

Sec. 38. Minnesota Statutes 1998, section 256B.0625, subdivision 19c, is amended to read:

Subd. 19c. [PERSONAL CARE.] Medical assistance covers personal care 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 ~~a registered nurse~~ 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 26; 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 the recipient or responsible party and 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. 39. Minnesota Statutes 1998, section 256B.0625, subdivision 26, is amended to read:

Subd. 26. [SPECIAL EDUCATION SERVICES.] (a) Medical assistance covers medical services identified in a recipient's individualized education plan and covered under the medical assistance state plan. Covered services include occupational therapy, physical therapy, speech-language therapy, clinical psychological services, nursing services, school psychological services, school social work services, personal care assistants serving as management aides, assistive technology devices, transportation services, and other services covered under the medical assistance state plan. The services may be provided by a Minnesota school district that is enrolled as a medical assistance provider or its subcontractor, and only if the services meet all the requirements otherwise applicable if the service had been provided by a provider other than a school district, in the following areas: medical necessity, physician's orders, documentation, personnel qualifications, and prior authorization requirements. The nonfederal share of costs for services provided under this subdivision is the responsibility of the local school district as provided in section 125A.74. Services listed in a child's individual education plan are eligible for medical assistance reimbursement only if those services meet criteria for federal financial participation under the Medicaid program.

(b) Approval of health-related services for inclusion in the individual education plan does not require prior authorization for purposes of reimbursement under this chapter. The commissioner may require physician review and approval of the plan not more than once annually or upon any modification of the individual education plan that reflects a change in health-related services.

(c) Services of a speech-language pathologist provided under this section are covered notwithstanding Minnesota Rules, part 9505.0390, subpart 1, item L, if the person:

(1) holds a masters degree in speech-language pathology;

(2) is licensed by the Minnesota board of teaching as an educational speech-language pathologist; and

(3) either has a certificate of clinical competence from the American Speech and Hearing Association, has completed the equivalent educational requirements and work experience necessary for the certificate or has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(d) Medical assistance coverage for medically necessary services provided under other subdivisions in this section may not be denied solely on the basis that the same or similar services are covered under this subdivision.

(e) The commissioner shall develop and implement package rates, bundled rates, or per diem rates for special education services under which separately covered services are grouped together and billed as a unit in order to reduce administrative complexity.

(f) The commissioner shall develop a cost-based payment structure for payment of these services.

(g) Effective July 1, 2000, medical assistance services provided under an individual education plan or an individual family service plan by local school districts shall not count against medical assistance authorization thresholds for that child.

(Effective Date: Section 39 (256B.0625, subdivision 26) is effective July 1, 2000.)

Sec. 40. Minnesota Statutes 1998, section 256B.0625, subdivision 28, is amended to read:

Subd. 28. [CERTIFIED NURSE PRACTITIONER SERVICES.] Medical assistance covers 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 services provided on an inpatient basis are not included as part of the cost for inpatient services included in the operating payment rate, if the services are otherwise covered under this chapter as a physician service, and if the service is within the scope of practice of the nurse practitioner's license as a registered nurse, as defined in section 148.171.

Sec. 41. Minnesota Statutes 1998, 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. ~~This paragraph takes effect only if the Minnesota health care reform waiver is approved by the federal government, and remains in effect for as long as the Minnesota health care reform waiver remains in effect. When the waiver expires, this paragraph expires, and the commissioner of human services shall publish a notice in the State Register and notify the revisor of statutes.~~

(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.

Sec. 42. Minnesota Statutes 1998, section 256B.0625, subdivision 32, is amended to read:

Subd. 32. [NUTRITIONAL PRODUCTS.] ~~(a)~~ Medical assistance covers nutritional products needed for nutritional supplementation because solid food or nutrients thereof cannot be properly absorbed by the body or needed for treatment of phenylketonuria, hyperlysinemia, maple syrup urine disease, a combined allergy to human milk, cow's milk, and soy formula, or any other childhood or adult diseases, conditions, or disorders identified by the commissioner as requiring a similarly necessary nutritional product. Nutritional products needed for the treatment of a combined allergy to human milk, cow's milk, and soy formula require prior authorization. Separate payment shall not be made for nutritional products for residents of long-term care facilities. Payment for dietary requirements is a component of the per diem rate paid to these facilities.

~~(b) The commissioner shall designate a nutritional supplementation products advisory committee to advise the commissioner on nutritional supplementation products for which payment is made. The committee shall consist of nine members, one of whom shall be a physician, one of whom shall be a pharmacist, two of whom shall be registered dietitians, one of whom shall be a public health nurse, one of whom shall be a representative of a home health care agency, one of whom shall be a provider of long-term care services, and two of whom shall be consumers of nutritional supplementation products. Committee members shall serve two-year terms and shall serve without compensation.~~

~~(c) The advisory committee shall review and recommend nutritional supplementation products which require prior authorization. The commissioner shall develop procedures for the operation of the advisory committee so that the advisory committee operates in a manner parallel to the drug formulary committee.~~

Sec. 43. Minnesota Statutes 1998, section 256B.0625, subdivision 35, is amended to read:

Subd. 35. [FAMILY COMMUNITY SUPPORT SERVICES.] Medical assistance covers family community support services as defined in section 245.4871, subdivision 17. In addition to the provisions of section 245.4871, and to the extent authorized by rules promulgated by the state agency, medical assistance covers the following services as family community support services:

(1) services identified in an individual treatment plan when provided by a trained mental health behavioral aide under the direction of a mental health practitioner or mental health professional;

(2) mental health crisis intervention and crisis stabilization services provided outside of hospital inpatient settings;
and

(3) the therapeutic components of preschool and therapeutic camp programs.

Sec. 44. Minnesota Statutes 1998, section 256B.0627, subdivision 1, is amended to read:

Subdivision 1. [DEFINITION.] (a) "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. An initial assessment for personal care services is conducted on individuals who are requesting personal care services or for those consumers who have never had a public health nurse assessment. The initial A face-to-face assessment must include: a face-to-face health status assessment and determination of baseline need, evaluation of service outcomes, collection of initial case data, identification of appropriate services and service plan development or modification, coordination of initial services, referrals and follow-up to appropriate payers and community resources, completion of required reports, obtaining service authorization, and consumer education. A reassessment visit face-to-face assessment for personal care 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 consumer recipient condition and or when there is a change in the need for personal care assistant services. The reassessment visit 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 outcomes, 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 waived 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) "Care plan" means a written description of personal care assistant services developed by the ~~agency nurse~~ qualified professional with the recipient or responsible party to be used by the personal care assistant with a copy provided to the recipient or responsible party.

(c) "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 ~~60~~ 62 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.

(d) "Medically necessary" has the meaning given in Minnesota Rules, parts 9505.0170 to 9505.0475.

(e) "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 services according to the recipient's care plan, responds appropriately to recipient needs, and reports changes in the recipient's condition to the supervising ~~registered nurse~~ qualified professional;

(5) is not a consumer of personal care services; and (6) is subject to criminal background checks and procedures specified in section 245A.04. An individual who has been convicted of a crime specified in Minnesota Rules, part 4668.0020, subpart 14, or a comparable crime in another jurisdiction is disqualified from being a personal care assistant, unless the individual meets the rehabilitation criteria specified in Minnesota Rules, part 4668.0020, subpart 15.

(f) "Personal care provider organization" means an organization enrolled to provide personal care 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) "Responsible party" means an individual residing with a recipient of personal care 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 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) "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) "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.

Sec. 45. Minnesota Statutes 1998, 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 services under section 256B.0625, subdivision 19a;

(5) ~~nursing~~ supervision of personal care assistant services provided by a qualified professional under section 256B.0625, subdivision 19a; ~~and~~

(6) consulting professional of personal care assistant services under the fiscal agent 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. 46. Minnesota Statutes 1998, section 256B.0627, subdivision 4, is amended to read:

Subd. 4. [PERSONAL CARE SERVICES.] (a) The personal care services that are eligible for payment are the following:

- (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 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) The personal care services that are not eligible for payment are the following:

- (1) services not ordered by the physician;
- (2) assessments by personal care 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 ~~adult~~ 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 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.

Sec. 47. Minnesota Statutes 1998, 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) ~~any initial assessment up to two face-to-face assessments to determine a recipient's need for personal care assistant services;~~

(2) ~~up to two reassessments per year~~ one service update done to determine a recipient's need for personal care services; and

(3) up to five 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 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 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. ~~The service update may substitute for the annual reassessment described in subdivision 1.~~

(e) [PRIOR AUTHORIZATION.] The commissioner, or the commissioner's designee, shall review the assessment, ~~the~~ 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.

(2) [PERSONAL CARE SERVICES.] (i) All personal care services and ~~registered nurse~~ supervision by a qualified professional 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 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 ~~nursing~~ supervision by a qualified professional of personal care services.

(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 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 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.

(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. Requests for home care services for recipients residing in a foster care setting must include the foster care placement agreement and determination of difficulty of care;

(2) personal care 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 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;

(4) home care 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 home care services be provided, and case management is provided as required in section 256B.0625, subdivision 19a; or

(5) home care services when combined with foster care payments, other than room and board payments that exceed the total amount that public funds would pay for the recipient's care in a medical institution.

Sec. 48. Minnesota Statutes 1998, section 256B.0627, subdivision 8, is amended to read:

Subd. 8. [SHARED PERSONAL CARE ASSISTANT SERVICES; ~~SHARED CARE~~.] (a) Medical assistance payments for shared personal care assistance ~~shared care~~ 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 care 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 care 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 care services on the date for which the service is billed. No more than three persons may receive shared care services from a personal care assistant in a single setting.

(c) Shared care service is the provision of personal care 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.

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 ~~care~~ personal care assistant services is an appropriate option based on the individual needs and preferences of the recipient; and

(2) the amount of shared ~~care~~ services allocated as part of the overall authorization of personal care services.

The recipient or the responsible party, in conjunction with the supervising ~~registered nurse~~ qualified professional, shall ~~approve~~ arrange the setting, ~~and grouping, and arrangement~~ of shared ~~care~~ services based on the individual needs and preferences of the recipients. Decisions on the selection of recipients to share ~~care~~ 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 ~~nurse~~ qualified professional, and documented in the recipient's ~~care plan~~ 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 ~~registered nurse~~ qualified professional within the first 14 days of shared ~~care~~ services, and monthly thereafter;

(3) the setting in which the shared ~~care~~ 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 ~~care~~ 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 ~~individual~~ one-on-one personal care assistant ~~care~~ services. The recipient or the responsible party can withdraw from participating in a shared ~~care~~ 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 ~~care~~ services:

(1) ~~authorization~~ permission by the recipient or the recipient's responsible party, if any, for the maximum number of shared ~~care~~ services hours per week chosen by the recipient;

(2) ~~authorization~~ permission by the recipient or the recipient's responsible party, if any, for personal care assistant services provided outside the recipient's residence;

(3) ~~authorization~~ permission by the recipient or the recipient's responsible party, if any, for others to receive shared ~~care~~ services in the recipient's residence;

(4) revocation by the recipient or the recipient's responsible party, if any, of the shared ~~care~~ service authorization, or the shared ~~care~~ service to be provided to others in the recipient's residence, or the shared ~~care~~ service to be provided outside the recipient's residence;

(5) supervision of the shared ~~care~~ personal care assistant services by the ~~supervisory nurse~~ qualified professional, including the date, time of day, number of hours spent supervising the provision of shared ~~care~~ services, whether the supervision was face-to-face or another method of supervision, changes in the recipient's condition, shared ~~care services~~ scheduling issues and recommendations;

(6) documentation by the ~~personal care assistant~~ qualified professional of telephone calls or other discussions with the ~~supervisory nurse~~ personal care assistant regarding services being provided to the recipient; and

(7) daily documentation of the shared ~~care~~ services provided by each identified personal care assistant including:

(i) the names of each recipient receiving shared ~~care~~ services together;

(ii) the setting for the ~~day's care~~ shared services, including the starting and ending times that the recipient received shared ~~care~~ services; and

(iii) notes by the personal care assistant regarding changes in the recipient's condition, problems that may arise from the sharing of ~~care services~~ services, scheduling issues, care issues, and other notes as required by the ~~supervising nurse~~ qualified professional.

(h) Unless otherwise provided in this subdivision, all other statutory and regulatory provisions relating to personal care services apply to shared ~~care~~ services.

Nothing in this subdivision shall be construed to reduce the total number of hours authorized for an individual recipient.

Sec. 49. Minnesota Statutes 1998, section 256B.0627, is amended by adding a subdivision to read:

Subd. 9. [FLEXIBLE USE OF PERSONAL CARE ASSISTANT HOURS.] (a) The commissioner may allow for the flexible use of personal care assistant hours. "Flexible use" means the scheduled use of authorized hours of personal care assistant services which vary within the length of the service authorization in order to more effectively meet the needs and schedule of the recipient. Recipients may use their approved hours flexibly within the service authorization period for medically necessary covered services specified in the assessment required in subdivision 1. The flexible use of authorized hours does not increase the total amount of authorized hours available to a recipient as determined under subdivision 5. The commissioner shall not authorize additional personal care assistant services to supplement a service authorization that is exhausted before the end date under a flexible service use plan, unless the county public health nurse determines a change in condition and a need for increased services is established.

(b) The recipient or responsible party, together with the county public health nurse, shall determine whether flexible use is an appropriate option based on the needs and preferences of the recipient or responsible party, and, if appropriate, must ensure that the allocation of hours covers the ongoing needs of the recipient over the entire service authorization period. As part of the assessment and service planning process, the recipient or responsible party works with the county public health nurse to develop a written month-to-month plan of the projected use of personal care assistant services that is part of the service plan and assures that:

(1) health and safety needs of the recipient will be met;

(2) total annual authorization will not exceed before the end date; and

(3) actual use of hours will be monitored.

(c) If the actual use of personal care assistant service varies significantly from the use projected in the plan, the written plan must be promptly updated by the recipient or responsible party and the county public health nurse.

(d) The recipient or responsible party, together with the provider, must work to monitor and document the use of authorized hours and ensure that a recipient is able to manage services effectively throughout the authorized period. The provider must assure that the month to month plan is incorporated into the care plan. Upon request of the recipient or responsible party, the provider must furnish regular updates to the recipient or responsible party on the amount of personal care assistant services used.

(e) The recipient or responsible party may revoke the authorization for flexible use of hours by notifying the provider and the county public health nurse in writing.

(f) If the requirements in paragraphs (a) to (e) have not substantially been met, the commissioner shall deny, revoke, or suspend the authorization to use authorized hours flexibly. The recipient or responsible party may appeal the commissioner's action according to section 256.045. The denial, revocation, or suspension to use the flexible hours option shall not affect the recipient's authorized level of personal care assistant services as determined under subdivision 5.

Sec. 50. Minnesota Statutes 1998, section 256B.0627, is amended by adding a subdivision to read:

Subd. 10. [FISCAL AGENT 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 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 services apply to a recipient using the fiscal agent option.

(b) The recipient or responsible party shall:

(1) hire, and terminate the personal care assistant and consulting professional, with the fiscal agent;

(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;

(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 professional and implement recommendations pertaining to the health and safety of the recipient;

(5) hire a qualified professional to train and supervise the performance of delegated tasks done by the personal care assistant;

(6) monitor services and verify in writing the hours worked by the personal care assistant and the consulting professional;

(7) develop and revise a care plan with assistance from a consulting professional;

(8) verify and document the credentials of the consulting professional; and

(9) enter into a written agreement, as specified in paragraph (f).

(c) The duties of the fiscal agent shall be to:

- (1) bill the medical assistance program for personal care assistant and consulting professional services;
- (2) request and secure background checks on personal care assistants and consulting professionals according to section 245A.04;
- (3) pay the personal care assistant and consulting professional based on actual hours of services provided;
- (4) withhold and pay all applicable federal and state taxes;
- (5) verify and document hours worked by the personal care assistant and consulting 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; and
- (8) enter into a written agreement as specified in paragraph (f) before services are provided.

(d) The fiscal agent:

- (1) may not be related to the recipient, consulting 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 professional to the extent specified in this section.

The fiscal agent or owners of the entity that provides fiscal agent services under this subdivision must pass a criminal background check as required in section 256B.0627, subdivision 1, paragraph (e).

(e) The consulting professional providing assistance to the recipient shall meet the qualifications specified in section 256B.0625, subdivision 19c. The 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. In performing this function, the professional must visit the recipient in the recipient's home at least once annually. The 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, recipient or responsible party, personal care assistant, and consulting professional shall enter into a written agreement before services are started. The agreement shall include:

- (1) the duties of the recipient, 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;
- (3) the administrative fee of the fiscal agent 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.

(g) The rates paid for personal care services, professional assistance, and fiscal agency services under this subdivision shall be the same rates paid for personal care services and qualified professional services under subdivision 2 respectively. Except for the administrative fee of the fiscal agent specified in paragraph (f), the remainder of the rates paid to the fiscal agent must be used to pay for the salary and benefits for the personal care assistant or those providing professional consultation.

(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:

(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 option if:

(1) it has been determined by the consulting 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 option shall not affect the recipient's authorized level of personal care assistant services as determined in subdivision 5. The effective date of this subdivision is the date of federal approval.

Sec. 51. Minnesota Statutes 1998, section 256B.0627, is amended by adding a subdivision 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 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.

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 several 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. 52. Minnesota Statutes 1998, section 256B.0635, subdivision 3, is amended to read:

Subd. 3. [MEDICAL ASSISTANCE FOR MFIP-S PARTICIPANTS WHO OPT TO DISCONTINUE MONTHLY CASH ASSISTANCE.] ~~Upon federal approval,~~ Medical assistance is available to persons who ~~received MFIP-S in at least three of the six months preceding the month in which the person opted~~ opt to discontinue receiving MFIP-S cash assistance under section 256J.31, subdivision 12. A person who is eligible for medical assistance under this section may receive medical assistance without reapplication as long as the person meets MFIP-S eligibility requirements, ~~unless the assistance unit does not include a dependent child.~~ Medical assistance may be paid pursuant to subdivisions 1 and 2 for persons who are no longer eligible for MFIP-S due to increased employment or child support. A person may be eligible for MinnesotaCare due to increased employment or child support, and as such must be informed of the option to transition onto MinnesotaCare.

Sec. 53. [256B.0914] [CONFLICTS OF INTEREST RELATED TO MEDICAID EXPENDITURES.]

Subdivision 1. [DEFINITIONS.] (a) "Contract" means a written, fully executed agreement for the purchase of goods and services involving a substantial expenditure of Medicaid funding. A contract under a renewal period shall be considered a separate contract.

(b) "Contractor bid or proposal information" means cost or pricing data, indirect costs, and proprietary information marked as such by the bidder in accordance with applicable law.

(c) "Particular expenditure" means a substantial expenditure as defined below, for a specified term, involving specific parties. The renewal of an existing contract for the substantial expenditure of Medicaid funds is considered a separate, particular expenditure from the original contract.

(d) "Source selection information" means any of the following information prepared for use by the state, county, or independent contractor for the purpose of evaluating a bid or proposal to enter into a Medicaid procurement contract, if that information has not been previously made available to the public or disclosed publicly:

- (1) bid prices submitted in response to a solicitation for sealed bids, or lists of the bid prices before bid opening;
- (2) proposed costs or prices submitted in response to a solicitation, or lists of those proposed costs or prices;
- (3) source selection plans;
- (4) technical evaluations plans;
- (5) technical evaluations of proposals;
- (6) cost or price evaluation of proposals;
- (7) competitive range determinations that identify proposals that have a reasonable chance of being selected for award of a contract;
- (8) rankings of bids, proposals, or competitors;
- (9) the reports and evaluations of source selection panels, boards, or advisory councils; and
- (10) other information marked as "source selection information" based on a case-by-case determination by the head of the agency, contractor, designees, or the contracting officer that disclosure of the information would jeopardize the integrity or successful completion of the Medicaid procurement to which the information relates.

(e) "Substantial expenditure" and "substantial amounts" mean a purchase of goods or services in excess of \$10,000,000 in Medicaid funding under this chapter or chapter 256L.

Subd. 2. [APPLICABILITY.] (a) Unless provided otherwise, this section applies to:

(1) any state or local officer, employee, or independent contractor who is responsible for the substantial expenditures of medical assistance or MinnesotaCare funding under this chapter or chapter 256L for which federal Medicaid matching funds are available;

(2) any individual who formerly was such an officer, employee, or independent contractor; and

(3) any partner of such a state or local officer, employee, or independent contractor.

(b) This section is intended to meet the requirements of state participation in the Medicaid program at United States Code, title 42, sections 1396a(a)(4) and 1396u-2(d)(3), which require that states have in place restrictions against conflicts of interest in the Medicaid procurement process, that are at least as stringent as those in effect under United States Code, title 41, section 423, and title 18, sections 207 and 208, as they apply to federal employees.

Subd. 3. [DISCLOSURE OF PROCUREMENT INFORMATION.] A person described in subdivision 2 may not knowingly disclose contractor bid or proposal information, or source selection information before the award by the state, county, or independent contractor of a Medicaid procurement contract to which the information relates unless the disclosure is otherwise authorized by law. No person, other than as provided by law, shall knowingly obtain contractor bid or proposal information or source selection information before the award of a Medicaid procurement contract to which the information relates.

Subd. 4. [OFFERS OF EMPLOYMENT.] When a person described in subdivision 2, paragraph (a), is participating personally and substantially in a Medicaid procurement for a contract contracts or is contacted by a person who is a bidder or offeror in the same procurement regarding possible employment outside of the entity by which the person is currently employed, the person must:

(1) report the contact in writing to the person's supervisor and employer's ethics officer; and

(2) either:

(i) reject the possibility of employment with the bidder or offeror; or

(ii) be disqualified from further participation in the procurement until the bidder or offeror is no longer involved in that procurement, or all discussions with the bidder or offeror regarding possible employment have terminated without an arrangement for employment. A bidder or offeror may not engage in employment discussions with an official who is subject to this subdivision, until the bidder or offeror is no longer involved in that procurement.

Subd. 5. [ACCEPTANCE OF COMPENSATION BY A FORMER OFFICIAL.] (a) A former official of the state or county, or a former independent contractor, described in subdivision 2 may not accept compensation from a Medicaid contractor of a substantial expenditure as an employee, officer, director, or consultant of the contractor within one year after the former official or independent contractor:

(1) served as the procuring contracting officer, the source selection authority, a member of the source selection evaluation board, or the chief of a financial or technical evaluation team in a procurement in which the contractor was selected for award;

(2) served as the program manager, deputy program manager, or administrative contracting officer for a contract awarded to the contractor; or

(3) personally made decisions for the state, county, or independent contractor to:

(i) award a contract, subcontract, modification of a contract or subcontract, or a task order or delivery order to the contractor;

(ii) establish overhead or other rates applicable to a contract or contracts with the contractor;

(iii) approve issuance of a contract payment or payments to the contractor; or

(iv) pay or settle a claim with the contractor.

(b) Paragraph (a) does not prohibit a former official of the state, county, or independent contractor from accepting compensation from any division or affiliate of a contractor not involved in the same or similar products or services as the division or affiliate of the contractor that is responsible for the contract referred to in paragraph (a), clause (1), (2), or (3).

(c) A contractor shall not provide compensation to a former official knowing that the former official is accepting that compensation in violation of this subdivision.

Subd. 6. [PERMANENT RESTRICTIONS ON REPRESENTATION AND COMMUNICATION.] (a) A person described in subdivision 2, after termination of his or her service with state, county, or independent contractor, is permanently restricted from knowingly making, with the intent to influence, any communication to or appearance before an officer or employee of a department, agency, or court of the United States, the state of Minnesota and its counties in connection with a particular expenditure:

(1) in which the United States, the state of Minnesota, or a Minnesota county is a party or has a direct and substantial interest;

(2) in which the person participated personally and substantially as an officer, employee, or independent contractor; and

(3) which involved a specific party or parties at the time of participation.

(b) For purposes of this subdivision and subdivisions 7 and 9, "participated" means an action taken through decision, approval, disapproval, recommendation, the rendering of advice, investigation, or other such action.

Subd. 7. [TWO-YEAR RESTRICTIONS ON REPRESENTATION AND COMMUNICATION.] No person described in subdivision 2, within two years after termination of service with the state, county, or independent contractor, shall knowingly make, with the intent to influence, any communication to or appearance before any officer or employee of any government department, agency, or court in connection with a particular expenditure:

(1) in which the United States, the state of Minnesota, or a Minnesota county is a party or has a direct and substantial interest;

(2) which the person knows or reasonably should know was actually pending under the official's responsibility as an officer, employee, or independent contractor within one year before the termination of the official's service with the state, county, or independent contractor; and

(3) which involved a specific party or parties at the time the expenditure was pending.

Subd. 8. [EXCEPTIONS TO PERMANENT AND TWO-YEAR RESTRICTIONS ON REPRESENTATION AND COMMUNICATION.] Subdivisions 6 and 7 do not apply to:

(1) communications or representations made in carrying out official duties on behalf of the United States, the state of Minnesota or local government, or as an elected official of the state or local government;

(2) communications made solely for the purpose of furnishing scientific or technological information; or

(3) giving testimony under oath. A person subject to subdivisions 6 and 7 may serve as an expert witness in that matter, without restriction, for the state, county, or independent contractor. Under court order, a person subject to subdivisions 6 and 7 may serve as an expert witness for others. Otherwise, the person may not serve as an expert witness in that matter.

Subd. 9. [WAIVER.] The commissioner of human services, or the governor in the case of the commissioner, may grant a waiver of a restriction in subdivisions 6 and 7 if he or she determines that a waiver is in the public interest and that the services of the officer or employee are critically needed for the benefit of the state or county government.

Subd. 10. [ACTS AFFECTING A PERSONAL FINANCIAL INTEREST.] A person described in subdivision 2, paragraph (a), clause (1), who participates in a particular expenditure in which the person has knowledge or has a financial interest, is subject to the penalties in subdivision 12. For purposes of this subdivision, "financial interest" also includes the financial interest of a spouse, minor child, general partner, organization in which the officer or employee is serving as an officer, director, trustee, general partner, or employee, or any person or organization with whom the individual is negotiating or has any arrangement concerning prospective employment.

Subd. 11. [EXCEPTIONS TO PROHIBITIONS REGARDING FINANCIAL INTEREST.] Subdivision 10 does not apply if:

(1) the person first advises the person's supervisor and the employer's ethics officer regarding the nature and circumstances of the particular expenditure and makes full disclosure of the financial interest and receives in advance a written determination made by the commissioner of human services, or the governor in the case of the commissioner, that the interest is not so substantial as to likely affect the integrity of the services which the government may expect from the officer, employee, or independent contractor;

(2) the financial interest is listed as an exemption at Code of Federal Regulations, title 5, sections 2640.201 to 2640.203, as too remote or inconsequential to affect the integrity of the services of the office, employee, or independent contractor to which the requirement applies.

Subd. 12. [CRIMINAL PENALTIES.] (a) A person who violates subdivisions 3 to 5 for the purpose of either exchanging the information covered by this section for anything of value, or for obtaining or giving anyone a competitive advantage in the award of a Medicaid contract, may be sentenced to imprisonment for not more than five years or payment of a fine of not more than \$50,000 for each violation, or the amount of compensation which the person received or offered for the prohibited conduct, whichever is greater, or both.

(b) A person who violates a provision of subdivisions 6 to 11 may be sentenced to imprisonment for not more than one year or payment of a fine of not more than \$50,000 for each violation or the amount of compensation which the person received or offered for the prohibited conduct, whichever amount is greater, or both. A person who willfully engages in conduct in violation of subdivisions 6 to 11 may be sentenced to imprisonment for not more than five years or to payment of fine of not more than \$50,000 for each violation or the amount of compensation which the person received or offered for the prohibited conduct, whichever amount is greater, or both.

(c) Nothing in this section precludes prosecution under other laws such as section 609.43.

Subd. 13. [CIVIL PENALTIES AND INJUNCTIVE RELIEF.] (a) The Minnesota attorney general may bring a civil action in Ramsey county district court against a person who violates subdivisions 3 to 5. Upon proof of such conduct by a preponderance of evidence, the person is subject to a civil penalty. An individual who violates subdivisions 3 to 5 is subject to a civil penalty of not more than \$50,000 for each violation plus twice the amount of compensation which the individual received or offered for the prohibited conduct. An organization that violates subdivisions 3 to 5 is subject to a civil penalty of not more than \$500,000 for each violation plus twice the amount of compensation which the organization received or offered for the prohibited conduct.

(b) If the Minnesota attorney general has reason to believe that a person is engaging in conduct in violation of subdivision 6, 7, or 9, the attorney general may petition the Ramsey county district court for an order prohibiting that person from engaging in such conduct. The court may issue an order prohibiting that person from engaging in such conduct if the court finds that the conduct constitutes such a violation. The filing of a petition under this subdivision does not preclude any other remedy which is available by law.

Subd. 14. [ADMINISTRATIVE ACTIONS.] (a) If a state agency, local agency, or independent contractor receives information that a contractor or a person has violated subdivisions 3 to 5, the state agency, local agency, or independent contractor may:

- (1) cancel the procurement if a contract has not already been awarded;
- (2) rescind the contract; or
- (3) initiate suspension or debarment proceedings according to applicable state or federal law.

(b) If the contract is rescinded, the state agency, local agency, or independent contractor is entitled to recover, in addition to any penalty prescribed by law, the amount expended under the contract.

(c) This section does not:

(1) restrict the disclosure of information to or from any person or class of persons authorized to receive that information;

(2) restrict a contractor from disclosing the contractor's bid or proposal information or the recipient from receiving that information;

(3) restrict the disclosure or receipt of information relating to a Medicaid procurement after it has been canceled by the state agency, county agency, or independent contractor before the contract award unless the agency or independent contractor plans to resume the procurement; or

(4) limit the applicability of any requirements, sanctions, contract penalties, and remedies established under any other law or regulation.

(d) No person may file a protest against the award or proposed award of a Medicaid contract alleging a violation of this section unless that person reported the information the person believes constitutes evidence of the offense to the applicable state agency, local agency, or independent contractor responsible for the procurement. The report must be made no later than 14 days after the person first discovered the possible violation.

Sec. 54. Minnesota Statutes 1998, section 256B.0916, is amended to read:

256B.0916 [EXPANSION OF HOME AND COMMUNITY-BASED SERVICES; MANAGEMENT AND ALLOCATION RESPONSIBILITIES.]

~~(a) The commissioner shall expand availability of home and community-based services for persons with mental retardation and related conditions to the extent allowed by federal law and regulation and shall assist counties in transferring persons from semi-independent living services to home and community-based services. The commissioner may transfer funds from the state semi-independent living services account available under section 252.275, subdivision 8, and state community social services aids available under section 256E.15 to the medical assistance account to pay for the nonfederal share of nonresidential and residential home and community-based services authorized under section 256B.092 for persons transferring from semi-independent living services.~~

~~(b) Upon federal approval, county boards are not responsible for funding semi-independent living services as a social service for those persons who have transferred to the home and community-based waiver program as a result of the expansion under this subdivision. The county responsibility for those persons transferred shall be assumed under section 256B.092. Notwithstanding the provisions of section 252.275, the commissioner shall continue to allocate funds under that section for semi-independent living services and county boards shall continue to fund services under sections 256E.06 and 256E.14 for those persons who cannot access home and community-based services under section 256B.092.~~

~~(c) Eighty percent of the state funds made available to the commissioner under section 252.275 as a result of persons transferring from the semi-independent living services program to the home and community-based services program shall be used to fund additional persons in the semi-independent living services program.~~

~~(d) Beginning August 1, 1998, the commissioner shall issue an annual report on the home and community-based waiver for persons with mental retardation or related conditions, that includes a list of the counties in which less than 95 percent of the allocation provided, excluding the county waived services reserve, has been committed for two or more quarters during the previous state fiscal year. For each listed county, the report shall include the amount of funds allocated but not used, the number and ages of individuals screened and waiting for services, the services needed, a description of the technical assistance provided by the commissioner to assist the counties in jointly planning with other counties in order to serve more persons, and additional actions which will be taken to serve those screened and waiting for services.~~

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, funding shall be increased to add 250 additional eligible persons each year beyond the November 1998 medical assistance forecast for the period July 1, 1999, to June 30, 2003.

Subd. 2. [DISTRIBUTION OF FUNDS; PARTNERSHIPS.] (a) Beginning with fiscal year 2000, the commissioner shall distribute all funding available for home and community-based waiver services for persons with mental retardation or related conditions to individual counties or to groups of counties that form partnerships to jointly plan, administer, and authorize funding for eligible individuals. The commissioner shall encourage counties to form partnerships that have a sufficient number of recipients and funding to adequately manage the risk and maximize use of available resources.

(b) Counties must submit a request for funds and a plan for administering the program as required by the commissioner. The plan must identify the number of clients to be served, their ages, and their priority listing based on:

- (1) requirements in Minnesota Rules, part 9525.1880;
- (2) unstable living situations due to the age or incapacity of the primary caregiver; and
- (3) the need for services to avoid out-of-home placement of children.

The plan must also identify changes made to improve services to eligible persons and to improve program management.

(c) In allocating resources to counties, priority must be given to groups of counties that form partnerships to jointly plan, administer, and authorize funding for eligible individuals and to counties determined by the commissioner to have sufficient waiver capacity to maximize resource use.

(d) Within 30 days after receiving the county request for funds and plans, the commissioner shall provide a written response to the plan that includes the level of resources available to serve additional persons.

(e) Counties are eligible to receive medical assistance administrative reimbursement for administrative costs under criteria established by the commissioner.

Subd. 3. [FAILURE TO DEVELOP PARTNERSHIPS OR SUBMIT A PLAN.] (a) By October 1 of each year the commissioner shall notify the county board if any county determined by the commissioner to have insufficient capacity to maximize use of available resources fails to develop a partnership with other counties or fails to submit a plan as required in subdivision 2. The commissioner shall provide needed technical assistance to a county or group of counties that fails to form a partnership or submit a plan. If a county has not joined a county partnership or submitted a plan within 30 days following the notice by the commissioner of its failure, the commissioner shall require and assist that county to develop a plan or contract with another county or group of counties to plan and administer the waiver services program in that county.

(b) Counties may request technical assistance, management information, and administrative support from the commissioner at any time. The commissioner shall respond to county requests within 30 days. Priority shall be given to activities that support the administrative needs of newly formed county partnerships.

Subd. 4. [ALLOWED RESERVE.] Counties or groups of counties participating in partnerships that have submitted a plan under this section may develop an allowed reserve amount to meet crises and other unmet needs of current home and community-based waiver recipients. The amount of the allowed reserve shall be a county specific amount based upon documented past experience and projected need for the coming year described in an allowed reserve plan submitted for approval to the commissioner with the allocation request for the fiscal year.

Subd. 5. [PRIORITIES FOR REASSIGNMENT OF RESOURCES AND APPROVAL OF INCREASED CAPACITY.] In order to maximize the number of persons served with waiver funds, the commissioner shall monitor county utilization of allocated resources and, as appropriate, reassign resources not utilized and approve increased capacity within available county allocations. Priority consideration for reassignment of resources and approval of increased capacity shall be given to counties with sufficient capacity and counties that form partnerships. In addition to the priorities listed in Minnesota Rules, part 9525.1880, the commissioner shall also give priority consideration to persons whose living situations are unstable due to the age or incapacity of the primary caregiver and to children to avoid out-of-home placement.

Subd. 6. [WAIVER REQUEST.] (a) The commissioner shall submit to the federal Health Care Financing Administration by September 1, 1999, a request for a waiver to include an option that would allow waiver service recipients to directly receive 95 percent of the funds that would be allocated to individuals based on written county criteria and procedures approved by the commissioner for the purchase of services to meet their long-term care needs. The waiver request must include a provision requiring recipients who receive funds directly to provide to the commissioner annually, a description of the type of services used, the amount paid for the services purchased, and the amount of unspent funds.

(b) The commissioner, in cooperation with county representatives, waiver service providers, recipients, recipients' families, legal guardians, and advocacy groups, shall develop criteria for:

- (1) eligibility to receive funding directly;
- (2) determination of the amount of funds made available to each eligible person based on need; and
- (3) the accountability required of persons directly receiving funds.

(c) If this waiver is approved and implemented, any unspent money from the waiver services allocation, including the five percent not directly allocated to recipients and any unspent portion of the money that is directly allocated, shall be used to meet the needs of other eligible persons waiting for services funded through the waiver.

(d) The commissioner, in consultation with county social services agencies, waiver services providers, recipients, recipients' families, legal guardians, and advocacy groups shall evaluate the effectiveness of this option within two years of its implementation.

Subd. 7. [ANNUAL REPORT BY COMMISSIONER.] Beginning October 1, 1999, and each October 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 waived services.

The commissioner shall specify intended outcomes for the program and the degree to which these specified outcomes are attained.

(e) Subd. 8. [FINANCIAL INFORMATION BY COUNTY.] The commissioner shall make available to interested parties, upon request, financial information by county including the amount of resources allocated for the home and community-based waiver for persons with mental retardation and related conditions, the resources committed, the number of persons screened and waiting for services, the type of services requested by those waiting, and the amount of allocated resources not committed.

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, or the consumer support grant program pursuant to section 256B.092, subdivision 7, 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, the commissioner shall submit, for federal approval, amendments to allow legal representatives to provide supports and receive reimbursement under the consumer-directed community support services section of the home and community-based waiver plan.

Sec. 55. Minnesota Statutes 1998, section 256B.0917, subdivision 8, is amended to read:

Subd. 8. [LIVING-AT-HOME/BLOCK NURSE PROGRAM GRANT.] (a) The organization awarded the contract under subdivision 7, shall develop and administer a grant program to establish or expand up to ~~27~~ 37 community-based organizations that will implement living-at-home/block nurse programs that are designed to enable senior citizens to live as independently as possible in their homes and in their communities. At least one-half of the programs must be in counties outside the seven-county metropolitan area. Nonprofit organizations and units of local government are eligible to apply for grants to establish the community organizations that will implement living-at-home/block nurse programs. In awarding grants, the organization awarded the contract under subdivision 7 shall give preference to nonprofit organizations and units of local government from communities that:

- (1) have high nursing home occupancy rates;
 - (2) have a shortage of health care professionals;
 - (3) are located in counties adjacent to, or are located in, counties with existing living-at-home/block nurse programs; and
 - (4) meet other criteria established by LAH/BN, Inc., in consultation with the commissioner.
- (b) Grant applicants must also meet the following criteria:
- (1) the local community demonstrates a readiness to establish a community model of care, including the formation of a board of directors, advisory committee, or similar group, of which at least two-thirds is comprised of community citizens interested in community-based care for older persons;
 - (2) the program has sponsorship by a credible, representative organization within the community;
 - (3) the program has defined specific geographic boundaries and defined its organization, staffing and coordination/delivery of services;
 - (4) the program demonstrates a team approach to coordination and care, ensuring that the older adult participants, their families, the formal and informal providers are all part of the effort to plan and provide services; and
 - (5) the program provides assurances that all community resources and funding will be coordinated and that other funding sources will be maximized, including a person's own resources.
- (c) Grant applicants must provide a minimum of five percent of total estimated development costs from local community funding. Grants shall be awarded for four-year periods, and the base amount shall not exceed \$80,000 per applicant for the grant period. The organization under contract may increase the grant amount for applicants from communities that have socioeconomic characteristics that indicate a higher level of need for assistance. Subject to the availability of funding, grants and grant renewals awarded or entered into on or after July 1, 1997, shall be

renewed by LAH/BN, Inc. every four years, unless LAH/BN, Inc. determines that the grant recipient has not satisfactorily operated the living-at-home/block nurse program in compliance with the requirements of paragraphs (b) and (d). Grants provided to living-at-home/block nurse programs under this paragraph may be used for both program development and the delivery of services.

(d) Each living-at-home/block nurse program shall be designed by representatives of the communities being served to ensure that the program addresses the specific needs of the community residents. The programs must be designed to:

(1) incorporate the basic community, organizational, and service delivery principles of the living-at-home/block nurse program model;

(2) provide senior citizens with registered nurse directed assessment, provision and coordination of health and personal care services on a sliding fee basis as an alternative to expensive nursing home care;

(3) provide information, support services, homemaking services, counseling, and training for the client and family caregivers;

(4) encourage the development and use of respite care, caregiver support, and in-home support programs, such as adult foster care and in-home adult day care;

(5) encourage neighborhood residents and local organizations to collaborate in meeting the needs of senior citizens in their communities;

(6) recruit, train, and direct the use of volunteers to provide informal services and other appropriate support to senior citizens and their caregivers; and

(7) provide coordination and management of formal and informal services to senior citizens and their families using less expensive alternatives.

Sec. 56. Minnesota Statutes 1998, 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 ~~13~~ 14 but not more than ~~20~~ 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; ~~and~~ 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.

Sec. 57. Minnesota Statutes 1998, 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.

Sec. 58. Minnesota Statutes 1998, section 256B.0955, is amended to read:

256B.0955 [DUTIES OF THE COMMISSIONER OF HUMAN SERVICES.]

(a) Effective July 1, 1998, the commissioner of human services shall delegate authority to perform licensing functions and activities, in accordance with section 245A.16, to counties participating in the alternative licensing system. The commissioner shall not license or reimburse a facility, program, or service for persons with developmental disabilities in a county that participates in the alternative licensing system if the commissioner has received from the appropriate county notification that the facility, program, or service has been reviewed by a quality assurance team and has failed to qualify for licensure.

(b) The commissioner may conduct random licensing inspections based on outcomes adopted under section 256B.0951 at facilities, programs, and services governed by the alternative licensing system. The role of such random inspections shall be to verify that the alternative licensing system protects the safety and well-being of consumers and maintains the availability of high-quality services for persons with developmental disabilities.

(c) The commissioner shall provide technical assistance and support or training to the alternative licensing system pilot project.

~~(d) The commissioner and the commission shall establish an ongoing evaluation process for the alternative licensing system.~~

~~(e) The commissioner shall contract with an independent entity to conduct a financial review of the alternative licensing system, including an evaluation of possible budgetary savings within the department of human services and the department of health as a result of implementation of the alternative quality assurance licensing system. This review must be completed by December 15, 2000.~~

~~(f) The commissioner and the commission shall submit a report to the legislature by January 15, 2001, on the results of the evaluation process of the alternative licensing system, 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.~~

Sec. 59. Minnesota Statutes 1998, section 256B.48, subdivision 1, is amended to read:

Subdivision 1. [PROHIBITED PRACTICES.] A nursing facility is not eligible to receive medical assistance payments unless it refrains from all of the following:

(a) Charging private paying residents rates for similar services which exceed those which are approved by the state agency for medical assistance recipients as determined by the prospective desk audit rate, except under the following circumstances: the nursing facility may (1) charge private paying residents a higher rate for a private room, and (2) charge for special services which are not included in the daily rate if medical assistance residents are charged separately at the same rate for the same services in addition to the daily rate paid by the commissioner. Services covered by the payment rate must be the same regardless of payment source. Special services, if offered, must be available to all residents in all areas of the nursing facility and charged separately at the same rate. Residents are free to select or decline special services. Special services must not include services which must be provided by the nursing facility in order to comply with licensure or certification standards and that if not provided would result in a deficiency or violation by the nursing facility. Services beyond those required to comply with licensure or certification standards must not be charged separately as a special service if they were included in the payment rate for the previous reporting year. A nursing facility that charges a private paying resident a rate in violation of this clause is subject to an action by the state of Minnesota or any of its subdivisions or agencies for civil damages. A private paying resident or the resident's legal representative has a cause of action for civil damages against a nursing facility that charges the resident rates in violation of this clause. The damages awarded shall include three times the payments that result from the violation, together with costs and disbursements, including reasonable attorneys' fees or their equivalent. A private paying resident or the resident's legal representative, the state, subdivision or agency, or a nursing facility may request a hearing to determine the allowed rate or rates at issue in the cause of action. Within 15 calendar days after receiving a request for such a hearing, the commissioner shall request assignment of an administrative law judge under sections 14.48 to 14.56 to conduct the hearing as soon as possible or according to agreement by the parties. The administrative law judge shall issue a report within 15 calendar days following the close of the hearing. The prohibition set forth in this clause shall not apply to facilities licensed as boarding care facilities which are not certified as skilled or intermediate care facilities level I or II for reimbursement through medical assistance.

(b) Requiring an applicant for admission to the facility, or the guardian or conservator of the applicant, as a condition of admission, to pay any fee or deposit in excess of \$100, loan any money to the nursing facility, or promise to leave all or part of the applicant's estate to the facility.

(c) Requiring any resident of the nursing facility to utilize a vendor of health care services chosen by the nursing facility. A nursing facility may require a resident to use pharmacies that utilize unit dose packing systems or other medication administration systems approved by the Minnesota board of pharmacy, and may require a resident to use pharmacies that are able to meet the nursing facility's standards for safe and timely administration of medications such as systems with specific number of doses, prompt delivery of medications, or access to medications on a 24-hour basis. Nursing facilities shall not restrict a resident's choice of pharmacy because the pharmacy utilizes a specific system of unit dose drug packing, providing the system is consistent with the other systems used by the facility.

(d) Providing differential treatment on the basis of status with regard to public assistance.

(e) Discriminating in admissions, services offered, or room assignment on the basis of status with regard to public assistance or refusal to purchase special services. Admissions discrimination shall include, but is not limited to:

(1) basing admissions decisions upon assurance by the applicant to the nursing facility, or the applicant's guardian or conservator, that the applicant is neither eligible for nor will seek public assistance for payment of nursing facility care costs; and

(2) engaging in preferential selection from waiting lists based on an applicant's ability to pay privately or an applicant's refusal to pay for a special service.

The collection and use by a nursing facility of financial information of any applicant pursuant to a preadmission screening program established by law shall not raise an inference that the nursing facility is utilizing that information for any purpose prohibited by this paragraph.

(f) Requiring any vendor of medical care as defined by section 256B.02, subdivision 7, who is reimbursed by medical assistance under a separate fee schedule, to pay any amount based on utilization or service levels or any portion of the vendor's fee to the nursing facility except as payment for renting or leasing space or equipment or purchasing support services from the nursing facility as limited by section 256B.433. All agreements must be disclosed to the commissioner upon request of the commissioner. Nursing facilities and vendors of ancillary services that are found to be in violation of this provision shall each be subject to an action by the state of Minnesota or any of its subdivisions or agencies for treble civil damages on the portion of the fee in excess of that allowed by this provision and section 256B.433. Damages awarded must include three times the excess payments together with costs and disbursements including reasonable attorney's fees or their equivalent.

(g) Refusing, for more than 24 hours, to accept a resident returning to the same bed or a bed certified for the same level of care, in accordance with a physician's order authorizing transfer, after receiving inpatient hospital services.

The prohibitions set forth in clause (b) shall not apply to a retirement facility with more than 325 beds including at least 150 licensed nursing facility beds and which:

- (1) is owned and operated by an organization tax-exempt under section 290.05, subdivision 1, clause (i); and
- (2) accounts for all of the applicant's assets which are required to be assigned to the facility so that only expenses for the cost of care of the applicant may be charged against the account; and
- (3) agrees in writing at the time of admission to the facility to permit the applicant, or the applicant's guardian, or conservator, to examine the records relating to the applicant's account upon request, and to receive an audited statement of the expenditures charged against the applicant's individual account upon request; and
- (4) agrees in writing at the time of admission to the facility to permit the applicant to withdraw from the facility at any time and to receive, upon withdrawal, the balance of the applicant's individual account.

For a period not to exceed 180 days, the commissioner may continue to make medical assistance payments to a nursing facility or boarding care home which is in violation of this section if extreme hardship to the residents would result. In these cases the commissioner shall issue an order requiring the nursing facility to correct the violation. The nursing facility shall have 20 days from its receipt of the order to correct the violation. If the violation is not corrected within the 20-day period the commissioner may reduce the payment rate to the nursing facility by up to 20 percent. The amount of the payment rate reduction shall be related to the severity of the violation and shall remain in effect until the violation is corrected. The nursing facility or boarding care home may appeal the commissioner's action pursuant to the provisions of chapter 14 pertaining to contested cases. An appeal shall be considered timely if written notice of appeal is received by the commissioner within 20 days of notice of the commissioner's proposed action.

In the event that the commissioner determines that a nursing facility is not eligible for reimbursement for a resident who is eligible for medical assistance, the commissioner may authorize the nursing facility to receive reimbursement on a temporary basis until the resident can be relocated to a participating nursing facility.

Certified beds in facilities which do not allow medical assistance intake on July 1, 1984, or after shall be deemed to be decertified for purposes of section 144A.071 only.

Sec. 60. Minnesota Statutes 1998, section 256B.501, subdivision 8a, is amended to read:

Subd. 8a. [~~PAYMENT FOR PERSONS WITH SPECIAL NEEDS FOR CRISIS INTERVENTION SERVICES.~~] ~~State-operated;~~ Community-based crisis services ~~provided in accordance with section 252.50, subdivision 7, to authorized by the commissioner or the commissioner's designee~~ for a resident of an intermediate care facility for persons with mental retardation (ICF/MR) reimbursed under this section shall be paid by medical assistance in accordance with the paragraphs (a) to ~~(h)~~ (g).

(a) "Crisis services" means the specialized services listed in clauses (1) to (3) provided to prevent the recipient from requiring placement in a more restrictive institutional setting such as an inpatient hospital or regional treatment center and to maintain the recipient in the present community setting.

(1) The crisis services provider shall assess the recipient's behavior and environment to identify factors contributing to the crisis.

(2) The crisis services provider shall develop a recipient-specific intervention plan in coordination with the service planning team and provide recommendations for revisions to the individual service plan if necessary to prevent or minimize the likelihood of future crisis situations. The intervention plan shall include a transition plan to aid the recipient in returning to the community-based ICF/MR if the recipient is receiving residential crisis services.

(3) The crisis services provider shall consult with and provide training and ongoing technical assistance to the recipient's service providers to aid in the implementation of the intervention plan and revisions to the individual service plan.

(b) "Residential crisis services" means crisis services that are provided to a recipient admitted to ~~the crisis services foster care setting~~ an alternative, state licensed site approved by the commissioner, because the ICF/MR receiving reimbursement under this section is not able, as determined by the commissioner, to provide the intervention and protection of the recipient and others living with the recipient that is necessary to prevent the recipient from requiring placement in a more restrictive institutional setting.

(c) Residential crisis services providers must be licensed by maintain a license from the commissioner under section 245A.03 to provide foster care, must exclusively provide for the residence when providing crisis services for short-term crisis intervention, and must not be located in a private residence.

(d) ~~Payment rates are determined annually for each crisis services provider based on cost of care for each provider as defined in section 246.50. Interim payment rates are calculated on a per diem basis by dividing the projected cost of providing care by the projected number of contact days for the fiscal year, as estimated by the commissioner. Final payment rates are calculated by dividing the actual cost of providing care by the actual number of contact days in the applicable fiscal year~~ will be established consistent with county negotiated crisis intervention services.

(e) ~~Payment shall be made for each contact day. "Contact day" means any day in which the crisis services provider has face-to-face contact with the recipient or any of the recipient's medical assistance service providers for the purpose of providing crisis services as defined in paragraph (c).~~

(~~f~~) Payment for residential crisis services is limited to 21 days, unless an additional period is authorized by the commissioner or part of an approved regional plan. ~~The additional period may not exceed 21 days.~~

(~~g~~) (f) Payment for crisis services shall be made only for services provided while the ICF/MR receiving reimbursement under this section:

(1) has a shared services agreement with the crisis services provider in effect ~~in accordance with~~ under section 246.57; and

(2) has reassigned payment for the provision of the crisis services under this subdivision to the commissioner in accordance with Code of Federal Regulations, title 42, section 447.10(e); and

(3) has executed a cooperative agreement with the crisis services provider to implement the intervention plan and revisions to the individual service plan as necessary to prevent or minimize the likelihood of future crisis situations, to maintain the recipient in the present community setting, and to prevent the recipient from requiring a more restrictive institutional setting.

(f) (g) Payment to the ICF/MR receiving reimbursement under this section shall be made for up to 18 therapeutic leave days during which the recipient is receiving residential crisis services, if the ICF/MR is otherwise eligible to receive payment for a therapeutic leave day under Minnesota Rules, part 9505.0415. Payment under this paragraph shall be terminated if the commissioner determines that the ICF/MR is not meeting the terms of the cooperative shared service agreement under paragraph (e) (f) or that the recipient will not return to the ICF/MR.

Sec. 61. Minnesota Statutes 1998, section 256B.69, subdivision 3a, is amended to read:

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

(b) The commissioner shall seek a federal waiver to allow a fee-for-service plan option to MinnesotaCare enrollees. The commissioner shall develop an increase of the premium fees required under section 256L.06 up to 20 percent of the premium fees for the enrollees who elect the fee-for-service option. Prior to implementation, the commissioner shall submit this fee schedule to the chair and ranking minority member of the senate health care committee, the senate health care and family services funding division, the house of representatives health and human services committee, and the house of representatives health and human services finance division.

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

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

(e) In the event that a county board or a single entity representing a group of county boards and the commissioner cannot reach agreement regarding: (i) the selection of participating health plans in that county; (ii) contract requirements; or (iii) implementation and enforcement of county requirements including provisions regarding local public health goals, the commissioner shall resolve all disputes after taking into account the recommendations of a three-person mediation panel. The panel shall be composed of one designee of the president of the association of Minnesota counties, one designee of the commissioner of human services, and one designee of the commissioner of health.

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

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

(1) identify the proposed date of implementation, ~~not later than October 1, 1999~~ as determined under section 256B.692, subdivision 5;

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

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

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

- (i) risk contracts with licensed health plans;
- (ii) risk arrangements with providers who are not licensed health plans;
- (iii) risk arrangements with other licensed insurance entities; and
- (iv) funding from other county resources;

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

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

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

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

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

Sec. 62. Minnesota Statutes 1998, section 256B.69, is amended by adding a subdivision to read:

Subd. 3b. [PROVISION OF DATA TO COUNTY BOARDS.] The commissioner of human services, in consultation with representatives of county boards of commissioners shall identify program information and data necessary on an ongoing basis for county boards to: (1) make recommendations to the commissioner related to state purchasing under the prepaid medical assistance program; and (2) effectively administer county-based purchasing. This information and data must include, but is not limited to, county-specific, individual-level fee-for-service and prepaid health plan claims information.

Sec. 63. Minnesota Statutes 1998, section 256B.69, is amended by adding a subdivision to read:

Subd. 4b. [INDIVIDUAL EDUCATION PLAN AND INDIVIDUALIZED FAMILY SERVICE PLAN SERVICES.] The commissioner shall amend the federal waiver allowing the state to separate out individual education plan and individualized family service plan services for children enrolled in the prepaid medical assistance program and the MinnesotaCare program. Effective July 1, 1999, or upon federal approval, medical assistance coverage of eligible individual education plan and individualized family service plan services shall not be included in the capitated services for children enrolled in health plans through the prepaid medical assistance program and the MinnesotaCare program. Upon federal approval, local school districts shall bill the commissioner for these services, and claims shall be paid on a fee-for-service basis.

Sec. 64. Minnesota Statutes 1998, section 256B.69, subdivision 5a, is amended to read:

Subd. 5a. [MANAGED CARE CONTRACTS.] Managed care contracts under this section, sections 256.9363, and 256D.03, shall be entered into or renewed on a calendar year basis beginning January 1, 1996. Managed care contracts which were in effect on June 30, 1995, and set to renew on July 1, 1995, shall be renewed for the period July 1, 1995 through December 31, 1995 at the same terms that were in effect on June 30, 1995.

A prepaid health plan providing covered health services for eligible persons pursuant to chapters 256B, 256D, and 256L, is responsible for complying with the terms of its contract with the commissioner. Requirements applicable to managed care programs under chapters 256B, 256D, and 256L, established after the effective date of a contract with the commissioner take effect when the contract is next issued or renewed, subject to the terms and conditions negotiated by the prepaid health plan and the commissioner.

Sec. 65. Minnesota Statutes 1998, 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 and general assistance medical care program contract rates set by the commissioner under subdivision 5 and effective on or after January 1, 2000, capitation rates for nonmetropolitan counties shall, on a weighted average, be no less than 92 percent of the capitation rates for metropolitan counties, excluding Hennepin county. The commissioner shall adjust the capitation rate paid to Hennepin county in order to make this provision budget neutral.

Sec. 66. Minnesota Statutes 1998, section 256B.69, is amended by adding a subdivision to read:

Subd. 5e. [MEDICAL EDUCATION AND RESEARCH PAYMENTS.] For the calendar years 1999, 2000, and 2001, a hospital that participates in funding the federal share of the medical education and research trust fund payment under Laws 1998, chapter 407, article 1, section 3, shall not be held liable for any amounts attributable to this payment above the charge limit of section 256.969, subdivision 3a. The commissioner of human services shall assume liability for any corresponding federal share of the payments above the charge limit.

Sec. 67. Minnesota Statutes 1998, section 256B.692, subdivision 2, is amended to read:

Subd. 2. [DUTIES OF THE COMMISSIONER OF HEALTH.] (a) Notwithstanding chapters 62D and 62N, a county that elects to purchase medical assistance and general assistance medical care in return for a fixed sum without regard to the frequency or extent of services furnished to any particular enrollee is not required to obtain a certificate of authority under chapter 62D or 62N. The county board of commissioners is the governing body of a county-based purchasing program. In a multicounty arrangement, the governing body is a joint powers board established under section 471.59.

(b) A county that elects to purchase medical assistance and general assistance medical care services under this section must satisfy the commissioner of health that the requirements for assurance of consumer and provider protection and fiscal solvency of chapter 62D, applicable to health maintenance organizations, or chapter 62N, applicable to community integrated service networks, will be met.

(c) A county must also assure the commissioner of health that the requirements of sections 62J.041; 62J.48; 62J.71 to 62J.73; 62M.01 to 62M.16; all applicable provisions of chapter 62Q, including sections 62Q.07; 62Q.075; 62Q.105; 62Q.1055; 62Q.106; 62Q.11; 62Q.12; 62Q.135; 62Q.14; 62Q.145; 62Q.19; 62Q.23, paragraph (c); 62Q.30; 62Q.43; 62Q.47; 62Q.50; 62Q.52 to 62Q.56; 62Q.58; 62Q.64; and 72A.201 will be met.

(d) All enforcement and rulemaking powers available under chapters 62D, 62J, 62M, 62N, and 62Q are hereby granted to the commissioner of health with respect to counties that purchase medical assistance and general assistance medical care services under this section.

(e) The commissioner, in consultation with county government, shall develop administrative and financial reporting requirements for county-based purchasing programs relating to sections 62D.041, 62D.042, 62D.045, 62D.08, 62N.28, 62N.29, and 62N.31, and other sections as necessary, that are specific to county administrative, accounting, and reporting systems and consistent with other statutory requirements of counties.

Sec. 68. Minnesota Statutes 1998, 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 ten 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.

(Effective Date: Section 68 (256B.75) is effective for services rendered on or after July 1, 1999.)

Sec. 69. Minnesota Statutes 1998, section 256B.76, is amended to read:

256B.76 [PHYSICIAN AND DENTAL REIMBURSEMENT.]

(a) The physician reimbursement increase provided in section 256B.74, subdivision 2, shall not be implemented. 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 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; ~~and~~

(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 October 1, 1999, payment rates for physician and professional services shall be increased by four percent over the rates in effect on September 30, 1999, except for home health agency and family planning agency services;

(5) the department shall present a proposal during the year 2000 legislative session detailing physician and professional services payment methodology conversion to Resource Based Relative Value Scale; and

(6) the increases in clause (4) shall be implemented January 1, 2000, for managed care.

(b) The dental reimbursement increase provided in section 256B.74, subdivision 5, shall not be implemented. 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; ~~and~~

(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 October 1, 1999, payment rates for dental services shall be increased by five percent over the rates in effect on September 30, 1999;

(4) the department shall increase payments by 20 percent over the October 1, 1999, fee-for-service rates, for those fee-for-service providers for whom public programs under MA, GAMC, and MinnesotaCare account for 20 percent or more of their practice;

(5) 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 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 utilizing dental hygienists and dental assistants to provide education, training, and screening for dental care needs including referrals to dentists for dental care treatment;

(iii) a pilot program for utilizing hygienists outside of a traditional dental office to provide dental hygiene services; and

(iv) 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.

(6) 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

(7) the increases listed in clauses (3), (4), and (6) 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 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.

Sec. 70. Minnesota Statutes 1998, section 256B.77, subdivision 7a, is amended to read:

Subd. 7a. [ELIGIBLE INDIVIDUALS.] (a) Persons are eligible for the demonstration project as provided in this subdivision.

(b) "Eligible individuals" means those persons living in the demonstration site who are eligible for medical assistance and are disabled based on a disability determination under section 256B.055, subdivisions 7 and 12, or who are eligible for medical assistance and have been diagnosed as having:

(1) serious and persistent mental illness as defined in section 245.462, subdivision 20;

(2) severe emotional disturbance as defined in section ~~245.487~~ 245.4871, subdivision 6; or

(3) mental retardation, or being a mentally retarded person as defined in section 252A.02, or a related condition as defined in section 252.27, subdivision 1a.

Other individuals may be included at the option of the county authority based on agreement with the commissioner.

~~(c) Eligible individuals residing on a federally recognized Indian reservation may be excluded from participation in the demonstration project at the discretion of the tribal government based on agreement with the commissioner, in consultation with the county authority.~~

~~(d)~~ Eligible individuals include individuals in excluded time status, as defined in chapter 256G. Enrollees in excluded time at the time of enrollment shall remain in excluded time status as long as they live in the demonstration site and shall be eligible for 90 days after placement outside the demonstration site if they move to excluded time status in a county within Minnesota other than their county of financial responsibility.

~~(e)~~ (d) A person who is a sexual psychopathic personality as defined in section 253B.02, subdivision 18a, or a sexually dangerous person as defined in section 253B.02, subdivision 18b, is excluded from enrollment in the demonstration project.

Sec. 71. Minnesota Statutes 1998, section 256B.77, is amended by adding a subdivision to read:

Subd. 7b. [AMERICAN INDIAN RECIPIENTS.] (a) Beginning on or after July 1, 1999, for American Indian recipients of medical assistance who are required to enroll with a county administrative entity or service delivery organization under subdivision 7, medical assistance shall cover health care services provided at American Indian

health services 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 256B.0625. 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 according to rates authorized under sections 256.969, subdivision 16, and 256B.0625, subdivision 34. Implementation of this purchasing model is contingent on federal approval.

(b) The commissioner of human services, in consultation with tribal governments, shall develop a plan for tribes to assist in the enrollment process for American Indian recipients enrolled in the demonstration project for people with disabilities under this section. This plan also shall address how tribes will be included in ensuring the coordination of care for American Indian recipients between Indian health service or tribal providers and other providers.

(c) 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.

Sec. 72. Minnesota Statutes 1998, section 256B.77, subdivision 8, is amended to read:

Subd. 8. [RESPONSIBILITIES OF THE COUNTY ADMINISTRATIVE ENTITY.] (a) The county administrative entity shall meet the requirements of this subdivision, unless the county authority or the commissioner, with written approval of the county authority, enters into a service delivery contract with a service delivery organization for any or all of the requirements contained in this subdivision.

(b) The county administrative entity shall enroll eligible individuals regardless of health or disability status.

(c) The county administrative entity shall provide all enrollees timely access to the medical assistance benefit set. Alternative services and additional services are available to enrollees at the option of the county administrative entity and may be provided if specified in the personal support plan. County authorities are not required to seek prior authorization from the department as required by the laws and rules governing medical assistance.

(d) The county administrative entity shall cover necessary services as a result of an emergency without prior authorization, even if the services were rendered outside of the provider network.

(e) The county administrative entity shall authorize necessary and appropriate services when needed and requested by the enrollee or the enrollee's legal representative in response to an urgent situation. Enrollees shall have 24-hour access to urgent care services coordinated by experienced disability providers who have information about enrollees' needs and conditions.

(f) The county administrative entity shall accept the capitation payment from the commissioner in return for the provision of services for enrollees.

(g) The county administrative entity shall maintain internal grievance and complaint procedures, including an expedited informal complaint process in which the county administrative entity must respond to verbal complaints within ten calendar days, and a formal grievance process, in which the county administrative entity must respond to written complaints within 30 calendar days.

(h) The county administrative entity shall provide a certificate of coverage, upon enrollment, to each enrollee and the enrollee's legal representative, if any, which describes the benefits covered by the county administrative entity, any limitations on those benefits, and information about providers and the service delivery network. This information must also be made available to prospective enrollees. This certificate must be approved by the commissioner.

(i) The county administrative entity shall present evidence of an expedited process to approve exceptions to benefits, provider network restrictions, and other plan limitations under appropriate circumstances.

(j) The county administrative entity shall provide enrollees or their legal representatives with written notice of their appeal rights under subdivision 16, and of ombudsman and advocacy programs under subdivisions 13 and 14, at the following times: upon enrollment, upon submission of a written complaint, when a service is reduced, denied, or terminated, or when renewal of authorization for ongoing service is refused.

(k) The county administrative entity shall determine immediate needs, including services, support, and assessments, within 30 calendar days ~~of~~ after enrollment, or within a shorter time frame if specified in the intergovernmental contract.

(l) The county administrative entity shall assess the need for services of new enrollees within 60 calendar days ~~of~~ after enrollment, or within a shorter time frame if specified in the intergovernmental contract, and periodically reassess the need for services for all enrollees.

(m) The county administrative entity shall ensure the development of a personal support plan for each person within 60 calendar days of enrollment, or within a shorter time frame if specified in the intergovernmental contract, unless otherwise agreed to by the enrollee and the enrollee's legal representative, if any. Until a personal support plan is developed and agreed to by the enrollee, enrollees must have access to the same amount, type, setting, duration, and frequency of covered services that they had at the time of enrollment unless other covered services are needed. For an enrollee who is not receiving covered services at the time of enrollment and for enrollees whose personal support plan is being revised, access to the medical assistance benefit set must be assured until a personal support plan is developed or revised. If an enrollee chooses not to develop a personal support plan, the enrollee will be subject to the network and prior authorization requirements of the county administrative entity or service delivery organization 60 days after enrollment. An enrollee can choose to have a personal support plan developed at any time. The personal support plan must be based on choices, preferences, and assessed needs and strengths of the enrollee. The service coordinator shall develop the personal support plan, in consultation with the enrollee or the enrollee's legal representative and other individuals requested by the enrollee. The personal support plan must be updated as needed or as requested by the enrollee. Enrollees may choose not to have a personal support plan.

(n) The county administrative entity shall ensure timely authorization, arrangement, and continuity of needed and covered supports and services.

(o) The county administrative entity shall offer service coordination that fulfills the responsibilities under subdivision 12 and is appropriate to the enrollee's needs, choices, and preferences, including a choice of service coordinator.

(p) The county administrative entity shall contract with schools and other agencies as appropriate to provide otherwise covered medically necessary medical assistance services as described in an enrollee's individual family support plan, as described in sections 125A.26 to 125A.48, or individual education plan, as described in chapter 125A.

(q) The county administrative entity shall develop and implement strategies, based on consultation with affected groups, to respect diversity and ensure culturally competent service delivery in a manner that promotes the physical, social, psychological, and spiritual well-being of enrollees and preserves the dignity of individuals, families, and their communities.

(r) When an enrollee changes county authorities, county administrative entities shall ensure coordination with the entity that is assuming responsibility for administering the medical assistance benefit set to ensure continuity of supports and services for the enrollee.

(s) The county administrative entity shall comply with additional requirements as specified in the intergovernmental contract.

(t) To the extent that alternatives are approved under subdivision 17, county administrative entities must provide for the health and safety of enrollees and protect the rights to privacy and to provide informed consent.

Sec. 73. Minnesota Statutes 1998, section 256B.77, subdivision 10, is amended to read:

Subd. 10. [CAPITATION PAYMENT.] (a) The commissioner shall pay a capitation payment to the county authority and, when applicable under subdivision 6, paragraph (a), to the service delivery organization for each medical assistance eligible enrollee. The commissioner shall develop capitation payment rates for the initial contract period for each demonstration site in consultation with an independent actuary, to ensure that the cost of services under the demonstration project does not exceed the estimated cost for medical assistance services for the covered population under the fee-for-service system for the demonstration period. For each year of the demonstration project, the capitation payment rate shall be based on 96 percent of the projected per person costs that would otherwise have been paid under medical assistance fee-for-service during each of those years. Rates shall be adjusted within the limits of the available risk adjustment technology, as mandated by section 62Q.03. In addition, the commissioner shall implement appropriate risk and savings sharing provisions with county administrative entities and, when applicable under subdivision 6, paragraph (a), service delivery organizations within the projected budget limits. Capitation rates shall be adjusted, at least annually, to include any rate increases and payments for expanded or newly covered services for eligible individuals. The initial demonstration project rate shall include an amount in addition to the fee-for-service payments to adjust for underutilization of dental services. Any savings beyond those allowed for the county authority, county administrative entity, or service delivery organization shall be first used to meet the unmet needs of eligible individuals. Payments to providers participating in the project are exempt from the requirements of sections 256.966 and 256B.03, subdivision 2.

(b) The commissioner shall monitor and evaluate annually the effect of the discount on consumers, the county authority, and providers of disability services. Findings shall be reported and recommendations made, as appropriate, to ensure that the discount effect does not adversely affect the ability of the county administrative entity or providers of services to provide appropriate services to eligible individuals, and does not result in cost shifting of eligible individuals to the county authority.

(c) For risk-sharing to occur under this subdivision, the aggregate fee-for-service cost of covered services provided by the county administrative entity under this section must exceed the aggregate sum of capitation payments made to the county administrative entity under this section. The county authority is required to maintain its current level of nonmedical assistance spending on enrollees. If the county authority spends less in nonmedical assistance dollars on enrollees than it spent the year prior to the contract year, the amount of underspending shall be deducted from the aggregate fee-for-service cost of covered services. The commissioner shall then compare the fee-for-service costs and capitation payments related to the services provided for the term of this contract. The commissioner shall base its calculation of the fee-for-service costs on application of the medical assistance fee schedule to services identified on the county administrative entity's encounter claims submitted to the commissioner. The aggregate fee-for-service cost shall not include any third-party recoveries or cost-avoided amounts.

If the commissioner finds that the aggregate fee-for-service cost is greater than the sum of the capitation payments, the commissioner shall settle according to the following schedule:

(1) For the first contract year for each project, the commissioner shall pay the county administrative entity 100 percent of the difference between the sum of the capitation payments and 100 percent of projected fee-for-service costs. For aggregate fee-for-service costs in excess of 100 percent of projected fee-for-service costs, the commissioner shall pay 50 percent of the difference between the aggregate fee-for-service cost and the projected fee-for-service cost, up to 104 percent of the projected fee-for-service costs. The county administrative entity shall be responsible for all costs in excess of 104 percent of projected fee-for-service costs.

(2) For the second contract year for each project, the commissioner shall pay the county administrative entity 75 percent of the difference between the sum of the capitation payments and 100 percent of projected fee-for-service costs. The county administrative entity shall be responsible for all costs in excess of 100 percent of projected fee-for-service costs.

(3) For the third contract year for each project, the commissioner shall pay the county administrative entity 50 percent of the difference between the sum of the capitation payments and 100 percent of projected fee-for-service costs. The county administrative entity shall be responsible for all costs in excess of 100 percent of projected fee-for-service costs.

(4) For the fourth and subsequent contract years for each project, the county administrative entity shall be responsible for all costs in excess of the capitation payments.

(d) In addition to other payments under this subdivision, the commissioner may increase payments by up to 0.5 percent of the projected per person costs that would otherwise have been paid under medical assistance fee-for-service. The commissioner may make the increased payments to:

(1) offset rate increases for regional treatment services under subdivision 22 which are higher than was expected by the commissioner when the capitation was set at 96 percent; and

(2) implement incentives to encourage appropriate, high quality, efficient services.

Sec. 74. Minnesota Statutes 1998, section 256B.77, subdivision 14, is amended to read:

Subd. 14. [EXTERNAL ADVOCACY.] In addition to ombudsman services, enrollees shall have access to advocacy services on a local or regional basis. The purpose of external advocacy includes providing individual advocacy services for enrollees who have complaints or grievances with the county administrative entity, service delivery organization, or a service provider; assisting enrollees to understand the service delivery system and select providers and, if applicable, a service delivery organization; and understand and exercise their rights as an enrollee. External advocacy contractors must demonstrate that they have the expertise to advocate on behalf of all categories of eligible individuals and are independent of the commissioner, county authority, county administrative entity, service delivery organization, or any service provider within the demonstration project.

These advocacy services shall be provided through the ombudsman for mental health and mental retardation directly, or under contract with private, nonprofit organizations, with funding provided through the demonstration project. The funding shall be provided annually to the ombudsman's office ~~based on 0.1 percent of the projected per person costs that would otherwise have been paid under medical assistance fee-for-service during those years.~~ Funding for external advocacy shall be provided for each year of the demonstration period through general fund appropriations. This funding is in addition to the capitation payment available under subdivision 10.

Sec. 75. Minnesota Statutes 1998, section 256B.77, is amended by adding a subdivision to read:

Subd. 27. [SERVICE COORDINATION TRANSITION.] Demonstration sites designated under subdivision 5, with the permission of an eligible individual, may implement the provisions of subdivision 12 beginning 60 calendar days prior to an individual's enrollment. This implementation may occur prior to the enrollment of eligible individuals, but is restricted to eligible individuals.

Sec. 76. Minnesota Statutes 1998, 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 the services are otherwise covered under this chapter as a physician service, if services provided on an inpatient basis are not included as part of the cost for inpatient services included in the operating payment rate, and if the service is within the scope of practice of the nurse practitioner's license as a registered nurse, as defined in section 148.171; ~~and~~
- (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. 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) The commissioner of human services may reduce payments provided under sections 256D.01 to 256D.21 and 261.23 in order to remain within the amount appropriated for general assistance medical care, within the following restrictions:

(i) For the period July 1, 1985 to December 31, 1985, reductions below the cost per service unit allowable under section 256.966, are permitted only as follows: payments for inpatient and outpatient hospital care provided in response to a primary diagnosis of chemical dependency or mental illness may be reduced no more than 30 percent; payments for all other inpatient hospital care may be reduced no more than 20 percent. Reductions below the payments allowable under general assistance medical care for the remaining general assistance medical care services allowable under this subdivision may be reduced no more than ten percent.

(ii) For the period January 1, 1986 to December 31, 1986, reductions below the cost per service unit allowable under section 256.966 are permitted only as follows: payments for inpatient and outpatient hospital care provided in response to a primary diagnosis of chemical dependency or mental illness may be reduced no more than 20 percent; payments for all other inpatient hospital care may be reduced no more than 15 percent. Reductions below the payments allowable under general assistance medical care for the remaining general assistance medical care services allowable under this subdivision may be reduced no more than five percent.

(iii) For the period January 1, 1987 to June 30, 1987, reductions below the cost per service unit allowable under section 256.966 are permitted only as follows: payments for inpatient and outpatient hospital care provided in response to a primary diagnosis of chemical dependency or mental illness may be reduced no more than 15 percent; payments for all other inpatient hospital care may be reduced no more than ten percent. Reductions below the payments allowable under medical assistance for the remaining general assistance medical care services allowable under this subdivision may be reduced no more than five percent.

(iv) For the period July 1, 1987 to June 30, 1988, reductions below the cost per service unit allowable under section 256.966 are permitted only as follows: payments for inpatient and outpatient hospital care provided in response to a primary diagnosis of chemical dependency or mental illness may be reduced no more than 15 percent; payments for all other inpatient hospital care may be reduced no more than five percent. Reductions below the payments allowable under medical assistance for the remaining general assistance medical care services allowable under this subdivision may be reduced no more than five percent.

(v) For the period July 1, 1988 to June 30, 1989, reductions below the cost per service unit allowable under section 256.966 are permitted only as follows: payments for inpatient and outpatient hospital care provided in response to a primary diagnosis of chemical dependency or mental illness may be reduced no more than 15 percent;

payments for all other inpatient hospital care may not be reduced. Reductions below the payments allowable under medical assistance for the remaining general assistance medical care services allowable under this subdivision may be reduced no more than five percent.

(f) 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.

(g) Any county may, from its own resources, provide medical payments for which state payments are not made.

(h) Chemical dependency services that are reimbursed under chapter 254B must not be reimbursed under general assistance medical care.

(i) 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.

(j) 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. 77. Minnesota Statutes 1998, 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.

Sec. 78. Minnesota Statutes 1998, 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.

(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.

Sec. 79. Minnesota Statutes 1998, section 256L.04, subdivision 8, is amended to read:

Subd. 8. [APPLICANTS POTENTIALLY ELIGIBLE FOR MEDICAL ASSISTANCE.] (a) Individuals who receive supplemental security income or retirement, survivors, or disability benefits due to a disability, or other disability-based pension, who qualify under subdivision 7, but who are potentially eligible for medical assistance

without a spenddown shall be allowed to enroll in MinnesotaCare for a period of 60 days, so long as the applicant meets all other conditions of eligibility. The commissioner shall identify and refer the applications of such individuals to their county social service agency. The county and the commissioner shall cooperate to ensure that the individuals obtain medical assistance coverage for any months for which they are eligible.

(b) The enrollee must cooperate with the county social service agency in determining medical assistance eligibility within the 60-day enrollment period. Enrollees who do not cooperate with medical assistance within the 60-day enrollment period shall be disenrolled from the plan within one calendar month. Persons disenrolled for nonapplication for medical assistance may not reenroll until they have obtained a medical assistance eligibility determination. Persons disenrolled for noncooperation with medical assistance may not reenroll until they have cooperated with the county agency and have obtained a medical assistance eligibility determination.

(c) Beginning January 1, 2000, counties that choose to become MinnesotaCare enrollment sites shall consider MinnesotaCare applications of individuals described in paragraph (a) to also be applications for medical assistance and shall first determine whether medical assistance eligibility exists. Adults with children with family income under 175 percent of the federal poverty guidelines for the applicable family size, pregnant women, and children who qualify under subdivision 1 Applicants who are potentially eligible for medical assistance, except for those described in paragraph (a), without a spenddown may choose to enroll in either MinnesotaCare or medical assistance.

(d) The commissioner shall redetermine provider payments made under MinnesotaCare to the appropriate medical assistance payments for those enrollees who subsequently become eligible for medical assistance.

Sec. 80. Minnesota Statutes 1998, section 256L.04, subdivision 13, is amended to read:

Subd. 13. [FAMILIES WITH GRANDPARENTS, RELATIVE CARETAKERS, FOSTER PARENTS, OR LEGAL GUARDIANS.] Beginning January 1, 1999, in families that include a ~~grandparent~~, relative caretaker as defined in the medical assistance program, foster parent, or legal guardian, the ~~grandparent~~, relative caretaker, foster parent, or legal guardian may apply as a family or may apply separately for the children. If the caretaker applies separately for the children, only the children's income is counted and the provisions of subdivision 1, paragraph (b), do not apply. If the ~~grandparent~~, relative caretaker, foster parent, or legal guardian applies with the children, their income is included in the gross family income for determining eligibility and premium amount.

Sec. 81. Minnesota Statutes 1998, section 256L.05, subdivision 4, is amended to read:

Subd. 4. [APPLICATION PROCESSING.] The commissioner of human services shall determine an applicant's eligibility for MinnesotaCare no more than 30 days from the date that the application is received by the department of human services. Beginning January 1, 2000, this requirement also applies to local county human services agencies that determine eligibility for MinnesotaCare. Once annually at application or reenrollment, to prevent processing delays, applicants or enrollees who, from the information provided on the application, appear to meet eligibility requirements shall be enrolled upon timely payment of premiums. The enrollee must provide all required verifications within 30 days of ~~enrollment~~ notification of the eligibility determination or coverage from the program shall be terminated. Enrollees who are determined to be ineligible when verifications are provided shall be disenrolled from the program.

Sec. 82. Minnesota Statutes 1998, 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. ~~Beginning July 1, 1998; Failure to pay includes payment with a dishonored check and, 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 ~~check,~~ 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. 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.

Sec. 83. Minnesota Statutes 1998, section 256L.07, is amended to read:

256L.07 [ELIGIBILITY FOR ~~SUBSIDIZED PREMIUMS BASED ON SLIDING SCALE~~ MINNESOTACARE.]

Subdivision 1. [GENERAL REQUIREMENTS.] (a) Children enrolled in the original children's health plan as of September 30, 1992, children who enrolled in the MinnesotaCare program after September 30, 1992, pursuant to Laws 1992, chapter 549, article 4, section 17, and children who have family gross incomes that are equal to or less than 150 percent of the federal poverty guidelines are eligible ~~for subsidized premium payments~~ 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.

(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, ~~determined over a four-month period as required by section 256L.15, subdivision 2,~~ 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.

Subd. 2. [MUST NOT HAVE ACCESS TO EMPLOYER-SUBSIDIZED COVERAGE.] (a) To be eligible ~~for subsidized premium payments based on a sliding scale,~~ a family or individual must not have access to subsidized health coverage through an employer. 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. 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.

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 ~~other health coverage meets the requirements of Minnesota Rules, part 9506.0020, subpart 3, item B:~~ 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) For purposes of this section, medical assistance, general assistance medical care, and civilian health and medical program of the uniformed service, CHAMPUS, are not considered insurance or health coverage.

(c) For purposes of this section, 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.

Sec. 84. Minnesota Statutes 1998, section 256L.15, subdivision 1, is amended to read:

Subdivision 1. [PREMIUM DETERMINATION.] Families with children and individuals shall pay a premium determined according to a sliding fee based on ~~the cost of coverage as~~ a percentage of the family's gross family income. 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. 85. Minnesota Statutes 1998, section 256L.15, subdivision 1b, is amended to read:

Subd. 1b. [PAYMENTS NONREFUNDABLE.] Only MinnesotaCare premiums are not refundable paid for future months of coverage for which a health plan capitation fee has not been paid may be refunded.

Sec. 86. Minnesota Statutes 1998, 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 ~~during the previous four months~~. The sliding fee scale must contain separate tables based on enrollment of one, two, or three or more persons. 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. 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. 87. Laws 1995, chapter 178, article 2, section 46, subdivision 10, is amended to read:

Subd. 10. [ADDITIONAL WAIVER REQUEST FOR EMPLOYED DISABLED PERSONS.] The commissioner shall seek a federal waiver in order to implement a work incentive for disabled persons ~~eligible for medical assistance~~ who are not residents of long-term care facilities, when determining their eligibility for medical assistance. The waiver shall request authorization to establish a medical assistance earned income disregard for employed disabled persons who, but for earned income, are eligible for SSDI and who ~~receive~~ require personal care assistance under the Medical Assistance Program. The disregard shall be equivalent to the threshold amount applied to persons who qualify under section 1619(b) of the Social Security Act, except that when a disabled person's earned income reaches the maximum income permitted at the threshold under section 1619(b), the person shall retain medical assistance eligibility and must contribute to the costs of medical care on a sliding fee basis.

Sec. 88. Laws 1997, chapter 225, article 4, section 4, is amended to read:

Sec. 4. [SENIOR DRUG PROGRAM.]

~~The commissioner shall administer the senior drug program so that the costs to the state total no more than \$4,000,000 plus the amount of the rebate. The commissioner is authorized to discontinue enrollment in order to meet this level of funding.~~

The commissioner shall report to the legislature the estimated costs of the senior drug program without funding caps. The report shall be included as part of the November and February forecasts.

The commissioner of finance shall annually reimburse the general fund with health care access funds for the estimated increased costs in the QMB/SLMB program directly associated with the senior drug program. This reimbursement shall sunset June 30, 2001.

Sec. 89. [HOME-BASED MENTAL HEALTH SERVICES.]

By January 1, 2000, the commissioner shall amend Minnesota Rules under the expedited process of Minnesota Statutes, section 14.389, to effect the following changes:

(1) amend Minnesota Rules, part 9505.0324, subpart 2, to permit a county board to contract with any agency qualified under Minnesota Rules, part 9505.0324, subparts 4 and 5, as an eligible provider of home-based mental health services;

(2) amend Minnesota Rules, part 9505.0324, subpart 2, to permit children's mental health collaboratives approved by the children's cabinet under Minnesota Statutes, section 245.493, to provide or to contract with any agency qualified under Minnesota Rules, part 9505.0324, subparts 4 and 5, as an eligible provider of home-based mental health services.

Sec. 90. [AMENDING MEDICAL ASSISTANCE RULES.]

By January 1, 2001, the commissioner shall amend Minnesota Rules, parts 9505.0323, 9505.0324, 9505.0326, and 9505.0327, as necessary to implement the changes outlined in Minnesota Statutes, section 256B.0625, subdivision 23.

Sec. 91. [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 February 15, 2000.

Sec. 92. [REPORTS ON ALTERNATIVE RESOURCE ALLOCATION METHODS AND PARENTS OF MINORS.]

(a) The commissioner of human services shall consider and evaluate administrative methods other than the current resource allocation system for the home and community-based waiver for persons with mental retardation and related conditions. In developing the alternatives, the commissioner shall consult with county commissioners from large and small counties, county agencies, consumers, advocates, and providers. The commissioner shall report to the chairs of the senate health and family security budget division and house health and human services finance committee by January 15, 2000.

(b) By January 15, 2000, the commissioner of human services shall present recommendations to the legislature on the conditions under which parents of minors may be reimbursed for services, consistent with federal requirements, health and safety, the child's needs, and not supplanting typical parental responsibilities.

Sec. 93. [REPORT ON RATE SETTING AND RISK ADJUSTMENT.]

The commissioner of human services shall report to the legislature, by January 15, 2000, on the current rate setting process for state prepaid health care programs, rate setting and risk adjustment methods in other states, and the results of the application of risk adjustment on a trial basis in Minnesota for calendar year 1999. The report must also present an analysis of the feasibility of requiring prepaid health plans to report vendor costs rather than charges, an analysis of capitation rate equalization for MinnesotaCare and the prepaid medical assistance program, an analysis of the fiscal impact on state and county government of repealing Minnesota Statutes 1998, section 256B.69, subdivision 5d, and recommendations for providing actuarial and market analyses related to setting prepaid health plan rates to the legislature on a timely basis that would allow this information to be used in the appropriations process.

Sec. 94. [REPORT ON PREPAID MEDICAL ASSISTANCE PROGRAM.]

The commissioner of human services shall present recommendations to the legislature, by December 15, 1999, on methods for implementing county board authority under the prepaid medical assistance program.

Sec. 95. [REQUEST FOR WAIVER.]

By October 1, 1999, the commissioner of human services or health shall request a waiver from the federal Department of Health and Human Services to implement Minnesota Statutes, 256B.0951, subdivision 7.

Sec. 96. [EXPANSION OF SPECIAL EDUCATION SERVICES.]

The commissioner shall examine opportunities to expand the scope of providers eligible for reimbursement for medical assistance services listed in a child's individual education plan, based on state and federal requirements for provider qualifications. The commissioner shall complete these activities, in consultation with the commissioner of children, families, and learning, by December 1999 and seek necessary federal approval.

Sec. 97. [DENTAL ACCESS STUDY.]

The commissioner of human services, in consultation with the commissioner of health, dental care providers, representatives of community clinics, client advocacy groups, and counties, shall review the dental access problem, evaluate the effects of the dental access initiatives adopted by the 1999 legislature, and make recommendations on other actions that could improve dental access for public program recipients. The commissioner shall present a progress report to the legislature by January 15, 2000, and shall present a final report to the legislature by January 15, 2001.

Sec. 98. [EXPIRATION; DEFINITION OF INCOME.]

The amendments to Minnesota Statutes, section 256L.01, subdivision 4, in section 77 expire July 1, 2002.

Sec. 99. [REVENUE MAXIMIZATION INITIATIVE.]

Subdivision 1. [PROPOSAL DESIGN.] The commissioner of human services, in consultation with representatives of county government, may, within the limits of available appropriations, design proposals to:

(1) provide medical assistance coverage for mental health treatment and other related rehabilitative services provided to children or youth placed by a county in a residential treatment facility;

(2) add rehabilitation services to the state medical assistance plan for adults with mental illness or other debilitating conditions, including, but not limited to, chemical dependency; and

(3) provide medical assistance coverage for targeted case management service activities for adults receiving services through a county or state agency who are in need of service coordination, including, but not limited to: people age 65 and older; people in need of adult protective services; people applying for financial assistance; people who have chemical dependency; and people who require community social services under Minnesota Statutes, chapter 256E.

Subd. 2. [RECOMMENDATIONS TO THE LEGISLATURE.] If proposals under this section are developed, the commissioner of human services shall submit to the legislature design and implementation recommendations, and draft legislation, for the proposals required by subdivision 1, by January 15, 2000. Implementation shall occur by July 1, 2000, but only upon legislative approval of these recommendations.

Subd. 3. [STATE MEDICAL ASSISTANCE PLAN AMENDMENTS.] The commissioner of human services may develop and submit to the federal Health Care Financing Administration, any medical assistance state plan amendments necessary for the implementation of the proposals in subdivision 1.

Sec. 100. [REPEALER.]

Laws 1997, chapter 203, article 7, section 27, is repealed.

Sec. 101. [EFFECTIVE DATE.]

When preparing the human services conference committee report for adoption by the legislature, the revisor shall combine all the bracketed effective date notations into this effective date section.

ARTICLE 5

STATE-OPERATED SERVICES; CHEMICAL DEPENDENCY; MENTAL HEALTH

Section 1. Minnesota Statutes 1998, section 16C.10, subdivision 5, is amended to read:

Subd. 5. [SPECIFIC PURCHASES.] The solicitation process described in this chapter is not required for acquisition of the following:

- (1) merchandise for resale purchased under policies determined by the commissioner;
- (2) farm and garden products which, as determined by the commissioner, may be purchased at the prevailing market price on the date of sale;
- (3) goods and services from the Minnesota correctional facilities;
- (4) goods and services from rehabilitation facilities and sheltered workshops that are certified by the commissioner of economic security;
- (5) goods and services for use by a community-based ~~residential~~ facility operated by the commissioner of human services;
- (6) goods purchased at auction or when submitting a sealed bid at auction provided that before authorizing such an action, the commissioner consult with the requesting agency to determine a fair and reasonable value for the goods considering factors including, but not limited to, costs associated with submitting a bid, travel, transportation, and storage. This fair and reasonable value must represent the limit of the state's bid; and
- (7) utility services where no competition exists or where rates are fixed by law or ordinance.

Sec. 2. Minnesota Statutes 1998, section 245.462, subdivision 4, is amended to read:

Subd. 4. [~~CASE MANAGER MANAGEMENT SERVICE PROVIDER.~~] (a) "~~Case manager management service provider~~" means ~~an individual a case manager or case manager associate~~ employed by the county or other entity authorized by the county board to provide case management services specified in section 245.4711.

A case manager must have a bachelor's degree in one of the behavioral sciences or related fields including, but not limited to, social work, psychology, or nursing from an accredited college or university ~~and~~. A case manager must have at least 2,000 hours of supervised experience in the delivery of services to adults with mental illness, must be skilled in the process of identifying and assessing a wide range of client needs, and must be knowledgeable about local community resources and how to use those resources for the benefit of the client. ~~The case manager shall meet in person with a mental health professional at least once each month to obtain clinical supervision of the case manager's activities. Case managers with a bachelor's degree but without 2,000 hours of supervised experience in the delivery of services to adults with mental illness must complete 40 hours of training approved by the~~

commissioner of human services in case management skills and in the characteristics and needs of adults with serious and persistent mental illness and must receive clinical supervision regarding individual service delivery from a mental health professional at least once each week until the requirement of 2,000 hours of supervised experience is met.

(b) Supervision for a case manager during the first year of service providing case management services shall be one hour per week of clinical supervision from a case management supervisor. After the first year, the case manager shall receive regular ongoing supervision totaling 38 hours per year, of which at least one hour per month must be clinical supervision regarding individual service delivery with a case management supervisor. The remainder may be provided by a case manager with two years of experience. Group supervision may not constitute more than one-half of the required supervision hours. Clinical supervision must be documented in the client record.

(c) A case manager with a bachelor's degree who is not licensed, registered, or certified by a health-related licensing board must receive 30 hours of continuing education and training in mental illness and mental health services annually.

(d) A case manager with a bachelor's degree but without 2,000 hours of supervised experience described in paragraph (a), must complete 40 hours of training approved by the commissioner covering case management skills and the characteristics and needs of adults with serious and persistent mental illness.

(e) Case managers without a bachelor's degree must meet one of the requirements in clauses (1) to (3):

(1) have three or four years of experience as a case manager associate;

(2) be a registered nurse without a bachelor's degree and have a combination of specialized training in psychiatry and work experience consisting of community interaction and involvement or community discharge planning in a mental health setting totaling three years; or

(3) be a person who qualified as a case manager under the 1998 department of human service federal waiver provision and meet the continuing education and mentoring requirements in this section.

(f) A case manager associate (CMA) must work under the direction of a case manager or case management supervisor and must be at least 21 years of age. A case manager associate must also have a high school diploma or its equivalent and meet one of the following criteria:

(1) have an associate of arts degree in one of the behavioral sciences or human services;

(2) be a registered nurse without a bachelor's degree;

(3) within the previous ten years, have three years of life experience with serious and persistent mental illness as defined in section 245.462, subdivision 20; or as a child had severe emotional disturbance as defined in section 245.4871, subdivision 6; or have three years life experience as a primary caregiver to an adult with serious and persistent mental illness within the previous ten years;

(4) have 6,000 hours work experience as a nondegreed state hospital technician; or

(5) be a mental health practitioner as defined in section 245.462, subdivision 17, clause (2).

Individuals meeting one of the criteria in clauses (1) to (4) may qualify as a case manager after four years of supervised work experience as a case manager associate. Individuals meeting the criteria in clause (5) may qualify as a case manager after three years of supervised experience as a case manager associate.

Case management associates must have 40 hours preservice training under paragraph (d) and receive at least 40 hours of continuing education in mental illness and mental health services annually. Case manager associates shall receive at least five hours of mentoring per week from a case management mentor. A "case management mentor" means a qualified, practicing case manager or case management supervisor who teaches or advises and provides intensive training and clinical supervision to one or more case manager associates. Mentoring may occur while providing direct services to consumers in the office or in the field and may be provided to individuals or groups of case manager associates. At least two mentoring hours per week must be individual and face-to-face.

(g) A case management supervisor must meet the criteria for mental health professionals, as specified in section 245.462, subdivision 18.

(h) Until June 30, 1999, An immigrant who does not have the qualifications specified in this subdivision may provide case management services to adult immigrants with serious and persistent mental illness who are members of the same ethnic group as the case manager if the person: (1) is currently enrolled in and is actively pursuing credits toward the completion of a bachelor's degree in one of the behavioral sciences or a related field including, but not limited to, social work, psychology, or nursing from an accredited college or university; (2) completes 40 hours of training as specified in this subdivision; and (3) receives clinical supervision at least once a week until the requirements of this subdivision are met.

(b) The commissioner may approve waivers submitted by counties to allow case managers without a bachelor's degree but with 6,000 hours of supervised experience in the delivery of services to adults with mental illness if the person:

(1) meets the qualifications for a mental health practitioner in subdivision 26;

(2) has completed 40 hours of training approved by the commissioner in case management skills and in the characteristics and needs of adults with serious and persistent mental illness; and

(3) demonstrates that the 6,000 hours of supervised experience are in identifying functional needs of persons with mental illness, coordinating assessment information and making referrals to appropriate service providers, coordinating a variety of services to support and treat persons with mental illness, and monitoring to ensure appropriate provision of services. The county board is responsible to verify that all qualifications, including content of supervised experience, have been met.

Sec. 3. Minnesota Statutes 1998, section 245.462, subdivision 17, is amended to read:

Subd. 17. [MENTAL HEALTH PRACTITIONER.] "Mental health practitioner" means a person providing services to persons with mental illness who is qualified in at least one of the following ways:

(1) holds a bachelor's degree in one of the behavioral sciences or related fields from an accredited college or university and either:

(i) has at least 2,000 hours of supervised experience in the delivery of services to persons with mental illness; or

(ii) is fluent in the non-English language of the ethnic group to which over 50 percent of the practitioner's clients belong, completes 40 hours of training in the delivery of services to persons with mental illness, and is supervised by a mental health professional at least once a week until 2,000 hours of supervised experience in delivering services to persons with mental illness is obtained;

(2) has at least 6,000 hours of supervised experience in the delivery of services to persons with mental illness;

(3) is a graduate student in one of the behavioral sciences or related fields and is formally assigned by an accredited college or university to an agency or facility for clinical training; or

(4) holds a master's or other graduate degree in one of the behavioral sciences or related fields from an accredited college or university and has less than 4,000 hours post-master's experience in the treatment of mental illness.

Sec. 4. Minnesota Statutes 1998, section 245.4711, subdivision 1, is amended to read:

Subdivision 1. [AVAILABILITY OF CASE MANAGEMENT SERVICES.] (a) By January 1, 1989, the county board shall provide case management services for all adults with serious and persistent mental illness who are residents of the county and who request or consent to the services and to each adult for whom the court appoints a case manager. Staffing ratios must be sufficient to serve the needs of the clients. The case manager must meet the requirements in section 245.462, subdivision 4.

(b) Case management services provided to adults with serious and persistent mental illness eligible for medical assistance must be billed to the medical assistance program under sections 256B.02, subdivision 8, and 256B.0625.

(c) Case management services are eligible for reimbursement under the medical assistance program. Costs associated with mentoring, supervision, and continuing education may be included in the reimbursement rate methodology used for case management services under the medical assistance program.

Sec. 5. Minnesota Statutes 1998, section 245.4712, subdivision 2, is amended to read:

Subd. 2. [DAY TREATMENT SERVICES PROVIDED.] (a) Day treatment services must be developed as a part of the community support services available to adults with serious and persistent mental illness residing in the county. Adults may be required to pay a fee according to section 245.481. Day treatment services must be designed to:

- (1) provide a structured environment for treatment;
- (2) provide support for residing in the community;
- (3) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet client need;
- (4) coordinate with or be offered in conjunction with a local education agency's special education program; and
- (5) operate on a continuous basis throughout the year.

(b) For purposes of complying with medical assistance requirements, an adult day treatment program may choose among the methods of clinical supervision specified in:

- (1) Minnesota Rules, part 9505.0323, subpart 1, item F;
- (2) Minnesota Rules, part 9505.0324, subpart 6, item F; or
- (3) Minnesota Rules, part 9520.0800, subparts 2 to 6.

A day treatment program may demonstrate compliance with these clinical supervision requirements by obtaining certification from the commissioner under Minnesota Rules, parts 9520.0750 to 9520.0870, or by documenting in its own records that it complies with one of the above methods.

(c) County boards may request a waiver from including day treatment services if they can document that:

- (1) an alternative plan of care exists through the county's community support services for clients who would otherwise need day treatment services;
- (2) day treatment, if included, would be duplicative of other components of the community support services; and
- (3) county demographics and geography make the provision of day treatment services cost ineffective and infeasible.

Sec. 6. Minnesota Statutes 1998, section 245.4871, subdivision 4, is amended to read:

Subd. 4. [~~CASE MANAGER MANAGEMENT SERVICE PROVIDER.~~] (a) "~~Case manager management service provider~~" means ~~an individual~~ a case manager or case manager associate employed by the county or other entity authorized by the county board to provide case management services specified in subdivision 3 for the child with severe emotional disturbance and the child's family. A case manager must have experience and training in working with children.

(b) A case manager must:

(1) have at least a bachelor's degree in one of the behavioral sciences or a related field including, but not limited to, social work, psychology, or nursing from an accredited college or university;

(2) have at least 2,000 hours of supervised experience in the delivery of mental health services to children;

(3) have experience and training in identifying and assessing a wide range of children's needs; and

(4) be knowledgeable about local community resources and how to use those resources for the benefit of children and their families.

(c) The case manager may be a member of any professional discipline that is part of the local system of care for children established by the county board.

(d) ~~The case manager must meet in person with a mental health professional at least once each month to obtain clinical supervision shall receive regular ongoing supervision totaling 38 hours per year, of which at least one hour per month must be clinical supervision regarding individual service delivery with a case management supervisor. The remainder may be provided by a case manager with two years of experience. Group supervision may not constitute more than one-half of the required supervision hours.~~

(e) Case managers with a bachelor's degree but without 2,000 hours of supervised experience in the delivery of mental health services to children with emotional disturbance must:

(1) begin 40 hours of training approved by the commissioner of human services in case management skills and in the characteristics and needs of children with severe emotional disturbance before beginning to provide case management services; and

(2) receive clinical supervision regarding individual service delivery from a mental health professional at least ~~once~~ one hour each week until the requirement of 2,000 hours of experience is met.

(f) Clinical supervision must be documented in the child's record. When the case manager is not a mental health professional, the county board must provide or contract for needed clinical supervision.

(g) The county board must ensure that the case manager has the freedom to access and coordinate the services within the local system of care that are needed by the child.

(h) Case managers who have a bachelor's degree but are not licensed, registered, or certified by a health-related licensing board must receive 30 hours of continuing education and training in severe emotional disturbance and mental health services annually.

(i) Case managers without a bachelor's degree must meet one of the requirements in clauses (1) to (3):

(1) have three or four years of experience as a case manager associate;

(2) be a registered nurse without a bachelor's degree who has a combination of specialized training in psychiatry and work experience consisting of community interaction and involvement or community discharge planning in a mental health setting totaling three years; or

(3) be a person who qualified as a case manager under the 1998 department of human service federal waiver provision and meets the continuing education and mentoring requirements in this section.

(i) A case manager associate (CMA) must work under the direction of a case manager or case management supervisor and must be at least 21 years of age. A case manager associate must also have a high school diploma or its equivalent and meet one of the following criteria:

(1) have an associate of arts degree in one of the behavioral sciences or human services;

(2) be a registered nurse without a bachelor's degree;

(3) have three years of life experience as a primary caregiver to a child with serious emotional disturbance as defined in section 245.4871, subdivision 6, within the previous ten years;

(4) have 6,000 hours work experience as a nondegreed state hospital technician; or

(5) be a mental health practitioner as defined in section 245.462, subdivision 17, clause (2).

Individuals meeting one of the criteria in clauses (1) to (4) may qualify as a case manager after four years of supervised work experience as a case manager associate. Individuals meeting the criteria in clause (5) may qualify as a case manager after three years of supervised experience as a case manager associate.

Case manager associates must have 40 hours of preservice training under paragraph (e), clause (1), and receive at least 40 hours of continuing education in severe emotional disturbance and mental health service annually. Case manager associates shall receive at least five hours of mentoring per week from a case management mentor. A "case management mentor" means a qualified, practicing case manager or case management supervisor who teaches or advises and provides intensive training and clinical supervision to one or more case manager associates. Mentoring may occur while providing direct services to consumers in the office or in the field and may be provided to individuals or groups of case manager associates. At least two mentoring hours per week must be individual and face-to-face.

(k) A case management supervisor must meet the criteria for a mental health professional as specified in section 245.4871, subdivision 27.

(l) Until June 30, 1999, An immigrant who does not have the qualifications specified in this subdivision may provide case management services to child immigrants with severe emotional disturbance of the same ethnic group as the immigrant if the person:

(1) is currently enrolled in and is actively pursuing credits toward the completion of a bachelor's degree in one of the behavioral sciences or related fields at an accredited college or university;

(2) completes 40 hours of training as specified in this subdivision; and

(3) receives clinical supervision at least once a week until the requirements of obtaining a bachelor's degree and 2,000 hours of supervised experience are met.

(i) The commissioner may approve waivers submitted by counties to allow case managers without a bachelor's degree but with 6,000 hours of supervised experience in the delivery of services to children with severe emotional disturbance if the person:

(1) meets the qualifications for a mental health practitioner in subdivision 26;

(2) has completed 40 hours of training approved by the commissioner in case management skills and in the characteristics and needs of children with severe emotional disturbance; and

(3) demonstrates that the 6,000 hours of supervised experience are in identifying functional needs of children with severe emotional disturbance, coordinating assessment information and making referrals to appropriate service providers, coordinating a variety of services to support and treat children with severe emotional disturbance, and monitoring to ensure appropriate provision of services. The county board is responsible to verify that all qualifications, including content of supervised experience, have been met.

Sec. 7. Minnesota Statutes 1998, section 245.4871, subdivision 26, is amended to read:

Subd. 26. [MENTAL HEALTH PRACTITIONER.] "Mental health practitioner" means a person providing services to children with emotional disturbances. A mental health practitioner must have training and experience in working with children. A mental health practitioner must be qualified in at least one of the following ways:

(1) holds a bachelor's degree in one of the behavioral sciences or related fields from an accredited college or university and either:

(i) has at least 2,000 hours of supervised experience in the delivery of mental health services to children with emotional disturbances; or

(ii) is fluent in the non-English language of the ethnic group to which over 50 percent of the practitioner's clients belong, completes 40 hours of training in the delivery of services to children with emotional disturbances, and is supervised by a mental health professional at least once a week until 2,000 hours of supervised experience in delivering mental health services to children with emotional disturbances is obtained;

(2) has at least 6,000 hours of supervised experience in the delivery of mental health services to children with emotional disturbances;

(3) is a graduate student in one of the behavioral sciences or related fields and is formally assigned by an accredited college or university to an agency or facility for clinical training; or

(4) holds a master's or other graduate degree in one of the behavioral sciences or related fields from an accredited college or university and has less than 4,000 hours post-master's experience in the treatment of emotional disturbance.

Sec. 8. Minnesota Statutes 1998, section 245.4881, subdivision 1, is amended to read:

Subdivision 1. [AVAILABILITY OF CASE MANAGEMENT SERVICES.] (a) By April 1, 1992, the county board shall provide case management services for each child with severe emotional disturbance who is a resident of the county and the child's family who request or consent to the services. Staffing ratios must be sufficient to serve the needs of the clients. The case manager must meet the requirements in section 245.4871, subdivision 4.

(b) Except as permitted by law and the commissioner under demonstration projects, case management services provided to children with severe emotional disturbance eligible for medical assistance must be billed to the medical assistance program under sections 256B.02, subdivision 8, and 256B.0625.

(c) Case management services are eligible for reimbursement under the medical assistance program. Costs of mentoring, supervision, and continuing education may be included in the reimbursement rate methodology used for case management services under the the medical assistance program.

Sec. 9. [245.99] [ADULT MENTAL ILLNESS CRISIS HOUSING ASSISTANCE PROGRAM.]

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Subdivision 1. [CREATION.] The adult mental illness crisis housing assistance program is established in the department of human services.

Subd. 2. [RENTAL ASSISTANCE.] The program shall pay up to 90 days of housing assistance for persons with a serious and persistent mental illness who require inpatient or residential care for stabilization. The commissioner of human services may extend the length of assistance on a case-by-case basis.

Subd. 3. [ELIGIBILITY.] Housing assistance under this section is available only to persons of low or moderate income as determined by the commissioner.

Subd. 4. [ADMINISTRATION.] The commissioner may contract with organizations or government units experienced in housing assistance to operate the program under this section.

Sec. 10. [246.0136] [PLANNING FOR TRANSITION OF REGIONAL TREATMENT CENTERS AND OTHER STATE-OPERATED SERVICES TO ENTERPRISE ACTIVITIES.]

Subdivision 1. [PLANNING FOR ENTERPRISE ACTIVITIES.] The commissioner of human services is directed to study and make recommendations to the legislature on establishing enterprise activities within state-operated services. Before implementing an enterprise activity, the commissioner must obtain statutory authorization for its implementation, except that the commissioner has authority to implement enterprise activities for adolescent services without statutory authorization. Enterprise activities are defined as the range of services, which are delivered by state employees, needed by people with disabilities and are fully funded by public or private third-party health insurance or other revenue sources available to clients that provide reimbursement for the services provided. Enterprise activities within state-operated services shall specialize in caring for vulnerable people for whom no other providers are available or for whom state-operated services may be the provider selected by the payer. In subsequent biennia after an enterprise activity is established within a state-operated service, the base state appropriation for that state-operated service shall be reduced proportionate to the size of the enterprise activity.

Subd. 2. [REQUIRED COMPONENTS OF ANY PROPOSAL; CONSIDERATIONS.] In any proposal for an enterprise activity brought to the legislature by the commissioner, the commissioner must demonstrate that there is public or private third-party health insurance or other revenue available to the people served, that the anticipated revenues to be collected will fully fund the services, that there will be sufficient funds for cash flow purposes, and that access to services by vulnerable populations served by state-operated services will not be limited by implementation of an enterprise activity. In studying the feasibility of establishing an enterprise activity, the commissioner must consider:

- (1) creating public or private partnerships to facilitate client access to needed services;
- (2) administrative simplification and efficiencies throughout the state-operated services system;
- (3) creating a public group practice for state-operated services medical staff to increase flexibility in meeting client needs and to maximize third-party reimbursement;
- (4) converting or disposing of buildings not utilized and surplus lands; and
- (5) exploring the efficiencies and benefits of establishing state-operated services as an independent state agency.

Sec. 11. Minnesota Statutes 1998, section 246.18, subdivision 6, is amended to read:

Subd. 6. [COLLECTIONS DEDICATED.] Except for state-operated programs and services funded through a direct appropriation from the legislature, money received within the regional treatment center system for the following state-operated services is dedicated to the commissioner for the provision of those services:

- (1) community-based residential and day training and habilitation services for mentally retarded persons;
- (2) community health clinic services;

(3) accredited hospital outpatient department services;

~~(4) certified rehabilitation agency and rehabilitation hospital services; or~~

~~(5) community-based transitional support services for adults with serious and persistent mental illness. Except for state-operated programs funded through a direct appropriation from the legislature, any state-operated program or service established and operated as an enterprise activity, shall retain the revenues earned in an interest-bearing account.~~

When the commissioner determines the intent to transition from a direct appropriation to enterprise activity for which the commissioner has authority, all collections for the targeted state-operated service shall be retained and deposited into an interest-bearing account. At the end of the fiscal year, prior to establishing the enterprise activity, collections up to the amount of the appropriation for the targeted service shall be deposited to the general fund. All funds in excess of the amount of the appropriation will be retained and used by the enterprise activity for cash flow purposes.

These funds must be deposited in the state treasury in a revolving account and funds in the revolving account are appropriated to the commissioner to operate the services authorized, and any unexpended balances do not cancel but are available until spent.

Sec. 12. Minnesota Statutes 1998, section 253B.045, is amended by adding a subdivision to read:

Subd. 5. [HEALTH PLAN COMPANY; DEFINITION.] For purposes of this section, "health plan company" has the meaning given it in section 62Q.01, subdivision 4, and also includes a demonstration provider as defined in section 256B.69, subdivision 2, paragraph (b), a county or group of counties participating in county-based purchasing according to section 256B.692, and a children's mental health collaborative under contract to provide medical assistance for individuals enrolled in the prepaid medical assistance and MinnesotaCare programs according to sections 245.493 to 245.496.

Sec. 13. Minnesota Statutes 1998, section 253B.045, is amended by adding a subdivision 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.

Sec. 14. Minnesota Statutes 1998, 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:

(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, 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 reasons for rejecting or recommending alternatives to involuntary placement; ~~and~~

(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.

(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 in any court proceedings unrelated to the commitment proceedings.

(c) 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.

(d) 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.

(e) 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 determine whether or not to proceed with the petition. Notice of the county attorney's determination shall be provided to the interested party.

(f) 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. 15. Minnesota Statutes 1998, section 253B.185, is amended by adding a subdivision to read:

Subd. 5. [AFTERCARE AND CASE MANAGEMENT.] The state, in collaboration with the designated agency, is responsible for arranging and funding the aftercare and case management services for persons under commitment as sexual psychopathic personalities and sexually dangerous persons discharged after July 1, 1999.

Sec. 16. Minnesota Statutes 1998, section 254A.07, subdivision 2, is amended to read:

Subd. 2. The county boards may make grants for local agency programs for prevention, care, and treatment of alcohol and other drug abuse as developed and defined by the state authority. Grants made for programs serving the American Indian community shall take into account the guidelines established in section 254A.03, subdivision 1, clause (j) (k). Grants may be made for the cost of these local agency programs and services whether provided directly by county boards or by other public and private agencies and organizations, both profit and nonprofit, and individuals, pursuant to contract. Nothing herein shall prevent the state authority from entering into contracts with and making grants to other state agencies for the purpose of providing specific services and programs, except that effective July 1, 2001, the state authority shall not make grants using state funds for chemical dependency prevention activities and for case management services for chronic alcoholics. With the approval of the county board, the state authority may make grants or contracts for research or demonstration projects specific to needs within that county.

Sec. 17. Minnesota Statutes 1998, section 254B.01, is amended by adding a subdivision to read:

Subd. 7. [ROOM AND BOARD RATE.] "Room and board rate" means a rate set for shelter, fuel, food, utilities, household supplies, and other costs necessary to provide room and board for a person in need of chemical dependency services.

Sec. 18. Minnesota Statutes 1998, 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, 1999, any funds deposited in the reserve account funds in excess of those needed to meet obligations incurred under this section and sections 254B.06 and 254B.09 shall cancel to the general fund.

Sec. 19. Minnesota Statutes 1998, 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 rate for vendors may not increase more than three percent above the rate approved in effect on January 1, 1997. The calendar year 1999 rate for vendors may not increase more than three percent above the rate in effect on January 1, 1998.

(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.

(e) The rates for vendors of inpatient treatment services for calendar year 2000 and calendar year 2001 may not increase above the rate in effect on January 1, 1999.

(f) The calendar year 2000 rate for vendors of outpatient treatment services may not increase more than two percent above the rate in effect on January 1, 1999. The calendar year 2001 rate for vendors of outpatient treatment services may not increase more than two percent above the rate in effect on January 1, 2000.

Sec. 20. Minnesota Statutes 1998, section 254B.03, subdivision 2, is amended to read:

Subd. 2. [CHEMICAL DEPENDENCY SERVICES FUND PAYMENT.] (a) Payment from the chemical dependency fund is limited to payments for services other than detoxification that, if located outside of federally recognized tribal lands, would be required to be licensed by the commissioner as a chemical dependency treatment or rehabilitation program under sections 245A.01 to 245A.16, and services other than detoxification provided in another state that would be required to be licensed as a chemical dependency program if the program were in the state. Out of state vendors must also provide the commissioner with assurances that the program complies substantially with state licensing requirements and possesses all licenses and certifications required by the host state to provide chemical dependency treatment. ~~Hospitals may apply for and receive licenses to be eligible vendors, notwithstanding the provisions of section 245A.03.~~ Except for chemical dependency transitional rehabilitation programs, vendors receiving payments from the chemical dependency fund must not require copayment from a recipient of benefits for services provided under this subdivision. Payment from the chemical dependency fund shall be made for necessary room and board costs provided by vendors certified according to section 254B.05, or in a community hospital licensed by the commissioner of health according to sections 144.50 to 144.56 to a client who is:

(1) determined to meet the criteria for placement in a residential chemical dependency treatment program according to rules adopted under section 254A.03, subdivision 3; and

(2) concurrently receiving a chemical dependency treatment service in a program licensed by the commissioner and reimbursed by the chemical dependency fund.

(b) A county may, from its own resources, provide chemical dependency services for which state payments are not made. A county may elect to use the same invoice procedures and obtain the same state payment services as are used for chemical dependency services for which state payments are made under this section if county payments are made to the state in advance of state payments to vendors. When a county uses the state system for payment, the commissioner shall make monthly billings to the county using the most recent available information to determine the anticipated services for which payments will be made in the coming month. Adjustment of any overestimate or underestimate based on actual expenditures shall be made by the state agency by adjusting the estimate for any succeeding month.

(c) The commissioner shall coordinate chemical dependency services and determine whether there is a need for any proposed expansion of chemical dependency treatment services. The commissioner shall deny vendor certification to any provider that has not received prior approval from the commissioner for the creation of new programs or the expansion of existing program capacity. The commissioner shall consider the provider's capacity to obtain clients from outside the state based on plans, agreements, and previous utilization history, when determining the need for new treatment services.

Sec. 21. Minnesota Statutes 1998, section 254B.05, subdivision 1, is amended to read:

Subdivision 1. [LICENSURE REQUIRED.] Programs licensed by the commissioner are eligible vendors. Hospitals may apply for and receive licenses to be eligible vendors, notwithstanding the provisions of section 245A.03. American Indian programs located on federally recognized tribal lands that provide chemical dependency primary treatment, extended care, transitional residence, or outpatient treatment services, and are licensed by tribal government are eligible vendors. Detoxification programs are not eligible vendors. Programs that are not licensed as a chemical dependency residential or nonresidential treatment program by the commissioner or by tribal government are not eligible vendors. To be eligible for payment under the Consolidated Chemical Dependency Treatment Fund, a vendor of a chemical dependency service must participate in the Drug and Alcohol Abuse Normative Evaluation System and the treatment accountability plan.

Effective January 1, 2000, vendors of room and board are eligible for chemical dependency fund payment if the vendor:

(1) is certified by the county or tribal governing body as having rules prohibiting residents bringing chemicals into the facility or using chemicals while residing in the facility and provide consequences for infractions of those rules;

(2) has a current contract with a county or tribal governing body;

(3) is determined to meet applicable health and safety requirements;

(4) is not a jail or prison; and

(5) is not concurrently receiving funds under chapter 256I for the recipient.

Sec. 22. Minnesota Statutes 1998, section 256.01, subdivision 6, is amended to read:

Subd. 6. [ADVISORY TASK FORCES.] The commissioner may appoint advisory task forces to provide consultation on any of the programs under the commissioner's administration and supervision. A task force shall expire and the compensation, terms of office and removal of members shall be as provided in section 15.059. Notwithstanding section 15.059, the commissioner may pay a per diem of \$35 to consumers and family members whose participation is needed in legislatively authorized state-level task forces, and whose participation on the task force is not as a paid representative of any agency, organization, or association.

Sec. 23. Laws 1995, chapter 207, article 8, section 41, as amended by Laws 1997, chapter 203, article 7, section 25, is amended to read:

Sec. 41. [245.4661] [~~PILOT PROJECTS TO TEST~~ PROVIDE ALTERNATIVES TO DELIVERY OF ADULT MENTAL HEALTH SERVICES.]

Subdivision 1. [AUTHORIZATION FOR PILOT PROJECTS.] The commissioner of human services may approve pilot projects to ~~test~~ provide alternatives to or ~~the enhanced~~ enhance coordination of the delivery of mental health services required under the Minnesota Comprehensive Adult Mental Health Act, Minnesota Statutes, sections 245.461 to 245.486.

Subd. 2. [PROGRAM DESIGN AND IMPLEMENTATION.] (a) The pilot projects shall be established to design, plan, and improve the mental health service delivery system for adults with serious and persistent mental illness that would:

(1) provide an expanded array of services from which clients can choose services appropriate to their needs;

(2) be based on purchasing strategies that improve access and coordinate services without cost shifting;

(3) incorporate existing state facilities and resources into the community mental health infrastructure through creative partnerships with local vendors; and

(4) utilize existing categorical funding streams and reimbursement sources in combined and creative ways, except appropriations to regional treatment centers and all funds that are attributable to the operation of state-operated services are excluded unless appropriated specifically by the legislature for a purpose consistent with this section.

(b) All projects funded by January 1, 1997, must complete the planning phase and be operational by June 30, 1997; all projects funded by January 1, 1998, must be operational by June 30, 1998.

Subd. 3. [PROGRAM EVALUATION.] Evaluation of each project will be based on outcome evaluation criteria negotiated with each project prior to implementation.

Subd. 4. [NOTICE OF PROJECT DISCONTINUATION.] Each project may be discontinued for any reason by the project's managing entity or the commissioner of human services, after 90 days' written notice to the other party.

Subd. 5. [PLANNING FOR PILOT PROJECTS.] Each local plan for a pilot project must be developed under the direction of the county board, or multiple county boards acting jointly, as the local mental health authority. The planning process for each pilot shall include, but not be limited to, mental health consumers, families, advocates, local mental health advisory councils, local and state providers, representatives of state and local public employee bargaining units, and the department of human services. As part of the planning process, the county board or boards shall designate a managing entity responsible for receipt of funds and management of the pilot project.

Subd. 6. [DUTIES OF COMMISSIONER.] (a) For purposes of the pilot projects, the commissioner shall facilitate integration of funds or other resources as needed and requested by each project. These resources may include:

(1) residential services funds administered under Minnesota Rules, parts 9535.2000 to 9535.3000, in an amount to be determined by mutual agreement between the project's managing entity and the commissioner of human services after an examination of the county's historical utilization of facilities located both within and outside of the county and licensed under Minnesota Rules, parts 9520.0500 to 9520.0690;

(2) community support services funds administered under Minnesota Rules, parts 9535.1700 to 9535.1760;

(3) other mental health special project funds;

(4) medical assistance, general assistance medical care, MinnesotaCare and group residential housing if requested by the project's managing entity, and if the commissioner determines this would be consistent with the state's overall health care reform efforts; and

(5) regional treatment center nonfiscal resources to the extent agreed to by the project's managing entity and the regional treatment center.

(b) The commissioner shall consider the following criteria in awarding start-up and implementation grants for the pilot projects:

(1) the ability of the proposed projects to accomplish the objectives described in subdivision 2;

(2) the size of the target population to be served; and

(3) geographical distribution.

(c) The commissioner shall review overall status of the projects initiatives at least every two years and recommend any legislative changes needed by January 15 of each odd-numbered year.

(d) The commissioner may waive administrative rule requirements which are incompatible with the implementation of the pilot project.

(e) The commissioner may exempt the participating counties from fiscal sanctions for noncompliance with requirements in laws and rules which are incompatible with the implementation of the pilot project.

(f) The commissioner may award grants to an entity designated by a county board or group of county boards to pay for start-up and implementation costs of the pilot project.

Subd. 7. [DUTIES OF COUNTY BOARD.] The county board, or other entity which is approved to administer a pilot project, shall:

(1) administer the project in a manner which is consistent with the objectives described in subdivision 2 and the planning process described in subdivision 5;

- (2) assure that no one is denied services for which they would otherwise be eligible; and
- (3) provide the commissioner of human services with timely and pertinent information through the following methods:
- (i) submission of community social services act plans and plan amendments;
 - (ii) submission of social services expenditure and grant reconciliation reports, based on a coding format to be determined by mutual agreement between the project's managing entity and the commissioner; and
 - (iii) submission of data and participation in an evaluation of the pilot projects, to be designed cooperatively by the commissioner and the projects.

Subd. 8. [EXPIRATION.] This section expires June 30, 2002.

Sec. 24. [CONVEYANCE OF STATE LANDS TO COUNTY OF ISANTI.]

(a) Notwithstanding Minnesota Statutes, sections 94.09 to 94.16, the commissioner of human services, through the commissioner of administration, may transfer to the county of Isanti the lands described in paragraph (c), for no consideration. The commissioner of human services and the county may attach to the transfer conditions that they agree are appropriate, including conditions that relate to water and sewer service. The deed to convey the property must contain a clause that the property shall revert to the state if the property ceases to be used for a public purpose.

(b) The conveyance must be in a form approved by the attorney general.

(c) The land that may be transferred consists of 21.9 acres, more or less, and is described as follows:

That part of the Southwest Quarter of the Southeast Quarter and that part of Government Lot 4, both in Section 32, Township 36, Range 23, Isanti County, Minnesota, described jointly as follows: Commencing at the southwest corner of the Southwest Quarter of the Southeast Quarter of Section 32; thence North 89 degrees 45 minutes 12 seconds East, assumed bearing, along the south line of said SW 1/4 of SE 1/4, a distance of 609.48 feet; thence North 1 degree 30 minutes 30 seconds West, a distance of 149.17 feet to the point of beginning of the parcel to be herein described; thence continuing North 1 degrees 30 minutes 30 seconds West, a distance of 1113.59 feet; thence South 89 degrees 59 minutes 36 seconds West, a distance of 496.41 feet; thence southwesterly along a tangential curve concave to the southeast, radius 318.10 feet, central angle 90 degrees 16 minutes 37 seconds, for an arc length of 501.21 feet; thence South 0 degrees 17 minutes 01 seconds East, tangent to said curve, for a distance of 86.59 feet; thence southerly along a tangential curve concave to the west, radius 398.10 feet, central angle 29 degrees 47 minutes 02 seconds, for an arc length of 206.94 feet; thence south 29 degrees 30 minutes 01 seconds West, tangent to said curve, for a distance of 34.23 feet; thence southerly along a tangential curve concave to the east, radius 318.10 feet, central angle 29 degrees 49 minutes 32 seconds, for an arc length of 165.59 feet; thence South 0 degrees 19 minutes 31 seconds East, tangent to said curve for a distance of 320.65 feet to the point of intersection with a line that bears West (North 90 degrees 00 minutes West) from the point of beginning; thence East (North 90 degrees 00 minutes East), a distance of 951.22 feet to the point of beginning.

Subject to the existing City of Cambridge water main easement.

(d) The county of Isanti may use the land for economic development. Economic development is a public purpose within the meaning of the term as used in Laws 1990, chapter 610, article 1, section 12, subdivision 5, and sales or conveyances to private parties shall be considered economic development. Property conveyed by the state under this section shall not revert to the state if it is conveyed or otherwise encumbered by the county as part of the county economic development activity.

Sec. 25. [CONVEYANCE OF STATE LAND TO CITY OF CAMBRIDGE.]

(a) Notwithstanding Minnesota Statutes, sections 94.09 to 94.16, the commissioner of human services, through the commissioner of administration, may transfer to the city of Cambridge the lands described in paragraph (c), for no consideration. The commissioner of human services and the city may attach to the transfer conditions that they agree are appropriate, including conditions that relate to water and sewer service. The deed to convey the property must contain a clause that the property shall revert to the state if the property ceases to be used for a public purpose.

(b) The conveyance must be in a form approved by the attorney general.

(c) Subject to the right-of-way for state trunk highway No. 293 and south Dellwood street and subject to other easements, reservations, road or street right-of-ways, and restrictions of record, if any, the land to be conveyed may include all or part of any of the parcels described as follows:

(1) that part of the Northeast Quarter of the Northeast Quarter of Section 5, Township 35, Range 23, Isanti County, Minnesota, lying north of a line drawn parallel with and 50 feet north of the center line of State Highway No. 293, as laid out and constructed and lying westerly of the following described line:

Commencing at a point where the West line of the right-of-way of the Great Northern Railway Company (presently the Burlington Northern and Santa Fe Railway) intersects the North line of said Section 5, said point now being the intersection of the North line of said Section 5 with the center line of State Trunk Highway No. 65 as now laid out and constructed (presently known as South Main Street); thence on a bearing of West and along the North line of said Section 5 a distance of 539.5 feet to the point of beginning of the line to be herein described; thence on a bearing of South, a distance of 451.75 feet to the point of intersection with a line drawn parallel with and distant 50 feet north of the center line of State Highway No. 293, as laid out and constructed and there terminating. Containing 1/4 acre, more or less.

(2) that part of the Northwest Quarter of the Southeast Quarter and that part of Governments Lots 3 and 4, all in Section 32, Township 36, Range 23, Isanti County, Minnesota, described jointly as follows:

Commencing at the East quarter corner of Section 32, Township 36, Range 23, Isanti County, Minnesota; thence South 89 degrees 44 minutes 35 seconds West, assumed bearing, along the east-west quarter line of said Section 32, a distance of 2251.43 feet; thence South 1 degree 48 minutes 40 seconds East, a distance of 344.47 feet to the south line of Lot 30 of Auditor's Subdivision No. 9; thence South 89 degrees 35 minutes 5 seconds West, along said south line and the westerly projection thereof, a distance of 740.00 feet to the point of beginning of the parcel to be herein described; thence North 89 degrees 35 minutes, 05 seconds East, retracing the last described course, a distance of 534.66 feet to the northwest corner of the recorded plat of RIVERWOOD VILLAGE; thence South 2 degrees 40 minutes 50 seconds East, a distance of 338.38 feet, along the westerly line of said RIVERWOOD VILLAGE to the southwest corner of said RIVERWOOD VILLAGE; thence North 89 degrees 44 minutes 50 seconds East, along the south line of said RIVERWOOD VILLAGE, a distance of 1074.56 feet; thence South 3 degrees 35 minutes 15 seconds East, a distance of 258.66 feet; thence southwesterly along a tangential curve concave to the northwest, radius 318.10 feet, central angle 93 degrees 34 minutes 51 seconds for an arc length of 519.56 feet; thence South 89 degrees 59 minutes 37 seconds West tangent to said curve for a distance of 825.86 feet; thence southwesterly along a tangential curve concave to the southeast, radius 398.10 feet, central angle 70 degrees 55 minutes 13 seconds, for an arc length of 492.76 feet; thence South 89 degrees 51 minutes 30 seconds West, not tangent to the last described curve for a distance of 523.31 feet; thence South 1 degree 57 minutes 33 seconds West, a distance of 29.59 feet; thence South 89 degrees 57 minutes 55 seconds West, a distance of 1020 feet, more or less, to the easterly shoreline of the Rum River; thence northerly along said easterly shoreline to the point of intersection with a line that bears North 45 degrees 24 minutes 55 seconds West from the point of beginning; thence South 45 degrees 24 minutes 55 seconds East, along said line, a distance of 180 feet, more or less, to the point of beginning. Containing 48 acres, more or less.

(3) that part of the Northwest Quarter of the Northeast Quarter and that part of the Northeast Quarter of the Northwest Quarter, both in Section 5, Township 35, Range 23, Isanti County, Minnesota, described jointly as follows:

Beginning at the northwest corner of the NW 1/4 of NE 1/4 of Section 5; thence North 89 degrees 45 minutes 12 seconds East, assumed bearing, along the north line of said NW 1/4 of NE 1/4, a distance of 1321.82 feet to the northeast corner of said NW 1/4 of NE 1/4 thence South 4 degrees 04 minutes 02 seconds West, along the east line of said NW 1/4 of NE 1/4, a distance of 452.83 feet; thence South 89 degrees 45 minutes 02 seconds West, a distance of 1393.6 feet; thence northwesterly, along a non-tangential curve concave to the northeast, radius 318.17 feet, central angle 75 degrees 28 minutes 03 seconds, for an arc length of 419.08 feet (the chord of said curve bears North 38 degrees 03 minutes 32 seconds West and has a length of 389.44 feet); thence North 0 degrees 19 minutes 31 seconds West, tangent to said curve, for a distance of 142.65 feet to the north line of the NE 1/4 of NW 1/4 of said Section 5; thence North 89 degrees 32 minutes 15 seconds East, along said north line, a distance of 344.81 feet to the point of beginning. Containing 16 acres, more or less.

(4) that part of the Southwest Quarter of the Southeast Quarter, that part of the Northwest Quarter of the Southeast Quarter and that part of Government Lot 4, all in Section 32, Township 36, Range 23, Isanti County, Minnesota, described jointly as follows:

Beginning at the southwest corner of the SW 1/4 of SE 1/4 of Section 32; thence North 89 degrees 45 minutes 12 seconds East, assumed bearing, along the south line of said SW 1/4 of SE 1/4, a distance of 1321.82 feet to the southeast corner of said SW 1/4 of SE 1/4 thence North 2 degrees 40 minutes 49 seconds West, along the east line of said SW 1/4 of SE 1/4 and along the east line of the NW 1/4 of SE 1/4, a distance of 1465.32 feet; thence southwesterly along a non-tangential curve concave to the northwest, radius 398.10 feet, central angle 60 degrees 52 minutes 54 seconds, for an arc length of 423.02 feet (said curve has a chord that bears South 59 degrees 33 minutes 09 seconds West and a chord length of 403.40 feet); thence South 89 degrees 59 minutes 37 seconds West, tangent to said curve, for a distance of 825.68 feet; thence southwesterly along a tangential curve concave to the southeast, radius 318.10 feet, central angle 90 degrees 16 minutes 37 seconds, for an arc length of 501.21 feet; thence South 0 degrees 17 minutes 01 seconds East, tangent to said curve, for a distance of 86.59 feet; thence southerly along a tangential curve concave to the West, radius 398.10 feet, central angle 29 degrees 47 minutes 02 seconds, for an arc length of 206.94 feet; thence South 29 degrees 30 minutes 01 seconds West tangent to said curve, for a distance of 34.23 feet; thence southerly along a tangential curve concave to the east, radius 318.20 feet, central angle 29 degrees 49 minutes 32 seconds for an arc length of 165.59 feet; thence South 0 degrees 19 minutes 31 seconds East, tangent to said curve, for a distance of 475.17 feet to the south line of Government Lot 4, Section 32; thence North 89 degrees 32 minutes 15 seconds East, along said south line, a distance of 344.81 feet to the point of beginning. Containing 44.9 acres, more or less.

EXCEPTING THEREFROM that parcel described on Quit Claim Deed from the State of Minnesota to Wilfred R. and June E. Norman, filed in Book 92 of Deeds, page 647, in the office of the County Recorder, Isanti County, Minnesota.

ALSO EXCEPTING THEREFROM that parcel described on Quit Claim Deed from the State of Minnesota to Frank C. Brody and Lorraine D.S. Brody, filed in Book 102 of Deeds, page 232, in the office of the County Recorder, Isanti County, Minnesota.

(d) The city of Cambridge may use the land for economic development. Economic development is a public purpose within the meaning of the term as used in Laws 1990, chapter 610, article 1, section 12, subdivision 5, and sales or conveyances to private parties shall be considered economic development. Property conveyed by the state under this section shall not revert to the state if it is conveyed or otherwise encumbered by the city as a part of the city economic development activity.

Sec. 26. [CONVEYANCE OF CITY LAND TO STATE OF MINNESOTA.]

(a) The commissioner of administration may accept all, or any part of, the land described in paragraph (d) from the city of Cambridge, after the city council passes a resolution which declares the property is surplus to its needs.

(b) The conveyance shall be in a form approved by the attorney general.

(c) The conveyance may be subject to a scenic easement, as defined in Minnesota Statutes, section 103F.311, subdivision 6. The easement shall be under the custodial control of the commissioner of natural resources and only required on the portion of conveyed land that is designated for inclusion in the wild and scenic river system under Minnesota Statutes, section 103F.325. The scenic easement shall allow for continued use of any existing structures located within the easement and for development of walking paths or trails within the easement.

(d) Subject to the right-of-way for state trunk highway No. 293, and subject to other easements, reservations, street right-of-ways, and restrictions of record, if any, the land to be conveyed may include all, or part of, the parcel described as follows:

That part of Government Lot 4 and that part of the Northeast Quarter of the Northwest Quarter, all in Section 5, Township 35, Range 23, Isanti County, Minnesota, described jointly as follows: Commencing at the Northeast corner of the Northwest Quarter of Section 5, thence South 89 degrees 47 minutes 10 seconds West, assumed bearing along the north line of the Northwest Quarter of Section 5, a distance of 656.00 feet to the point of beginning of the parcel to be herein described, thence South 00 degrees 03 minutes 35 seconds East, a distance of 350.00 feet, thence South 89 degrees 47 minutes 10 seconds West, parallel with the north line of said Northwest Quarter of Section 5 to the easterly shoreline of the Rum River, thence northeasterly along said easterly shoreline to the north line of the Northwest Quarter of Section 5, thence North 89 degrees 47 minutes 10 seconds East, along said north line to the point of beginning.

Sec. 27. [REPORT TO LEGISLATURE ON CHEMICAL DEPENDENCY GRANT PROGRAMS.]

The commissioner of human services shall report and provide detailed outcome measures to the legislature, by January 1, 2001, on chemical dependency grant activities for:

(1) chemical dependency prevention, education, community awareness, and treatment services to Native Americans under Minnesota Statutes, sections 254A.03, subdivision 2, and 254A.031;

(2) chemical dependency case management services for chronic alcoholics under Minnesota Statutes, section 254A.07, subdivision 2;

(3) chemical dependency prevention activities under Minnesota Statutes, section 254A.07, subdivision 2; and

(4) chemical dependency treatment services to pregnant women and women with children under Minnesota Statutes, section 254A.17, subdivision 1a.

The report must contain sufficient information to assist the legislature in determining whether these grant activities are a cost-effective use of state funds and whether these grant activities should continue or be repealed.

Sec. 28. [REPORT TO LEGISLATURE ON ESTABLISHING ENTERPRISE ACTIVITIES WITHIN STATE-OPERATED SERVICES.]

The commissioner of human services shall report and make recommendations to the legislature, by December 15, 1999, on establishing enterprise activities within state-operated services, under Minnesota Statutes, section 246.0136, and their status.

Sec. 29. [REPEALER.]

(a) Minnesota Statutes 1998, section 254A.145, is repealed.

(b) Minnesota Statutes 1998, sections 462A.208; and 462A.21, subdivision 19, are repealed.

(c) Minnesota Statutes, sections 254A.03, subdivision 2; 254A.031; and 254A.17, subdivision 1a, are repealed June 30, 2001.

ARTICLE 6

MFIP AND ADULT SUPPORTS

Section 1. Minnesota Statutes 1998, section 256D.06, subdivision 5, is amended to read:

Subd. 5. Any applicant, otherwise eligible for general assistance and possibly eligible for maintenance benefits from any other source shall (a) make application for those benefits within 30 days of the general assistance application; and (b) execute an interim assistance authorization agreement on a form as directed by the commissioner. The commissioner shall review a denial of an application for other maintenance benefits and may require a recipient of general assistance to file an appeal of the denial if appropriate. If found eligible for benefits from other sources, and a payment received from another source relates to the period during which general assistance was also being received, the recipient shall be required to reimburse the county agency for the interim assistance paid. Reimbursement shall not exceed the amount of general assistance paid during the time period to which the other maintenance benefits apply and shall not exceed the state standard applicable to that time period. The commissioner shall adopt rules authorizing county agencies or other client representatives to retain from the amount recovered under an interim assistance agreement 25 percent plus actual reasonable fees, costs, and disbursements of appeals and litigation, of providing special assistance to the recipient in processing the recipient's claim for maintenance benefits from another source. The money retained under this section shall be from the state share of the recovery. The commissioner or the county agency may contract with qualified persons to provide the special assistance. The rules adopted by the commissioner shall include the methods by which county agencies shall identify, refer, and assist recipients who may be eligible for benefits under federal programs for the disabled. This subdivision does not require repayment of per diem payments made to shelters for battered women pursuant to section 256D.05, subdivision 3.

Sec. 2. Minnesota Statutes 1998, section 256J.02, subdivision 2, is amended to read:

Subd. 2. [USE OF MONEY.] State money appropriated for purposes of this section and TANF block grant money must be used for:

- (1) financial assistance to or on behalf of any minor child who is a resident of this state under section 256J.12;
- (2) employment and training services under this chapter or chapter 256K;
- (3) emergency financial assistance and services under section 256J.48;
- (4) diversionary assistance under section 256J.47; ~~and~~
- (5) family assets for independence accounts under Laws 1998, First Special Session chapter 1, article 1;
- (6) the pathways program under section 116L.04, subdivision 1a;
- (7) welfare-to-work extended employment services for MFIP participants with severe impairment to employment as defined in section 268A.15, subdivision 1a;
- (8) the family homeless prevention and assistance program under section 462A.204;
- (9) the rent assistance for family stabilization demonstration project under section 462A.205; and
- (10) program administration under this chapter.

Sec. 3. Minnesota Statutes 1998, section 256J.08, subdivision 11, is amended to read:

Subd. 11. [CAREGIVER.] "Caregiver" means a minor child's natural or adoptive parent or parents and stepparent who live in the home with the minor child. For purposes of determining eligibility for this program, caregiver also means any of the following individuals, if adults, who live with and provide care and support to a minor child when the minor child's natural or adoptive parent or parents or stepparents do not reside in the same home: legal custodian or guardian, grandfather, grandmother, brother, sister, half-brother, half-sister, stepbrother, stepsister, uncle, aunt, first cousin or first cousin once removed, nephew, niece, person of preceding generation as denoted by prefixes of "great," "great-great," or "great-great-great," or a spouse of any person named in the above groups even after the marriage ends by death or divorce.

Sec. 4. Minnesota Statutes 1998, section 256J.08, is amended by adding a subdivision to read:

Subd. 28a. [ENCUMBRANCE.] "Encumbrance" means a legal claim against real or personal property that is payable upon the sale of that property.

Sec. 5. Minnesota Statutes 1998, section 256J.08, is amended by adding a subdivision 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;

(2) the shared household standard, section 256J.24, subdivision 9; and

(3) the interstate transition standard, section 256J.43.

Sec. 6. Minnesota Statutes 1998, section 256J.08, subdivision 65, is amended to read:

Subd. 65. [PARTICIPANT.] "Participant" means a person who is currently receiving cash assistance ~~and~~ or the food portion available through ~~MFIP-S MFIP~~ as funded by TANF and the food stamp program. A person who fails to withdraw or access electronically any portion of the person's cash and food assistance payment by the end of the payment month, who makes a written request for closure before the first of a payment month and repays cash and food assistance electronically issued for that payment month within that payment month, or who returns any uncashed assistance check and food coupons and withdraws from the program is not a participant. A person who withdraws a cash or food assistance payment by electronic transfer or receives and cashes ~~a cash an MFIP~~ assistance check or food coupons and is subsequently determined to be ineligible for assistance for that period of time is a participant, regardless whether that assistance is repaid. The term "participant" includes the caregiver relative and the minor child whose needs are included in the assistance payment. A person in an assistance unit who does not receive a cash and food assistance payment because the person has been suspended from ~~MFIP-S or because the person's need falls below the \$10 minimum payment level MFIP~~ is a participant.

Sec. 7. Minnesota Statutes 1998, section 256J.08, subdivision 82, is amended to read:

Subd. 82. [SANCTION.] "Sanction" means the reduction of a family's assistance payment by a specified percentage of the ~~applicable transitional~~ MFIP standard of need because: a nonexempt participant fails to comply with the requirements of sections 256J.52 to 256J.55; a parental caregiver fails without good cause to cooperate with the child support enforcement requirements; or a participant fails to comply with the insurance, tort liability, or other requirements of this chapter.

Sec. 8. Minnesota Statutes 1998, section 256J.08, subdivision 86a, is amended to read:

Subd. 86a. [UNRELATED MEMBER.] "Unrelated member" means an individual in the household who does not meet the definition of an eligible caregiver, ~~but does not include an individual who provides child care to a child in the assistance unit.~~

Sec. 9. Minnesota Statutes 1998, section 256J.11, subdivision 2, is amended to read:

Subd. 2. [NONCITIZENS; FOOD PORTION.] ~~(a) For the period September 1, 1997, to October 31, 1997, noncitizens who do not meet one of the exemptions in section 412 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, but were residing in this state as of July 1, 1997, are eligible for the 6/10 of the average value of food stamps for the same family size and composition until MFIP-S is operative in the noncitizen's county of financial responsibility and thereafter, the 6/10 of the food portion of MFIP-S. However, federal food stamp dollars cannot be used to fund the food portion of MFIP-S benefits for an individual under this subdivision.~~

~~(b) For the period November 1, 1997, to June 30, 1999, noncitizens who do not meet one of the exemptions in section 412 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, and are receiving cash assistance under the AFDC, family general assistance, MFIP or MFIP-S programs are eligible for the average value of food stamps for the same family size and composition until MFIP-S is operative in the noncitizen's county of financial responsibility and thereafter, the food portion of MFIP-S. However, federal food stamp dollars cannot be used to fund the food portion of MFIP-S benefits for an individual under this subdivision.~~ State dollars shall fund the food portion of a noncitizen's MFIP benefits when federal food stamp dollars cannot be used to fund those benefits. The assistance provided under this subdivision, which is designated as a supplement to replace lost benefits under the federal food stamp program, must be disregarded as income in all programs that do not count food stamps as income where the commissioner has the authority to make the income disregard determination for the program.

~~(c) The commissioner shall submit a state plan to the secretary of agriculture to allow the commissioner to purchase federal Food Stamp Program benefits in an amount equal to the MFIP-S food portion for each legal noncitizen receiving MFIP-S assistance who is 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. The commissioner shall enter into a contract as necessary with the secretary to use the existing federal Food Stamp Program benefits delivery system for the purposes of administering the food portion of MFIP-S under this subdivision.~~

Sec. 10. Minnesota Statutes 1998, section 256J.11, subdivision 3, is amended to read:

Subd. 3. [BENEFITS FUNDED WITH STATE MONEY.] Legal adult noncitizens who have resided in the country for four years or more as a lawful permanent resident, whose benefits are funded entirely with state money, and who are under 70 years of age, must, as a condition of eligibility:

- (1) be enrolled in a literacy class, English as a second language class, or a citizen class;
- (2) be applying for admission to a literacy class, English as a second language class, and is on a waiting list;
- (3) be in the process of applying for a waiver from the Immigration and Naturalization Service of the English language or civics requirements of the citizenship test;
- (4) have submitted an application for citizenship to the Immigration and Naturalization Service and is waiting for a testing date or a subsequent swearing in ceremony; or
- (5) have been denied citizenship due to a failure to pass the test after two attempts or because of an inability to understand the rights and responsibilities of becoming a United States citizen, as documented by the Immigration and Naturalization Service or the county.

If the county social service agency determines that a legal noncitizen subject to the requirements of this subdivision will require more than one year of English language training, then the requirements of clause (1) or (2) shall be imposed after the legal noncitizen has resided in the country for three years. Individuals who reside in a facility licensed under chapter 144A, 144D, 245A, or 256I are exempt from the requirements of this subdivision.

Sec. 11. Minnesota Statutes 1998, section 256J.12, subdivision 1a, is amended to read:

Subd. 1a. [30-DAY RESIDENCY REQUIREMENT.] An assistance unit is considered to have established residency in this state only when a child or caregiver has resided in this state for at least 30 consecutive days with the intention of making the person's home here and not for any temporary purpose. The birth of a child in Minnesota to a member of the assistance unit does not automatically establish the residency in this state under this subdivision of the other members of the assistance unit. Time spent in a shelter for battered women shall count toward satisfying the 30-day residency requirement.

Sec. 12. Minnesota Statutes 1998, section 256J.12, subdivision 2, is amended to read:

Subd. 2. [EXCEPTIONS.] (a) A county shall waive the 30-day residency requirement where unusual hardship would result from denial of assistance.

(b) For purposes of this section, unusual hardship means an assistance unit:

- (1) is without alternative shelter; or
- (2) is without available resources for food.

(c) For purposes of this subdivision, the following definitions apply (1) "metropolitan statistical area" is as defined by the U.S. Census Bureau; (2) "alternative shelter" includes any shelter that is located within the metropolitan statistical area containing the county and for which the family is eligible, provided the assistance unit does not have to travel more than 20 miles to reach the shelter and has access to transportation to the shelter. Clause (2) does not apply to counties in the Minneapolis-St. Paul metropolitan statistical area.

(d) Applicants are considered to meet the residency requirement under subdivision 1a if they once resided in Minnesota and:

- (1) joined the United States armed services, returned to Minnesota within 30 days of leaving the armed services, and intend to remain in Minnesota; or
- (2) left to attend school in another state, paid nonresident tuition or Minnesota tuition rates under a reciprocity agreement, and returned to Minnesota within 30 days of graduation with the intent to remain in Minnesota.

(e) The 30-day residence requirement is met when:

- (1) a minor child or a minor caregiver moves from another state to the residence of a relative caregiver; and
- ~~(2) the minor caregiver applies for and receives family cash assistance;~~
- ~~(3) the relative caregiver chooses not to be part of the MFIP-S assistance unit; and~~
- ~~(4) the relative caregiver has resided in Minnesota for at least 30 days prior to the date the assistance unit applies for cash assistance.~~

~~(f) Ineligible mandatory unit members who have resided in Minnesota for 12 months immediately before the unit's date of application establish the other assistance unit members' eligibility for the MFIP-S transitional standard.~~

(2) the relative caregiver has resided in Minnesota for at least 30 consecutive days and:

(i) the minor caregiver applies for and receives MFIP; or

(ii) the relative caregiver applies for assistance for the minor child but does not choose to be a member of the MFIP assistance unit.

Sec. 13. Minnesota Statutes 1998, section 256J.14, is amended to read:

256J.14 [ELIGIBILITY FOR PARENTING OR PREGNANT MINORS.]

(a) The definitions in this paragraph only apply to this subdivision.

(1) "Household of a parent, legal guardian, or other adult relative" means the place of residence of:

(i) a natural or adoptive parent;

(ii) a legal guardian according to appointment or acceptance under section 260.242, 525.615, or 525.6165, and related laws;

(iii) a caregiver as defined in section 256J.08, subdivision 11; or

(iv) an appropriate adult relative designated by a county agency.

(2) "Adult-supervised supportive living arrangement" means a private family setting which assumes responsibility for the care and control of the minor parent and minor child, or other living arrangement, not including a public institution, licensed by the commissioner of human services which ensures that the minor parent receives adult supervision and supportive services, such as counseling, guidance, independent living skills training, or supervision.

(b) A minor parent and the minor child who is in the care of the minor parent must reside in the household of a parent, legal guardian, other adult relative, or in an adult-supervised supportive living arrangement in order to receive ~~MFIP-S~~ MFIP unless:

(1) the minor parent has no living parent, other adult relative, or legal guardian whose whereabouts is known;

(2) no living parent, other adult relative, or legal guardian of the minor parent allows the minor parent to live in the parent's, other adult relative's, or legal guardian's home;

(3) the minor parent lived apart from the minor parent's own parent or legal guardian for a period of at least one year before either the birth of the minor child or the minor parent's application for ~~MFIP-S~~ MFIP;

(4) the physical or emotional health or safety of the minor parent or minor child would be jeopardized if the minor parent and the minor child resided in the same residence with the minor parent's parent, other adult relative, or legal guardian; or

(5) an adult supervised supportive living arrangement is not available for the minor parent and child in the county in which the minor parent and child currently reside. If an adult supervised supportive living arrangement becomes available within the county, the minor parent and child must reside in that arrangement.

(c) The county agency shall inform minor applicants ~~must be informed both~~ orally and in writing about the eligibility requirements ~~and~~, their rights and obligations under the ~~MFIP-S~~ MFIP program, and any other applicable orientation information. The county must advise the minor of the possible exemptions and specifically ask whether one or more of these exemptions is applicable. If the minor alleges one or more of these exemptions, then the county must assist the minor in obtaining the necessary verifications to determine whether or not these exemptions apply.

(d) If the county worker has reason to suspect that the physical or emotional health or safety of the minor parent or minor child would be jeopardized if they resided with the minor parent's parent, other adult relative, or legal guardian, then the county worker must make a referral to child protective services to determine if paragraph (b), clause (4), applies. A new determination by the county worker is not necessary if one has been made within the last six months, unless there has been a significant change in circumstances which justifies a new referral and determination.

(e) If a minor parent is not living with a parent, legal guardian, or other adult relative due to paragraph (b), clause (1), (2), or (4), the minor parent must reside, when possible, in a living arrangement that meets the standards of paragraph (a), clause (2).

(f) ~~When a minor parent and minor child live with a parent, other adult relative, legal guardian, or in an adult-supervised supportive~~ Regardless of living arrangement, ~~MFIP-S MFIP~~ must be paid, when possible, in the form of a protective payment on behalf of the minor parent and minor child according to section 256J.39, subdivisions 2 to 4.

Sec. 14. Minnesota Statutes 1998, section 256J.20, subdivision 3, is amended to read:

Subd. 3. [OTHER PROPERTY LIMITATIONS.] To be eligible for ~~MFIP-S MFIP~~, the equity value of all nonexcluded real and personal property of the assistance unit must not exceed \$2,000 for applicants and \$5,000 for ongoing participants. The value of assets in clauses (1) to (20) must be excluded when determining the equity value of real and personal property:

(1) a licensed vehicle up to a loan value of less than or equal to \$7,500. The county agency shall apply any excess loan value as if it were equity value to the asset limit described in this section. If the assistance unit owns more than one licensed vehicle, the county agency shall determine the vehicle with the highest loan value and count only the loan value over \$7,500, excluding: (i) the value of one vehicle per physically disabled person when the vehicle is needed to transport the disabled unit member; this exclusion does not apply to mentally disabled people; (ii) the value of special equipment for a handicapped member of the assistance unit; and (iii) any vehicle used for long-distance travel, other than daily commuting, for the employment of a unit member.

The county agency shall count the loan value of all other vehicles and apply this amount as if it were equity value to the asset limit described in this section. ~~The value of special equipment for a handicapped member of the assistance unit is excluded.~~ To establish the loan value of vehicles, a county agency must use the N.A.D.A. Official Used Car Guide, Midwest Edition, for newer model cars. When a vehicle is not listed in the guidebook, or when the applicant or participant disputes the loan value listed in the guidebook as unreasonable given the condition of the particular vehicle, the county agency may require the applicant or participant document the loan value by securing a written statement from a motor vehicle dealer licensed under section 168.27, stating the amount that the dealer would pay to purchase the vehicle. The county agency shall reimburse the applicant or participant for the cost of a written statement that documents a lower loan value;

(2) the value of life insurance policies for members of the assistance unit;

(3) one burial plot per member of an assistance unit;

(4) the value of personal property needed to produce earned income, including tools, implements, farm animals, inventory, business loans, business checking and savings accounts used at least annually and used exclusively for the operation of a self-employment business, and any motor vehicles if at least 50 percent of the vehicle's use is to produce income and if the vehicles are essential for the self-employment business;

(5) the value of personal property not otherwise specified which is commonly used by household members in day-to-day living such as clothing, necessary household furniture, equipment, and other basic maintenance items essential for daily living;

(6) the value of real and personal property owned by a recipient of Supplemental Security Income or Minnesota supplemental aid;

(7) the value of corrective payments, but only for the month in which the payment is received and for the following month;

(8) a mobile home or other vehicle used by an applicant or participant as the applicant's or participant's home;

(9) money in a separate escrow account that is needed to pay real estate taxes or insurance and that is used for this purpose;

(10) money held in escrow to cover employee FICA, employee tax withholding, sales tax withholding, employee worker compensation, business insurance, property rental, property taxes, and other costs that are paid at least annually, but less often than monthly;

(11) monthly assistance, emergency assistance, and diversionary payments for the current month's needs;

(12) the value of school loans, grants, or scholarships for the period they are intended to cover;

(13) payments listed in section 256J.21, subdivision 2, clause (9), which are held in escrow for a period not to exceed three months to replace or repair personal or real property;

(14) income received in a budget month through the end of the payment month;

(15) savings from earned income of a minor child or a minor parent that are set aside in a separate account designated specifically for future education or employment costs;

(16) the federal earned income credit, Minnesota working family credit, state and federal income tax refunds, state homeowners and renters credits under chapter 290A, property tax rebates ~~under Laws 1997, chapter 231, article 1, section 16;~~ and other federal or state tax rebates in the month received and the following month;

(17) payments excluded under federal law as long as those payments are held in a separate account from any nonexcluded funds;

(18) money received by a participant of the corps to career program under section 84.0887, subdivision 2, paragraph (b), as a postservice benefit under the federal Americorps Act;

(19) the assets of children ineligible to receive ~~MFIP-S~~ MFIP benefits because foster care or adoption assistance payments are made on their behalf; and

(20) the assets of persons whose income is excluded under section 256J.21, subdivision 2, clause (43).

Sec. 15. Minnesota Statutes 1998, 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, or 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) ~~property tax rebates under Laws 1997, chapter 231, article 1, section 16; and~~

~~(v) other 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, including retroactive payments;

(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;

(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 ~~or~~ 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-S~~ MFIP child care payments under section 119B.05;

(29) all other payments made through ~~MFIP-S~~ 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 ~~the MFIP-S program~~ 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 ~~parent~~ parents and ~~stepparent~~ stepparents when determining the grant for the minor parent in households that include a minor parent living with a ~~parent~~ parents or ~~stepparent~~ stepparents on ~~MFIP-S~~ MFIP with other children; and

(43) income of the minor parent's ~~parent~~ parents and ~~stepparent~~ 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 a ~~parent~~ parents or ~~stepparent~~ stepparents not on ~~MFIP-S~~ 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.

Sec. 16. Minnesota Statutes 1998, section 256J.21, subdivision 3, is amended to read:

Subd. 3. [INITIAL INCOME TEST.] The county agency shall determine initial eligibility by considering all earned and unearned income that is not excluded under subdivision 2. To be eligible for ~~MFIP-S~~ MFIP, the assistance unit's countable income minus the disregards in paragraphs (a) and (b) must be below the transitional standard of assistance according to section 256J.24 for that size assistance unit.

(a) The initial eligibility determination must disregard the following items:

(1) the employment disregard is 18 percent of the gross earned income whether or not the member is working full time or part time;

(2) dependent care costs must be deducted from gross earned income for the actual amount paid for dependent care up to a maximum of \$200 per month for each child less than two years of age, and \$175 per month for each child two years of age and older under this chapter and chapter 119B;

(3) all payments made according to a court order for spousal support or the support of children not living in the assistance unit's household shall be disregarded from the income of the person with the legal obligation to pay support, provided that, if there has been a change in the financial circumstances of the person with the legal obligation to pay support since the support order was entered, the person with the legal obligation to pay support has petitioned for a modification of the support order; and

(4) an allocation for the unmet need of an ineligible spouse or an ineligible child under the age of 21 for whom the caregiver is financially responsible and who lives with the caregiver according to section 256J.36.

(b) Notwithstanding paragraph (a), when determining initial eligibility for applicant units when at least one member has received ~~AFDC, family general assistance, MFIP, MFIP-R,~~ work first, or ~~MFIP-S~~ MFIP in this state within four months of the most recent application for ~~MFIP-S~~ MFIP, the ~~employment~~ disregard for all unit members is 36 percent of the gross earned income.

After initial eligibility is established, the assistance payment calculation is based on the monthly income test.

Sec. 17. Minnesota Statutes 1998, section 256J.21, subdivision 4, is amended to read:

Subd. 4. [MONTHLY INCOME TEST AND DETERMINATION OF ASSISTANCE PAYMENT.] The county agency shall determine ongoing eligibility and the assistance payment amount according to the monthly income test. To be eligible for ~~MFIP-S~~ MFIP, the result of the computations in paragraphs (a) to (e) must be at least \$1.

(a) Apply a 36 percent income disregard to gross earnings and subtract this amount from the family wage level. If the difference is equal to or greater than the ~~transitional~~ MFIP standard of need, the assistance payment is equal to the ~~transitional~~ MFIP standard of need. If the difference is less than the ~~transitional~~ MFIP standard of need, the assistance payment is equal to the difference. The employment disregard in this paragraph must be deducted every month there is earned income.

(b) All payments made according to a court order for spousal support or the support of children not living in the assistance unit's household must be disregarded from the income of the person with the legal obligation to pay support, provided that, if there has been a change in the financial circumstances of the person with the legal obligation to pay support since the support order was entered, the person with the legal obligation to pay support has petitioned for a modification of the court order.

(c) An allocation for the unmet need of an ineligible spouse or an ineligible child under the age of 21 for whom the caregiver is financially responsible and who lives with the caregiver must be made according to section 256J.36.

(d) Subtract unearned income dollar for dollar from the MFIP ~~transitional~~ standard of need to determine the assistance payment amount.

(e) When income is both earned and unearned, the amount of the assistance payment must be determined by first treating gross earned income as specified in paragraph (a). After determining the amount of the assistance payment under paragraph (a), unearned income must be subtracted from that amount dollar for dollar to determine the assistance payment amount.

(f) When the monthly income is greater than the ~~transitional or family wage level~~ MFIP standard of need after ~~applicable~~ deductions and the income will only exceed the standard for one month, the county agency must suspend the assistance payment for the payment month.

Sec. 18. Minnesota Statutes 1998, 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.

Sec. 19. Minnesota Statutes 1998, section 256J.24, subdivision 3, is amended to read:

Subd. 3. [INDIVIDUALS WHO MUST BE EXCLUDED FROM AN ASSISTANCE UNIT.] (a) The following individuals who are part of the assistance unit determined under subdivision 2 are ineligible to receive ~~MFIP-S~~ MFIP:

- (1) individuals receiving Supplemental Security Income or Minnesota supplemental aid;
- (2) ~~individuals living at home while performing court-imposed, unpaid community service work due to a criminal conviction;~~
- (3) individuals disqualified from the food stamp program or ~~MFIP-S~~ MFIP, until the disqualification ends;

(4) (3) children on whose behalf federal, state, or local foster care payments are made, except as provided in sections 256J.13, subdivision 2, and 256J.74, subdivision 2; and

(5) (4) children receiving ongoing monthly adoption assistance payments under section 259.67.

(b) The exclusion of a person under this subdivision does not alter the mandatory assistance unit composition.

Sec. 20. Minnesota Statutes 1998, section 256J.24, subdivision 7, is amended to read:

Subd. 7. [FAMILY WAGE LEVEL STANDARD.] The family wage level standard is 110 percent of the transitional standard under subdivision 5 and is the standard used when there is earned income in the assistance unit. As specified in section 256J.21, earned income is subtracted from the family wage level to determine the amount of the assistance payment. Not including the family wage level standard, assistance payments may not exceed the ~~shared household standard or the transitional~~ MFIP standard of need for the assistance unit, ~~whichever is less~~.

Sec. 21. Minnesota Statutes 1998, section 256J.24, subdivision 8, is amended to read:

Subd. 8. [ASSISTANCE PAID TO ELIGIBLE ASSISTANCE UNITS.] Except for assistance units where a nonparental caregiver is not included in the grant, payments for shelter up to the amount of the cash portion of ~~MFIP-S~~ MFIP benefits for which the assistance unit is eligible shall be vendor paid for as many months as the assistance unit is eligible or six months, whichever comes first. The residual amount of the grant after vendor payment, if any, must be paid to the ~~MFIP-S~~ MFIP caregiver.

Sec. 22. Minnesota Statutes 1998, section 256J.24, subdivision 9, is amended to read:

Subd. 9. [SHARED HOUSEHOLD STANDARD; ~~MFIP-S~~ 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 violence and has an approved safety 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;
or

(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 minor 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-S~~ MFIP waiver.

Sec. 23. Minnesota Statutes 1998, 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 ~~AFDC or MFIP-S~~ 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-S transitional MFIP standard of need, the shared household standard, or the interstate transitional standard, whichever is applicable~~ 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-S transitional standard, the shared household standard, or the interstate transitional standard, whichever is applicable~~ MFIP standard of need.

(3) A participant who fails an initial drug test and is under a sanction due to other MFIP program requirements is subject to the sanction in clause (2)(i).

(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.

(c) For the purposes of this subdivision, "drug offense" means ~~a conviction~~ 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. 24. Minnesota Statutes 1998, section 256J.30, subdivision 2, is amended to read:

Subd. 2. [REQUIREMENT TO APPLY FOR OTHER BENEFITS.] An applicant or participant must apply for, accept if eligible, and follow through with appealing any denials of eligibility for benefits from other programs for which the applicant or participant is potentially eligible and which would, if received, offset assistance payments. An applicant's or participant's failure to complete application for these benefits without good cause results in denial or termination of assistance. Good cause for failure to apply for these benefits is allowed when circumstances beyond the control of the applicant or participant prevent the applicant or participant from making an application.

Sec. 25. Minnesota Statutes 1998, section 256J.30, subdivision 7, is amended to read:

Subd. 7. [DUE DATE OF ~~MFIP-S~~ MFIP HOUSEHOLD REPORT FORM.] An ~~MFIP-S~~ MFIP household report form must be received by the county agency by the eighth calendar day of the month following the reporting period covered by the form. When the eighth calendar day of the month falls on a weekend or holiday, the ~~MFIP-S~~ MFIP household report form must be received by the county agency the first working day that follows the eighth calendar day. ~~The county agency must send a notice of termination because of a late or incomplete MFIP-S household report form.~~

Sec. 26. Minnesota Statutes 1998, section 256J.30, subdivision 8, is amended to read:

Subd. 8. [~~LATE MFIP-S MFIP~~ HOUSEHOLD REPORT FORMS.] Paragraphs (a) to (d) apply to the reporting requirements in subdivision 7.

(a) ~~When a caregiver submits the county agency receives an incomplete MFIP-S MFIP household report form before the last working day of the month on which a ten-day notice of termination can be issued, the county agency must immediately return the incomplete form on or before the ten-day notice deadline or any previously sent ten-day notice of termination is invalid and clearly state what the caregiver must do for the form to be complete.~~

(b) ~~When a complete MFIP-S household report form is not received by a county agency before the last ten days of the month in which the form is due, the county agency must send A The automated eligibility system must send a notice of proposed termination of assistance to the assistance unit if a complete MFIP household report form is not received by a county agency. The automated notice must be mailed to the caregiver by approximately the 16th of the month.~~ When a caregiver submits an incomplete form on or after the date a notice of proposed termination has been sent, the termination is valid unless the caregiver submits a complete form before the end of the month.

(c) An assistance unit required to submit an ~~MFIP-S MFIP~~ household report form is considered to have continued its application for assistance if a complete ~~MFIP-S MFIP~~ household report form is received within a calendar month after the month in which ~~assistance was received the form was due~~ and assistance shall be paid for the period beginning with the first day of ~~the month in which the report was due that calendar month.~~

(d) A county agency must allow good cause exemptions from the reporting requirements under subdivisions 5 and 6 when any of the following factors cause a caregiver to fail to provide the county agency with a completed ~~MFIP-S MFIP~~ household report form before the end of the month in which the form is due:

- (1) an employer delays completion of employment verification;
- (2) a county agency does not help a caregiver complete the ~~MFIP-S MFIP~~ household report form when the caregiver asks for help;
- (3) a caregiver does not receive an ~~MFIP-S MFIP~~ household report form due to mistake on the part of the department or the county agency or due to a reported change in address;
- (4) a caregiver is ill, or physically or mentally incapacitated; or
- (5) some other circumstance occurs that a caregiver could not avoid with reasonable care which prevents the caregiver from providing a completed ~~MFIP-S MFIP~~ household report form before the end of the month in which the form is due.

Sec. 27. Minnesota Statutes 1998, section 256J.30, subdivision 9, is amended to read:

Subd. 9. [~~CHANGES THAT MUST BE REPORTED.~~] A caregiver must report the changes or anticipated changes specified in clauses (1) to ~~(16)~~ (17) within ten days of the date they occur, ~~within ten days of the date the caregiver learns that the change will occur,~~ at the time of the periodic recertification of eligibility under section 256J.32, subdivision 6, or within eight calendar days of a reporting period as in subdivision 5 or 6, whichever occurs first. A caregiver must report other changes at the time of the periodic recertification of eligibility under section 256J.32, subdivision 6, or at the end of a reporting period under subdivision 5 or 6, as applicable. A caregiver must make these reports in writing to the county agency. When a county agency could have reduced or terminated assistance for one or more payment months if a delay in reporting a change specified under clauses (1) to (16) had not occurred, the county agency must determine whether a timely notice under section 256J.31, subdivision 4, could have been issued on the day that the change occurred. When a timely notice could have been issued, each month's overpayment subsequent to that notice must be considered a client error overpayment under section 256J.38. Calculation of overpayments for late reporting under clause (17) is specified in section 256J.09, subdivision 9. Changes in circumstances which must be reported within ten days must also be reported on the ~~MFIP-S MFIP~~ household report form for the reporting period in which those changes occurred. Within ten days, a caregiver must report:

- (1) a change in initial employment;
- (2) a change in initial receipt of unearned income;
- (3) a recurring change in unearned income;
- (4) a nonrecurring change of unearned income that exceeds \$30;
- (5) the receipt of a lump sum;
- (6) an increase in assets that may cause the assistance unit to exceed asset limits;
- (7) a change in the physical or mental status of an incapacitated member of the assistance unit if the physical or mental status is the basis of exemption from an ~~MFIP-S work and training~~ MFIP employment services program;
- (8) a change in employment status;
- (9) ~~a change in household composition, including births, returns to and departures from the home of assistance unit members and financially responsible persons, or a change in the custody of a minor child~~ information affecting an exception under section 256J.24, subdivision 9;
- (10) a change in health insurance coverage;
- (11) the marriage or divorce of an assistance unit member;
- (12) the death of a parent, minor child, or financially responsible person;
- (13) a change in address or living quarters of the assistance unit;
- (14) the sale, purchase, or other transfer of property;
- (15) a change in school attendance of a custodial parent or an employed child; ~~and~~
- (16) filing a lawsuit, a workers' compensation claim, or a monetary claim against a third party; and
- (17) a change in household composition, including births, returns to and departures from the home of assistance unit members and financially responsible persons, or a change in the custody of a minor child.

Sec. 28. Minnesota Statutes 1998, section 256J.31, subdivision 5, is amended to read:

Subd. 5. [MAILING OF NOTICE.] The notice of adverse action shall be issued according to paragraphs (a) to ~~(e)~~ (d).

(a) ~~A county agency shall mail~~ a notice of adverse action must be mailed at least ten days before the effective date of the adverse action, except as provided in paragraphs (b) ~~and (c)~~ to (d).

(b) ~~A county agency must mail~~ a notice of adverse action at least five days before the effective date of the adverse action when the county agency has factual information that requires an action to reduce, suspend, or terminate assistance based on probable fraud.

~~(c) A county agency shall mail~~ A notice of adverse action before or on the effective date of the adverse action must be mailed no later than four working days before the end of the month when the county agency:

(1) ~~receives the caregiver's signed monthly MFIP-S household report form that includes information that requires payment reduction, suspension, or termination;~~

- (2) is informed of the death of a ~~participant~~ the only caregiver or the payee in an assistance unit;
- (3) (2) receives a signed statement from the caregiver that assistance is no longer wanted;
- (4) ~~receives a signed statement from the caregiver that provides information that requires the termination or reduction of assistance~~ (3) has factual information to reduce, suspend, or terminate assistance based on the failure to timely report changes;
- (5) ~~verifies that a member of the assistance unit is absent from the home and does not meet temporary absence provisions in section 256J.13~~;
- (6) (4) verifies that a member of the assistance unit has entered a regional treatment center or a licensed residential facility for medical or psychological treatment or rehabilitation;
- (7) (5) verifies that a member of an assistance unit has been removed from the home as a result of a judicial determination or placed in foster care, and the provisions of section 256J.13, subdivision 2, paragraph (c), clause (2), do not apply;
- (8) ~~verifies that a member of an assistance unit has been approved to receive assistance by another state~~; or
- (9) (6) cannot locate a caregiver.
- (c) A notice of adverse action must be mailed for a payment month when the caregiver makes a written request for closure before the first of that payment month.
- (d) A notice of adverse action must be mailed before the effective date of the adverse action when the county agency receives the caregiver's signed and completed MFIP household report form or recertification form that includes information that requires payment reduction, suspension, or termination.

Sec. 29. Minnesota Statutes 1998, 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 ~~MFIP-S~~ 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.

Sec. 30. Minnesota Statutes 1998, 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-S~~ 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) ~~anticipated graduation date of an 18-year-old;~~
- ~~(19)~~ burial accounts;
- ~~(20)~~ (19) school attendance, if related to eligibility;
- ~~(21)~~ (20) residence;
- ~~(22)~~ (21) a claim of domestic violence if used as a basis for a deferral or exemption from the 60-month time limit in section 256J.42 or employment and training services requirements in section 256J.56; ~~and~~
- ~~(23)~~ (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.

Sec. 31. Minnesota Statutes 1998, section 256J.32, subdivision 6, is amended to read:

Subd. 6. [RECERTIFICATION.] The county agency shall recertify eligibility in an annual face-to-face interview with the participant and verify the following:

- (1) presence of the minor child in the home, if questionable;
- (2) income, unless excluded, including self-employment expenses used as a deduction or deposits or withdrawals from business accounts;
- (3) assets when the value is within \$200 of the asset limit; ~~and~~
- (4) information to establish an exception under section 256J.24, subdivision 9, if questionable; and
- (5) inconsistent information, if related to eligibility.

Sec. 32. Minnesota Statutes 1998, section 256J.33, is amended to read:

256J.33 [PROSPECTIVE AND RETROSPECTIVE DETERMINATION OF ~~MFIP-S~~ MFIP ELIGIBILITY.]

Subdivision 1. [DETERMINATION OF ELIGIBILITY.] A county agency must determine ~~MFIP-S~~ MFIP eligibility prospectively for a payment month based on retrospectively assessing income and the county agency's best estimate of the circumstances that will exist in the payment month.

Except as described in section 256J.34, subdivision 1, when prospective eligibility exists, a county agency must calculate the amount of the assistance payment using retrospective budgeting. To determine ~~MFIP-S~~ MFIP eligibility and the assistance payment amount, a county agency must apply countable income, described in section 256J.37, subdivisions 3 to 10, received by members of an assistance unit or by other persons whose income is counted for the assistance unit, described under sections 256J.21 and 256J.37, subdivisions 1 to 2.

This income must be applied to the ~~transitional MFIP standard, shared household standard, of need or family wage standard level~~ subject to this section and sections 256J.34 to 256J.36. Income received in a calendar month and not otherwise excluded under section 256J.21, subdivision 2, must be applied to the needs of an assistance unit.

Subd. 2. [PROSPECTIVE ELIGIBILITY.] A county agency must determine whether the eligibility requirements that pertain to an assistance unit, including those in sections 256J.11 to 256J.15 and 256J.20, will be met prospectively for the payment month. Except for the provisions in section 256J.34, subdivision 1, the income test will be applied retrospectively.

Subd. 3. [RETROSPECTIVE ELIGIBILITY.] After the first two months of ~~MFIP-S~~ MFIP eligibility, a county agency must continue to determine whether an assistance unit is prospectively eligible for the payment month by looking at all factors other than income and then determine whether the assistance unit is retrospectively income eligible by applying the monthly income test to the income from the budget month. When the monthly income test is not satisfied, the assistance payment must be suspended when ineligibility exists for one month or ended when ineligibility exists for more than one month.

Subd. 4. [MONTHLY INCOME TEST.] A county agency must apply the monthly income test retrospectively for each month of ~~MFIP-S~~ MFIP eligibility. An assistance unit is not eligible when the countable income equals or exceeds the ~~transitional MFIP standard, shared household standard, of need or the family wage level~~ for the assistance unit. The income applied against the monthly income test must include:

(1) gross earned income from employment, prior to mandatory payroll deductions, voluntary payroll deductions, wage authorizations, and after the disregards in section 256J.21, subdivision 4, and the allocations in section 256J.36, unless the employment income is specifically excluded under section 256J.21, subdivision 2;

(2) gross earned income from self-employment less deductions for self-employment expenses in section 256J.37, subdivision 5, but prior to any reductions for personal or business state and federal income taxes, personal FICA, personal health and life insurance, and after the disregards in section 256J.21, subdivision 4, and the allocations in section 256J.36;

(3) unearned income after deductions for allowable expenses in section 256J.37, subdivision 9, and allocations in section 256J.36, unless the income has been specifically excluded in section 256J.21, subdivision 2;

(4) gross earned income from employment as determined under clause (1) which is received by a member of an assistance unit who is a minor child or minor caregiver and less than a half-time student;

(5) child support and spousal support received or anticipated to be received by an assistance unit;

(6) the income of a parent when that parent is not included in the assistance unit;

(7) the income of an eligible relative and spouse who seek to be included in the assistance unit; and

(8) the unearned income of a minor child included in the assistance unit.

Subd. 5. [WHEN TO TERMINATE ASSISTANCE.] When an assistance unit is ineligible for ~~MFIP-S~~ MFIP assistance for two consecutive months, the county agency must terminate ~~MFIP-S~~ MFIP assistance.

Sec. 33. Minnesota Statutes 1998, section 256J.34, subdivision 1, is amended to read:

Subdivision 1. [PROSPECTIVE BUDGETING.] A county agency must use prospective budgeting to calculate the assistance payment amount for the first two months for an applicant who has not received assistance in this state for at least one payment month preceding the first month of payment under a current application. Notwithstanding subdivision 3, paragraph (a), clause (2), a county agency must use prospective budgeting for the first two months for a person who applies to be added to an assistance unit. Prospective budgeting is not subject to overpayments or underpayments unless fraud is determined under section 256.98.

(a) The county agency must apply the income received or anticipated in the first month of ~~MFIP-S~~ MFIP eligibility against the need of the first month. The county agency must apply the income received or anticipated in the second month against the need of the second month.

(b) When the assistance payment for any part of the first two months is based on anticipated income, the county agency must base the initial assistance payment amount on the information available at the time the initial assistance payment is made.

(c) The county agency must determine the assistance payment amount for the first two months of ~~MFIP-S~~ MFIP eligibility by budgeting both recurring and nonrecurring income for those two months.

(d) The county agency must budget the child support income received or anticipated to be received by an assistance unit to determine the assistance payment amount from the month of application through the date in which ~~MFIP-S~~ MFIP eligibility is determined and assistance is authorized. Child support income which has been budgeted to determine the assistance payment in the initial two months is considered nonrecurring income. An assistance unit must forward any payment of child support to the child support enforcement unit of the county agency following the date in which assistance is authorized.

Sec. 34. Minnesota Statutes 1998, section 256J.34, subdivision 3, is amended to read:

Subd. 3. [ADDITIONAL USES OF RETROSPECTIVE BUDGETING.] Notwithstanding subdivision 1, the county agency must use retrospective budgeting to calculate the monthly assistance payment amount for the first two months under paragraphs (a) and (b).

(a) The county agency must use retrospective budgeting to determine the amount of the assistance payment in the first two months of ~~MFIP-S~~ MFIP eligibility:

(1) when an assistance unit applies for assistance for the same month for which assistance has been interrupted, the interruption in eligibility is less than one payment month, the assistance payment for the preceding month was issued in this state, and the assistance payment for the immediately preceding month was determined retrospectively; or

(2) when a person applies in order to be added to an assistance unit, that assistance unit has received assistance in this state for at least the two preceding months, and that person has been living with and has been financially responsible for one or more members of that assistance unit for at least the two preceding months.

(b) Except as provided in clauses (1) to (4), the county agency must use retrospective budgeting and apply income received in the budget month by an assistance unit and by a financially responsible household member who is not included in the assistance unit against the ~~appropriate transitional or family wage level~~ MFIP standard of need or family wage level to determine the assistance payment to be issued for the payment month.

(1) When a source of income ends prior to the third payment month, that income is not considered in calculating the assistance payment for that month. When a source of income ends prior to the fourth payment month, that income is not considered when determining the assistance payment for that month.

(2) When a member of an assistance unit or a financially responsible household member leaves the household of the assistance unit, the income of that departed household member is not budgeted retrospectively for any full payment month in which that household member does not live with that household and is not included in the assistance unit.

(3) When an individual is removed from an assistance unit because the individual is no longer a minor child, the income of that individual is not budgeted retrospectively for payment months in which that individual is not a member of the assistance unit, except that income of an ineligible child in the household must continue to be budgeted retrospectively against the child's needs when the parent or parents of that child request allocation of their income against any unmet needs of that ineligible child.

(4) When a person ceases to have financial responsibility for one or more members of an assistance unit, the income of that person is not budgeted retrospectively for the payment months which follow the month in which financial responsibility ends.

Sec. 35. Minnesota Statutes 1998, section 256J.34, subdivision 4, is amended to read:

Subd. 4. [SIGNIFICANT CHANGE IN GROSS INCOME.] The county agency must recalculate the assistance payment when an assistance unit experiences a significant change, as defined in section 256J.08, resulting in a reduction in the gross income received in the payment month from the gross income received in the budget month. The county agency must issue a supplemental assistance payment based on the county agency's best estimate of the assistance unit's income and circumstances for the payment month. ~~Budget adjustments~~ Supplemental assistance payments that result from significant changes are limited to two in a 12-month period regardless of the reason for the change. ~~Budget adjustments~~ Notwithstanding any other statute or rule of law, supplementary assistance payments shall not be made when the significant change in income is the result of receipt of a lump sum, receipt of an extra paycheck, business fluctuation in self-employment income, or an assistance unit member's participation in a strike or other labor action. Supplementary assistance payments due to a significant change in the amount of direct support received must not be made after the date the assistance unit is required to forward support to the child support enforcement unit under subdivision 1, paragraph (d).

Sec. 36. Minnesota Statutes 1998, section 256J.35, is amended to read:

256J.35 [AMOUNT OF ASSISTANCE PAYMENT.]

Except as provided in paragraphs (a) to ~~(d)~~ (c), the amount of an assistance payment is equal to the difference between the ~~transitional MFIP standard, shared household standard, of need~~ or the Minnesota family wage level in section 256J.24, ~~whichever is less~~, and countable income.

(a) When ~~MFIP-S~~ MFIP eligibility exists for the month of application, the amount of the assistance payment for the month of application must be prorated from the date of application or the date all other eligibility factors are met for that applicant, whichever is later. This provision applies when an applicant loses at least one day of ~~MFIP-S~~ MFIP eligibility.

(b) ~~MFIP-S~~ MFIP overpayments to an assistance unit must be recouped according to section 256J.38, subdivision 4.

(c) An initial assistance payment must not be made to an applicant who is not eligible on the date payment is made.

~~(d) An individual whose needs have been otherwise provided for in another state, in whole or in part by county, state, or federal dollars during a month, is ineligible to receive MFIP-S for the month.~~

Sec. 37. Minnesota Statutes 1998, section 256J.36, is amended to read:

256J.36 [ALLOCATION FOR UNMET NEED OF OTHER HOUSEHOLD MEMBERS.]

Except as prohibited in paragraphs (a) and (b), an allocation of income is allowed from the caregiver's income to meet the unmet need of an ineligible spouse or an ineligible child under the age of 21 for whom the caregiver is financially responsible who also lives with the caregiver. That allocation is allowed in an amount up to the difference between the ~~MFIP-S transitional~~ MFIP standard of need for the assistance unit when that ineligible person is included in the assistance unit and the ~~MFIP-S family allowance~~ MFIP standard of need for the assistance unit when the ineligible person is not included in the assistance unit. These allocations must be deducted from the caregiver's counted earnings and from unearned income subject to paragraphs (a) and (b).

(a) Income of a minor child in the assistance unit must not be allocated to meet the need of an ineligible person, including the child's parent, even when that parent is the payee of the child's income.

(b) Income of a caregiver must not be allocated to meet the needs of a disqualified person.

Sec. 38. Minnesota Statutes 1998, section 256J.37, subdivision 1, is amended to read:

Subdivision 1. [DEEMED INCOME FROM INELIGIBLE HOUSEHOLD MEMBERS.] Unless otherwise provided under subdivision 1a or 1b, the income of ineligible household members must be deemed after allowing the following disregards:

- (1) the first 18 percent of the ineligible family member's gross earned income;
- (2) amounts the ineligible person actually paid to individuals not living in the same household but whom the ineligible person claims or could claim as dependents for determining federal personal income tax liability;
- (3) all payments made by the ineligible person according to a court order for spousal support or the support of children not living in the assistance unit's household, provided that, if there has been a change in the financial circumstances of the ineligible person since the support order was entered, the ineligible person has petitioned for a modification of the support order; and
- (4) an amount for the needs of the ineligible person and other persons who live in the household but are not included in the assistance unit and are or could be claimed by an ineligible person as dependents for determining federal personal income tax liability. This amount is equal to the difference between the ~~MFIP-S transitional~~ MFIP standard of need when the ineligible person is included in the assistance unit and the ~~MFIP-S transitional~~ MFIP standard of need when the ineligible person is not included in the assistance unit.

Sec. 39. Minnesota Statutes 1998, section 256J.37, subdivision 1a, is amended to read:

Subd. 1a. [DEEMED INCOME FROM DISQUALIFIED MEMBERS.] The income of disqualified members must be deemed after allowing the following disregards:

- (1) the first 18 percent of the disqualified member's gross earned income;
- (2) amounts the disqualified member actually paid to individuals not living in the same household but whom the disqualified member claims or could claim as dependents for determining federal personal income tax liability;
- (3) all payments made by the disqualified member according to a court order for spousal support or the support of children not living in the assistance unit's household, provided that, if there has been a change in the financial circumstances of the disqualified member's legal obligation to pay support since the support order was entered, the disqualified member has petitioned for a modification of the support order; and

(4) an amount for the needs of other persons who live in the household but are not included in the assistance unit and are or could be claimed by the disqualified member as dependents for determining federal personal income tax liability. This amount is equal to the difference between the ~~MFIP-S transitional~~ MFIP standard of need when the ineligible person is included in the assistance unit and the ~~MFIP-S transitional~~ MFIP standard of need when the ineligible person is not included in the assistance unit. An amount shall not be allowed for the needs of a disqualified member.

Sec. 40. Minnesota Statutes 1998, section 256J.37, subdivision 2, is amended to read:

Subd. 2. [DEEMED INCOME AND ASSETS OF SPONSOR OF NONCITIZENS.] (a) If a noncitizen applies for or receives MFIP, the county must deem the income and assets of the noncitizen's sponsor and the sponsor's spouse as provided in this paragraph and paragraph (b) or (c), whichever is applicable. The deemed income of a sponsor and the sponsor's spouse is considered unearned income of the noncitizen. The deemed assets of a sponsor and the sponsor's spouse are considered available assets of the noncitizen.

(b) The income and assets of a sponsor who signed an affidavit of support under title IV, sections 421, 422, and 423, of Public Law Number 104-193, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, and the income and assets of the sponsor's spouse, must be deemed to the noncitizen to the extent required by those sections of Public Law Number 104-193.

(c) The income and assets of a sponsor and the sponsor's spouse to whom the provisions of paragraph (b) do not apply must be deemed to the noncitizen to the full extent allowed under title V, section 5505, of Public Law Number 105-33, the Balanced Budget Act of 1997.

~~If a noncitizen applies for or receives MFIP-S, the county must deem the income and assets of the noncitizen's sponsor and the sponsor's spouse who have signed an affidavit of support for the noncitizen as specified in Public Law Number 104-193, title IV, sections 421 and 422, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. The income of a sponsor and the sponsor's spouse is considered unearned income of the noncitizen. The assets of a sponsor and the sponsor's spouse are considered available assets of the noncitizen.~~

Sec. 41. Minnesota Statutes 1998, section 256J.37, subdivision 9, is amended to read:

Subd. 9. [UNEARNED INCOME.] (a) The county agency must apply unearned income to the ~~transitional~~ 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, 1999, 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. 42. Minnesota Statutes 1998, section 256J.37, subdivision 10, is amended to read:

Subd. 10. [TREATMENT OF LUMP SUMS.] (a) The county agency must treat lump-sum payments as earned or unearned income. If the lump-sum payment is included in the category of income identified in subdivision 9, it must be treated as unearned income. A lump sum is counted as income in the month received and budgeted either prospectively or retrospectively depending on the budget cycle at the time of receipt. When an individual receives a lump-sum payment, that lump sum must be combined with all other earned and unearned income received in the same budget month, and it must be applied according to paragraphs (a) to (c). A lump sum may not be carried over into subsequent months. Any funds that remain in the third month after the month of receipt are counted in the asset limit.

(b) For a lump sum received by an applicant during the first two months, prospective budgeting is used to determine the payment and the lump sum must be combined with other earned or unearned income received and budgeted in that prospective month.

(c) For a lump sum received by a participant after the first two months of ~~MFIP-S~~ MFIP eligibility, the lump sum must be combined with other income received in that budget month, and the combined amount must be applied retrospectively against the applicable payment month.

(d) When a lump sum, combined with other income under paragraphs (b) and (c), is less than the ~~transitional MFIP standard of need~~ for the ~~applicable~~ appropriate payment month, the assistance payment must be reduced according to the amount of the countable income. When the countable income is greater than the ~~transitional MFIP standard or the family wage standard or family wage level~~, the assistance payment must be suspended for the payment month.

Sec. 43. Minnesota Statutes 1998, section 256J.38, subdivision 4, is amended to read:

Subd. 4. [RECOUPING OVERPAYMENTS FROM PARTICIPANTS.] A participant may voluntarily repay, in part or in full, an overpayment even if assistance is reduced under this subdivision, until the total amount of the overpayment is repaid. When an overpayment occurs due to fraud, the county agency must recover ten percent of the ~~transitional~~ applicable standard or the amount of the monthly assistance payment, whichever is less. When a nonfraud overpayment occurs, the county agency must recover three percent of the ~~transitional MFIP standard of need~~ or the amount of the monthly assistance payment, whichever is less.

Sec. 44. Minnesota Statutes 1998, section 256J.42, subdivision 1, is amended to read:

Subdivision 1. [TIME LIMIT.] (a) Except for the exemptions in this section ~~and in section 256J.11, subdivision 2~~, 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, ~~MFIP-S or from a tribal TANF program~~, MFIP, AFDC, or family general assistance, funded in whole or in part by state appropriations, is ineligible to receive ~~MFIP-S 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-S 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 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 receive received assistance as part of the field trials as an MFIP, MFIP-R, or MFIP or MFIP-R comparison group family under sections 256.031 to 256.0361 or sections 256.047 to 256.048~~ are not included in the 60-month time limit.

Sec. 45. Minnesota Statutes 1998, 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 is in the category in section 256J.56, paragraph (a), clause (1). ~~The exemption applies for the period of time the caregiver belongs to one of the categories specified in this subdivision.~~

(b) From July 1, 1997, until the date ~~MFIP-S~~ MFIP is operative in the caregiver's county of financial responsibility, any cash assistance received by a caregiver who is complying with sections 256.73, subdivision 5a, and 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.

(c) Any diversionary assistance or emergency assistance received does not count toward the 60-month limit.

(d) 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. 46. Minnesota Statutes 1998, section 256J.43, is amended to read:

256J.43 [INTERSTATE ~~PAYMENT~~ TRANSITIONAL STANDARDS.]

Subdivision 1. [PAYMENT.] (a) Effective July 1, 1997, the amount of assistance paid to an eligible unit in which all members have resided in this state for fewer than 12 consecutive calendar months immediately preceding the date of application shall be the lesser of either the interstate transitional standard that would have been received by the assistance unit from the state of immediate prior residence, or the amount calculated in accordance with ~~AFDC or MFIP-S~~ MFIP standards. The lesser payment must continue until the assistance unit meets the 12-month requirement. An assistance unit that has not resided in Minnesota for 12 months from the date of application is not exempt from the interstate ~~payment transitional standards~~ provisions solely because a child is born in Minnesota to a member of the assistance unit. Payment must be calculated by applying this state's MFIP's budgeting policies, and the unit's net income must be deducted from the payment standard in the other state or the MFIP transitional or shared household standard in this state, whichever is lower. Payment shall be made in vendor form for shelter and utilities, up to the limit of the grant amount, and residual amounts, if any, shall be paid directly to the assistance unit.

(b) During the first 12 months an assistance unit resides in this state, the number of months that a unit is eligible to receive ~~AFDC or MFIP-S~~ MFIP benefits is limited to the number of months the assistance unit would have been eligible to receive similar benefits in the state of immediate prior residence.

(c) This policy applies whether or not the assistance unit received similar benefits while residing in the state of previous residence.

(d) When an assistance unit moves to this state from another state where the assistance unit has exhausted that state's time limit for receiving benefits under that state's TANF program, the unit will not be eligible to receive any ~~AFDC or MFIP-S~~ MFIP benefits in this state for 12 months from the date the assistance unit moves here.

(e) For the purposes of this section, "state of immediate prior residence" means:

(1) the state in which the applicant declares the applicant spent the most time in the 30 days prior to moving to this state; or

(2) the state in which an applicant who is a migrant worker maintains a home.

(f) The commissioner shall annually verify and update all other states' payment standards as they are to be in effect in July of each year.

(g) Applicants must provide verification of their state of immediate prior residence, in the form of tax statements, a driver's license, automobile registration, rent receipts, or other forms of verification approved by the commissioner.

(h) Migrant workers, as defined in section 256J.08, and their immediate families are exempt from this section, provided the migrant worker provides verification that the migrant family worked in this state within the last 12 months and earned at least \$1,000 in gross wages during the time the migrant worker worked in this state.

Subd. 2. [TEMPORARY ABSENCE FROM MINNESOTA.] (a) For an assistance unit that has met the requirements of section 256J.12, the number of months that the assistance unit receives benefits under the interstate ~~payment~~ transitional standards in this section is not affected by an absence from Minnesota for fewer than 30 consecutive days.

(b) For an assistance unit that has met the requirements of section 256J.12, the number of months that the assistance unit receives benefits under the interstate ~~payment~~ transitional standards in this section is not affected by an absence from Minnesota for more than 30 consecutive days but fewer than 90 consecutive days, provided the assistance unit continues to maintain a residence in Minnesota during the period of absence.

Subd. 3. [EXCEPTIONS TO THE INTERSTATE PAYMENT POLICY.] Applicants who lived in another state in the 12 months prior to applying for assistance are exempt from the interstate payment policy for the months that a member of the unit:

(1) served in the United States armed services, provided the person returned to Minnesota within 30 days of leaving the armed forces, and intends to remain in Minnesota;

(2) attended school in another state, paid nonresident tuition or Minnesota tuition rates under a reciprocity agreement, provided the person left Minnesota specifically to attend school and returned to Minnesota within 30 days of graduation with the intent to remain in Minnesota; or

(3) meets the following criteria:

(i) a minor child or a minor caregiver moves from another state to the residence of a relative caregiver;

(ii) the minor caregiver applies for and receives family cash assistance;

(iii) the relative caregiver chooses not to be part of the MFIP-S assistance unit; and

(iv) the relative caregiver has resided in Minnesota for at least 12 months from the date the assistance unit applies for cash assistance.

Subd. 4. [INELIGIBLE MANDATORY UNIT MEMBERS.] Ineligible mandatory unit members who have resided in Minnesota for 12 months immediately before the unit's date of application establish the other assistance unit members' eligibility for the ~~MFIP-S~~ MFIP transitional standard, shared household or family wage level, whichever is applicable.

Sec. 47. Minnesota Statutes 1998, section 256J.45, subdivision 1, is amended to read:

Subdivision 1. [COUNTY AGENCY TO PROVIDE ORIENTATION.] A county agency must provide each ~~MFIP-S~~ MFIP caregiver who is not exempt under section 256J.56, paragraph (a), clause (6) or (8), with a face-to-face orientation. ~~The caregiver must attend the orientation.~~ The county agency must inform the caregiver caregivers who are not exempt under section 256J.56, paragraph (a), clause (6) or (8), 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. 48. Minnesota Statutes 1998, section 256J.45, is amended by adding a subdivision to read:

Subd. 1a. [PREGNANT AND PARENTING MINORS.] Pregnant and parenting minors who are complying with the provisions of section 256J.54 are exempt from the requirement under subdivision 1, however, the county agency must provide information to the minor as required under section 256J.14.

Sec. 49. Minnesota Statutes 1998, 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 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 assistance unit's grant shall be reduced by ten percent of the ~~MFIP-S transitional MFIP standard, the shared household standard, or the interstate transitional standard of need~~ for an assistance unit of the same size, ~~whichever is applicable~~, 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-S 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-S 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-S transitional MFIP standard, the shared household standard, or the interstate transitional standard of need~~ for an assistance unit of the same size, ~~whichever is applicable~~, 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.

(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.

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 good cause exception.

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.

Sec. 50. Minnesota Statutes 1998, section 256J.46, subdivision 2, is amended to read:

Subd. 2. [SANCTIONS FOR REFUSAL TO COOPERATE WITH SUPPORT REQUIREMENTS.] The grant of an ~~MFIP-S~~ MFIP caregiver who refuses to cooperate, as determined by the child support enforcement agency, with support requirements under section 256.741, shall be subject to sanction as specified in this subdivision. The assistance unit's grant must be reduced by 25 percent of the applicable ~~transitional~~ MFIP standard of need. The residual amount of the grant, if any, must be paid to the caregiver. A sanction under this subdivision becomes effective the first month following the month in which a required notice is given. A sanction must not be imposed when a caregiver comes into compliance with the requirements under section 256.741 prior to the effective date of the sanction. The sanction shall be removed in the month following the month that the caregiver cooperates with the support requirements. Each month that an ~~MFIP-S~~ MFIP caregiver fails to comply with the requirements of section 256.741 must be considered a separate occurrence of noncompliance. An ~~MFIP-S~~ MFIP caregiver who has had one or more sanctions imposed must remain in compliance with the requirements of section 256.741 for six months in order for a subsequent sanction to be considered a first occurrence.

Sec. 51. Minnesota Statutes 1998, 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;

the participant shall be sanctioned as provided in subdivision 1, paragraph (b), clause (2), and the requirement that the county conduct a review as specified in subdivision 1, paragraph (c), 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 ~~transitional~~ 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), clause (2).

The requirement that the county conduct a review as specified in subdivision 1, paragraph (c), 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), removed upon completion of the review under subdivision 1, paragraph (c).

A participant remains subject to sanction under subdivision 1, paragraph (b), if the participant cooperates and is no longer subject to sanction under subdivision 2.

Sec. 52. Minnesota Statutes 1998, section 256J.47, subdivision 4, is amended to read:

Subd. 4. [INELIGIBILITY FOR ~~MFIP-S~~ MFIP; EMERGENCY ASSISTANCE; AND EMERGENCY GENERAL ASSISTANCE.] Upon receipt of diversionary assistance, the family is ineligible for ~~MFIP-S~~ MFIP, emergency assistance, and emergency general assistance for a period of time. To determine the period of ineligibility, the county shall use the following formula: regardless of household changes, the county agency must calculate the number of days of ineligibility by dividing the diversionary assistance issued by the transitional MFIP standard of need a family of the same size and composition would have received under ~~MFIP-S~~, or if applicable the interstate transitional standard, MFIP multiplied by 30, truncating the result. The ineligibility period begins the date the diversionary assistance is issued.

Sec. 53. Minnesota Statutes 1998, section 256J.48, subdivision 2, is amended to read:

Subd. 2. [ELIGIBILITY.] Notwithstanding other eligibility provisions of this chapter, any family without resources immediately available to meet emergency needs identified in subdivision 3 shall be eligible for an emergency grant under the following conditions:

(1) a family member has resided in this state for at least 30 days;

(2) the family is without resources immediately available to meet emergency needs;

(3) assistance is necessary to avoid destitution or provide emergency shelter arrangements;

(4) the family's destitution or need for shelter or utilities did not arise because the assistance unit is under sanction, the caregiver is disqualified, or the child or relative caregiver refused without good cause under section 256J.57 to accept employment or training for employment in this state or another state; and

(5) at least one child or pregnant woman in the emergency assistance unit meets ~~MFIP-S~~ MFIP citizenship requirements in section 256J.11.

Sec. 54. Minnesota Statutes 1998, section 256J.48, subdivision 3, is amended to read:

Subd. 3. [EMERGENCY NEEDS.] Emergency needs are limited to the following:

(a) [RENT.] A county agency may deny assistance to prevent eviction from rented or leased shelter of an otherwise eligible applicant when the county agency determines that an applicant's anticipated income will not cover continued payment for shelter, subject to conditions in clauses (1) to (3):

(1) a county agency must not deny assistance when an applicant can document that the applicant is unable to locate habitable shelter, unless the county agency can document that one or more habitable shelters are available in the community that will result in at least a 20 percent reduction in monthly expense for shelter and that this shelter will be cost-effective for the applicant;

(2) when no alternative shelter can be identified by either the applicant or the county agency, the county agency shall not deny assistance because anticipated income will not cover rental obligation; and

(3) when cost-effective alternative shelter is identified, the county agency shall issue assistance for moving expenses as provided in paragraph (e).

(b) [DEFINITIONS.] For purposes of paragraph (a), the following definitions apply (1) "metropolitan statistical area" is as defined by the United States Census Bureau; (2) "alternative shelter" includes any shelter that is located within the metropolitan statistical area containing the county and for which the applicant is eligible, provided the applicant does not have to travel more than 20 miles to reach the shelter and has access to transportation to the shelter. Clause (2) does not apply to counties in the Minneapolis-St. Paul metropolitan statistical area.

(c) [MORTGAGE AND CONTRACT FOR DEED ARREARAGES.] A county agency shall issue assistance for mortgage or contract for deed arrearages on behalf of an otherwise eligible applicant according to clauses (1) to (4):

(1) assistance for arrearages must be issued only when a home is owned, occupied, and maintained by the applicant;

(2) assistance for arrearages must be issued only when no subsequent foreclosure action is expected within the 12 months following the issuance;

(3) assistance for arrearages must be issued only when an applicant has been refused refinancing through a bank or other lending institution and the amount payable, when combined with any payments made by the applicant, will be accepted by the creditor as full payment of the arrearage;

(4) costs paid by a family which are counted toward the payment requirements in this clause are: principal and interest payments on mortgages or contracts for deed, balloon payments, homeowner's insurance payments, manufactured home lot rental payments, and tax or special assessment payments related to the homestead. Costs which are not counted include closing costs related to the sale or purchase of real property.

To be eligible for assistance for costs specified in clause (4) which are outstanding at the time of foreclosure, an applicant must have paid at least 40 percent of the family's gross income toward these costs in the month of application and the 11-month period immediately preceding the month of application.

When an applicant is eligible under clause (4), a county agency shall issue assistance up to a maximum of four times the ~~MFIP-S MFIP~~ transitional standard of need for a comparable assistance unit.

(d) [DAMAGE OR UTILITY DEPOSITS.] A county agency shall issue assistance for damage or utility deposits when necessary to alleviate the emergency. The county may require that assistance paid in the form of a damage deposit, less any amount retained by the landlord to remedy a tenant's default in payment of rent or other funds due to the landlord under a rental agreement, or to restore the premises to the condition at the commencement of the tenancy, ordinary wear and tear excepted, be returned to the county when the individual vacates the premises or be paid to the recipient's new landlord as a vendor payment. The county may require that assistance paid in the form of a utility deposit less any amount retained to satisfy outstanding utility costs be returned to the county when the person vacates the premises, or be paid for the person's new housing unit as a vendor payment. The vendor payment of returned funds shall not be considered a new use of emergency assistance.

(e) [MOVING EXPENSES.] A county agency shall issue assistance for expenses incurred when a family must move to a different shelter according to clauses (1) to (4):

(1) moving expenses include the cost to transport personal property belonging to a family, the cost for utility connection, and the cost for securing different shelter;

(2) moving expenses must be paid only when the county agency determines that a move is cost-effective;

(3) moving expenses must be paid at the request of an applicant, but only when destitution or threatened destitution exists; and

(4) moving expenses must be paid when a county agency denies assistance to prevent an eviction because the county agency has determined that an applicant's anticipated income will not cover continued shelter obligation in paragraph (a).

(f) [HOME REPAIRS.] A county agency shall pay for repairs to the roof, foundation, wiring, heating system, chimney, and water and sewer system of a home that is owned and lived in by an applicant.

The applicant shall document, and the county agency shall verify the need for and method of repair.

The payment must be cost-effective in relation to the overall condition of the home and in relation to the cost and availability of alternative housing.

(g) [UTILITY COSTS.] Assistance for utility costs must be made when an otherwise eligible family has had a termination or is threatened with a termination of municipal water and sewer service, electric, gas or heating fuel service, refuse removal service, or lacks wood when that is the heating source, subject to the conditions in clauses (1) and (2):

(1) a county agency must not issue assistance unless the county agency receives confirmation from the utility provider that assistance combined with payment by the applicant will continue or restore the utility; and

(2) a county agency shall not issue assistance for utility costs unless a family paid at least eight percent of the family's gross income toward utility costs due during the preceding 12 months.

Clauses (1) and (2) must not be construed to prevent the issuance of assistance when a county agency must take immediate and temporary action necessary to protect the life or health of a child.

(h) [SPECIAL DIETS.] Effective January 1, 1998, a county shall pay for special diets or dietary items for ~~MFP-S~~ MFIP participants. Persons receiving emergency assistance funds for special diets or dietary items are also eligible to receive emergency assistance for shelter and utility emergencies, if otherwise eligible. The need for special diets or dietary items must be prescribed by a licensed physician. Costs for special diets shall be determined as percentages of the allotment for a one-person household under the Thrifty Food Plan as defined by the United States Department of Agriculture. The types of diets and the percentages of the Thrifty Food Plan that are covered are as follows:

- (1) high protein diet, at least 80 grams daily, 25 percent of Thrifty Food Plan;
- (2) controlled protein diet, 40 to 60 grams and requires special products, 100 percent of Thrifty Food Plan;
- (3) controlled protein diet, less than 40 grams and requires special products, 125 percent of Thrifty Food Plan;
- (4) low cholesterol diet, 25 percent of Thrifty Food Plan;
- (5) high residue diet, 20 percent of Thrifty Food Plan;
- (6) pregnancy and lactation diet, 35 percent of Thrifty Food Plan;
- (7) gluten-free diet, 25 percent of Thrifty Food Plan;
- (8) lactose-free diet, 25 percent of Thrifty Food Plan;
- (9) antidumping diet, 15 percent of Thrifty Food Plan;

(10) hypoglycemic diet, 15 percent of Thrifty Food Plan; or

(11) ketogenic diet, 25 percent of Thrifty Food Plan.

Sec. 55. Minnesota Statutes 1998, section 256J.50, subdivision 1, is amended to read:

Subdivision 1. [EMPLOYMENT AND TRAINING SERVICES COMPONENT OF ~~MFIP-S~~ MFIP.] (a) By January 1, 1998, each county must develop and implement an employment and training services component of ~~MFIP-S~~ MFIP which is designed to put participants on the most direct path to unsubsidized employment. Participation in these services is mandatory for all ~~MFIP-S~~ MFIP caregivers, unless the caregiver is exempt under section 256J.56.

(b) ~~A county may provide employment and training services to MFIP-S caregivers who are exempt from the employment and training services component but volunteer for the services. 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.~~

Sec. 56. Minnesota Statutes 1998, 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-S 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.

Failure to attend the overview of employment and training services without good cause results in the imposition of a sanction under section 256J.46.

Sec. 57. Minnesota Statutes 1998, section 256J.52, subdivision 1, is amended to read:

Subdivision 1. [APPLICATION LIMITED TO CERTAIN PARTICIPANTS.] This section applies to participants receiving ~~MFIP-S~~ MFIP assistance who are not exempt under section 256J.56, and to caregivers who volunteer for employment and training services ~~under section 256J.50.~~

Sec. 58. Minnesota Statutes 1998, 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: 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 search support plan may also specify that the participant fulfill a specified portion of the required hours of job search through attending adult basic education or English as a second language classes.

(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. 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, 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.

Sec. 59. Minnesota Statutes 1998, section 256J.52, subdivision 4, is amended to read:

Subd. 4. [SECONDARY ASSESSMENT.] (a) The job counselor must conduct a secondary assessment for those participants who:

(1) in the judgment of the job counselor, have barriers to obtaining employment that will not be overcome with a job search support plan under subdivision 3;

(2) have completed eight weeks of job search under subdivision 3 without obtaining suitable employment;

(3) have not received a secondary assessment, are working at least 20 hours per week, and the participant, job counselor, or county agency requests a secondary assessment; or

(4) have an existing job search plan or employment plan developed for another program or are already involved in training or education activities under section 256J.55, subdivision 5.

(b) In the secondary assessment the job counselor must evaluate the participant's skills and prior work experience, family circumstances, interests and abilities, need for preemployment activities, supportive or educational services, and the extent of any barriers to employment. Failure to complete a secondary assessment shall result in the imposition of a sanction as specified in sections 256J.46 and 256J.57. The job counselor must use the information gathered through the secondary assessment to develop an employment plan under subdivision 5.

(c) In the secondary assessment the job counselor may require the participant to complete an appropriate and culturally competent professional chemical use assessment to be performed according to the rules adopted under section 254A.03, subdivision 3, or a professional psychological assessment as a component of the secondary assessment, when the job counselor has a reasonable belief, based on objective evidence, that a participant's ability to obtain and retain suitable employment is impaired by a medical condition. The job counselor must ensure that appropriate services, including child care assistance and transportation, are available to the participant to meet needs identified by the assessment. Data gathered as part of a professional assessment must be classified and disclosed according to the provisions in section 13.46.

(d) The provider shall make available to participants information regarding additional vendors or resources which provide employment and training services that may be available to the participant under a plan developed under this section. At a minimum, the provider must make available information on the following resources: business and higher education partnerships operated under the Minnesota job skills partnership, community and technical colleges, adult basic education programs, and services offered by vocational rehabilitation programs. The

information must include a brief summary of services provided and related performance indicators. Performance indicators must include, but are not limited to, the average time to complete program offerings, placement rates, entry and average wages, and retention rates. To be included in the information given to participants, a vendor or resource must provide counties with relevant information in the format required by the county.

Sec. 60. Minnesota Statutes 1998, section 256J.52, subdivision 5, is amended to read:

Subd. 5. [EMPLOYMENT PLAN; CONTENTS.] Based on the secondary assessment under subdivision 4, the job counselor and the participant must develop an employment plan for the participant that includes specific activities that are tied to an employment goal and a plan for long-term self-sufficiency, and that is designed to move the participant along the most direct path to unsubsidized employment. The employment plan must list the specific steps that will be taken to obtain employment and a timetable for completion of each of the steps. Upon agreement by the job counselor and the participant, the employment plan may limit a job search to jobs that are consistent with the participant's employment goal. As part of the development of the participant's employment plan, the participant shall have the option of selecting from among the vendors or resources that the job counselor determines will be effective in supplying one or more of the services necessary to meet the employment goals specified in the participant's plan. In compiling the list of vendors and resources that the job counselor determines would be effective in meeting the participant's employment goals, the job counselor must determine that adequate financial resources are available for the vendors or resources ultimately selected by the participant. The job counselor and the participant must sign the developed plan to indicate agreement between the job counselor and the participant on the contents of the plan.

Sec. 61. Minnesota Statutes 1998, section 256J.52, is amended by adding a subdivision to read:

Subd. 5a. [BASIC EDUCATION ACTIVITIES IN PLAN.] Participants with low skills in reading or mathematics who are proficient only at or below an eighth-grade level must be allowed to include basic education activities or an English as a second language program in a job search support plan or an employment plan, whichever is applicable. An English as a second language program may be included in a participant's job search support plan or employment plan under this subdivision for as long as the participant is making satisfactory progress in the program and the participant's lack of proficiency in English remains a barrier to obtaining suitable employment.

Sec. 62. Minnesota Statutes 1998, section 256J.54, subdivision 2, is amended to read:

Subd. 2. [RESPONSIBILITY FOR ASSESSMENT AND EMPLOYMENT PLAN.] For caregivers who are under age 18 without a high school diploma or its equivalent, the assessment under subdivision 1 and the employment plan under subdivision 3 must be completed by the social services agency under section 257.33. For caregivers who are age 18 or 19 without a high school diploma or its equivalent, the assessment under subdivision 1 and the employment plan under subdivision 3 must be completed by the job counselor or, at county option, by the social services agency under section 257.33. Upon reaching age 18 or 19 a caregiver who received social services under section 257.33 and is without a high school diploma or its equivalent has the option to choose whether to continue receiving services under the caregiver's plan from the social services agency or to utilize an MFIP employment and training service provider. The social services agency or the job counselor shall consult with representatives of educational agencies that are required to assist in developing educational plans under section 124D.331.

Sec. 63. Minnesota Statutes 1998, section 256J.55, subdivision 4, is amended to read:

Subd. 4. [CHOICE OF PROVIDER.] ~~A participant MFIP caregivers~~ must be able to choose from at least two employment and training service providers, unless the county has demonstrated to the commissioner that the provision of multiple employment and training service providers would result in financial hardship for the county, or the county is utilizing a workforce center as specified in section 256J.50, subdivision 8. Both parents in a two-parent family must choose the same employment and training service provider unless a special need, such as bilingual services, is identified but not available through one service provider.

Sec. 64. Minnesota Statutes 1998, section 256J.56, is amended to read:

256J.56 [EMPLOYMENT AND TRAINING SERVICES COMPONENT; EXEMPTIONS.]

(a) An ~~MFIP-S~~ 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 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;

(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; 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.

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-S~~ 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. 65. Minnesota Statutes 1998, section 256J.62, subdivision 1, is amended to read:

Subdivision 1. [ALLOCATION.] Money appropriated for ~~MFIP-S~~ MFIP employment and training services must be allocated to counties and eligible tribal providers as specified in this section.

Sec. 66. Minnesota Statutes 1998, section 256J.62, is amended by adding a subdivision 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;

(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; and

(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.

Any funds specified in this paragraph 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 (4).

Sec. 67. Minnesota Statutes 1998, section 256J.62, subdivision 6, is amended to read:

Subd. 6. [BILINGUAL EMPLOYMENT AND TRAINING SERVICES TO REFUGEES.] Funds appropriated to cover the costs of bilingual employment and training services to refugees shall be allocated to county agencies as follows:

(1) for state fiscal year 1998, the allocation shall be based on the county's proportion of the total statewide number of AFDC refugee cases in the previous fiscal year. Counties with less than one percent of the statewide number of AFDC, MFIP-R, or MFIP refugee cases shall not receive an allocation of bilingual employment and training services funds; and

(2) for each subsequent fiscal year, the allocation shall be based on the county's proportion of the total statewide number of ~~MFIP-S~~ MFIP refugee cases in the previous fiscal year. Counties with less than one percent of the statewide number of ~~MFIP-S~~ MFIP refugee cases shall not receive an allocation of bilingual employment and training services funds.

Sec. 68. Minnesota Statutes 1998, section 256J.62, subdivision 7, is amended to read:

Subd. 7. [WORK LITERACY LANGUAGE PROGRAMS.] Funds appropriated to cover the costs of work literacy language programs to non-English-speaking recipients shall be allocated to county agencies as follows:

(1) for state fiscal year 1998, the allocation shall be based on the county's proportion of the total statewide number of AFDC or MFIP cases in the previous fiscal year where the lack of English is a barrier to employment. Counties with less than two percent of the statewide number of AFDC or MFIP cases where the lack of English is a barrier to employment shall not receive an allocation of the work literacy language program funds; and

(2) for each subsequent fiscal year, the allocation shall be based on the county's proportion of the total statewide number of ~~MFIP-S~~ MFIP cases in the previous fiscal year where the lack of English is a barrier to employment. Counties with less than two percent of the statewide number of ~~MFIP-S~~ MFIP cases where the lack of English is a barrier to employment shall not receive an allocation of the work literacy language program funds.

Sec. 69. Minnesota Statutes 1998, section 256J.62, subdivision 8, is amended to read:

Subd. 8. [REALLOCATION.] The commissioner of human services shall review county agency expenditures of ~~MFIP-S~~ MFIP employment and training services funds at the end of the third quarter of the first year of the biennium and each quarter after that and may reallocate unencumbered or unexpended money appropriated under this section to those county agencies that can demonstrate a need for additional money.

Sec. 70. Minnesota Statutes 1998, 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 ~~six~~ 12 months following termination of the participant's eligibility for ~~MFIP-S~~ 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-S~~ MFIP eligibility.

Sec. 71. Minnesota Statutes 1998, section 256J.67, subdivision 4, is amended to read:

Subd. 4. [EMPLOYMENT PLAN.] (a) The caretaker's employment plan must include the length of time needed in the work experience program, the need to continue job-seeking activities while participating in work experience, and the caregiver's employment goals.

(b) After each six months of a caregiver's participation in a work experience job placement, and at the conclusion of each work experience assignment under this section, the county agency shall reassess and revise, as appropriate, the caregiver's employment plan.

(c) A caregiver may claim good cause under section 256J.57, subdivision 1, for failure to cooperate with a work experience job placement.

(d) The county agency shall limit the maximum number of hours any participant may work under this section to the amount of the ~~transitional~~ MFIP standard of need divided by the federal or applicable state minimum wage, whichever is higher. After a participant has been assigned to a position for nine months, the participant may not continue in that assignment unless the maximum number of hours a participant works is no greater than the amount of the ~~transitional~~ MFIP standard of need divided by the rate of pay for individuals employed in the same or similar occupations by the same employer at the same site. This limit does not apply if it would prevent a participant from counting toward the federal work participation rate.

Sec. 72. Minnesota Statutes 1998, section 256J.74, subdivision 2, is amended to read:

Subd. 2. [CONCURRENT ELIGIBILITY, LIMITATIONS.] (a) An individual whose needs have been otherwise provided for in another state, in whole or in part by county, state, or federal dollars during a month, is ineligible to receive MFIP for the month.

(b) A county agency must not count an applicant or participant as a member of more than one assistance unit in this state in a given payment month, except as provided in clauses (1) and (2).

(1) A participant who is a member of an assistance unit ~~in this state~~ is eligible to be included in a second assistance unit the ~~first full~~ month after the month the participant joins the second unit.

(2) An applicant whose needs are met through federal, state, or local foster care ~~that is reimbursed under title IV-E of the Social Security Act~~ payments for the first part of an application month is eligible to receive assistance for the remaining part of the month in which the applicant returns home. ~~Title IV-E Foster care payments and adoption assistance payments~~ must be considered prorated payments rather than a duplication of ~~MFIP-S~~ MFIP need.

Sec. 73. [256J.751] [COUNTY PERFORMANCE MANAGEMENT.]

(a) From July 1, 1999, to June 30, 2001, the commissioner shall report quarterly to all counties 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; and
- (5) median placement wage.

(b) By January 1, 2000, the commissioner shall, in consultation with counties, develop measures for county performance in addition to those in paragraph (a). 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;
- (3) participant's earnings at a follow-up point after the participant has left MFIP; and
- (4) customer satisfaction, including participant and employer satisfaction.

(c) 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) 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. 74. Minnesota Statutes 1998, section 256J.76, subdivision 1, is amended to read:

Subdivision 1. [ADMINISTRATIVE FUNCTIONS.] Beginning July 1, 1997, counties will receive federal funds from the TANF block grant for use in supporting eligibility, fraud control, and other related administrative functions. The federal funds available for distribution, as determined by the commissioner, must be an amount equal to federal administrative aid distributed for fiscal year 1996 under titles IV-A and IV-F of the Social Security Act in effect prior to October 1, 1996. This amount must include the amount paid for local collaboratives under sections 245.4932 and 256F.13, but must not include administrative aid associated with child care under section 119B.05, with emergency assistance intensive family preservation services under section 256.8711, with administrative activities as part of the employment and training services under section 256.736, or with fraud prevention investigation activities under section 256.983. Before July 15, 1999, a county may ask for a review of the commissioner's determination where the county believes fiscal year 1996 information was inaccurate or incomplete. By August 15, 1999, the commissioner must adjust that county's base when the commissioner has determined that inaccurate or incomplete information was used to develop that base. The commissioner shall adjust the county's 1999 allocation amount to reflect the base change.

Sec. 75. Minnesota Statutes 1998, section 256J.76, subdivision 2, is amended to read:

Subd. 2. [ALLOCATION OF COUNTY FUNDS.] (a) The commissioner shall determine and allocate the funds available to each county, on a calendar year basis, proportional to the amount paid to each county for fiscal year 1996, excluding the amount paid for local collaboratives under sections 245.4932 and 256F.13. For the period beginning July 1, 1997, and ending December 31, 1998, each county shall receive 150 percent of its base year allocation.

(b) Beginning January 1, 2000, the commissioner shall allocate funds made available under this section on a calendar year basis to each county first, in amounts equal to each county's guaranteed floor as described in clause (1), second, to provide an allocation of up to \$2,000 to each county as provided for in clause (2), and third, any remaining funds shall be allocated in proportion to the sum of each county's average monthly MFIP cases plus ten percent of each county's average monthly MFIP recipients with budgeted earnings as determined by the most recent calendar year data available.

(1) Each county's guaranteed floor shall be calculated as follows:

(i) 90 percent of that county's allocation in the preceding calendar year; or

(ii) when the amount of funds available is less than the guaranteed floor, each county's allocation shall be equal to the previous calendar year allocation reduced by the same percentage that the statewide allocation was reduced.

(2) Each county shall be allocated up to \$2,000. If, after application of the guaranteed floor, funds are insufficient to provide \$2,000 per county, each county's allocation under this clause shall be an equal share of remaining funds available.

Sec. 76. Minnesota Statutes 1998, section 256J.76, subdivision 4, is amended to read:

Subd. 4. [REPORTING REQUIREMENT AND REIMBURSEMENT.] The commissioner shall specify requirements for reporting according to section 256.01, subdivision 2, paragraph (17). Each county shall be reimbursed at a rate of 50 percent of eligible expenditures up to the limit of its allocation. The commissioner shall regularly review each county's eligible expenditures compared to its allocation. The commissioner may reallocate funds at any time, from counties which have not or will not have expended their allocations, to counties that have eligible expenditures in excess of their allocation.

Sec. 77. [256J.80] [TRUANCY PREVENTION PROGRAM.]

Subdivision 1. [PILOT PROJECTS.] The commissioner of human services, in consultation with the commissioner of children, families, and learning, shall develop a truancy prevention pilot program to prevent tardiness and ensure school attendance of children receiving assistance under this chapter. The pilot program shall be developed in at least two school districts, one rural and one urban. The pilots shall be developed in voluntary collaboration with local school districts and county social service agencies and shall serve families on MFIP whose children are under the age of 13 and are subject to the compulsory attendance requirements of section 120A.22, and are frequently tardy or are not attending school regularly, as defined by the local school district. The program shall require the local schools to refer these families to county social service agencies for an assessment and development of a corrective action plan to ensure punctual and regular school attendance by the children in the family. The corrective action plan must require that the children demonstrate satisfactory attendance as defined by the local school district. Families that fail to follow the corrective action plan shall be reported to the county agency and may be subject to sanction under section 256J.46, subdivision 1, paragraphs (a) and (b). The commissioner of human services may at its discretion expand the program to other districts with the districts' agreement and shall present a report to the legislature by November 30, 2000, on the success of the implementation of the pilot projects authorized by this section.

Subd. 2. [TRANSFER OF ATTENDANCE DATA.] Notwithstanding section 13.32, the commissioners of children, families, and learning and human services shall develop procedures to implement the transmittal of data on student attendance, to the extent consistent with federal law, to county social services agencies to implement the program authorized by this section.

Sec. 78. [RECOMMENDATIONS TO 60-MONTH LIMIT.]

By January 15, 2000, the commissioner of human services shall submit to the legislature recommendations regarding MFIP families that include an adult caregiver who has received 60 months of cash assistance funded in whole or in part by the TANF block grant.

Sec. 79. [PROPOSAL REQUIRED.]

By January 15, 2000, the commissioner shall submit to the legislature a proposal for creating an MFIP incentive bonus program for high-performing counties. The proposal must include recommendations on how to implement a system that would provide an incentive bonus to a county that demonstrates high performance with respect to the county's MFIP participants, as reflected in wage rate measures and career advancement measures reported by the county.

Sec. 80. [ASSESSMENT PROTOCOLS.]

The commissioner of human services shall consult with county agencies, employment and training service providers, the commissioner of human rights, and advocates to develop protocols to guide the implementation of Minnesota Statutes, section 256J.52, subdivision 4, paragraph (c), as amended.

Sec. 81. [FATHER PROJECT; TIME-LIMITED WAIVER OF EXISTING STATUTORY PROVISIONS.]

The commissioner of human services shall waive the enforcement of any existing specific statutory program requirements, administrative rules, and standards, including the relevant provisions of the following sections of Minnesota Statutes:

(1) 256.741, subdivision 2, paragraph (a);

(2) 256J.30, subdivision 11;

(3) 256J.33, subdivision 4, clause (5); and

(4) 256J.34, subdivision 1, paragraph (d).

The waivers permitted under this section are for the limited purposes of allowing the entire amount of direct child support payments to be passed through for the children of individuals participating in the FATHER project and excluding any direct child support payments paid by participants in the FATHER project as income under the MFIP program for individuals receiving the child support payments who also receive MFIP assistance. State dollars to offset the increased costs to the state of implementing the waivers are available only to the extent that they are matched on a dollar for dollar basis by money provided by the private philanthropical community. The waiver authority granted by this section sunsets on July 1, 2002.

Sec. 82. [REPEALER.]

Minnesota Statutes 1998, sections 256D.053, subdivision 4; and 256J.62, subdivisions 2, 3, and 5; and Laws 1997, chapter 85, article 1, section 63, are repealed.

ARTICLE 7

CHILD SUPPORT

Section 1. Minnesota Statutes 1998, section 13.46, subdivision 2, is amended to read:

Subd. 2. [GENERAL.] (a) Unless the data is summary data or a statute specifically provides a different classification, data on individuals collected, maintained, used, or disseminated by the welfare system is private data on individuals, and shall not be disclosed except:

- (1) according to section 13.05;
- (2) according to court order;
- (3) according to a statute specifically authorizing access to the private data;
- (4) to an agent of the welfare system, including a law enforcement person, attorney, or investigator acting for it in the investigation or prosecution of a criminal or civil proceeding relating to the administration of a program;
- (5) to personnel of the welfare system who require the data to determine eligibility, amount of assistance, and the need to provide services of additional programs to the individual;
- (6) to administer federal funds or programs;
- (7) between personnel of the welfare system working in the same program;
- (8) the amounts of cash public assistance and relief paid to welfare recipients in this state, including their names, social security numbers, income, addresses, and other data as required, upon request by the department of revenue to administer the property tax refund law, supplemental housing allowance, early refund of refundable tax credits, and the income tax. "Refundable tax credits" means the dependent care credit under section 290.067, the Minnesota working family credit under section 290.0671, the property tax refund under section 290A.04, and, if the required federal waiver or waivers are granted, the federal earned income tax credit under section 32 of the Internal Revenue Code;
- (9) between the department of human services and the Minnesota department of economic security for the purpose of monitoring the eligibility of the data subject for reemployment insurance, for any employment or training program administered, supervised, or certified by that agency, for the purpose of administering any rehabilitation program, whether alone or in conjunction with the welfare system, or to monitor and evaluate the statewide Minnesota family investment program by exchanging data on recipients and former recipients of food stamps, cash assistance under chapter 256, 256D, 256J, or 256K, child care assistance under chapter 119B, or medical programs under chapter 256B, 256D, or 256L;
- (10) to appropriate parties in connection with an emergency if knowledge of the information is necessary to protect the health or safety of the individual or other individuals or persons;
- (11) data maintained by residential programs as defined in section 245A.02 may be disclosed to the protection and advocacy system established in this state according to Part C of Public Law Number 98-527 to protect the legal and human rights of persons with mental retardation or other related conditions who live in residential facilities for these persons if the protection and advocacy system receives a complaint by or on behalf of that person and the person does not have a legal guardian or the state or a designee of the state is the legal guardian of the person;
- (12) to the county medical examiner or the county coroner for identifying or locating relatives or friends of a deceased person;

(13) data on a child support obligor who makes payments to the public agency may be disclosed to the higher education services office to the extent necessary to determine eligibility under section 136A.121, subdivision 2, clause (5);

(14) participant social security numbers and names collected by the telephone assistance program may be disclosed to the department of revenue to conduct an electronic data match with the property tax refund database to determine eligibility under section 237.70, subdivision 4a;

(15) the current address of a recipient of aid to families with dependent children or Minnesota family investment program-statewide may be disclosed to law enforcement officers who provide the name of the recipient and notify the agency that:

(i) the recipient:

(A) is a fugitive felon fleeing to avoid prosecution, or custody or confinement after conviction, for a crime or attempt to commit a crime that is a felony under the laws of the jurisdiction from which the individual is fleeing; or

(B) is violating a condition of probation or parole imposed under state or federal law;

(ii) the location or apprehension of the felon is within the law enforcement officer's official duties; and

(iii) the request is made in writing and in the proper exercise of those duties;

(16) the current address of a recipient of general assistance or general assistance medical care may be disclosed to probation officers and corrections agents who are supervising the recipient and to law enforcement officers who are investigating the recipient in connection with a felony level offense;

(17) information obtained from food stamp applicant or recipient households may be disclosed to local, state, or federal law enforcement officials, upon their written request, for the purpose of investigating an alleged violation of the Food Stamp Act, according to Code of Federal Regulations, title 7, section 272.1(c);

(18) the address, social security number, and, if available, photograph of any member of a household receiving food stamps shall be made available, on request, to a local, state, or federal law enforcement officer if the officer furnishes the agency with the name of the member and notifies the agency that:

(i) the member:

(A) is fleeing to avoid prosecution, or custody or confinement after conviction, for a crime or attempt to commit a crime that is a felony in the jurisdiction the member is fleeing;

(B) is violating a condition of probation or parole imposed under state or federal law; or

(C) has information that is necessary for the officer to conduct an official duty related to conduct described in subitem (A) or (B);

(ii) locating or apprehending the member is within the officer's official duties; and

(iii) the request is made in writing and in the proper exercise of the officer's official duty;

(19) certain information regarding child support obligors who are in arrears may be made public according to section 518.575;

(20) data on child support payments made by a child support obligor and data on the distribution of those payments excluding identifying information on obligees may be disclosed to all obligees to whom the obligor owes support, and data on the enforcement actions undertaken by the public authority, the status of those actions, and data on the income of the obligor or obligee may be disclosed to the other party;

(21) data in the work reporting system may be disclosed under section 256.998, subdivision 7;

(22) to the department of children, families, and learning for the purpose of matching department of children, families, and learning student data with public assistance data to determine students eligible for free and reduced price meals, meal supplements, and free milk according to United States Code, title 42, sections 1758, 1761, 1766, 1766a, 1772, and 1773; to produce accurate numbers of students receiving aid to families with dependent children or Minnesota family investment program-statewide as required by section 126C.06; to allocate federal and state funds that are distributed based on income of the student's family; and to verify receipt of energy assistance for the telephone assistance plan;

(23) the current address and telephone number of program recipients and emergency contacts may be released to the commissioner of health or a local board of health as defined in section 145A.02, subdivision 2, when the commissioner or local board of health has reason to believe that a program recipient is a disease case, carrier, suspect case, or at risk of illness, and the data are necessary to locate the person;

(24) to other state agencies, statewide systems, and political subdivisions of this state, including the attorney general, and agencies of other states, interstate information networks, federal agencies, and other entities as required by federal regulation or law for the administration of the child support enforcement program;

(25) to personnel of public assistance programs as defined in section 256.741, for access to the child support system database for the purpose of administration, including monitoring and evaluation of those public assistance programs; ~~or~~

(26) to monitor and evaluate the statewide Minnesota family investment program by exchanging data between the departments of human services and children, families, and learning, on recipients and former recipients of food stamps, cash assistance under chapter 256, 256D, 256J, or 256K, child care assistance under chapter 119B, or medical programs under chapter 256B, 256D, or 256L; ~~or~~

(27) to evaluate child support program performance and to identify and prevent fraud in the child support program by exchanging data between the department of human services, department of revenue, department of health, department of economic security, and other state agencies as is reasonably necessary to perform these functions.

(b) Information on persons who have been treated for drug or alcohol abuse may only be disclosed according to the requirements of Code of Federal Regulations, title 42, sections 2.1 to 2.67.

(c) Data provided to law enforcement agencies under paragraph (a), clause (15), (16), (17), or (18), or paragraph (b), are investigative data and are confidential or protected nonpublic while the investigation is active. The data are private after the investigation becomes inactive under section 13.82, subdivision 5, paragraph (a) or (b).

(d) Mental health data shall be treated as provided in subdivisions 7, 8, and 9, but is not subject to the access provisions of subdivision 10, paragraph (b).

Sec. 2. Minnesota Statutes 1998, section 256.87, subdivision 1a, is amended to read:

Subd. 1a. [CONTINUING SUPPORT CONTRIBUTIONS.] In addition to granting the county or state agency a money judgment, the court may, upon a motion or order to show cause, order continuing support contributions by a parent found able to reimburse the county or state agency. The order shall be effective for the period of time during which the recipient receives public assistance from any county or state agency and thereafter. The order shall require support according to chapter 518 and include the names and social security numbers of the father, mother, and the

child or children. An order for continuing contributions is reinstated without further hearing upon notice to the parent by any county or state agency that public assistance, as defined in section 256.741, is again being provided for the child of the parent. The notice shall be in writing and shall indicate that the parent may request a hearing for modification of the amount of support or maintenance.

Sec. 3. Minnesota Statutes 1998, section 256.978, subdivision 1, is amended to read:

Subdivision 1. [REQUEST FOR INFORMATION.] (a) The public authority responsible for child support in this state or any other state, in order to locate a person or to obtain information necessary to establish paternity and child support or to modify or enforce child support or distribute collections, may request information reasonably necessary to the inquiry from the records of (1) all departments, boards, bureaus, or other agencies of this state, which shall, notwithstanding the provisions of section 268.19 or any other law to the contrary, provide the information necessary for this purpose; and (2) employers, utility companies, insurance companies, financial institutions, credit grantors, and labor associations doing business in this state. They shall provide information as provided under subdivision 2 a response upon written or electronic request by an agency responsible for child support enforcement regarding individuals owing or allegedly owing a duty to support within 30 days of service of the request made by the public authority. Information requested and used or transmitted by the commissioner according to the authority conferred by this section may be made available to other agencies, statewide systems, and political subdivisions of this state, and agencies of other states, interstate information networks, federal agencies, and other entities as required by federal regulation or law for the administration of the child support enforcement program.

(b) For purposes of this section, "state" includes the District of Columbia, Puerto Rico, the United States Virgin Islands, and any territory or insular possession subject to the jurisdiction of the United States.

Sec. 4. Minnesota Statutes 1998, section 257.62, subdivision 5, is amended to read:

Subd. 5. [POSITIVE TEST RESULTS.] (a) If the results of blood or genetic tests completed in a laboratory accredited by the American Association of Blood Banks indicate that the likelihood of the alleged father's paternity, calculated with a prior probability of no more than 0.5 (50 percent), is 92 percent or greater, upon motion the court shall order the alleged father to pay temporary child support determined according to chapter 518. The alleged father shall pay the support money to the public authority if the public authority is a party and is providing services to the parties or, if not, into court pursuant to the rules of civil procedure to await the results of the paternity proceedings.

(b) If the results of blood or genetic tests completed in a laboratory accredited by the American Association of Blood Banks indicate that likelihood of the alleged father's paternity, calculated with a prior probability of no more than 0.5 (50 percent), is 99 percent or greater, the alleged father is presumed to be the parent and the party opposing the establishment of the alleged father's paternity has the burden of proving by clear and convincing evidence that the alleged father is not the father of the child.

Sec. 5. Minnesota Statutes 1998, section 257.75, subdivision 2, is amended to read:

Subd. 2. [REVOCATION OF RECOGNITION.] A recognition may be revoked in a writing signed by the mother or father before a notary public and filed with the state registrar of vital statistics within the earlier of ~~30~~ 60 days after the recognition is executed or the date of an administrative or judicial hearing relating to the child in which the revoking party is a party to the related action. A joinder in a recognition may be revoked in a writing signed by the man who executed the joinder and filed with the state registrar of vital statistics within ~~30~~ 60 days after the joinder is executed. Upon receipt of a revocation of the recognition of parentage or joinder in a recognition, the state registrar of vital statistics shall forward a copy of the revocation to the nonrevoking parent, or, in the case of a joinder in a recognition, to the mother and father who executed the recognition.

Sec. 6. Minnesota Statutes 1998, section 518.10, is amended to read:

518.10 [REQUISITES OF PETITION.]

The petition for dissolution of marriage or legal separation shall state and allege:

(a) the name, address, and, in circumstances in which child support or spousal maintenance will be addressed, social security number of the petitioner and any prior or other name used by the petitioner;

(b) the name and, if known, the address and, in circumstances in which child support or spousal maintenance will be addressed, social security number of the respondent and any prior or other name used by the respondent and known to the petitioner;

(c) the place and date of the marriage of the parties;

(d) in the case of a petition for dissolution, that either the petitioner or the respondent or both:

(1) has resided in this state for not less than 180 days immediately preceding the commencement of the proceeding, or

(2) has been a member of the armed services and has been stationed in this state for not less than 180 days immediately preceding the commencement of the proceeding, or

(3) has been a domiciliary of this state for not less than 180 days immediately preceding the commencement of the proceeding;

(e) the name at the time of the petition and any prior or other name, social security number, age, and date of birth of each living minor or dependent child of the parties born before the marriage or born or adopted during the marriage and a reference to, and the expected date of birth of, a child of the parties conceived during the marriage but not born;

(f) whether or not a separate proceeding for dissolution, legal separation, or custody is pending in a court in this state or elsewhere;

(g) in the case of a petition for dissolution, that there has been an irretrievable breakdown of the marriage relationship;

(h) in the case of a petition for legal separation, that there is a need for a decree of legal separation;

(i) any temporary or permanent maintenance, child support, child custody, disposition of property, attorneys' fees, costs and disbursements applied for without setting forth the amounts; and

(j) whether an order for protection under chapter 518B or a similar law of another state that governs the parties or a party and a minor child of the parties is in effect and, if so, the district court or similar jurisdiction in which it was entered.

The petition shall be verified by the petitioner or petitioners, and its allegations established by competent evidence.

Sec. 7. [518.146] [SOCIAL SECURITY NUMBERS; TAX RETURNS; IDENTITY PROTECTION.]

The social security numbers and tax returns required under this chapter are private data, except that they must be disclosed to the other parties to a proceeding.

Sec. 8. Minnesota Statutes 1998, section 518.551, is amended by adding a subdivision to read:

Subd. 15. [LICENSE SUSPENSION.] (a) Upon motion of an obligee or the public authority, which has been properly served on the obligor by first class mail at the last known address or in person, and if at a hearing, the court or an administrative law judge finds (1) 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, or (2) has failed, after receiving notice, to comply with a subpoena relating to a paternity or child support proceeding, the court or administrative law judge may direct the commissioner of natural resources to suspend or bar receipt of the obligor's recreational license or licenses.

(b) For the purposes of this subdivision, a recreational license includes all licenses, permits, and stamps issued centrally by the commissioner of natural resources under sections 97B.301, 97B.401, 97B.501, 97B.515, 97B.601, 97B.715, 97B.721, 97B.801, 97C.301, and 97C.305.

(c) An obligor whose recreational license or licenses have been suspended or barred may provide proof to the court or administrative law judge that the obligor is in compliance with all written payment agreements regarding both current support and arrearages. Within 15 days of receipt of that proof, the court or administrative law judge may notify the commissioner of natural resources that the obligor's recreational license or licenses should no longer be suspended nor should receipt be barred.

Sec. 9. Minnesota Statutes 1998, section 518.57, subdivision 3, is amended to read:

Subd. 3. [SATISFACTION OF CHILD SUPPORT OBLIGATION.] The court ~~may~~ must conclude that an obligor has satisfied a child support obligation by providing a home, care, and support for the child while the child is living with the obligor, if the court finds that the child was integrated into the family of the obligor with the consent or acquiescence of the obligee and child support payments were not assigned to the public agency under section 256.74.

Sec. 10. Minnesota Statutes 1998, section 518.5851, is amended by adding a subdivision to read:

Subd. 6. [CREDITOR COLLECTIONS.] The central collections unit under this section is not a third party under chapters 550, 552, and 571 for purposes of creditor collection efforts against child support and maintenance order obligors or obligees, and shall not be subject to creditor levy, attachment, or garnishment.

Sec. 11. Minnesota Statutes 1998, section 518.5853, is amended by adding a subdivision to read:

Subd. 11. [COLLECTIONS UNIT RECOUPMENT ACCOUNT.] The commissioner of human services may establish a revolving account to cover funds issued in error due to insufficient funds or other reasons. Appropriations for this purpose and all recoupments against payments from the account shall be deposited in the collections unit's recoupment account and are appropriated to the commissioner. Any unexpended balance in the account does not cancel, but is available until expended.

Sec. 12. Minnesota Statutes 1998, 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 sections 256.72 to 256.87 or 256B.01 to 256B.40; (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.

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. 13. Minnesota Statutes 1998, section 548.09, subdivision 1, is amended to read:

Subdivision 1. [ENTRY AND DOCKETING; SURVIVAL OF JUDGMENT.] Except as provided in section 548.091, every judgment requiring the payment of money shall be ~~docketed~~ entered by the court administrator ~~upon its entry when ordered by the court and will be docketed by the court administrator upon the filing of an affidavit as provided in subdivision 2.~~ Upon a transcript of the docket being filed with the court administrator in any other county, the court administrator shall also docket it. From the time of docketing the judgment is a lien, in the amount unpaid, upon all real property in the county then or thereafter owned by the judgment debtor, but it is not a lien upon registered land unless it is also filed pursuant to sections 508.63 and 508A.63. The judgment survives, and the lien continues, for ten years after its entry. Child support judgments may be renewed ~~by service of notice upon the debtor. Service shall be by certified mail at the last known address of the debtor or in the manner provided for the service of civil process. Upon the filing of the notice and proof of service the court administrator shall renew the judgment for child support without any additional filing fee pursuant to section 548.091.~~

Sec. 14. Minnesota Statutes 1998, section 548.091, subdivision 1, is amended to read:

Subdivision 1. [ENTRY AND DOCKETING OF MAINTENANCE JUDGMENT.] (a) A judgment for unpaid amounts under a judgment or decree of dissolution or legal separation that provides for installment or periodic payments of maintenance shall be entered ~~and docketed~~ by the court administrator ~~only~~ when ordered by the court or shall be entered and docketed by the court administrator when the following conditions are met:

(a) (1) the obligee determines that the obligor is at least 30 days in arrears;

(b) (2) the obligee serves a copy of an affidavit of default and notice of intent to enter and docket judgment on the obligor by first class mail at the obligor's last known post office address. Service shall be deemed complete upon mailing in the manner designated. The affidavit shall state the full name, occupation, place of residence, and last known post office address of the obligor, the name and post office address of the obligee, the date of the first unpaid amount, the date of the last unpaid amount, and the total amount unpaid;

(c) (3) the obligor fails within 20 days after mailing of the notice either to pay all unpaid amounts or to request a hearing on the issue of whether arrears claimed owing have been paid and to seek, ex parte, a stay of entry of judgment; and

(4) not less than 20 days after service on the obligor in the manner provided, the obligee files with the court administrator the affidavit of default together with proof of service and, if payments have been received by the obligee since execution of the affidavit of default, a supplemental affidavit setting forth the amount of payment received and the amount for which judgment is to be entered and docketed.

(b) A judgment entered and docketed under this subdivision has the same effect and is subject to the same procedures, defenses, and proceedings as any other judgment in district court, and may be enforced or satisfied in the same manner as judgments under section 548.09.

(c) An obligor whose property is subject to the lien of a judgment for installment of periodic payments of maintenance under section 548.09, and who claims that no amount of maintenance is in arrears, may move the court ex parte for an order directing the court administrator to vacate the lien of the judgment on the docket and register of the action where it was entered. The obligor shall file with the motion an affidavit stating:

- (1) the lien attached upon the docketing of a judgment or decree of dissolution or separate maintenance;
- (2) the docket was made while no installment or periodic payment of maintenance was unpaid or overdue; and
- (3) no installment or periodic payment of maintenance that was due prior to the filing of the motion remains unpaid or overdue.

The court shall grant the obligor's motion as soon as possible if the pleadings and affidavit show that there is and has been no default.

Sec. 15. Minnesota Statutes 1998, 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 260.251, 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 ~~and~~, 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.

Sec. 16. Minnesota Statutes 1998, section 548.091, subdivision 2a, is amended to read:

Subd. 2a. [ENTRY AND DOCKETING OF CHILD SUPPORT JUDGMENT.] (a) On or after the date an unpaid amount becomes a judgment by operation of law under subdivision 1a, the obligee or the public authority may file with the court administrator, ~~either electronically or by other means:~~

(1) a statement identifying, or a copy of, the judgment or decree of dissolution or legal separation, determination of parentage, order under chapter ~~518B or~~ 518C, an order under section 256.87, an order under section 260.251, or judgment, decree, or order for child support by a court in any other state, which provides for periodic installments of child support, or a judgment or notice of attorney fees and collection costs under section 518.14, subdivision 2;

(2) an affidavit of default. The affidavit of default must state the full name, occupation, place of residence, and last known post office address of the obligor, the name and post office address of the obligee, the date or dates payment was due and not received and judgment was obtained by operation of law, the total amount of the judgments to the date of filing, and the amount and frequency of the periodic installments of child support that will continue to become due and payable subsequent to the date of filing be entered and docketed; and

(3) an affidavit of service of a notice of intent to enter and docket judgment and to recover attorney fees and collection costs on the obligor, in person or by first class mail at the obligor's last known post office address. Service is completed upon mailing in the manner designated. Where applicable, a notice of interstate lien in the form promulgated under United States Code, title 42, section 652(a), is sufficient to satisfy the requirements of clauses (1) and (2).

(b) A judgment entered and docketed under this subdivision has the same effect and is subject to the same procedures, defenses, and proceedings as any other judgment in district court, and may be enforced or satisfied in the same manner as judgments under section 548.09, except as otherwise provided.

Sec. 17. Minnesota Statutes 1998, section 548.091, subdivision 3a, is amended to read:

Subd. 3a. [ENTRY, DOCKETING, AND SURVIVAL OF CHILD SUPPORT JUDGMENT.] Upon receipt of the documents filed under subdivision 2a, the court administrator shall enter and docket the judgment in the amount of the unpaid obligation identified in the affidavit of default, ~~and note the amount and frequency of the periodic installments of child support that will continue to become due and payable after the date of docketing. From the time of docketing, the judgment is a lien upon all the real property in the county owned by the judgment debtor, but it is not a lien on registered land unless the obligee or the public authority causes a notice of judgment lien or certified copy of the judgment to be memorialized on the certificate of title or certificate of possessory title under section 508.63 or 508A.63. The judgment survives and the lien continues for ten years after the date the judgment was docketed.~~

Subd. 3b. [CHILD SUPPORT JUDGMENT ADMINISTRATIVE RENEWALS.] Child support judgments may be renewed by service of notice upon the debtor. Service ~~shall~~ must be by certified first class mail at the last known address of the debtor, with service deemed complete upon mailing in the manner designated, or in the manner provided for the service of civil process. Upon the filing of the notice and proof of service, the court administrator shall administratively renew the judgment for child support without any additional filing fee in the same court file as the original child support judgment. The judgment must be renewed in an amount equal to the unpaid principle plus the accrued unpaid interest. Child support judgments may be renewed multiple times until paid.

Sec. 18. Minnesota Statutes 1998, section 548.091, subdivision 4, is amended to read:

Subd. 4. [CHILD SUPPORT HEARING.] A child support obligor may request a hearing under the rules of civil procedure on the issue of whether the judgment amount or amounts have been paid and may move the court for an order directing the court administrator to vacate or modify the judgment or judgments ~~on the docket and register in any county or other jurisdiction in which judgment or judgments were~~ entered pursuant to this action.

The court shall grant the obligor's motion if it determines that there is no default.

Sec. 19. Minnesota Statutes 1998, section 548.091, is amended by adding a subdivision to read:

Subd. 5a. [ADDITIONAL CHILD SUPPORT JUDGMENTS.] As child support payments continue to become due and are unpaid, additional judgments may be entered and docketed by following the procedures in subdivision 1a. Each judgment entered and docketed for unpaid child support payments must be treated as a distinct judgment for purposes of enforcement and satisfaction.

Sec. 20. Minnesota Statutes 1998, section 548.091, subdivision 10, is amended to read:

~~Subd. 10. [RELEASE OF LIEN.] Upon payment of the amount due under subdivision 5, the public authority shall execute and deliver a satisfaction of the judgment lien within five business days.~~

Sec. 21. Minnesota Statutes 1998, section 548.091, subdivision 11, is amended to read:

Subd. 11. [SPECIAL PROCEDURES.] The public authority shall negotiate a release of lien on specific property for less than the full amount due where the proceeds of a sale or financing, less reasonable and necessary closing expenses, are not sufficient to satisfy all encumbrances on the lien property. Partial releases do not release the obligor's personal liability for the amount unpaid. A partial satisfaction for the amount received must be filed with the court administrator.

Sec. 22. Minnesota Statutes 1998, section 548.091, subdivision 12, is amended to read:

Subd. 12. [CORRECTING ERRORS.] The public authority shall maintain a process to review the identity of the obligor and to issue releases of lien in cases of misidentification. The public authority shall maintain a process to review the amount of child support determined to be delinquent and to issue amended notices of judgment lien in cases of incorrectly docketed judgments arising by operation of law. The public authority may move the court for an order to amend the judgment when the amount of judgment entered and docketed is incorrect.

Sec. 23. Minnesota Statutes 1998, section 552.05, subdivision 10, is amended to read:

~~Subd. 10. [FORMS.] The commissioner of human services shall develop statutory forms for use as required under this chapter. In developing these forms, the commissioner shall consult with the attorney general, representatives of financial institutions, and legal services. The commissioner shall report back to the legislature by February 1, 1998, with recommended forms to be included in this chapter. The supreme court is requested to develop forms for use in proceedings under this chapter.~~

Sec. 24. Laws 1995, chapter 257, article 1, section 35, subdivision 1, is amended to read:

~~Subdivision 1. [CHILD SUPPORT ASSURANCE.] The commissioner of human services shall seek a waiver from the secretary of the United States Department of Health and Human Services to enable the department of human services to operate a demonstration project of child support assurance. The commissioner shall seek authority from the legislature to implement a demonstration project of child support assurance when enhanced federal funds become available for this purpose. The department of human services shall continue to plan a demonstration project of child support assurance by administering the grant awarded under the federal program entitled "Developing a Plan for a Child Support Assurance Program."~~

Sec. 25. [REPEALER.]

Minnesota Statutes 1998, section 548.091, subdivisions 3, 5, and 6, are repealed.

ARTICLE 8

HEALTH OCCUPATIONS

Section 1. [144E.37] [COMPREHENSIVE ADVANCED LIFE SUPPORT.]

The board shall establish a comprehensive advanced life support educational program to train rural medical personnel, including physicians, physician assistants, nurses, and allied health care providers, in a team approach to anticipate, recognize, and treat life-threatening emergencies before serious injury or cardiac arrest occurs.

ARTICLE 9

CHILD PROTECTION

Section 1. Minnesota Statutes 1998, 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, education, and welfare 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, Minnesota family investment program-statewide, 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, MFIP-S, and AFDC programs, 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, MFIP-S, 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 senior citizen 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. 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.

Sec. 2. Minnesota Statutes 1998, section 256B.094, subdivision 3, is amended to read:

Subd. 3. [COORDINATION AND PROVISION OF SERVICES.] (a) In a county or reservation where a prepaid medical assistance provider has contracted under section 256B.031 or 256B.69 to provide mental health services, the case management provider shall coordinate with the prepaid provider to ensure that all necessary mental health services required under the contract are provided to recipients of case management services.

(b) When the case management provider determines that a prepaid provider is not providing mental health services as required under the contract, the case management provider shall assist the recipient to appeal the prepaid provider's denial pursuant to section 256.045, and may make other arrangements for provision of the covered services.

(c) The case management provider may bill the provider of prepaid health care services for any mental health services provided to a recipient of case management services which the county or tribal social services arranges for or provides and which are included in the prepaid provider's contract, and which were determined to be medically necessary as a result of an appeal pursuant to section 256.045. The prepaid provider must reimburse the mental health provider, at the prepaid provider's standard rate for that service, for any services delivered under this subdivision.

(d) If the county or tribal social services has not obtained prior authorization for this service, or an appeal results in a determination that the services were not medically necessary, the county or tribal social services may not seek reimbursement from the prepaid provider.

Sec. 3. Minnesota Statutes 1998, section 256B.094, subdivision 5, is amended to read:

Subd. 5. [CASE MANAGER.] To provide case management services, a case manager must be employed or contracted by and authorized by the case management provider to provide case management services and meet all requirements under section 256F.10.

Sec. 4. Minnesota Statutes 1998, section 256B.094, subdivision 6, is amended to read:

Subd. 6. [MEDICAL ASSISTANCE REIMBURSEMENT OF CASE MANAGEMENT SERVICES.] (a) Medical assistance reimbursement for services under this section shall be made on a monthly basis. Payment is based on face-to-face or telephone contacts between the case manager and the client, client's family, primary caregiver, legal representative, or other relevant person identified as necessary to the development or implementation of the goals of the individual service plan regarding the status of the client, the individual service plan, or the goals for the client. These contacts must meet the minimum standards in clauses (1) and (2):

(1) there must be a face-to-face contact at least once a month except as provided in clause (2); and

(2) for a client placed outside of the county of financial responsibility in an excluded time facility under section 256G.02, subdivision 6, or through the Interstate Compact on the Placement of Children, section 257.40, and the placement in either case is more than 60 miles beyond the county boundaries, there must be at least one contact per month and not more than two consecutive months without a face-to-face contact.

(b) Except as provided under paragraph (c), the payment rate is established using time study data on activities of provider service staff and reports required under sections 245.482, 256.01, subdivision 2, paragraph (17), and 256E.08, subdivision 8.

(c) Payments for tribes may be made according to section 256B.0625 for child welfare targeted case management provided by Indian health services and facilities operated by a tribe or tribal organization.

(d) Payment for case management provided by county or tribal social services contracted vendors shall be based on a monthly rate negotiated by the host county or tribal social services. 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 tribal social services 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 tribal social services, except to reimburse the county or tribal social services for advance funding provided by the county or tribal social services to the vendor.

(e) If the service is provided by a team that includes contracted vendors and county or tribal social services staff, the costs for county or tribal social services staff participation in the team shall be included in the rate for county or tribal social services provided services. In this case, the contracted vendor and the county or tribal social services may each receive separate payment for services provided by each entity in the same month. To prevent duplication of services, each entity must document, in the recipient's file, the need for team case management and a description of the roles and services of the team members.

Separate payment rates may be established for different groups of providers to maximize reimbursement as determined by the commissioner. The payment rate will be reviewed annually and revised periodically to be consistent with the most recent time study and other data. Payment for services will be made upon submission of a valid claim and verification of proper documentation described in subdivision 7. Federal administrative revenue earned through the time study, or under paragraph (c), shall be distributed according to earnings, to counties, reservations, or groups of counties or reservations which have the same payment rate under this subdivision, and to the group of counties or reservations which are not certified providers under section 256F.10. The commissioner shall modify the requirements set out in Minnesota Rules, parts 9550.0300 to 9550.0370, as necessary to accomplish this.

Sec. 5. Minnesota Statutes 1998, section 256F.03, subdivision 5, is amended to read:

Subd. 5. [FAMILY-BASED SERVICES.] "Family-based services" means one or more of the services described in paragraphs (a) to ~~(f)~~ (e) provided to families primarily in their own home for a limited time.

(a) [CRISIS SERVICES.] "Crisis services" means professional services provided within 24 hours of referral to alleviate a family crisis and to offer an alternative to placing a child outside the family home. The services are intensive and time limited. The service may offer transition to other appropriate community-based services.

(b) [COUNSELING SERVICES.] "Counseling services" means professional family counseling provided to alleviate individual and family dysfunction; provide an alternative to placing a child outside the family home; or permit a child to return home. The duration, frequency, and intensity of the service is determined in the individual or family service plan.

(c) [LIFE MANAGEMENT SKILLS SERVICES.] "Life management skills services" means paraprofessional services that teach family members skills in such areas as parenting, budgeting, home management, and communication. The goal is to strengthen family skills as an alternative to placing a child outside the family home or to permit a child to return home. A social worker shall coordinate these services within the family case plan.

~~(d) [CASE COORDINATION SERVICES.] "Case coordination services" means professional services provided to an individual, family, or caretaker as an alternative to placing a child outside the family home, to permit a child to return home, or to stabilize the long-term or permanent placement of a child. Coordinated services are provided directly, are arranged, or are monitored to meet the needs of a child and family. The duration, frequency, and intensity of services is determined in the individual or family service plan.~~

~~(e)~~ [MENTAL HEALTH SERVICES.] "Mental health services" means the professional services defined in section 245.4871, subdivision 31.

~~(f)~~ (e) [EARLY INTERVENTION SERVICES.] "Early intervention services" means family-based intervention services designed to help at-risk families avoid crisis situations.

Sec. 6. Minnesota Statutes 1998, section 256F.05, subdivision 8, is amended to read:

Subd. 8. [USES OF FAMILY PRESERVATION FUND GRANTS.] (a) A county which has not demonstrated that year that its family preservation core services are developed as provided in subdivision 1a, must use its family preservation fund grant exclusively for family preservation services defined in section 256F.03, subdivision 5, paragraphs (a), (b), (c), and ~~(e)~~ (d).

(b) A county which has demonstrated that year that its family preservation core services are developed becomes eligible either to continue using its family preservation fund grant as provided in paragraph (a), or to exercise the expanded service option under paragraph (c).

(c) The expanded service option permits an eligible county to use its family preservation fund grant for child welfare preventive services. For purposes of this section, child welfare preventive services are those services directed toward a specific child or family that further the goals of section 256F.01 and include assessments, family preservation services, service coordination, community-based treatment, crisis nursery services when the parents retain custody and there is no voluntary placement agreement with a child-placing agency, respite care except when it is provided under a medical assistance waiver, home-based services, and other related services. For purposes of this section, child welfare preventive services shall not include shelter care or other placement services under the authority of the court or public agency to address an emergency. To exercise this option, an eligible county must notify the commissioner in writing of its intention to do so ~~no later than 30 days into the quarter during which it intends to begin~~ or select this option in its county plan, as provided in section 256F.04, subdivision 2. Effective with the first day of ~~that quarter~~ the grant period in which this option is selected, the county must maintain its base level of expenditures for child welfare preventive services and use the family preservation fund to expand them. The base level of expenditures for a county shall be that established under section 256F.10, subdivision 7. For counties which have no such base established, a comparable base shall be established with the base year being the calendar year ending at least two calendar quarters before the first calendar quarter in which the county exercises its expanded service option. The commissioner shall, at the request of the counties, reduce, suspend, or eliminate either or both of a county's obligations to continue the base level of expenditures and to expand child welfare preventive services under extraordinary circumstances.

(d) Notwithstanding paragraph (a), a county that is participating in the child protection assessments or investigations community collaboration pilot program under section 626.5560, or in the concurrent permanency planning pilot program under section 257.0711, may use its family preservation fund grant for those programs.

Sec. 7. Minnesota Statutes 1998, section 256F.10, subdivision 1, is amended to read:

Subdivision 1. [ELIGIBILITY.] Persons under 21 years of age who are eligible to receive medical assistance are eligible for child welfare targeted case management services under section 256B.094 and this section if they have received an assessment and have been determined by the local county or tribal social services agency to be:

- (1) at risk of placement or in placement as described in section 257.071, subdivision 1;
- (2) at risk of maltreatment or experiencing maltreatment as defined in section 626.556, subdivision 10e; or
- (3) in need of protection or services as defined in section 260.015, subdivision 2a.

Sec. 8. Minnesota Statutes 1998, section 256F.10, subdivision 4, is amended to read:

Subd. 4. [PROVIDER QUALIFICATIONS AND CERTIFICATION STANDARDS.] The commissioner must certify each provider before enrolling it as a child welfare targeted case management provider of services under section 256B.094 and this section. The certification process shall examine the provider's ability to meet the qualification requirements and certification standards in this subdivision and other federal and state requirements of this service. A certified child welfare targeted case management provider is an enrolled medical assistance provider who is determined by the commissioner to have all of the following:

(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) administrative capacity and experience in serving the target population for whom it will provide services and in ensuring 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.

Sec. 9. Minnesota Statutes 1998, section 256F.10, subdivision 6, is amended to read:

Subd. 6. [DISTRIBUTION OF NEW FEDERAL REVENUE.] (a) Except for portion set aside in paragraph (b), the federal funds earned under this section and section 256B.094 by ~~counties~~ providers shall be paid to each ~~county~~ provider based on its earnings, and must be used by each ~~county~~ provider to expand preventive child welfare services.

If a county or tribal social services chooses to be a provider of child welfare targeted case management and if that county or tribal social services also joins a local children's mental health collaborative as authorized by the 1993 legislature, then the federal reimbursement received by the county or tribal social services for providing child welfare targeted case management services to children served by the local collaborative shall be transferred by the county or tribal social services to the integrated fund. The federal reimbursement transferred to the integrated fund by the county or tribal social services must not be used for residential care other than respite care described under subdivision 7, paragraph (d).

(b) 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 sections 256.8711 and 256B.094;

(2) programming the information systems; and

(3) the lost federal revenue for the central office claim directly caused by the implementation of these sections.

Any unexpended funds from the set aside under this paragraph shall be distributed to ~~counties~~ providers according to paragraph (a).

Sec. 10. Minnesota Statutes 1998, section 256F.10, subdivision 7, is amended to read:

Subd. 7. [EXPANSION OF SERVICES AND BASE LEVEL OF EXPENDITURES.] (a) Counties and tribal social services must continue the base level of expenditures for preventive child welfare services from either or both of any state, county, or federal funding source, which, in the absence of federal funds earned under this section, would have been available for these services. The commissioner shall review the county or tribal social services expenditures annually using reports required under sections 245.482, 256.01, subdivision 2, paragraph 17, and 256E.08, subdivision 8, to ensure that the base level of expenditures for preventive child welfare services is continued from sources other than the federal funds earned under this section.

(b) The commissioner may reduce, suspend, or eliminate either or both of a county's or tribal social services' obligations to continue the base level of expenditures and to expand child welfare preventive services if the commissioner determines that one or more of the following conditions apply to that county or reservation:

(1) imposition of levy limits that significantly reduce available social service funds;

(2) reduction in the net tax capacity of the taxable property within a county or reservation that significantly reduces available social service funds;

(3) reduction in the number of children under age 19 in the county or reservation by 25 percent when compared with the number in the base year using the most recent data provided by the state demographer's office; or

(4) termination of the federal revenue earned under this section.

(c) The commissioner may suspend for one year either or both of a county's or tribal social services' obligations to continue the base level of expenditures and to expand child welfare preventive services if the commissioner determines that in the previous year one or more of the following conditions applied to that county or reservation:

(1) the total number of children in placement under sections 257.071 and 393.07, subdivisions 1 and 2, has been reduced by 50 percent from the total number in the base year; or

(2) the average number of children in placement under sections 257.071 and 393.07, subdivisions 1 and 2, on the last day of each month is equal to or less than one child per 1,000 children in the county or reservation.

(d) For the purposes of this section, child welfare preventive services are those services directed toward a specific child or family that further the goals of section 256F.01 and include assessments, family preservation services, service coordination, community-based treatment, crisis nursery services when the parents retain custody and there is no voluntary placement agreement with a child-placing agency, respite care except when it is provided under a medical assistance waiver, home-based services, and other related services. For the purposes of this section, child welfare preventive services shall not include shelter care placements under the authority of the court or public agency to address an emergency, residential services except for respite care, child care for the purposes of employment and training, adult services, services other than child welfare targeted case management when they are provided under medical assistance, placement services, or activities not directed toward a specific child or family. Respite care must be planned, routine care to support the continuing residence of the child with its family or long-term primary caretaker and must not be provided to address an emergency.

(e) For the counties and tribal social services beginning to claim federal reimbursement for services under this section and section 256B.094, the base year is the calendar year ending at least two calendar quarters before the first calendar quarter in which the county provider begins claiming reimbursement. For the purposes of this section, the base level of expenditures is the level of county or tribal social services expenditures in the base year for eligible child welfare preventive services described in this subdivision.

Sec. 11. Minnesota Statutes 1998, section 256F.10, subdivision 8, is amended to read:

Subd. 8. [PROVIDER RESPONSIBILITIES.] (a) Notwithstanding section 256B.19, subdivision 1, for the purposes of child welfare targeted case management under section 256B.094 and this section, the nonfederal share of costs shall be provided by the provider of child welfare targeted case management from sources other than federal funds or funds used to match other federal funds except when allowed by federal law or agreement.

(b) Provider expenditures eligible for federal reimbursement under this section must not be made from federal funds or funds used to match other federal funds except when allowed by federal law or agreement.

(c) The commissioner may suspend, reduce, or terminate the federal reimbursement to a provider that does not meet the reporting or other requirements of section 256B.094 and this section. The county or reservation is responsible for any federal disallowances. The county or reservation may share this responsibility with its contracted vendors.

Sec. 12. Minnesota Statutes 1998, section 256F.10, subdivision 10, is amended to read:

Subd. 10. [CENTRALIZED DISBURSEMENT OF MEDICAL ASSISTANCE PAYMENTS.] Notwithstanding section 256B.041, county provider payments for the cost of child welfare targeted case management services shall not be made to the state treasurer. For the purposes of child welfare targeted case management services under section 256B.094 and this section, the centralized disbursement of payments to providers under section 256B.041 consists only of federal earnings from services provided under section 256B.094 and this section.

Sec. 13. Minnesota Statutes 1998, section 257.071, subdivision 1, is amended to read:

Subdivision 1. [PLACEMENT; PLAN.] (a) A case plan shall be prepared within 30 days after any child is placed in a residential facility by court order or by the voluntary release of the child by the parent or parents.

For purposes of this section, a residential facility means any group home, family foster home or other publicly supported out-of-home residential facility, including any out-of-home residential facility under contract with the state, county or other political subdivision, or any agency thereof, to provide those services or foster care as defined in section 260.015, subdivision 7.

(b) When a child is in placement, the responsible local social services agency shall make diligent efforts to identify, locate, and, where appropriate, offer services to both parents of the child. If a noncustodial or nonadjudicated parent is willing and capable of providing for the day-to-day care of the child, the local social services agency may seek authority from the custodial parent or the court to have that parent assume day-to-day care of the child. If a parent is not an adjudicated parent, the local social services agency shall require the nonadjudicated parent to cooperate with paternity establishment procedures as part of the case plan.

(c) If, after assessment, the local social services agency determines that the child cannot be in the day-to-day care of either parent, the agency shall prepare a case plan addressing the conditions that each parent must mitigate before the child could be in that parent's day-to-day care.

(d) If, after the provision of services following a case plan under this section and ordered by the juvenile court, the child cannot return to the care of the parent from whom the child was removed or who had legal custody at the time the child was placed in foster care, the agency may petition on behalf of a noncustodial parent to establish legal custody with that parent under section 260.191, subdivision 3b. If paternity has not already been established, it may be established in the same proceeding in the manner provided for under this chapter.

The responsible social services agency may be relieved of the requirement to locate and offer services to both parents by the juvenile court upon a finding of good cause after the filing of a petition under section 260.131.

(e) For the purposes of this section, a case plan means a written document which is ordered by the court or which is prepared by the social ~~service~~ services agency responsible for the residential facility placement and is signed by the parent or parents, or other custodian, of the child, the child's legal guardian, the social ~~service~~ services agency responsible for the residential facility placement, and, if possible, the child. The document shall be explained to all persons involved in its implementation, including the child who has signed the document, and shall set forth:

(1) the specific reasons for the placement of the child in a residential facility, including a description of the problems or conditions in the home of the parent or parents which necessitated removal of the child from home;

(2) the specific actions to be taken by the parent or parents of the child to eliminate or correct the problems or conditions identified in clause (1), and the time period during which the actions are to be taken;

(3) the financial responsibilities and obligations, if any, of the parents for the support of the child during the period the child is in the residential facility;

(4) the visitation rights and obligations of the parent or parents or other relatives as defined in section 260.181, if such visitation is consistent with the best interest of the child, during the period the child is in the residential facility;

(5) the social and other supportive services to be provided to the parent or parents of the child, the child, and the residential facility during the period the child is in the residential facility;

(6) the date on which the child is expected to be returned to and safely maintained in the home of the parent or parents or placed for adoption or otherwise permanently removed from the care of the parent by court order;

(7) the nature of the effort to be made by the social ~~service~~ services agency responsible for the placement to reunite the family; ~~and~~

(8) notice to the parent or parents;

(i) that placement of the child in foster care may result in termination of parental rights but only after notice and a hearing as provided in chapter 260; and

(ii) in cases where the agency has determined that both reasonable efforts to reunify the child with the parents, and reasonable efforts to place the child in a permanent home away from the parent that may become legally permanent are appropriate, notice of:

(A) time limits on the length of placement and of reunification services;

(B) the nature of the services available to the parent;

(C) the consequences to the parent and the child if the parent fails or is unable to use services to correct the circumstances that led to the child's placement;

(D) the first consideration for relative placement; and

(E) the benefit to the child in getting the child out of residential care as soon as possible, preferably by returning the child home, but if that is not possible, through legally permanent placement of the child away from the parent;

(9) a permanency hearing under section 260.191, subdivision 3b, or a termination of parental rights hearing under sections 260.221 to 260.245, where the agency asks the court to find that the child should be permanently placed away from the parent and includes documentation of the steps taken by the responsible social services agency to find an adoptive family or other legally permanent living arrangement for the child, to place the child with an adoptive family, a fit and willing relative through an award of permanent legal and physical custody, or in another planned and legally permanent living arrangement. The documentation must include child-specific recruitment efforts; and

(10) if the court has issued an order terminating the rights of both parents of the child or of the only known, living parent of the child, documentation of steps to finalize the adoption or legal guardianship of the child.

(f) The parent or parents and the child each shall have the right to legal counsel in the preparation of the case plan and shall be informed of the right at the time of placement of the child. The child shall also have the right to a guardian ad litem. If unable to employ counsel from their own resources, the court shall appoint counsel upon the request of the parent or parents or the child or the child's legal guardian. The parent or parents may also receive assistance from any person or social ~~service~~ services agency in preparation of the case plan.

After the plan has been agreed upon by the parties involved, the foster parents shall be fully informed of the provisions of the case plan and shall be provided a copy of the plan.

(g) When an agency accepts a child for placement, the agency shall determine whether the child has had a physical examination by or under the direction of a licensed physician within the 12 months immediately preceding the date when the child came into the agency's care. If there is documentation that the child has had such an examination within the last 12 months, the agency is responsible for seeing that the child has another physical examination within one year of the documented examination and annually in subsequent years. If the agency determines that the child has not had a physical examination within the 12 months immediately preceding placement, the agency shall ensure that the child has the examination within 30 days of coming into the agency's care and once a year in subsequent years.

Sec. 14. Minnesota Statutes 1998, section 257.071, subdivision 1d, is amended to read:

Subd. 1d. [RELATIVE SEARCH; NATURE.] (a) As soon as possible, but in any event within six months after a child is initially placed in a residential facility, the local social services agency shall identify any relatives of the child and notify them of the need for a foster care home for the child and of the possibility of the need for a permanent out-of-home placement of the child. Relatives should also be notified that a decision not to be a placement resource at the beginning of the case may affect the relative being considered for placement of the child with that relative later. The relatives must be notified that they must keep the local social services agency informed of their current address in order to receive notice that a permanent placement is being sought for the child. A relative who fails to provide a current address to the local social services agency forfeits the right to notice of the possibility of permanent placement. If the child's parent refuses to give the responsible social services agency information sufficient to identify relatives of the child, the agency shall determine whether the parent's refusal is in the child's best interests. If the agency determines the parent's refusal is not in the child's best interests, the agency shall file a petition under section 260.131, and shall ask the juvenile court to order the parent to provide the necessary information.

(b) Unless required under the Indian Child Welfare Act or relieved of this duty by the court because the child is placed with an appropriate relative who wishes to provide a permanent home for the child or the child is placed with a foster home that has committed to being the legally permanent placement for the child and the responsible social services agency approves of that foster home for permanent placement of the child, when the agency determines that it is necessary to prepare for the permanent placement determination hearing, or in anticipation of filing a termination of parental rights petition, the agency shall send notice to the relatives, any adult with whom the child is currently residing, any adult with whom the child has resided for one year or longer in the past, and any adults who have maintained a relationship or exercised visitation with the child as identified in the agency case plan. The notice must state that a permanent home is sought for the child and that the individuals receiving the notice may indicate to the agency their interest in providing a permanent home. The notice must state that within 30 days of receipt of the notice an individual receiving the notice must indicate to the agency the individual's interest in providing a permanent home for the child or that the individual may lose the opportunity to be considered for a permanent placement. This notice need not be sent if the child is placed with an appropriate relative who wishes to provide a permanent home for the child.

Sec. 15. Minnesota Statutes 1998, section 257.071, subdivision 4, is amended to read:

Subd. 4. [REVIEW OF DEVELOPMENTALLY DISABLED AND EMOTIONALLY HANDICAPPED CHILD PLACEMENTS.] If a developmentally disabled child, as that term is defined in United States Code, title 42, section 6001 (7), as amended through December 31, 1979, or a child diagnosed with an emotional handicap as defined in section 252.27, subdivision 1a, has been placed in a residential facility pursuant to a voluntary release by the child's parent or parents because of the child's handicapping conditions or need for long-term residential treatment or supervision, the social ~~service~~ services agency responsible for the placement shall bring a petition for review of the child's foster care status, pursuant to section 260.131, ~~subdivision 1a, rather than a~~ after the child has been in placement for six months. If a child is in placement due solely to the child's handicapping condition and custody of the child is not transferred to the responsible social services agency under section 260.191, subdivision 1, paragraph (a), clause (2), no petition ~~as is~~ is required by section 260.191, subdivision 3b, ~~after the child has been in foster care for six months or, in the case of a child with an emotional handicap, after the child has been in a residential facility for six months.~~ Whenever a petition for review is brought pursuant to this subdivision, a guardian ad litem shall be appointed for the child.

Sec. 16. Minnesota Statutes 1998, section 257.85, subdivision 2, is amended to read:

Subd. 2. [SCOPE.] The provisions of this section apply to those situations in which the legal and physical custody of a child is established with a relative or important friend with whom the child has resided or had significant contact according to section 260.191, subdivision 3b, by a court order issued on or after July 1, 1997.

Sec. 17. Minnesota Statutes 1998, section 257.85, subdivision 3, is amended to read:

Subd. 3. [DEFINITIONS.] For purposes of this section, the terms defined in this subdivision have the meanings given them.

(a) "~~AFDC or MFIP standard~~" means the ~~monthly standard of need used to calculate assistance under the AFDC program, the transitional standard used to calculate assistance under the MFIP-S program, or, if neither of those is applicable~~ permanent legal and physical custody of the child is given to a relative custodian residing outside of Minnesota, the analogous transitional standard or standard of need used to calculate assistance under the MFIP or MFIP-R programs TANF program of the state where the relative custodian lives.

(b) "Local agency" means the local social ~~service~~ services agency with legal custody of a child prior to the transfer of permanent legal and physical custody ~~to a relative.~~

(c) "Permanent legal and physical custody" means permanent legal and physical custody ordered by a Minnesota juvenile court under section 260.191, subdivision 3b.

(d) "Relative" ~~means an individual, other than a parent, who is related to a child by blood, marriage, or adoption~~ has the meaning given in section 260.015, subdivision 13.

(e) "Relative custodian" means a ~~relative of a child for whom the relative~~ person who has permanent legal and physical custody of a child. When siblings, including half-siblings and step siblings, are placed together in the permanent legal and physical custody ~~of a relative of one of the siblings,~~ the person receiving permanent legal and physical custody of the siblings is considered a relative custodian of all of the siblings for purposes of this section.

(f) "Relative custody assistance agreement" means an agreement entered into between a local agency and ~~the~~ relative of a child person who has been or will be awarded permanent legal and physical custody of ~~the~~ a child.

(g) "Relative custody assistance payment" means a monthly cash grant made to a relative custodian pursuant to a relative custody assistance agreement and in an amount calculated under subdivision 7.

(h) "Remains in the physical custody of the relative custodian" means that the relative custodian is providing day-to-day care for the child and that the child lives with the relative custodian; absence from the relative custodian's home for a period of more than 120 days raises a presumption that the child no longer remains in the physical custody of the relative custodian.

Sec. 18. Minnesota Statutes 1998, section 257.85, subdivision 7, is amended to read:

Subd. 7. [AMOUNT OF RELATIVE CUSTODY ASSISTANCE PAYMENTS.] (a) The amount of a monthly relative custody assistance payment shall be determined according to the provisions of this paragraph.

(1) The total maximum assistance rate is equal to the base assistance rate plus, if applicable, the supplemental assistance rate.

(i) The base assistance rate is equal to the maximum amount that could be received as basic maintenance for a child of the same age under the adoption assistance program.

(ii) The local agency shall determine whether the child has physical, mental, emotional, or behavioral disabilities that require care, supervision, or structure beyond that ordinarily provided in a family setting to children of the same age such that the child would be eligible for supplemental maintenance payments under the adoption assistance program if an adoption assistance agreement were entered on the child's behalf. If the local agency determines that the child has such a disability, the supplemental assistance rate shall be the maximum amount of monthly supplemental maintenance payment that could be received on behalf of a child of the same age, disabilities, and circumstances under the adoption assistance program.

(2) The net maximum assistance rate is equal to the total maximum assistance rate from clause (1) less the following offsets:

(i) if the child is or will be part of an assistance unit receiving an ~~AFDC, MFIP-S, or other MFIP grant~~ or a grant from a similar program of another state, the portion of the ~~AFDC or MFIP~~ standard relating to the child as calculated under paragraph (b), clause (2);

(ii) Supplemental Security Income payments received by or on behalf of the child;

(iii) veteran's benefits received by or on behalf of the child; and

(iv) any other income of the child, including child support payments made on behalf of the child.

(3) The relative custody assistance payment to be made to the relative custodian shall be a percentage of the net maximum assistance rate calculated in clause (2) based upon the gross income of the relative custodian's family, including the child for whom the relative custodian has permanent legal and physical custody. In no case shall the amount of the relative custody assistance payment exceed that which the child could qualify for under the adoption assistance program if an adoption assistance agreement were entered on the child's behalf. The relative custody assistance payment shall be calculated as follows:

(i) if the relative custodian's gross family income is less than or equal to 200 percent of federal poverty guidelines, the relative custody assistance payment shall be the full amount of the net maximum assistance rate;

(ii) if the relative custodian's gross family income is greater than 200 percent and less than or equal to 225 percent of federal poverty guidelines, the relative custody assistance payment shall be 80 percent of the net maximum assistance rate;

(iii) if the relative custodian's gross family income is greater than 225 percent and less than or equal to 250 percent of federal poverty guidelines, the relative custody assistance payment shall be 60 percent of the net maximum assistance rate;

(iv) if the relative custodian's gross family income is greater than 250 percent and less than or equal to 275 percent of federal poverty guidelines, the relative custody assistance payment shall be 40 percent of the net maximum assistance rate;

(v) if the relative custodian's gross family income is greater than 275 percent and less than or equal to 300 percent of federal poverty guidelines, the relative custody assistance payment shall be 20 percent of the net maximum assistance rate; or

(vi) if the relative custodian's gross family income is greater than 300 percent of federal poverty guidelines, no relative custody assistance payment shall be made.

(b) ~~This paragraph specifies the provisions pertaining to the relationship between relative custody assistance and AFDC, MFIP-S, or other MFIP programs.~~ The following provisions cover the relationship between relative custody assistance and assistance programs:

(1) The relative custodian of a child for whom the relative custodian is receiving relative custody assistance is expected to seek whatever assistance is available for the child through ~~the AFDC, MFIP-S, or other MFIP,~~ if the relative custodian resides in a state other than Minnesota, or similar programs of that state. If a relative custodian fails to apply for assistance through ~~AFDC, MFIP-S, or other MFIP~~ program for which the child is eligible, the child's portion of the ~~AFDC or MFIP~~ standard will be calculated as if application had been made and assistance received;

(2) The portion of the ~~AFDC or MFIP~~ standard relating to each child for whom relative custody assistance is being received shall be calculated as follows:

(i) determine the total ~~AFDC or MFIP~~ standard for the assistance unit;

(ii) determine the amount that the ~~AFDC or MFIP~~ standard would have been if the assistance unit had not included the children for whom relative custody assistance is being received;

(iii) subtract the amount determined in item (ii) from the amount determined in item (i); and

(iv) divide the result in item (iii) by the number of children for whom relative custody assistance is being received that are part of the assistance unit; ~~or,~~

(3) If a child for whom relative custody assistance is being received is not eligible for assistance through ~~the AFDC, MFIP-S, or other MFIP~~ similar programs of another state, the portion of ~~AFDC or MFIP~~ standard relating to that child shall be equal to zero.

Sec. 19. Minnesota Statutes 1998, section 257.85, subdivision 9, is amended to read:

Subd. 9. [RIGHT OF APPEAL.] A relative custodian who enters or seeks to enter into a relative custody assistance agreement with a local agency has the right to appeal to the commissioner according to section 256.045 when the local agency establishes, denies, terminates, or modifies the agreement. Upon appeal, the commissioner may review only:

(1) whether the local agency has met the legal requirements imposed by this chapter for establishing, denying, terminating, or modifying the agreement;

(2) whether the amount of the relative custody assistance payment was correctly calculated under the method in subdivision 7;

(3) whether the local agency paid for correct time periods under the relative custody assistance agreement;

(4) whether the child remains in the physical custody of the relative custodian;

(5) whether the local agency correctly ~~calculated~~ modified the amount of the supplemental assistance rate based on a change in the child's physical, mental, emotional, or behavioral needs, or based on the relative custodian's failure to document provide documentation, after the local agency has requested such documentation, that the continuing need for the supplemental assistance rate after the local agency has requested such documentation child continues to have physical, mental, emotional, or behavioral needs that support the current amount of relative custody assistance; and

(6) whether the local agency correctly ~~calculated~~ modified or terminated the amount of relative custody assistance based on a change in the gross income of the relative custodian's family or based on the relative custodian's failure to provide documentation of the gross income of the relative custodian's family after the local agency has requested such documentation.

Sec. 20. Minnesota Statutes 1998, section 257.85, subdivision 11, is amended to read:

Subd. 11. [FINANCIAL CONSIDERATIONS.] (a) Payment of relative custody assistance under a relative custody assistance agreement is subject to the availability of state funds and payments may be reduced or suspended on order of the commissioner if insufficient funds are available.

(b) Upon receipt from a local agency of a claim for reimbursement, the commissioner shall reimburse the local agency in an amount equal to 100 percent of the relative custody assistance payments provided to relative custodians. The local agency may not seek and the commissioner shall not provide reimbursement for the administrative costs associated with performing the duties described in subdivision 4.

(c) For the purposes of determining eligibility or payment amounts under ~~the AFDC, MFIP-S, and other MFIP programs;~~ relative custody assistance payments shall be ~~considered~~ excluded in determining the family's available income.

Sec. 21. Minnesota Statutes 1998, section 259.29, subdivision 2, is amended to read:

Subd. 2. [PLACEMENT WITH RELATIVE ~~OR~~ FRIEND, OR MARRIED COUPLE.] The authorized child-placing agency shall consider placement, consistent with the child's best interests and in the following order, with (1) a relative or relatives of the child, ~~or~~ (2) an important friend with whom the child has resided or had significant contact, or (3) a married couple. In implementing this section, an authorized child-placing agency may disclose private or confidential data, as defined in section 13.02, to relatives of the child for the purpose of locating a suitable adoptive home. The agency shall disclose only data that is necessary to facilitate implementing the preference.

If the child's birth parent or parents explicitly request that placement with relatives or important friends not be considered, the authorized child-placing agency shall honor that request consistent with the best interests of the child.

If the child's birth parent or parents express a preference for placing the child in an adoptive home of the same or a similar religious background to that of the birth parent or parents, the agency shall place the child with a family that meets the birth parent's religious preference.

This subdivision does not affect the Indian Child Welfare Act, United States Code, title 25, sections 1901 to 1923, and the Minnesota Indian Family Preservation Act, sections 257.35 to 257.3579.

Sec. 22. Minnesota Statutes 1998, section 259.67, subdivision 6, is amended to read:

Subd. 6. [RIGHT OF APPEAL.] (a) The adoptive parents have the right to appeal to the commissioner pursuant to section 256.045, when the commissioner denies, discontinues, or modifies the agreement.

(b) Adoptive parents who believe that their adopted child was incorrectly denied adoption assistance, or who did not seek adoption assistance on the child's behalf because of being provided with inaccurate or insufficient information about the child or the adoption assistance program, may request a hearing under section 256.045. Notwithstanding subdivision 2, the purpose of the hearing shall be to determine whether, under standards established by the federal Department of Health and Human Services, the circumstances surrounding the child's adoption warrant making an adoption assistance agreement on behalf of the child after the final decree of adoption has been issued. The commissioner shall enter into an adoption assistance agreement on the child's behalf if it is determined that:

(1) at the time of the adoption and at the time the request for a hearing was submitted the child was eligible for adoption assistance under United States Code, title 42, chapter 7, subchapter IV, part E, sections 670 to 679a, at the time of the adoption and at the time the request for a hearing was submitted but, because of extenuating circumstances, did not receive or for state funded adoption assistance under subdivision 4; and

(2) an adoption assistance agreement was not entered into on behalf of the child before the final decree of adoption because of extenuating circumstances as the term is used in the standards established by the federal Department of Health and Human Services. An adoption assistance agreement made under this paragraph shall be effective the date the request for a hearing was received by the commissioner or the local agency.

Sec. 23. Minnesota Statutes 1998, section 259.67, subdivision 7, is amended to read:

Subd. 7. [REIMBURSEMENT OF COSTS.] (a) Subject to rules of the commissioner, and the provisions of this subdivision a ~~Minnesota-licensed~~ child-placing agency licensed in Minnesota or any other state, or local social services agency shall receive a reimbursement from the commissioner equal to 100 percent of the reasonable and appropriate cost of providing adoption services for a child certified as eligible for adoption assistance under subdivision 4. Such assistance may include adoptive family recruitment, counseling, and special training when needed. A ~~Minnesota-licensed~~ child-placing agency licensed in Minnesota or any other state shall receive reimbursement for adoption services it purchases for or directly provides to an eligible child. A local social services agency shall receive such reimbursement only for adoption services it purchases for an eligible child.

(b) A ~~Minnesota-licensed~~ child-placing agency licensed in Minnesota or any other state or local social services agency seeking reimbursement under this subdivision shall enter into a reimbursement agreement with the commissioner before providing adoption services for which reimbursement is sought. No reimbursement under this subdivision shall be made to an agency for services provided prior to entering a reimbursement agreement. Separate reimbursement agreements shall be made for each child and separate records shall be kept on each child for whom a reimbursement agreement is made. Funds encumbered and obligated under such an agreement for the child remain available until the terms of the agreement are fulfilled or the agreement is terminated.

(c) When a local social services agency uses a purchase of service agreement to provide services reimbursable under a reimbursement agreement, the commissioner may make reimbursement payments directly to the agency providing the service if direct reimbursement is specified by the purchase of service agreement, and if the request for reimbursement is submitted by the local social services agency along with a verification that the service was provided.

Sec. 24. Minnesota Statutes 1998, section 259.73, is amended to read:

259.73 [REIMBURSEMENT OF NONRECURRING ADOPTION EXPENSES.]

The commissioner of human services shall provide reimbursement of up to \$2,000 to the adoptive parent or parents for costs incurred in adopting a child with special needs. The commissioner shall determine the child's eligibility for adoption expense reimbursement under title IV-E of the Social Security Act, United States Code, title 42, sections 670 to 676. To be reimbursed, costs must be reasonable, necessary, and directly related to the legal adoption of the child.

Sec. 25. Minnesota Statutes 1998, section 259.85, subdivision 2, is amended to read:

Subd. 2. [ELIGIBILITY CRITERIA.] A child may be certified by the local social ~~service~~ services agency as eligible for a postadoption service grant after a final decree of adoption ~~and before the child's 18th birthday~~ if:

~~(a)~~ (1) the child was a ward of the commissioner or a Minnesota licensed child-placing agency before adoption;

~~(b)~~ (2) the child had special needs at the time of adoption. For the purposes of this section, "special needs" means a child who had a physical, mental, emotional, or behavioral disability at the time of an adoption or has a preadoption background to which the current development of such disabilities can be attributed; ~~and~~

~~(c)~~ (3) the adoptive parents have exhausted all other available resources. Available resources include public income support programs, medical assistance, health insurance coverage, services available through community resources, and any other private or public benefits or resources available to the family or to the child to meet the child's special needs; and

(4) the child is under 18 years of age, or if the child is under 22 years of age and remains dependent on the adoptive parent or parents for care and financial support and is enrolled in a secondary education program as a full-time student.

Sec. 26. Minnesota Statutes 1998, section 259.85, subdivision 3, is amended to read:

Subd. 3. [CERTIFICATION STATEMENT.] The local social ~~service~~ services agency shall certify a child's eligibility for a postadoption service grant in writing to the commissioner. The certification statement shall include:

(1) a description and history of the special needs upon which eligibility is based; ~~and~~

(2) separate certification for each of the eligibility criteria under subdivision 2, that the criteria are met; and

(3) applicable supporting documentation including:

(i) the child's individual service plan;

(ii) medical, psychological, or special education evaluations;

(iii) documentation that all other resources have been exhausted; and

(iv) an estimate of the costs necessary to meet the special needs of the child.

Sec. 27. Minnesota Statutes 1998, section 259.85, subdivision 5, is amended to read:

Subd. 5. [GRANT PAYMENTS.] The amount of the postadoption service grant payment shall be based on the special needs of the child and the determination that other resources to meet those special needs are not available. The amount of any grant payments shall be based on the severity of the child's disability and the effect of the disability on the family and must not exceed \$10,000 annually. Adoptive parents are eligible for grant payments until their child's 18th birthday, or if the child is under 22 years of age and remains dependent on the adoptive parent or parents for care and financial support and is enrolled in a secondary education program as a full-time student.

Permissible expenses that may be paid from grants shall be limited to:

(1) medical expenses not covered by the family's health insurance or medical assistance;

(2) therapeutic expenses, including individual and family therapy; and

(3) nonmedical services, items, or equipment required to meet the special needs of the child.

The grants under this section shall not be used for maintenance for out-of-home placement of the child in substitute care.

Sec. 28. Minnesota Statutes 1998, section 259.89, is amended by adding a subdivision to read:

Subd. 6. [DETERMINATION OF ELIGIBILITY FOR ENROLLMENT OR MEMBERSHIP IN A FEDERALLY RECOGNIZED AMERICAN INDIAN TRIBE.] The state registrar shall provide a copy of an adopted person's original birth certificate to an authorized representative of a federally recognized American Indian tribe for the sole purpose of determining the adopted person's eligibility for enrollment or membership in the tribe.

Sec. 29. Minnesota Statutes 1998, section 260.012, is amended to read:

260.012 [DUTY TO ENSURE PLACEMENT PREVENTION AND FAMILY REUNIFICATION; REASONABLE EFFORTS.]

(a) ~~If~~ Once a child alleged to be in need of protection or services is under the court's jurisdiction, the court shall ensure that reasonable efforts including culturally appropriate services by the social ~~service~~ services agency are made to prevent placement or to eliminate the need for removal and to reunite the child with the child's family at the earliest possible time, consistent with the best interests, safety, and protection of the child. ~~The court may, upon motion and hearing, order the cessation of reasonable efforts if the court finds that provision of services or further services for the purpose of rehabilitation and reunification is futile and therefore unreasonable under the circumstances.~~ In determining reasonable efforts to be made with respect to a child and in making those reasonable efforts, the child's health and safety must be of paramount concern. Reasonable efforts for rehabilitation and reunification are not required ~~if~~ upon a determination by the court determines that:

(1) a termination of parental rights petition has been filed stating a prima facie case that:

~~(i) the parent has subjected the a child to egregious harm as defined in section 260.015, subdivision 29; or;~~

~~(ii) the parental rights of the parent to a sibling another child have been terminated involuntarily; or~~

~~(iii) the child is an abandoned infant under section 260.221, subdivision 1a, paragraph (a), clause (2);~~

~~(2) the county attorney has filed a determination not to proceed with a termination of parental rights petition on these grounds was made under section 260.221, subdivision 1b, paragraph (b), and a permanency hearing is held within 30 days of the determination; or~~

~~(3) a termination of parental rights petition or other petition according to section 260.191, subdivision 3b, has been filed alleging a prima facie case that the provision of services or further services for the purpose of reunification is futile and therefore unreasonable under the circumstances.~~

In the case of an Indian child, in proceedings under sections 260.172, 260.191, and 260.221 the juvenile court must make findings and conclusions consistent with the Indian Child Welfare Act of 1978, United States Code, title 25, section 1901 et seq., as to the provision of active efforts. If a child is under the court's delinquency jurisdiction, it shall be the duty of the court to ensure that reasonable efforts are made to reunite the child with the child's family at the earliest possible time, consistent with the best interests of the child and the safety of the public.

(b) "Reasonable efforts" means the exercise of due diligence by the responsible social ~~service~~ services agency to use appropriate and available services to meet the needs of the child and the child's family in order to prevent removal of the child from the child's family; or upon removal, services to eliminate the need for removal and reunite the family.

(1) Services may include those listed under section 256F.07, subdivision 3, and other appropriate services available in the community.

(2) At each stage of the proceedings where the court is required to review the appropriateness of the responsible social services agency's reasonable efforts, the social service services agency has the burden of demonstrating that it has made reasonable efforts, or that provision of services or further services for the purpose of rehabilitation and reunification is futile and therefore unreasonable under the circumstances: or that reasonable efforts aimed at reunification are not required under this section. The agency may meet this burden by stating facts in a sworn petition filed under section 260.131, or by filing an affidavit summarizing the agency's reasonable efforts or facts the agency believes demonstrate there is no need for reasonable efforts to reunify the parent and child.

(3) No reasonable efforts for reunification are required when the court makes a determination under paragraph (a) unless, after a hearing according to section 260.155, the court finds there is not clear and convincing evidence of the facts upon which the court based its prima facie determination. In this case, the court may proceed under section 260.235.

Reunification of a surviving child with a parent is not required if the parent has been convicted of:

(+) (i) a violation of, or an attempt or conspiracy to commit a violation of, sections 609.185 to 609.20; 609.222, subdivision 2; or 609.223 in regard to another child of the parent;

(-) (ii) a violation of section 609.222, subdivision 2; or 609.223, in regard to the surviving child; or

(-) (iii) a violation of, or an attempt or conspiracy to commit a violation of, United States Code, title 18, section 1111(a) or 1112(a), in regard to another child of the parent.

(c) The juvenile court, in proceedings under sections 260.172, 260.191, and 260.221 shall make findings and conclusions as to the provision of reasonable efforts. When determining whether reasonable efforts have been made, the court shall consider whether services to the child and family were:

- (1) relevant to the safety and protection of the child;
- (2) adequate to meet the needs of the child and family;
- (3) culturally appropriate;
- (4) available and accessible;
- (5) consistent and timely; and
- (6) realistic under the circumstances.

In the alternative, the court may determine that provision of services or further services for the purpose of rehabilitation is futile and therefore unreasonable under the circumstances or that reasonable efforts are not required as provided in paragraph (a).

(d) This section does not prevent out-of-home placement for treatment of a child with a mental disability when the child's diagnostic assessment or individual treatment plan indicates that appropriate and necessary treatment cannot be effectively provided outside of a residential or inpatient treatment program.

(e) If continuation of reasonable efforts described in paragraph (b) is determined by the court to be inconsistent with the permanency permanent plan for the child, or upon a determination under paragraph (a), reasonable efforts must be made to place the child in a timely manner in accordance with the permanency permanent plan ordered by the court and to complete whatever steps are necessary to finalize the permanency permanent plan for the child.

(f) Reasonable efforts to place a child for adoption or in another permanent placement may be made concurrently with reasonable efforts as described in paragraphs (a) and (b). When the responsible social services agency decides to concurrently make reasonable efforts for both reunification and permanent placement away from the parent under paragraphs (a) and (b), the agency shall disclose its decision and both plans for concurrent reasonable efforts to all parties and the court. When the agency discloses its decision to proceed on both plans for reunification and permanent placement away from the parent, the court's review of the agency's reasonable efforts shall include the agency's efforts under paragraphs (a) and (b).

Sec. 30. Minnesota Statutes 1998, section 260.015, subdivision 13, is amended to read:

Subd. 13. [RELATIVE.] "Relative" means a parent, stepparent, grandparent, brother, sister, uncle, or aunt of the minor. This relationship may be by blood or marriage. For an Indian child, relative includes members of the extended family as defined by the law or custom of the Indian child's tribe or, in the absence of laws or custom, nieces, nephews, or first or second cousins, as provided in the Indian Child Welfare Act of 1978, United States Code, title 25, section 1903. For purposes of ~~dispositions, relative has the meaning given in section 260.181, subdivision 3; a child in need of protection or services proceedings, termination of parental rights proceedings, and permanency proceedings under section 260.191, subdivision 3b,~~ relative means a person related to the child by blood, marriage, or adoption, or an individual who is an important friend with whom the child has resided or had significant contact.

Sec. 31. Minnesota Statutes 1998, section 260.015, subdivision 29, is amended to read:

Subd. 29. [EGREGIOUS HARM.] "Egregious harm" means the infliction of bodily harm to a child or neglect of a child which demonstrates a grossly inadequate ability to provide minimally adequate parental care. The egregious harm need not have occurred in the state or in the county where a termination of parental rights action is otherwise properly venued. Egregious harm includes, but is not limited to:

(1) conduct towards a child that constitutes a violation of sections 609.185 to 609.21, 609.222, subdivision 2, 609.223, or any other similar law of any other state;

(2) the infliction of "substantial bodily harm" to a child, as defined in section 609.02, subdivision 7a;

(3) conduct towards a child that constitutes felony malicious punishment of a child under section 609.377;

(4) conduct towards a child that constitutes felony unreasonable restraint of a child under section 609.255, subdivision 3;

(5) conduct towards a child that constitutes felony neglect or endangerment of a child under section 609.378;

(6) conduct towards a child that constitutes assault under section 609.221, 609.222, or 609.223;

(7) conduct towards a child that constitutes solicitation, inducement, or promotion of, or receiving profit derived from prostitution under section 609.322;

(8) conduct toward a child that constitutes murder or voluntary manslaughter as defined by United States Code, title 18, section 1111(a) or 1112(a); ~~or~~

(9) conduct toward a child that constitutes aiding or abetting, attempting, conspiring, or soliciting to commit a murder or voluntary manslaughter that constitutes a violation of United States Code, title 18, section 1111(a) or 1112(a); or

(10) conduct toward a child that constitutes criminal sexual conduct under sections 609.342 to 609.345.

Sec. 32. Minnesota Statutes 1998, section 260.131, subdivision 1a, is amended to read:

Subd. 1a. [REVIEW OF FOSTER CARE STATUS.] The social ~~service~~ services agency responsible for the placement of a child in a residential facility, as defined in section 257.071, subdivision 1, pursuant to a voluntary release by the child's parent or parents may bring a petition in juvenile court to review the foster care status of the child in the manner provided in this section. The responsible social services agency shall file either a petition alleging the child to be in need of protection or services or a petition to terminate parental rights or other permanency petition under section 260.191, subdivision 3b.

(a) In the case of a child in voluntary placement according to section 257.071, subdivision 3, the petition shall be filed within 90 days of the date of the voluntary placement agreement and shall state the reasons why the child is in placement, the progress on the case plan required under section 257.071, subdivision 1, and the statutory basis for the petition under section 260.015, subdivision 2a, 260.191, subdivision 3b, or 260.221.

(1) In the case of a petition filed under this paragraph, if all parties agree and the court finds it is in the best interests of the child, the court may find the petition states a prima facie case that:

(i) the child's needs are being met;

(ii) the placement of the child in foster care is in the best interests of the child; and

(iii) the child will be returned home in the next six months.

(2) If the court makes findings under paragraph (a), clause (1), the court shall approve the voluntary arrangement and continue the matter for up to six more months to ensure the child returns to the parents' home. The responsible social services agency shall:

(i) report to the court when the child returns home and the progress made by the parent on the case plan required under section 257.071, in which case the court shall dismiss jurisdiction;

(ii) report to the court that the child has not returned home, in which case the matter shall be returned to the court for further proceedings under section 260.155; or

(iii) if any party does not agree to continue the matter under paragraph (a), clause (1), and this paragraph, the matter shall proceed under section 260.155.

(b) In the case of a child in voluntary placement according to section 257.071, subdivision 4, the petition shall be filed within six months of the date of the voluntary placement agreement and shall state the date of the voluntary placement agreement, the nature of the child's developmental delay or emotional handicap, the plan for the ongoing care of the child, the parents' participation in the plan, and the statutory basis for the petition.

(1) In the case of petitions filed under this paragraph, the court may find, based on the contents of the sworn petition, and the agreement of all parties, including the child, where appropriate, that the voluntary arrangement is in the best interests of the child, approve the voluntary arrangement, and dismiss the matter from further jurisdiction. The court shall give notice to the responsible social services agency that the matter must be returned to the court for further review if the child remains in placement after 12 months.

(2) If any party, including the child, disagrees with the voluntary arrangement, the court shall proceed under section 260.155.

Sec. 33. Minnesota Statutes 1998, section 260.133, subdivision 1, is amended to read:

Subdivision 1. [PETITION.] The local welfare agency may bring an emergency petition on behalf of minor family or household members seeking relief from acts of domestic child abuse. The petition shall be brought according to section 260.131 and shall allege the existence of or immediate and present danger of domestic child abuse, ~~and shall~~

~~be accompanied by an affidavit made under oath stating the specific facts and circumstances from which relief is sought. The court has jurisdiction over the parties to a domestic child abuse matter notwithstanding that there is a parent in the child's household who is willing to enforce the court's order and accept services on behalf of the family.~~

Sec. 34. Minnesota Statutes 1998, section 260.135, is amended by adding a subdivision to read:

Subd. 1a. [NOTICE.] After a petition has been filed alleging a child to be in need of protection or services and unless the persons named in clauses (1) to (4) voluntarily appear or are summoned according to subdivision 1, the court shall issue a notice to:

(1) an adjudicated or presumed father of the child;

(2) an alleged father of the child;

(3) a noncustodial mother; and

(4) a grandparent with the right to participate under section 260.155, subdivision 1a.

Sec. 35. Minnesota Statutes 1998, section 260.155, subdivision 4, is amended to read:

Subd. 4. [GUARDIAN AD LITEM.] (a) The court shall appoint a guardian ad litem to protect the interests of the minor when it appears, at any stage of the proceedings, that the minor is without a parent or guardian, or that the minor's parent is a minor or incompetent, or that the parent or guardian is indifferent or hostile to the minor's interests, and in every proceeding alleging a child's need for protection or services under section 260.015, subdivision 2a. In any other case the court may appoint a guardian ad litem to protect the interests of the minor when the court feels that such an appointment is desirable. The court shall appoint the guardian ad litem on its own motion or in the manner provided for the appointment of a guardian ad litem in the district court. The court may appoint separate counsel for the guardian ad litem if necessary.

(b) A guardian ad litem shall carry out the following responsibilities:

(1) conduct an independent investigation to determine the facts relevant to the situation of the child and the family, which must include, unless specifically excluded by the court, reviewing relevant documents; meeting with and observing the child in the home setting and considering the child's wishes, as appropriate; and interviewing parents, caregivers, and others with knowledge relevant to the case;

(2) advocate for the child's best interests by participating in appropriate aspects of the case and advocating for appropriate community services when necessary;

(3) maintain the confidentiality of information related to a case, with the exception of sharing information as permitted by law to promote cooperative solutions that are in the best interests of the child;

(4) monitor the child's best interests throughout the judicial proceeding; and

(5) present written reports on the child's best interests that include conclusions and recommendations and the facts upon which they are based.

(c) Except in cases where the child is alleged to have been abused or neglected, the court may waive the appointment of a guardian ad litem pursuant to clause (a), whenever counsel has been appointed pursuant to subdivision 2 or is retained otherwise, and the court is satisfied that the interests of the minor are protected.

(d) In appointing a guardian ad litem pursuant to clause (a), the court shall not appoint the party, or any agent or employee thereof, filing a petition pursuant to section 260.131.

(e) The following factors shall be considered when appointing a guardian ad litem in a case involving an Indian or minority child:

- (1) whether a person is available who is the same racial or ethnic heritage as the child or, if that is not possible;
- (2) whether a person is available who knows and appreciates the child's racial or ethnic heritage.

Sec. 36. Minnesota Statutes 1998, section 260.155, subdivision 8, is amended to read:

Subd. 8. [WAIVER.] (a) Waiver of any right which a child has under this chapter must be an express waiver voluntarily and intelligently made by the child after the child has been fully and effectively informed of the right being waived. ~~If a child is not represented by counsel, any waiver must be given or any objection must be offered by the child's guardian ad litem.~~

(b) Waiver of a child's right to be represented by counsel provided under the juvenile court rules must be an express waiver voluntarily and intelligently made by the child after the child has been fully and effectively informed of the right being waived. In determining whether a child has voluntarily and intelligently waived the right to counsel, the court shall look to the totality of the circumstances which includes but is not limited to the child's age, maturity, intelligence, education, experience, and ability to comprehend, and the presence and competence of the child's parents, guardian, or guardian ad litem. If the court accepts the child's waiver, it shall state on the record the findings and conclusions that form the basis for its decision to accept the waiver.

Sec. 37. Minnesota Statutes 1998, section 260.172, subdivision 1, is amended to read:

Subdivision 1. [HEARING AND RELEASE REQUIREMENTS.] (a) If a child was taken into custody under section 260.165, subdivision 1, clause (a) or (c)(2), the court shall hold a hearing within 72 hours of the time the child was taken into custody, excluding Saturdays, Sundays, and holidays, to determine whether the child should continue in custody.

(b) In all other cases, the court shall hold a detention hearing:

(1) within 36 hours of the time the child was taken into custody, excluding Saturdays, Sundays, and holidays, if the child is being held at a juvenile secure detention facility or shelter care facility; or

(2) within 24 hours of the time the child was taken into custody, excluding Saturdays, Sundays, and holidays, if the child is being held at an adult jail or municipal lockup.

(c) Unless there is reason to believe that the child would endanger self or others, not return for a court hearing, run away from the child's parent, guardian, or custodian or otherwise not remain in the care or control of the person to whose lawful custody the child is released, or that the child's health or welfare would be immediately endangered, the child shall be released to the custody of a parent, guardian, custodian, or other suitable person, subject to reasonable conditions of release including, but not limited to, a requirement that the child undergo a chemical use assessment as provided in section 260.151, subdivision 1. In determining whether the child's health or welfare would be immediately endangered, the court shall consider whether the child would reside with a perpetrator of domestic child abuse. In a proceeding regarding a child in need of protection or services, the court, before determining whether a child should continue in custody, shall also make a determination, consistent with section 260.012 as to whether reasonable efforts, or in the case of an Indian child, active efforts, according to the Indian Child Welfare Act of 1978, United States Code, title 25, section 1912(d), were made to prevent placement or to reunite the child with the child's family, or that reasonable efforts were not possible. The court shall also determine whether there are available services that would prevent the need for further detention.

If the court finds the social services agency's preventive or reunification efforts have not been reasonable but further preventive or reunification efforts could not permit the child to safely remain at home, the court may nevertheless authorize or continue the removal of the child.

~~The court may determine (d) At the detention hearing, or at any time prior to an adjudicatory hearing, that reasonable efforts are not required because the facts, if proved, will demonstrate that the parent has subjected the child to egregious harm as defined in section 260.015, subdivision 29, or the parental rights of the parent to a sibling of the child have been terminated involuntarily: and upon notice and request of the county attorney, the court shall make the following determinations:~~

(1) whether a termination of parental rights petition has been filed stating a prima facie case that:

(i) the parent has subjected a child to egregious harm as defined in section 260.015, subdivision 29;

(ii) the parental rights of the parent to another child have been involuntarily terminated; or

(iii) the child is an abandoned infant under section 260.221, subdivision 1a, paragraph (a), clause (2);

(2) that the county attorney has determined not to proceed with a termination of parental rights petition under section 260.221, subdivision 1b; or

(3) whether a termination of parental rights petition or other petition according to section 260.191, subdivision 3b, has been filed alleging a prima facie case that the provision of services or further services for the purpose of rehabilitation and reunification is futile and therefore unreasonable under the circumstances.

If the court determines that the county attorney is not proceeding with a termination of parental rights petition under section 260.221, subdivision 1b, but is proceeding with a petition under section 260.191, subdivision 3b, the court shall schedule a permanency hearing within 30 days. If the county attorney has filed a petition under section 260.221, subdivision 1b, the court shall schedule a trial under section 260.155 within 90 days of the filing of the petition except when the county attorney determines that the criminal case shall proceed to trial first under section 260.191, subdivision 1b.

(e) If the court determines the child should be ordered into out-of-home placement and the child's parent refuses to give information to the responsible social services agency regarding the child's father or relatives of the child, the court may order the parent to disclose the names, addresses, telephone numbers, and other identifying information to the local social services agency for the purpose of complying with the requirements of sections 257.071, 257.072, and 260.135.

Sec. 38. Minnesota Statutes 1998, section 260.172, is amended by adding a subdivision to read:

Subd. 5. [CASE PLAN.] (a) A case plan required under section 257.071 shall be filed with the court within 30 days of the filing of a petition alleging the child to be in need of protection or services under section 260.131.

(b) Upon the filing of the case plan, the court may approve the case plan based on the allegations contained in the petition. A parent may agree to comply with the terms of the case plan filed with the court.

(c) Upon notice and motion by a parent who agrees to comply with the terms of a case plan, the court may modify the case and order the responsible social services agency to provide other or additional services for reunification, if reunification efforts are required, and the court determines the agency's case plan inadequate under section 260.012.

(d) Unless the parent agrees to comply with the terms of the case plan, the court may not order a parent to comply with the provisions of the case plan until the court makes a determination under section 260.191, subdivision 1.

Sec. 39. Minnesota Statutes 1998, section 260.181, subdivision 3, is amended to read:

Subd. 3. [PROTECTION OF CHILD'S BEST INTERESTS.] (a) The policy of the state is to ensure that the best interests of children are met by requiring individualized determinations of the needs of the child and of how the selected placement will serve the needs of the child in foster care placements.

(b) Among the factors to be considered in determining the needs of the child are:

(1) the child's current functioning and behaviors;

(2) the medical, educational, and developmental needs of the child;

(3) the child's history and past experience;

(4) the child's religious and cultural needs;

(5) the child's connection with a community, school, and church;

(6) the child's interests and talents;

(7) the child's relationship to current caretakers, parents, siblings, and relatives; and

(8) the reasonable preference of the child, if the court, or in the case of a voluntary placement the child-placing agency, deems the child to be of sufficient age to express preferences.

(c) The court, in transferring legal custody of any child or appointing a guardian for the child under the laws relating to juvenile courts, shall consider placement, consistent with the child's best interests and in the following order, in the legal custody or guardianship of an individual who (1) is related to the child by blood, marriage, or adoption, ~~or~~ (2) is an important friend with whom the child has resided or had significant contact, or (3) a married couple. Placement of a child cannot be delayed or denied based on race, color, or national origin of the foster parent or the child. Whenever possible, siblings should be placed together unless it is determined not to be in the best interests of a sibling.

(d) If the child's birth parent or parents explicitly request that a relative or important friend not be considered, the court shall honor that request if it is consistent with the best interests of the child.

If the child's birth parent or parents express a preference for placing the child in a foster or adoptive home of the same or a similar religious background to that of the birth parent or parents, the court shall order placement of the child with an individual who meets the birth parent's religious preference.

(e) This subdivision does not affect the Indian Child Welfare Act, United States Code, title 25, sections 1901 to 1923, and the Minnesota Indian Family Preservation Act, sections 257.35 to 257.3579.

Sec. 40. Minnesota Statutes 1998, section 260.191, 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 ~~child's own~~ 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~~ 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 1a;

(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 ~~order of preference stated in~~ requirements of section 260.181, subdivision 3;

(3) if the child is in need of special treatment and care for reasons of physical or mental health, the court may order the child's parent, guardian, or custodian to provide it. If the parent, guardian, or custodian fails or is unable to provide this treatment or care, the court may order it provided. 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. 41. Minnesota Statutes 1998, section 260.191, subdivision 3b, is amended to read:

Subd. 3b. [REVIEW OF COURT ORDERED PLACEMENTS; PERMANENT PLACEMENT DETERMINATION.] (a) Except for cases where the child is in placement due solely to the child's status as developmentally delayed under United States Code, title 42, section 6001(7), or emotionally handicapped under section 252.27, and where custody has not been transferred to the responsible social services agency, the court shall conduct a hearing to determine the permanent status of a child not later than 12 months after the child is placed out of the home of the parent, except that if the child was under eight years of age at the time the petition was filed, the hearing must be conducted no later than six months after the child is placed out of the home of the parent.

For purposes of this subdivision, the date of the child's placement out of the home of the parent is the earlier of the first court-ordered placement or 60 days after the date on which the child has been voluntarily placed out of the home.

For purposes of this subdivision, 12 months is calculated as follows:

(1) during the pendency of a petition alleging that a child is in need of protection or services, all time periods when a child is placed out of the home of the parent are cumulated;

(2) if a child has been placed out of the home of the parent within the previous five years ~~in connection with one or more prior petitions for a child in need of protection or services,~~ the lengths of all prior time periods when the child was placed out of the home within the previous five years ~~and under the current petition,~~ are cumulated. If a

child under this clause has been out of the home for 12 months or more, the court, if it is in the best interests of the child and for compelling reasons, may extend the total time the child may continue out of the home under the current petition up to an additional six months before making a permanency determination.

(b) Unless the responsible social services agency recommends return of the child to the custodial parent or parents, not later than ten 30 days prior to this hearing, the responsible social service services agency shall file pleadings in juvenile court to establish the basis for the juvenile court to order permanent placement determination of the child according to paragraph (d). Notice of the hearing and copies of the pleadings must be provided pursuant to section 260.141. If a termination of parental rights petition is filed before the date required for the permanency planning determination, and there is a trial under section 260.155 scheduled on that petition within 90 days of the filing of the petition, no hearing need be conducted under this subdivision.

(c) At the conclusion of the hearing, the court shall ~~determine whether order~~ the child ~~is to be~~ returned home or, if not, what order a permanent placement is consistent with in the child's best interests. The "best interests of the child" means all relevant factors to be considered and evaluated.

(~~e~~) (d) At a hearing under this subdivision, if the child was under eight years of age at the time the petition was filed alleging the child in need of protection or services, the court shall review the progress of the case and the case plan, including the provision of services. The court may order the local social ~~service~~ services agency to show cause why it should not file a termination of parental rights petition. Cause may include, but is not limited to, the following conditions:

(1) the parents or guardians have maintained regular contact with the child, the parents are complying with the court-ordered case plan, and the child would benefit from continuing this relationship;

(2) grounds for termination under section 260.221 do not exist; or

(3) the permanent plan for the child is transfer of permanent legal and physical custody to a relative. When the permanent plan for the child is transfer of permanent legal and physical custody to a relative, a petition supporting the plan shall be filed in juvenile court within 30 days of the hearing required under this subdivision and a hearing on the petition held within 30 days of the filing of the pleadings.

(~~d~~) (e) If the child is not returned to the home, the court must order one of the following dispositions ~~available for permanent placement determination are~~:

(1) permanent legal and physical custody to a relative in the best interests of the child. In transferring permanent legal and physical custody to a relative, the juvenile court shall follow the standards and procedures applicable under chapter 257 or 518. An order establishing permanent legal or physical custody under this subdivision must be filed with the family court. A transfer of legal and physical custody includes responsibility for the protection, education, care, and control of the child and decision making on behalf of the child. The social ~~service~~ services agency may petition on behalf of the proposed custodian;

(2) termination of parental rights ~~and adoption~~; unless the social service services agency shall file has already filed a petition for termination of parental rights under section 260.231, the court may order such a petition filed and all the requirements of sections 260.221 to 260.245 remain applicable. An adoption completed subsequent to a determination under this subdivision may include an agreement for communication or contact under section 259.58; or

(3) long-term foster care; transfer of legal custody and adoption are preferred permanency options for a child who cannot return home. The court may order a child into long-term foster care only if it finds that neither an award of legal and physical custody to a relative, nor termination of parental rights nor adoption is in the child's best interests. Further, the court may only order long-term foster care for the child under this section if it finds the following:

(i) the child has reached age 12 and reasonable efforts by the responsible social ~~service~~ services agency have failed to locate an adoptive family for the child; or

(ii) the child is a sibling of a child described in clause (i) and the siblings have a significant positive relationship and are ordered into the same long-term foster care home; or

(4) foster care for a specified period of time may be ordered only if:

(i) the sole basis for an adjudication that ~~a~~ the child is in need of protection or services is ~~that the child is a runaway, is an habitual truant, or committed a delinquent act before age ten~~ the child's behavior; and

(ii) the court finds that foster care for a specified period of time is in the best interests of the child.

(e) In ordering a permanent placement of a child, the court must be governed by the best interests of the child, including a review of the relationship between the child and relatives and the child and other important persons with whom the child has resided or had significant contact.

(f) Once a permanent placement determination has been made and permanent placement has been established, further court reviews and dispositional hearings are only necessary if the placement is made under paragraph (d), clause (4), review is otherwise required by federal law, an adoption has not yet been finalized, or there is a disruption of the permanent or long-term placement.

(g) An order under this subdivision must include the following detailed findings:

(1) how the child's best interests are served by the order;

(2) the nature and extent of the responsible social ~~service~~ services agency's reasonable efforts, or, in the case of an Indian child, active efforts, to reunify the child with the parent or parents;

(3) the parent's or parents' efforts and ability to use services to correct the conditions which led to the out-of-home placement; and

(4) whether the conditions which led to the out-of-home placement have been corrected so that the child can return home; ~~and~~

~~(5) if the child cannot be returned home, whether there is a substantial probability of the child being able to return home in the next six months.~~

(h) An order for permanent legal and physical custody of a child may be modified under sections 518.18 and 518.185. The social ~~service~~ services agency is a party to the proceeding and must receive notice. An order for long-term foster care is reviewable upon motion and a showing by the parent of a substantial change in the parent's circumstances such that the parent could provide appropriate care for the child and that removal of the child from the child's permanent placement and the return to the parent's care would be in the best interest of the child.

(i) The court shall issue an order required under this section within 15 days of the close of the proceedings. The court may extend issuing the order an additional 15 days when necessary in the interests of justice and the best interests of the child.

Sec. 42. Minnesota Statutes 1998, section 260.192, is amended to read:

260.192 [DISPOSITIONS; VOLUNTARY FOSTER CARE PLACEMENTS.]

Unless the court disposes of the petition under section 260.131, subdivision 1a, upon a petition for review of the foster care status of a child, the court may:

~~(a) In the case of a petition required to be filed under section 257.071, subdivision 3, find that the child's needs are being met, that the child's placement in foster care is in the best interests of the child, and that the child will be returned home in the next six months, in which case the court shall approve the voluntary arrangement and continue the matter for six months to assure the child returns to the parent's home.~~

~~(b) In the case of a petition required to be filed under section 257.071, subdivision 4, find that the child's needs are being met and that the child's placement in foster care is in the best interests of the child, in which case the court shall approve the voluntary arrangement. The court shall order the social service agency responsible for the placement to bring a petition under section 260.131, subdivision 1 or 1a, as appropriate, within 12 months.~~

~~(e)~~ Find that the child's needs are not being met, in which case the court shall order the social ~~service~~ services agency or the parents to take whatever action is necessary and feasible to meet the child's needs, including, when appropriate, the provision by the social ~~service~~ services agency of services to the parents which would enable the child to live at home, and order a disposition under section 260.191.

~~(d)~~ (b) Find that the child has been abandoned by parents financially or emotionally, or that the developmentally disabled child does not require out-of-home care because of the handicapping condition, in which case the court shall order the social ~~service~~ services agency to file an appropriate petition pursuant to sections 260.131, subdivision 1, or 260.231.

Nothing in this section shall be construed to prohibit bringing a petition pursuant to section 260.131, subdivision 1 or 2, sooner than required by court order pursuant to this section.

Sec. 43. Minnesota Statutes 1998, section 260.221, subdivision 1, is amended to read:

Subdivision 1. [VOLUNTARY AND INVOLUNTARY.] The juvenile court may upon petition, terminate all rights of a parent to a child:

(a) with the written consent of a parent who for good cause desires to terminate parental rights; or

(b) if it finds that one or more of the following conditions exist:

(1) that the parent has abandoned the child;

(2) that the parent has substantially, continuously, or repeatedly refused or neglected to comply with the duties imposed upon that parent by the parent and child relationship, including but not limited to providing the child with necessary food, clothing, shelter, education, and other care and control necessary for the child's physical, mental, or emotional health and development, if the parent is physically and financially able, and either reasonable efforts by the social ~~service~~ services agency have failed to correct the conditions that formed the basis of the petition or reasonable efforts would be futile and therefore unreasonable;

(3) that a parent has been ordered to contribute to the support of the child or financially aid in the child's birth and has continuously failed to do so without good cause. This clause shall not be construed to state a grounds for termination of parental rights of a noncustodial parent if that parent has not been ordered to or cannot financially contribute to the support of the child or aid in the child's birth;

(4) that a parent is palpably unfit to be a party to the parent and child relationship because of a consistent pattern of specific conduct before the child or of specific conditions directly relating to the parent and child relationship either of which are determined by the court to be of a duration or nature that renders the parent unable, for the reasonably foreseeable future, to care appropriately for the ongoing physical, mental, or emotional needs of the child. It is presumed that a parent is palpably unfit to be a party to the parent and child relationship upon a showing that:

~~(i) the child was adjudicated in need of protection or services due to circumstances described in section 260.015, subdivision 2a, clause (1), (2), (3), (5), or (8); and~~

~~(ii) the parent's parental rights to one or more other children were involuntarily terminated under clause (1), (2), (4), or (7), or under clause (5) if the child was initially determined to be in need of protection or services due to circumstances described in section 260.015, subdivision 2a, clause (1), (2), (3), (5), or (8);~~

(5) that following upon a ~~determination of neglect or dependency, or of a child's need for protection or services~~ the child's placement out of the home, reasonable efforts, under the direction of the court, have failed to correct the conditions leading to the ~~determination~~ child's placement. It is presumed that reasonable efforts under this clause have failed upon a showing that:

(i) a child has resided out of the parental home under court order for a cumulative period of ~~more than one year within a five-year period following an adjudication of dependency, neglect, need for protection or services under section 260.015, subdivision 2a, clause (1), (2), (3), (6), (8), or (9), or neglected and in foster care, and an order for disposition under section 260.191, including adoption of the case plan required by section 257.071; 12 months within the preceding 22 months. In the case of a child under age eight at the time the petition was filed alleging the child to be in need of protection or services, the presumption arises when the child has resided out of the parental home under court order for six months unless the parent has maintained regular contact with the child and the parent is complying with the case plan;~~

(ii) the court has approved a case plan required under section 257.071 and filed with the court under section 260.172;

(iii) conditions leading to the ~~determination will out-of-home placement have not been corrected within the reasonably foreseeable future. It is presumed that conditions leading to a child's out-of-home placement will have not been corrected in the reasonably foreseeable future upon a showing that the parent or parents have not substantially complied with the court's orders and a reasonable case plan, and the conditions which led to the out-of-home placement have not been corrected;~~ and

(iii) (iv) reasonable efforts have been made by the social ~~service~~ services agency to rehabilitate the parent and reunite the family.

This clause does not prohibit the termination of parental rights prior to one year, or in the case of a child under age eight, within six months after a child has been placed out of the home.

It is also presumed that reasonable efforts have failed under this clause upon a showing that:

(i) (A) the parent has been diagnosed as chemically dependent by a professional certified to make the diagnosis;

(ii) (B) the parent has been required by a case plan to participate in a chemical dependency treatment program;

(iii) (C) the treatment programs offered to the parent were culturally, linguistically, and clinically appropriate;

(iv) (D) the parent has either failed two or more times to successfully complete a treatment program or has refused at two or more separate meetings with a caseworker to participate in a treatment program; and

(v) (E) the parent continues to abuse chemicals.

~~Provided, that this presumption applies only to parents required by a case plan to participate in a chemical dependency treatment program on or after July 1, 1990;~~

(6) that a child has experienced egregious harm in the parent's care which is of a nature, duration, or chronicity that indicates a lack of regard for the child's well-being, such that a reasonable person would believe it contrary to the best interest of the child or of any child to be in the parent's care;

(7) that in the case of a child born to a mother who was not married to the child's father when the child was conceived nor when the child was born the person is not entitled to notice of an adoption hearing under section 259.49 and the person has not registered with the fathers' adoption registry under section 259.52;

(8) that the child is neglected and in foster care; or

(9) that the parent has been convicted of a crime listed in section 260.012, paragraph (b), clauses (1) to (3).

In an action involving an American Indian child, sections 257.35 to 257.3579 and the Indian Child Welfare Act, United States Code, title 25, sections 1901 to 1923, control to the extent that the provisions of this section are inconsistent with those laws.

Sec. 44. Minnesota Statutes 1998, section 260.221, subdivision 1b, is amended to read:

Subd. 1b. [REQUIRED TERMINATION OF PARENTAL RIGHTS.] (a) The county attorney shall file a termination of parental rights petition within 30 days of the responsible social services agency determining that a child's placement in out-of-home care if the child has been subjected to egregious harm as defined in section 260.015, subdivision 29, is determined to be the sibling of another child of the parent who was subjected to egregious harm, or is an abandoned infant as defined in subdivision 1a, paragraph (a), clause (2). The local social services agency shall concurrently identify, recruit, process, and approve an adoptive family for the child. If a termination of parental rights petition has been filed by another party, the local social services agency shall be joined as a party to the petition. If criminal charges have been filed against a parent arising out of the conduct alleged to constitute egregious harm, the county attorney shall determine which matter should proceed to trial first, consistent with the best interests of the child and subject to the defendant's right to a speedy trial.

(b) This requirement does not apply if the county attorney determines and files with the court ~~its determination that:~~

(1) a petition for transfer of permanent legal and physical custody to a relative is in the best interests of the child or there is under section 260.191, subdivision 3b, including a determination that the transfer is in the best interests of the child; or

(2) a petition alleging the child and, where appropriate, the child's siblings to be in need of protection or services accompanied by a case plan prepared by the responsible social services agency documenting a compelling reason documented by the local social services agency that why filing the a termination of parental rights petition would not be in the best interests of the child.

Sec. 45. Minnesota Statutes 1998, section 260.221, subdivision 1c, is amended to read:

Subd. 1c. [CURRENT FOSTER CARE CHILDREN.] Except for cases where the child is in placement due solely to the child's status as developmentally delayed under United States Code, title 42, section 6001(7), or emotionally handicapped under section 252.27, and where custody has not been transferred to the responsible social services agency, the county attorney shall file a termination of parental rights petition or other a petition to support another permanent placement proceeding under section 260.191, subdivision 3b, for all children determined to be in need of protection or services who are placed in out-of-home care for reasons other than care or treatment of the child's disability, and who are in out-of-home placement on April 21, 1998, and have been in out-of-home care for 15 of the most recent 22 months. This requirement does not apply if there is a compelling reason documented in a case plan filed with the court for determining that filing a termination of parental rights petition or other permanency petition would not be in the best interests of the child or if the responsible social services agency has not provided reasonable efforts necessary for the safe return of the child, if reasonable efforts are required.

Sec. 46. Minnesota Statutes 1998, section 260.221, subdivision 3, is amended to read:

Subd. 3. [WHEN PRIOR FINDING REQUIRED.] For purposes of subdivision 1, clause (b), no prior judicial finding of ~~dependency, neglect,~~ need for protection or services, or neglected and in foster care is required, except as provided in subdivision 1, clause (b), item (5).

Sec. 47. Minnesota Statutes 1998, section 260.221, subdivision 5, is amended to read:

Subd. 5. [FINDINGS REGARDING REASONABLE EFFORTS.] In any proceeding under this section, the court shall make specific findings:

(1) regarding the nature and extent of efforts made by the social ~~service~~ services agency to rehabilitate the parent and reunite the family; or

~~(2) that provision of services or further services for the purpose of rehabilitation and reunification is futile and therefore unreasonable under the circumstances; or~~

~~(3) that reasonable efforts at reunification are not required as provided under section 260.012.~~

ARTICLE 10

OTHER HEALTH AND HUMAN SERVICES PROVISIONS

Section 1. Minnesota Statutes 1998, section 256.485, is amended to read:

256.485 [CHILD WELFARE SERVICES TO MINOR REFUGEES.]

Subdivision 1. [SPECIAL PROJECTS.] The commissioner of human services shall establish a grant program to provide specialized child welfare services to Asian and Amerasian refugees under the age of 18 who reside in Minnesota.

Subd. 2. [DEFINITIONS.] For the purpose of this section, the following terms have the meanings given them:

(a) "Refugee" means refugee or asylee status granted by the United States Immigration and Naturalization Service.

(b) "Child welfare services" means treatment or services, including workshops or training regarding independent living skills, coping skills, and responsible parenting, and family or individual counseling regarding career planning, intergenerational relationships and communications, and emotional or psychological stress.

Subd. 3. [PROJECT SELECTION.] The commissioner shall select projects for funding under this section. Projects selected must be administered by service providers who have experience in providing child welfare services to minor Asian and Amerasian refugees.

Subd. 4. [PROJECT DESIGN.] Project proposals selected under this section must:

(1) use existing resources when possible;

(2) provide bilingual services;

(3) clearly specify program goals and timetables for project operation;

(4) identify support services, social services, and referral procedures to be used; and

(5) identify the training and experience that enable project staff to provide services to targeted refugees, as well as the number of staff with bilingual service expertise.

Subd. 5. [ANNUAL REPORT.] Selected service providers must report to the commissioner by June 30 of each year on the number of refugees served, the average cost per refugee served, the number and percentage of refugees who are successfully assisted through child welfare services, and recommendations for modifications in service delivery for the upcoming year.

Subd. 6. [EXPIRATION.] This section expires June 30, 2001.

Sec. 2. [REPEALER.]

Minnesota Statutes 1998, section 256.973, is repealed.

ARTICLE 11

HEALTH PLAN COMPANY REGULATION

Section 1. Minnesota Statutes 1998, section 62D.11, subdivision 1, is amended to read:

Subdivision 1. [ENROLLEE COMPLAINT SYSTEM.] Every health maintenance organization shall establish and maintain a complaint system, as required under ~~section 62Q.105~~ sections 62Q.68 to 62Q.72 to provide reasonable procedures for the resolution of written complaints initiated by or on behalf of enrollees concerning the provision of health care services. ~~"Provision of health services" includes, but is not limited to, questions of the scope of coverage, quality of care, and administrative operations. The health maintenance organization must inform enrollees that they may choose to use arbitration to appeal a health maintenance organization's internal appeal decision. The health maintenance organization must also inform enrollees that they have the right to use arbitration to appeal a health maintenance organization's internal appeal decision not to certify an admission, procedure, service, or extension of stay under section 62M.06. If an enrollee chooses to use arbitration, the health maintenance organization must participate.~~

(Effective Date: Section 1 (62D.11, subdivision 1) is effective January 1, 2000.)

Sec. 2. Minnesota Statutes 1998, section 62M.01, is amended to read:

62M.01 [CITATION, JURISDICTION, AND SCOPE.]

Subdivision 1. [POPULAR NAME.] Sections 62M.01 to 62M.16 may be cited as the "Minnesota Utilization Review Act of 1992."

Subd. 2. [JURISDICTION.] Sections 62M.01 to 62M.16 apply to any insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01; a health service plan licensed under chapter 62C; a health maintenance organization licensed under chapter 62D; a community integrated service network licensed under chapter 62N; an accountable provider network operating under chapter 62T; a fraternal benefit society operating under chapter 64B; a joint self-insurance employee health plan operating under chapter 62H; a multiple employer welfare arrangement, as defined in section 3 of the Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, section 1103, as amended; a third party administrator licensed under section 60A.23, subdivision 8, that provides utilization review services for the administration of benefits under a health benefit plan as defined in section 62M.02; or any entity performing utilization review on behalf of a business entity in this state pursuant to a health benefit plan covering a Minnesota resident.

Subd. 3. [SCOPE.] ~~Sections 62M.02, 62M.07, and 62M.09, subdivision 4, apply to prior authorization of services. Nothing in sections 62M.01 to 62M.16 applies to review of claims after submission to determine eligibility for benefits under a health benefit plan. The appeal procedure described in section 62M.06 applies to any complaint as defined under section 62Q.68, subdivision 2, that requires a medical determination in its resolution.~~

(Effective Date: Section 2 (62M.01, subdivisions 2 and 3) are effective January 1, 2000.)

Sec. 3. Minnesota Statutes 1998, section 62M.02, subdivision 3, is amended to read:

Subd. 3. [ATTENDING DENTIST.] "Attending dentist" means the dentist with primary responsibility for the dental care provided to ~~a patient~~ an enrollee.

(Effective Date: Section 3 (62M.02, subdivision 3) is effective January 1, 2000.)

Sec. 4. Minnesota Statutes 1998, section 62M.02, subdivision 4, is amended to read:

Subd. 4. [~~ATTENDING PHYSICIAN HEALTH CARE PROFESSIONAL.~~] "Attending ~~physician health care professional~~" means the ~~physician health care professional~~ with primary responsibility for the care provided to a ~~patient in a hospital or other health care facility~~ an enrollee.

(Effective Date: Section 4 (62M.02, subdivision 4) is effective January 1, 2000.)

Sec. 5. Minnesota Statutes 1998, section 62M.02, subdivision 5, is amended to read:

Subd. 5. [CERTIFICATION.] "Certification" means a determination by a utilization review organization that an admission, extension of stay, or other health care service has been reviewed and that it, based on the information provided, meets the utilization review requirements of the applicable health plan and the health ~~carrier plan company~~ will then pay for the covered benefit, provided the preexisting limitation provisions, the general exclusion provisions, and any deductible, copayment, coinsurance, or other policy requirements have been met.

(Effective Date: Section 5 (62M.02, subdivision 5) is effective January 1, 2000.)

Sec. 6. Minnesota Statutes 1998, section 62M.02, subdivision 6, is amended to read:

Subd. 6. [CLAIMS ADMINISTRATOR.] "Claims administrator" means an entity that reviews and determines whether to pay claims to enrollees, ~~physicians, hospitals, or others~~ or providers based on the contract provisions of the health plan contract. Claims administrators may include insurance companies licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01; a health service plan licensed under chapter 62C; a health maintenance organization licensed under chapter 62D; a community integrated service network licensed under chapter 62N; an accountable provider network operating under chapter 62T; a fraternal benefit society operating under chapter 64B; a multiple employer welfare arrangement, as defined in section 3 of the Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, section 1103, as amended.

(Effective Date: Section 6 (62M.02, subdivision 6) is effective January 1, 2000.)

Sec. 7. Minnesota Statutes 1998, section 62M.02, subdivision 7, is amended to read:

Subd. 7. [CLAIMANT.] "Claimant" means the enrollee ~~or covered person~~ who files a claim for benefits or a provider of services who, pursuant to a contract with a claims administrator, files a claim on behalf of an enrollee or covered person.

(Effective Date: Section 7 (62M.02, subdivision 7) is effective January 1, 2000.)

Sec. 8. Minnesota Statutes 1998, section 62M.02, subdivision 9, is amended to read:

Subd. 9. [CONCURRENT REVIEW.] "Concurrent review" means utilization review conducted during ~~a patient's~~ an enrollee's hospital stay or course of treatment and has the same meaning as continued stay review.

(Effective Date: Section 8 (62M.02, subdivision 9) is effective January 1, 2000.)

Sec. 9. Minnesota Statutes 1998, section 62M.02, subdivision 10, is amended to read:

Subd. 10. [DISCHARGE PLANNING.] "Discharge planning" means the process that assesses ~~a patient's~~ an enrollee's need for treatment after hospitalization in order to help arrange for the necessary services and resources to effect an appropriate and timely discharge.

(Effective Date: Section 9 (62M.02, subdivision 10) is effective January 1, 2000.)

Sec. 10. Minnesota Statutes 1998, section 62M.02, subdivision 11, is amended to read:

Subd. 11. [ENROLLEE.] "Enrollee" means an individual ~~who has elected to contract for, or participate in, a health benefit plan for enrollee coverage or for dependent coverage covered by a health benefit plan and includes an insured policyholder, subscriber contract holder, member, covered person, or certificate holder.~~

(Effective Date: Section 10 (62M.02, subdivision 11) is effective January 1, 2000.)

Sec. 11. Minnesota Statutes 1998, section 62M.02, subdivision 12, is amended to read:

Subd. 12. [HEALTH BENEFIT PLAN.] "Health benefit plan" means a policy, contract, or certificate issued by a health carrier ~~to an employer or individual plan company~~ for the coverage of medical, dental, or hospital benefits. A health benefit plan does not include coverage that is:

- (1) limited to disability or income protection coverage;
- (2) automobile medical payment coverage;
- (3) supplemental to liability insurance;
- (4) designed solely to provide payments on a per diem, fixed indemnity, or nonexpense incurred basis;
- (5) credit accident and health insurance issued under chapter 62B;
- (6) blanket accident and sickness insurance as defined in section 62A.11;
- (7) accident only coverage issued by a licensed and tested insurance agent; or
- (8) workers' compensation.

(Effective Date: Section 11 (62M.02, subdivision 12) is effective January 1, 2000.)

Sec. 12. Minnesota Statutes 1998, section 62M.02, is amended by adding a subdivision to read:

Subd. 12a. [HEALTH PLAN COMPANY.] "Health plan company" means a health plan company as defined in section 62Q.01, subdivision 4, and includes an accountable provider network operating under chapter 62T.

(Effective Date: Section 12 (62M.02, subdivision 12a) is effective January 1, 2000.)

Sec. 13. Minnesota Statutes 1998, section 62M.02, subdivision 17, is amended to read:

Subd. 17. [PROVIDER.] "Provider" means a licensed health care facility, physician, or other health care professional that delivers health care services to an enrollee ~~or covered person.~~

(Effective Date: Section 13 (62M.02, subdivision 17) is effective January 1, 2000.)

Sec. 14. Minnesota Statutes 1998, section 62M.02, subdivision 20, is amended to read:

Subd. 20. [UTILIZATION REVIEW.] "Utilization review" means the evaluation of the necessity, appropriateness, and efficacy of the use of health care services, procedures, and facilities, by a person or entity other than the attending ~~physician health care professional~~, for the purpose of determining the medical necessity of the service or admission. Utilization review also includes review conducted after the admission of the enrollee. It includes situations where the enrollee is unconscious or otherwise unable to provide advance notification. ~~Utilization review does not include the imposition of a requirement that services be received by or upon referral from a participating provider.~~

(Effective Date: Section 14 (62M.02, subdivision 20) is effective January 1, 2000.)

Sec. 15. Minnesota Statutes 1998, section 62M.02, subdivision 21, is amended to read:

Subd. 21. [UTILIZATION REVIEW ORGANIZATION.] "Utilization review organization" means an entity including but not limited to an insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01; a health service plan licensed under chapter 62C; a health maintenance organization licensed under chapter 62D; a community integrated service network licensed under chapter 62N; an accountable provider network operating under chapter 62T; a fraternal benefit society operating under chapter 64B; a joint self-insurance employee health plan operating under chapter 62H; a multiple employer welfare arrangement, as defined in section 3 of the Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, section 1103, as amended; a third party administrator licensed under section 60A.23, subdivision 8, which conducts utilization review and determines certification of an admission, extension of stay, or other health care services for a Minnesota resident; or any entity performing utilization review that is affiliated with, under contract with, or conducting utilization review on behalf of, a business entity in this state.

(Effective Date: Section 15 (62M.02, subdivision 21) is effective January 1, 2000.)

Sec. 16. Minnesota Statutes 1998, section 62M.03, subdivision 1, is amended to read:

Subdivision 1. [LICENSED UTILIZATION REVIEW ORGANIZATION.] Beginning January 1, 1993, any organization that meets the definition of utilization review organization in section 62M.02, subdivision 21, must be licensed under chapter 60A, 62C, 62D, 62N, 62T, or 64B, or registered under this chapter and must comply with sections 62M.01 to 62M.16 and section 72A.201, subdivisions 8 and 8a. Each licensed community integrated service network or health maintenance organization that has an employed staff model of providing health care services shall comply with sections 62M.01 to 62M.16 and section 72A.201, subdivisions 8 and 8a, for any services provided by providers under contract.

(Effective Date: Section 16 (62M.03, subdivision 1) is effective January 1, 2000.)

Sec. 17. Minnesota Statutes 1998, section 62M.03, subdivision 3, is amended to read:

Subd. 3. [PENALTIES AND ENFORCEMENTS.] If a utilization review organization fails to comply with sections 62M.01 to 62M.16, the organization may not provide utilization review services for any Minnesota resident. The commissioner of commerce may issue a cease and desist order under section 45.027, subdivision 5, to enforce this provision. The cease and desist order is subject to appeal under chapter 14. A nonlicensed utilization review organization that fails to comply with the provisions of sections 62M.01 to 62M.16 is subject to all applicable penalty and enforcement provisions of section 72A.201. Each utilization review organization licensed under chapter 60A, 62C, 62D, 62N, 62T, or 64B shall comply with sections 62M.01 to 62M.16 as a condition of licensure.

(Effective Date: Section 17 (62M.03, subdivision 3) is effective January 1, 2000.)

Sec. 18. Minnesota Statutes 1998, section 62M.04, subdivision 1, is amended to read:

Subdivision 1. [RESPONSIBILITY FOR OBTAINING CERTIFICATION.] A health benefit plan that includes utilization review requirements must specify the process for notifying the utilization review organization in a timely manner and obtaining certification for health care services. Each health plan company must provide a clear and concise description of this process to an enrollee as part of the policy, subscriber contract, or certificate of coverage. In addition to the enrollee, the utilization review organization must allow any ~~licensed hospital, physician or the physician's provider or provider's~~ designee, or responsible patient representative, including a family member, to fulfill the obligations under the health plan.

A claims administrator that contracts directly with providers for the provision of health care services to enrollees may, through contract, require the provider to notify the review organization in a timely manner and obtain certification for health care services.

(Effective Date: Section 18 (62M.04, subdivision 1) is effective January 1, 2000.)

Sec. 19. Minnesota Statutes 1998, section 62M.04, subdivision 2, is amended to read:

Subd. 2. [INFORMATION UPON WHICH UTILIZATION REVIEW IS CONDUCTED.] If the utilization review organization is conducting routine prospective and concurrent utilization review, utilization review organizations must collect only the information necessary to certify the admission, procedure of treatment, and length of stay.

(a) Utilization review organizations may request, but may not require, ~~hospitals, physicians, or other~~ providers to supply numerically encoded diagnoses or procedures as part of the certification process.

(b) Utilization review organizations must not routinely request copies of medical records for all patients reviewed. In performing prospective and concurrent review, copies of the pertinent portion of the medical record should be required only when a difficulty develops in certifying the medical necessity or appropriateness of the admission or extension of stay.

(c) Utilization review organizations may request copies of medical records retrospectively for a number of purposes, including auditing the services provided, quality assurance review, ensuring compliance with the terms of either the health benefit plan or the provider contract, and compliance with utilization review activities. Except for reviewing medical records associated with an appeal or with an investigation or audit of data discrepancies, ~~health care~~ providers must be reimbursed for the reasonable costs of duplicating records requested by the utilization review organization for retrospective review unless otherwise provided under the terms of the provider contract.

(Effective Date: Section 19 (62M.04, subdivision 2) is effective January 1, 2000.)

Sec. 20. Minnesota Statutes 1998, section 62M.04, subdivision 3, is amended to read:

Subd. 3. [DATA ELEMENTS.] Except as otherwise provided in sections 62M.01 to 62M.16, for purposes of certification a utilization review organization must limit its data requirements to the following elements:

(a) Patient information that includes the following:

- (1) name;
- (2) address;
- (3) date of birth;
- (4) sex;
- (5) social security number or patient identification number;
- (6) name of health ~~carrier~~ plan company or health plan; and
- (7) plan identification number.

(b) Enrollee information that includes the following:

- (1) name;
- (2) address;
- (3) social security number or employee identification number;
- (4) relation to patient;

- (5) employer;
 - (6) health benefit plan;
 - (7) group number or plan identification number; and
 - (8) availability of other coverage.
- (c) Attending ~~physician or provider~~ health care professional information that includes the following:
- (1) name;
 - (2) address;
 - (3) telephone numbers;
 - (4) degree and license;
 - (5) specialty or board certification status; and
 - (6) tax identification number or other identification number.
- (d) Diagnosis and treatment information that includes the following:
- (1) primary diagnosis with associated ICD or DSM coding, if available;
 - (2) secondary diagnosis with associated ICD or DSM coding, if available;
 - (3) tertiary diagnoses with associated ICD or DSM coding, if available;
 - (4) proposed procedures or treatments with ICD or associated CPT codes, if available;
 - (5) surgical assistant requirement;
 - (6) anesthesia requirement;
 - (7) proposed admission or service dates;
 - (8) proposed procedure date; and
 - (9) proposed length of stay.
- (e) Clinical information that includes the following:
- (1) support and documentation of appropriateness and level of service proposed; and
 - (2) identification of contact person for detailed clinical information.
- (f) Facility information that includes the following:
- (1) type;
 - (2) licensure and certification status and DRG exempt status;

- (3) name;
- (4) address;
- (5) telephone number; and
- (6) tax identification number or other identification number.
- (g) Concurrent or continued stay review information that includes the following:
 - (1) additional days, services, or procedures proposed;
 - (2) reasons for extension, including clinical information sufficient for support of appropriateness and level of service proposed; and
 - (3) diagnosis status.
- (h) For admissions to facilities other than acute medical or surgical hospitals, additional information that includes the following:
 - (1) history of present illness;
 - (2) patient treatment plan and goals;
 - (3) prognosis;
 - (4) staff qualifications; and
 - (5) 24-hour availability of staff.

Additional information may be required for other specific review functions such as discharge planning or catastrophic case management. Second opinion information may also be required, when applicable, to support benefit plan requirements.

(Effective Date: Section 20 (62M.04, subdivision 3) is effective January 1, 2000.)

Sec. 21. Minnesota Statutes 1998, section 62M.04, subdivision 4, is amended to read:

Subd. 4. [ADDITIONAL INFORMATION.] A utilization review organization may request information in addition to that described in subdivision 3 when there is significant lack of agreement between the utilization review organization and the ~~health care~~ provider regarding the appropriateness of certification during the review or appeal process. For purposes of this subdivision, "significant lack of agreement" means that the utilization review organization has:

- (1) tentatively determined through its professional staff that a service cannot be certified;
- (2) referred the case to a physician for review; and
- (3) talked to or attempted to talk to the attending ~~physician~~ health care professional for further information.

Nothing in sections 62M.01 to 62M.16 prohibits a utilization review organization from requiring submission of data necessary to comply with the quality assurance and utilization review requirements of chapter 62D or other appropriate data or outcome analyses.

(Effective Date: Section 21 (62M.04, subdivision 4) is effective January 1, 2000.)

Sec. 22. Minnesota Statutes 1998, section 62M.05, is amended to read:

62M.05 [PROCEDURES FOR REVIEW DETERMINATION.]

Subdivision 1. [WRITTEN PROCEDURES.] A utilization review organization must have written procedures to ensure that reviews are conducted in accordance with the requirements of this chapter ~~and section 72A.201, subdivision 4a.~~

Subd. 2. [CONCURRENT REVIEW.] A utilization review organization may review ongoing inpatient stays based on the severity or complexity of the ~~patient's~~ enrollee's condition or on necessary treatment or discharge planning activities. Such review must not be consistently conducted on a daily basis.

Subd. 3. [NOTIFICATION OF DETERMINATIONS.] A utilization review organization must have written procedures for providing notification of its determinations on all certifications in accordance with ~~the following; this section.~~

Subd. 3a. [STANDARD REVIEW DETERMINATION.] (a) Notwithstanding subdivision 3b, an initial determination on all requests for utilization review must be communicated to the provider and enrollee in accordance with this subdivision within ten business days of the request, provided that all information reasonably necessary to make a determination on the request has been made available to the utilization review organization.

(b) When an initial determination is made to certify, notification must be provided promptly by telephone to the provider. The utilization review organization shall send written notification to the hospital, attending physician, or applicable service provider within ten business days of the determination in accordance with section 72A.201, subdivision 4a; provider or shall maintain an audit trail of the determination and telephone notification. For purposes of this subdivision, "audit trail" includes documentation of the telephone notification, including the date; the name of the person spoken to; the enrollee or patient; the service, procedure, or admission certified; and the date of the service, procedure, or admission. If the utilization review organization indicates certification by use of a number, the number must be called the "certification number."

(b) (c) When a an initial determination is made not to certify a hospital or surgical facility admission or extension of a hospital stay, or other service requiring review determination, notification must be provided by telephone within one working day after making the decision determination to the attending physician health care professional and hospital must be notified by telephone and a written notification must be sent to the hospital, attending physician health care professional, and enrollee or patient. The written notification must include the principal reason or reasons for the determination and the process for initiating an appeal of the determination. Upon request, the utilization review organization shall provide the attending physician or provider or enrollee with the criteria used to determine the necessity, appropriateness, and efficacy of the health care service and identify the database, professional treatment parameter, or other basis for the criteria. Reasons for a determination not to certify may include, among other things, the lack of adequate information to certify after a reasonable attempt has been made to contact the attending physician provider or enrollee.

(d) When an initial determination is made not to certify, the written notification must inform the enrollee and the attending health care professional of the right to submit an appeal to the internal appeal process described in section 62M.06 and the procedure for initiating the internal appeal.

Subd. 3b. [EXPEDITED REVIEW DETERMINATION.] (a) An expedited initial determination must be utilized if the attending health care professional believes that an expedited determination is warranted.

(b) Notification of an expedited initial determination to either certify or not to certify must be provided to the hospital, the attending health care professional, and the enrollee as expeditiously as the enrollee's medical condition requires, but no later than 72 hours from the initial request. When an expedited initial determination is made not to certify, the utilization review organization must also notify the enrollee and the attending health care professional of the right to submit an appeal to the expedited internal appeal as described in section 62M.06 and the procedure for initiating an internal expedited appeal.

Subd. 4. [FAILURE TO PROVIDE NECESSARY INFORMATION.] A utilization review organization must have written procedures to address the failure of a ~~health care provider, patient, or representative of either or enrollee~~ to provide the necessary information for review. If the ~~patient enrollee or provider~~ will not release the necessary information to the utilization review organization, the utilization review organization may deny certification in accordance with its own policy or the policy described in the health benefit plan.

Subd. 5. [NOTIFICATION TO CLAIMS ADMINISTRATOR.] If the utilization review organization and the claims administrator are separate entities, the utilization review organization must forward, electronically or in writing, a notification of certification or determination not to certify to the appropriate claims administrator for the health benefit plan.

(Effective Date: Section 22 (62M.05, subdivisions 1 to 5) are effective January 1, 2000.)

Sec. 23. Minnesota Statutes 1998, section 62M.06, is amended to read:

62M.06 [APPEALS OF DETERMINATIONS NOT TO CERTIFY.]

Subdivision 1. [PROCEDURES FOR APPEAL.] A utilization review organization must have written procedures for appeals of determinations not to certify ~~an admission, procedure, service, or extension of stay~~. The right to appeal must be available to the enrollee ~~or designee~~ and to the attending ~~physician~~ health care professional. ~~The right of appeal must be communicated to the enrollee or designee or to the attending physician, whomever initiated the original certification request, at the time that the original determination is communicated.~~

Subd. 2. [EXPEDITED APPEAL.] (a) When an initial determination not to certify a health care service is made prior to or during an ongoing service requiring review; and the attending ~~physician~~ health care professional believes that the determination warrants ~~immediate~~ an expedited appeal, the utilization review organization must ensure that the ~~enrollee and the attending physician, enrollee, or designee~~ health care professional have an opportunity to appeal the determination over the telephone on an expedited basis. In such an appeal, the utilization review organization must ensure reasonable access to its consulting physician or health care provider. ~~Expedited appeals that are not resolved may be resubmitted through the standard appeal process.~~

(b) The utilization review organization shall notify the enrollee and attending health care professional by telephone of its determination on the expedited appeal as expeditiously as the enrollee's medical condition requires, but no later than 72 hours after receiving the expedited appeal.

(c) If the determination not to certify is not reversed through the expedited appeal, the utilization review organization must include in its notification the right to submit the appeal to the external appeal process described in section 62Q.73 and the procedure for initiating the process. This information must be provided in writing to the enrollee and the attending health care professional as soon as practical.

Subd. 3. [STANDARD APPEAL.] The utilization review organization must establish procedures for appeals to be made either in writing or by telephone.

(a) ~~Each~~ A utilization review organization shall notify in writing the enrollee ~~or patient~~, attending ~~physician~~ health care professional, and claims administrator of its determination on the appeal ~~as soon as practical, but in no case later than 45 days after receiving the required documentation on the appeal within 30 days upon receipt of the notice of appeal.~~

(b) The documentation required by the utilization review organization may include copies of part or all of the medical record and a written statement from the attending health care provider professional.

(c) Prior to upholding the ~~original decision~~ initial determination not to certify for clinical reasons, the utilization review organization shall conduct a review of the documentation by a physician who did not make the ~~original~~ initial determination not to certify.

(d) The process established by a utilization review organization may include defining a period within which an appeal must be filed to be considered. The time period must be communicated to the ~~patient, enrollee, or~~ and attending physician health care professional when the initial determination is made.

(e) An attending physician health care professional or enrollee who has been unsuccessful in an attempt to reverse a determination not to certify shall, consistent with section 72A.285, be provided the following:

(1) a complete summary of the review findings;

(2) qualifications of the reviewers, including any license, certification, or specialty designation; and

(3) the relationship between the enrollee's diagnosis and the review criteria used as the basis for the decision, including the specific rationale for the reviewer's decision.

(f) In cases of appeal to reverse a determination not to certify for clinical reasons, the utilization review organization must, upon request of the attending physician health care professional, ensure that a physician of the utilization review organization's choice in the same or a similar general specialty as typically manages the medical condition, procedure, or treatment under discussion is reasonably available to review the case.

(g) If the initial determination is not reversed on appeal, the utilization review organization must include in its notification the right to submit the appeal to the external review process described in section 62Q.73 and the procedure for initiating the external process.

Subd. 4. [NOTIFICATION TO CLAIMS ADMINISTRATOR.] If the utilization review organization and the claims administrator are separate entities, the utilization review organization must forward notify, either electronically or in writing, a notification of certification or determination not to certify to the appropriate claims administrator for the health benefit plan of any determination not to certify that is reversed on appeal.

(Effective Date: Section 23 (62M.06, subdivisions 1 to 4) are effective January 1, 2000.)

Sec. 24. Minnesota Statutes 1998, section 62M.07, is amended to read:

62M.07 [PRIOR AUTHORIZATION OF SERVICES.]

(a) Utilization review organizations conducting prior authorization of services must have written standards that meet at a minimum the following requirements:

(1) written procedures and criteria used to determine whether care is appropriate, reasonable, or medically necessary;

(2) a system for providing prompt notification of its determinations to enrollees and providers and for notifying the provider, enrollee, or enrollee's designee of appeal procedures under clause (4);

(3) compliance with section ~~72A.201~~ 62M.05, subdivision ~~4~~ 3, regarding time frames for approving and disapproving prior authorization requests;

(4) written procedures for appeals of denials of prior authorization which specify the responsibilities of the enrollee and provider, and which meet the requirements of ~~section~~ sections 62M.06 and 72A.285, regarding release of summary review findings; and

(5) procedures to ensure confidentiality of patient-specific information, consistent with applicable law.

(b) No utilization review organization, health plan company, or claims administrator may conduct or require prior authorization of emergency confinement or emergency treatment. The enrollee or the enrollee's authorized representative may be required to notify the health plan company, claims administrator, or utilization review organization as soon after the beginning of the emergency confinement or emergency treatment as reasonably possible.

(Effective Date: Section 24 (62M.07) is effective January 1, 2000.)

Sec. 25. Minnesota Statutes 1998, section 62M.09, subdivision 3, is amended to read:

Subd. 3. [PHYSICIAN REVIEWER INVOLVEMENT.] A physician must review all cases in which the utilization review organization has concluded that a determination not to certify for clinical reasons is appropriate. The physician should be reasonably available by telephone to discuss the determination with the attending ~~physician~~ health care professional. This subdivision does not apply to outpatient mental health or substance abuse services governed by subdivision 3a.

(Effective Date: Section 25 (62M.09, subdivision 3) is effective January 1, 2000.)

Sec. 26. Minnesota Statutes 1998, section 62M.10, subdivision 2, is amended to read:

Subd. 2. [REVIEWS DURING NORMAL BUSINESS HOURS.] A utilization review organization must conduct its telephone reviews, on-site reviews, and hospital communications during ~~hospitals' and physicians'~~ reasonable and normal business hours, unless otherwise mutually agreed.

(Effective Date: Section 26 (62M.10, subdivision 2) is effective January 1, 2000.)

Sec. 27. Minnesota Statutes 1998, section 62M.10, subdivision 5, is amended to read:

Subd. 5. [ORAL REQUESTS FOR INFORMATION.] Utilization review organizations shall orally inform, upon request, designated hospital personnel or the attending ~~physician~~ health care professional of the utilization review requirements of the specific health benefit plan and the general type of criteria used by the review agent. Utilization review organizations should also orally inform, upon request, ~~hospitals, physicians, and other health care professionals~~ a provider of the operational procedures in order to facilitate the review process.

(Effective Date: Section 27 (62M.10, subdivision 5) is effective January 1, 2000.)

Sec. 28. Minnesota Statutes 1998, section 62M.10, subdivision 7, is amended to read:

Subd. 7. [AVAILABILITY OF CRITERIA.] Upon request, a utilization review organization shall provide to an enrollee or to ~~an attending physician or~~ a provider the criteria used for a specific procedure to determine the necessity, appropriateness, and efficacy of that procedure and identify the database, professional treatment guideline, or other basis for the criteria.

(Effective Date: Section 28 (62M.10, subdivision 7) is effective January 1, 2000.)

Sec. 29. Minnesota Statutes 1998, section 62M.12, is amended to read:

62M.12 [PROHIBITION OF INAPPROPRIATE INCENTIVES.]

No individual who is performing utilization review may receive any financial incentive based on the number of denials of certifications made by such individual, provided that utilization review organizations may establish medically appropriate performance standards. This prohibition does not apply to financial incentives established between health ~~plans~~ plan companies and ~~their~~ providers.

(Effective Date: Section 29 (62M.12) is effective January 1, 2000.)

Sec. 30. Minnesota Statutes 1998, section 62M.15, is amended to read:

62M.15 [APPLICABILITY OF OTHER CHAPTER REQUIREMENTS.]

The requirements of this chapter regarding the conduct of utilization review are in addition to any specific requirements contained in chapter 62A, 62C, 62D, 62Q, or 72A.

(Effective Date: Section 30 (62M.15) is effective January 1, 2000.)

Sec. 31. Minnesota Statutes 1998, section 62Q.106, is amended to read:

62Q.106 [DISPUTE RESOLUTION BY COMMISSIONER.]

A complainant may at any time submit a complaint to the appropriate commissioner to investigate. After investigating a complaint, or reviewing a company's decision, the appropriate commissioner may order a remedy as authorized under ~~section 62Q.30~~ or chapter 45, 60A, or 62D.

(Effective Date: Section 31 (62Q.106) is effective January 1, 2000.)

Sec. 32. Minnesota Statutes 1998, section 62Q.19, subdivision 5a, is amended to read:

Subd. 5a. [COOPERATION.] Each health plan company and essential community provider shall cooperate to facilitate the use of the essential community provider by the high risk and special needs populations. This includes cooperation on the submission and processing of claims, sharing of all pertinent records and data, including performance indicators and specific outcomes data, and the use of all dispute resolution methods ~~as defined in section 62Q.11, subdivision 1.~~

(Effective Date: Section 32 (62Q.19, subdivision 5a) is effective January 1, 2000.)

Sec. 33. [62Q.68] [DEFINITIONS.]

Subdivision 1. [APPLICATION.] For purposes of sections 62Q.68 to 62Q.72, the terms defined in this section have the meanings given them. For purposes of sections 62Q.69 and 62Q.70, the term "health plan company" does not include an insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01.

Subd. 2. [COMPLAINT.] "Complaint" means any grievance against a health plan company that is not the subject of litigation and that has been submitted by a complainant to a health plan company regarding the provision of health services including, but not limited to, the scope of coverage for health care services; retrospective denials or limitations of payment for services; eligibility issues; denials, cancellations, or nonrenewals of coverage; administrative operations; and the quality, timeliness, and appropriateness of health care services rendered. If the complaint is from an applicant, the complaint must relate to the application. If the complaint is from a former enrollee, the complaint must relate to services received during the period of time the individual was an enrollee. Any grievance requiring a medical determination in its resolution must be processed under the appeal procedure described in section 62M.06.

Subd. 3. [COMPLAINANT.] "Complainant" means an enrollee, applicant, or former enrollee, or anyone acting on behalf of an enrollee, applicant, or former enrollee who submits a complaint.

(Effective Date: Section 33 (62Q.68, subdivisions 1 to 3) are effective January 1, 2000.)

Sec. 34. [62Q.69] [COMPLAINT RESOLUTION.]

Subdivision 1. [ESTABLISHMENT.] Each health plan company must establish and maintain an internal complaint resolution process that meets the requirements of this section to provide for the resolution of a complaint initiated by a complainant.

Subd. 2. [PROCEDURES FOR FILING A COMPLAINT.] (a) A complainant may submit a complaint to a health plan company either by telephone or in writing. If a complaint is submitted orally and the resolution of the complaint is partially or wholly adverse to the complainant, or the oral complaint is not resolved by the health plan company within ten days of receiving the complaint, the health plan company must inform the complainant that the complaint may be submitted in writing and must promptly mail a complaint form to the complainant. The complaint form must include the following information:

(1) the telephone number of the office of health care consumer assistance, advocacy, and information, and the health plan company member services or other departments or persons equipped to advise complainants on complaint resolution;

(2) the address to which the form must be sent;

(3) a description of the health plan company's internal complaint procedure and the applicable time limits; and

(4) the toll-free telephone number of either the commissioner of health or commerce and notification that the complainant has the right to submit the complaint at any time to the appropriate commissioner for investigation.

(b) Upon receipt of a written complaint, the health plan company must notify the complainant within ten business days that the complaint was received, unless the complaint is resolved to the satisfaction of the complainant within the ten business days.

(c) At the complainant's request, a health plan company must provide a complainant with any assistance needed to file a written complaint.

(d) Each health plan company must provide, in the member handbook, subscriber contract, or certification of coverage, a clear and concise description of how to submit a complaint and a statement that, upon request, assistance in submitting a written complaint is available from the health plan company.

Subd. 3. [NOTIFICATION OF COMPLAINT DECISIONS.] (a) The health plan company must notify the complainant in writing of its decision and the reasons for it as soon as practical but in no case later than 30 days after receipt of a written complaint.

(b) If the decision is partially or wholly adverse to the complainant, the notification must inform the complainant of the right to appeal the decision to the health plan company's internal appeal process described in section 62Q.70 and the procedure for initiating an appeal.

(c) The notification must also inform the complainant of the right to submit the complaint at any time to either the commissioner of health or commerce for investigation and the toll-free telephone number of the appropriate commissioner.

(Effective Date: Section 34 (62Q.69, subdivisions 1 to 3) are effective January 1, 2000.)

Sec. 35. [62Q.70] [APPEAL OF THE COMPLAINT DECISION.]

Subdivision 1. [ESTABLISHMENT.] (a) Each health plan company shall establish an internal appeal process for reviewing a health plan company's decision regarding a complaint filed in accordance with section 62Q.69. The appeal process must meet the requirements of this section.

(b) The person or persons with authority to resolve or recommend the resolution of the internal appeal must not be solely the same person or persons who made the complaint decision under section 62Q.69.

(c) The internal appeal process must permit the receipt of testimony, correspondence, explanations, or other information from the complainant, staff persons, administrators, providers, or other persons as deemed necessary by the person or persons investigating or presiding over the appeal.

Subd. 2. [PROCEDURES FOR FILING AN APPEAL.] If a complainant notifies the health plan company of the complainant's desire to appeal the health plan company's decision regarding the complaint through the internal appeal process, the health plan company must provide the complainant the option for the appeal to occur either in writing or by hearing.

Subd. 3. [NOTIFICATION OF APPEAL DECISIONS.] (a) Written notice of the appeal decision and all key findings must be given to the complainant within 30 days of the health plan company's receipt of the complainant's written notice of appeal.

(b) If the appeal decision is partially or wholly adverse to the complainant, the notice must advise the complainant of the right to submit the appeal decision to the external review process described in section 62Q.73 and the procedure for initiating the external process.

(c) Upon the request of the complainant, the health plan company must provide the complainant with a complete summary of the appeal decision.

(Effective Date: Section 35 (62Q.70, subdivisions 1 to 3) are effective January 1, 2000.)

Sec. 36. [62Q.71] [NOTICE TO ENROLLEES.]

Each health plan company shall provide to enrollees a clear and concise description of their complaint resolution procedure and the procedure used for utilization review as defined under chapter 62M as part of the member handbook, subscriber contract, or certificate of coverage. The description must specifically inform enrollees:

(1) how to submit a complaint to the health plan company;

(2) if the health plan includes utilization review requirements, how to notify the utilization review organization in a timely manner and how to obtain certification for health care services;

(3) how to request an appeal either through the procedures described in sections 62Q.69 and 62Q.70 or through the procedures described in chapter 62M;

(4) of the right to file a complaint with either the commissioner of health or commerce at any time during the complaint and appeal process;

(5) the toll-free telephone number of the appropriate commissioner;

(6) the telephone number of the office of consumer assistance, advocacy, and information; and

(7) of the right to obtain an external review under section 62Q.73 and a description of when and how that right may be exercised.

(Effective Date: Section 36 (62Q.71) is effective January 1, 2000.)

Sec. 37. [62Q.72] [RECORDKEEPING; REPORTING.]

Subdivision 1. [RECORDKEEPING.] Each health plan company shall maintain records of all enrollee complaints and their resolutions. These records shall be retained for five years and shall be made available to the appropriate commissioner upon request.

Subd. 2. [REPORTING.] Each health plan company shall submit to the appropriate commissioner, as part of the company's annual filing, data on the number and type of complaints that are not resolved within 30 days. A health plan company shall also make this information available to the public upon request.

(Effective Date: Section 37 (62Q.72, subdivisions 1 and 2) are effective January 1, 2000.)

Sec. 38. [62Q.73] [EXTERNAL REVIEW OF ADVERSE DETERMINATIONS.]

Subdivision 1. [DEFINITIONS.] (a) For purposes of this section, the term defined in this subdivision has the meaning given it.

(b) An adverse determination means:

(1) a complaint decision relating to a health care service or claim that has been appealed in accordance with section 62Q.70 and the appeal decision is partially or wholly adverse to the complainant; or

(2) any initial determination not to certify that has been appealed in accordance with section 62M.06 and the appeal did not reverse the initial determination not to certify.

An adverse determination does not include complaints relating to fraudulent marketing practices or agent misrepresentation.

Subd. 2. [RIGHT TO EXTERNAL REVIEW.] (a) Any enrollee or anyone acting on behalf of an enrollee who has received an adverse determination may submit a written request for an external review of the adverse determination to the commissioner of health if the request involves a health plan company regulated by that commissioner or to the commissioner of commerce if the request involves a health plan company regulated by that commissioner. The written request must be accompanied by a filing fee of \$25. The fee may be waived by the commissioner of health or commerce in cases of financial hardship.

(b) Nothing in this section requires the commissioner of health or commerce to independently investigate an adverse determination referred for independent external review.

(c) If an enrollee requests an external review, the health plan company must participate in the external review. The cost of the external review in excess of the filing fee described in paragraph (a) shall be borne by the health plan company.

Subd. 3. [CONTRACT.] Pursuant to a request for proposal, the commissioner of administration, in consultation with the commissioners of health and commerce, shall contract with an organization or business entity to provide independent external reviews of all adverse determinations submitted for external review. The contract shall ensure that the fees for services rendered in connection with the reviews be reasonable.

Subd. 4. [CRITERIA.] The request for proposal must require that the entity be affiliated with an institution of higher learning and demonstrate:

(1) no conflicts of interest in that it is not owned, a subsidiary of, or affiliated with a health plan company or utilization review organization;

(2) an expertise in dispute resolution;

(3) an expertise in health related law;

(4) an ability to conduct reviews using a variety of procedures depending upon the nature of the dispute;

(5) an ability to provide data to the commissioners of health and commerce on reviews conducted; and

(6) an ability to ensure confidentiality of medical records and other enrollee information.

Subd. 5. [PROCESS.] (a) Upon receiving a request for an external review, the external review entity must provide immediate notice of the review to the enrollee and to the health plan company. Within ten business days of receiving notice of the review the health plan company and the enrollee must provide the external review entity with any information that they wish to be considered. Each party shall be provided an opportunity to present its version of the facts and arguments. An enrollee may be assisted or represented by a person of the enrollee's choice.

(b) As part of the external review process, an independent medical opinion may be sought as necessary. A medical review panel may be used to provide additional technical expertise when the issue presented is complex and clinical guidelines are absent, ambiguous, unclear, or conflicting.

(c) An external review shall be made as soon as practical but in no case later than 40 days after receiving the request for an external review and must promptly send written notice of the decision and the reasons for it to the enrollee, the health plan company, and to the commissioner who is responsible for regulating the health plan company.

Subd. 6. [EFFECTS OF EXTERNAL REVIEW.] A decision rendered under this section shall be nonbinding on the enrollee and binding on the health plan company. The health plan company may seek judicial review of the decision on the grounds that the decision was arbitrary and capricious or involved an abuse of discretion.

Subd. 7. [IMMUNITY FROM CIVIL LIABILITY.] A person who participates in an external review by investigating, reviewing materials, providing technical expertise, or rendering a decision shall not be civilly liable for any action that is taken in good faith, that is within the scope of the person's duties, and that does not constitute willful or reckless misconduct.

Subd. 8. [DATA REPORTING.] The commissioners shall make available to the public, upon request, summary data on the decisions rendered under this section, including the number of reviews heard and decided and the final outcomes. Any data released to the public must not individually identify the enrollee initiating the request for external review.

(Effective Date: Section 38 (62Q.73, subdivisions 1 to 8) are effective January 1, 2000.)

Sec. 39. Minnesota Statutes 1998, section 62T.04, is amended to read:

62T.04 [COMPLAINT SYSTEM.]

Accountable provider networks must establish and maintain an enrollee complaint system as required under ~~section 62Q.105~~ sections 62Q.68 to 62Q.72. The accountable provider network may contract with the health care purchasing alliance or a vendor for operation of this system.

(Effective Date: Section 39 (62T.04) is effective January 1, 2000.)

Sec. 40. Minnesota Statutes 1998, section 72A.201, subdivision 4a, is amended to read:

Subd. 4a. [STANDARDS FOR PREAUTHORIZATION APPROVAL.] If a policy of accident and sickness insurance or a subscriber contract requires preauthorization approval for any nonemergency services or benefits, the decision to approve or disapprove the requested services or benefits must be communicated to the insured or the insured's health care provider within ten business days of the preauthorization request provided that all information reasonably necessary to make a decision on the request has been made available to the insurer processed according to section 62M.07.

(Effective Date: Section 40 (72A.201, subdivision 4a) is effective January 1, 2000.)

Sec. 41. Minnesota Statutes 1998, section 256B.692, subdivision 2, is amended to read:

Subd. 2. [DUTIES OF THE COMMISSIONER OF HEALTH.] Notwithstanding chapters 62D and 62N, a county that elects to purchase medical assistance and general assistance medical care in return for a fixed sum without regard to the frequency or extent of services furnished to any particular enrollee is not required to obtain a certificate of authority under chapter 62D or 62N. A county that elects to purchase medical assistance and general assistance medical care services under this section must satisfy the commissioner of health that the requirements of chapter 62D, applicable to health maintenance organizations, or chapter 62N, applicable to community integrated service networks, will be met. A county must also assure the commissioner of health that the requirements of sections 62J.041; 62J.48; 62J.71 to 62J.73; 62M.01 to 62M.16; all applicable provisions of chapter 62Q, including sections 62Q.07; 62Q.075; ~~62Q.105~~; 62Q.1055; 62Q.106; ~~62Q.11~~; 62Q.12; 62Q.135; 62Q.14; 62Q.145; 62Q.19; 62Q.23, paragraph (c); ~~62Q.30~~; 62Q.43; 62Q.47; 62Q.50; 62Q.52 to 62Q.56; 62Q.58; 62Q.64; 62Q.68 to 62Q.72; and 72A.201 will be met. All enforcement and rulemaking powers available under chapters 62D, 62J, 62M, 62N, and 62Q are hereby granted to the commissioner of health with respect to counties that purchase medical assistance and general assistance medical care services under this section.

(Effective Date: Section 41 (256B.692, subdivision 2) is effective January 1, 2000.)

Sec. 42. [REPEALER.]

(a) Minnesota Statutes 1998, sections 62D.11, subdivisions 1b and 2; and 62Q.11, are repealed effective January 1, 2000.

(b) Minnesota Statutes 1998, sections 62Q.105 and 62Q.30, are repealed effective July 1, 1999.

(c) Minnesota Rules, parts 4685.0100, subparts 4 and 4a; and 4685.1700, are repealed effective January 1, 2000.

Sec. 43. [EFFECTIVE DATE.]

When preparing the health and human services conference committee report for adoption by the legislature, the revisor shall combine all the effective date notations into this effective date section."

Delete the title and insert:

"A bill for an act relating to health and human services; modifying provisions relating to health; health department; abortions; abortion reporting; human services; human services department; long-term care; medical assistance; general assistance medical care; MinnesotaCare; senior drug program; home and community-based waivers; services for persons with disabilities; medical assistance reimbursement for special education and other services; county-based purchasing; group residential housing; state-operated services; chemical dependency; mental health; Minnesota family investment program; general assistance program; child support enforcement; adoption; recreational licenses; paternity; children in need of protection or services; termination of parental rights; child protection; the regulation of health plan companies and utilization review organizations; veterans nursing homes board; health-related licensing boards; emergency medical services regulatory board; Minnesota state council on disability; ombudsman for mental health and mental retardation; ombudsman for families; modifying fees; providing penalties; requiring reports; appropriating money; amending Minnesota Statutes 1998, sections 13.46, subdivision 2; 13.99, by adding a subdivision; 15.059, subdivision 5a; 16C.10, subdivision 5; 31.96; 62D.11, subdivision 1; 62J.04, subdivision 3; 62J.06; 62J.07, subdivisions 1 and 3; 62J.09, subdivision 8; 62J.2930, subdivision 3; 62J.451, subdivisions 6a, 6b, and 6c; 62J.69, by adding subdivisions; 62J.77; 62M.01; 62M.02, subdivisions 3, 4, 5, 6, 7, 9, 10, 11, 12, 17, 20, 21, and by adding a subdivision; 62M.03, subdivisions 1 and 3; 62M.04, subdivisions 1, 2, 3, and 4; 62M.05; 62M.06; 62M.07; 62M.09, subdivision 3; 62M.10, subdivisions 2, 5, and 7; 62M.12; 62M.15; 62Q.03, subdivision 5a; 62Q.075; 62Q.106; 62Q.19, subdivisions 1, 2, 5a, and 6; 62R.06, subdivision 1; 62T.04; 72A.201, subdivision 4a; 122A.09, subdivision 4; 125A.08; 125A.21, subdivision 1; 125A.74, subdivisions 1 and 2; 125A.744, subdivision 3; 125A.76, subdivision 2; 144.121, by adding a subdivision; 144.147; 144.1483; 144.1492,

subdivision 3; 144.413, subdivision 2; 144.414, subdivision 1; 144.4165; 144.56, subdivision 2b; 144.99, subdivision 1, and by adding a subdivision; 144A.073; 144A.10, by adding subdivisions; 144A.4605, subdivision 2; 144D.01, subdivision 4; 145.924; 145.9255, subdivisions 1 and 4; 148.5194; 245.462, subdivisions 4 and 17; 245.4711, subdivision 1; 245.4712, subdivision 2; 245.4871, subdivisions 4 and 26; 245.4881, subdivision 1; 245B.05, subdivision 7; 245B.07, subdivisions 5, 8, and 10; 246.18, subdivision 6; 252.28, subdivision 1; 252.32, subdivision 3a; 252.46, subdivision 6; 253B.045, by adding subdivisions; 253B.07, subdivision 1; 253B.185, by adding a subdivision; 254A.07, subdivision 2; 254B.01, by adding a subdivision; 254B.02, subdivision 3; 254B.03, subdivisions 1 and 2; 254B.05, subdivision 1; 256.01, subdivisions 2, 6, and by adding a subdivision; 256.014, by adding a subdivision; 256.485; 256.87, subdivision 1a; 256.955, subdivisions 2, 3, 4, 7, and 9; 256.9685, subdivision 1a; 256.969, subdivision 1; 256.978, subdivision 1; 256B.04, subdivision 16, and by adding a subdivision; 256B.055, subdivision 3a; 256B.056, subdivision 4; 256B.057, by adding a subdivision; 256B.0575; 256B.0625, subdivisions 6a, 8, 8a, 13, 17, 19c, 26, 28, 30, 32, 35, and by adding subdivisions; 256B.0627, subdivisions 1, 2, 4, 5, 8, and by adding subdivisions; 256B.0635, subdivision 3; 256B.0911, subdivision 6; 256B.0913, subdivisions 5, 10, and 12; 256B.0916; 256B.0917, subdivision 8; 256B.094, subdivisions 3, 5, and 6; 256B.0951, subdivisions 1 and 3; 256B.0955; 256B.431, subdivision 17, and by adding a subdivision; 256B.434, subdivisions 3 and 13; 256B.435; 256B.48, subdivisions 1, 1a, 1b, and 6; 256B.50, subdivision 1e; 256B.501, subdivision 8a, and by adding a subdivision; 256B.5011, subdivisions 1 and 2; 256B.69, subdivisions 3a, 5a, 5b, 6a, 6b, and by adding subdivisions; 256B.692, subdivision 2; 256B.75; 256B.76; 256B.77, subdivisions 7a, 8, 10, 14, and by adding subdivisions; 256D.03, subdivision 4; 256D.06, subdivision 5; 256F.03, subdivision 5; 256F.05, subdivision 8; 256F.10, subdivisions 1, 4, 6, 7, 8, and 10; 256I.04, subdivision 3; 256I.05, subdivisions 1, 1a, and by adding a subdivision; 256J.02, subdivision 2; 256J.08, subdivisions 11, 65, 82, 86a, and by adding subdivisions; 256J.11, subdivisions 2 and 3; 256J.12, subdivisions 1a and 2; 256J.14; 256J.20, subdivision 3; 256J.21, subdivisions 2, 3, and 4; 256J.24, subdivisions 2, 3, 7, 8, and 9; 256J.26, subdivision 1; 256J.30, subdivisions 2, 7, 8, and 9; 256J.31, subdivisions 5 and 12; 256J.32, subdivisions 4 and 6; 256J.33; 256J.34, subdivisions 1, 3, and 4; 256J.35; 256J.36; 256J.37, subdivisions 1, 1a, 2, 9, and 10; 256J.38, subdivision 4; 256J.39, subdivision 1; 256J.42, subdivisions 1 and 5; 256J.43; 256J.45, subdivision 1, and by adding a subdivision; 256J.46, subdivisions 1, 2, and 2a; 256J.47, subdivision 4; 256J.48, subdivisions 2 and 3; 256J.50, subdivision 1; 256J.515; 256J.52, subdivisions 1, 3, 4, 5, and by adding a subdivision; 256J.54, subdivision 2; 256J.55, subdivision 4; 256J.56; 256J.62, subdivisions 1, 6, 7, 8, 9, and by adding a subdivision; 256J.67, subdivision 4; 256J.74, subdivision 2; 256J.76, subdivisions 1, 2, and 4; 256L.01, subdivision 4; 256L.04, subdivisions 2, 8, and 13; 256L.05, subdivision 4; 256L.06, subdivision 3; 256L.07; 256L.15, subdivisions 1, 1b, and 2; 257.071, subdivisions 1, 1d, and 4; 257.62, subdivision 5; 257.75, subdivision 2; 257.85, subdivisions 2, 3, 7, 9, and 11; 259.29, subdivision 2; 259.67, subdivisions 6 and 7; 259.73; 259.85, subdivisions 2, 3, and 5; 259.89, by adding a subdivision; 260.012; 260.015, subdivisions 13 and 29; 260.131, subdivision 1a; 260.133, subdivision 1; 260.135, by adding a subdivision; 260.155, subdivisions 4 and 8; 260.172, subdivision 1, and by adding a subdivision; 260.181, subdivision 3; 260.191, subdivisions 1 and 3b; 260.192; 260.221, subdivisions 1, 1b, 1c, 3, and 5; 518.10; 518.551, by adding a subdivision; 518.57, subdivision 3; 518.5851, by adding a subdivision; 518.5853, by adding a subdivision; 518.64, subdivision 2; 548.09, subdivision 1; 548.091, subdivisions 1, 1a, 2a, 3a, 4, 10, 11, 12, and by adding a subdivision; and 552.05, subdivision 10; Laws 1995, chapter 178, article 2, section 46, subdivision 10; Laws 1995, chapter 207, articles 3, section 21; and 8, section 41, as amended; Laws 1995, chapter 257, article 1, section 35, subdivision 1; Laws 1997, chapter 225, article 4, section 4; proposing coding for new law in Minnesota Statutes, chapters 62J; 62Q; 127A; 144; 144A; 144E; 145; 145A; 214; 245; 246; 252; 256B; 256J; and 518; repealing Minnesota Statutes 1998, sections 13.99, subdivision 19m; 62D.11, subdivisions 1b and 2; 62J.78; 62J.79; 62Q.105; 62Q.11; 62Q.30; 144.0723; 144.1475; 144.148; 144.9507, subdivision 4; 144.9511; 144A.33; 145.46; 157.011, subdivision 2; 254A.03, subdivision 2; 254A.031; 254A.145; 254A.17, subdivision 1a; 256.973; 256B.434, subdivision 17; 256B.501, subdivision 3g; 256B.5011, subdivision 3; 256D.053, subdivision 4; 256J.03; 256J.62, subdivisions 2, 3, and 5; 462A.208; 462A.21, subdivision 19; and 548.091, subdivisions 3, 5, and 6; Laws 1997, chapter 85, article 1, section 63; Laws 1997, chapter 203, article 7, section 27; Laws 1998, chapter 407, article 2, section 104; Minnesota Rules, parts 4685.0100, subparts 4 and 4a; 4685.1700; and 4688.0030."

The motion prevailed and the amendment was adopted.

Goodno moved to amend S. F. No. 2225, as amended, as follows:

Page 4, after line 20, insert:

"[INDIRECT COSTS NOT TO FUND PROGRAMS.] The commissioner shall not use indirect cost allocations to pay for the operational costs of any program for which the commissioner is responsible."

Page 29, delete line 22

Page 29, delete lines 42 to 57

Page 30, delete lines 1 to 5

Page 30, after line 18, insert:

"Sec. 14. Minnesota Statutes 1998, section 144.05, is amended by adding a subdivision to read:

Subd. 3. [APPROPRIATION TRANSFERS TO BE REPORTED.] When the commissioner transfers operational money between programs under section 16A.285, in addition to the requirements of that section the commissioner must provide the chairs of the legislative committees that have jurisdiction over the agency's budget with sufficient detail to identify the account to which the money was originally appropriated, and the account to which the money is being transferred.

Sec. 15. Minnesota Statutes 1998, section 198.003, is amended by adding a subdivision to read:

Subd. 5. [APPROPRIATION TRANSFERS TO BE REPORTED.] When the board transfers operational money between programs under section 16A.285, in addition to the requirements of that section the board must provide the chairs of the legislative committees that have jurisdiction over the board's budget with sufficient detail to identify the account to which the money was originally appropriated, and the account to which the money is being transferred.

Page 39, after line 25, insert:

"Sec. 16. Minnesota Statutes 1998, section 256.01, is amended by adding a subdivision to read:

Subd. 18. [APPROPRIATION TRANSFERS TO BE REPORTED.] When the commissioner transfers operational money between programs under section 16A.285, in addition to the requirements of that section the commissioner must provide the chairs of the legislative committees that have jurisdiction over the agency's budget with sufficient detail to identify the account to which the money was originally appropriated, and the account to which the money is being transferred.

Renumber the sections in article 1 in sequence

Page 51, lines 24 and 29, delete "104-91" and insert "104-191"

Page 96, line 6, strike "contract"

Page 96, line 7, strike everything before "develop"

Page 96, line 9, strike "attorney general's office" and insert "commissioner of health"

Page 96, line 13, strike everything after the period

Page 96, strike line 14

Page 142, line 19, after "that" insert "a"

Page 195, line 6, delete the new language

Page 195, line 7, delete the new language and strike everything after "individual"

Page 197, lines 19 to 23, reinstate the stricken language

Page 507, after line 12, insert:

"Sec. 2. Minnesota Statutes 1998, section 256.974, is amended to read:

256.974 [OFFICE OF OMBUDSMAN FOR OLDER MINNESOTANS; LOCAL PROGRAMS.]

The ombudsman for older Minnesotans serves in the classified service under section 256.01, subdivision 7, in an office within the Minnesota board on aging that incorporates the long-term care ombudsman program required by the Older Americans Act, Public Law Number 100-75, United States Code, title 42, section 3027(a)(12), and established within the Minnesota board on aging. The Minnesota board on aging may make grants to and designate local programs for the provision of ombudsman services to clients in county or multicounty areas, except that, beginning July 1, 2001, no state dollars may be used to make grants for the provision of ombudsman services regarding in-home health care services. The local program may not be an agency engaged in the provision of nursing home care, hospital care, or home care services either directly or by contract, or have the responsibility for planning, coordinating, funding, or administering nursing home care, hospital care, or home care services."

Re-number the sections in sequence and correct internal references

Amend the title accordingly

The motion prevailed and the amendment was adopted.

Goodno moved to amend S. F. No. 2225, as amended, as follows:

Pages 507 to 536, delete article 11 and insert:

"ARTICLE 11

HEALTH PLAN COMPANY REGULATION

Section 1. Minnesota Statutes 1998, section 62D.11, subdivision 1, is amended to read:

Subdivision 1. [ENROLLEE COMPLAINT SYSTEM.] Every health maintenance organization shall establish and maintain a complaint system, as required under ~~section 62Q.105~~ sections 62Q.68 to 62Q.72 to provide reasonable procedures for the resolution of written complaints initiated by or on behalf of enrollees concerning the provision of health care services. "Provision of health services" includes, but is not limited to, questions of the scope of coverage, quality of care, and administrative operations. The health maintenance organization must inform enrollees that they may choose to use arbitration to appeal a health maintenance organization's internal appeal decision. The health maintenance organization must also inform enrollees that they have the right to use arbitration to appeal a health maintenance organization's internal appeal decision not to certify an admission, procedure, service, or extension of stay under section 62M.06. ~~If an enrollee chooses to use arbitration, the health maintenance organization must participate.~~

(Effective Date: Section 1 (62D.11, subdivision 1) is effective July 1, 2000.)

Sec. 2. Minnesota Statutes 1998, section 62M.01, is amended to read:

62M.01 [CITATION, JURISDICTION, AND SCOPE.]

Subdivision 1. [POPULAR NAME.] Sections 62M.01 to 62M.16 may be cited as the "Minnesota Utilization Review Act of 1992."

Subd. 2. [JURISDICTION.] Sections 62M.01 to 62M.16 apply to any insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01; a health service plan licensed under chapter 62C; a health maintenance organization licensed under chapter 62D; a community integrated service network licensed under chapter 62N; an accountable provider network operating under chapter 62T; a fraternal benefit society operating under chapter 64B; a joint self-insurance employee health plan operating under chapter 62H; a multiple employer welfare arrangement, as defined in section 3 of the Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, section 1103, as amended; a third party administrator licensed under section 60A.23, subdivision 8, that provides utilization review services for the administration of benefits under a health benefit plan as defined in section 62M.02; or any entity performing utilization review on behalf of a business entity in this state pursuant to a health benefit plan covering a Minnesota resident.

Subd. 3. [SCOPE.] ~~Sections 62M.02, 62M.07, and 62M.09, subdivision 4, apply to prior authorization of services.~~ Nothing in sections 62M.01 to 62M.16 applies to review of claims after submission to determine eligibility for benefits under a health benefit plan. The appeal procedure described in section 62M.06 applies to any complaint as defined under section 62Q.68, subdivision 2, that requires a medical determination in its resolution.

(Effective Date: Section 2 (62M.01, subdivisions 2 and 3) is effective July 1, 2000.)

Sec. 3. Minnesota Statutes 1998, section 62M.02, subdivision 3, is amended to read:

Subd. 3. [ATTENDING DENTIST.] "Attending dentist" means the dentist with primary responsibility for the dental care provided to ~~a patient~~ an enrollee.

(Effective Date: Section 3 (62M.02, subdivision 3) is effective July 1, 2000.)

Sec. 4. Minnesota Statutes 1998, section 62M.02, subdivision 4, is amended to read:

Subd. 4. [ATTENDING PHYSICIAN HEALTH CARE PROFESSIONAL.] "Attending ~~physician health care professional~~" means the physician health care professional with primary responsibility for the care provided to ~~a patient in a hospital or other health care facility~~ an enrollee and shall include only physicians; chiropractors; dentists; mental health professionals as defined in section 245.462, subdivision 18, or section 245.4871, subdivision 27; podiatrists; and advanced practice nurses.

(Effective Date: Section 4 (62M.02, subdivision 4) is effective July 1, 2000.)

Sec. 5. Minnesota Statutes 1998, section 62M.02, subdivision 5, is amended to read:

Subd. 5. [CERTIFICATION.] "Certification" means a determination by a utilization review organization that an admission, extension of stay, or other health care service has been reviewed and that it, based on the information provided, meets the utilization review requirements of the applicable health plan and the health ~~carrier plan company~~ carrier plan company will then pay for the covered benefit, provided the preexisting limitation provisions, the general exclusion provisions, and any deductible, coinsurance, or other policy requirements have been met.

(Effective Date: Section 5 (62M.02, subdivision 5) is effective July 1, 2000.)

Sec. 6. Minnesota Statutes 1998, section 62M.02, subdivision 6, is amended to read:

Subd. 6. [CLAIMS ADMINISTRATOR.] "Claims administrator" means an entity that reviews and determines whether to pay claims to enrollees, ~~physicians, hospitals, or others~~ or providers based on the contract provisions of the health plan contract. Claims administrators may include insurance companies licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01; a health service plan licensed under chapter 62C; a health maintenance organization licensed under chapter 62D; a community integrated service network licensed under chapter 62N; an accountable provider network operating under chapter 62T; a fraternal benefit society operating under chapter 64B; a multiple employer welfare arrangement, as defined in section 3 of the Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, section 1103, as amended.

(Effective Date: Section 6 (62M.02, subdivision 6) is effective July 1, 2000.)

Sec. 7. Minnesota Statutes 1998, section 62M.02, subdivision 7, is amended to read:

Subd. 7. [CLAIMANT.] "Claimant" means the enrollee ~~or covered person~~ who files a claim for benefits or a provider of services who, pursuant to a contract with a claims administrator, files a claim on behalf of an enrollee or covered person.

(Effective Date: Section 7 (62M.02, subdivision 7) is effective July 1, 2000.)

Sec. 8. Minnesota Statutes 1998, section 62M.02, subdivision 9, is amended to read:

Subd. 9. [CONCURRENT REVIEW.] "Concurrent review" means utilization review conducted during ~~a patient's~~ an enrollee's hospital stay or course of treatment and has the same meaning as continued stay review.

(Effective Date: Section 8 (62M.02, subdivision 9) is effective July 1, 2000.)

Sec. 9. Minnesota Statutes 1998, section 62M.02, subdivision 10, is amended to read:

Subd. 10. [DISCHARGE PLANNING.] "Discharge planning" means the process that assesses ~~a patient's~~ an enrollee's need for treatment after hospitalization in order to help arrange for the necessary services and resources to effect an appropriate and timely discharge.

(Effective Date: Section 9 (62M.02, subdivision 10) is effective July 1, 2000.)

Sec. 10. Minnesota Statutes 1998, section 62M.02, subdivision 11, is amended to read:

Subd. 11. [ENROLLEE.] "Enrollee" means an individual ~~who has elected to contract for, or participate in, a health benefit plan for enrollee coverage or for dependent coverage~~ covered by a health benefit plan and includes an insured policyholder, subscriber contract holder, member, covered person, or certificate holder.

(Effective Date: Section 10 (62M.02, subdivision 11) is effective July 1, 2000.)

Sec. 11. Minnesota Statutes 1998, section 62M.02, subdivision 12, is amended to read:

Subd. 12. [HEALTH BENEFIT PLAN.] "Health benefit plan" means a policy, contract, or certificate issued by a health ~~carrier to an employer or individual~~ plan company for the coverage of medical, dental, or hospital benefits. A health benefit plan does not include coverage that is:

- (1) limited to disability or income protection coverage;
- (2) automobile medical payment coverage;

- (3) supplemental to liability insurance;
- (4) designed solely to provide payments on a per diem, fixed indemnity, or nonexpense incurred basis;
- (5) credit accident and health insurance issued under chapter 62B;
- (6) blanket accident and sickness insurance as defined in section 62A.11;
- (7) accident only coverage issued by a licensed and tested insurance agent; or
- (8) workers' compensation.

(Effective Date: Section 11 (62M.02, subdivision 12) is effective July 1, 2000.)

Sec. 12. Minnesota Statutes 1998, section 62M.02, is amended by adding a subdivision to read:

Subd. 12a. [HEALTH PLAN COMPANY.] "Health plan company" means a health plan company as defined in section 62Q.01, subdivision 4, and includes an accountable provider network operating under chapter 62T.

(Effective Date: Section 12 (62M.02, subdivision 12a) is effective July 1, 2000.)

Sec. 13. Minnesota Statutes 1998, section 62M.02, subdivision 17, is amended to read:

Subd. 17. [PROVIDER.] "Provider" means a licensed health care facility, physician, or other health care professional that delivers health care services to an enrollee ~~or covered person~~.

(Effective Date: Section 13 (62M.02, subdivision 17) is effective July 1, 2000.)

Sec. 14. Minnesota Statutes 1998, section 62M.02, subdivision 20, is amended to read:

Subd. 20. [UTILIZATION REVIEW.] "Utilization review" means the evaluation of the necessity, appropriateness, and efficacy of the use of health care services, procedures, and facilities, by a person or entity other than the attending ~~physician health care professional~~, for the purpose of determining the medical necessity of the service or admission. Utilization review also includes review conducted after the admission of the enrollee. It includes situations where the enrollee is unconscious or otherwise unable to provide advance notification. ~~Utilization review does not include the imposition of a requirement that services be received by or upon referral from a participating provider.~~

(Effective Date: Section 14 (62M.02, subdivision 20) is effective July 1, 2000.)

Sec. 15. Minnesota Statutes 1998, section 62M.02, subdivision 21, is amended to read:

Subd. 21. [UTILIZATION REVIEW ORGANIZATION.] "Utilization review organization" means an entity including but not limited to an insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01; a health service plan licensed under chapter 62C; a health maintenance organization licensed under chapter 62D; a community integrated service network licensed under chapter 62N; an accountable provider network operating under chapter 62T; a fraternal benefit society operating under chapter 64B; a joint self-insurance employee health plan operating under chapter 62H; a multiple employer welfare arrangement, as defined in section 3 of the Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, section 1103, as amended; a third party administrator licensed under section 60A.23, subdivision 8, which conducts utilization review and determines certification of an admission, extension of stay, or other health care services for a Minnesota resident; or any entity performing utilization review that is affiliated with, under contract with, or conducting utilization review on behalf of, a business entity in this state.

(Effective Date: Section 15 (62M.02, subdivision 21) is effective July 1, 2000.)

Sec. 16. Minnesota Statutes 1998, section 62M.03, subdivision 1, is amended to read:

Subdivision 1. [LICENSED UTILIZATION REVIEW ORGANIZATION.] Beginning January 1, 1993, any organization that meets the definition of utilization review organization in section 62M.02, subdivision 21, must be licensed under chapter 60A, 62C, 62D, 62N, 62T, or 64B, or registered under this chapter and must comply with sections 62M.01 to 62M.16 and section 72A.201, subdivisions 8 and 8a. Each licensed community integrated service network or health maintenance organization that has an employed staff model of providing health care services shall comply with sections 62M.01 to 62M.16 and section 72A.201, subdivisions 8 and 8a, for any services provided by providers under contract.

(Effective Date: Section 16 (62M.03, subdivision 1) is effective July 1, 2000.)

Sec. 17. Minnesota Statutes 1998, section 62M.03, subdivision 3, is amended to read:

Subd. 3. [PENALTIES AND ENFORCEMENTS.] If a utilization review organization fails to comply with sections 62M.01 to 62M.16, the organization may not provide utilization review services for any Minnesota resident. The commissioner of commerce may issue a cease and desist order under section 45.027, subdivision 5, to enforce this provision. The cease and desist order is subject to appeal under chapter 14. A nonlicensed utilization review organization that fails to comply with the provisions of sections 62M.01 to 62M.16 is subject to all applicable penalty and enforcement provisions of section 72A.201. Each utilization review organization licensed under chapter 60A, 62C, 62D, 62N, 62T, or 64B shall comply with sections 62M.01 to 62M.16 as a condition of licensure.

(Effective Date: Section 17 (62M.03, subdivision 3) is effective July 1, 2000.)

Sec. 18. Minnesota Statutes 1998, section 62M.04, subdivision 1, is amended to read:

Subdivision 1. [RESPONSIBILITY FOR OBTAINING CERTIFICATION.] A health benefit plan that includes utilization review requirements must specify the process for notifying the utilization review organization in a timely manner and obtaining certification for health care services. Each health plan company must provide a clear and concise description of this process to an enrollee as part of the policy, subscriber contract, or certificate of coverage. In addition to the enrollee, the utilization review organization must allow any ~~licensed hospital, physician or the physician's provider or provider's~~ designee, or responsible patient representative, including a family member, to fulfill the obligations under the health plan.

A claims administrator that contracts directly with providers for the provision of health care services to enrollees may, through contract, require the provider to notify the review organization in a timely manner and obtain certification for health care services.

(Effective Date: Section 18 (62M.04, subdivision 1) is effective July 1, 2000.)

Sec. 19. Minnesota Statutes 1998, section 62M.04, subdivision 2, is amended to read:

Subd. 2. [INFORMATION UPON WHICH UTILIZATION REVIEW IS CONDUCTED.] If the utilization review organization is conducting routine prospective and concurrent utilization review, utilization review organizations must collect only the information necessary to certify the admission, procedure of treatment, and length of stay.

(a) Utilization review organizations may request, but may not require, ~~hospitals, physicians, or other~~ providers to supply numerically encoded diagnoses or procedures as part of the certification process.

(b) Utilization review organizations must not routinely request copies of medical records for all patients reviewed. In performing prospective and concurrent review, copies of the pertinent portion of the medical record should be required only when a difficulty develops in certifying the medical necessity or appropriateness of the admission or extension of stay.

(c) Utilization review organizations may request copies of medical records retrospectively for a number of purposes, including auditing the services provided, quality assurance review, ensuring compliance with the terms of either the health benefit plan or the provider contract, and compliance with utilization review activities. Except for reviewing medical records associated with an appeal or with an investigation or audit of data discrepancies, ~~health care~~ providers must be reimbursed for the reasonable costs of duplicating records requested by the utilization review organization for retrospective review unless otherwise provided under the terms of the provider contract.

(Effective Date: Section 19 (62M.04, subdivision 2) is effective July 1, 2000.)

Sec. 20. Minnesota Statutes 1998, section 62M.04, subdivision 3, is amended to read:

Subd. 3. [DATA ELEMENTS.] Except as otherwise provided in sections 62M.01 to 62M.16, for purposes of certification a utilization review organization must limit its data requirements to the following elements:

(a) Patient information that includes the following:

- (1) name;
- (2) address;
- (3) date of birth;
- (4) sex;
- (5) social security number or patient identification number;
- (6) name of health ~~carrier~~ plan company or health plan; and
- (7) plan identification number.

(b) Enrollee information that includes the following:

- (1) name;
- (2) address;
- (3) social security number or employee identification number;
- (4) relation to patient;
- (5) employer;
- (6) health benefit plan;
- (7) group number or plan identification number; and
- (8) availability of other coverage.

(c) Attending ~~physician or provider~~ health care professional information that includes the following:

- (1) name;
- (2) address;

- (3) telephone numbers;
 - (4) degree and license;
 - (5) specialty or board certification status; and
 - (6) tax identification number or other identification number.
- (d) Diagnosis and treatment information that includes the following:
- (1) primary diagnosis with associated ICD or DSM coding, if available;
 - (2) secondary diagnosis with associated ICD or DSM coding, if available;
 - (3) tertiary diagnoses with associated ICD or DSM coding, if available;
 - (4) proposed procedures or treatments with ICD or associated CPT codes, if available;
 - (5) surgical assistant requirement;
 - (6) anesthesia requirement;
 - (7) proposed admission or service dates;
 - (8) proposed procedure date; and
 - (9) proposed length of stay.
- (e) Clinical information that includes the following:
- (1) support and documentation of appropriateness and level of service proposed; and
 - (2) identification of contact person for detailed clinical information.
- (f) Facility information that includes the following:
- (1) type;
 - (2) licensure and certification status and DRG exempt status;
 - (3) name;
 - (4) address;
 - (5) telephone number; and
 - (6) tax identification number or other identification number.
- (g) Concurrent or continued stay review information that includes the following:
- (1) additional days, services, or procedures proposed;
 - (2) reasons for extension, including clinical information sufficient for support of appropriateness and level of service proposed; and

(3) diagnosis status.

(h) For admissions to facilities other than acute medical or surgical hospitals, additional information that includes the following:

- (1) history of present illness;
- (2) patient treatment plan and goals;
- (3) prognosis;
- (4) staff qualifications; and
- (5) 24-hour availability of staff.

Additional information may be required for other specific review functions such as discharge planning or catastrophic case management. Second opinion information may also be required, when applicable, to support benefit plan requirements.

(Effective Date: Section 20 (62M.04, subdivision 3) is effective July 1, 2000.)

Sec. 21. Minnesota Statutes 1998, section 62M.04, subdivision 4, is amended to read:

Subd. 4. [ADDITIONAL INFORMATION.] A utilization review organization may request information in addition to that described in subdivision 3 when there is significant lack of agreement between the utilization review organization and the ~~health care~~ provider regarding the appropriateness of certification during the review or appeal process. For purposes of this subdivision, "significant lack of agreement" means that the utilization review organization has:

- (1) tentatively determined through its professional staff that a service cannot be certified;
- (2) referred the case to a physician for review; and
- (3) talked to or attempted to talk to the attending ~~physician~~ health care professional for further information.

Nothing in sections 62M.01 to 62M.16 prohibits a utilization review organization from requiring submission of data necessary to comply with the quality assurance and utilization review requirements of chapter 62D or other appropriate data or outcome analyses.

(Effective Date: Section 21 (62M.04, subdivision 4) is effective July 1, 2000.)

Sec. 22. Minnesota Statutes 1998, section 62M.05, is amended to read:

62M.05 [PROCEDURES FOR REVIEW DETERMINATION.]

Subdivision 1. [WRITTEN PROCEDURES.] A utilization review organization must have written procedures to ensure that reviews are conducted in accordance with the requirements of this chapter ~~and section 72A.201, subdivision 4a.~~

Subd. 2. [CONCURRENT REVIEW.] A utilization review organization may review ongoing inpatient stays based on the severity or complexity of the ~~patient's~~ enrollee's condition or on necessary treatment or discharge planning activities. Such review must not be consistently conducted on a daily basis.

Subd. 3. [NOTIFICATION OF DETERMINATIONS.] A utilization review organization must have written procedures for providing notification of its determinations on all certifications in accordance with ~~the following:~~ this section.

Subd. 3a. [STANDARD REVIEW DETERMINATION.] (a) Notwithstanding subdivision 3b, an initial determination on all requests for utilization review must be communicated to the provider and enrollee in accordance with this subdivision within ten business days of the request, provided that all information reasonably necessary to make a determination on the request has been made available to the utilization review organization.

(b) When an initial determination is made to certify, notification must be provided promptly by telephone to the provider. The utilization review organization shall send written notification to the ~~hospital, attending physician, or applicable service provider within ten business days of the determination in accordance with section 72A.201, subdivision 4a,~~ provider or shall maintain an audit trail of the determination and telephone notification. For purposes of this subdivision, "audit trail" includes documentation of the telephone notification, including the date; the name of the person spoken to; the enrollee ~~or patient~~; the service, procedure, or admission certified; and the date of the service, procedure, or admission. If the utilization review organization indicates certification by use of a number, the number must be called the "certification number."

~~(b)~~ (c) When ~~a~~ an initial determination is made not to certify ~~a hospital or surgical facility admission or extension of a hospital stay, or other service requiring review determination,~~ notification must be provided by telephone within one working day after making the decision determination to the attending physician health care professional and hospital health care professional, and enrollee ~~or patient~~. The written notification must include the principal reason or reasons for the determination and the process for initiating an appeal of the determination. Upon request, the utilization review organization shall provide the ~~attending physician or provider or enrollee~~ with the criteria used to determine the necessity, appropriateness, and efficacy of the health care service and identify the database, professional treatment parameter, or other basis for the criteria. Reasons for a determination not to certify may include, among other things, the lack of adequate information to certify after a reasonable attempt has been made to contact the attending physician provider or enrollee.

(d) When an initial determination is made not to certify, the written notification must inform the enrollee and the attending health care professional of the right to submit an appeal to the internal appeal process described in section 62M.06 and the procedure for initiating the internal appeal.

Subd. 3b. [EXPEDITED REVIEW DETERMINATION.] (a) An expedited initial determination must be utilized if the attending health care professional believes that an expedited determination is warranted.

(b) Notification of an expedited initial determination to either certify or not to certify must be provided to the hospital, the attending health care professional, and the enrollee as expeditiously as the enrollee's medical condition requires, but no later than 72 hours from the initial request. When an expedited initial determination is made not to certify, the utilization review organization must also notify the enrollee and the attending health care professional of the right to submit an appeal to the expedited internal appeal as described in section 62M.06 and the procedure for initiating an internal expedited appeal.

Subd. 4. [FAILURE TO PROVIDE NECESSARY INFORMATION.] A utilization review organization must have written procedures to address the failure of a ~~health care provider, patient, or representative of either or enrollee~~ to provide the necessary information for review. If the ~~patient enrollee~~ or provider will not release the necessary information to the utilization review organization, the utilization review organization may deny certification in accordance with its own policy or the policy described in the health benefit plan.

Subd. 5. [NOTIFICATION TO CLAIMS ADMINISTRATOR.] If the utilization review organization and the claims administrator are separate entities, the utilization review organization must forward, electronically or in writing, a notification of certification or determination not to certify to the appropriate claims administrator for the health benefit plan.

(Effective Date: Section 22 (62M.05, subdivisions 1 to 5) are effective July 1, 2000.)

Sec. 23. Minnesota Statutes 1998, section 62M.06, is amended to read:

62M.06 [APPEALS OF DETERMINATIONS NOT TO CERTIFY.]

Subdivision 1. [PROCEDURES FOR APPEAL.] A utilization review organization must have written procedures for appeals of determinations not to certify ~~an admission, procedure, service, or extension of stay~~. The right to appeal must be available to the enrollee ~~or designee~~ and to the attending physician health care professional. ~~The right of appeal must be communicated to the enrollee or designee or to the attending physician, whomever initiated the original certification request, at the time that the original determination is communicated.~~

Subd. 2. [EXPEDITED APPEAL.] (a) When an initial determination not to certify a health care service is made prior to or during an ongoing service requiring review; and the attending physician health care professional believes that the determination warrants ~~immediate~~ an expedited appeal, the utilization review organization must ensure that the enrollee and the attending physician, enrollee, or designee has health care professional have an opportunity to appeal the determination over the telephone on an expedited basis. In such an appeal, the utilization review organization must ensure reasonable access to its consulting physician or health care provider. ~~Expedited appeals that are not resolved may be resubmitted through the standard appeal process.~~

(b) The utilization review organization shall notify the enrollee and attending health care professional by telephone of its determination on the expedited appeal as expeditiously as the enrollee's medical condition requires, but no later than 72 hours after receiving the expedited appeal.

(c) If the determination not to certify is not reversed through the expedited appeal, the utilization review organization must include in its notification the right to submit the appeal to the external appeal process described in section 62Q.73 and the procedure for initiating the process. This information must be provided in writing to the enrollee and the attending health care professional as soon as practical.

Subd. 3. [STANDARD APPEAL.] The utilization review organization must establish procedures for appeals to be made either in writing or by telephone.

(a) ~~Each~~ A utilization review organization shall notify in writing the enrollee ~~or patient~~, attending physician health care professional, and claims administrator of its determination on the appeal ~~as soon as practical, but in no case later than 45 days after receiving the required documentation on the appeal within 30 days upon receipt of the notice of appeal. If the utilization review organization cannot make a determination within 30 days due to circumstances outside the control of the utilization review organization, the utilization review organization may take up to 14 additional days to notify the enrollee, attending health care professional, and claims administrator of its determination. If the utilization review organization takes any additional days beyond the initial 30-day period to make its determination, it must inform the enrollee, attending health care professional, and claims administrator, in advance, of the extension and the reasons for the extension.~~

(b) The documentation required by the utilization review organization may include copies of part or all of the medical record and a written statement from the attending health care provider professional.

(c) Prior to upholding the ~~original decision~~ initial determination not to certify for clinical reasons, the utilization review organization shall conduct a review of the documentation by a physician who did not make the ~~original~~ initial determination not to certify.

(d) The process established by a utilization review organization may include defining a period within which an appeal must be filed to be considered. The time period must be communicated to the ~~patient, enrollee, or~~ and attending physician health care professional when the initial determination is made.

(e) An attending physician health care professional or enrollee who has been unsuccessful in an attempt to reverse a determination not to certify shall, consistent with section 72A.285, be provided the following:

(1) a complete summary of the review findings;

(2) qualifications of the reviewers, including any license, certification, or specialty designation; and

(3) the relationship between the enrollee's diagnosis and the review criteria used as the basis for the decision, including the specific rationale for the reviewer's decision.

(f) In cases of appeal to reverse a determination not to certify for clinical reasons, the utilization review organization must, upon request of the attending ~~physician~~ health care professional, ensure that a physician of the utilization review organization's choice in the same or a similar general specialty as typically manages the medical condition, procedure, or treatment under discussion is reasonably available to review the case.

(g) If the initial determination is not reversed on appeal, the utilization review organization must include in its notification the right to submit the appeal to the external review process described in section 62Q.73 and the procedure for initiating the external process.

Subd. 4. [NOTIFICATION TO CLAIMS ADMINISTRATOR.] If the utilization review organization and the claims administrator are separate entities, the utilization review organization must ~~forward~~ notify, either electronically or in writing, a notification of certification or determination not to certify to the appropriate claims administrator for the health benefit plan of any determination not to certify that is reversed on appeal.

(Effective Date: Section 23 (62M.06, subdivisions 1 to 4) are effective July 1, 2000.)

Sec. 24. Minnesota Statutes 1998, section 62M.07, is amended to read:

62M.07 [PRIOR AUTHORIZATION OF SERVICES.]

(a) Utilization review organizations conducting prior authorization of services must have written standards that meet at a minimum the following requirements:

(1) written procedures and criteria used to determine whether care is appropriate, reasonable, or medically necessary;

(2) a system for providing prompt notification of its determinations to enrollees and providers and for notifying the provider, enrollee, or enrollee's designee of appeal procedures under clause (4);

(3) compliance with section ~~72A.201~~ 62M.05, subdivision ~~4a~~ 3a, regarding time frames for approving and disapproving prior authorization requests;

(4) written procedures for appeals of denials of prior authorization which specify the responsibilities of the enrollee and provider, and which meet the requirements of ~~section~~ sections 62M.06 and 72A.285, regarding release of summary review findings; and

(5) procedures to ensure confidentiality of patient-specific information, consistent with applicable law.

(b) No utilization review organization, health plan company, or claims administrator may conduct or require prior authorization of emergency confinement or emergency treatment. The enrollee or the enrollee's authorized representative may be required to notify the health plan company, claims administrator, or utilization review organization as soon after the beginning of the emergency confinement or emergency treatment as reasonably possible.

(Effective Date: Section 24 (62M.07) is effective July 1, 2000.)

Sec. 25. Minnesota Statutes 1998, section 62M.09, subdivision 3, is amended to read:

Subd. 3. [PHYSICIAN REVIEWER INVOLVEMENT.] A physician must review all cases in which the utilization review organization has concluded that a determination not to certify for clinical reasons is appropriate. The physician should be reasonably available by telephone to discuss the determination with the attending ~~physician~~ health care professional. This subdivision does not apply to outpatient mental health or substance abuse services governed by subdivision 3a.

(Effective Date: Section 25 (62M.09, subdivision 3) is effective July 1, 2000.)

Sec. 26. Minnesota Statutes 1998, section 62M.10, subdivision 2, is amended to read:

Subd. 2. [REVIEWS DURING NORMAL BUSINESS HOURS.] A utilization review organization must conduct its telephone reviews, on-site reviews, and hospital communications during ~~hospitals' and physicians'~~ reasonable and normal business hours, unless otherwise mutually agreed.

(Effective Date: Section 26 (62M.10, subdivision 2) is effective July 1, 2000.)

Sec. 27. Minnesota Statutes 1998, section 62M.10, subdivision 5, is amended to read:

Subd. 5. [ORAL REQUESTS FOR INFORMATION.] Utilization review organizations shall orally inform, upon request, designated hospital personnel or the attending ~~physician~~ health care professional of the utilization review requirements of the specific health benefit plan and the general type of criteria used by the review agent. Utilization review organizations should also orally inform, upon request, ~~hospitals, physicians, and other health care professionals~~ a provider of the operational procedures in order to facilitate the review process.

(Effective Date: Section 27 (62M.10, subdivision 5) is effective July 1, 2000.)

Sec. 28. Minnesota Statutes 1998, section 62M.10, subdivision 7, is amended to read:

Subd. 7. [AVAILABILITY OF CRITERIA.] Upon request, a utilization review organization shall provide to an enrollee or to ~~an attending physician or~~ a provider the criteria used for a specific procedure to determine the necessity, appropriateness, and efficacy of that procedure and identify the database, professional treatment guideline, or other basis for the criteria.

(Effective Date: Section 28 (62M.10, subdivision 7) is effective July 1, 2000.)

Sec. 29. Minnesota Statutes 1998, section 62M.12, is amended to read:

62M.12 [PROHIBITION OF INAPPROPRIATE INCENTIVES.]

No individual who is performing utilization review may receive any financial incentive based on the number of denials of certifications made by such individual, provided that utilization review organizations may establish medically appropriate performance standards. This prohibition does not apply to financial incentives established between health ~~plans~~ plan companies and ~~their~~ providers.

(Effective Date: Section 29 (62M.12) is effective July 1, 2000.)

Sec. 30. Minnesota Statutes 1998, section 62M.15, is amended to read:

62M.15 [APPLICABILITY OF OTHER CHAPTER REQUIREMENTS.]

The requirements of this chapter regarding the conduct of utilization review are in addition to any specific requirements contained in chapter 62A, 62C, 62D, 62Q, 62T, or 72A.

(Effective Date: Section 30 (62M.15) is effective July 1, 2000.)

Sec. 31. Minnesota Statutes 1998, section 62Q.106, is amended to read:

62Q.106 [DISPUTE RESOLUTION BY COMMISSIONER.]

A complainant may at any time submit a complaint to the appropriate commissioner to investigate. After investigating a complaint, or reviewing a company's decision, the appropriate commissioner may order a remedy as authorized under ~~section 62Q.30~~ or chapter 45, 60A, or 62D.

(Effective Date: Section 31 (62Q.106) is effective July 1, 2000.)

Sec. 32. Minnesota Statutes 1998, section 62Q.19, subdivision 5a, is amended to read:

Subd. 5a. [COOPERATION.] Each health plan company and essential community provider shall cooperate to facilitate the use of the essential community provider by the high risk and special needs populations. This includes cooperation on the submission and processing of claims, sharing of all pertinent records and data, including performance indicators and specific outcomes data, and the use of all dispute resolution methods ~~as defined in section 62Q.11, subdivision 1.~~

(Effective Date: Section 32 (62Q.19, subdivision 5a) is effective July 1, 2000.)

Sec. 33. [62Q.68] [DEFINITIONS.]

Subdivision 1. [APPLICATION.] For purposes of sections 62Q.68 to 62Q.72, the terms defined in this section have the meanings given them.

Subd. 2. [COMPLAINT.] "Complaint" means any grievance against a health plan company that is not the subject of litigation and that has been submitted by a complainant to a health plan company regarding the provision of health services including, but not limited to, the scope of coverage for health care services; retrospective denials or limitations of payment for services; eligibility issues; denials, cancellations, or nonrenewals of coverage; administrative operations; and the quality, timeliness, and appropriateness of health care services rendered. If the complaint is from an applicant, the complaint must relate to the application. If the complaint is from a former enrollee, the complaint must relate to services received during the period of time the individual was an enrollee. Any complaint requiring a medical determination in its resolution must have the medical determination aspect of the complaint processed under the appeal procedure described in section 62M.06.

Subd. 3. [COMPLAINANT.] "Complainant" means an enrollee, applicant, or former enrollee, or anyone acting on behalf of an enrollee, applicant, or former enrollee who submits a complaint.

(Effective Date: Section 33 (62Q.68, subdivisions 1 to 3) are effective July 1, 2000.)

Sec. 34. [62Q.681] [APPLICATION.]

(a) Sections 62Q.69 and 62Q.70 do not apply to governmental programs. For purposes of this section, "governmental programs" means the medical assistance program, the MinnesotaCare program, the general assistance medical care program, and the federal Medicare program.

(b) For purposes of sections 62Q.69 and 62Q.70, the term "health plan company" does not include an insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01 or a nonprofit health service plan corporation regulated under chapter 62C that only provides dental coverage or vision coverage.

(Effective Date: Section 34 (62Q.681) is effective July 1, 2000.)

Sec. 35. [62Q.69] [COMPLAINT RESOLUTION.]

Subdivision 1. [ESTABLISHMENT.] Each health plan company must establish and maintain an internal complaint resolution process that meets the requirements of this section to provide for the resolution of a complaint initiated by a complainant.

Subd. 2. [PROCEDURES FOR FILING A COMPLAINT.] (a) A complainant may submit a complaint to a health plan company either by telephone or in writing. If a complaint is submitted orally and the resolution of the complaint, as determined by the complainant, is partially or wholly adverse to the complainant, or the oral complaint is not resolved to the satisfaction of the complainant, by the health plan company within ten days of receiving the complaint, the health plan company must inform the complainant that the complaint may be submitted in writing. If the complainant wants to submit in writing a complaint that was previously submitted orally and so informs the health plan company, the health plan company must complete the complaint form and promptly mail the completed form to the complainant for the complainant's signature. The complaint form must include the following information:

(1) the telephone number of the office of health care consumer assistance, advocacy, and information, and the health plan company member services or other departments or persons equipped to advise complainants on complaint resolution;

(2) the address to which the form must be sent;

(3) a description of the health plan company's internal complaint procedure and the applicable time limits; and

(4) the toll-free telephone number of either the commissioner of health or commerce and notification that the complainant has the right to submit the complaint at any time to the appropriate commissioner for investigation.

(b) Upon receipt of a written complaint, the health plan company must notify the complainant within ten business days that the complaint was received, unless the complaint is resolved to the satisfaction of the complainant within the ten business days.

(c) At the complainant's request, a health plan company must provide a complainant with any assistance needed to submit a written complaint.

(d) Each health plan company must provide, in the member handbook, subscriber contract, or certification of coverage, a clear and concise description of how to submit a complaint and a statement that, upon request, assistance in submitting a written complaint is available from the health plan company.

Subd. 3. [NOTIFICATION OF COMPLAINT DECISIONS.] (a) The health plan company must notify the complainant in writing of its decision and the reasons for it as soon as practical but in no case later than 30 days after receipt of a written complaint. If the health plan company cannot make a decision within 30 days due to circumstances outside the control of the health plan company, the health plan company may take up to 14 additional days to notify the complainant of its decision. If the health plan company takes any additional days beyond the initial 30-day period to make its decision, it must inform the complainant, in advance, of the extension and the reasons for the extension.

(b) If the decision is partially or wholly adverse to the complainant, the notification must inform the complainant of the right to appeal the decision to the health plan company's internal appeal process described in section 62Q.70 and the procedure for initiating an appeal.

(c) The notification must also inform the complainant of the right to submit the complaint at any time to either the commissioner of health or commerce for investigation and the toll-free telephone number of the appropriate commissioner.

(Effective Date: Section 34 (62Q.69, subdivisions 1 to 3) are effective July 1, 2000.)

Sec. 36. [62Q.70] [APPEAL OF THE COMPLAINT DECISION.]

Subdivision 1. [ESTABLISHMENT.] (a) Each health plan company shall establish an internal appeal process for reviewing a health plan company's decision regarding a complaint filed in accordance with section 62Q.69. The appeal process must meet the requirements of this section.

(b) The person or persons with authority to resolve or recommend the resolution of the internal appeal must not be solely the same person or persons who made the complaint decision under section 62Q.69.

(c) The internal appeal process must permit the receipt of testimony, correspondence, explanations, or other information from the complainant, staff persons, administrators, providers, or other persons as deemed necessary by the person or persons investigating or presiding over the appeal.

Subd. 2. [PROCEDURES FOR FILING AN APPEAL.] If a complainant notifies the health plan company of the complainant's desire to appeal the health plan company's decision regarding the complaint through the internal appeal process, the health plan company must provide the complainant the option for the appeal to occur either in writing or by hearing.

Subd. 3. [NOTIFICATION OF APPEAL DECISIONS.] (a) If a complainant appeals in writing, the health plan company must give the complainant written notice of the appeal decision and all key findings within 30 days of the health plan company's receipt of the complainant's written reconsideration materials. If a complainant appeals by hearing, the health plan company must give the complainant written notice of the appeal decision and all key findings within 45 days of the hearing.

(b) If the appeal decision is partially or wholly adverse to the complainant, the notice must advise the complainant of the right to submit the appeal decision to the external review process described in section 62Q.73 and the procedure for initiating the external process.

(c) Upon the request of the complainant, the health plan company must provide the complainant with a complete summary of the appeal decision.

(Effective Date: Section 35 (62Q.70, subdivisions 1 to 3) are effective July 1, 2000.)

Sec. 37. [62Q.71] [NOTICE TO ENROLLEES.]

Each health plan company shall provide to enrollees a clear and concise description of its complaint resolution procedure, as applicable under section 62Q.681, and of the procedure used for utilization review as defined under chapter 62M as part of the member handbook, subscriber contract, or certificate of coverage. If the health plan company does not issue a member handbook, the health plan company may provide the description in another written document. The description must specifically inform enrollees:

(1) how to submit a complaint to the health plan company;

(2) if the health plan includes utilization review requirements, how to notify the utilization review organization in a timely manner and how to obtain certification for health care services;

(3) how to request an appeal either through the procedures described in sections 62Q.69 and 62Q.70 or through the procedures described in chapter 62M;

(4) of the right to file a complaint with either the commissioner of health or commerce at any time during the complaint and appeal process;

(5) the toll-free telephone number of the appropriate commissioner;

(6) the telephone number of the office of consumer assistance, advocacy, and information; and

(7) of the right to obtain an external review under section 62Q.73 and a description of when and how those rights may be exercised.

(Effective Date: Section 36 (62Q.71) is effective July 1, 2000.)

Sec. 38. [62Q.72] [RECORDKEEPING; REPORTING.]

Subdivision 1. [RECORDKEEPING.] Each health plan company shall maintain records of all enrollee complaints and their resolutions. These records shall be retained for five years and shall be made available to the appropriate commissioner upon request. An insurance company licensed under chapter 60A may instead comply with section 72A.20, subdivision 30.

Subd. 2. [REPORTING.] Each health plan company shall submit to the appropriate commissioner, as part of the company's annual filing, data on the number and type of complaints that are not resolved within 30 days, except that the time period is 30 business days as provided under section 72A.201, subdivision 4, clause (3), for insurance companies licensed under chapter 60A. The commissioner shall also make this information available to the public upon request.

(Effective Date: Section 37 (62Q.72, subdivisions 1 and 2) are effective July 1, 2000.)

Sec. 39. [62Q.73] [EXTERNAL REVIEW OF ADVERSE DETERMINATIONS.]

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

(b) An "adverse determination" means:

(1) a complaint decision relating to a health care service or claim that has been appealed in accordance with section 62Q.70 and the appeal decision is partially or wholly adverse to the complainant; or

(2) any initial determination not to certify that has been appealed in accordance with section 62M.06 and the appeal did not reverse the initial determination not to certify.

An adverse determination does not include complaints relating to fraudulent marketing practices or agent misrepresentation.

(c) "Qualified neutral" means a person certified by the commissioners of health and commerce under this section to perform external reviews.

Subd. 2. [RIGHT TO EXTERNAL REVIEW.] (a) Any enrollee or anyone acting on behalf of an enrollee who has received an adverse determination may submit a written request for an external review of the adverse determination if applicable under section 62Q.681 or 62M.06 to the commissioner of health if the request involves a health plan company regulated by that commissioner or to the commissioner of commerce if the request involves a health plan company regulated by that commissioner. The written request must be accompanied by a filing fee of \$25.

(b) Nothing in this section requires the commissioner of health or commerce to independently investigate an adverse determination referred for independent external review.

(c) If an enrollee requests an external review, the health plan company must participate in the external review. The cost of the external review in excess of the filing fee described in paragraph (a) shall be borne by the health plan company.

Subd. 3. [LIST OF QUALIFIED NEUTRALS.] The commissioners of health and commerce shall jointly establish and maintain a list of qualified neutrals certified under this section to perform external reviews. The commissioners shall ensure, to the extent practicable, that the qualified neutrals on the list together have sufficient capacity to fulfill the expected demand for external reviews in a timely fashion. The commissioners shall ensure that the fees for services rendered in connection with the reviews are reasonable. The commissioners shall publish the list of qualified neutrals at least annually.

Subd. 4. [CERTIFICATION OF QUALIFIED NEUTRALS.] (a) The commissioners of health and commerce may certify any qualified neutrals that satisfy the requirements of this subdivision. To apply for certification, a person must submit to the commissioners an application for certification, on a form prescribed by the commissioners. After certification, a qualified neutral must report to the commissioners any changes in the information provided on the application form within 30 days. Certification for qualified neutrals shall be renewed every two years.

(b) The commissioners shall provide ongoing oversight of the qualified neutrals to ensure their compliance with this section and to ensure their neutrality. The commissioners may suspend or revoke a certification or take other disciplinary and enforcement actions permitted under chapter 45 or 144, and may establish data reporting requirements and reporting schedules for certified qualified neutrals.

(c) To be certified and maintain certification, an applicant for certification must meet the following standards to the satisfaction of the commissioners:

(1) no conflicts of interest in that it is not owned, a subsidiary, or affiliate as defined in section 302A.11, subdivision 43, of a health plan company or utilization review organization;

(2) an expertise in dispute resolution;

(3) an expertise in health-related law;

(4) an ability to conduct reviews using a variety of procedures depending upon the nature of the dispute;

(5) an ability to provide data to the commissioners of health and commerce on reviews conducted; and

(6) an ability to ensure confidentiality of medical records and other enrollee information.

Subd. 5. [STANDARDS OF REVIEW.] (a) For an external review of any issue in an adverse determination that does not require a medical determination, the external review must be based on whether the adverse determination was in compliance with the complainant's health benefit plan.

(b) For an external review of any issue in an adverse determination that requires a medical determination, the external review must be based on standards of medical necessity that are generally accepted by practicing health care providers in the community.

Subd. 6. [PROCESS.] (a) Upon receipt of a request for an external review, the appropriate commissioner shall promptly assign and transmit the request to a qualified neutral. The assignment of a request to a qualified neutral must be random, except that the commissioner may take into account the capacity and areas of expertise of each qualified neutral. Upon receiving a request for an external review, the qualified neutral must provide immediate notice of the review to the enrollee and to the health plan company. Within ten business days of receiving notice of the review the health plan company and the enrollee must provide the qualified neutral with any information that they wish to be considered. Each party shall be provided an opportunity to present its version of the facts and arguments. An enrollee may be assisted or represented by a person of the enrollee's choice.

(b) As part of the external review process, an independent medical opinion may be sought as necessary. A medical review panel may be used to provide additional technical expertise when the issue presented is complex and clinical guidelines are absent, ambiguous, unclear, or conflicting.

(c) An external review shall be made as soon as practical but in no case later than 40 days after receiving the request for an external review. The qualified neutral must promptly send written notice of the decision and the reasons for it to the enrollee, the health plan company, and to the commissioner who is responsible for regulating the health plan company.

Subd. 7. [EFFECTS OF EXTERNAL REVIEW.] A decision rendered under this section shall be binding on the health plan company and the enrollee. The health plan company and the enrollee may seek judicial review of the decision on the grounds that the decision was arbitrary and capricious or involved an abuse of discretion.

Subd. 8. [IMMUNITY FROM CIVIL LIABILITY.] A person who participates in an external review by investigating, reviewing materials, providing technical expertise, or rendering a decision shall not be civilly liable for any action that is taken in good faith, that is within the scope of the person's duties, and that does not constitute willful or reckless misconduct.

Subd. 9. [DATA REPORTING.] The commissioners shall make available to the public, upon request, summary data on the decisions rendered under this section, including the number of reviews heard and decided and the final outcomes. Any data released to the public must not individually identify the enrollee initiating the request for external review.

(Effective Date: Section 38 (62Q.73, subdivisions 1 to 9) are effective July 1, 2000.)

Sec. 40. Minnesota Statutes 1998, section 62T.04, is amended to read:

62T.04 [COMPLAINT SYSTEM.]

Accountable provider networks must establish and maintain an enrollee complaint system as required under ~~section 62Q.105~~ sections 62Q.68 to 62Q.72. The accountable provider network may contract with the health care purchasing alliance or a vendor for operation of this system.

(Effective Date: Section 39 (62T.04) is effective July 1, 2000.)

Sec. 41. Minnesota Statutes 1998, section 72A.201, subdivision 4a, is amended to read:

Subd. 4a. [STANDARDS FOR PREAUTHORIZATION APPROVAL.] If a policy of accident and sickness insurance or a subscriber contract requires preauthorization approval for any nonemergency services or benefits, the decision to approve or disapprove the requested services or benefits must be communicated to the insured or the insured's health care provider within ten business days of the preauthorization request provided that all information reasonably necessary to make a decision on the request has been made available to the insurer processed according to section 62M.07.

(Effective Date: Section 40 (72A.201, subdivision 4a) is effective July 1, 2000.)

Sec. 42. Minnesota Statutes 1998, section 256B.692, subdivision 2, is amended to read:

Subd. 2. [DUTIES OF THE COMMISSIONER OF HEALTH.] Notwithstanding chapters 62D and 62N, a county that elects to purchase medical assistance and general assistance medical care in return for a fixed sum without regard to the frequency or extent of services furnished to any particular enrollee is not required to obtain a certificate of authority under chapter 62D or 62N. A county that elects to purchase medical assistance and general assistance medical care services under this section must satisfy the commissioner of health that the requirements of chapter 62D, applicable to health maintenance organizations, or chapter 62N, applicable to community integrated service networks, will be met. A county must also assure the commissioner of health that the requirements of sections 62J.041; 62J.48; 62J.71 to 62J.73; 62M.01 to 62M.16; all applicable provisions of chapter 62Q, including sections 62Q.07; 62Q.075; ~~62Q.105~~; 62Q.1055; 62Q.106; ~~62Q.11~~; 62Q.12; 62Q.135; 62Q.14; 62Q.145; 62Q.19; 62Q.23, paragraph (c); ~~62Q.30~~; 62Q.43; 62Q.47; 62Q.50; 62Q.52 to 62Q.56; 62Q.58; 62Q.64; 62Q.68 to 62Q.72; and

72A.201 will be met. All enforcement and rulemaking powers available under chapters 62D, 62J, 62M, 62N, and 62Q are hereby granted to the commissioner of health with respect to counties that purchase medical assistance and general assistance medical care services under this section.

(Effective Date: Section 41 (256B.692, subdivision 2) is effective July 1, 2000.)

Sec. 43. [REPEALER.]

(a) Minnesota Statutes 1998, sections 62D.11, subdivisions 1b and 2; and 62Q.11, are repealed effective July 1, 2000.

(b) Minnesota Statutes 1998, sections 62Q.105 and 62Q.30, are repealed effective July 1, 1999.

(c) Minnesota Rules, parts 4685.0100, subparts 4 and 4a; and 4685.1700, are repealed effective July 1, 2000.

Sec. 44. [EFFECTIVE DATE.]

When preparing the health and human services conference committee report for adoption by the legislature, the revisor shall combine all the effective date notations into this effective date section."

The motion prevailed and the amendment was adopted.

Koskinen, Schumacher, Gleason, Hausman, McCollum and Skoe moved to amend S. F. No. 2225, as amended, as follows:

Page 5, line 41, delete "116,439,000" and insert "117,863,000" and delete "147,484,000" and insert "152,194,000"

Page 5, after line 41, insert:

"[SENIOR DRUG PROGRAM.] Of this appropriation, \$1,421,000 in fiscal year 2000 and \$4,710,000 in fiscal year 2001 is to increase the income limit for the senior drug program to 150 percent of the federal poverty guidelines, as provided under Minnesota Statutes, section 256.955, subdivision 2, paragraph (d)."

Adjust the totals and summary by fund accordingly

Pages 194 to 195, delete section 16 and insert:

"Sec. 16. Minnesota Statutes 1998, 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 senior citizen" means ~~an individual age 65 or older~~ a Medicare enrollee who:

~~(1) 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~~ has a household income that does not

exceed 150 percent of the federal poverty guidelines for family size, using the income methodologies specified for aged, blind, or disabled persons in section 256B.056, subdivision 1a. Persons who are determined eligible for medical assistance according to section 256B.0575, who are eligible for medical assistance or general assistance medical care without a spenddown, or who are enrolled in MinnesotaCare, are not eligible for this program;

(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; and

(6) meets the asset standard for aged, blind, or disabled persons in section 256B.056, subdivision 3."

A roll call was requested and properly seconded.

The question was taken on the Koskinen et al amendment and the roll was called. There were 61 yeas and 68 nays as follows:

Those who voted in the affirmative were:

Anderson, I.	Gleason	Juhnke	Marko	Pelowski	Tunheim
Bakk	Gray	Kalis	McCollum	Peterson	Wagenius
Biernat	Greenfield	Kelliher	McGuire	Pugh	Wejcman
Carlson	Greiling	Koskinen	Milbert	Rest	Wenzel
Carruthers	Hasskamp	Kubly	Mullery	Rukavina	Westerberg
Chaudhary	Hausman	Larson, D.	Murphy	Schumacher	Winter
Clark, K.	Hilty	Leighton	Opatz	Skoe	
Dawkins	Huntley	Lenczewski	Osskopp	Skoglund	
Dorn	Jaros	Lieder	Osthoff	Solberg	
Entenza	Jennings	Luther	Otremba	Tomassoni	
Folliard	Johnson	Mariani	Paymar	Trimble	

Those who voted in the negative were:

Abeler	Dehler	Hackbarth	McElroy	Rostberg	Van Dellen
Abrams	Dempsey	Harder	Molnau	Seagren	Vandever
Anderson, B.	Dorman	Holsten	Mulder	Seifert, J.	Westfall
Bishop	Erhardt	Hoves	Ness	Seifert, M.	Westrom
Boudreau	Erickson	Kielkucki	Nornes	Smith	Wilkin
Bradley	Finseth	Knoblach	Olson	Stanek	Wolf
Broecker	Fuller	Krinkie	Ozment	Stang	Workman
Buesgens	Gerlach	Kuisle	Paulsen	Storm	Spk. Sviggum
Cassell	Goodno	Larsen, P.	Pawlenty	Swenson	
Clark, J.	Gunther	Leppik	Reuter	Sykora	
Daggett	Haake	Lindner	Rhodes	Tingelstad	
Davids	Haas	Mares	Rifenberg	Tuma	

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

The Speaker resumed the Chair.

Paymar; Gleason; Kelliher; Mariani; McCollum; Larson, D., and Trimble moved to amend S. F. No. 2225, as amended, as follows:

Page 10, line 35, delete "42,309,000" and insert "32,309,000"

Page 20, line 4, delete "\$236,425,000" and insert "\$246,425,000"

Page 21, after line 24, insert:

"(5) Of the amounts in clause (1), \$10,000,000 in fiscal year 2000 is transferred to the state's federal Title XX block grant. Notwithstanding the provisions of Minnesota Statutes, section 256E.07, the commissioner shall allocate this portion of the state's federal Title XX block grant funds based on the formula in Minnesota Statutes, section 256E.06. This is a one-time appropriation that shall not become part of base level funding for this activity for the 2002-2003 biennial budget. The commissioner shall ensure that this money is used according to the requirements of United States Code, title 42, section 604(d)(3)(B)."

Renumber the remaining clauses in sequence

Page 22, line 28, delete "78,582,000" and insert "88,582,000"

Page 22, after line 53, insert:

"[CHARITY CARE EQUITY FUND.] Of this general fund appropriation, \$10,000,000 in fiscal year 2000 is for the commissioner to establish and operate the charity care equity fund under Minnesota Statutes, section 62J.85. Of this amount, \$5,000,000 is available until June 30, 2001."

Correct the totals and the summaries by fund accordingly

Page 52, after line 34, insert:

"Sec. 17. [62J.85] [CHARITY CARE EQUITY FUND.]

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

(b) "Charity care services" means health care services provided to low-income or uninsured patients who are determined personally unable to pay for the cost of health care services. The patient's inability to pay shall be determined in accordance with generally accepted accounting principles through examination of individual and family income, assets, employment status, family size, or availability of alternative sources of payment. A hospital may determine the patient's inability to pay at the time services are rendered or through subsequent efforts to collect sufficient information to make such a determination.

(c) "Statewide charity care average" means the sum of all charity care services provided in Minnesota hospitals divided by the sum of all hospital operating expenses in Minnesota. This shall be annually calculated by the commissioner from audited financial statements filed under Minnesota Rules, part 4650.0110.

(d) "Qualified hospital" means a hospital certified for medical assistance under title XIX of the Social Security Act that provides a level of charity care services relative to its total hospital operating expenses that exceeds the statewide charity care average. Qualified hospital does not include a state-owned hospital.

(e) "Qualified charity care services" means the sum of all charity care services in excess of the statewide charity care average provided at all qualified hospitals.

Subd. 2. [ESTABLISHMENT.] The commissioner shall establish a charity care equity fund for the purpose of compensating qualified hospitals for qualified charity care services.

Subd. 3. [REPORT.] (a) To be eligible to receive funds from the charity care equity fund, a qualified hospital must:

(1) adopt policies and procedures to ensure documentation of charity care services; and

(2) file by July 15 of each year a report with the commissioner prepared from the hospital's audited financial statements filed under Minnesota Rules, parts 4650.0110 to 4650.0112, that sets forth the aggregate amount of charity care charges, total charges, and total operating expenses for the previous fiscal year.

(b) The commissioner may audit any report filed pursuant to this subdivision to validate the calculation of charity care services.

Subd. 4. [FUND DISTRIBUTION.] (a) The commissioner shall annually distribute to each qualified hospital an amount proportionately equal to the hospital's share of qualified charity care services.

(b) No qualified hospital shall receive a distribution amount that exceeds 60 percent of the qualified hospital's aggregate charges for charity care services."

Renumber the sections in sequence and correct internal references

Amend the title accordingly

A roll call was requested and properly seconded.

The question was taken on the Paymar et al amendment and the roll was called. There were 57 yeas and 72 nays as follows:

Those who voted in the affirmative were:

Anderson, I.	Folliard	Juhnke	Mariani	Otremba	Tomassoni
Bakk	Gleason	Kahn	Marko	Paymar	Trimble
Biernat	Gray	Kalis	McCollum	Pelowski	Tunheim
Carlson	Greenfield	Kelliher	McGuire	Pugh	Wagenius
Carruthers	Greiling	Koskinen	Milbert	Rest	Wejzman
Chaudhary	Hasskamp	Larson, D.	Mullery	Rukavina	Wenzel
Clark, K.	Hilty	Leighton	Murphy	Schumacher	Winter
Dawkins	Huntley	Lenczewski	Opatz	Skoe	
Dorn	Jaros	Lieder	Orfield	Skoglund	
Entenza	Jennings	Luther	Osthoff	Solberg	

Those who voted in the negative were:

Abeler	Bishop	Broecker	Clark, J.	Dehler	Erickson
Abrams	Boudreau	Buesgens	Daggett	Dorman	Finseth
Anderson, B.	Bradley	Cassell	Davids	Erhardt	Fuller

Gerlach	Johnson	Mares	Paulsen	Seifert, M.	Van Dellen
Goodno	Kielkucki	McElroy	Pawlenty	Smith	Vandever
Gunther	Knoblach	Molnau	Peterson	Stanek	Westerberg
Haake	Krinkie	Mulder	Reuter	Stang	Westfall
Haas	Kubly	Ness	Rhodes	Storm	Westrom
Hackbarth	Kuisle	Nornes	Rifenberg	Swenson	Wilkin
Harder	Larsen, P.	Olson	Rostberg	Sykora	Wolf
Holsten	Leppik	Osskopp	Seagren	Tingelstad	Workman
Howes	Lindner	Ozment	Seifert, J.	Tuma	Spk. Sviggum

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

Wejcman moved to amend S. F. No. 2225, as amended, as follows:

Page 10, line 35, delete "42,309,000" and insert "40,734,000"

Page 20, line 4, delete "\$236,425,000" and insert "\$238,800,000"

Page 21, after line 24, insert:

"(5) Of the amounts in clause (1), \$1,575,000 in fiscal year 2000 is transferred to the state's federal title XX block grant. Notwithstanding the provisions of Minnesota Statutes, section 256E.07, the commissioner shall allocate this portion of the state's federal title XX block grant funds based on the formula in Minnesota Statutes, section 256E.06. This is a one-time appropriation that shall not become part of base level funding for the CSSA block grant for the 2002-2003 biennial budget. The commissioner shall ensure that this money is used according to the requirements of United States Code, title 42, section 604(d)(3)(B)."

Renumber the remaining clauses in sequence

Page 26, line 46, delete "4,640,000" and insert "6,215,000"

Correct the totals and the summaries by fund accordingly

Page 52, line 24, reinstate the stricken language

Page 52, line 25, reinstate the stricken language and delete the new language

Page 52, lines 33 and 34, reinstate the stricken language

Page 104, delete lines 27 and 28

Reletter the remaining paragraphs in section 66 in sequence

A roll call was requested and properly seconded.

The question was taken on the Wejzman amendment and the roll was called. There were 61 yeas and 70 nays as follows:

Those who voted in the affirmative were:

Anderson, I.	Gleason	Juhnke	Mariani	Paymar	Trimble
Bakk	Gray	Kahn	Marko	Pelowski	Tunheim
Biernat	Greenfield	Kalis	McCollum	Peterson	Wagenius
Carlson	Greiling	Kelliher	McGuire	Pugh	Wejzman
Carruthers	Hasskamp	Koskinen	Milbert	Rest	Wenzel
Chaudhary	Hausman	Kubly	Mullery	Rukavina	Winter
Clark, K.	Hilty	Larson, D.	Murphy	Schumacher	
Dawkins	Huntley	Leighton	Opatz	Skoe	
Dorn	Jaros	Lenczewski	Orfield	Skoglund	
Entenza	Jennings	Lieder	Osthoff	Solberg	
Folliard	Johnson	Luther	Otremba	Tomassoni	

Those who voted in the negative were:

Abeler	Dehler	Hackbarth	McElroy	Rifenberg	Tuma
Abrams	Dempsey	Harder	Molnau	Rostberg	Van Dellen
Anderson, B.	Dorman	Holsten	Mulder	Seagren	Vandever
Bishop	Erhardt	Howes	Ness	Seifert, J.	Westerberg
Boudreau	Erickson	Kielkucki	Nornes	Seifert, M.	Westfall
Bradley	Finseth	Knoblach	Olson	Smith	Westrom
Broecker	Fuller	Krinkie	Osskopp	Stanek	Wilkin
Buesgens	Gerlach	Kuisle	Ozment	Stang	Wolf
Cassell	Goodno	Larsen, P.	Paulsen	Storm	Workman
Clark, J.	Gunther	Leppik	Pawlenty	Swenson	Spk. Sviggum
Daggett	Haake	Lindner	Reuter	Sykora	
Davids	Haas	Mares	Rhodes	Tingelstad	

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

Greenfield moved to amend S. F. No. 2225, as amended, as follows:

Page 5, line 41, delete "116,439,000" and insert "120,985,000" and delete "147,484,000" and insert "158,472,000"

Page 5, after line 41, insert:

"[EXPANSION OF ELIGIBILITY.] Of this appropriation, \$4,546,000 in fiscal year 2000 and \$10,988,000 in fiscal year 2001 is to increase the income limit for single adults and households with no children, as provided under Minnesota Statutes, section 256L.04, subdivision 7."

Page 6, line 50, delete "129,661,000" and insert "129,504,000"

Correct the totals and summary by fund accordingly

Page 301, after line 18, insert:

"Sec. 79. Minnesota Statutes 1998, section 256L.04, subdivision 7, is amended to read:

Subd. 7. [SINGLE ADULTS AND HOUSEHOLDS WITH NO CHILDREN.] The definition of eligible persons includes all individuals and households with no children who have gross family incomes that are equal to or less than ~~175~~ 275 percent of the federal poverty guidelines."

Page 305, line 7, after "1" insert "or 7"

Page 305, strike lines 10 to 12

Page 305, strike everything before "For"

A roll call was requested and properly seconded.

The question was taken on the Greenfield amendment and the roll was called. There were 60 yeas and 72 nays as follows:

Those who voted in the affirmative were:

Anderson, I.	Folliard	Jennings	Lenczewski	Opatz	Schumacher
Bakk	Gleason	Johnson	Lieder	Orfield	Skoe
Biernat	Gray	Juhnke	Luther	Osthoff	Skoglund
Carlson	Greenfield	Kahn	Mariani	Otremba	Solberg
Carruthers	Greiling	Kalis	Marko	Paymar	Tomassoni
Chaudhary	Hasskamp	Kelliher	McCollum	Pelowski	Trimble
Clark, K.	Hausman	Koskinen	McGuire	Peterson	Tunheim
Dawkins	Hilty	Kubly	Milbert	Pugh	Wagenius
Dorn	Huntley	Larson, D.	Mullery	Rest	Wejzman
Entenza	Jaros	Leighton	Murphy	Rukavina	Winter

Those who voted in the negative were:

Abeler	Dehler	Hackbarth	Mares	Rhodes	Tingelstad
Abrams	Dempsey	Harder	McElroy	Rifenberg	Tuma
Anderson, B.	Dorman	Holberg	Molnau	Rostberg	Van Dellen
Bishop	Erhardt	Holsten	Mulder	Seagren	Vandever
Boudreau	Erickson	Howes	Ness	Seifert, J.	Wenzel
Bradley	Finseth	Kielkucki	Nornes	Seifert, M.	Westerberg
Broecker	Fuller	Knoblach	Olson	Smith	Westfall
Buesgens	Gerlach	Krinkie	Osskopp	Stanek	Westrom
Cassell	Goodno	Kuisle	Ozment	Stang	Wilkin
Clark, J.	Gunther	Larsen, P.	Paulsen	Storm	Wolf
Daggett	Haake	Leppik	Pawlenty	Swenson	Workman
Davids	Haas	Lindner	Reuter	Sykora	Spk. Sviggum

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

Luther and Dorn moved to amend S. F. No. 2225, as amended, as follows:

Page 64, after line 27, insert:

"Sec. 28. [144.1461] [MEDICAL EDUCATION AND RESEARCH COSTS ENDOWMENT.]

Subdivision 1. [ESTABLISHMENT; PURPOSE.] The medical education and research costs endowment fund is established as a nonexpendable trust fund to support medical education and research activities throughout the state. The commissioner of health shall administer the fund. All earnings of the endowment must be credited to the fund.

The commissioner of finance shall credit to the fund 50 percent of the tobacco settlement payments received by the state on January 2, 2002, and January 2, 2003, as a result of the settlement of State v. Philip Morris Inc., No. C1-94-8565 (Minnesota District Court, Second Judicial District).

Subd. 2. [APPROPRIATION.] Beginning in fiscal year 2002, the accrued earnings of the medical education and research costs endowment fund, not to exceed \$10,000,000, is annually appropriated to the commissioner of health for distribution according to section 62J.69.

Subd. 3. [REVIEW.] The purpose of the endowment fund shall be reviewed in the governor's budget each biennium."

Page 80, after line 11, insert:

"Sec. 34. [144.3942] [TOBACCO PREVENTION ENDOWMENT FUND.]

Subdivision 1. [CREATION.] The tobacco prevention endowment fund is created as an account in the state treasury. The commissioner of finance shall credit to the fund 50 percent of the tobacco settlement payments received by the state on January 2, 2002, and January 2, 2003, as a result of the settlement of State v. Philip Morris Inc., No. C1-94-8565 (Minnesota District Court, Second Judicial District). The state board of investment shall invest the fund under section 11A.24. All earnings of the fund must be credited to the fund.

Subd. 2. [APPROPRIATION; EXPENDITURES.] The purpose of the fund is to provide money to reduce the human and economic consequences of tobacco use through tobacco prevention measures. On July 1 of each year beginning in 2003, a sum equal to five percent of the market value of the fund on the preceding July 1 is appropriated from the fund to the commissioner of health for grants for activities against tobacco use. A portion of the activities shall be grants distributed to local boards of health for tobacco use prevention measures. Local boards of health are encouraged to use these grant funds in collaboration with schools or other public or private entities conducting similar or related initiatives, in a manner that does not duplicate existing efforts.

Subd. 3. [AUDITS REQUIRED.] The legislative auditor shall audit endowment fund expenditures to ensure that the money is spent for tobacco prevention measures.

Subd. 4. [REPORT.] Beginning January 15, 2004, and annually thereafter, the commissioner of health must submit a report to the legislature on the prevention measures and initiatives that have been undertaken during the preceding year."

Renumber the sections in sequence and correct internal references

Amend the title accordingly

A roll call was requested and properly seconded.

The question was taken on the Luther and Dorn amendment and the roll was called. There were 60 yeas and 70 nays as follows:

Those who voted in the affirmative were:

Anderson, I.	Chaudhary	Entenza	Greiling	Jennings	Kelliher
Bakk	Clark, K.	Folliard	Hausman	Johnson	Koskinen
Biernat	Dawkins	Gleason	Hilty	Juhnke	Kubly
Carlson	Dehler	Gray	Huntley	Kahn	Larson, D.
Carruthers	Dorn	Greenfield	Jaros	Kalis	Leighton

Lenczewski	McCollum	Opatz	Peterson	Skoe	Tunheim
Lieder	McGuire	Orfield	Pugh	Skoglund	Wagenius
Luther	Milbert	Otremba	Rest	Solberg	Wejzman
Mariani	Mullery	Paymar	Rukavina	Tomassoni	Wenzel
Marko	Murphy	Pelowski	Schumacher	Trimble	Winter

Those who voted in the negative were:

Abeler	Dempsey	Harder	McElroy	Rhodes	Tingelstad
Abrams	Dorman	Holberg	Molnau	Rifenberg	Tuma
Anderson, B.	Erhardt	Holsten	Mulder	Rostberg	Van Dellen
Bishop	Erickson	Howes	Ness	Seagren	Vandever
Boudreau	Finseth	Kielkucki	Nornes	Seifert, J.	Westerberg
Bradley	Fuller	Knoblach	Olson	Seifert, M.	Westfall
Broecker	Gerlach	Krinkie	Osskopp	Smith	Westrom
Buesgens	Goodno	Kuisle	Osthoff	Stanek	Wilkin
Cassell	Gunther	Larsen, P.	Ozment	Stang	Wolf
Clark, J.	Haake	Leppik	Paulsen	Storm	Spk. Sviggum
Daggett	Haas	Lindner	Pawlenty	Swenson	
Davids	Hackbarth	Mares	Reuter	Sykora	

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

The Speaker called Abrams to the Chair.

Seagren; Ness; Smith; Anderson, I.; Mares; Solberg; Broecker; Larson, D.; Dorman; Wolf; Swenson; Seifert, M.; Wilkin; Vandever; Dempsey; Workman; Reuter; Lieder; Osskopp; Kalis; Tomassoni; Rostberg; Olson; Boudreau; Tuma; Ozment; Lindner; Anderson, B.; Smith; Peterson; Westrom; Jennings; Rukavina; Cassell; Hasskamp; Tunheim; Nornes; Fuller; Rifenberg; Sykora; Gunther; Seifert, J.; Abeler; Kielkucki; Huntley; Davids; Stang and Molnau moved to amend S. F. No. 2225, as amended, as follows:

Page 51, after line 32, insert:

"Sec. 14. Minnesota Statutes 1998, section 62J.69, is amended by adding a subdivision to read:

Subd. 1a. [ADVISORY COMMITTEE.] The commissioner shall appoint an advisory committee to provide advice and oversight on the distribution of funds from the medical education and research trust fund. If a committee is appointed, the commissioner shall:

- (1) consider the interest of all stakeholders when selecting committee members;
- (2) select members that represent both urban and rural interests; and
- (3) select members that include ambulatory care as well as inpatient perspectives.

The commissioner shall appoint to the advisory committee representatives of the following groups: medical researchers; public and private academic medical centers, including a representative from each academic center offering an accredited training program for physicians, pharmacists, chiropractors, dentists, and nurses; managed care organizations; Blue Cross and Blue Shield of Minnesota; commercial carriers; Minnesota Medical Association; Minnesota Nurses Association; Minnesota Chiropractic Association; medical product manufacturers; employers; and other relevant stakeholders, including consumers. The advisory committee is governed by section 15.059 for membership terms and removal of members, and expires on June 30, 2001.

(Effective Date: Section 14 (62J.69, subd. 1a) is effective the day following final enactment.)

Sec. 15. Minnesota Statutes 1998, section 62J.69, subdivision 2, is amended to read:

Subd. 2. [ALLOCATION AND FUNDING FOR MEDICAL EDUCATION AND RESEARCH.] (a) The commissioner may establish a trust fund for the purposes of funding medical education and research activities in the state of Minnesota.

~~(b) By January 1, 1997, the commissioner may appoint an advisory committee to provide advice and oversight on the distribution of funds from the medical education and research trust fund. If a committee is appointed, the commissioner shall: (1) consider the interest of all stakeholders when selecting committee members; (2) select members that represent both urban and rural interest; and (3) select members that include ambulatory care as well as inpatient perspectives. The commissioner shall appoint to the advisory committee representatives of the following groups: medical researchers, public and private academic medical centers, managed care organizations, Blue Cross and Blue Shield of Minnesota, commercial carriers, Minnesota Medical Association, Minnesota Nurses Association, medical product manufacturers, employers, and other relevant stakeholders, including consumers. The advisory committee is governed by section 15.059, for membership terms and removal of members and will sunset on June 30, 1999.~~

~~(c)~~ Eligible applicants for funds are accredited medical education teaching institutions, consortia, and programs operating in Minnesota. Applications must be submitted by the sponsoring institution on behalf of the teaching program, and must be received by September 30 of each year for distribution in January of the following year. An application for funds must include the following:

(1) the official name and address of the sponsoring institution and the official name and address of the facility or programs on whose behalf the institution is applying for funding;

(2) the name, title, and business address of those persons responsible for administering the funds;

(3) for each accredited medical education program for which funds are being sought the type and specialty orientation of trainees in the program, the name, address, and medical assistance provider number of each training site used in the program, the total number of trainees at each site, and the total number of eligible trainees at each training site;

(4) audited clinical training costs per trainee for each medical education program where available or estimates of clinical training costs based on audited financial data;

(5) a description of current sources of funding for medical education costs including a description and dollar amount of all state and federal financial support, including Medicare direct and indirect payments;

(6) other revenue received for the purposes of clinical training; and

(7) other supporting information the commissioner, with advice from the advisory committee, determines is necessary for the equitable distribution of funds.

~~(d)~~ (c) The commissioner shall distribute medical education funds to all qualifying applicants based on the following basic criteria: (1) total medical education funds available; (2) total eligible trainees in each eligible education program; and (3) the statewide average cost per trainee, by type of trainee, in each medical education program. Funds distributed shall not be used to displace current funding appropriations from federal or state sources. Funds shall be distributed to the sponsoring institutions indicating the amount to be paid to each of the sponsor's medical education programs based on the criteria in this paragraph. Sponsoring institutions which receive funds from the trust fund must distribute approved funds to the medical education program according to the commissioner's approval letter. Further, programs must distribute funds among the sites of training as specified in the commissioner's approval letter. Any funds not distributed as directed by the commissioner's approval letter shall be returned to the medical education and research trust fund within 30 days of a notice from the commissioner. The commissioner shall distribute returned funds to the appropriate entities in accordance with the commissioner's approval letter.

~~(e)~~ (d) Medical education programs receiving funds from the trust fund must submit a medical education and research grant verification report (GVR) through the sponsoring institution based on criteria established by the commissioner. If the sponsoring institution fails to submit the GVR by the stated deadline, or to request and meet the deadline for an extension, the sponsoring institution is required to return the full amount of the medical education and research trust fund grant to the medical education and research trust fund within 30 days of a notice from the commissioner. The commissioner shall distribute returned funds to the appropriate entities in accordance with the commissioner's approval letter. The reports must include:

- (1) the total number of eligible trainees in the program;
- (2) the programs and residencies funded, the amounts of trust fund payments to each program, and within each program, the dollar amount distributed to each training site; and
- (3) other information the commissioner, with advice from the advisory committee, deems appropriate to evaluate the effectiveness of the use of funds for clinical training.

The commissioner, with advice from the advisory committee, will provide an annual summary report to the legislature on program implementation due February 15 of each year.

~~(f)~~ (e) The commissioner is authorized to distribute funds made available through:

- (1) voluntary contributions by employers or other entities;
- (2) allocations for the department of human services to support medical education and research; and
- (3) other sources as identified and deemed appropriate by the legislature for inclusion in the trust fund.

~~(g) The advisory committee shall continue to study and make recommendations on:~~

~~(1) the funding of medical research consistent with work currently mandated by the legislature and under way at the department of health; and~~

~~(2) the costs and benefits associated with medical education and research.~~

(Effective Date: Section 15 (62J.69, subd. 2) is effective the day following final enactment.)"

Page 51, line 36, delete "(c) and (d)" and insert "(b) and (c)"

Page 52, after line 4, insert:

"Sec. 17. Minnesota Statutes 1998, section 62J.69, subdivision 4, is amended to read:

Subd. 4. [TRANSFERS FROM THE COMMISSIONER OF HUMAN SERVICES.] (a) The amount transferred according to section 256B.69, subdivision 5c, shall be distributed by the commissioner to qualifying applicants 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 trainees and the total statewide average costs per trainee, by type of trainee, in each 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 trust fund pool.

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) Public program revenue for the formula in paragraph (a) 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 payments from the prepaid medical assistance program transfer pool.

(Effective Date: Section 17 (62J.69, subdivision 4) is effective the day following final enactment.)

Sec. 18. Minnesota Statutes 1998, section 62J.69, subdivision 5, is amended to read:

Subd. 5. [REVIEW OF ELIGIBLE PROVIDERS.] ~~(a) Provider groups added after January 1, 1998, to the list of providers eligible for the trust fund shall not receive funding from the trust fund without prior evaluation by the commissioner and the medical education and research costs advisory committee. The evaluation shall consider the degree to which the training of the provider group:~~

- ~~(1) takes place in patient care settings, which are consistent with the purposes of this section;~~
- ~~(2) is funded with patient care revenues;~~
- ~~(3) takes place in patient care settings, which face increased financial pressure as a result of competition with nonteaching patient care entities; and~~
- ~~(4) emphasizes primary care or specialties, which are in undersupply in Minnesota.~~

~~Results of this evaluation shall be reported to the legislative commission on health care access. The legislative commission on health care access must approve funding for the provider group prior to their receiving any funding from the trust fund. In the event that a reviewed provider group is not approved by the legislative commission on health care access, trainees in that provider group shall be considered ineligible trainees for the trust fund distribution.~~

~~(b) The commissioner and the medical education and research costs advisory committee may also review the eligible list of provider groups, which were added to the eligible list of provider groups prior to January 1, 1998, to assure that the trust fund money continues to be is distributed consistent with the purpose of this section. The results of any such reviews must be reported to the legislative commission on health care access. Trainees in provider groups, which were added prior to January 1, 1998, and which are reviewed by the commissioner and the medical education and research costs advisory committee, shall be considered eligible trainees for purposes of the trust fund distribution unless and until the legislative commission on health care access disapproves their eligibility, in which case they shall be considered ineligible trainees.~~

(Effective Date: Section 18 (62J.69, subd. 5) is effective the day following final enactment.)

Page 105, after line 1, insert:

"(g) Minnesota Statutes 1998, section 62J.69, subdivision 3, is repealed effective the day following final enactment."

Renumber the sections in sequence and correct internal references

Amend the title accordingly

A roll call was requested and properly seconded.

The question was taken on the Seagren et al amendment and the roll was called. There were 125 yeas and 6 nays as follows:

Those who voted in the affirmative were:

Abeler	Dorman	Holberg	Lieder	Paulsen	Storm
Abrams	Dorn	Holsten	Lindner	Pawlenty	Swenson
Anderson, B.	Entenza	Howes	Luther	Paymar	Sykora
Anderson, I.	Erhardt	Huntley	Mares	Pelowski	Tingelstad
Bakk	Erickson	Jaros	Mariani	Peterson	Tomassoni
Biernat	Finseth	Jennings	Marko	Pugh	Trimble
Bishop	Folliard	Johnson	McCollum	Rest	Tuma
Boudreau	Fuller	Juhnke	McElroy	Reuter	Tunheim
Bradley	Gerlach	Kalis	McGuire	Rhodes	Van Dellen
Broecker	Gleason	Kelliher	Milbert	Rifenberg	Vandever
Buesgens	Goodno	Kielkucki	Molnau	Rostberg	Wejzman
Carlson	Gray	Knoblach	Murphy	Rukavina	Wenzel
Cassell	Greiling	Koskinen	Ness	Schumacher	Westerberg
Chaudhary	Gunther	Krinkie	Nornes	Seagren	Westfall
Clark, J.	Haake	Kubly	Olson	Seifert, J.	Westrom
Clark, K.	Haas	Kuisle	Opatz	Seifert, M.	Wilkin
Daggett	Hackbarth	Larsen, P.	Orfield	Skoe	Winter
Davids	Harder	Larson, D.	Osskopp	Smith	Wolf
Dawkins	Hasskamp	Leighton	Osthoff	Solberg	Workman
Dehler	Hausman	Lenczewski	Otremba	Stanek	Spk. Sviggum
Dempsey	Hilty	Leppik	Ozment	Stang	

Those who voted in the negative were:

Carruthers	Greenfield	Kahn	Mulder	Skoglund	Wagenius
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The motion prevailed and the amendment was adopted.

S. F. No. 2225, as amended, was read for the third time.

MOTION FOR RECONSIDERATION

Carruthers moved that the action whereby S. F. No. 2225, as amended, was read for the third time be now reconsidered. The motion prevailed.

Koskinen, Huntley and Schumacher moved to amend S. F. No. 2225, as amended, as follows:

Page 14, line 19, delete "compensation"

Page 14, line 20, delete "packages of" and insert "additional revenue from the reimbursement rate increases under this provision be used to increase wages paid to"

Page 14, line 21, delete "be increased"

Page 14, line 22, after the period, insert:

"In order to qualify for the rate increases in clause (1), providers listed in that clause must increase wages paid to employees who perform direct care duties by three percent each year of the biennium. A provider must submit a plan to the commissioner detailing how the provider will distribute the rate increases as a salary adjustment to employees who perform direct care duties. The commissioner must review the plan to ensure the salary adjustment is used solely to increase the wages paid to provider employees, except management employees who do not perform direct care duties. After the commissioner has reviewed the plan, the provider must post a copy of the plan at the provider's place of business so that it is available for review by interested employees who perform direct care duties.

(4) In addition to the requirements of clause (3), in order to qualify for the rate increases under this provision for services provided on or after July 1, 2000, the provider must certify to the commissioner that the entire amount of the rate increases received under this provision for services provided on or after July 1, 1999, was used solely to increase the wages of the provider's employees who perform direct care duties.

(5) For providers whose employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative after July 1, 1999, or July 1, 2000, respectively, may constitute the salary adjustment plan required under clause (3)."

Renumber the remaining clauses in sequence

Page 138, after line 9, insert:

"(c) In order to qualify for the rate increases under this subdivision, facilities must submit to the commissioner a plan to increase wages paid to employees, except management employees who do not perform direct care duties, by the specified percentage in paragraph (a) or (b) that applies to the facility, for the rate years beginning July 1, 1999 and July 1, 2000. For facilities whose employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative, after July 1, 1999, or July 1, 2000, may constitute the plan for the salary distribution. The commissioner shall review the plan to ensure that the salary adjustment is used solely to increase the wages of facility employees, except management employees who do not perform direct care duties. After the commissioner has reviewed the salary distribution plan, the employer must post a copy of the plan at the facility so that it is available for review by interested nonadministrative employees. To be eligible, a facility must submit its plan for the salary distribution by December 31, 1999, and December 31, 2000. If a facility's plan for salary distribution is effective for its employees after July 1, 1999, or July 1, 2000, the salary adjustment shall be effective the same date as its plan.

(d) In addition to the requirements in paragraph (c), in order to qualify for the rate increases for services on or after July 1, 2000, the employer must certify to the commissioner that the rate increase received by the facility for services on or after July 1, 1999, was used to increase the wages of the facility's nonadministrative employees by the specified percentage in paragraph (a) or (b) that applies to the facility."

Page 157, after line 14, insert:

"(c) In order to qualify for the rate increases under this subdivision, facilities must submit to the commissioner a plan to increase wages paid to employees, except management employees who do not perform direct care duties, by three percent for the rate years beginning October 1, 1999 and October 1, 2000. For facilities whose employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative, after October 1, 1999, or October 1, 2000, may constitute the plan for the salary distribution. The commissioner shall review the plan to ensure that the salary adjustment is used solely to increase the wages of facility employees, except management employees who do not perform direct care duties. After the commissioner has reviewed the salary distribution plan, the employer must post a copy of the plan at the facility so that it is available for review by interested nonadministrative employees. To be eligible, a facility must submit its plan for the salary distribution by December 31, 1999, and December 31, 2000. If a facility's plan for salary distribution is effective for its employees after October 1, 1999, or October 1, 2000, the salary adjustment shall be effective the same date as its plan.

(d) In addition to the requirements in paragraph (c), in order to qualify for the rate increases for services on or after October 1, 2000, the employer must certify to the commissioner that the rate increase received by the facility for services on or after October 1, 1999, was used to increase the wages of the facility's nonadministrative employees by three percent."

A roll call was requested and properly seconded.

The question was taken on the Koskinen et al amendment and the roll was called. There were 58 yeas and 73 nays as follows:

Those who voted in the affirmative were:

Anderson, I.	Folliard	Jennings	Lieder	Orfield	Skoglund
Bakk	Gleason	Johnson	Luther	Osthoff	Tomassoni
Biernat	Gray	Kahn	Mariani	Otremba	Trimble
Carlson	Greenfield	Kalis	Marko	Paymar	Tunheim
Carruthers	Greiling	Kelliher	McCollum	Pelowski	Wagenius
Chaudhary	Hasskamp	Koskinen	McGuire	Peterson	Wejman
Clark, K.	Hausman	Kubly	Milbert	Pugh	Wenzel
Dawkins	Hilty	Larson, D.	Mullery	Rest	Winter
Dorn	Huntley	Leighton	Murphy	Rukavina	
Entenza	Jaros	Lenczewski	Opatz	Skoe	

Those who voted in the negative were:

Abeler	Dempsey	Holberg	Molnau	Schumacher	Vandever
Abrams	Dorman	Holsten	Mulder	Seagren	Westerberg
Anderson, B.	Erhardt	Howes	Ness	Seifert, J.	Westfall
Bishop	Erickson	Juhnke	Nornes	Seifert, M.	Westrom
Boudreau	Finseth	Kielkucki	Olson	Smith	Wilkin
Bradley	Fuller	Knoblach	Osskopp	Stanek	Wolf
Broecker	Gerlach	Krinkie	Ozment	Stang	Workman
Buesgens	Goodno	Kuisle	Paulsen	Storm	Spk. Sviggum
Cassell	Gunther	Larsen, P.	Pawlenty	Swenson	
Clark, J.	Haake	Leppik	Reuter	Sykora	
Daggett	Haas	Lindner	Rhodes	Tingelstad	
Davids	Hackbarth	Mares	Rifenberg	Tuma	
Dehler	Harder	McElroy	Rostberg	Van Dellen	

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

Mariani moved to amend S. F. No. 2225, as amended, as follows:

Page 10, line 35, delete "42,309,000" and insert "40,137,000"

Page 18, after line 8, insert:

"(c) AFDC/Other Assistance

General	2,172,000	...,-0-,...
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[FOOD ASSISTANCE FOR NONCITIZENS.] The appropriation for the Minnesota food assistance program is available for either year of the biennium."

Reletter the paragraphs in subdivision 10 in sequence

Correct the totals and the summaries by fund accordingly

Page 20, line 4, delete "\$236,425,000" and insert "\$238,597,000"

Page 21, after line 24, insert:

"(5) Of the amounts in clause (1), \$2,172,000 in fiscal year 2000 is transferred to the state's federal Title XX block grant. Notwithstanding the provisions of Minnesota Statutes, section 256E.07, the commissioner shall allocate this portion of the state's federal Title XX block grant funds based on the formula in Minnesota Statutes, section 256E.06. This is a one-time appropriation that shall not become part of the base level funding for the CSSA block grant for the 2002-2003 biennial budget. The commissioner shall ensure that this money is used according to the requirements of United States Code, title 42, section 604(d)(3)(B)."

Renumber the remaining clauses in sequence

Page 348, after line 19, insert:

"Sec. 1. Minnesota Statutes 1998, section 256D.053, subdivision 1, is amended to read:

Subdivision 1. [PROGRAM ESTABLISHED.] For the period of July 1, 1998, to June 30, ~~1999~~ 2001, 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."

Renumber the sections in sequence and correct internal references

Amend the title accordingly

A roll call was requested and properly seconded.

The question was taken on the Mariani amendment and the roll was called. There were 49 yeas and 80 nays as follows:

Those who voted in the affirmative were:

Anderson, I.	Entenza	Jaros	Luther	Paymar	Wagenius
Bakk	Folliard	Johnson	Mariani	Pugh	Wejzman
Biernat	Gleason	Juhnke	McCollum	Rukavina	Wenzel
Carlson	Gray	Kahn	McGuire	Schumacher	Winter
Carruthers	Greenfield	Kalis	Milbert	Skoglund	
Chaudhary	Greiling	Kelliher	Mullery	Solberg	
Clark, K.	Hausman	Kubly	Murphy	Tomassoni	
Dawkins	Hilty	Leighton	Orfield	Trimble	
Dorn	Huntley	Lieder	Osthoff	Tunheim	

Those who voted in the negative were:

Abeler	Erhardt	Howes	Molnau	Rhodes	Tuma
Abrams	Erickson	Jennings	Mulder	Rifenberg	Van Dellen
Anderson, B.	Finseth	Kielkucki	Ness	Rostberg	Vandever
Boudreau	Fuller	Knoblach	Nornes	Seagren	Westerberg
Bradley	Gerlach	Krinkie	Olson	Seifert, J.	Westfall
Broecker	Goodno	Kuisle	Opatz	Seifert, M.	Westrom
Buesgens	Gunther	Larsen, P.	Osskopp	Skoe	Wilkin
Cassell	Haake	Larson, D.	Ozment	Smith	Wolf
Clark, J.	Haas	Lenczewski	Paulsen	Stanek	Workman
Daggett	Hackbarth	Leppik	Pawlenty	Stang	Spk. Sviggum
Dauids	Harder	Lindner	Pelowski	Storm	
Dehler	Hasskamp	Mares	Peterson	Swenson	
Dempsey	Holberg	Marko	Rest	Sykora	
Dorman	Holsten	McElroy	Reuter	Tingelstad	

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

The Speaker resumed the Chair.

Pelowski moved to amend S. F. No. 2225, as amended, as follows:

Page 10, line 35, delete "42,309,000" and insert "43,109,000"

Page 10, line 39, delete "8,841,000" and insert "9,641,000"

Page 11, after line 24, insert:

"[HOMESHARING PROGRAM.] Of the general fund appropriation, \$800,000 is for the homesharing program under Minnesota Statutes, section 256.973. This appropriation is available until June 30, 2001."

Page 20, line 4, delete "\$236,425,000" and insert "\$237,225,000"

Page 21, after line 24, insert:

"(5) Of the amounts in clause (1), \$800,000 in fiscal year 2000 is transferred to the state's federal Title XX block grant. Notwithstanding the provisions of Minnesota Statutes, section 256E.07, the commissioner shall allocate this portion of the state's federal title XX block grant funds based on the formula in Minnesota Statutes, section 256E.06. This is a one-time appropriation that shall not become part of base level funding for the CSSA block grant for the 2002-2003 biennial budget. The commissioner shall ensure that this money is used according to the requirements of United States Code, title 42, section 604(d)(3)(B)."

Renumber the remaining clauses in sequence

Page 507, delete section 2

Correct the totals and the summaries by fund accordingly

Renumber the sections in sequence and correct internal references

Amend the title accordingly

A roll call was requested and properly seconded.

The question was taken on the Pelowski amendment and the roll was called. There were 62 yeas and 69 nays as follows:

Those who voted in the affirmative were:

Anderson, I.	Gleason	Kahn	Marko	Pelowski	Trimble
Bakk	Gray	Kalis	McCollum	Peterson	Tunheim
Biernat	Greenfield	Kelliher	McGuire	Pugh	Wagenius
Carlson	Hasskamp	Koskinen	Milbert	Rest	Wejcman
Carruthers	Hausman	Kubly	Mullery	Rostberg	Wenzel
Chaudhary	Hilty	Larson, D.	Murphy	Rukavina	Westerberg
Clark, K.	Huntley	Leighton	Opatz	Schumacher	Winter
Dawkins	Jaros	Lenczewski	Orfield	Skoe	
Dorn	Jennings	Lieder	Osthoff	Skoglund	
Entenza	Johnson	Luther	Otremba	Solberg	
Folliard	Juhnke	Mariani	Paymar	Tomassoni	

Those who voted in the negative were:

Abeler	Cassell	Erickson	Hackbarth	Kuisle	Ness
Abrams	Clark, J.	Finseth	Harder	Larsen, P.	Nornes
Anderson, B.	Daggett	Fuller	Holberg	Leppik	Olson
Bishop	Davids	Gerlach	Holsten	Lindner	Osskopp
Boudreau	Dehler	Goodno	Howes	Mares	Ozment
Bradley	Dempsey	Gunther	Kielkucki	McElroy	Paulsen
Broecker	Dorman	Haake	Knoblach	Molnau	Pawlenty
Buesgens	Erhardt	Haas	Krinkie	Mulder	Reuter

Rhodes	Seifert, M.	Storm	Tuma	Westrom	Spk. Sviggum
Rifenberg	Smith	Swenson	Van Dellen	Wilkin	
Seagren	Stanek	Sykora	Vandever	Wolf	
Seifert, J.	Stang	Tingelstad	Westfall	Workman	

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

Otremba moved to amend S. F. No. 2225, as amended, as follows:

Page 22, line 34, delete "9,749,000" and insert "9,992,000" and delete "9,858,000" and insert "10,101,000"

Page 45, line 18, reinstate the stricken "provide technical assistance to regional"

Page 45, line 19, after "~~boards~~" insert "health care access councils" and reinstate the stricken semicolon

Page 45, line 20, reinstate the stricken language

Page 45, line 23, delete the new language and reinstate the stricken language

Page 46, lines 1, 3, 5, 13, and 17, delete the new language and reinstate the stricken language

Page 46, line 22, reinstate the stricken "the regional" and after "~~boards~~" insert "health care access councils" and reinstate the stricken "established"

Page 46, line 23, reinstate the stricken language

Page 46, line 32, reinstate the stricken "the regional" and after "~~boards~~" insert "health care access councils" and reinstate the stricken comma

Page 47, line 4, reinstate the stricken ", the regional" and after "~~boards~~" insert "health care access councils" and reinstate the stricken comma

Page 47, delete lines 16 to 19 and insert:

"Sec. 8. Minnesota Statutes 1998, section 62J.09, is amended to read:

62J.09 [~~REGIONAL COORDINATING BOARDS~~ HEALTH CARE ACCESS COUNCILS.]

Subdivision 1. [GENERAL DUTIES.] (a) The commissioner shall divide the state into six regions, one of these regions being the seven-county metropolitan area.

(b) Each region shall establish a locally controlled regional ~~coordinating board~~ health care access council consisting of providers, health plan companies, employers, consumers, and elected officials. Regional ~~coordinating boards may~~ health care access councils shall:

(1) identify barriers to health care access in their regions, cooperating with other local, regional, and statewide entities as appropriate;

(2) develop and implement programs or projects to reduce and eliminate barriers to health care access in their regions; and

(3) develop and submit to the commissioner of health, by August 15, 2002, a transition plan for sustaining regional health care access work beyond June 30, 2005.

(c) Regional health care access councils may:

(1) develop recommendations for statewide programs or projects to reduce and eliminate barriers to health care access and for programs, projects, or policy changes requiring legislative action. If a council develops such recommendations, the council shall forward the recommendations to the commissioner by May 30, 2000, or May 30, 2002;

(2) undertake voluntary activities to educate consumers, providers, and purchasers about community plans and projects promoting health care cost containment, consumer accountability, access, and quality and efforts to achieve public health goals;

(2) make recommendations to the commissioner regarding ways of improving affordability, accessibility, and quality of health care in the region and throughout the state;

(3) provide technical assistance to parties interested in establishing or operating a community integrated service network within the region. This assistance must complement assistance provided by the commissioner under section 62N.23;

(4) (3) advise the commissioner on public health goals, taking into consideration the relevant portions of the community health service plans, plans required by the Minnesota Comprehensive Adult Mental Health Act, the Minnesota Comprehensive Children's Mental Health Act, and the Community Social Service Act plans developed by county boards or community health boards in the region under chapters 145A, 245, and 256E; and

(5) prepare an annual regional education plan that is consistent with and supportive of public health goals identified by community health boards in the region; and

(6) serve as advisory bodies to identify potential applicants for federal Health Professional Shortage Area and federal Medically Underserved Area designation as requested by the commissioner.

(4) seek additional funds for program development and implementation from public and private sources.

(d) The commissioner shall provide staff support to the regional councils.

Subd. 2. [MEMBERSHIP.] (a) [NUMBER OF MEMBERS.] Each regional ~~coordinating board~~ health care access council consists of ~~17~~ at least 15 and no more than 18 members as provided in this subdivision. ~~A member may designate a representative to act as a member of the board in the member's absence. The governor shall appoint the chair of each regional board. Every two years, members of each council shall elect a chair from among its members. The appointing authorities under each paragraph for which there is to be chosen more than one member shall consult prior to appointments being made to ensure that, to the extent possible, the board includes a representative from each county within the region.~~

(b) [PROVIDER REPRESENTATIVES.] Each regional ~~board must~~ council may include up to four members representing health care providers who practice in the region. ~~One member is appointed by The Minnesota Medical Association. One member is appointed by~~ may appoint one member. ~~The Minnesota Hospital Association. One member is appointed by~~ and Healthcare Partnership may appoint one member. ~~The Minnesota Nurses' Association. The remaining member is appointed by~~ may appoint one member. The governor may appoint one member to represent providers other than physicians, hospitals, and nurses.

(c) [HEALTH PLAN COMPANY REPRESENTATIVES.] Each regional ~~board includes four~~ council may include up to three members representing health plan companies who provide coverage for residents of the region, ~~including one member representing health insurers who is elected by a vote of all.~~ Health insurers providing coverage in the region, ~~one member elected by a vote of all~~ may appoint one member. Health maintenance organizations providing coverage in the region, ~~and one member appointed by~~ may appoint one member. Blue Cross and Blue Shield of Minnesota. ~~The fourth member is appointed by the governor~~ may appoint one member.

(d) [EMPLOYER REPRESENTATIVES.] Regional ~~boards~~ councils ~~may include three up to two~~ members representing employers in the region. ~~Employer representatives are appointed by The Minnesota chamber of commerce from nominations provided by members of or local chambers of commerce in the region. At least one member must represent self-insured employers~~ may appoint these members.

(e) [EMPLOYEE UNIONS.] Regional ~~boards~~ councils ~~may include one member appointed by the AFL-CIO Minnesota who is a union member residing or working in the region or who is a representative of a union that is active in the region.~~

(f) [PUBLIC MEMBERS.] Regional ~~boards~~ councils ~~may include three up to five~~ consumer members. ~~One consumer member is elected by the Community health boards in the region, with each community health board having one vote. One consumer member is elected by~~ may appoint one member. The legislative commission on health care access. ~~One consumer member is appointed by~~ may appoint one member. The governor may appoint up to three consumer members who represent senior citizens, minority groups, clergy, social service agencies, or other consumer groups.

(g) [COUNTY COMMISSIONER.] Regional ~~boards~~ councils ~~may include one member up to two members who is a~~ are county board member members. The county board member is elected by a vote of all of the county board members in the region, with each county board having one vote. Association of Minnesota Counties may appoint these members.

(h) [STATE AGENCY DEPARTMENT OF HUMAN SERVICES.] Regional ~~boards~~ councils ~~may include one state agency commissioner appointed by the governor to represent state health coverage programs~~ employee of the Minnesota department of human services who is appointed by the commissioner of human services.

(i) [DUTIES OF COMMISSIONER.] The commissioner shall ensure that each council's membership is geographically representative of the council's region and may make appointments to the councils as necessary to ensure that the councils meet the requirements for the number of members in paragraph (a). The commissioner shall notify council members of the expiration of their terms, as governed by section 15.0575.

Subd. 4. [FINANCIAL INTERESTS OF MEMBERS.] A member representing employers, consumers, or employee unions must not have any personal financial interest in the health care system except as an individual consumer of health care services. An employee who participates in the management of a health benefit plan may serve as a member representing employers or unions.

Subd. 5. [CONFLICTS OF INTEREST.] No member may vote in regional ~~coordinating board~~ health care access council proceedings involving an individual provider, purchaser, or patient, or a specific activity or transaction, if the member has a direct financial interest in the outcome of the regional ~~coordinating board's~~ health care access council's proceedings other than as an individual consumer of health care services. A member with a direct financial interest may participate in the proceedings, without voting, provided that the member discloses any direct financial interest to the regional ~~coordinating board~~ health care access council at the beginning of the proceedings.

Subd. 6. [TECHNICAL ASSISTANCE.] The commissioner shall provide technical assistance to regional ~~coordinating boards.~~ Technical assistance includes providing each regional board with timely information concerning action plans, enrollment data, and health care expenditures affecting the regional board's region health care access councils as appropriate.

Subd. 6a. [CONTRACTING.] The commissioner, at the request of a regional ~~coordinating board~~ health care access council, may contract on behalf of the ~~board council~~ with an appropriate regional organization to provide staff support to the ~~board council~~, in order to assist the ~~board council~~ in carrying out the duties assigned in this section.

Subd. 7. [TERMS; COMPENSATION; REMOVAL; AND VACANCIES.] Regional coordinating boards are governed by section 15.0575, ~~except that.~~ Except for members listed in subdivision 2, paragraph (f), members do not receive per diem payments.

Subd. 8. [REPEALER.] This section is repealed effective July 1, ~~2000~~ 2004, except that the regional coordinating board covering the seven-county metropolitan area shall expire on June 30, 1999."

Page 47, line 32, reinstate the stricken "regional" and after "~~board~~" insert "health care access council"

Page 55, line 25, reinstate the stricken language

Page 55, line 26, reinstate the stricken "regional" and after "~~boards~~" insert "health care access councils" and reinstate the stricken comma

Page 56, line 5, reinstate the stricken "regional" and after "~~boards~~" insert "health care"

Page 56, line 14, reinstate the stricken language

Page 56, line 15, after "~~boards~~" insert "health care access councils" and reinstate the stricken comma

Page 72, line 8, delete the new language and reinstate the stricken language

Page 72, line 9, reinstate the stricken "the regional" and after "~~board~~" insert "health care access council" and reinstate the stricken "for the area"

Renumber the sections in sequence

Correct internal references

Amend the title accordingly

Correct the totals and summaries by fund accordingly

A roll call was requested and properly seconded.

The question was taken on the Otremba amendment and the roll was called. There were 57 yeas and 75 nays as follows:

Those who voted in the affirmative were:

Anderson, I.	Folliard	Johnson	Mariani	Paymar	Tomassoni
Bakk	Gleason	Juhnke	Marko	Pelowski	Trimble
Biernat	Gray	Kahn	McCollum	Peterson	Tunheim
Carlson	Greenfield	Kalis	McGuire	Pugh	Wagenius
Carruthers	Greiling	Kelliher	Milbert	Rostberg	Wejcman
Chaudhary	Hausman	Koskinen	Mullery	Rukavina	Wenzel
Clark, K.	Hilty	Kubly	Murphy	Schumacher	Winter
Dawkins	Huntley	Leighton	Orfield	Skoe	
Dorn	Jaros	Lieder	Osthoff	Skoglund	
Entenza	Jennings	Luther	Otremba	Solberg	

Those who voted in the negative were:

Abeler	Bishop	Broecker	Clark, J.	Dehler	Erhardt
Abrams	Boudreau	Buesgens	Daggett	Dempsey	Erickson
Anderson, B.	Bradley	Cassell	Davids	Dorman	Finseth

Fuller	Holsten	Lindner	Ozment	Smith	Westerberg
Gerlach	Howes	Mares	Paulsen	Stanek	Westfall
Goodno	Kielkucki	McElroy	Pawlenty	Stang	Westrom
Gunther	Knoblach	Molnau	Rest	Storm	Wilkin
Haake	Krinkie	Mulder	Reuter	Swenson	Wolf
Haas	Kuisle	Ness	Rhodes	Sykora	Workman
Hackbarth	Larsen, P.	Nornes	Rifenberg	Tingelstad	Spk. Sviggum
Harder	Larson, D.	Olson	Seagren	Tuma	
Hasskamp	Lenczewski	Opatz	Seifert, J.	Van Dellen	
Holberg	Leppik	Osskopp	Seifert, M.	Vandever	

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

Opatz moved to amend S. F. No. 2225, as amended, as follows:

Page 506, after line 8, insert:

"Section 1. Minnesota Statutes 1998, section 62A.041, subdivision 2, is amended to read:

Subd. 2. [LIMITATION ON COVERAGE PROHIBITED.] Each group policy of accident and health insurance, except for policies which only provide coverage for specified diseases, or each group subscriber contract of accident and health insurance or health maintenance contract, issued or renewed after August 1, 1987, shall include maternity benefits in the same manner as any other illness covered under the policy or contract, except that policy waiting periods for these benefits may not be imposed.

(Effective date: Section 1 (62A.041, subdivision 2) is effective August 1, 1999, and applies to health plans issued or renewed to provide coverage to Minnesota residents on or after that date.)

Sec. 2. Minnesota Statutes 1998, section 62A.0411, is amended to read:

62A.0411 [MATERNITY CARE.]

Every health plan as defined in section 62Q.01, subdivision 3, that provides maternity benefits must, consistent with other coinsurance, copayment, deductible, and related contract terms, provide coverage of a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a caesarean section for a mother and her newborn. The health plan may not impose waiting periods for these benefits. The health plan shall not provide any compensation or other nonmedical remuneration to encourage a mother and newborn to leave inpatient care before the duration minimums specified in this section.

The health plan must also provide coverage for postdelivery care to a mother and her newborn if the duration of inpatient care is less than the minimums provided in this section.

Postdelivery care consists of a minimum of one home visit by a registered nurse. Services provided by the registered nurse include, but are not limited to, parent education, assistance and training in breast and bottle feeding, and conducting any necessary and appropriate clinical tests. The home visit must be conducted within four days following the discharge of the mother and her child.

(Effective date: Section 2 (62A.0411) is effective August 1, 1999, and applies to health plans issued or renewed to provide coverage to Minnesota residents on or after that date.)

Sec. 3. Minnesota Statutes 1998, section 62A.047, is amended to read:

62A.047 [CHILDREN'S HEALTH SUPERVISION SERVICES AND PRENATAL CARE SERVICES.]

A policy of individual or group health and accident insurance regulated under this chapter, or individual or group subscriber contract regulated under chapter 62C, health maintenance contract regulated under chapter 62D, or health benefit certificate regulated under chapter 64B, issued, renewed, or continued to provide coverage to a Minnesota resident, must provide coverage for child health supervision services and prenatal care services. The policy, contract, or certificate must specifically exempt reasonable and customary charges for child health supervision services and prenatal care services from a deductible, copayment, or other coinsurance or dollar limitation requirement. ~~This section does not prohibit~~ and the use of policy waiting periods or preexisting condition limitations for these services. Minimum benefits may be limited to one visit payable to one provider for all of the services provided at each visit cited in this section subject to the schedule set forth in this section. Nothing in this section applies to a commercial health insurance policy issued as a companion to a health maintenance organization contract, a policy designed primarily to provide coverage payable on a per diem, fixed indemnity, or nonexpense incurred basis, or a policy that provides only accident coverage.

"Child health supervision services" means pediatric preventive services, appropriate immunizations, developmental assessments, and laboratory services appropriate to the age of a child from birth to age six, and appropriate immunizations from ages six to 18, as defined by Standards of Child Health Care issued by the American Academy of Pediatrics. Reimbursement must be made for at least five child health supervision visits from birth to 12 months, three child health supervision visits from 12 months to 24 months, once a year from 24 months to 72 months.

"Prenatal care services" means the comprehensive package of medical and psychosocial support provided throughout the pregnancy, including risk assessment, serial surveillance, prenatal education, and use of specialized skills and technology, when needed, as defined by Standards for Obstetric-Gynecologic Services issued by the American College of Obstetricians and Gynecologists.

(Effective date: Section 3 (62A.047) is effective August 1, 1999, and applies to health plans issued or renewed to provide coverage to Minnesota residents on or after that date.)"

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

A roll call was requested and properly seconded.

The question was taken on the Opatz amendment and the roll was called. There were 130 yeas and 2 nays as follows:

Those who voted in the affirmative were:

Abeler	Carlson	Dempsey	Gleason	Hasskamp	Juhnke
Abrams	Carruthers	Dorman	Goodno	Hausman	Kahn
Anderson, B.	Cassell	Dorn	Gray	Hilty	Kalis
Anderson, I.	Chaudhary	Entenza	Greenfield	Holberg	Kelliher
Bakk	Clark, J.	Erhardt	Greiling	Holsten	Kielkucki
Biernat	Clark, K.	Erickson	Gunther	Howes	Knoblach
Bishop	Daggett	Finseth	Haake	Huntley	Koskinen
Boudreau	Davids	Folliard	Haas	Jaros	Krinkie
Broecker	Dawkins	Fuller	Hackbarth	Jennings	Kubly
Buesgens	Dehler	Gerlach	Harder	Johnson	Kuisle

Larsen, P.	McElroy	Osthoff	Rifenberg	Stang	Wejman
Larson, D.	McGuire	Otremba	Rostberg	Storm	Wenzel
Leighton	Milbert	Ozment	Rukavina	Swenson	Westerberg
Lenczewski	Molnau	Paulsen	Schumacher	Sykora	Westfall
Leppik	Mullery	Pawlenty	Seagren	Tingelstad	Westrom
Lieder	Murphy	Paymar	Seifert, J.	Tomassoni	Wilkin
Lindner	Ness	Pelowski	Seifert, M.	Trimble	Winter
Luther	Nornes	Peterson	Skoe	Tuma	Wolf
Mares	Olson	Pugh	Skoglund	Tunheim	Workman
Mariani	Opatz	Rest	Smith	Van Dellen	Spk. Sviggum
Marko	Orfield	Reuter	Solberg	Vandever	
McCollum	Osskopp	Rhodes	Stanek	Wagenius	

Those who voted in the negative were:

Bradley Mulder

The motion prevailed and the amendment was adopted.

McCollum and Otremba moved to amend S. F. No. 2225, as amended, as follows:

Page 26, after line 32, insert:

"Health care access

755,000 -0-"

Page 26, after line 44, insert:

"[BREAST AND CERVICAL CANCER SCREENING SERVICES.] Of the health care access fund appropriation, \$755,000 for the biennium is for the breast and cervical cancer control program to fund breast and cervical cancer screening through local health care providers for low-income individuals without adequate health insurance. Base level funding for this activity shall be established at \$378,000 in the 2002-2003 biennial budget, and shall be provided through the health care access fund established under Minnesota Statutes, section 16A.724, to the extent that the health care access fund has a positive balance."

Correct the totals and the summaries by fund accordingly

The motion prevailed and the amendment was adopted.

Orfield moved to amend S. F. No. 2225, as amended, as follows:

Page 507, after line 16, insert:

"Section 1. Minnesota Statutes 1998, section 62A.60, is amended to read:

62A.60 [RETROACTIVE DENIAL OF EXPENSES.]

In cases where the subscriber or insured is liable for costs beyond applicable copayments or deductibles, no insurer may retroactively deny payment to a person who is covered when the services are provided for health care services that are otherwise covered, if the insurer or its representative failed to provide prior or concurrent review or authorization for the expenses when required to do so under the policy, plan, or certificate. ~~If prior or concurrent review or authorization was provided by the insurer or its representative, and the preexisting condition limitation provision, the general exclusion provision and any other coinsurance, or other policy requirements have been met, the insurer may not deny payment for the authorized service or time period except in cases where fraud or substantive misrepresentation occurred.~~ A health carrier that has given preauthorization approval for a service or treatment may not subsequently deny payment for that service or treatment on the grounds that the service or treatment is not covered by the health plan. At the time a decision regarding the medical necessity of a service or treatment is communicated to an enrollee in accordance with section 62M.05, a health carrier shall also communicate whether the requested service or treatment is a covered benefit.

Page 508, after line 2, insert:

"Sec. 2. Minnesota Statutes 1998, section 62J.72, is amended by adding a subdivision to read:

Subd. 1a. [DISCLOSURE OF COVERAGE AGREEMENT OR SUBSCRIBER CONTRACT.] A health plan company shall, upon request, provide to a prospective enrollee a specimen copy of the actual certificate or other evidence of coverage required to be filed with the commissioner of commerce or commissioner of health under chapter 62A, 62C, or 62D.

Page 524, after line 32, insert:

"(c) A utilization review organization, health plan company, or claims administrator that uses the written procedures required by paragraph (a), clause (1), in determining that care is not appropriate, reasonable, or medically necessary, must provide a copy of the written procedures to the enrollee seeking the care."

Page 525, line 4, strike "should" and insert "shall"

Page 525, line 6, after "professional" insert "and either or both of the following: (1) the enrollee; or (2) the enrollee's representative"

Renumber the sections in sequence and correct internal references

Amend the title accordingly

A roll call was requested and properly seconded.

The question was taken on the Orfield amendment and the roll was called. There were 58 yeas and 71 nays as follows:

Those who voted in the affirmative were:

Abrams	Clark, K.	Greiling	Juhnke	Lenczewski	Mullery
Anderson, I.	Dawkins	Hasskamp	Kahn	Luther	Murphy
Bakk	Dorn	Hausman	Kalis	Mariani	Opatz
Biernat	Entenza	Hilty	Kelliher	Marko	Orfield
Carlson	Folliard	Jaros	Kubly	McCollum	Osthoff
Carruthers	Gleason	Jennings	Larson, D.	McGuire	Otremba
Chaudhary	Gray	Johnson	Leighton	Milbert	Paymar

Pelowski	Rest	Skoglund	Trimble	Wagenius	Winter
Peterson	Rukavina	Solberg	Tunheim	Wejcman	
Pugh	Schumacher	Tomassoni	Vanderveer	Wenzel	

Those who voted in the negative were:

Abeler	Dempsey	Holberg	Mares	Rhodes	Sykora
Anderson, B.	Dorman	Holsten	McElroy	Rifenberg	Tingelstad
Bishop	Erhardt	Howes	Molnau	Rostberg	Tuma
Boudreau	Erickson	Huntley	Mulder	Seagren	Van Dellen
Bradley	Finseth	Kielkucki	Ness	Seifert, J.	Westerberg
Broecker	Fuller	Knoblach	Nornes	Seifert, M.	Westfall
Buesgens	Gerlach	Krinkie	Olson	Skoe	Westrom
Cassell	Goodno	Kuisle	Osskopp	Smith	Wilkin
Clark, J.	Gunther	Larsen, P.	Ozment	Stanek	Wolf
Daggett	Haake	Leppik	Paulsen	Stang	Workman
Davids	Haas	Lieder	Pawlenty	Storm	Spk. Sviggum
Dehler	Harder	Lindner	Reuter	Swenson	

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

Orfield moved to amend S. F. No. 2225, as amended, as follows:

Page 508, after line 2, insert:

"Sec. 2. Minnesota Statutes 1998, section 62J.71, subdivision 1, is amended to read:

Subdivision 1. [PROHIBITED AGREEMENTS AND DIRECTIVES.] The following types of agreements and directives are contrary to state public policy, are prohibited under this section, and are null and void:

(1) any agreement or directive that prohibits a health care provider from communicating with an enrollee with respect to the enrollee's health status, health care, or treatment options, if the health care provider is acting in good faith and within the provider's scope of practice as defined by law;

(2) any agreement or directive that prohibits a health care provider from making a recommendation regarding the suitability or desirability of a health plan company, health insurer, or health coverage plan for an enrollee, unless the provider has a financial conflict of interest in the enrollee's choice of health plan company, health insurer, or health coverage plan;

(3) any agreement or directive that prohibits a provider from providing testimony, supporting or opposing legislation, or making any other contact with state or federal legislators or legislative staff or with state and federal executive branch officers or staff;

(4) any agreement or directive that prohibits a health care provider from disclosing accurate information about whether services or treatment will be paid for by a patient's health plan company or health insurer or health coverage plan; ~~and~~

(5) any agreement or directive that prohibits a health care provider from informing an enrollee about the nature of the reimbursement methodology used by an enrollee's health plan company, health insurer, or health coverage plan to pay the provider; and

(6) any agreement or directive that provides either a financial or other reward or penalty to a health care provider for making or not making a referral or for prescribing or not prescribing a good or service to be provided by other providers not owned, operated, or otherwise subject to the control of the provider."

Renumber the sections in sequence and correct internal references

Amend the title accordingly

A roll call was requested and properly seconded.

The question was taken on the Orfield amendment and the roll was called. There were 61 yeas and 69 nays as follows:

Those who voted in the affirmative were:

Abrams	Folliard	Kahn	Marko	Pelowski	Tunheim
Anderson, I.	Gleason	Kalis	McCollum	Peterson	Vandever
Bakk	Gray	Kelliher	McGuire	Pugh	Wagenius
Biernat	Greiling	Koskinen	Milbert	Rest	Wejcman
Carlson	Hasskamp	Kubly	Mullery	Rukavina	Wenzel
Carruthers	Hausman	Larson, D.	Murphy	Schumacher	Winter
Chaudhary	Hilty	Leighton	Opatz	Skoe	
Clark, K.	Jaros	Lenczewski	Orfield	Skoglund	
Dawkins	Jennings	Lieder	Osthoff	Solberg	
Dorn	Johnson	Luther	Otremba	Tomassoni	
Entenza	Juhnke	Mariani	Paymar	Trimble	

Those who voted in the negative were:

Abeler	Dempsey	Harder	McElroy	Rifenberg	Tuma
Anderson, B.	Dorman	Holberg	Molnau	Rostberg	Van Dellen
Bishop	Erhardt	Holsten	Mulder	Seagren	Westerberg
Boudreau	Erickson	Howes	Ness	Seifert, J.	Westfall
Bradley	Finseth	Kielkucki	Nornes	Seifert, M.	Westrom
Broecker	Fuller	Knoblach	Olson	Smith	Wilkin
Buesgens	Gerlach	Krinkie	Osskopp	Stanek	Wolf
Cassell	Goodno	Kuisle	Ozment	Stang	Workman
Clark, J.	Gunther	Larsen, P.	Paulsen	Storm	Spk. Sviggum
Daggett	Haake	Leppik	Pawlenty	Swenson	
Davids	Haas	Lindner	Reuter	Sykora	
Dehler	Hackbarth	Mares	Rhodes	Tingelstad	

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

Mullery moved to amend S. F. No. 2225, as amended, as follows:

Page 21, in the third Goodno amendment, after line 28, insert:

"Sec. 33. [62Q.235] [MEDICALLY NECESSARY CARE.]

For purposes of coverage under a health plan, "medically necessary care" means diagnostic testing, preventive services, and health care services that are appropriate, in terms of types, frequency, level, setting, and duration, to the enrollee's diagnosis or condition. Medically necessary care must be consistent with generally accepted practice parameters, as determined by practicing health care providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue and must:

- (1) help restore, establish, maintain, or improve the enrollee's health or function;
- (2) prevent deterioration of the enrollee's health condition; or
- (3) prevent the reasonably likely onset of a health problem or detect an incipient problem."

Renumber the sections in sequence and correct internal references

Amend the title accordingly

A roll call was requested and properly seconded.

The question was taken on the Mullery amendment and the roll was called. There were 42 yeas and 84 nays as follows:

Those who voted in the affirmative were:

Abrams	Clark, K.	Jaros	Mullery	Pugh	Tomassoni
Anderson, I.	Entenza	Kalis	Opatz	Rest	Trimble
Bakk	Folliard	Kelliher	Orfield	Rukavina	Tunheim
Biernat	Gleason	Leighton	Osthoff	Schumacher	Wagenius
Carlson	Gray	Lenczewski	Paymar	Skoe	Wejzman
Carruthers	Greiling	Mariani	Pelowski	Skoglund	Wenzel
Chaudhary	Hilty	Milbert	Peterson	Solberg	Winter

Those who voted in the negative were:

Abeler	Dorn	Holberg	Larson, D.	Osskopp	Storm
Anderson, B.	Erhardt	Holsten	Leppik	Ozment	Swenson
Bishop	Erickson	Howes	Lindner	Paulsen	Sykora
Boudreau	Finseth	Huntley	Luther	Pawlenty	Tingelstad
Bradley	Fuller	Johnson	Mares	Reuter	Tuma
Broecker	Gerlach	Juhnke	Marko	Rhodes	Van Dellen
Buesgens	Goodno	Kahn	McElroy	Rifenberg	Vandever
Cassell	Greenfield	Kielkucki	McGuire	Rostberg	Westerberg
Clark, J.	Gunther	Knoblach	Molnau	Seagren	Westfall
Daggett	Haake	Koskinen	Mulder	Seifert, J.	Westrom
Davids	Haas	Krinkie	Murphy	Seifert, M.	Wilkin
Dehler	Hackbarth	Kubly	Ness	Smith	Wolf
Dempsey	Harder	Kuisle	Nornes	Stanek	Workman
Dorman	Hasskamp	Larsen, P.	Olson	Stang	Spk. Sviggum

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

Mullery and Orfield offered an amendment to S. F. No. 2225, as amended.

POINT OF ORDER

Pawlenty raised a point of order pursuant to rule 3.21 that the Mullery and Orfield amendment was not in order. The Speaker ruled the point of order well taken and the Mullery and Orfield amendment out of order.

S. F. No. 2225, A bill for an act relating to human services; appropriating money for the departments of human services and health, the veterans nursing homes board, the health-related boards, the emergency medical services board, the council on disability, the ombudsman for mental health and mental retardation, and the ombudsman for families; establishing the state board of physical therapy; amending Minnesota Statutes 1998, sections 13.99, subdivision 38a, and by adding a subdivision; 16A.76, subdivision 2; 16C.10, subdivision 5; 60A.15, subdivision 1; 62A.045; 62E.11, by adding a subdivision; 62J.69; 116L.02; 125A.08; 125A.21, subdivision 1; 125A.74, subdivisions 1 and 2; 144.065; 144.148; 144.1761, subdivision 1; 144.99, subdivision 1, and by adding a subdivision; 144A.073, subdivision 5; 144A.10, by adding subdivisions; 144A.46, subdivision 2; 144D.01, subdivision 4; 144E.001, by adding subdivisions; 144E.10, subdivision 1; 144E.11, by adding a subdivision; 144E.16, subdivision 4; 144E.18; 144E.27, by adding subdivisions; 144E.50, by adding a subdivision; 145.924; 145.9255, subdivisions 1 and 4; 145A.02, subdivision 10; 145.9255, subdivisions 1 and 4; 148.5194, subdivisions 2, 3, 4, and by adding a subdivision; 148.66; 148.67; 148.70; 148.705; 148.71; 148.72, subdivisions 1, 2, and 4; 148.73; 148.74; 148.75; 148.76; 148.78; 148B.32, subdivision 1; 150A.10, subdivision 1; 214.01, subdivision 2; 245.462, subdivisions 4 and 17; 245.4711, subdivision 1; 245.4712, subdivision 2; 245.4871, subdivisions 4 and 26; 245.4881, subdivision 1; 245A.04, subdivision 3a; 245A.08, subdivision 5; 245A.30; 245B.05, subdivision 7; 245B.07, subdivisions 5, 8, and 10; 246.18, subdivision 6; 252.28, subdivision 1; 252.291, by adding a subdivision; 252.32, subdivision 3a; 252.46, subdivision 6; 253B.045, by adding subdivisions; 253B.07, subdivision 1; 253B.185, by adding a subdivision; 254B.01, by adding a subdivision; 254B.03, subdivision 2; 254B.04, subdivision 1; 254B.05, subdivision 1; 256.01, subdivision 2; 256.015, subdivisions 1 and 3; 256.87, subdivision 1a; 256.955, subdivisions 3, 4, 7, 8, and 9; 256.9685, subdivision 1a; 256.969, subdivision 1; 256B.04, subdivision 16, and by adding a subdivision; 256B.042, subdivisions 1, 2, and 3; 256B.055, subdivision 3a; 256B.056, subdivision 4; 256B.057, subdivision 3, and by adding a subdivision; 256B.0575; 256B.061; 256B.0625, subdivisions 6a, 8, 8a, 13, 19c, 20, 26, 28, 30, 32, 35, and by adding subdivisions; 256B.0627, subdivisions 1, 2, 4, 5, 8, and by adding subdivisions; 256B.0635, subdivision 3; 256B.064, subdivisions 1a, 1b, 1c, 2, and by adding a subdivision; 256B.0911, subdivision 6; 256B.0913, subdivisions 5, 10, 12, and 16; 256B.0917, subdivision 8; 256B.094, subdivisions 3, 5, and 6; 256B.37, subdivision 2; 256B.431, subdivisions 2i, 17, 26, and by adding a subdivision; 256B.434, subdivisions 3, 4, 13, and by adding a subdivision; 256B.435; 256B.48, subdivisions 1, 1a, 1b, and 6; 256B.50, subdivision 1e; 256B.501, subdivision 8a, and by adding a subdivision; 256B.5011, subdivisions 1 and 2; 256B.69, subdivisions 3a, 5b, 6a, 6b, and by adding subdivisions; 256B.692, subdivision 2; 256B.75; 256B.76; 256B.77, subdivisions 7a, 8, and by adding subdivisions; 256D.03, subdivisions 3, 4, and 8; 256D.051, subdivision 2a, and by adding a subdivision; 256D.053, subdivision 1; 256D.06, subdivision 5; 256F.03, subdivision 5; 256F.05, subdivision 8; 256F.10, subdivisions 1, 4, 6, 7, 8, 9, and 10; 256I.04, subdivision 3; 256I.05, subdivisions 1 and 1a; 256J.08, subdivisions 11, 24, 65, 82, 83, 86a, and by adding subdivisions; 256J.11, subdivisions 2 and 3; 256J.12, subdivisions 1a and 2; 256J.14; 256J.20, subdivision 3; 256J.21, subdivisions 2, 3, and 4; 256J.24, subdivisions 2, 3, 7, 8, 9, and by adding a subdivision; 256J.26, subdivision 1; 256J.30, subdivisions 2, 7, 8, and 9; 256J.31, subdivisions 5 and 12; 256J.32, subdivisions 4 and 6; 256J.33; 256J.34, subdivisions 1, 3, and 4; 256J.35; 256J.36; 256J.37, subdivisions 1, 1a, 2, 9, and 10; 256J.38, subdivision 4; 256J.42, subdivisions 1, 5, and by adding a subdivision; 256J.43; 256J.45, subdivision 1; 256J.46, subdivisions 1, 2, and 2a; 256J.47, subdivision 4; 256J.48, subdivisions 2 and 3; 256J.50, subdivision 1; 256J.515; 256J.52, subdivisions 1, 4, 8, and by adding a subdivision; 256J.55, subdivision 4; 256J.56; 256J.57, subdivision 1; 256J.62, subdivisions 1, 6, 7, 8, 9, and by adding a subdivision; 256J.67, subdivision 4; 256J.74, subdivision 2; 256J.76, subdivisions 1, 2, and 4; 256L.03, subdivisions 5 and 6; 256L.04, subdivisions 2, 7, 8, 11, and 13; 256L.05, subdivision 4, and by adding a subdivision; 256L.06, subdivision 3; 256L.07; 256L.15, subdivisions 1, 1b, 2, and 3; 257.071, subdivisions 1, 1a, 1c, 1d, 1e, 3, and 4; 257.66, subdivision 3; 257.75, subdivision 2; 257.85, subdivisions 2, 3, 4, 5, 6, 7, 9, and 11; 259.29, subdivision 2; 259.67, subdivisions 6 and 7; 259.73; 259.85, subdivisions 2, 3, and 5; 259.89, by adding a

subdivision; 260.011, subdivision 2; 260.012; 260.015, subdivisions 2a, 13, and 29; 260.131, subdivision 1a; 260.133, subdivisions 1 and 2; 260.135, by adding a subdivision; 260.172, subdivision 1, and by adding a subdivision; 260.181, subdivision 3; 260.191, subdivisions 1, 1a, 1b, and 3b; 260.192; 260.221, subdivisions 1, 1a, 1b, 1c, 3, and 5; 326.40, subdivisions 2, 4, and 5; 518.10; 518.158, subdivisions 1 and 2; 518.551, by adding a subdivision; 518.5853, by adding a subdivision; 626.556, subdivisions 2, 3, 4, 7, 10, 10b, 10d, 10e, 10f, 10i, 10j, 11, 11b, 11c, and by adding a subdivision; and 626.558, subdivision 1; Laws 1995, chapter 178, article 2, section 46, subdivision 10; chapter 207, article 8, section 41, as amended; Laws 1997, chapter 203, article 9, section 19; Laws 1998, chapter 407, article 7, section 2, subdivision 3; proposing coding for new law in Minnesota Statutes, chapters 10; 62J; 116L; 137; 144; 144A; 144E; 148; 214; 245; 246; 252; 254A; 256; 256B; 256J; and 626; proposing coding for new law as Minnesota Statutes, chapter 256M; repealing Minnesota Statutes 1998, sections 62J.77; 62J.78; 62J.79; 144.0723; 144E.16, subdivisions 1, 2, 3, and 6; 144E.17; 144E.25; 144E.30, subdivisions 1, 2, and 6; 145.46; 256B.434, subdivision 17; 256B.501, subdivision 3g; 256B.5011, subdivision 3; 256B.74, subdivisions 2 and 5; 256D.051, subdivisions 6 and 19; 256D.053, subdivision 4; 256J.03; 256J.30, subdivision 6; 256J.53, subdivision 4; 256J.62, subdivisions 2, 3, and 5; 257.071, subdivisions 8 and 10; and 462A.208; Laws 1997, chapter 85, article 1, section 63; chapter 203, article 4, section 55; chapter 225, article 6, section 8; Laws 1998, chapter 407, article 2, section 104; Minnesota Rules, parts 4690.0100, subparts 4, 13, 15, 19, 20, 21, 22, 23, 24, 26, 27, and 29; 4690.0300; 4690.0400; 4690.0500; 4690.0600; 4690.0700; 4690.0800, subparts 1 and 2; 4690.0900; 4690.1000; 4690.1100; 4690.1200; 4690.1300; 4690.1600; 4690.1700; 4690.2100; 4690.2200, subparts 1, 3, 4, and 5; 4690.2300; 4690.2400, subparts 1, 2, and 3; 4690.2500; 4690.2900; 4690.3000; 4690.3700; 4690.3900; 4690.4000; 4690.4100; 4690.4200; 4690.4300; 4690.4400; 4690.4500; 4690.4600; 4690.4700; 4690.4800; 4690.4900; 4690.5000; 4690.5100; 4690.5200; 4690.5300; 4690.5400; 4690.5500; 4690.5700; 4690.5800; 4690.5900; 4690.6000; 4690.6100; 4690.6200; 4690.6300; 4690.6400; 4690.6500; 4690.6600; 4690.6700; 4690.6800; 4690.7000; 4690.7100; 4690.7200; 4690.7300; 4690.7400; 4690.7500; 4690.7600; 4690.7700; 4690.7800; 4690.8300, subparts 1, 2, 3, 4, and 5; and 4735.5000.

The bill was read for the third time, as amended, and placed upon its final passage.

The question was taken on the passage of the bill and the roll was called. There were 92 yeas and 40 nays as follows:

Those who voted in the affirmative were:

Abeler	Finseth	Juhnke	Mulder	Rifenberg	Tunheim
Anderson, B.	Fuller	Kalis	Murphy	Rostberg	Van Dellen
Anderson, I.	Gerlach	Kielkucki	Ness	Schumacher	Vandeveer
Boudreau	Goodno	Knoblach	Nornes	Seagren	Wenzel
Bradley	Greenfield	Krinkie	Olson	Seifert, J.	Westerberg
Broecker	Gunther	Kubly	Opatz	Seifert, M.	Westfall
Buesgens	Haake	Kuisle	Osskopp	Skoe	Westrom
Carlson	Haas	Larsen, P.	Otremba	Smith	Wilkin
Cassell	Hackbarth	Lenczewski	Ozment	Solberg	Winter
Clark, J.	Harder	Lieder	Paulsen	Stanek	Wolf
Daggett	Hasskamp	Lindner	Pawlenty	Stang	Workman
Davids	Holberg	Luther	Pelowski	Storm	Spk. Sviggum
Dehler	Holsten	Mares	Peterson	Swenson	
Dempsey	Howes	McCollum	Pugh	Sykora	
Dorman	Jennings	Milbert	Rest	Tingelstad	
Erickson	Johnson	Molnau	Reuter	Tuma	

Those who voted in the negative were:

Abrams	Bishop	Clark, K.	Entenza	Gleason	Hausman
Bakk	Carruthers	Dawkins	Erhardt	Gray	Hilty
Biernat	Chaudhary	Dorn	Folliard	Greiling	Huntley

Jaros	Larson, D.	Marko	Orfield	Rukavina	Wagenius
Kahn	Leighton	McElroy	Osthoff	Skoglund	Wejcman
Kelliher	Leppik	McGuire	Paymar	Tomassoni	
Koskinen	Mariani	Mullery	Rhodes	Trimble	

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

Greenfield was excused for the remainder of today's session.

Reuter was excused between the hours of 6:30 p.m. and 10:20 p.m.

Pawlenty moved that the House recess subject to the call of the Chair. The motion prevailed.

RECESS

RECONVENED

The House reconvened and was called to order by the Speaker.

FISCAL CALENDAR ANNOUNCEMENT

Pursuant to rule 1.22, Bishop announced his intention to place H. F. No. 2333 on the Fiscal Calendar for Monday, April 26, 1999.

FISCAL CALENDAR

Pursuant to rule 1.22, Bishop requested immediate consideration of S. F. No. 2223.

S. F. No. 2223 was reported to the House.

Seifert, M.; Leppik and Cassell moved to amend S. F. No. 2223, the unofficial engrossment, as follows:

Page 54, line 24, after the period, insert "Nothing in this section shall be construed as diminishing any rights defined in collective bargaining agreements provided for under Minnesota Statutes, chapter 179A. The percentages in clauses (a) and (b) shall be applied using methods delineated in section 58, subdivision 3, and section 59."

A roll call was requested and properly seconded.

The question was taken on the Seifert, M., et al amendment and the roll was called. There were 130 yeas and 0 nays as follows:

Those who voted in the affirmative were:

Abeler	Anderson, I.	Bishop	Broecker	Carruthers	Clark, J.
Abrams	Bakk	Boudreau	Buesgens	Cassell	Clark, K.
Anderson, B.	Biernat	Bradley	Carlson	Chaudhary	Daggett

Davids	Haas	Koskinen	Molnau	Rest	Tomassoni
Dawkins	Hackbarth	Krinkie	Mulder	Rhodes	Trimble
Dehler	Harder	Kubly	Mullery	Rifenberg	Tuma
Dempsey	Hasskamp	Kuisle	Murphy	Rostberg	Tunheim
Dorman	Hausman	Larsen, P.	Ness	Rukavina	Van Dellen
Dorn	Hilty	Larson, D.	Nornes	Schumacher	Vandever
Entenza	Holberg	Leighton	Olson	Seagren	Wagenius
Erhardt	Holsten	Lenczewski	Opatz	Seifert, J.	Wejcman
Erickson	Howes	Leppik	Orfield	Seifert, M.	Wenzel
Finseth	Huntley	Lieder	Osskopp	Skoe	Westerberg
Folliard	Jaros	Lindner	Osthoff	Skoglund	Westfall
Fuller	Jennings	Luther	Otremba	Smith	Westrom
Gerlach	Johnson	Mares	Ozment	Solberg	Wilkin
Gleason	Juhnke	Mariani	Paulsen	Stanek	Winter
Goodno	Kahn	Marko	Pawlenty	Stang	Wolf
Gray	Kalis	McCollum	Paymar	Storm	Workman
Greiling	Kelliher	McElroy	Pelowski	Swenson	Spk. Sviggum
Gunther	Kielkucki	McGuire	Peterson	Sykora	
Haake	Knoblach	Milbert	Pugh	Tingelstad	

The motion prevailed and the amendment was adopted.

Stanek moved to amend S. F. No. 2223, the unofficial engrossment, as amended, as follows:

Page 5, delete lines 21 to 36

A roll call was requested and properly seconded.

The question was taken on the Stanek amendment and the roll was called. There were 63 yeas and 64 nays as follows:

Those who voted in the affirmative were:

Abeler	Entenza	Holsten	Marko	Rifenberg	Tuma
Abrams	Erhardt	Howes	McElroy	Seagren	Van Dellen
Boudreau	Folliard	Kielkucki	Molnau	Seifert, J.	Vandever
Bradley	Fuller	Knoblach	Ness	Seifert, M.	Westerberg
Broecker	Gerlach	Kuisle	Osthoff	Smith	Wilkin
Carlson	Goodno	Larsen, P.	Ozment	Stanek	Wolf
Chaudhary	Haake	Larson, D.	Paulsen	Stang	Workman
Daggett	Haas	Lenczewski	Pawlenty	Storm	Spk. Sviggum
Davids	Hackbarth	Lindner	Pelowski	Swenson	
Dempsey	Harder	Luther	Rest	Sykora	
Dorman	Holberg	Mares	Rhodes	Tingelstad	

Those who voted in the negative were:

Anderson, B.	Buesgens	Dawkins	Gleason	Hilty	Juhnke
Anderson, I.	Carruthers	Dehler	Gray	Huntley	Kahn
Bakk	Cassell	Dorn	Greiling	Jaros	Kalis
Biernat	Clark, J.	Erickson	Gunther	Jennings	Kelliher
Bishop	Clark, K.	Finseth	Hausman	Johnson	Krinkie

Kubly	McGuire	Opatz	Pugh	Solberg	Wenzel
Leighton	Milbert	Orfield	Rostberg	Tomassoni	Westfall
Leppik	Mulder	Osskopp	Rukavina	Trimble	Westrom
Lieder	Mullery	Otremba	Schumacher	Tunheim	Winter
Mariani	Nornes	Paymar	Skoe	Wagenius	
McCollum	Olson	Peterson	Skoglund	Wejzman	

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

Ozment; Kalis; Winter; Harder; Rukavina; Smith; Fuller; Daggett; Olson; Stanek; Hackbarth; Larsen, P.; Wolf; Westerberg; Howes; Lindner; Abeler; Westrom; Davids; Kuisle; Tomassoni; Rostberg; Erhardt; Hasskamp; Seifert, J.; Bakk; Schumacher; Cassell and Clark, J., offered an amendment to S. F. No. 2223, the unofficial engrossment, as amended.

Kahn requested a division of the Ozment et al amendment to S. F. No. 2223, the unofficial engrossment, as amended.

The first portion of the Ozment et al amendment to S. F. No. 2223, the unofficial engrossment, as amended, reads as follows:

Page 5, line 50, delete "9,124,000" and insert "8,770,000" and delete "9,462,000" and insert "9,108,000"

Pages 48 and 49, delete article 2, section 45

A roll call was requested and properly seconded.

The question was taken on the first portion of the Ozment et al amendment and the roll was called. There were 116 yeas and 14 nays as follows:

Those who voted in the affirmative were:

Abeler	Dorman	Holsten	Luther	Pelowski	Sykora
Abrams	Dorn	Howes	Mares	Peterson	Tingelstad
Anderson, I.	Entenza	Huntley	Mariani	Pugh	Tomassoni
Bakk	Erhardt	Jaros	Marko	Rest	Trimble
Biernat	Finseth	Jennings	McCollum	Rhodes	Tuma
Bishop	Folliard	Johnson	McElroy	Rifenberg	Tunheim
Boudreau	Fuller	Juhnke	McGuire	Rostberg	Wagenius
Bradley	Gleason	Kalis	Milbert	Rukavina	Wejzman
Broecker	Goodno	Kelliher	Molnau	Schumacher	Wenzel
Carlson	Gray	Knoblach	Mullery	Seagren	Westerberg
Carruthers	Greiling	Koskinen	Murphy	Seifert, J.	Westfall
Cassell	Gunther	Kubly	Ness	Seifert, M.	Westrom
Chaudhary	Haake	Kuisle	Nornes	Skoe	Winter
Clark, J.	Haas	Larsen, P.	Opatz	Skoglund	Wolf
Clark, K.	Hackbarth	Larson, D.	Orfield	Smith	Workman
Daggett	Harder	Leighton	Otremba	Solberg	Spk. Sviggum
Davids	Hasskamp	Lenczewski	Ozment	Stanek	
Dawkins	Hausman	Leppik	Paulsen	Stang	
Dehler	Hilty	Lieder	Pawlenty	Storm	
Dempsey	Holberg	Lindner	Paymar	Swenson	

Those who voted in the negative were:

Anderson, B.	Gerlach	Krinkie	Osskopp	Vandever
Buesgens	Kahn	Mulder	Osthoff	Wilkin
Erickson	Kielkucki	Olson	Van Dellen	

The motion prevailed and the first portion of the Ozment et al amendment was adopted.

The second portion of the Ozment et al amendment to S. F. No. 2223, the unofficial engrossment, as amended, reads as follows:

Page 56, line 23, after "207A.10;" insert "356.219;"

A roll call was requested and properly seconded.

POINT OF ORDER

Kahn raised a point of order pursuant to rule 3.21 that the second portion of the Ozment et al amendment was not in order. The Speaker ruled the point of order not well taken and the second portion of the Ozment et al amendment in order.

The question recurred on the second portion of the Ozment et al amendment and the roll was called. There were 115 yeas and 15 nays as follows:

Those who voted in the affirmative were:

Abeler	Dorman	Huntley	Mares	Peterson	Tingelstad
Abrams	Dorn	Jaros	Mariani	Pugh	Tomassoni
Anderson, I.	Entenza	Jennings	Marko	Rest	Tuma
Bakk	Erhardt	Johnson	McCollum	Rhodes	Tunheim
Biernat	Finseth	Juhnke	McElroy	Rifenberg	Vandever
Bishop	Folliard	Kalis	McGuire	Rostberg	Wejcman
Boudreau	Fuller	Kelliher	Milbert	Rukavina	Wenzel
Bradley	Gleason	Kielkucki	Molnau	Schumacher	Westerberg
Broecker	Goodno	Knoblach	Mullery	Seagren	Westfall
Carlson	Gray	Koskinen	Murphy	Seifert, J.	Westrom
Carruthers	Gunther	Kubly	Ness	Seifert, M.	Wilkin
Cassell	Haake	Kuisle	Nornes	Skoe	Winter
Chaudhary	Haas	Larsen, P.	Opatz	Skoglund	Wolf
Clark, J.	Hackbarth	Larsen, D.	Orfield	Smith	Workman
Clark, K.	Harder	Leighton	Otremba	Solberg	Spk. Sviggum
Daggett	Hasskamp	Lenczewski	Ozment	Stanek	
Dauids	Hilty	Leppik	Paulsen	Stang	
Dawkins	Holberg	Lieder	Pawlenty	Storm	
Dehler	Holsten	Lindner	Paymar	Swenson	
Dempsey	Howes	Luther	Pelowski	Sykora	

Those who voted in the negative were:

Anderson, B.	Gerlach	Kahn	Olson	Trimble
Buesgens	Greiling	Krinkie	Osskopp	Van Dellen
Erickson	Hausman	Mulder	Osthoff	Wagenius

The motion prevailed and the second portion of the Ozment et al amendment was adopted.

Dempsey; Stanek; Larsen, P.; Cassell; Ozment; Jennings; Smith; Rostberg and Howes moved to amend S. F. No. 2223, the unofficial engrossment, as amended, as follows:

Page 9, line 33, delete "\$3,810,000" and insert "\$3,576,000"

Delete page 9, line 34 to page 10, line 1

Adjust section and bill totals accordingly

A roll call was requested and properly seconded.

The question was taken on the Dempsey et al amendment and the roll was called. There were 85 yeas and 42 nays as follows:

Those who voted in the affirmative were:

Abeler	Dorman	Howes	Leppik	Ozment	Swenson
Anderson, I.	Dorn	Huntley	Lieder	Paymar	Tingelstad
Bakk	Entenza	Jaros	Luther	Pelowski	Tomassoni
Biernat	Folliard	Jennings	Mariani	Pugh	Trimble
Boudreau	Fuller	Johnson	Marko	Rest	Tunheim
Broecker	Gleason	Juhnke	McCollum	Rhodes	Vandever
Carlson	Goodno	Kahn	McGuire	Rostberg	Wagenius
Carruthers	Gray	Kalis	Milbert	Rukavina	Wejzman
Cassell	Greiling	Kelliher	Mullery	Schumacher	Wenzel
Chaudhary	Haas	Koskinen	Murphy	Seifert, J.	Winter
Clark, K.	Hackbarth	Kubly	Nornes	Skoe	
Daggett	Hasskamp	Larsen, P.	Opatz	Skoglund	
Dawkins	Hausman	Larson, D.	Orfield	Smith	
Dehler	Hilty	Leighton	Osskopp	Solberg	
Dempsey	Holsten	Lenczewski	Otremba	Stanek	

Those who voted in the negative were:

Abrams	Erhardt	Kielkucki	Molnau	Seagren	Westerberg
Anderson, B.	Erickson	Knoblach	Mulder	Seifert, M.	Westfall
Bishop	Finseth	Krinkie	Olson	Stang	Westrom
Bradley	Gerlach	Kuisle	Paulsen	Storm	Wilkin
Buesgens	Haake	Lindner	Pawlenty	Sykora	Wolf
Clark, J.	Harder	Mares	Peterson	Tuma	Workman
Davids	Holberg	McElroy	Rifenberg	Van Dellen	Spk. Sviggum

The motion prevailed and the amendment was adopted.

Entenza moved to amend S. F. No. 2223, the unofficial engrossment, as amended, as follows:

Page 6, line 38, delete "14,994,000" and insert "\$13,091,000"

Page 6, line 39, delete "\$6,000,000" and insert "\$4,097,000"

Page 11, line 3, delete "\$1,250,000" and insert "\$2,050,000"

Page 11, line 4, delete "\$1,250,000" and insert "\$2,050,000"

Page 11, line 36, delete "\$233,000" and insert "\$384,000" and delete "\$232,000" and insert "\$384,000"

Page 11, line 42, before the period, insert "and Minnesota Public Radio, Inc."

Increase subdivision and section totals accordingly

A roll call was requested and properly seconded.

Howes, Fuller and Dorman moved to amend the Entenza amendment to S. F. No. 2223, the unofficial engrossment, as amended, as follows:

Page 1, delete lines 3 and 4 and insert:

"Page 5, line 52, delete "27,862,000" and insert "25,959,000"

Page 5, line 54, delete "25,554,000" and insert "23,651,000"

A roll call was requested and properly seconded.

The question was taken on the amendment to the amendment and the roll was called. There were 70 yeas and 59 nays as follows:

Those who voted in the affirmative were:

Abeler	Dehler	Hackbarth	Mares	Rifenberg	Tuma
Abrams	Dempsey	Harder	McElroy	Rostberg	Van Dellen
Anderson, B.	Dorman	Holberg	Molnau	Seagren	Vandever
Bishop	Erhardt	Holsten	Mulder	Seifert, J.	Westerberg
Boudreau	Erickson	Howes	Ness	Seifert, M.	Westfall
Bradley	Finseth	Kielkucki	Nornes	Smith	Westrom
Broecker	Fuller	Knoblach	Olson	Stanek	Wilkin
Buesgens	Gerlach	Krinkie	Osskopp	Stang	Wolf
Cassell	Goodno	Kuisle	Ozment	Storm	Workman
Clark, J.	Gunther	Larsen, P.	Paulsen	Swenson	Spk. Sviggum
Daggett	Haake	Leppik	Pawlenty	Sykora	
Davids	Haas	Lindner	Rhodes	Tingelstad	

Those who voted in the negative were:

Anderson, I.	Carlson	Clark, K.	Entenza	Gray	Hausman
Bakk	Carruthers	Dawkins	Folliard	Greiling	Hilty
Biernat	Chaudhary	Dorn	Gleason	Hasskamp	Huntley

Jaros	Koskinen	Mariani	Opatz	Pugh	Tomassoni
Jennings	Kubly	Marko	Orfield	Rest	Trimble
Johnson	Larson, D.	McCollum	Osthoff	Rukavina	Tunheim
Juhnke	Leighton	McGuire	Otremba	Schumacher	Wejcman
Kahn	Lenczewski	Milbert	Paymar	Skoe	Wenzel
Kalis	Lieder	Mullery	Pelowski	Skoglund	Winter
Kelliher	Luther	Murphy	Peterson	Solberg	

The motion prevailed and the amendment to the amendment was adopted.

The question recurred on the Entenza amendment, as amended, and the roll was called. There were 44 yeas and 83 nays as follows:

Those who voted in the affirmative were:

Anderson, I.	Dorman	Hausman	Leighton	Opatz	Solberg
Bakk	Entenza	Howes	Lenczewski	Orfield	Tomassoni
Biernat	Folliard	Jaros	Lieder	Otremba	Trimble
Carlson	Fuller	Johnson	Luther	Peterson	Westrom
Carruthers	Gleason	Juhnke	Mariani	Pugh	
Chaudhary	Gray	Kahn	Marko	Rukavina	
Clark, K.	Greiling	Koskinen	McCollum	Schumacher	
Dawkins	Hasskamp	Kubly	McGuire	Skoe	

Those who voted in the negative were:

Abeler	Dorn	Huntley	Milbert	Rhodes	Tuma
Abrams	Erhardt	Jennings	Molnau	Rifenberg	Tunheim
Anderson, B.	Erickson	Kalis	Mulder	Rostberg	Van Dellen
Bishop	Finseth	Kelliher	Mullery	Seagren	Vandever
Boudreau	Gerlach	Kielkucki	Murphy	Seifert, J.	Wejcman
Bradley	Goodno	Knoblach	Ness	Seifert, M.	Wenzel
Broecker	Gunther	Krinkie	Nornes	Skoglund	Westerberg
Buesgens	Haake	Kuisle	Olson	Smith	Westfall
Cassell	Haas	Larsen, P.	Osskopp	Stanek	Wilkin
Clark, J.	Hackbarth	Larson, D.	Osthoff	Stang	Winter
Daggett	Harder	Leppik	Ozment	Storm	Wolf
Davids	Hilty	Lindner	Paulsen	Swenson	Workman
Dehler	Holberg	Mares	Pawlenty	Sykora	Spk. Sviggum
Dempsey	Holsten	McElroy	Pelowski	Tingelstad	

The motion did not prevail and the amendment, as amended, was not adopted.

The Speaker called Abrams to the Chair.

S. F. No. 2223, A bill for an act relating to the organization and operation of state government; appropriating money for the general legislative and administrative expenses of state government with certain conditions; amending Minnesota Statutes 1998, sections 3.17; 3C.12, subdivision 2; 8.15, subdivisions 1, 2, and 3; 13.03, subdivision 2; 13.05, by adding a subdivision; 13.073, by adding a subdivision; 15.50, subdivision 2; 16A.102, subdivision 1; 16A.129, subdivision 3; 16A.45, subdivision 1; 16A.85, subdivision 1; 16B.03; 16B.104; 16B.24, subdivision 5; 16B.31, subdivision 2; 16B.32, subdivision 2; 16B.42, subdivision 1; 16B.465, subdivision 3; 16B.72; 16B.73;

16C.14, subdivision 1; 16D.04, subdivision 2; 16E.01, subdivision 1; 16E.02; 16E.08; 43A.047; 43A.22; 43A.23, subdivisions 1 and 2; 43A.30, by adding a subdivision; 43A.31, subdivision 2, and by adding a subdivision; 138.17, subdivisions 7 and 8; 192.49, subdivision 3; 197.79, subdivision 10; 204B.25, subdivision 2, and by adding a subdivision; 204B.27, by adding a subdivision; 204B.28, subdivision 1; 240A.09; 297F.08, by adding a subdivision; 325K.03, by adding a subdivision; 325K.04; 325K.05, subdivision 1; 325K.09, by adding a subdivision; 325K.10, subdivision 5; 325K.14, by adding a subdivision; 325K.15, by adding a subdivision; and 349.163, subdivision 4; Laws 1993, chapter 192, section 16; Laws 1994, chapter 643, section 69, subdivision 1; Laws 1995, First Special Session chapter 3, article 12, section 7, subdivision 1, as amended; Laws 1997, chapter 202, article 2, section 61; and Laws 1998, chapter 366, section 2; proposing coding for new law in Minnesota Statutes, chapters 16B; 43A; 240A; and 325F; repealing Minnesota Statutes 1998, sections 16A.103, subdivision 3; 16E.11; 16E.12; and 16E.13; Laws 1991, chapter 235, article 5, section 3, as amended; Minnesota Rules, part 8275.0045, subpart 2.

The bill was read for the third time, as amended, and placed upon its final passage.

The question was taken on the passage of the bill and the roll was called. There were 70 yeas and 59 nays as follows:

Those who voted in the affirmative were:

Abeler	Dehler	Hackbarth	Lindner	Rhodes	Tuma
Abrams	Dempsey	Harder	Mares	Rifenberg	Van Dellen
Anderson, B.	Dorman	Holberg	McElroy	Rostberg	Vandever
Bishop	Erhardt	Holsten	Molnau	Seagren	Westerberg
Boudreau	Erickson	Howes	Mulder	Seifert, J.	Westfall
Bradley	Finseth	Kahn	Ness	Seifert, M.	Westrom
Broecker	Fuller	Kielkucki	Nornes	Smith	Wilkin
Buesgens	Gerlach	Knoblach	Olson	Stang	Wolf
Cassell	Goodno	Krinkie	Osskopp	Storm	Workman
Clark, J.	Gunther	Kuisle	Ozment	Swenson	Spk. Sviggum
Daggett	Haake	Larsen, P.	Paulsen	Sykora	
Davids	Haas	Leppik	Pawlenty	Tingelstad	

Those who voted in the negative were:

Anderson, I.	Folliard	Juhnke	Mariani	Otremba	Skoglund
Bakk	Gleason	Kalis	Marko	Paymar	Solberg
Biernat	Gray	Kelliher	McCollum	Pelowski	Tomassoni
Carlson	Greiling	Koskinen	McGuire	Peterson	Trimble
Carruthers	Hasskamp	Kubly	Milbert	Pugh	Tunheim
Chaudhary	Hausman	Larson, D.	Mullery	Rest	Wagenius
Clark, K.	Huntley	Leighton	Murphy	Reuter	Wejcman
Dawkins	Jaros	Lenczewski	Opatz	Rukavina	Wenzel
Dorn	Jennings	Lieder	Orfield	Schumacher	Winter
Entenza	Johnson	Luther	Osthoff	Skoe	

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

The Speaker resumed the Chair.

CALENDAR FOR THE DAY

Pawlenty moved that the Calendar for the Day be continued. The motion prevailed.

MOTIONS AND RESOLUTIONS

Sviggum moved that the name of Bishop be added as chief author and Sviggum be shown as second author on H. F. No. 90. The motion prevailed.

Clark, K., moved that her name be stricken as an author on H. F. No. 337. The motion prevailed.

Clark, K., moved that her name be stricken as an author on House Resolution No. 2. The motion prevailed.

Ozment; Osthoff; Westfall; Tingelstad; Rostberg; Anderson, I.; Osskopp; Swenson; Bakk; Skoe; Peterson; Kelliher; Holsten and Hausman introduced:

House Resolution No. 10, A house resolution recognizing Earth Day as a day of service, education, and awareness.

SUSPENSION OF RULES

Ozment moved that the rules be so far suspended that House Resolution No. 10 be now considered and be placed upon its adoption. The motion prevailed.

HOUSE RESOLUTION NO. 10

A house resolution recognizing Earth Day as a day of service, education, and awareness.

Whereas, protection of our environment is of vital importance to the people of Minnesota; and

Whereas, each person has a right to clean and healthful air and water and wise public management of our natural resources without infringement by other persons or organizations; and

Whereas, Earth Day has become universally recognized as the state and national day of environmental action, serving as a renewal to a pledge of environmental commitment, and a public demonstration of the people's common voice for the earth; and

Whereas, Minnesota has demonstrated and acknowledged its commitment to the environment by the enactment of many strong environmental laws and educational opportunities since the original Earth Day; *Now, Therefore*,

Be It Resolved by the House of Representatives of the State of Minnesota that it recognizes Earth Day, April 22, as a day of service and education and a commitment to the preservation of the environment and its natural resources.

Be It Further Resolved that the Chief Clerk of the House of Representatives deliver an enrolled copy of this resolution to Representative Willard Munger whose presence is missed in the House of Representatives.

Ozment moved that House Resolution No. 10 be now adopted. The motion prevailed and House Resolution No. 10 was adopted.

ANNOUNCEMENTS BY THE SPEAKER

The Speaker announced the appointment of the following members of the House to a Conference Committee on H. F. No. 621:

Fuller; Larsen, P., and McGuire.

The Speaker announced the appointment of the following members of the House to a Conference Committee on H. F. No. 2390:

McElroy, Gunther, Davids, Lindner and Trimble.

The Speaker announced the appointment of the following members of the House to a Conference Committee on S. F. No. 556:

Leighton, McCollum and Davids.

The Speaker announced the appointment of the following members of the House to a Conference Committee on S. F. No. 1204:

Rostberg, Rhodes and Gleason.

The Speaker announced the appointment of the following members of the House to a Conference Committee on S. F. No. 1471:

Storm; Larsen, P., and Kubly.

ADJOURNMENT

Pawlenty moved that when the House adjourns today it adjourn until 12:00 noon, Monday, April 26, 1999. The motion prevailed.

Pawlenty moved that the House adjourn. The motion prevailed, and the Speaker declared the House stands adjourned until 12:00 noon, Monday, April 26, 1999.

EDWARD A. BURDICK, Chief Clerk, House of Representatives

