropriation, $2,200,000 in the first year and $2,400,000 in the second year are to increase the state capacity to identify and respond to emerging health threats.

(b) Of these amounts, $1,900,000 in the first year and $2,100,000 in the second year are to expand state laboratory capacity to identify infectious disease organisms, evaluate environmental contaminants, develop new analytical techniques, provide emergency response, and support local government by training health care system workers to deal with biological and chemical health threats.

(c) $300,000 each year is to train, consult, and otherwise assist local officials responding to clandestine drug laboratories and minimizing health risks to responders and the public.

| | | |
|---|---|---|
| Subd. 5. Management and Support Services | 4,964,000 | 4,962,000 |
| Summary by Fund | | |
| General | 4,817,000 | 4,815,000 |
| State Government Special Revenue | 147,000 | 147,000 |
| Sec. 4. VETERANS NURSING HOMES BOARD | 30,336,000 | 28,784,000 |

[VETERANS HOMES SPECIAL REVENUE ACCOUNT.] The general fund appropriations made to the board may be transferred to a veterans homes special revenue account in the special revenue fund in the same manner as other receipts are deposited according to Minnesota Statutes, section 198.34, and are appropriated to the board for the operation of board facilities and programs.

[SETTING COST OF CARE.] The cost of care for the domiciliary residents at the Minneapolis veterans home for fiscal year 2002 and fiscal year 2003 shall be calculated based on 100 percent occupancy at each facility.

[DEFICIENCY FUNDING.] Of the general fund appropriation in fiscal year 2002, $2,000,000 is available with the approval of the commissioner of finance. Approval of the commissioner of finance is contingent upon review of the board's submittal of a report outlining the following:

(1) a long-term revenue outlook for the homes;

(2) a review and recommendation of alternative funding sources for the homes' operations; and

(3) administrative and service options to bring cost growth in line with revenues.

Sec. 5. HEALTH-RELATED BOARDS

| | | |
|---|---|---|
| Subdivision 1. Total Appropriation | 10,800,000 | 10,892,000 |

[STATE GOVERNMENT SPECIAL REVENUE FUND.] The appropriations in this section are from the state government special revenue fund.

[NO SPENDING IN EXCESS OF REVENUES.] The commissioner of finance shall not permit the allotment, encumbrance, or expenditure of money appropriated in this section in excess of the anticipated biennial revenues or accumulated surplus revenues from fees collected by the boards. Neither this provision nor Minnesota Statutes, section 214.06, applies to transfers from the general contingent account.

| | | |
|---|---|---|
| Subd. 2. Board of Chiropractic Examiners | 361,000 | 361,000 |
| Subd. 3. Board of Dentistry | 806,000 | 806,000 |
| Subd. 4. Board of Dietetic and Nutrition Practice | 95,000 | 95,000 |
| Subd. 5. Board of Marriage and Family Therapy | 111,000 | 111,000 |
| Subd. 6. Board of Medical Practice | 3,270,000 | 3,270,000 |
| Subd. 7. Board of Nursing | 2,704,000 | 2,772,000 |

[HEALTH PROFESSIONAL SERVICES ACTIVITY.] Of these appropriations, $534,000 in fiscal year 2002 and $566,000 in fiscal year 2003 are for the Health Professional Services Activity.

| | | |
|---|---|---|
| Subd. 8. Board of Nursing Home Administrators | 194,000 | 186,000 |
| Subd. 9. Board of Optometry | 90,000 | 90,000 |
| Subd. 10. Board of Pharmacy | 1,301,000 | 1,316,000 |

[ADMINISTRATIVE SERVICES UNIT.] Of this appropriation, $433,000 the first year and $441,000 the second year are for the health boards administrative services unit. The administrative services unit may receive and expend reimbursements for services performed for other agencies.

| | | |
|---|---|---|
| Subd. 11. Board of Physical Therapy | 185,000 | 185,000 |
| Subd. 12. Board of Podiatry | 52,000 | 42,000 |
| Subd. 13. Board of Psychology | 653,000 | 647,000 |
| Subd. 14. Board of Social Work | 825,000 | 832,000 |
| Subd. 15. Board of Veterinary Medicine | 153,000 | 179,000 |
| Sec. 6. EMERGENCY MEDICAL SERVICES BOARD | 3,033,000 | 3,037,000 |

Summary by Fund

| | | |
|---|---|---|
| General | 3,033,000 | 3,037,000 |

[COMPREHENSIVE ADVANCED LIFE SUPPORT (CALS).] $500,000 in fiscal year 2002 and $500,000 in fiscal year 2003 are for the comprehensive advanced life support educational program under Minnesota Statutes, section 144E.37.

| | | |
|---|---|---|
| Sec. 7. COUNCIL ON DISABILITY | 692,000 | 714,000 |
| Sec. 8. OMBUDSMAN FOR MENTAL HEALTH AND MENTAL RETARDATION | 1,378,000 | 1,378,000 |
| Sec. 9. OMBUDSMAN FOR FAMILIES | 171,000 | 171,000 |

Sec. 10. TRANSFERS

Subdivision 1. Grants

The commissioner of human services, with the approval of the commissioner of finance, and after notification of the chair of the senate health and family security budget division and the chair of the house health and human services finance committee, may transfer unencumbered appropriation balances for the biennium ending June 30, 2003, within fiscal years among the MFIP, general assistance, general assistance medical care, medical assistance, Minnesota supplemental aid, and group residential housing programs, and the entitlement portion of the chemical dependency consolidated treatment fund, and between fiscal years of the biennium.

Subd. 2. Administration

Positions, salary money, and nonsalary administrative money may be transferred within the departments of human services and health and within the programs operated by the veterans nursing homes board as the commissioners and the board consider necessary, with the advance approval of the commissioner of finance. The commissioner or the board shall inform the chairs of the house health and human services

finance committee and the senate health and family security budget division quarterly about transfers made under this provision.

Sec. 11. INDIRECT COSTS NOT TO FUND PROGRAMS.

The commissioners of health and of human services shall not use indirect cost allocations to pay for the operational costs of any program for which they are responsible.

Sec. 12. CARRYOVER LIMITATION

None of the appropriations in this article which are allowed to be carried forward from fiscal year 2002 to fiscal year 2003 shall become part of the base level funding for the 2004-2005 biennial budget, unless specifically directed by the legislature.

Sec. 13. SUNSET OF UNCODIFIED LANGUAGE

All uncodified language contained in this article expires on June 30, 2003, unless a different expiration date is explicit.

Sec. 14. [246.141] [PROJECT LABOR.]

Wages for project labor may be paid by the commissioner out of repairs and betterments money if the individual is to be engaged in a construction project or a repair project of short-term and nonrecurring nature. Compensation for project labor shall be based on the prevailing wage rates, as defined in section 177.42, subdivision 6. Project laborers are excluded from the provisions of sections 43A.22 to 43A.30, and shall not be eligible for state-paid insurance and benefits."

Amend the title accordingly

The question was taken on the adoption of the amendment.

The roll was called, and there were yeas 27 and nays 39, as follows:

Those who voted in the affirmative were:

| | | | | |
|---|---|---|---|---|
| Bachmann | Fowler | Kleis | Olson | Schwab |
| Belanger | Frederickson | Knutson | Ourada | Stevens |
| Berg | Johnson, Debbie | Larson | Pariseau | Vickerman |
| Day | Kelly, R.C. | Lesewski | Reiter | |
| Dille | Kierlin | Limmer | Robling | |
| Fischbach | Kinkel | Neuville | Scheevel | |

Those who voted in the negative were:

| | | | | |
|---|---|---|---|---|
| Anderson | Johnson, Dave | Lourey | Pogemiller | Samuelson |
| Berglin | Johnson, Dean | Marty | Price | Scheid |
| Betzold | Johnson, Doug | Metzen | Ranum | Stumpf |
| Chaudhary | Kelley, S.P. | Moe, R.D. | Rest | Terwilliger |
| Cohen | Kiscaden | Murphy | Ring | Tomassoni |
| Foley | Krentz | Oliver | Robertson | Wiener |
| Higgins | Langseth | Orfield | Sabo | Wiger |
| Hottinger | Lessard | Pappas | Sams | |

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

Senator Neuville moved to amend the Berglin amendment to H.F. No. 1947, adopted by the Senate May 15, 2001, as follows:

Page 42, line 19, strike "including" and insert "excluding"

Page 42, line 36, strike "family planning and" and after "care" insert "excluding prepregnancy family planning services"

Page 43, line 2, strike "decrease the"

Page 43, line 3, strike "occurrence of inappropriate pregnancy and"

Page 44, delete section 47 and insert:

"Sec. 47. Minnesota Statutes 2000, section 145.925, subdivision 1, is amended to read:

Subdivision 1. [ELIGIBLE ORGANIZATIONS; PURPOSE.] The commissioner of health may make special grants to cities, counties, groups of cities or counties~~, or nonprofit corporations~~ to provide prepregnancy family planning services targeted to low-income populations. A city, county, or group of cities or counties that receives a grant is responsible for ensuring that the grant funds are used for services targeted to low-income populations, and must establish a goal for reducing specific pregnancy rates in the service area. In determining populations to serve and services to provide, a city, county, or group of cities or counties must consider the spacing of pregnancies in low-income populations in the service area, teen birth rates in the service area, and the needs of populations of color in the service area. A city, county, or group of cities or counties may contract for the provision of prepregnancy family planning services using grant funds provided under this section only if the contract is specifically authorized by the governing body of the city or county that is contracting for the services.

Sec. 48. Minnesota Statutes 2000, section 145.925, subdivision 1a, is amended to read:

Subd. 1a. [FAMILY PLANNING SERVICES; DEFINED.] "Family planning services" means counseling by trained personnel regarding family planning; distribution of information relating to family planning, referral to licensed physicians or local health agencies for consultation, examination, medical treatment, genetic counseling, and prescriptions for the purpose of family planning; and the distribution of family planning products, such as charts, thermometers, drugs, medical preparations, and contraceptive devices. Family planning services do not include services that, directly or indirectly, encourage, counsel, refer, or provide abortions or abortion referrals. For purposes of sections 145A.01 to 145A.14, family planning shall mean voluntary action by individuals to prevent or aid conception but does not include ~~the performance, or make referrals for encouragement of voluntary termination of pregnancy~~ services that, directly or indirectly, encourage, counsel, refer, or provide abortions or abortion referrals. Any organization or an affiliate of an organization which provides abortions, promotes abortions, or directly refers for abortions, shall be ineligible to receive funds under this section."

Page 46, line 23, after the period, insert "No funds awarded under this section may be used for services that, directly or indirectly, encourage, counsel, refer, or provide abortions or abortion referrals. Any organization or an affiliate of an organization which provides abortions, promotes abortions, or directly refers for abortions, shall be ineligible to receive funds under this section."

Renumber the sections in sequence and correct the internal references

The question was taken on the adoption of the amendment.

The roll was called, and there were yeas 29 and nays 37, as follows:

Those who voted in the affirmative were:

| | | | | |
|---|---|---|---|---|
| Bachmann | Fowler | Larson | Ourada | Scheevel |
| Belanger | Frederickson | Lesewski | Pariseau | Schwab |
| Berg | Johnson, Debbie | Lessard | Reiter | Stevens |
| Day | Kierlin | Limmer | Robling | Stumpf |
| Dille | Kleis | Neuville | Sams | Vickerman |
| Fischbach | Knutson | Olson | Samuelson | |

Those who voted in the negative were:

| | | | | |
|---|---|---|---|---|
| Anderson | Johnson, Dave | Langseth | Pappas | Scheid |
| Berglin | Johnson, Dean | Lourey | Pogemiller | Terwilliger |
| Betzold | Johnson, Doug | Marty | Price | Tomassoni |
| Chaudhary | Kelley, S.P. | Metzen | Ranum | Wiener |
| Cohen | Kelly, R.C. | Moe, R.D. | Rest | Wiger |
| Foley | Kinkel | Murphy | Ring | |
| Higgins | Kiscaden | Oliver | Robertson | |
| Hottinger | Krentz | Orfield | Sabo | |

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

Senator Limmer moved to amend H.F. No. 1947, as amended pursuant to Rule 45, adopted by the Senate May 11, 2001, as follows:

(The text of the amended House File is identical to S.F. No. 1345.)

Page 2, line 17, after the period, insert "The birth record is not a medical record of the mother or the child."

The motion prevailed. So the amendment was adopted.

Senator Day moved that H.F. No. 1947 be re-referred to the Committee on Finance.

The question was taken on the adoption of the motion.

The roll was called, and there were yeas 29 and nays 36, as follows:

Those who voted in the affirmative were:

| | | | | |
|---|---|---|---|---|
| Bachmann | Fowler | Knutson | Olson | Scheevel |
| Belanger | Frederickson | Larson | Pariseau | Schwab |
| Berg | Johnson, Debbie | Lesewski | Reiter | Stevens |
| Day | Kierlin | Lessard | Robling | Stumpf |
| Dille | Kinkel | Limmer | Sams | Vickerman |
| Fischbach | Kleis | Neuville | Samuelson | |

Those who voted in the negative were:

| | | | | |
|---|---|---|---|---|
| Anderson | Johnson, Dave | Lourey | Pogemiller | Terwilliger |
| Berglin | Johnson, Dean | Marty | Price | Tomassoni |
| Betzold | Johnson, Doug | Metzen | Ranum | Wiener |
| Chaudhary | Kelley, S.P. | Moe, R.D. | Rest | Wiger |
| Cohen | Kelly, R.C. | Murphy | Ring | |
| Foley | Kiscaden | Oliver | Robertson | |
| Higgins | Krentz | Orfield | Sabo | |
| Hottinger | Langseth | Pappas | Scheid | |

The motion did not prevail.

H.F. No. 1947 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 35 and nays 30, as follows:

Those who voted in the affirmative were:

| | | | | |
|---|---|---|---|---|
| Anderson | Hottinger | Langseth | Pappas | Sams |
| Berglin | Johnson, Dave | Lourey | Pogemiller | Scheid |
| Betzold | Johnson, Dean | Marty | Price | Stumpf |
| Chaudhary | Johnson, Doug | Metzen | Ranum | Terwilliger |
| Cohen | Kelley, S.P. | Moe, R.D. | Rest | Tomassoni |
| Foley | Kiscaden | Murphy | Ring | Wiener |
| Higgins | Krentz | Orfield | Sabo | Wiger |

Those who voted in the negative were:

| | | | | |
|---|---|---|---|---|
| Bachmann | Day | Fowler | Kelly, R.C. | Kleis |
| Belanger | Dille | Frederickson | Kierlin | Knutson |
| Berg | Fischbach | Johnson, Debbie | Kinkel | Larson |

| | | | | |
|---|---|---|---|---|
| Lesewski | Neuville | Pariseau | Robling | Schwab |
| Lessard | Oliver | Reiter | Samuelson | Stevens |
| Limmer | Olson | Robertson | Scheevel | Vickerman |

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

## 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. 1397:** A bill for an act relating to health and human services; changing requirements to background studies for licensed programs; amending Minnesota Statutes 2000, sections 13.46, subdivision 4; 144.057; 245A.02, subdivisions 1, 9, by adding a subdivision; 245A.03, subdivision 2, by adding a subdivision; 245A.035, subdivision 1; 245A.04, subdivisions 3, 3a, 3b, 3d, 6, 11, by adding a subdivision; 245A.06, subdivision 6; 245A.16, subdivision 1; proposing coding for new law in Minnesota Statutes, chapter 245A; repealing Minnesota Rules, parts 9543.3000; 9543.3010; 9543.3020; 9543.3030; 9543.3040; 9543.3050; 9543.3060; 9543.3080; 9543.3090.

Senate File No. 1397 is herewith returned to the Senate.

Edward A. Burdick, Chief Clerk, House of Representatives

Returned May 14, 2001

Senator Kiscaden moved that the Senate do not concur in the amendments by the House to S.F. No. 1397, and that a Conference Committee of 5 members be appointed by the Subcommittee on Committees on the part of the Senate, to act with a like Conference Committee to be appointed on the part of the House. The motion prevailed.

## MOTIONS AND RESOLUTIONS - CONTINUED

Senator Kiscaden moved that her name be stricken as chief author, and the name of Senator Berglin be added as chief author to S.F. No. 1397. The motion prevailed.

Senator Higgins moved that her name be stricken as chief author, and the name of Senator Berglin be added as chief author to S.F. No. 1345. The motion prevailed.

Senator Berglin moved that S.F. No. 218, No. 9 on General Orders, be stricken and re-referred to the Committee on Jobs, Housing and Community Development. The motion prevailed.

## RECESS

Senator Moe, R.D. 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 Moe, R.D. from the Subcommittee on Committees recommends that the following Senators be and they hereby are appointed as a Conference Committee on:

S.F. No. 722: Senators Metzen; Scheevel; Kelley, S.P.; Anderson and Sams.

S.F. No. 1154: Senators Kelley, S.P.; Fowler and Robling.

H.F. No. 1507: Senators Langseth, Vickerman and Wiger.

H.F. No. 707: Senators Kelly, R.C.; Betzold and Limmer.

S.F. No. 1215: Senators Cohen, Betzold and Neuville.

S.F. No. 491: Senators Berglin, Sams and Kiscaden.

H.F. No. 1153: Senators Lesewski, Stevens and Murphy.

H.F. No. 1487: Senators Lessard, Stumpf and Stevens.

Senator Moe, R.D. moved that the foregoing appointments be approved. The motion prevailed.

## 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. 1407:** A bill for an act relating to human services; modifying provisions in health care access programs; amending Minnesota Statutes 2000, sections 245B.02, by adding a subdivision; 245B.03, subdivision 1; 252.28, subdivisions 3a and 3b; 256B.056, subdivisions 1a, 4, and 5a; 256B.0595, subdivisions 1 and 2; 256B.0625, subdivision 9; 256B.0635, subdivision 1; 256B.071, subdivision 2; 256B.094, subdivisions 6 and 8; 256B.5013, subdivision 1; 256B.69, subdivision 3a; 256D.03, subdivision 3; and 256L.15, subdivision 1a; Laws 1996, chapter 451, article 2, sections 61 and 62; repealing Minnesota Statutes 2000, section 256B.071, subdivision 5; Laws 1995, chapter 178, article 2, section 46, subdivision 10; Laws 1996, chapter 451, article 2, sections 12, 14, 16, 18, 29, and 30.

Senate File No. 1407 is herewith returned to the Senate.

Edward A. Burdick, Chief Clerk, House of Representatives

Returned May 14, 2001

Senator Ring moved that the Senate do not concur in the amendments by the House to S.F. No. 1407, and that a Conference Committee of 3 members be appointed by the Subcommittee on Committees on the part of the Senate, to act with a like Conference Committee to be appointed on the part of the House. The motion prevailed.

## MOTIONS AND RESOLUTIONS - CONTINUED

Pursuant to Rule 26, Senator Moe, R.D., Chair of the Committee on Rules and Administration, designated S.F. No. 1481 a Special Order to be heard immediately.

## SPECIAL ORDER

**S.F. No. 1481:** A bill for an act relating to state government; appropriating money for development and operation of a shooting sports program.

## CALL OF THE SENATE

Senator Pariseau imposed a call of the Senate for the balance of the proceedings on S.F. No. 1481. The Sergeant at Arms was instructed to bring in the absent members.

Senator Pariseau moved to amend S.F. No. 1481 as follows:

Page 1, delete section 1 and insert:

"Section 1. Minnesota Statutes 2000, section 609.66, subdivision 1d, is amended to read:

Subd. 1d. [FELONY; POSSESSION ON SCHOOL PROPERTY.] (a) Except as provided under paragraph (c), whoever possesses, stores, or keeps a dangerous weapon or uses or brandishes a replica firearm or a BB gun on school property or at a child care center licensed under chapter 245A is guilty of a felony and may be sentenced to imprisonment for not more than two years or to payment of a fine of not more than $5,000, or both.

(b) Whoever possesses, stores, or keeps a replica firearm or a BB gun on school property is guilty of a gross misdemeanor.

(c) It is a gross misdemeanor for a person with a permit to carry a pistol issued under section 624.714 to carry a pistol on school property or at a child care center licensed under chapter 245A unless:

(1) the person is in a vehicle dropping-off or picking-up a child; or

(2) otherwise permitted under paragraph (e).

~~(c)~~ (d) As used in this subdivision:

(1) "BB gun" means a device that fires or ejects a shot measuring .18 of an inch or less in diameter;

(2) "dangerous weapon" has the meaning given it in section 609.02, subdivision 6;

(3) "replica firearm" has the meaning given it in section 609.713; and

(4) "school property" means:

(i) a public or private elementary, middle, or secondary school building and its grounds, whether leased or owned by the school; and

(ii) the area within a school bus when that bus is being used to transport one or more elementary, middle, or secondary school students.

~~(d)~~ (e) This subdivision does not apply to:

(1) licensed peace officers, military personnel, or students participating in military training, who are performing official duties;

(2) ~~persons who carry pistols according to the terms of a permit;~~

~~(3)~~ persons who keep or store in a motor vehicle pistols in accordance with ~~sections~~ section 624.714 ~~and~~ or 624.715 or other firearms in accordance with section 97B.045;

~~(4)~~ (3) firearm safety or marksmanship courses or activities conducted on school property;

~~(5)~~ (4) possession of dangerous weapons, BB guns, or replica firearms by a ceremonial color guard;

~~(6)~~ (5) a gun or knife show held on school property; or

~~(7)~~ (6) possession of dangerous weapons, BB guns, or replica firearms with written permission of the principal or director of a child care center.

Sec. 2. Minnesota Statutes 2000, section 624.714, is amended by adding a subdivision to read:

Subd. 1a. [SHORT TITLE.] This section may be cited as the Minnesota Citizens' Personal Protection Act of 2001.

Sec. 3. Minnesota Statutes 2000, section 624.714, is amended by adding a subdivision to read:

Subd. 1b. [PENALTY.] (a) A person, other than a peace officer, as defined in section 626.84, subdivision 1, who carries, holds, or possesses a pistol in a motor vehicle, snowmobile, or boat, or on or about the person's clothes or the person, or otherwise in possession or control in a public place, as defined in section 624.7181, subdivision 1, paragraph (c), without first having obtained a permit to carry the pistol is guilty of a gross misdemeanor. A person who is convicted a second or subsequent time is guilty of a felony.

(b) The holder of a permit to carry must have the permit card in immediate possession at all times when carrying a pistol and must display it upon lawful demand by a peace officer, as defined in section 626.84, subdivision 1. A violation of this paragraph is a petty misdemeanor. The fine for a first offense must not exceed $25.

Sec. 4. Minnesota Statutes 2000, section 624.714, is amended by adding a subdivision to read:

Subd. 1c. [SENTENCE ENHANCEMENT.] (a) A permit holder who uses a pistol to facilitate the commission of a felony may be sentenced to 125 percent of the maximum sentence otherwise provided by statute.

(b) It is an affirmative defense to the application of paragraph (a) that the actor had an honest belief at the inception of the course of conduct that the actor was acting in lawful self-defense.

Sec. 5. Minnesota Statutes 2000, section 624.714, is amended by adding a subdivision to read:

Subd. 1d. [POSSESSING A PISTOL WHILE UNDER THE INFLUENCE.] (a) It is a crime for any person to carry a pistol in a public place on or about the person's clothes or person:

(1) when the person is under the influence of alcohol;

(2) when the person is under the influence of a controlled substance;

(3) when the person is knowingly under the influence of a hazardous substance that affects the nervous system, brain, or muscles of the person so as to substantially impair the person's clearness of intellect or physical control;

(4) when the person is under the influence of a combination of any two or more of the elements named in clauses (1), (2), and (3);

(5) when the person's alcohol concentration at the time, or within two hours of the time, of carrying a pistol in a public place on or about the person's clothes or person is 0.10 or more;

(6) when the person's body contains any amount of a controlled substance listed in schedule I or II; or

(7) when the person's alcohol concentration at the time, or within two hours of the time, of carrying a pistol in a public place on or about the person's clothes or person is 0.04 or more.

(b) Any person who carries a pistol in a public place on or about the person's clothes or person consents to a chemical test of that person's blood, breath, or urine for the purpose of determining the presence of alcohol, controlled substances, or hazardous substances. The test must be administered at the direction of a peace officer. The administrative procedures under section 169A.50 apply to the test except for provisions that clearly cannot be applied to incidents under this subdivision.

(c) It is a crime for any person to refuse to submit to a chemical test of the person's blood, breath, or urine if a peace officer has probable cause to believe that the person has violated paragraph (a).

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

(e) If a person with a permit to carry a pistol issued under this section is charged with a violation under this subdivision, the person's permit may be suspended by the court as a condition of release.

(f) A permit issued to a person under this section is revoked and a new permit may not be issued for one year from the date of conviction if the person is convicted of a violation of paragraph (a), clause (7).

(g) A permit issued to a person under this section is revoked and a new permit may not be issued for three years from the date of conviction if the person is convicted of a violation of paragraph (a), clauses (1) to (6), or a second violation of paragraph (a), clause (7).

(h) A permit issued to a person under this section is revoked and a new permit may not be issued for the remainder of the person's lifetime if the person is convicted of a second violation of paragraph (a), clauses (1) to (6), or a third violation of paragraph (a), clause (7).

Sec. 6. Minnesota Statutes 2000, section 624.714, subdivision 2, is amended to read:

Subd. 2. [~~WHERE APPLICATION MADE~~ AUTHORITY TO ISSUE PERMIT; CRITERIA; SCOPE.] ~~Applications for permits to carry shall be made to the chief of police of an organized full-time police department of the municipality where the applicant resides or to the county sheriff where there is no such local chief of police where the applicant resides. At the time of application, the local police authority shall provide the applicant with a dated receipt for the application.~~ (a) County sheriffs have the sole authority to issue permits to carry pistols pursuant to this section. A sheriff must issue a permit to a person if the person:

(1) is not prohibited from possessing a firearm under section 624.713;

(2) has training in the safe use of a pistol;

(3) completes an application for a permit;

(4) is not listed in the criminal gang investigative data system under section 299C.091, subdivision 2; and

(5) is at least 21 years old.

(b) A sheriff may contract with a police chief to process permit applications under this section. If a sheriff contracts with a police chief, the sheriff remains the issuing authority and the police chief acts as the sheriff's agent. If a sheriff contracts with a police chief, all of the provisions of this section still apply.

(c) A permit to carry a pistol issued under this section is a state permit and is valid throughout the state.

Sec. 7. Minnesota Statutes 2000, section 624.714, is amended by adding a subdivision to read:

Subd. 2a. [TRAINING IN THE SAFE USE OF A PISTOL.] (a) An applicant for a permit under this section must present evidence that the applicant received training in the safe use of a pistol. This requirement is satisfied if the applicant was licensed as a peace officer in Minnesota within the last three years. If the applicant was not licensed as a peace officer, within three years prior to the date of filing an original or renewal application the applicant must complete a firearms safety or training class conducted by a certified instructor that provides basic training in the safe use of a pistol including:

(1) instruction in the fundamentals of pistol use;

(2) successful completion of a live fire shooting exercise with an instructor certified by an agency or organization listed in paragraph (b); and

(3) instruction in the fundamental legal aspects of pistol possession and use, including self-defense and the restrictions on the use of deadly force.

(b) Firearms instructors certified by only the following agencies or organizations are qualified to conduct courses required under this subdivision:

(1) the American Society of Law Enforcement Trainers;

(2) the Minnesota Association of Law Enforcement Firearms Instructors;

(3) the National Rifle Association;

(4) the peace officer standards and training board of this state or a similar agency of another state;

(5) the department of natural resources of this state or a similar agency of another state; or

(6) the department of public safety of this state or a similar agency of another state.

Sec. 8. Minnesota Statutes 2000, section 624.714, subdivision 3, is amended to read:

Subd. 3. [FORM AND CONTENTS OF APPLICATION.] (a) Applications for permits to carry ~~shall~~ must be on an official, standardized application form, adopted under section 624.7151, and must set forth in writing only the following information:

(1) the name, residence, telephone number, if any, and driver's license number or nonqualification certificate number, if any, of the applicant;

(2) the sex, date of birth, height, weight, and color of eyes and hair, and distinguishing physical characteristics, if any, of the applicant;

(3) a statement by the applicant that, to the best of the applicant's knowledge and belief, the applicant is not prohibited by section 624.713 from possessing a firearm; and

(4) a statement that the applicant authorizes the release to the ~~local police authority~~ sheriff of commitment information about the applicant maintained by the commissioner of human services or such similar agency or department of a state of residence, to the extent that the information relates to the applicant's eligibility to possess a ~~pistol or semiautomatic military-style assault weapon~~ firearm under section 624.713, subdivision 1~~;~~

~~(4) a statement by the applicant that the applicant is not prohibited by section 624.713 from possessing a pistol or semiautomatic military-style assault weapon; and~~

~~(5) a recent color photograph of the applicant.~~

~~The application shall be signed and dated by the applicant.~~ The statement under clause ~~(3)~~ (4) must comply with any applicable requirements of Code of Federal Regulations, title 42, sections 2.31 to 2.35, with respect to consent to disclosure of alcohol or drug abuse patient records.

(b) An applicant must submit to the sheriff an application packet consisting only of the following items:

(1) a completed application form, signed and dated by the applicant;

(2) a photocopy of a certificate, affidavit, or other document that is submitted as the applicant's evidence of training in the safe use of a pistol; and

(3) a recent color photograph or other image of the applicant in which the head, including hair, is the size required by the standardized carry permit card described in subdivision 7, unless the commissioner of public safety authorizes use of the image contained on the applicant's Minnesota driver's license or nonqualification certificate.

(c) If the application packet is not submitted in person, the application form must be notarized.

(d) The sheriff may charge a new application processing fee in an amount not to exceed $45. Of this amount, $35 must be submitted to the commissioner of public safety and deposited into the general fund.

(e) This subdivision prescribes the complete and exclusive set of items an applicant is required to submit in order to apply for a new or renewal permit to carry. The applicant must not be asked or required to submit, voluntarily or involuntarily, any information, fees, or documentation beyond that specifically required by this subdivision.

(f) Forms for new and renewal applications must be available at all sheriff's offices and the commissioner of public safety must make the forms available on the Internet. Application forms must clearly display a notice that a permit, if granted, is void and must be immediately returned to the sheriff if the permit holder becomes ineligible to possess a firearm under section 624.713. The notice may list the applicable offenses.

(g) Upon receipt of an application packet and any required fee, a sheriff must provide a receipt indicating the date of submission.

Sec. 9. Minnesota Statutes 2000, section 624.714, subdivision 4, is amended to read:

Subd. 4. [INVESTIGATION.] (a) The ~~application authority shall~~ sheriff must check criminal records, histories, and warrant information on each applicant through the Minnesota Crime Information System. ~~The chief of police or sheriff shall~~ and, to the extent necessary, the National Instant Check System and the National Crime Record Repository, and must make a reasonable effort to check other available state and local recordkeeping systems. The sheriff must also obtain commitment information from the commissioner of human services as provided in section 245.041 or, if the information is reasonably available, as provided by a similar statute from another state. A sheriff must conduct a background check on a permit holder at least yearly to ensure continuing eligibility. A sheriff may conduct additional background checks on a permit holder at anytime during the period that a permit is in effect.

(b) When an application for a permit is filed under this section, the sheriff must notify the chief of police, if any, of the municipality where the applicant resides. The police chief may provide the sheriff with any information the chief deems relevant to the issuance of the permit.

Sec. 10. Minnesota Statutes 2000, section 624.714, subdivision 6, is amended to read:

Subd. 6. [~~FAILURE TO GRANT~~ GRANTING AND DENIAL OF PERMITS.] (a) The sheriff must, within 30 calendar days after the date of receipt of the application packet described in subdivision 3:

(1) issue the permit to carry;

(2) deny the application for a permit to carry solely on the grounds that the applicant failed to qualify under the criteria described in subdivision 2; or

(3) file and serve a petition under subdivision 12a.

(b) Failure of the ~~chief police officer or the county~~ sheriff to ~~deny the application or issue a permit to carry a pistol~~ notify the applicant of the denial of the application or file a petition under subdivision 12a within ~~21~~ 30 calendar days ~~of~~ after the date of receipt of the application ~~shall be deemed to be a grant thereof.~~ packet constitutes issuance of the permit to carry and the sheriff must promptly fulfill the requirements under paragraph (c). To deny the application, the ~~local police authority shall~~ sheriff must provide ~~an~~ the applicant with written notification of ~~a denial and~~ the specific ~~reason~~ factual basis for the denial and the source of the factual basis and must inform the applicant of the applicant's right to submit, within 20 business days, any additional documentation relating to the propriety of the denial. ~~A chief of police or a sheriff may charge a fee to cover the cost of conducting a background check, not to exceed $10. The permit shall specify the activities for which it shall be valid.~~ Upon receiving any additional documentation, the sheriff must reconsider the denial and inform the applicant within 15 business days of the result of the reconsideration. Any denial after reconsideration must be in the same form and substance as the original denial and must specifically address any continued deficiencies in light of the additional documentation submitted by the applicant. The applicant must be informed of the right to seek de novo review of the denial as provided in subdivision 12.

(c) Upon issuing a permit to carry, the sheriff must provide a provisional permit card to the applicant by first class mail or personal delivery. A provisional permit card must clearly display a notice that a permit, if granted, is void and must be immediately returned to the sheriff if the permit holder becomes ineligible to possess a firearm under section 624.713. The notice may list the applicable offenses. Within two business days, the sheriff must submit all necessary information to the commissioner of public safety for the production of a durable permit card.

(d) Notwithstanding paragraphs (a) to (c), the sheriff may suspend the application process if a charge is pending against the applicant that, if resulting in conviction, will disqualify the applicant from possessing a firearm under section 624.713.

Sec. 11. Minnesota Statutes 2000, section 624.714, subdivision 7, is amended to read:

Subd. 7. [PERMIT CARD CONTENTS; EXPIRATION; RENEWAL.] ~~Permits to carry a pistol issued pursuant to this section shall expire after one year and shall thereafter be renewed in the same manner and subject to the same provisions by which the original permit was obtained, except that all renewed permits must comply with the standards adopted by the commissioner of public safety under section 624.7161.~~ (a) Permits to carry must be on an official, standardized permit card adopted by the commissioner of public safety, containing only the following information about the permit holder:

(1) the name, residence, and driver's license number or nonqualification certificate number, if any;

(2) the sex, date of birth, height, weight, color of eyes and hair, and distinguishing characteristics, if any;

(3) a recent color photograph or image of the permit holder; and

(4) the permit holder's signature.

(b) The permit card must also state the expiration date of the permit and must clearly display a notice that a permit, if granted, is void and must be immediately returned to the sheriff if the permit holder becomes ineligible to possess a firearm under section 624.713.

(c) A permit to carry a pistol issued under this section shall expire after three years and shall thereafter be renewed in the same manner and under the same criteria which the original permit was obtained, subject to the following procedures:

(1) no earlier than 90 days prior to the expiration date on the permit, the permit holder may renew the permit by submitting to the sheriff the application packet described in subdivision 3 and a renewal processing fee not to exceed $15. Of this amount, $3 must be submitted to the commissioner of public safety and deposited into the general fund. The sheriff must process the renewal application in accordance with subdivisions 4 and 6; and

(2) a permit holder who submits a renewal application packet after the expiration date of the permit but within 30 days after expiration, may renew the permit as provided in clause (1) by paying an additional late fee of $10.

(d) The renewal permit is effective beginning on the expiration date of the prior permit to carry.

Sec. 12. Minnesota Statutes 2000, section 624.714, is amended by adding a subdivision to read:

Subd. 7a. [CHANGE OF ADDRESS; LOSS OR DESTRUCTION OF PERMIT.] (a) Within 30 days after changing permanent address, or within 30 days of having lost or destroyed the permit card, the permit holder must notify the sheriff of the change, loss, or destruction. Failure to notify the sheriff as required by this subdivision is a petty misdemeanor. The fine for a first offense must not exceed $25.

(b) After notice is given under paragraph (a), a permit holder may obtain a replacement permit card by paying $15 to the sheriff. The request for a replacement permit card must be made on an application adopted for this purpose under section 624.7151, and, except in the case of an address change, must include a notarized statement that the permit card has been lost or destroyed. The sheriff must provide a provisional permit card as provided under subdivision 6, paragraph (c).

Sec. 13. Minnesota Statutes 2000, section 624.714, subdivision 8, is amended to read:

Subd. 8. [PERMIT TO CARRY VOIDED OR REVOKED.] (a) The permit to carry ~~shall be~~ is void and must be revoked at the time that the permit holder becomes prohibited from possessing a ~~pistol~~ firearm under section 624.713, in which event the holder ~~shall~~ must return the permit card to the sheriff within five business days ~~to the application authority~~ after the holder knows or should know that the holder is a prohibited person. If a permit is revoked under this subdivision, the sheriff must give notice to the permit holder in writing in the same manner as a denial. Failure of the holder to return the permit within the five days is a gross misdemeanor unless the court finds that the circumstances or the physical or mental condition of the permit holder prevented the holder from complying with the return requirement.

(b) When a permit holder is convicted of an offense that disqualifies the permit holder from possessing a firearm under section 624.713, the court must revoke and take possession of the permit.

Sec. 14. Minnesota Statutes 2000, section 624.714, is amended by adding a subdivision to read:

Subd. 8a. [PROSECUTOR'S DUTY.] Whenever a person is charged with an offense that would disqualify the person from possessing a firearm under section 624.713, the prosecuting attorney must ascertain whether the person is a permit holder under this section. If the person is a permit holder, the prosecutor must notify the sheriff that issued the permit that the person has been charged with a disqualifying offense. The prosecutor must also notify the sheriff of the final disposition of the case.

Sec. 15. Minnesota Statutes 2000, section 624.714, subdivision 10, is amended to read:

Subd. 10. [FALSE REPRESENTATIONS.] A person who gives or causes to be given any false material information in applying for a permit to carry, knowing or having reason to know the information is false, is guilty of a gross misdemeanor.

Sec. 16. Minnesota Statutes 2000, section 624.714, is amended by adding a subdivision to read:

Subd. 11a. [EMERGENCY ISSUANCE OF PERMITS.] A sheriff may issue an emergency permit to a person if the sheriff determines that the person is in an emergency situation that may constitute an immediate risk to the safety of the person or someone residing in the person's household. A person seeking an emergency permit must complete an application form and must sign an affidavit describing the emergency situation. An emergency permit applicant does not need to provide a photograph or evidence of training. An emergency permit is valid for 30 days, may not be renewed, and may be revoked without a hearing. No fee may be charged for an emergency permit. An emergency permit holder may seek a regular permit under subdivision 3 and subject to the other applicable provisions of this section.

Sec. 17. Minnesota Statutes 2000, section 624.714, subdivision 12, is amended to read:

Subd. 12. [HEARING UPON DENIAL OR REVOCATION.] Any person aggrieved by denial or revocation of a permit to carry may appeal the denial by petition to the district court having jurisdiction ~~over~~ in the county ~~or municipality wherein the notification or denial occurred~~ where the application was submitted. The petition must list the sheriff as the respondent. The district court must hold a hearing at the earliest practicable date and in any event no later than 60 days following the filing of the petition for review. The district court may issue a writ of mandamus or other relief as the court may deem appropriate. A person granted relief under this subdivision must be awarded reasonable costs and expenses including attorney fees. The matter ~~shall~~ must be heard de novo without a jury.

Sec. 18. Minnesota Statutes 2000, section 624.714, is amended by adding a subdivision to read:

Subd. 12a. [DENIAL OR SUSPENSION BY COURT ORDER.] (a) The issuing sheriff or the police chief of the Minnesota municipality where the applicant or permit holder resides may file a petition with the district court seeking a court order denying an application for or suspending a permit to carry. The petition must be filed in the county where the application was made, together with proof of service of a copy on the applicant or permit holder. The court may not grant any relief before the completion of the hearing. If a petition is filed under this subdivision, a sheriff must not issue a permit until the matter is resolved by the district court.

(b) The court may grant the relief requested in the petition only if the petitioner establishes, by clear and convincing evidence, that there is a substantial likelihood that the applicant will act under the permit in a manner dangerous to the public. The applicant's dangerousness to the public may be established only after a showing that the applicant or permit holder has engaged in a pattern of behavior within the past three years involving verified, reported incidents of unlawful violence, not including incidents for which the applicant was charged and acquitted.

(c) If the court denies a petition brought under paragraph (a), the court must award the applicant or permit holder reasonable costs and expenses including attorney fees.

Sec. 19. Minnesota Statutes 2000, section 624.714, is amended by adding a subdivision to read:

Subd. 12b. [SUSPENSION AS CONDITION OF RELEASE.] The district court may order suspension of the application process for a permit or suspend the permit of a permit holder as a condition of release pursuant to the same criteria as the surrender of firearms under section 629.715.

Sec. 20. Minnesota Statutes 2000, section 624.714, is amended by adding a subdivision to read:

Subd. 14. [RECORDS.] (a) A sheriff must not maintain records or data collected, made, or held under this section concerning any applicant or permit holder that are not necessary under this section to support a permit that is outstanding or eligible for renewal under subdivision 7, paragraph (b). Notwithstanding section 138.163, a sheriff must completely purge all files and databases by March 1 of each year to delete all information collected under this section concerning all persons who are no longer current permit holders or currently eligible to renew their permit.

(b) Paragraph (a) does not apply to records or data concerning an applicant or permit holder who has had a permit denied or revoked under subdivision 2, paragraph (a), clause (1), or subdivision 12a.

Sec. 21. Minnesota Statutes 2000, section 624.714, is amended by adding a subdivision to read:

Subd. 15. [COMMISSIONER OF PUBLIC SAFETY; CONTRACTS; DATABASE.] (a) The commissioner of public safety may contract with one or more vendors to implement the requirements of this section.

(b) The commissioner of public safety must maintain an automated database of persons authorized to carry pistols under this section that is available 24 hours a day, seven days a week, to law enforcement agencies, including prosecutors carrying out their duties under subdivision 8a, solely to verify permit status.

Sec. 22. Minnesota Statutes 2000, section 624.714, is amended by adding a subdivision to read:

Subd. 16. [RECOGNITION OF PERMITS FROM OTHER STATES.] (a) The attorney general must establish and publish a list of other states that have laws governing the issuance of permits to carry pistols that are not substantially similar to this section. A person holding a concealed weapons license or permit from a state not on the list may use the license or permit in this state subject to the rights, privileges, and requirements of this section.

(b) Notwithstanding paragraph (a), no license or permit from another state is valid in this state if the holder is or becomes prohibited from possessing a firearm under section 624.713.

(c) Any sheriff may file a petition under subdivision 12a in any county in the state where a person holding a license or permit from another state resides or can be found.

Sec. 23. Minnesota Statutes 2000, section 624.714, is amended by adding a subdivision to read:

Subd. 17. [IMMUNITY.] Neither the sheriff, any employee of the sheriff involved in the permit issuing process, nor any certified instructor is liable for damages resulting or arising from acts with a firearm committed by a permit holder, unless the sheriff or other person had actual knowledge at the time the permit was issued or the instruction was given that the applicant was disqualified by law from possessing a firearm.

Sec. 24. Minnesota Statutes 2000, section 624.714, is amended by adding a subdivision to read:

Subd. 18. [MONITORING.] (a) By March 1 of each year, the commissioner of public safety must report to the legislature on:

(1) the number of permits to carry issued, suspended, revoked, and denied since the previous submission, and in total;

(2) the number of permits to carry currently valid;

(3) the specific reasons for each suspension, revocation, and denial and the number of reversed, canceled, or corrected actions;

(4) the number of convictions and types of crimes committed since the previous submission, and in total, by individuals with permits to carry, including data as to whether a firearm lawfully carried solely by virtue of a permit to carry was actually used in furtherance of the crime; and

(5) to the extent known or determinable, data on the lawful and justifiable use of firearms by permit holders.

(b) Sheriffs must supply the department of public safety with the basic data the department requires to complete the report under paragraph (a). Sheriffs may submit data classified as private to the department of public safety under this paragraph.

(c) Copies of the report under paragraph (a) must be made available to the public at the actual cost of duplication.

(d) Nothing contained in any provision of this section or any other law requires or authorizes the registration, documentation, collection, or providing of serial numbers or other data on firearms or on firearms owners.

Sec. 25. Minnesota Statutes 2000, section 624.714, is amended by adding a subdivision to read:

Subd. 19. [EXCLUSIVITY.] This section sets forth the complete and exclusive criteria and procedures for the issuance of permits to carry and no sheriff or other person may change, modify, or supplement these criteria or procedures.

Sec. 26. [TEMPORARY EXTENSION ON SHERIFF'S TURNAROUND TIME.]

Notwithstanding section 10, until March 1, 2002: (1) a sheriff has five business days to send

information relating to a background check required under section 9 for a new or renewal permit to the commissioner of public safety; and (2) the sheriff's 30-calendar day turnaround period under section 10 is stayed until the commissioner of public safety responds to the sheriff with the results of the background check.

Sec. 27. [GRANDFATHER CLAUSE.]

Permits to carry pistols issued prior to the effective date of the provisions of this act relating to permits to carry pistols remain in effect and are valid under the terms of issuance until the date of expiration applicable at the time of issuance. However, a person holding a permit that was issued prior to the effective date of these provisions may nevertheless apply for a permit under the terms and conditions specified in this act.

Sec. 28. [STUDY; REPORT TO LEGISLATURE.]

The Minnesota amateur sports commission shall study the advantages and disadvantages of a nonprofit corporation operating a shooting sports program at a state-owned facility that is designed to train participants and coaches in shooting sports that are Olympic events. By January 15, 2002, the commission shall report to the legislature on the results of the study.

Sec. 29. [APPROPRIATION.]

$1,618,000 for the fiscal year ending June 30, 2002, and $308,000 for the fiscal year ending June 30, 2003, are appropriated from the general fund to the commissioner of public safety to implement the provisions of this act relating to permits to carry pistols.

Sec. 30. [REPEALER.]

Minnesota Statutes 2000, section 624.714, subdivisions 1 and 5, are repealed.

Sec. 31. [EFFECTIVE DATES.]

Sections 1 to 27 and 30 are effective August 1, 2001, and apply to crimes committed on or after that date, except that the attorney general must promulgate the list required under section 22 within 90 days of final enactment."

Delete the title and insert:

"A bill for an act relating to public safety; enacting the Minnesota Citizens' Personal Protection Act of 2001; recognizing the inherent right of law-abiding citizens to self-protection through the lawful use of self-defense; providing a system under which responsible, competent adults can exercise their right to self-protection by authorizing them to obtain a permit to carry a pistol; providing criminal penalties; appropriating money; amending Minnesota Statutes 2000, sections 609.66, subdivision 1d; 624.714, subdivisions 2, 3, 4, 6, 7, 8, 10, 12, by adding subdivisions; repealing Minnesota Statutes 2000, section 624.714, subdivisions 1, 5."

## RECESS

Senator Moe, R.D. 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 Betzold imposed a call of the Senate. The Sergeant at Arms was instructed to bring in the absent members.

The Senate resumed consideration of S.F. No. 1481 and the Pariseau amendment.

Senator Pariseau moved to amend the Pariseau amendment to S.F. No. 1481 as follows:

Page 14, line 21, delete ", reported"

The motion prevailed. So the amendment to the amendment was adopted.

Senator Murphy moved to amend the first Pariseau amendment to S.F. No. 1481 as follows:

Pages 1 to 5, delete sections 1 to 6

Pages 6 to 9, delete sections 8 and 9 and insert:

"Sec. 2. Minnesota Statutes 2000, section 624.714, subdivision 5, is amended to read:

Subd. 5. [GRANTING OF PERMITS.] No permit to carry shall be granted to a person unless the applicant:

(a) is not a person prohibited by section 624.713 from possessing a pistol;

(b) ~~Provides a firearms safety certificate recognized by the department of natural resources, evidence of successful completion of a test of ability to use a firearm supervised by the chief of police or sheriff or other satisfactory proof of ability to use a pistol safely~~ is trained in the safe use of a pistol under subdivision 2a; ~~and~~

(c) has an occupation or personal safety hazard requiring a permit to carry; and

(d) is at least 21 years of age."

Page 9, lines 6 to 27, delete the new language and reinstate the stricken language

Page 9, delete line 28 and insert ". This notification must specifically describe the process for the applicant to seek administrative or judicial review of the denial under subdivision 12, including, but not limited to, for each option: the timeline for requesting a review, the fees, the standard of review, and the appeal rights. A chief of police or a sheriff"

Page 9, lines 29 to 36, delete the new language and reinstate the stricken language

Page 10, lines 1 to 17, delete the new language

Pages 10 to 13, delete sections 11 to 16

Page 13, line 23, delete "OR REVOCATION" and before "Any" insert "(a)"

Page 13, line 24, delete "or revocation" and after "may" insert "seek administrative review of the denial. The issuing authority must be listed as the respondent. An administrative law judge shall conduct a de novo review of the application on the record and determine whether the permit should be issued. A hearing under this paragraph must be conducted in a simple and informal manner. If the judge decides in the applicant's favor, the judge shall order the issuing authority to pay the applicant's costs related to the review, including reasonable attorney fees if applicable. The order of the administrative law judge constitutes the final decision in the case. A party aggrieved by the final decision is entitled to judicial review of the decision under sections 14.63 to 14.69, except that the district court, instead of the court of appeals, shall conduct the review in accordance with those provisions.

(b) As an alternative to seeking administrative review under paragraph (a), a person aggrieved by denial of a permit to carry may"

Page 13, line 28, delete "sheriff" and insert "issuing authority"

Page 13, line 29, delete everything after "respondent"

Page 13, delete lines 30 to 34

Page 13, delete line 35 and insert ". ~~The matter~~ A judge shall ~~be heard~~ conduct a de novo review of the application"

Page 13, line 36, after "jury" insert "and determine whether the application should be granted"

Pages 14 to 18, delete sections 18 to 31 and insert:

"Sec. 5. [DATA COLLECTION; REPORT.]

(a) By October 15, 2002, each chief of police and sheriff shall report to the superintendent of the bureau of criminal apprehension the following summary data related to applications for permits to carry pistols under Minnesota Statutes, section 624.714, for the one-year period beginning on July 1, 2001, and ending on August 31, 2002:

(1) the number of applications received;

(2) the number of permits granted;

(3) the reasons given by the applicants for seeking the permits; and

(4) for those applications that were denied, the specific reason for the denial.

The specific reason for the denial required in clause (4) includes, but is not limited to, the applicant being prohibited from possessing a firearm under Minnesota Statutes, section 624.713, the applicant not providing a firearms safety certificate, and the applicant not having an occupation or personal safety hazard requiring a permit to carry. If the applicant was denied the permit based on being prohibited under Minnesota Statutes, section 624.713, the specific prohibition must be cited. If the denial is based on a criminal conviction, the specific crime of conviction must be cited. The data collected under clauses (1) to (4) must be collected generally and must also be broken down based on the race and gender of the applicant.

(b) By January 15, 2003, the superintendent shall report a summary of the data collected under paragraph (a) to the chairs and ranking minority members of the senate and house committees having jurisdiction over criminal justice policy.

Sec. 6. [STUDY; REPORT TO LEGISLATURE.]

The Minnesota amateur sports commission shall study the advantages and disadvantages of a nonprofit corporation operating a shooting sports program at a state-owned facility that is designed to train participants and coaches in shooting sports that are Olympic events. By January 15, 2002, the commission shall report to the legislature on the results of the study."

Renumber the sections in sequence and correct the internal references

Amend the title amendment accordingly

The question was taken on the adoption of the Murphy amendment to the first Pariseau amendment.

The roll was called, and there were yeas 34 and nays 32, as follows:

Those who voted in the affirmative were:

| | | | | |
|---|---|---|---|---|
| Anderson | Higgins | Krentz | Orfield | Robertson |
| Belanger | Hottinger | Lourey | Pappas | Sabo |
| Berglin | Johnson, Dave | Marty | Pogemiller | Scheid |
| Betzold | Johnson, Dean | Metzen | Price | Terwilliger |
| Chaudhary | Kelley, S.P. | Moe, R.D. | Ranum | Wiener |
| Cohen | Kelly, R.C. | Murphy | Rest | Wiger |
| Foley | Kiscaden | Oliver | Ring | |

Those who voted in the negative were:

| | | | | |
|---|---|---|---|---|
| Bachmann | Berg | Day | Dille | Fischbach |

| | | | | |
|---|---|---|---|---|
| Fowler | Kleis | Limmer | Robling | Stumpf |
| Frederickson | Knutson | Neuville | Sams | Tomassoni |
| Johnson, Debbie | Langseth | Olson | Samuelson | Vickerman |
| Johnson, Doug | Larson | Ourada | Scheevel | |
| Kierlin | Lesewski | Pariseau | Schwab | |
| Kinkel | Lessard | Reiter | Stevens | |

The motion prevailed. So the amendment to the amendment was adopted.

Senator Pariseau withdrew her first amendment.

Senator Lessard moved that S.F. No. 1481 be laid on the table. The motion prevailed.

## MOTIONS AND RESOLUTIONS - CONTINUED

Senator Hottinger moved that House Concurrent Resolution No. 3 be taken from the table. The motion prevailed.

**House Concurrent Resolution No. 3:** A House concurrent resolution relating to adopting Permanent Joint Rules of the Senate and House of Representatives.

BE IT RESOLVED, by the House of Representatives of the State of Minnesota, the Senate concurring that:

(1) The DFL majority leader and Republican minority leader of the senate and speaker and DFL minority leader of the house of representatives shall each appoint one-fourth of the members of a bicameral task force to study and report to the House of Representatives and the Senate by January 1, 2002, recommending improvements in legislative rules for the purposes of:

(a) enhancing the openness and accessibility of the legislative process to citizens,

(b) relieving the end-of-session crush of legislative business,

(c) controlling excessive work hours and late-night committee and floor meetings toward the end of session,

(d) making more effective and efficient use of limited session time and the time of legislators and staff, executive branch officials and staff, and other participants in the legislative process,

(e) improving communication and cooperation between the two houses on legislation,

(f) making the decision-making process more open, deliberative, and reflective, particularly in the closing weeks of session, and

(g) enhancing the decision-making authority of individual legislators by reducing the current reliance on decision-making through large omnibus fiscal bills covering multiple subjects within a subject area negotiated in end-of-session conference committees.

(2) The task force shall report on at least the following proposals for advancing these goals:

(a) eliminate all but emergency legislative meetings after 10:00 p.m. and forbid meetings after 12:00 midnight,

(b) provide better information to legislators on legislation repealing administrative rules,

(c) split up omnibus fiscal bills into smaller bills,

(d) obtain earlier, detailed bicameral agreement on taxes and revenues, so as to provide a more uniform context for spending decisions in both houses,

(e) authorize the production of bicameral legislative fiscal notes on disputed matters,

(f) use joint committees in the legislative process and better coordinate session and committee meeting times so as to enhance the opportunity for joint committee meetings,

(g) reduce the use of conference committees by not requiring the house of origin to request a conference committee upon the first sign of disagreement between the houses,

(h) restrict the authority of conference committees to include extraneous matter and to reach agreements not authorized or consented to by the members of the two houses,

(i) establish and enforce earlier deadlines for conference committees and forbid conference committees to report in the closing days of session,

(j) require that every conference committee report be available to members at least 24 hours before action on the report, and

(k) limit the number of conference committee reports on major bills that may be considered in one day.

(3) The task force shall recommend a procedure whereby a joint convention of the senate and house of representatives must meet to elect regents by a date certain prior to adjournment.

Senator Hottinger moved that House Concurrent Resolution No. 3 be now adopted. The motion prevailed.

## RECESS

Senator Moe, R.D. 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 Moe, R.D. from the Subcommittee on Committees recommends that the following Senators be and they hereby are appointed as a Conference Committee on:

S.F. No. 1397: Senators Berglin, Ring, Kiscaden, Sams and Foley.

S.F. No. 1407: Senators Ring, Lourey and Kiscaden.

Senator Moe, R.D. moved that the foregoing appointments be approved. The motion prevailed.

## MEMBERS EXCUSED

Senator Terwilliger was excused from the Session of today from 11:00 a.m. to 12:00 noon.

## ADJOURNMENT

Senator Moe, R.D. moved that the Senate do now adjourn until 10:00 a.m., Wednesday, May 16, 2001. The motion prevailed.

Patrick E. Flahaven, Secretary of the Senate

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