

STATE OF MINNESOTA

EIGHTY-SECOND SESSION — 2001

 TWENTY-FOURTH DAY

SAINT PAUL, MINNESOTA, WEDNESDAY, MARCH 21, 2001

The House of Representatives convened at 3:00 p.m. and was called to order by Speaker pro tempore Steve Dehler.

Prayer was offered by the Reverend Lonnie E. Titus, House Chaplain.

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

The roll was called and the following members were present:

Abeler	Dorn	Howes	Lindner	Paulsen	Swenson
Abrams	Eastlund	Huntley	Lipman	Pawlenty	Sykora
Anderson, B.	Entenza	Jacobson	Luther	Paymar	Thompson
Anderson, I.	Erhardt	Jaros	Mahoney	Pelowski	Tingelstad
Bakk	Erickson	Jennings	Mares	Penas	Tuma
Bernardy	Evans	Johnson, J.	Mariani	Peterson	Vandever
Biernat	Finseth	Johnson, R.	Marko	Pugh	Wagenius
Bishop	Folliard	Johnson, S.	Marquart	Rhodes	Walker
Boudreau	Fuller	Juhnke	McElroy	Rifenberg	Walz
Bradley	Gerlach	Kahn	McGuire	Rukavina	Wasiluk
Buesgens	Gleason	Kalis	Milbert	Ruth	Wenzel
Carlson	Goodno	Kelliher	Molnau	Schumacher	Westerberg
Cassell	Gray	Kielkucki	Mulder	Seagren	Westrom
Clark, J.	Greiling	Knoblach	Mullery	Seifert	Wilkin
Clark, K.	Gunther	Koskinen	Murphy	Sertich	Winter
Daggett	Haas	Krinkie	Ness	Skoe	Wolf
Davids	Hackbarth	Kubly	Nornes	Skoglund	Workman
Davnie	Harder	Kuisle	Olson	Slawik	Spk. Sviggum
Dawkins	Hausman	Larson	Opatz	Smith	
Dehler	Hilstrom	Leighton	Osskopp	Solberg	
Dempsey	Hilty	Lenczewski	Osthoff	Stanek	
Dibble	Holberg	Leppik	Otremba	Stang	
Dorman	Holsten	Lieder	Ozment	Swapinski	

A quorum was present.

Goodwin was excused.

The Chief Clerk proceeded to read the Journal of the preceding day. Paulsen moved that further reading of the Journal be suspended and that the Journal be approved as corrected by the Chief Clerk. The motion prevailed.

PETITIONS AND COMMUNICATIONS

The following communications were received:

STATE OF MINNESOTA
OFFICE OF THE GOVERNOR
SAINT PAUL 55155

March 16, 2001

The Honorable Steve Sviggum
Speaker of the House of Representatives
The State of Minnesota

Dear Speaker Sviggum:

It is my honor to inform you that I have received, approved, signed and deposited in the Office of the Secretary of State the following House Files:

H. F. No. 80, relating to natural resources; allowing the commissioner of natural resources to install a lake level control for Coon Lake.

H. F. No. 393, relating to local government; allowing employees of Ramsey county and the city of St. Paul equal competition for vacant county jobs in combined city-county departments.

Sincerely,

JESSE VENTURA
Governor

STATE OF MINNESOTA
OFFICE OF THE SECRETARY OF STATE
ST. PAUL 55155

The Honorable Steve Sviggum
Speaker of the House of Representatives

The Honorable Don Samuelson
President of the Senate

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

<i>S.F. No.</i>	<i>H.F. No.</i>	<i>Session Laws Chapter No.</i>	<i>Time and Date Approved 2001</i>	<i>Date Filed 2001</i>
	80	8	10:30 a.m. March 16	March 16
	393	9	10:30 a.m. March 16	March 16
289		10	10:30 a.m. March 16	March 16

Sincerely,

MARY KIFFMEYER
Secretary of State

REPORTS OF STANDING COMMITTEES

Dempsey from the Committee on Local Government and Metropolitan Affairs to which was referred:

H. F. No. 62, A bill for an act relating to tornado relief; providing disaster relief and other assistance for counties designated a major disaster area due to the July 25, 2000, tornado; appropriating money; amending Minnesota Statutes 2000, sections 17.101, subdivision 5; and 41A.09, subdivisions 3a and 5a.

Reported the same back with the following amendments:

Delete everything after the enacting clause and insert:

"Section 1. [APPROPRIATIONS; ELIGIBILITY.]

The sums in the column under "APPROPRIATIONS" are appropriated from the general fund for fiscal year 2001, to be spent for disaster relief and other assistance, as specified in this act. Disaster relief and assistance under this act are limited to the areas that sustained damage from the tornado that struck Yellow Medicine and Chippewa counties on July 25, 2000, and were added to the Presidential Declaration of Major Disaster, DR1333, by amendment number 5 dated July 28, 2000, and amendment number 6 dated August 14, 2000. The appropriations are available until June 30, 2002, unless otherwise specified. If there is a shortage of funds in any of the programs under sections 2 and 3, unused funds in any of the other programs under those sections may be transferred by interagency agreement to cover the shortfall.

Summary by Fund

PUBLIC SAFETY	\$ 226,104
TRADE AND ECONOMIC DEVELOPMENT	1,761,398
REVENUE	200,000
CHILDREN, FAMILIES, AND LEARNING	156,000
TOTAL	\$2,343,502

APPROPRIATIONS

\$

Sec. 2. PUBLIC SAFETY

Subdivision 1. To the commissioner of public safety for the purposes of this section 226,104

Subd. 2. Disaster Assistance Match 206,104

For grants to local units of government for the applicant's share of federal disaster assistance funds under Minnesota Statutes, section 12.221. The commissioner must award grants based on the amount of the local share in the signed grant agreement.

Subd. 3. Hospital Digital Paging 20,000

For a grant to the Granite Falls municipal hospital for a digital paging system.

Sec. 3. TRADE AND ECONOMIC DEVELOPMENT

Subdivision 1. To the commissioner of trade and economic development for purposes of this section 1,761,398

Subd. 2. Project Turnabout 400,000

For a grant to Project Turnabout for capital expenditures necessitated by the tornado.

Subd. 3. Public Infrastructure 1,305,000

For a grant to the city of Granite Falls to assist with the cost of damage assessment, repair, replacement, extension, or improvement of publicly owned wastewater and municipal utility service and drinking water systems.

Subd. 4. Lost Interest 56,398

For grants to local units of government for the cost of lost interest earnings to the local units of government.

Sec. 4. REVENUE 200,000

To the commissioner of revenue to be apportioned among the counties in amendment number 5 and amendment number 6 to the Presidential Declaration of Major Disaster, DR1333, to provide

APPROPRIATIONS

\$

reimbursement for abatements granted under section 8, for taxes payable in 2000 and 2001 to properties damaged from tornadoes on July 25, 2000. The apportionment shall be based upon the amount of disaster-related market value loss in each county. Counties must be reimbursed only for property taxes that were actually abated, not to exceed each county's apportioned amount.

Sec. 5. CHILDREN, FAMILIES, AND LEARNING

181,720

For payment of declining pupil unit aid for independent school district No. 2190, Yellow Medicine East, in fiscal year 2001 under section 11.

Sec. 6. [TEMPORARY WAIVER OF FEES.]

Notwithstanding any law to the contrary, for fiscal year 2001, an agency, with the approval of the governor, may waive fees that would otherwise be charged for agency services. The waiver of fees must be confined to geographic areas within counties eligible for assistance under section 1 and to the minimum periods of times necessary to deal with the emergency situation. The agency must promptly report the reasons for and the impact of any suspended fees to the chairs of the legislative committees that oversee the policy and budgetary affairs of the agency.

Sec. 7. [SOLID WASTE MANAGEMENT TAX WAIVER.]

Notwithstanding any law to the contrary, the commissioner of revenue may waive solid waste management taxes under Minnesota Statutes, chapter 297H, for construction debris generated from repair and demolition activities in the area eligible for assistance under section 1 due to tornado and other weather damage on July 25, 2000, and disposed of in a waste management facility designated by the commissioner of the pollution control agency. The commissioner of revenue's authority under this section to waive the taxes expires for waste transported to the designated facilities after July 25, 2001.

Sec. 8. [PROPERTY TAX ABATEMENTS; PROPERTY DAMAGED BY TORNADO.]

Subdivision 1. [AUTHORIZATION.] Notwithstanding the requirements of Minnesota Statutes, section 375.192, a city council by resolution may request the county board of a qualified county to grant abatements on eligible property for taxes payable in 2000 and 2001 as provided in this section. The full amount of taxes payable in 2000 on an eligible property may be abated. Up to 50 percent of the taxes payable in 2001 on an eligible property that does not qualify for reimbursement under Minnesota Statutes, section 273.123, subdivision 4, may be abated. The owner of the eligible property is not required to apply for the abatement.

Subd. 2. [DEFINITIONS.] (a) As used in this section, the terms defined in this subdivision have the meanings given them.

(b) "Qualified county" means any county in the area added to the Presidential Declaration of Major Disaster, DR1333, by amendment number 5 dated July 28, 2000, and amendment number 6 dated August 14, 2000.

(c) "Eligible property" means a parcel of taxable property located in a qualified county that contains a structure that has been determined by the assessor to have lost over 50 percent of its estimated market value due to wind damage. In the case of agricultural property, the abatement is limited to the taxes on the parcel attributable to the value of the house, garage, and surrounding one acre, if the house has lost over 50 percent of its estimated market value; and the tax attributable to the value of any farm buildings and structures that have lost over 50 percent of their estimated market value.

Subd. 3. [ASSESSORS' DUTIES.] As soon as practicable, local and county assessors in qualified counties shall notify the county board and property owners of parcels of eligible property.

Sec. 9. [VALUATION EXCLUSION FOR IMPROVEMENTS TO CERTAIN BUSINESS PROPERTY.]

(a) Property classified under Minnesota Statutes, section 273.13, subdivision 24, which is eligible for the preferred class rate on the market value up to \$150,000, shall qualify for a valuation exclusion for assessment purposes, provided all of the following conditions are met:

(1) the building must be damaged by the tornadoes of July 25, 2000;

(2) the building must be located within an area added to the Presidential Declaration of Major Disaster, DR1333, by amendment number 5 dated July 28, 2000, and amendment number 6 dated August 14, 2000, as eligible for federal aid due to the tornadoes of July 25, 2000;

(3) the total estimated market value of the land and buildings must be \$150,000 or less prior to the damage caused by the tornadoes of July 25, 2000;

(4) a building permit must have been issued prior to the commencement of the improvement, or if the building is located in a city or town that does not have a building permit process, the property owner must notify the assessor prior to the commencement of the improvement;

(5) the property, including its improvements, has received no public assistance, grants, or financing;

(6) the property is not receiving a property tax abatement under Minnesota Statutes, section 469.1813; and

(7) the improvements are made after July 25, 2000, and prior to July 1, 2001.

(b) The assessor shall estimate the market value of the building in the assessment year immediately following the year that (1) the building permit was taken out, or (2) the taxpayer notified the assessor that an improvement was to be made. If the estimated market value of the building has increased over the prior year's assessment, the assessor shall note the amount of the increase on the property's record, and that amount shall be subtracted from the value of the property in each year for five years after the improvement has been made, at which time an amount equal to 20 percent of the excluded value shall be added back in each of the five subsequent assessment years.

(c) For any property, there can be no more than two improvements qualifying for exclusion under this subdivision. The maximum amount of value that can be excluded from any property under this subdivision is \$50,000.

(d) The assessor shall require an application. Applications must be received prior to July 1 of any year in order to be effective for taxes payable in the following year.

Sec. 10. [DELAY OF FINANCIAL REPORT FILING; DISASTER AREAS.]

For any city or town located in whole or in part within a county that is eligible for assistance under section 1 due to the tornadoes of July 25, 2000, the deadline by which financial reports are required to be filed under Minnesota Statutes, section 471.697 or 471.698, is extended by 90 days.

Sec. 11. [DECLINING PUPIL UNIT AID; YELLOW MEDICINE EAST.]

Subdivision 1. [FISCAL YEAR 2001.] For fiscal year 2001, independent school district No. 2190, Yellow Medicine East, is eligible for tornado impact declining enrollment aid equal to \$156,000.

Subd. 2. [FISCAL YEAR 2002.] For fiscal year 2002, independent school district No. 2190, Yellow Medicine East, is eligible for tornado impact declining enrollment aid equal to 75 percent of the fiscal year 2001 appropriation in subdivision 1.

Subd. 3. [FISCAL YEAR 2003.] For fiscal year 2003, independent school district No. 2190, Yellow Medicine East, is eligible for tornado impact declining enrollment aid equal to 50 percent of the fiscal year 2001 appropriation in subdivision 1.

Subd. 4. [FISCAL YEAR 2004.] For fiscal year 2004, independent school district No. 2190, Yellow Medicine East, is eligible for tornado impact declining enrollment aid equal to 25 percent of the fiscal year 2001 appropriation in subdivision 1.

Sec. 12. [APPROPRIATION.]

The sums indicated in this section are appropriated for the fiscal years designated from the general fund to the commissioner of children, families, and learning for grants to independent school district No. 2190, for tornado impact declining enrollment aid.

<u>\$156,000</u>	<u>2001</u>
<u>\$117,000</u>	<u>2002</u>
<u>\$78,000</u>	<u>2003</u>

Sec. 13. [EFFECTIVE DATE.]

Except as otherwise provided in this act, this act is effective the day following its final enactment."

Delete the title and insert:

"A bill for an act relating to tornado relief; providing disaster relief and other assistance for counties designated a major disaster area due to the July 25, 2000, tornado; appropriating money."

With the recommendation that when so amended the bill pass and be re-referred to the Committee on Jobs and Economic Development Finance.

The report was adopted.

Wolf from the Committee on Regulated Industries to which was referred:

H. F. No. 118, A resolution memorializing the television networks to actively reduce the amount of violence-laden, sexually explicit material on television programs and to produce television material that promotes wholesome family values and helps to strengthen the family.

Reported the same back with the recommendation that the bill pass.

The report was adopted.

Dempsey from the Committee on Local Government and Metropolitan Affairs to which was referred:

H. F. No. 570, A bill for an act relating to peace officers; prescribing grounds for license revocation, suspension, or denial; removing the requirement that the peace officer standards and training board report to the legislature on the activities of the minority recruiter; repealing the law empowering council members of certain cities to act as peace officers to suppress riotous or disorderly conduct; amending Laws 1997, chapter 239, article 1, section 9; proposing coding for new law in Minnesota Statutes, chapter 626; repealing Minnesota Statutes 2000, section 412.101.

Reported the same back with the recommendation that the bill pass.

The report was adopted.

Dempsey from the Committee on Local Government and Metropolitan Affairs to which was referred:

H. F. No. 610, A bill for an act relating to local government; adding an exception to the local public officer's conflict of interest law; amending Minnesota Statutes 2000, section 471.88, by adding a subdivision.

Reported the same back with the following amendments:

Delete everything after the enacting clause and insert:

"Section 1. Minnesota Statutes 2000, section 471.88, is amended by adding a subdivision to read:

Subd. 17. [SMALL CITIES IN ST. LOUIS COUNTY; CERTAIN FEDERAL FUNDING PROGRAMS.] If a city with a population of 2,000 or less in St. Louis county administers a loan or grant program with community development block grant funds or federal economic development administration funds for property owners within the geographic boundaries of the city, the city may make a grant or loan from these funds to a public officer of the city who applies, if the public officer first discloses, as part of the official minutes of a meeting of the city, that the public officer has applied for the funds and the public officer abstains from voting on the public officer's application.

Sec. 2. [LOCAL APPROVAL NOT REQUIRED.]

Section 1 does not require local approval because it enables certain cities in St. Louis county to exercise authority not granted by general law and thus fits in the class in Minnesota Statutes, section 645.023, subdivision 1, clause (a)."

With the recommendation that when so amended the bill pass.

The report was adopted.

Bradley from the Committee on Health and Human Services Policy to which was referred:

H. F. No. 812, A bill for an act relating to mental health; establishing duties for reducing and preventing suicides; establishing requirements for discharge plans and transition services for offenders with mental illness; providing coverage requirements for health plans; adjusting payment rates for certain mental health providers; establishing coverage requirements for mental health services and treatment; requiring studies; appropriating money; amending Minnesota Statutes 2000, sections 144.56, by adding a subdivision; 245.462, subdivisions 3, 6, 8, 18, 20, and by adding subdivisions; 245.466, subdivision 2; 245.4711, by adding a subdivision; 245.474, subdivision 2, and by adding a subdivision; 245.4871, subdivisions 10, 17, 27, 29, and by adding subdivisions; 245.4875, subdivision 2;

245.4876, subdivision 1, and by adding subdivisions; 245.488, by adding a subdivision; 245.4885, subdivision 1; 245.70, by adding a subdivision; 246.54; 256.969, subdivision 3a, and by adding a subdivision; 256B.0625, subdivision 17, and by adding subdivisions; 256B.69, by adding subdivisions; 256E.12, subdivision 1, and by adding a subdivision; 260C.201, subdivision 1; proposing coding for new law in Minnesota Statutes, chapters 62Q; 145; 244; 245; 246; 256B; and 299A;

Reported the same back with the following amendments:

Page 1, line 35, delete "evidenced-based" and insert "evidence-based"

Page 4, line 23, after the period, insert "The data must be summary data as defined in section 13.02 and must not identify individuals."

Page 5, line 25, before the period, insert ", or to statistics directly related to the commission of a crime"

Page 7, line 35, after "offender" insert ", if eligible."

Page 8, line 29, delete "case manager" and insert "mental health case management"

Page 9, line 19, after "corrections" insert ", in collaboration with the commissioner of human services."

Page 10, line 36, delete "ANNUAL"

Page 11, delete line 1 and insert "On"

Page 11, line 2, delete "each July 1 thereafter" and insert "July 1, 2002"

Page 11, delete lines 7 to 23 and insert "three percent each fiscal year."

Page 13, line 24, delete "2002" and insert "2001"

Page 13, line 32, delete "July 1, 2001" and insert "January 1, 2002"

Page 14, line 7, delete "20" and insert "ten"

Page 14, line 8, delete "June 30" and insert "July 1"

Page 14, delete line 24 and insert "On July 1, 2001, and July 1, 2002,"

Page 14, line 25, delete "2004,"

Page 14, line 29, delete everything after "by" and insert "three percent each fiscal year."

Page 14, delete lines 30 to 36

Page 15, delete lines 1 to 10

Page 15, line 12, delete "ANNUAL"

Page 16, line 8, delete "25" and insert "22"

Page 16, line 33, delete the first comma and insert "and" and delete ", and support services"

Page 16, line 36, after "assistance" insert "to consumers"

Page 18, lines 6 and 7, delete "includes education, consultation, and support services" and insert "may include education and consultation"

Page 21, line 29, delete "25" and insert "22"

Page 23, line 17, delete "shall" and insert "may"

Page 23, line 18, delete "25" and insert "22"

Page 24, line 1, delete the second comma and insert "and"

Page 24, line 2, delete everything after "cooperatives"

Page 24, delete line 3

Page 24, line 4, delete everything before the period

Page 25, line 14, delete everything after "treatment" and insert "may include education and consultation"

Page 26, line 22, delete the first comma and insert "and" and delete ", and support services"

Page 26, line 25, after "assistance" insert "to consumers"

Page 28, line 36, delete the comma and insert "and"

Page 29, line 1, delete ", and support services"

Page 33, line 23, delete "proceedings" and insert "commitment or petition"

Page 35, line 16, delete "proceedings" and insert "commitment or petition"

Pages 37 to 39, delete sections 38 to 40

Page 40, line 5, after the period, insert "Section 62Q.535 applies to an order for mental health services directed to the child's health plan."

Pages 42 and 43, delete section 42

Page 43, delete lines 33 to 36

Page 44, delete lines 1 to 5

Page 44, line 6, delete "Subd. 2." and insert "Subdivision 1."

Page 44, line 15, delete "3" and insert "2"

Page 44, line 22, delete "for" and insert "under the" and after "assistance" insert "contract under Minnesota Statutes, section 256.969, subdivision 3b."

Page 44, delete lines 25 to 29

Page 44, line 30, delete "5" and insert "3"

Page 45, delete lines 3 to 7

Page 45, line 8, delete "7" and insert "4"

Page 45, line 16, delete "8" and insert "5"

Page 47, line 22, delete "includes" and insert "means" and after "all" insert "covered"

Page 47, line 26, after "plan" insert "company"

Page 47, line 27, delete everything after the headnote and insert "All health plan companies that provide coverage for mental health services must cover or provide mental health services ordered by a court of competent jurisdiction under a court order that is issued on the basis of a behavioral care evaluation, performed by a licensed psychiatrist or a doctoral level licensed psychologist, which includes a diagnosis and an individual treatment plan. The health plan company must be given a copy of the court order and behavioral evaluation. The health plan company shall be financially liable for the evaluation if performed by a participating provider of the health plan company and the care included in the treatment plan if the care is covered by the health plan company and ordered to be provided by a participating provider. This coverage must not be subject to a medical necessity determination by a health plan company."

Page 47, delete lines 28 to 31

Pages 48 and 49, delete sections 1 to 3

Re-number the sections in sequence and correct internal references

Amend the title as follows:

Page 1, line 6, after the semicolon, insert "providing for a calculation to regional treatment centers based on population size;"

Page 1, line 9, after the first semicolon, insert "adding certain services covered under case management, community support, and day treatment services;" and after "studies;" insert "defining certain mental health provisions; establishing team case management services and continuing care benefit program; covering certain transportation costs; adding provisions to the prepaid health plan; requiring development of a payment system;"

Page 1, line 11, delete "144.56, by adding a subdivision;"

Page 1, line 13, after "subdivision 2;" insert "245.470, by adding a subdivision"

Page 1, lines 14 and 15, delete "245.474, subdivision 2, and by adding a subdivision;"

Page 1, line 19, delete everything after the semicolon

Page 1, line 20, delete everything before "246.54;"

Page 1, line 23, delete everything after the semicolon

Page 1, line 24, delete "subdivision;"

Page 1, line 26, delete the fifth semicolon and insert a period

With the recommendation that when so amended the bill pass and be re-referred to the Committee on Crime Prevention.

The report was adopted.

Rhodes from the Committee on Governmental Operations and Veterans Affairs Policy to which was referred:

H. F. No. 894, A bill for an act relating to horse racing; card clubs; defining terms; modifying wagers; amending Minnesota Statutes 2000, sections 240.01, subdivision 26, and by adding a subdivision; and 240.30, subdivision 8.

Reported the same back with the following amendments:

Page 1, line 17, delete "do not"

With the recommendation that when so amended the bill pass.

The report was adopted.

Bradley from the Committee on Health and Human Services Policy to which was referred:

H. F. No. 985, A bill for an act relating to human services; creating a program for respite care for family adult foster care providers; proposing coding for new law in Minnesota Statutes, chapter 256.

Reported the same back with the recommendation that the bill pass and be re-referred to the Committee on Health and Human Services Finance.

The report was adopted.

Bradley from the Committee on Health and Human Services Policy to which was referred:

H. F. No. 994, A bill for an act relating to health; establishing procedure for requesting a variance or waiver for rules regarding the operation, construction, and equipment of hospitals; proposing coding for new law in Minnesota Statutes, chapter 144.

Reported the same back with the recommendation that the bill pass and be re-referred to the Committee on Governmental Operations and Veterans Affairs Policy.

The report was adopted.

Rhodes from the Committee on Governmental Operations and Veterans Affairs Policy to which was referred:

H. F. No. 995, A bill for an act relating to horse racing; modifying license applicant requirements; modifying medication requirements; amending Minnesota Statutes 2000, sections 240.08, subdivision 2; and 240.24, subdivision 2.

Reported the same back with the following amendments:

Page 1, line 15, delete "within ten"

Page 1, line 16, delete the new language

With the recommendation that when so amended the bill pass.

The report was adopted.

Rhodes from the Committee on Governmental Operations and Veterans Affairs Policy to which was referred:

H. F. No. 1021, A bill for an act relating to horse racing; card clubs; authorizing licensee of commission to detain persons suspected of cheating; proposing coding for new law in Minnesota Statutes, chapter 240.

Reported the same back with the following amendments:

Page 1, delete lines 8 to 13 and insert:

"Subdivision 1. [GENERALLY.] A licensee of the commission may detain a person if the licensee has reasonable cause to believe that the person detained has violated section 609.76, subdivisions 3 to 7. For purposes of this section, "licensee" means the commission's director of racing security or a security officer licensed pursuant to Minnesota Rules, chapter 7878."

Page 2, line 17, before the period, insert ", subdivisions 3 to 7"

With the recommendation that when so amended the bill pass and be re-referred to the Committee on Crime Prevention.

The report was adopted.

Rhodes from the Committee on Governmental Operations and Veterans Affairs Policy to which was referred:

H. F. No. 1053, A bill for an act relating to insurance; revising certain provisions involving state regulation of private health coverage; transferring certain regulatory control; establishing requirements for managed care plans; amending Minnesota Statutes 2000, sections 62A.021, subdivision 1; 62A.041, subdivisions 1 and 2; 62A.042; 62A.043, subdivision 1; 62A.105; 62A.14; 62A.149, subdivision 1; 62A.15, subdivision 1; 62A.152, subdivision 1; 62A.153; 62A.20; 62A.21; 62A.615; 62A.616; 62A.65, subdivision 5; 62D.02, subdivisions 3 and 8; 62D.12, subdivisions 1 and 1a; 62D.15, subdivision 1; 62D.24; 62E.05, subdivision 2; 62E.11, subdivision 13; 62E.14, subdivision 6; 62E.16; 62J.041, subdivision 4; 62J.701; 62J.74, subdivisions 1 and 2; 62J.75; 62L.02, subdivision 8; 62L.05, subdivision 12; 62L.08, subdivisions 10 and 11; 62L.09, subdivision 3; 62L.10, subdivision 4; 62L.11, subdivision 2; 62L.12, subdivision 2; 62M.11; 62M.16; 62N.02, subdivision 4; 62N.26; 62Q.01, subdivision 2; 62Q.03, subdivision 5a; 62Q.07; 62Q.106; 62Q.22, subdivisions 2, 6, and 7; 62Q.32; 62Q.33, subdivision 2; 62Q.49, subdivision 2; 62Q.51, subdivision 3; 62Q.525, subdivision 3; 62Q.68, subdivision 1; 62Q.69, subdivisions 2 and 3; 62Q.71; 62Q.72; 62Q.73, subdivisions 3, 4, 5, and 6; 62R.04, subdivision 5; 62R.06, subdivision 1; 62T.01, subdivision 4; 256B.692, subdivisions 2 and 7; and 257.34, subdivision 1; proposing coding for new law as Minnesota Statutes, chapter 62U; repealing Minnesota Statutes 2000, sections 62A.049; 62A.21, subdivision 3; 62C.14, subdivisions 5, 5a, 5b, and 14; 62C.142; 62D.09, subdivision 3; 62D.101; 62D.105; 62D.12, subdivision 19; 62D.123, subdivisions 2, 3, and 4; 62D.124; 62Q.095; 62Q.10; and 62Q.45; Minnesota Rules, parts 4685.0801, subpart 7; 4685.1010; 4685.1105; 4685.1110; 4685.1115; 4685.1120; 4685.1125; 4685.1130; 4685.1300; 4685.1900; 4685.2000; and 4685.2200, subpart 3.

Reported the same back with the recommendation that the bill pass and be re-referred to the Committee on Health and Human Services Policy.

The report was adopted.

Rhodes from the Committee on Governmental Operations and Veterans Affairs Policy to which was referred:

H. F. No. 1069, A bill for an act relating to gambling; modifying definition of lawful purpose; amending Minnesota Statutes 2000, sections 297E.06, subdivision 4; 349.12, subdivision 25; 349.15, subdivision 1, and by adding a subdivision; 349.155, subdivision 4a; 349.17, by adding a subdivision; 349.2127, subdivision 7; and 349.213; repealing Minnesota Statutes 2000, section 349.168.

Reported the same back with the following amendments:

Delete everything after the enacting clause and insert:

"Section 1. Minnesota Statutes 2000, section 297E.06, subdivision 4, is amended to read:

Subd. 4. [ANNUAL AUDIT.] (a) An organization licensed under chapter 349 with gross receipts from lawful gambling of more than ~~\$250,000~~ \$300,000 in any year must have an annual financial audit of its lawful gambling activities and funds for that year. An organization licensed under chapter 349 with gross receipts from lawful gambling of more than ~~\$50,000~~ \$150,000 but not more than ~~\$250,000~~ \$300,000 in any year must have an annual financial review of its lawful gambling activities and funds for that year. Audits and financial reviews under this subdivision must be performed by an independent accountant licensed by the state of Minnesota.

(b) The commissioner of revenue shall prescribe standards for audits and financial review required under this subdivision. The standards may vary based on the gross receipts of the organization. The standards must incorporate and be consistent with standards prescribed by the American institute of certified public accountants. A complete, true, and correct copy of the audit report must be filed as prescribed by the commissioner.

Sec. 2. Minnesota Statutes 2000, section 349.12, subdivision 25, is amended to read:

Subd. 25. [LAWFUL PURPOSE.] (a) "Lawful purpose" means one or more of the following:

(1) any expenditure by or contribution to a 501(c)(3) or festival organization, as defined in subdivision 15a, provided that the organization and expenditure or contribution are in conformity with standards prescribed by the board under section 349.154, which standards must apply to both types of organizations in the same manner and to the same extent;

(2) a contribution to an individual or family suffering from poverty, homelessness, or physical or mental disability, which is used to relieve the effects of that poverty, homelessness, or disability;

(3) a contribution to an individual for treatment for delayed posttraumatic stress syndrome or a contribution to a program recognized by the Minnesota department of human services for the education, prevention, or treatment of compulsive gambling;

(4) a contribution to or expenditure on a public or private nonprofit educational institution registered with or accredited by this state or any other state;

(5) a contribution to a scholarship fund for defraying the cost of education to individuals where the funds are awarded through an open and fair selection process;

(6) activities by an organization or a government entity which recognize humanitarian or military service to the United States, the state of Minnesota, or a community, subject to rules of the board, provided that the rules must not include mileage reimbursements in the computation of the per occasion reimbursement limit and must impose no aggregate annual limit on the amount of reasonable and necessary expenditures made to support:

(i) members of a military marching or color guard unit for activities conducted within the state;

- (ii) members of an organization solely for services performed by the members at funeral services; or
- (iii) members of military marching, color guard, or honor guard units may be reimbursed for participating in color guard, honor guard, or marching unit events within the state or states contiguous to Minnesota at a per participant rate of up to \$35 per occasion;
- (7) recreational, community, and athletic facilities and activities intended primarily for persons under age 21, provided that such facilities and activities do not discriminate on the basis of gender and the organization complies with section 349.154;
- (8) payment of local taxes authorized under this chapter, taxes imposed by the United States on receipts from lawful gambling, the taxes imposed by section 297E.02, subdivisions 1, 4, 5, and 6, and the tax imposed on unrelated business income by section 290.05, subdivision 3;
- (9) payment of real estate taxes and assessments on permitted gambling premises wholly owned by the licensed organization paying the taxes, not to exceed:
 - (i) for premises used for bingo, the amount that an organization may expend under board rules on rent for bingo; and
 - (ii) \$35,000 per year for premises used for other forms of lawful gambling;
- (10) a contribution to the United States, this state or any of its political subdivisions, or any agency or instrumentality thereof other than a direct contribution to a law enforcement or prosecutorial agency;
- (11) a contribution to or expenditure by a nonprofit organization which is a church or body of communicants gathered in common membership for mutual support and edification in piety, worship, or religious observances;
- (12) payment of ~~one-half~~ of the reasonable costs of an audit required in section 297E.06, subdivision 4, provided the annual audit is filed in a timely manner with the department of revenue;
- (13) a contribution to or expenditure on a wildlife management project that benefits the public at-large, provided that the state agency with authority over that wildlife management project approves the project before the contribution or expenditure is made;
- (14) expenditures, approved by the commissioner of natural resources, by an organization for grooming and maintaining snowmobile trails and all-terrain vehicle trails that are (1) grant-in-aid trails established under section 85.019, or (2) other trails open to public use, including purchase or lease of equipment for this purpose; or
- (15) conducting nutritional programs, food shelves, and congregate dining programs primarily for persons who are age 62 or older or disabled; or
- (16) a contribution to a community arts organization, or an expenditure to sponsor arts programs in the community, including but not limited to visual, literary, performing, or musical arts.
 - (b) Notwithstanding paragraph (a), "lawful purpose" does not include:
 - (1) any expenditure made or incurred for the purpose of influencing the nomination or election of a candidate for public office or for the purpose of promoting or defeating a ballot question;
 - (2) any activity intended to influence an election or a governmental decision-making process;

(3) the erection, acquisition, improvement, expansion, repair, or maintenance of real property or capital assets owned or leased by an organization, unless the board has first specifically authorized the expenditures after finding that (i) the real property or capital assets will be used exclusively for one or more of the purposes in paragraph (a); (ii) with respect to expenditures for repair or maintenance only, that the property is or will be used extensively as a meeting place or event location by other nonprofit organizations or community or service groups and that no rental fee is charged for the use; (iii) with respect to expenditures, including a mortgage payment or other debt service payment, for erection or acquisition only, that the erection or acquisition is necessary to replace with a comparable building, a building owned by the organization and destroyed or made uninhabitable by fire or natural disaster, provided that the expenditure may be only for that part of the replacement cost not reimbursed by insurance; (iv) with respect to expenditures, including a mortgage payment or other debt service payment, for erection or acquisition only, that the erection or acquisition is necessary to replace with a comparable building a building owned by the organization that was acquired from the organization by eminent domain or sold by the organization to a purchaser that the organization reasonably believed would otherwise have acquired the building by eminent domain, provided that the expenditure may be only for that part of the replacement cost that exceeds the compensation received by the organization for the building being replaced; or (v) with respect to an expenditure to bring an existing building into compliance with the Americans with Disabilities Act under item (ii), an organization has the option to apply the amount of the board-approved expenditure to the erection or acquisition of a replacement building that is in compliance with the Americans with Disabilities Act;

(4) an expenditure by an organization which is a contribution to a parent organization, foundation, or affiliate of the contributing organization, if the parent organization, foundation, or affiliate has provided to the contributing organization within one year of the contribution any money, grants, property, or other thing of value;

(5) a contribution by a licensed organization to another licensed organization unless the board has specifically authorized the contribution. The board must authorize such a contribution when requested to do so by the contributing organization unless it makes an affirmative finding that the contribution will not be used by the recipient organization for one or more of the purposes in paragraph (a); or

(6) a contribution to a statutory or home rule charter city, county, or town by a licensed organization with the knowledge that the governmental unit intends to use the contribution for a pension or retirement fund.

Sec. 3. Minnesota Statutes 2000, section 349.15, subdivision 1, is amended to read:

Subdivision 1. [EXPENDITURE RESTRICTIONS.] Gross profits from lawful gambling may be expended only for lawful purposes or allowable expenses as authorized by the membership of the conducting organization at a monthly meeting of the organization's membership. Provided that no more than ~~65~~ 70 percent of the gross profit less the tax imposed under section 297E.02, subdivision 1, from bingo, and no more than 55 percent of the gross profit from other forms of lawful gambling, may be expended for allowable expenses related to lawful gambling.

Sec. 4. Minnesota Statutes 2000, section 349.15, is amended by adding a subdivision to read:

Subd. 1a. [NATURAL DISASTER RELIEF.] An organization may expend net profits from lawful gambling to relieve the effects of a natural disaster without the prior approval of its membership if:

(1) the contribution is a lawful purpose under section 349.12, subdivision 25;

(2) the contribution is authorized by the organization's chief executive officer and gambling manager; and

(3) the contribution is approved by the membership of the organization at its next regularly scheduled monthly meeting.

If the contribution is not approved by the membership of the organization at its next regularly scheduled monthly meeting, the organization shall reimburse its gambling account in the amount of the contribution.

Sec. 5. Minnesota Statutes 2000, section 349.155, subdivision 4a, is amended to read:

Subd. 4a. [ILLEGAL GAMBLING.] (a) The board may not deny, suspend, revoke, or refuse to renew an organization's premises permit because illegal gambling occurred at the site for which the premises permit was issued, unless the board determines that: (1) the organization knowingly participated in the illegal gambling; or (2) the organization or any of its agents knew or reasonably should have known of the illegal gambling and the organization did not notify the lessor of the premises, in writing and with specificity, that illegal gambling was being conducted on the premises and requesting that the lessor take appropriate action. For purposes of this paragraph "agent" means any person, compensated or otherwise, who participates in the conduct of the organization's lawful gambling.

(b) The board may not deny, suspend, revoke, or refuse to renew an organization's license because illegal gambling occurred at a site for which a premises permit was issued to the organization unless the board determines that the organization's chief executive officer, gambling manager, or one or more of its assistant gambling managers participated in or authorized the illegal gambling.

Sec. 6. Minnesota Statutes 2000, section 349.168, subdivision 1, is amended to read:

Subdivision 1. [REGISTRATION OF EMPLOYEES.] A person may not receive compensation for participating in the conduct of lawful gambling as an employee of a licensed organization unless the person has first registered with the board on a form the board prescribes. The form must require each registrant to provide: (1) the person's name, address, date of birth, and social security number; (2) ~~a current photograph~~; ~~(3) the name, address, and license number of the employing organization;~~ and ~~(4) (3) a listing of all employment in the conduct of lawful gambling within the previous three years, including the name and address of each employing organization and the circumstances under which the employment was terminated.~~

Sec. 7. Minnesota Statutes 2000, section 349.168, subdivision 2, is amended to read:

Subd. 2. [IDENTIFICATION OF EMPLOYEES.] ~~The board shall issue to each person registering under subdivision 1 a registration number and identification card which must include the employee's photograph. Each person receiving compensation for the conduct of lawful gambling must wear the identification card provided by the board publicly display the person's first name at the point of sale at all times while conducting the lawful gambling.~~

Sec. 8. Minnesota Statutes 2000, section 349.17, is amended by adding a subdivision to read:

Subd. 7. [NOON HOUR BINGO.] Notwithstanding subdivisions 1 and 3, an organization may conduct bingo subject to the following restrictions:

(1) the bingo is conducted only between the hours of 11:00 a.m. and 2:00 p.m.;

(2) the bingo is conducted at a site the organization owns or leases and which has a license for the sale of intoxicating beverages on the premises under chapter 340A;

(3) the bingo is limited to one progressive bingo game per site as defined by section 349.211, subdivision 2;

(4) the bingo is conducted using only bingo paper sheets; and

(5) if the premise is leased, the rent may not exceed \$25 per day for each day bingo is conducted.

Sec. 9. Minnesota Statutes 2000, section 349.2127, subdivision 7, is amended to read:

Subd. 7. [CHECKS FOR GAMBLING PURCHASES.] An organization may not accept checks in payment for the purchase of any gambling equipment or for the chance to participate in any form of lawful gambling except a raffle. If an organization accepts a check, the payment of which is subsequently dishonored, the organization shall

reimburse its gambling account for the amount of the dishonored check within 30 days of receiving notice of the dishonor. This subdivision does not apply to gaming activities conducted pursuant to the Indian Gaming Regulatory Act, United States Code, title 25, section 2701 et seq.

Sec. 10. Minnesota Statutes 2000, section 349.213, is amended to read:

349.213 [LOCAL AUTHORITY.]

Subdivision 1. [LOCAL REGULATION.] (a) A statutory or home rule city or county has the authority to adopt more stringent regulation of lawful gambling within its jurisdiction, including the prohibition of lawful gambling, and may require a permit for the conduct of gambling exempt from licensing under section 349.166. The fee for a permit issued under this subdivision may not exceed \$100. The authority granted by this subdivision does not include the authority to require a license or permit to conduct gambling by organizations or sales by distributors licensed by the board. The authority granted by this subdivision does not include the authority to require an organization to make specific expenditures of more than ten percent per year from its net profits derived from lawful gambling. For the purposes of this subdivision, net profits are gross profits less amounts expended for allowable expenses and paid in taxes assessed on lawful gambling. A statutory or home rule charter city or a county may not require an organization conducting lawful gambling within its jurisdiction to make an expenditure to the city or county as a condition to operate within that city or county, except as authorized under section 349.16, subdivision 8, or 297E.02; provided, however, that an ordinance requirement that such organizations must contribute ten percent per year of their net profits derived from lawful gambling conducted at premises within the city's or county's jurisdiction to a fund administered and regulated by the responsible local unit of government without cost to such fund, for disbursement by the responsible local unit of government of the receipts for (i) lawful purposes, or (ii) police, fire, and other emergency or public safety-related services, equipment, and training, excluding pension obligations, is not considered an expenditure to the city or county nor a tax under section 297E.02, and is valid and lawful. A city or county making expenditures authorized under this paragraph must by March 15 of each year file a report with the board, on a form the board prescribes, that lists all such revenues collected and expenditures for the previous calendar year.

(b) A statutory or home rule city or county may by ordinance require that a licensed organization conducting lawful gambling within its jurisdiction expend all or a portion of its expenditures for lawful purposes on lawful purposes conducted or located within the city's or county's trade area. Such an ordinance must be limited to lawful purpose expenditures of gross profits derived from lawful gambling conducted at premises within the city's or county's jurisdiction, must define the city's or county's trade area, and must specify the percentage of lawful purpose expenditures which must be expended within the trade area. A trade area defined by a city under this subdivision must include each city and township contiguous to the defining city.

(c) A more stringent regulation or prohibition of lawful gambling adopted by a political subdivision under this subdivision must apply equally to all forms of lawful gambling within the jurisdiction of the political subdivision, except a political subdivision may prohibit the use of paddlewheels.

Subd. 2. [LOCAL APPROVAL.] Before issuing or renewing a premises permit or bingo hall license, the board must notify the city council of the statutory or home rule city in which the organization's premises or the bingo hall is located or, if the premises or hall is located outside a city, the county board of the county and the town board of the town where the premises or hall is located. The board may require organizations or bingo halls to notify the appropriate local government at the time of application. This required notification is sufficient to constitute the notice required by this subdivision. The board may not issue or renew a premises permit or bingo hall license unless the organization submits a resolution from the city council or county board approving the premises permit or bingo hall license. The resolution must have been adopted within ~~60~~ 90 days of the date of application for the new or renewed permit or license.

Subd. 3. [LOCAL GAMBLING TAX.] A statutory or home rule charter city that has one or more licensed organizations operating lawful gambling, and a county that has one or more licensed organizations outside incorporated areas operating lawful gambling, may impose a local gambling tax on each licensed organization within

the city's or county's jurisdiction. The tax may be imposed only if the amount to be received by the city or county is necessary to cover the costs incurred by the city or county to regulate lawful gambling. The tax imposed by this subdivision may not exceed three percent per year of the gross receipts of a licensed organization from all lawful gambling less prizes actually paid out by the organization. A city or county may not use money collected under this subdivision for any purpose other than to regulate lawful gambling. A tax imposed under this subdivision is in lieu of all other local taxes and local investigation fees on lawful gambling. A city or county that imposes a tax under this subdivision shall annually, by March 15, file a report with the board in a form prescribed by the board showing (1) the amount of revenue produced by the tax during the preceding calendar year, and (2) the use of the proceeds of the tax.

Sec. 11. [EFFECTIVE DATE.]

Sections 1 to 10 are effective the day following final enactment."

Delete the title and insert:

"A bill for an act relating to gambling; adjusting annual audit amounts for organizations licensed under chapter 349; modifying definition of lawful purpose; modifying gross profit expenditures; modifying certain license and registration requirements; providing for conduct of bingo; permitting organizations to accept checks for participation in raffles; modifying local government's authority to tax and regulate gambling; amending Minnesota Statutes 2000, sections 297E.06, subdivision 4; 349.12, subdivision 25; 349.15, subdivision 1, by adding a subdivision; 349.155, subdivision 4a; 349.168, subdivisions 1, 2; 349.17, by adding a subdivision; 349.2127, subdivision 7; 349.213."

With the recommendation that when so amended the bill pass.

The report was adopted.

Rhodes from the Committee on Governmental Operations and Veterans Affairs Policy to which was referred:

H. F. No. 1070, A bill for an act relating to lawful gambling; creating a new class of premises permit; establishing fees; amending Minnesota Statutes 2000, section 349.165, subdivisions 1 and 3.

Reported the same back with the recommendation that the bill pass and be re-referred to the Committee on State Government Finance.

The report was adopted.

Dempsey from the Committee on Local Government and Metropolitan Affairs to which was referred:

H. F. No. 1077, A bill for an act relating to taxation; aggregate removal; extending the tax to counties that vote to impose the tax; increasing the rate of tax; amending Minnesota Statutes 2000, section 298.75, subdivisions 1 and 2.

Reported the same back with the following amendments:

Page 3, after line 14, insert:

"Sec. 3. Minnesota Statutes 2000, section 298.75, subdivision 7, is amended to read:

Subd. 7. ~~(a) All money collected as taxes under this section shall be deposited in the county treasury and credited as follows, for expenditure by the county board:~~ according to this subdivision.

~~(b) The county auditor may retain an annual administrative fee of up to five percent of the total taxes collected in any year.~~

~~(c) The balance of the taxes, after any deduction under paragraph (b), shall be credited as follows:~~

~~(a) Sixty (1) 42.5 percent to the county road and bridge fund for expenditure for the maintenance, construction and reconstruction of roads, highways and bridges;~~

~~(b) Thirty (2) 42.5 percent to the road and bridge fund of those towns as determined by the county board and to the general fund or other designated fund of those cities as determined by the county board city or town in which the mine is located, or to the county if unorganized, to be expended for maintenance, construction and reconstruction of roads, highways and bridges; and~~

~~(c) Ten (3) 15 percent to a special reserve fund which is hereby established, for expenditure for the restoration of abandoned pits, quarries, or deposits located upon public and tax forfeited lands within the county.~~

If there are no abandoned pits, quarries, or deposits located upon public or tax forfeited lands within the county, this portion of the tax ~~shall~~ may be deposited in the county road and bridge fund for expenditure for the maintenance, construction, and reconstruction of roads, highways, and bridges or may be used for any other unmet reclamation need. Reclamation shall be prioritized as follows: reclamation of pits and quarries on public or tax-forfeited land, reclamation of abandoned pits or quarries on private land, and reclamation of active pits and quarries on private land.

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

Amend the title as follows:

Page 1, line 4, after the semicolon, insert "providing for use of tax proceeds;"

Page 1, line 5, delete "1 and 2" and insert "1, 2, 7"

With the recommendation that when so amended the bill pass and be re-referred to the Committee on Taxes.

The report was adopted.

Bradley from the Committee on Health and Human Services Policy to which was referred:

H. F. No. 1123, A bill for an act relating to human services; increasing prepaid medical assistance program capitation rates for nonmetropolitan counties; amending Minnesota Statutes 2000, section 256B.69, subdivision 5b.

Reported the same back with the following amendments:

Page 1, line 25, delete everything after "to"

Page 2, line 1, delete "nonmetropolitan counties" and insert "Hennepin county"

Page 2, after line 5, insert:

"(d) The commissioner shall require prepaid health plans to use all revenue received from the increase in capitation rates for nonmetropolitan counties from 89 to no less than 95 percent of the capitation rate for metropolitan counties, excluding Hennepin county, to increase reimbursement rates, effective January 1, 2002, for providers under contract with the prepaid health plan to serve enrollees from nonmetropolitan counties."

Amend the title as follows:

Page 1, line 2, delete "increasing" and insert "modifying"

Page 1, line 4, delete "nonmetropolitan" and insert "certain"

With the recommendation that when so amended the bill pass and be re-referred to the Committee on Health and Human Services Finance.

The report was adopted.

Bradley from the Committee on Health and Human Services Policy to which was referred:

H. F. No. 1124, A bill for an act relating to human services; adjusting inpatient hospital rates for certain diagnosis-related groups for facilities located outside of the metropolitan area; amending Minnesota Statutes 2000, section 256.969, by adding a subdivision.

Reported the same back with the recommendation that the bill pass and be re-referred to the Committee on Health and Human Services Finance.

The report was adopted.

Bradley from the Committee on Health and Human Services Policy to which was referred:

H. F. No. 1193, A bill for an act relating to human services; changing provisions to improve access to home and community-based options for individuals with disabilities; modifying provisions for consumer control in some services; creating a consumer-directed home care demonstration project; amending Minnesota Statutes 2000, sections 252.275, subdivision 4b; 254B.03, subdivision 1; 254B.09, by adding a subdivision; 256.01, by adding a subdivision; 256.476, subdivisions 1, 2, 3, 4, 5, 8, and by adding a subdivision; 256B.0625, subdivisions 7, 19a, 19c, 20, and by adding a subdivision; 256B.0627, subdivisions 1, 2, 4, 5, 7, 8, 10, 11, and by adding subdivisions; 256B.0911, by adding a subdivision; 256B.093, subdivision 3; 256B.095; 256B.0951, subdivisions 1, 3, 4, 5, 6, and by adding a subdivision; 256B.0952, subdivisions 1 and 4; 256B.0955; 256B.49, by adding subdivisions; 256B.5012, by adding

a subdivision; and 256D.44, subdivision 5; repealing Minnesota Statutes 2000, sections 145.9245; 256.476, subdivision 7; 256B.0912; 256B.0915, subdivisions 3a, 3b, and 3c; 256B.0951, subdivision 7; and 256B.49, subdivisions 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10; Minnesota Rules, parts 9505.2455; 9505.2458; 9505.2460; 9505.2465; 9505.2470; 9505.2473; 9505.2475; 9505.2480; 9505.2485; 9505.2486; 9505.2490; 9505.2495; 9505.2496; 9505.2500; 9505.3010; 9505.3015; 9505.3020; 9505.3025; 9505.3030; 9505.3035; 9505.3040; 9505.3065; 9505.3085; 9505.3135; 9505.3500; 9505.3510; 9505.3520; 9505.3530; 9505.3535; 9505.3540; 9505.3545; 9505.3550; 9505.3560; 9505.3570; 9505.3575; 9505.3580; 9505.3585; 9505.3600; 9505.3610; 9505.3620; 9505.3622; 9505.3624; 9505.3626; 9505.3630; 9505.3635; 9505.3640; 9505.3645; 9505.3650; 9505.3660; and 9505.3670.

Reported the same back with the following amendments:

Delete everything after the enacting clause and insert:

"Section 1. Minnesota Statutes 2000, section 245A.13, subdivision 7, is amended to read:

Subd. 7. [RATE RECOMMENDATION.] The commissioner of human services may review rates of a residential program participating in the medical assistance program which is in receivership and that has needs or deficiencies documented by the department of health or the department of human services. If the commissioner of human services determines that a review of the rate established under ~~section 256B.501~~ sections 256B.5012 and 256B.5013 is needed, the commissioner shall:

- (1) review the order or determination that cites the deficiencies or needs; and
- (2) determine the need for additional staff, additional annual hours by type of employee, and additional consultants, services, supplies, equipment, repairs, or capital assets necessary to satisfy the needs or deficiencies.

Sec. 2. Minnesota Statutes 2000, section 245A.13, subdivision 8, is amended to read:

Subd. 8. [ADJUSTMENT TO THE RATE.] Upon review of rates under subdivision 7, the commissioner may adjust the residential program's payment rate. The commissioner shall review the circumstances, together with the residential ~~program cost report~~ program's most recent income and expense report, to determine whether or not the deficiencies or needs can be corrected or met by reallocating residential program staff, costs, revenues, or any other resources including ~~any investments, efficiency incentives, or allowances~~. If the commissioner determines that any deficiency cannot be corrected or the need cannot be met with the payment rate currently being paid, the commissioner shall determine the payment rate adjustment by dividing the additional annual costs established during the commissioner's review by the residential program's actual resident days from the most recent ~~desk-audited cost income and expense~~ income and expense report or the estimated resident days in the projected receivership period. The payment rate adjustment ~~must meet the conditions in Minnesota Rules, parts 9553.0010 to 9553.0080, and~~ remains in effect during the period of the receivership or until another date set by the commissioner. Upon the subsequent sale, closure, or transfer of the residential program, the commissioner may recover amounts that were paid as payment rate adjustments under this subdivision. This recovery shall be determined through a review of actual costs and resident days in the receivership period. The costs the commissioner finds to be allowable shall be divided by the actual resident days for the receivership period. This rate shall be compared to the rate paid throughout the receivership period, with the difference, multiplied by resident days, being the amount to be repaid to the commissioner. Allowable costs shall be determined by the commissioner as those ordinary, necessary, and related to resident care by prudent and cost-conscious management. The buyer or transferee shall repay this amount to the commissioner within 60 days after the commissioner notifies the buyer or transferee of the obligation to repay. This provision does not limit the liability of the seller to the commissioner pursuant to section 256B.0641.

Sec. 3. Minnesota Statutes 2000, section 252.275, subdivision 4b, is amended to read:

Subd. 4b. [GUARANTEED FLOOR.] Each county ~~with an original allocation for the preceding year that is equal to or less than the guaranteed floor minimum index shall have a guaranteed floor equal to its original allocation for the preceding year. Each county with an original allocation for the preceding year that is greater than the guaranteed floor minimum index shall have a guaranteed floor equal to the lesser of clause (1) or (2):~~

(1) the county's original allocation for the preceding year; or

(2) 70 percent of the county's reported expenditures eligible for reimbursement during the 12 months ending on June 30 of the preceding calendar year.

~~For calendar year 1993, the guaranteed floor minimum index shall be \$20,000. For each subsequent year, the index shall be adjusted by the projected change in the average value in the United States Department of Labor Bureau of Labor Statistics consumer price index (all urban) for that year.~~

Notwithstanding this subdivision, no county shall be allocated a guaranteed floor of less than \$1,000.

When the amount of funds available for allocation is less than the amount available in the previous year, each county's previous year allocation shall be reduced in proportion to the reduction in the statewide funding, to establish each county's guaranteed floor.

Sec. 4. Minnesota Statutes 2000, section 254B.03, subdivision 1, is amended to read:

Subdivision 1. [LOCAL AGENCY DUTIES.] (a) Every local agency shall provide chemical dependency services to persons residing within its jurisdiction who meet criteria established by the commissioner for placement in a chemical dependency residential or nonresidential treatment service. Chemical dependency money must be administered by the local agencies according to law and rules adopted by the commissioner under sections 14.001 to 14.69.

(b) In order to contain costs, the county board shall, with the approval of the commissioner of human services, select eligible vendors of chemical dependency services who can provide economical and appropriate treatment. Unless the local agency is a social services department directly administered by a county or human services board, the local agency shall not be an eligible vendor under section 254B.05. The commissioner may approve proposals from county boards to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided. If a county implements a demonstration or experimental medical services funding plan, the commissioner shall transfer the money as appropriate. If a county selects a vendor located in another state, the county shall ensure that the vendor is in compliance with the rules governing licensure of programs located in the state.

(c) The calendar year ~~1998~~ 2002 rate for vendors may not increase more than ~~three~~ two percent above the rate approved in effect on January 1, ~~1997~~ 2001. The calendar year ~~1999~~ 2003 rate for vendors may not increase more than ~~three~~ two percent above the rate in effect on January 1, ~~1998~~ 2002.

(d) A culturally specific vendor that provides assessments under a variance under Minnesota Rules, part 9530.6610, shall be allowed to provide assessment services to persons not covered by the variance.

Sec. 5. Minnesota Statutes 2000, section 254B.09, is amended by adding a subdivision to read:

Subd. 8. [PAYMENTS TO IMPROVE SERVICES TO AMERICAN INDIANS.] The commissioner may set rates for chemical dependency services according to the American Indian Health Improvement Act, Public Law Number 94-437, for eligible vendors. These rates shall supersede rates set in county purchase of service agreements when payments are made on behalf of clients eligible according to Public Law Number 94-437.

Sec. 6. Minnesota Statutes 2000, section 256.01, is amended by adding a subdivision to read:

Subd. 19. [GRANTS FOR CASE MANAGEMENT SERVICES TO PERSONS WITH HIV OR AIDS.] The commissioner may award grants to eligible vendors for the development, implementation, and evaluation of case management services for individuals infected with the human immunodeficiency virus. HIV/AIDS case management services will be provided to increase access to cost effective health care services, to reduce the risk of HIV transmission, to ensure that basic client needs are met, and to increase client access to needed community supports or services.

Sec. 7. Minnesota Statutes 2000, section 256.476, subdivision 1, is amended to read:

Subdivision 1. [PURPOSE AND GOALS.] The commissioner of human services shall establish a consumer support grant program ~~to assist for~~ individuals with functional limitations and their families ~~in purchasing and securing supports which the individuals need to live as independently and productively in the community as possible who wish to purchase and secure their own supports.~~ The commissioner and local agencies shall jointly develop an implementation plan which must include a way to resolve the issues related to county liability. The program shall:

(1) make support grants available to individuals or families as an effective alternative to existing programs and services, such as the developmental disability family support program, ~~the alternative care program,~~ personal care attendant services, home health aide services, and private duty nursing facility services;

(2) provide consumers more control, flexibility, and responsibility over ~~the needed supports~~ their services and supports;

(3) promote local program management and decision making; and

(4) encourage the use of informal and typical community supports.

Sec. 8. Minnesota Statutes 2000, section 256.476, subdivision 2, is amended to read:

Subd. 2. [DEFINITIONS.] For purposes of this section, the following terms have the meanings given them:

(a) "County board" means the county board of commissioners for the county of financial responsibility as defined in section 256G.02, subdivision 4, or its designated representative. When a human services board has been established under sections 402.01 to 402.10, it shall be considered the county board for the purposes of this section.

(b) "Family" means the person's birth parents, adoptive parents or stepparents, siblings or stepsiblings, children or stepchildren, grandparents, grandchildren, niece, nephew, aunt, uncle, or spouse. For the purposes of this section, a family member is at least 18 years of age.

(c) "Functional limitations" means the long-term inability to perform an activity or task in one or more areas of major life activity, including self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living. For the purpose of this section, the inability to perform an activity or task results from a mental, emotional, psychological, sensory, or physical disability, condition, or illness.

(d) "Informed choice" means a voluntary decision made by the person or the person's legal representative, after becoming familiarized with the alternatives to:

(1) select a preferred alternative from a number of feasible alternatives;

(2) select an alternative which may be developed in the future; and

(3) refuse any or all alternatives.

(e) "Local agency" means the local agency authorized by the county board to carry out the provisions of this section.

(f) "Person" or "persons" means a person or persons meeting the eligibility criteria in subdivision 3.

(g) "Authorized representative" means an individual designated by the person or their legal representative to act on their behalf. This individual may be a family member, guardian, representative payee, or other individual designated by the person or their legal representative, if any, to assist in purchasing and arranging for supports. For the purposes of this section, an authorized representative is at least 18 years of age.

(h) "Screening" means the screening of a person's service needs under sections 256B.0911 and 256B.092.

(i) "Supports" means services, care, aids, ~~home~~ environmental modifications, or assistance purchased by the person or the person's family. Examples of supports include respite care, assistance with daily living, and ~~adaptive aids~~ assistive technology. For the purpose of this section, notwithstanding the provisions of section 144A.43, supports purchased under the consumer support program are not considered home care services.

(j) "Program of origination" means the program the individual transferred from when approved for the consumer support grant program.

Sec. 9. Minnesota Statutes 2000, section 256.476, subdivision 3, is amended to read:

Subd. 3. [ELIGIBILITY TO APPLY FOR GRANTS.] (a) A person is eligible to apply for a consumer support grant if the person meets all of the following criteria:

(1) the person is eligible for and has been approved to receive services under medical assistance as determined under sections 256B.055 and 256B.056 ~~or the person is eligible for and has been approved to receive services under alternative care services as determined under section 256B.0913~~ or the person has been approved to receive a grant under the developmental disability family support program under section 252.32;

(2) the person is able to direct and purchase the person's own care and supports, or the person has a family member, legal representative, or other authorized representative who can purchase and arrange supports on the person's behalf;

(3) the person has functional limitations, requires ongoing supports to live in the community, and is at risk of or would continue institutionalization without such supports; and

(4) the person will live in a home. For the purpose of this section, "home" means the person's own home or home of a person's family member. These homes are natural home settings and are not licensed by the department of health or human services.

(b) Persons may not concurrently receive a consumer support grant if they are:

(1) receiving home and community-based services under United States Code, title 42, section 1396h(c); personal care attendant and home health aide services under section 256B.0625; a developmental disability family support grant; or alternative care services under section 256B.0913; or

(2) residing in an institutional or congregate care setting.

(c) A person or person's family receiving a consumer support grant shall not be charged a fee or premium by a local agency for participating in the program.

(d) The commissioner may limit the participation of nursing facility residents, residents of intermediate care facilities for persons with mental retardation, and the recipients of services from federal waiver programs in the consumer support grant program if the participation of these individuals will result in an increase in the cost to the state.

(e) The commissioner shall establish a budgeted appropriation each fiscal year for the consumer support grant program. The number of individuals participating in the program will be adjusted so the total amount allocated to counties does not exceed the amount of the budgeted appropriation. The budgeted appropriation will be adjusted annually to accommodate changes in demand for the consumer support grants.

Sec. 10. Minnesota Statutes 2000, section 256.476, subdivision 4, is amended to read:

Subd. 4. [SUPPORT GRANTS; CRITERIA AND LIMITATIONS.] (a) A county board may choose to participate in the consumer support grant program. If a county board chooses to participate in the program, the local agency shall establish written procedures and criteria to determine the amount and use of support grants. These procedures must include, at least, the availability of respite care, assistance with daily living, and adaptive aids. The local agency may establish monthly or annual maximum amounts for grants and procedures where exceptional resources may be required to meet the health and safety needs of the person on a time-limited basis, however, the total amount awarded to each individual may not exceed the limits established in subdivision 5, paragraph (f).

(b) Support grants to a person or a person's family will be provided through a monthly subsidy payment and be in the form of cash, voucher, or direct county payment to vendor. Support grant amounts must be determined by the local agency. Each service and item purchased with a support grant must meet all of the following criteria:

(1) it must be over and above the normal cost of caring for the person if the person did not have functional limitations;

(2) it must be directly attributable to the person's functional limitations;

(3) it must enable the person or the person's family to delay or prevent out-of-home placement of the person; and

(4) it must be consistent with the needs identified in the service plan, when applicable.

(c) Items and services purchased with support grants must be those for which there are no other public or private funds available to the person or the person's family. Fees assessed to the person or the person's family for health and human services are not reimbursable through the grant.

(d) In approving or denying applications, the local agency shall consider the following factors:

(1) the extent and areas of the person's functional limitations;

(2) the degree of need in the home environment for additional support; and

(3) the potential effectiveness of the grant to maintain and support the person in the family environment or the person's own home.

(e) At the time of application to the program or screening for other services, the person or the person's family shall be provided sufficient information to ensure an informed choice of alternatives by the person, the person's legal representative, if any, or the person's family. The application shall be made to the local agency and shall specify the needs of the person and family, the form and amount of grant requested, the items and services to be reimbursed, and evidence of eligibility for medical assistance ~~or alternative care program~~.

(f) Upon approval of an application by the local agency and agreement on a support plan for the person or person's family, the local agency shall make grants to the person or the person's family. The grant shall be in an amount for the direct costs of the services or supports outlined in the service agreement.

(g) Reimbursable costs shall not include costs for resources already available, such as special education classes, day training and habilitation, case management, other services to which the person is entitled, medical costs covered by insurance or other health programs, or other resources usually available at no cost to the person or the person's family.

(h) The state of Minnesota, the county boards participating in the consumer support grant program, or the agencies acting on behalf of the county boards in the implementation and administration of the consumer support grant program shall not be liable for damages, injuries, or liabilities sustained through the purchase of support by the individual, the individual's family, or the authorized representative under this section with funds received through the consumer support grant program. Liabilities include but are not limited to: workers' compensation liability, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA). For purposes of this section, participating county boards and agencies acting on behalf of county boards are exempt from the provisions of section 268.04.

Sec. 11. Minnesota Statutes 2000, section 256.476, subdivision 5, is amended to read:

Subd. 5. [REIMBURSEMENT, ALLOCATIONS, AND REPORTING.] (a) For the purpose of transferring persons to the consumer support grant program from specific programs or services, such as the developmental disability family support program and ~~alternative care program~~, personal care attendant services, home health aide services, or ~~nursing facility private duty nursing~~ services, the amount of funds transferred by the commissioner between the developmental disability family support program account, ~~the alternative care account~~, the medical assistance account, or the consumer support grant account shall be based on each county's participation in transferring persons to the consumer support grant program from those programs and services.

(b) At the beginning of each fiscal year, county allocations for consumer support grants shall be based on:

(1) the number of persons to whom the county board expects to provide consumer supports grants;

(2) their eligibility for current program and services;

(3) the amount of nonfederal dollars expended on those individuals for those programs and services or, in situations where an individual is unable to obtain the support needed from the program of origination due to the unavailability of service providers at the time or the location where the supports are needed, the allocation will be based on the county's best estimate of the nonfederal dollars that would have been expended if the services had been available; and

(4) projected dates when persons will start receiving grants. County allocations shall be adjusted periodically by the commissioner based on the actual transfer of persons or service openings, and the nonfederal dollars associated with those persons or service openings, to the consumer support grant program.

(c) The amount of funds transferred by the commissioner from ~~the alternative care account~~ and the medical assistance account for an individual may be changed if it is determined by the county or its agent that the individual's need for support has changed.

(d) The authority to utilize funds transferred to the consumer support grant account for the purposes of implementing and administering the consumer support grant program will not be limited or constrained by the spending authority provided to the program of origination.

(e) The commissioner shall use up to five percent of each county's allocation, as adjusted, for payments to that county for administrative expenses, to be paid as a proportionate addition to reported direct service expenditures.

(f) Except as provided in this paragraph, the county allocation for each individual or individual's family cannot exceed 80 percent of the total nonfederal dollars expended on the individual by the program of origination except for the developmental disabilities family support grant program which can be approved up to 100 percent of the nonfederal dollars and in situations as described in paragraph (b), clause (3). In situations where exceptional need exists or the individual's need for support increases, up to 100 percent of the nonfederal dollars expended by the consumer's program of origination may be allocated to the county. Allocations that exceed 80 percent of the nonfederal dollars expended on the individual by the program of origination must be approved by the commissioner. The remainder of the amount expended on the individual by the program of origination will be used in the following proportions: half will be made available to the consumer support grant program and participating counties for consumer training, resource development, and other costs, and half will be returned to the state general fund.

(g) The commissioner may recover, suspend, or withhold payments if the county board, local agency, or grantee does not comply with the requirements of this section.

Sec. 12. Minnesota Statutes 2000, section 256.476, subdivision 8, is amended to read:

Subd. 8. [COMMISSIONER RESPONSIBILITIES.] The commissioner shall:

- (1) transfer and allocate funds pursuant to this section;
- (2) determine allocations based on projected and actual local agency use;
- (3) monitor and oversee overall program spending;
- (4) evaluate the effectiveness of the program;
- (5) provide training and technical assistance for local agencies and consumers to help identify potential applicants to the program; and
- (6) develop guidelines for local agency program administration and consumer information; ~~and~~
- (7) ~~apply for a federal waiver or take any other action necessary to maximize federal funding for the program by September 1, 1999.~~

Sec. 13. Minnesota Statutes 2000, section 256B.0625, subdivision 7, is amended to read:

Subd. 7. [PRIVATE DUTY NURSING.] Medical assistance covers private duty nursing services in a recipient's home. Recipients who are authorized to receive private duty nursing services in their home may use approved hours outside of the home during hours when normal life activities take them outside of their home ~~and when, without the provision of private duty nursing, their health and safety would be jeopardized.~~ To use private duty nursing services at school, the recipient or responsible party must provide written authorization in the care plan identifying the chosen provider and the daily amount of services to be used at school. Medical assistance does not cover private duty nursing services for residents of a hospital, nursing facility, intermediate care facility, or a health care facility licensed by the commissioner of health, except as authorized in section 256B.64 for ventilator-dependent recipients in hospitals or unless a resident who is otherwise eligible is on leave from the facility and the facility either pays for the private duty nursing services or forgoes the facility per diem for the leave days that private duty nursing services are used. Total hours of service and payment allowed for services outside the home cannot exceed that which is otherwise allowed in an in-home setting according to section 256B.0627. All private duty nursing services must be provided according to the limits established under section 256B.0627. Private duty nursing services may not be reimbursed if the nurse is the ~~spouse of the recipient or the parent or foster care provider of a recipient who is under age 18, or the recipient's legal guardian.~~

Sec. 14. Minnesota Statutes 2000, section 256B.0625, subdivision 19a, is amended to read:

Subd. 19a. [PERSONAL CARE SERVICES.] Medical assistance covers personal care services in a recipient's home. To qualify for personal care services, recipients or responsible parties must be able to identify the recipient's needs, direct and evaluate task accomplishment, and provide for health and safety. Approved hours may be used outside the home when normal life activities take them outside the home ~~and when, without the provision of personal care, their health and safety would be jeopardized.~~ To use personal care services at school, the recipient or responsible party must provide written authorization in the care plan identifying the chosen provider and the daily amount of services to be used at school. Total hours for services, whether actually performed inside or outside the recipient's home, cannot exceed that which is otherwise allowed for personal care services in an in-home setting according to section 256B.0627. Medical assistance does not cover personal care services for residents of a hospital, nursing facility, intermediate care facility, health care facility licensed by the commissioner of health, or unless a resident who is otherwise eligible is on leave from the facility and the facility either pays for the personal care services or forgoes the facility per diem for the leave days that personal care services are used. All personal care services must be provided according to section 256B.0627. Personal care services may not be reimbursed if the personal care assistant is the spouse or legal guardian of the recipient or the parent of a recipient under age 18, or the responsible party or the foster care provider of a recipient who cannot direct the recipient's own care unless, in the case of a foster care provider, a county or state case manager visits the recipient as needed, but not less than every six months, to monitor the health and safety of the recipient and to ensure the goals of the care plan are met. Parents of adult recipients, adult children of the recipient or adult siblings of the recipient may be reimbursed for personal care services ~~if they are not the recipient's legal guardian and, if they are granted a waiver under section 256B.0627.~~ ~~Until July 1, 2001, and~~ Notwithstanding the provisions of section 256B.0627, subdivision 4, paragraph (b), clause (4), the noncorporate legal guardian or conservator of an adult, who is not the responsible party and not the personal care provider organization, may be granted a hardship waiver under section 256B.0627, to be reimbursed to provide personal care assistant services to the recipient, and shall not be considered to have a service provider interest for purposes of participation on the screening team under section 256B.092, subdivision 7.

Sec. 15. Minnesota Statutes 2000, 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 the recipient ~~under the fiscal agent option according to section 256B.0627, subdivision 10,~~ or a qualified professional. "Qualified professional" means a mental health professional as defined in section 245.462, subdivision 18, or 245.4871, subdivision 27; or a registered nurse as defined in sections 148.171 to 148.285. As part of the assessment, the county public health nurse will ~~consult with~~ assist the recipient or responsible party ~~and to~~ identify the most appropriate person to provide supervision of the personal care assistant. The qualified professional shall perform the duties described in Minnesota Rules, part 9505.0335, subpart 4.

Sec. 16. Minnesota Statutes 2000, section 256B.0625, subdivision 20, is amended to read:

Subd. 20. [MENTAL HEALTH CASE MANAGEMENT.] (a) To the extent authorized by rule of the state agency, medical assistance covers case management services to persons with serious and persistent mental illness and children with severe emotional disturbance. Services provided under this section must meet the relevant standards in sections 245.461 to 245.4888, the Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

(b) Entities meeting program standards set out in rules governing family community support services as defined in section 245.4871, subdivision 17, are eligible for medical assistance reimbursement for case management services for children with severe emotional disturbance when these services meet the program standards in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

(c) Medical assistance and MinnesotaCare payment for mental health case management shall be made on a monthly basis. In order to receive payment for an eligible child, the provider must document at least a face-to-face contact with the child, the child's parents, or the child's legal representative. To receive payment for an eligible adult, the provider must document:

(1) at least a face-to-face contact with the adult or the adult's legal representative; or

(2) at least a telephone contact with the adult or the adult's legal representative and document a face-to-face contact with the adult or the adult's legal representative within the preceding two months.

(d) Payment for mental health case management provided by county or state staff shall be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph (b), with separate rates calculated for child welfare and mental health, and within mental health, separate rates for children and adults.

(e) Payment for mental health case management provided by county-contracted vendors shall be based on a monthly rate negotiated by the host county. The negotiated rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the county may negotiate a team rate with a vendor who is a member of the team. The team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county, except to reimburse the county for advance funding provided by the county to the vendor.

(f) If the service is provided by a team which includes contracted vendors and county or state staff, the costs for county or state staff participation in the team shall be included in the rate for county-provided services. In this case, the contracted vendor and the county may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services, the county must document, in the recipient's file, the need for team case management and a description of the roles of the team members.

(g) The commissioner shall calculate the nonfederal share of actual medical assistance and general assistance medical care payments for each county, based on the higher of calendar year 1995 or 1996, by service date, project that amount forward to 1999, and transfer one-half of the result from medical assistance and general assistance medical care to each county's mental health grants under sections 245.4886 and 256E.12 for calendar year 1999. The annualized minimum amount added to each county's mental health grant shall be \$3,000 per year for children and \$5,000 per year for adults. The commissioner may reduce the statewide growth factor in order to fund these minimums. The annualized total amount transferred shall become part of the base for future mental health grants for each county.

(h) Any net increase in revenue to the county as a result of the change in this section must be used to provide expanded mental health services as defined in sections 245.461 to 245.4888, the Comprehensive Adult and Children's Mental Health Acts, excluding inpatient and residential treatment. For adults, increased revenue may also be used for services and consumer supports which are part of adult mental health projects approved under Laws 1997, chapter 203, article 7, section 25. For children, increased revenue may also be used for respite care and nonresidential individualized rehabilitation services as defined in section 245.492, subdivisions 17 and 23. "Increased revenue" has the meaning given in Minnesota Rules, part 9520.0903, subpart 3.

(i) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for mental health case management shall be provided by the recipient's county of responsibility, as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds used to match other federal funds.

(j) The commissioner may suspend, reduce, or terminate the reimbursement to a provider that does not meet the reporting or other requirements of this section. The county of responsibility, as defined in sections 256G.01 to 256G.12, is responsible for any federal disallowances. The county may share this responsibility with its contracted vendors.

(k) The commissioner shall set aside a portion of the federal funds earned under this section to repay the special revenue maximization account under section 256.01, subdivision 2, clause (15). The repayment is limited to:

(1) the costs of developing and implementing this section; and

(2) programming the information systems.

(l) Notwithstanding section 256.025, subdivision 2, payments to counties for case management expenditures under this section shall only be made from federal earnings from services provided under this section. Payments to contracted vendors shall include both the federal earnings and the county share.

(m) Notwithstanding section 256B.041, county payments for the cost of mental health case management services provided by county or state staff shall not be made to the state treasurer. For the purposes of mental health case management services provided by county or state staff under this section, the centralized disbursement of payments to counties under section 256B.041 consists only of federal earnings from services provided under this section.

(n) Case management services under this subdivision do not include therapy, treatment, legal, or outreach services.

(o) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital, and the recipient's institutional care is paid by medical assistance, payment for case management services under this subdivision is limited to the last ~~30~~ 180 days of the recipient's residency in that facility and may not exceed more than ~~two~~ six months in a calendar year.

(p) Payment for case management services under this subdivision shall not duplicate payments made under other program authorities for the same purpose.

(q) By July 1, 2000, the commissioner shall evaluate the effectiveness of the changes required by this section, including changes in number of persons receiving mental health case management, changes in hours of service per person, and changes in caseload size.

(r) For each calendar year beginning with the calendar year 2001, the annualized amount of state funds for each county determined under paragraph (g) shall be adjusted by the county's percentage change in the average number of clients per month who received case management under this section during the fiscal year that ended six months prior to the calendar year in question, in comparison to the prior fiscal year.

(s) For counties receiving the minimum allocation of \$3,000 or \$5,000 described in paragraph (g), the adjustment in paragraph (r) shall be determined so that the county receives the higher of the following amounts:

(1) a continuation of the minimum allocation in paragraph (g); or

(2) an amount based on that county's average number of clients per month who received case management under this section during the fiscal year that ended six months prior to the calendar year in question, in comparison to the prior fiscal year, times the average statewide grant per person per month for counties not receiving the minimum allocation.

(t) The adjustments in paragraphs (r) and (s) shall be calculated separately for children and adults.

Sec. 17. Minnesota Statutes 2000, section 256B.0625, is amended by adding a subdivision to read:

Subd. 43. [TARGETED CASE MANAGEMENT.] (a) For purposes of this section, the following terms have the meanings given them:

(1) "Home care service recipients" means those individuals receiving the following services under section 256B.0627: skilled nursing visits, home health aide visits, private duty nursing, personal care attendants, or therapies provided through a home health agency.

(2) "Home care targeted case management" means the provision of targeted case management services for the purpose of assisting home care service recipients to gain access to needed services and supports so that they may remain in the community.

(3) "Institutions" means hospitals, consistent with Code of Federal Regulations, title 42, section 440.10; regional treatment center inpatient services, consistent with Minnesota Statutes, section 245.474; nursing facilities; and intermediate care facilities for people with mental retardation.

(4) "Relocation targeted case management" means the provision of targeted case management services for the purpose of assisting recipients to gain access to needed services and supports if they choose to move from an institution to the community. Relocation targeted case management may be provided during the last 180 consecutive days of an eligible recipient's institutional stay.

(5) "Targeted case management" means case management services provided to help recipients gain access to needed medical, social, educational, and other services and supports.

(b) The following persons are eligible for relocation targeted case management or home care targeted case management:

(1) Medical assistance eligible persons residing in institutions who choose to move into the community are eligible for relocation case management services.

(2) Medical assistance eligible persons receiving home care services, who are not eligible for any other medical assistance reimbursable case management service, are eligible for home care targeted case management services beginning January 1, 2003.

(c) A provider of targeted case management under subdivision 20 may be deemed a certified provider of relocation targeted case management.

(d) The following provider qualifications and certification standards must be met:

The commissioner must certify each provider of relocation targeted case management or home care targeted case management before enrollment. The certification process shall examine the provider's ability to meet the requirements in this subdivision and other state and federal requirements of this service. A relocation targeted case management provider or a home care targeted case management provider is an enrolled medical assistance provider who has a minimum of a bachelor's degree, a license in a health or human services field, and is determined by the commissioner to have all of the following characteristics:

(i) the demonstrated capacity and experience to provide the components of case management to coordinate and link community resources needed by the eligible population;

(ii) the administrative capacity and experience to serve the target population for whom it will provide services and ensure quality of services under state and federal requirements;

(iii) a financial management system that provides accurate documentation of services and costs under state and federal requirements;

(iv) the capacity to document and maintain individual case records under state and federal requirements; and

(v) the capacity to coordinate with county administrative functions.

(d) Services eligible for medical assistance reimbursement include:

(1) assessment of the recipient's need for targeted case management services;

(2) development, completion, and regular review of a written individual service plan, which is based upon the assessment of the recipient's needs and choices, and which will ensure access to medical, social, educational, and other related services and supports;

(3) routine contact or communication with the recipient, the recipient's family, primary caregiver, legal representative, substitute care provider, service providers, or other relevant persons identified as necessary to the development or implementation of the goals of the individual service plan;

(4) coordinating referrals for, and the provision of, case management services for the recipient with appropriate service providers, consistent with section 1902(a)(23) of the Social Security Act;

(5) coordinating and monitoring the overall service delivery to ensure quality of services, appropriateness, and continued need;

(6) completing and maintaining necessary documentation that supports and verifies the activities in this subdivision;

(7) traveling to conduct a visit with the recipient or other relevant person necessary to develop or implement the goals of the individual service plan; and

(8) coordinating with the institution discharge planner in the 180-day period before the recipient's discharge.

(e) The following time lines must be met for assigning a case manager:

(1) For relocation targeted case management, an eligible recipient must be assigned a case manager within 30 days of requesting one.

(2) For home care targeted case management, an eligible recipient must be assigned a case manager within 30 days of requesting one from a home care targeted case management provider, as defined in paragraph (c), clause (2).

(f) The commissioner shall evaluate the delivery of targeted case management, including, but not limited to, access to case management services, consumer satisfaction with case management services, and quality of case management services.

(g) The case manager must document each face-to-face and telephone contact with the recipient and others involved in the recipient's individual service plan.

(h) The commissioner shall set payment rates for targeted case management under this subdivision. Case managers may bill according to the following criteria:

(1) For relocation targeted case management, case managers may bill for direct case management activities, including face-to-face and telephone contacts, in the 180 days preceding an eligible recipient's discharge from an institution.

(2) For home care targeted case management, case managers may bill for direct case management activities, including face-to-face and telephone contacts.

(3) Billings for targeted case management services under this subdivision shall not duplicate payments made under other program authorities for the same purpose.

Sec. 18. Minnesota Statutes 2000, section 256B.0627, subdivision 1, is amended to read:

Subdivision 1. [DEFINITION.] (a) "Activities of daily living" includes eating, toileting, grooming, dressing, bathing, transferring, mobility, and positioning.

(b) "Assessment" means a review and evaluation of a recipient's need for home care services conducted in person. Assessments for private duty nursing shall be conducted by a registered private duty nurse. Assessments for home health agency services shall be conducted by a home health agency nurse. Assessments for personal care assistant services shall be conducted by the county public health nurse or a certified public health nurse under contract with the county. A face-to-face assessment must include: documentation of health status, determination of need, evaluation of service effectiveness, identification of appropriate services, service plan development or modification, coordination of services, referrals and follow-up to appropriate payers and community resources, completion of required reports, recommendation of service authorization, and consumer education. Once the need for personal care assistant services is determined under this section, the county public health nurse or certified public health nurse under contract with the county is responsible for communicating this recommendation to the commissioner and the recipient. A face-to-face assessment for personal care services is conducted on those recipients who have never had a county public health nurse assessment. A face-to-face assessment must occur at least annually or when there is a significant change in the recipient's condition or when there is a change in the need for personal care assistant services. A service update may substitute for the annual face-to-face assessment when there is not a significant change in recipient condition or a change in the need for personal care assistant service. A service update or review for temporary increase includes a review of initial baseline data, evaluation of service effectiveness, redetermination of service need, modification of service plan and appropriate referrals, update of initial forms, obtaining service authorization, and on going consumer education. Assessments for medical assistance home care services for mental retardation or related conditions and alternative care services for developmentally disabled home and community-based 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)~~ (c) "Care plan" means a written description of personal care assistant services developed by the qualified professional or the recipient's physician with the recipient or responsible party to be used by the personal care assistant with a copy provided to the recipient or responsible party.

(d) "Complex and regular private duty nursing care" means, effective January 1, 2003:

(1) complex care is private duty nursing provided to recipients who are ventilator dependent or for whom a physician has certified that were it not for private duty nursing the recipient would meet the criteria for inpatient hospital intensive care unit (ICU) level of care; and

(2) regular care is private duty nursing provided to all other recipients.

(e) "Health-related functions" means functions that can be delegated or assigned by a licensed health care professional under state law to be performed by a personal care attendant.

~~(e)~~ (f) "Home care services" means a health service, determined by the commissioner as medically necessary, that is ordered by a physician and documented in a service plan that is reviewed by the physician at least once every ~~62~~ 60 days for the provision of home health services, or private duty nursing, or at least once every 365 days for personal care. Home care services are provided to the recipient at the recipient's residence that is a place other than a hospital or long-term care facility or as specified in section 256B.0625.

(g) "Instrumental activities of daily living" includes meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communication by telephone and other media, and getting around and participating in the community.

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

~~(e)~~ (i) "Personal care assistant" means a person who:

(1) is at least 18 years old, except for persons 16 to 18 years of age who participated in a related school-based job training program or have completed a certified home health aide competency evaluation;

(2) is able to effectively communicate with the recipient and personal care provider organization;

(3) effective July 1, 1996, has completed one of the training requirements as specified in Minnesota Rules, part 9505.0335, subpart 3, items A to D;

(4) has the ability to, and provides covered personal care services according to the recipient's care plan, responds appropriately to recipient needs, and reports changes in the recipient's condition to the supervising qualified professional or physician;

(5) is not a consumer of personal care services; and

(6) is subject to criminal background checks and procedures specified in section 245A.04.

~~(f)~~ (j) "Personal care provider organization" means an organization enrolled to provide personal care assistant services under the medical assistance program that complies with the following: (1) owners who have a five percent interest or more, and managerial officials are subject to a background study as provided in section 245A.04. This applies to currently enrolled personal care provider organizations and those agencies seeking enrollment as a personal care provider organization. An organization will be barred from enrollment if an owner or managerial official of the organization has been convicted of a crime specified in section 245A.04, or a comparable crime in another jurisdiction, unless the owner or managerial official meets the reconsideration criteria specified in section 245A.04; (2) the organization must maintain a surety bond and liability insurance throughout the duration of enrollment and provides proof thereof. The insurer must notify the department of human services of the cancellation or lapse of policy; and (3) the organization must maintain documentation of services as specified in Minnesota Rules, part 9505.2175, subpart 7, as well as evidence of compliance with personal care assistant training requirements.

~~(g)~~ (k) "Responsible party" means an individual residing with a recipient of personal care assistant services who is capable of providing the supportive care necessary to assist the recipient to live in the community, is at least 18 years old, and is not a personal care assistant. Responsible parties who are parents of minors or guardians of minors or incapacitated persons may delegate the responsibility to another adult during a temporary absence of at least 24 hours but not more than six months. The person delegated as a responsible party must be able to meet the definition of responsible party, except that the delegated responsible party is required to reside with the recipient only while serving as the responsible party. Foster care license holders may be designated the responsible party for residents of the foster care home if case management is provided as required in section 256B.0625, subdivision 19a. For persons who, as of April 1, 1992, are sharing personal care assistant services in order to obtain the availability of 24-hour coverage, an employee of the personal care provider organization may be designated as the responsible party if case management is provided as required in section 256B.0625, subdivision 19a.

~~(h)~~ (l) "Service plan" means a written description of the services needed based on the assessment developed by the nurse who conducts the assessment together with the recipient or responsible party. The service plan shall include a description of the covered home care services, frequency and duration of services, and expected outcomes

and goals. The recipient and the provider chosen by the recipient or responsible party must be given a copy of the completed service plan within 30 calendar days of the request for home care services by the recipient or responsible party.

(i) (m) "Skilled nurse visits" are provided in a recipient's residence under a plan of care or service plan that specifies a level of care which the nurse is qualified to provide. These services are:

(1) nursing services according to the written plan of care or service plan and accepted standards of medical and nursing practice in accordance with chapter 148;

(2) services which due to the recipient's medical condition may only be safely and effectively provided by a registered nurse or a licensed practical nurse;

(3) assessments performed only by a registered nurse; and

(4) teaching and training the recipient, the recipient's family, or other caregivers requiring the skills of a registered nurse or licensed practical nurse.

(n) "Telehomecare" means the use of telecommunications technology by a home health care professional to deliver home health care services, within the professional's scope of practice, to a patient located at a site other than the site where the practitioner is located.

Sec. 19. Minnesota Statutes 2000, section 256B.0627, subdivision 2, is amended to read:

Subd. 2. [SERVICES COVERED.] Home care services covered under this section include:

(1) nursing services under section 256B.0625, subdivision 6a;

(2) private duty nursing services under section 256B.0625, subdivision 7;

(3) home health ~~aid~~ services under section 256B.0625, subdivision 6a;

(4) personal care services under section 256B.0625, subdivision 19a;

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

(6) ~~consulting~~ qualified professional of personal care assistant services under the fiscal ~~agent~~ intermediary option as specified in subdivision 10;

(7) face-to-face assessments by county public health nurses for services under section 256B.0625, subdivision 19a; and

(8) service updates and review of temporary increases for personal care assistant services by the county public health nurse for services under section 256B.0625, subdivision 19a.

Sec. 20. Minnesota Statutes 2000, 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: services and supports furnished to an individual, as needed, to assist in accomplishing activities of daily living; instrumental activities of daily living; health-related functions through hands-on assistance, supervision, and cuing; and redirection and intervention for behavior including observation and monitoring.~~

(b) Payment for services will be made within the limits approved using the prior authorized process established in subdivision 5.

(c) The amount and type of services authorized shall be based on an assessment of the recipient's needs in these areas:

- (1) bowel and bladder care;
- (2) skin care to maintain the health of the skin;
- (3) repetitive maintenance range of motion, muscle strengthening exercises, and other tasks specific to maintaining a recipient's optimal level of function;
- (4) respiratory assistance;
- (5) transfers and ambulation;
- (6) bathing, grooming, and hairwashing necessary for personal hygiene;
- (7) turning and positioning;
- (8) assistance with furnishing medication that is self-administered;
- (9) application and maintenance of prosthetics and orthotics;
- (10) cleaning medical equipment;
- (11) dressing or undressing;
- (12) assistance with eating and meal preparation and necessary grocery shopping;
- (13) accompanying a recipient to obtain medical diagnosis or treatment;
- (14) assisting, monitoring, or prompting the recipient to complete the services in clauses (1) to (13);
- (15) redirection, monitoring, and observation that are medically necessary and an integral part of completing the personal care services described in clauses (1) to (14);
- (16) redirection and intervention for behavior, including observation and monitoring;
- (17) interventions for seizure disorders, including monitoring and observation if the recipient has had a seizure that requires intervention within the past three months;
- (18) tracheostomy suctioning using a clean procedure if the procedure is properly delegated by a registered nurse. Before this procedure can be delegated to a personal care assistant, a registered nurse must determine that the tracheostomy suctioning can be accomplished utilizing a clean rather than a sterile procedure and must ensure that the personal care assistant has been taught the proper procedure; and
- (19) incidental household services that are an integral part of a personal care service described in clauses (1) to (18).

For purposes of this subdivision, monitoring and observation means watching for outward visible signs that are likely to occur and for which there is a covered personal care service or an appropriate personal care intervention. For purposes of this subdivision, a clean procedure refers to a procedure that reduces the numbers of microorganisms or prevents or reduces the transmission of microorganisms from one person or place to another. A clean procedure may be used beginning 14 days after insertion.

- (b) (d) The personal care assistant services that are not eligible for payment are the following:
- (1) services not ordered by the physician;
 - (2) assessments by personal care assistant provider organizations or by independently enrolled registered nurses;
 - (3) services that are not in the service plan;
 - (4) services provided by the recipient's spouse, legal guardian for an adult or child recipient, or parent of a recipient under age 18;
 - (5) services provided by a foster care provider of a recipient who cannot direct the recipient's own care, unless monitored by a county or state case manager under section 256B.0625, subdivision 19a;
 - (6) services provided by the residential or program license holder in a residence for more than four persons;
 - (7) services that are the responsibility of a residential or program license holder under the terms of a service agreement and administrative rules;
 - (8) sterile procedures;
 - (9) injections of fluids into veins, muscles, or skin;
 - (10) services provided by parents of adult recipients, adult children, or siblings of the recipient, unless these relatives meet one of the following hardship criteria and the commissioner waives this requirement:
 - (i) the relative resigns from a part-time or full-time job to provide personal care for the recipient;
 - (ii) the relative goes from a full-time to a part-time job with less compensation to provide personal care for the recipient;
 - (iii) the relative takes a leave of absence without pay to provide personal care for the recipient;
 - (iv) the relative incurs substantial expenses by providing personal care for the recipient; or
 - (v) because of labor conditions, special language needs, or intermittent hours of care needed, the relative is needed in order to provide an adequate number of qualified personal care assistants to meet the medical needs of the recipient;
 - (11) homemaker services that are not an integral part of a personal care assistant services;
 - (12) home maintenance, or chore services;
 - (13) services not specified under paragraph (a); and
 - (14) services not authorized by the commissioner or the commissioner's designee.

(e) The recipient or responsible party may choose to supervise the personal care assistant or to have a qualified professional, as defined in section 256B.0625, subdivision 19c, provide the supervision. As required under section 256B.0625, subdivision 19c, the county public health nurse, as a part of the assessment, will assist the recipient or responsible party to identify the most appropriate person to provide supervision of the personal care assistant. Health-related delegated tasks performed by the personal care assistant will be under the supervision of a qualified professional or the direction of the recipient's physician. If the recipient has a qualified professional, Minnesota Rules, part 9505.0335, subpart 4, applies.

Sec. 21. Minnesota Statutes 2000, section 256B.0627, subdivision 5, is amended to read:

Subd. 5. [LIMITATION ON PAYMENTS.] Medical assistance payments for home care services shall be limited according to this subdivision.

(a) [LIMITS ON SERVICES WITHOUT PRIOR AUTHORIZATION.] A recipient may receive the following home care services during a calendar year:

- (1) up to two face-to-face assessments to determine a recipient's need for personal care assistant services;
- (2) one service update done to determine a recipient's need for personal care services; and
- (3) up to ~~five~~ nine skilled nurse visits.

(b) [PRIOR AUTHORIZATION; EXCEPTIONS.] All home care services above the limits in paragraph (a) must receive the commissioner's prior authorization, except when:

(1) the home care services were required to treat an emergency medical condition that if not immediately treated could cause a recipient serious physical or mental disability, continuation of severe pain, or death. The provider must request retroactive authorization no later than five working days after giving the initial service. The provider must be able to substantiate the emergency by documentation such as reports, notes, and admission or discharge histories;

(2) the home care services were provided on or after the date on which the recipient's eligibility began, but before the date on which the recipient was notified that the case was opened. Authorization will be considered if the request is submitted by the provider within 20 working days of the date the recipient was notified that the case was opened;

(3) a third-party payor for home care services has denied or adjusted a payment. Authorization requests must be submitted by the provider within 20 working days of the notice of denial or adjustment. A copy of the notice must be included with the request;

(4) the commissioner has determined that a county or state human services agency has made an error; or

(5) the professional nurse determines an immediate need for up to 40 skilled nursing or home health aide visits per calendar year and submits a request for authorization within 20 working days of the initial service date, and medical assistance is determined to be the appropriate payer.

(c) [RETROACTIVE AUTHORIZATION.] A request for retroactive authorization will be evaluated according to the same criteria applied to prior authorization requests.

(d) [ASSESSMENT AND SERVICE PLAN.] Assessments under section 256B.0627, subdivision 1, paragraph (a), shall be conducted initially, and at least annually thereafter, in person with the recipient and result in a completed service plan using forms specified by the commissioner. Within 30 days of recipient or responsible party request for home care services, the assessment, the service plan, and other information necessary to determine medical necessity such as diagnostic or testing information, social or medical histories, and hospital or facility discharge summaries shall be submitted to the commissioner. For personal care 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.

(e) [PRIOR AUTHORIZATION.] The commissioner, or the commissioner's designee, shall review the assessment, service update, request for temporary services, service plan, and any additional information that is submitted. The commissioner shall, within 30 days after receiving a complete request, assessment, and service plan, authorize home care services as follows:

(1) [HOME HEALTH SERVICES.] All home health services provided by a ~~licensed nurse or a home health aide~~ must be prior authorized by the commissioner or the commissioner's designee. Prior authorization must be based on medical necessity and cost-effectiveness when compared with other care options. When home health services are used in combination with personal care and private duty nursing, the cost of all home care services shall be considered for cost-effectiveness. ~~The commissioner shall limit nurse and home health aide visits to no more than one visit each per day.~~ The commissioner, or the commissioner's designee, may authorize up to two home health aide or skilled nurse visits per day.

(2) [PERSONAL CARE SERVICES.] (i) All personal care services and supervision by a qualified professional, if requested by the recipient, must be prior authorized by the commissioner or the commissioner's designee except for the assessments established in paragraph (a). The amount of personal care services authorized must be based on the recipient's home care rating. A child may not be found to be dependent in an activity of daily living if because of the child's age an adult would either perform the activity for the child or assist the child with the activity and the amount of assistance needed is similar to the assistance appropriate for a typical child of the same age. Based on medical necessity, the commissioner may authorize:

(A) up to two times the average number of direct care hours provided in nursing facilities for the recipient's comparable case mix level; or

(B) up to three times the average number of direct care hours provided in nursing facilities for recipients who have complex medical needs or are dependent in at least seven activities of daily living and need physical assistance with eating or have a neurological diagnosis; or

(C) up to 60 percent of the average reimbursement rate, as of July 1, 1991, for care provided in a regional treatment center for recipients who have Level I behavior, plus any inflation adjustment as provided by the legislature for personal care service; or

(D) up to the amount the commissioner would pay, as of July 1, 1991, plus any inflation adjustment provided for home care services, for care provided in a regional treatment center for recipients referred to the commissioner by a regional treatment center preadmission evaluation team. For purposes of this clause, home care services means all services provided in the home or community that would be included in the payment to a regional treatment center; or

(E) up to the amount medical assistance would reimburse for facility care for recipients referred to the commissioner by a preadmission screening team established under section 256B.0911 or 256B.092; and

(F) a reasonable amount of time for the provision of supervision by a qualified professional of personal care assistant services, if a qualified professional is requested by the recipient or responsible party.

(ii) The number of direct care hours shall be determined according to the annual cost report submitted to the department by nursing facilities. The average number of direct care hours, as established by May 1, 1992, shall be calculated and incorporated into the home care limits on July 1, 1992. These limits shall be calculated to the nearest quarter hour.

(iii) The home care rating shall be determined by the commissioner or the commissioner's designee based on information submitted to the commissioner by the county public health nurse on forms specified by the commissioner. The home care rating shall be a combination of current assessment tools developed under sections 256B.0911 and 256B.501 with an addition for seizure activity that will assess the frequency and severity of seizure activity and with adjustments, additions, and clarifications that are necessary to reflect the needs and conditions of recipients who need home care including children and adults under 65 years of age. The commissioner shall establish these forms and protocols under this section and shall use an advisory group, including representatives of recipients, providers, and counties, for consultation in establishing and revising the forms and protocols.

(iv) A recipient shall qualify as having complex medical needs if the care required is difficult to perform and because of recipient's medical condition requires more time than community-based standards allow or requires more skill than would ordinarily be required and the recipient needs or has one or more of the following:

(A) daily tube feedings;

(B) daily parenteral therapy;

(C) wound or decubiti care;

(D) postural drainage, percussion, nebulizer treatments, suctioning, tracheotomy care, oxygen, mechanical ventilation;

(E) catheterization;

(F) ostomy care;

(G) quadriplegia; or

(H) other comparable medical conditions or treatments the commissioner determines would otherwise require institutional care.

(v) A recipient shall qualify as having Level I behavior if there is reasonable supporting evidence that the recipient exhibits, or that without supervision, observation, or redirection would exhibit, one or more of the following behaviors that cause, or have the potential to cause:

(A) injury to the recipient's own body;

(B) physical injury to other people; or

(C) destruction of property.

(vi) Time authorized for personal care relating to Level I behavior in subclause (v), items (A) to (C), shall be based on the predictability, frequency, and amount of intervention required.

(vii) A recipient shall qualify as having Level II behavior if the recipient exhibits on a daily basis one or more of the following behaviors that interfere with the completion of personal care services under subdivision 4, paragraph (a):

- (A) unusual or repetitive habits;
- (B) withdrawn behavior; or
- (C) offensive behavior.

(viii) A recipient with a home care rating of Level II behavior in subclause (vii), items (A) to (C), shall be rated as comparable to a recipient with complex medical needs under subclause (iv). If a recipient has both complex medical needs and Level II behavior, the home care rating shall be the next complex category up to the maximum rating under subclause (i), item (B).

(3) [PRIVATE DUTY NURSING SERVICES.] All private duty nursing services shall be prior authorized by the commissioner or the commissioner's designee. Prior authorization for private duty nursing services shall be based on medical necessity and cost-effectiveness when compared with alternative care options. The commissioner may authorize medically necessary private duty nursing services in quarter-hour units when:

- (i) the recipient requires more individual and continuous care than can be provided during a nurse visit; or
- (ii) the cares are outside of the scope of services that can be provided by a home health aide or personal care assistant.

The commissioner may authorize:

(A) up to two times the average amount of direct care hours provided in nursing facilities statewide for case mix classification "K" as established by the annual cost report submitted to the department by nursing facilities in May 1992;

(B) private duty nursing in combination with other home care services up to the total cost allowed under clause (2);

(C) up to 16 hours per day if the recipient requires more nursing than the maximum number of direct care hours as established in item (A) and the recipient meets the hospital admission criteria established under Minnesota Rules, parts ~~9505.0500~~ 9505.0501 to 9505.0540.

The commissioner may authorize up to 16 hours per day of medically necessary private duty nursing services or up to 24 hours per day of medically necessary private duty nursing services until such time as the commissioner is able to make a determination of eligibility for recipients who are cooperatively applying for home care services under the community alternative care program developed under section 256B.49, or until it is determined by the appropriate regulatory agency that a health benefit plan is or is not required to pay for appropriate medically necessary health care services. Recipients or their representatives must cooperatively assist the commissioner in obtaining this determination. Recipients who are eligible for the community alternative care program may not receive more hours of nursing under this section than would otherwise be authorized under section 256B.49.

Beginning July 1, 2001, private duty nursing services will be authorized for complex and regular care according to section 256B.0627.

(4) [VENTILATOR-DEPENDENT RECIPIENTS.] If the recipient is ventilator-dependent, the monthly medical assistance authorization for home care services shall not exceed what the commissioner would pay for care at the highest cost hospital designated as a long-term hospital under the Medicare program. For purposes of this clause,

home care services means all services provided in the home that would be included in the payment for care at the long-term hospital. "Ventilator-dependent" means an individual who receives mechanical ventilation for life support at least six hours per day and is expected to be or has been dependent for at least 30 consecutive days.

(f) [PRIOR AUTHORIZATION; TIME LIMITS.] The commissioner or the commissioner's designee shall determine the time period for which a prior authorization shall be effective. If the recipient continues to require home care services beyond the duration of the prior authorization, the home care provider must request a new prior authorization. Under no circumstances, other than the exceptions in paragraph (b), shall a prior authorization be valid prior to the date the commissioner receives the request or for more than 12 months. A recipient who appeals a reduction in previously authorized home care services may continue previously authorized services, other than temporary services under paragraph (h), pending an appeal under section 256.045. The commissioner must provide a detailed explanation of why the authorized services are reduced in amount from those requested by the home care provider.

(g) [APPROVAL OF HOME CARE SERVICES.] The commissioner or the commissioner's designee shall determine the medical necessity of home care services, the level of caregiver according to subdivision 2, and the institutional comparison according to this subdivision, the cost-effectiveness of services, and the amount, scope, and duration of home care services reimbursable by medical assistance, based on the assessment, primary payer coverage determination information as required, the service plan, the recipient's age, the cost of services, the recipient's medical condition, and diagnosis or disability. The commissioner may publish additional criteria for determining medical necessity according to section 256B.04.

(h) [PRIOR AUTHORIZATION REQUESTS; TEMPORARY SERVICES.] The agency nurse, the independently enrolled private duty nurse, or county public health nurse may request a temporary authorization for home care services by telephone. The commissioner may approve a temporary level of home care services based on the assessment, and service or care plan information, and primary payer coverage determination information as required. Authorization for a temporary level of home care services including nurse supervision is limited to the time specified by the commissioner, but shall not exceed 45 days, unless extended because the county public health nurse has not completed the required assessment and service plan, or the commissioner's determination has not been made. The level of services authorized under this provision shall have no bearing on a future prior authorization.

(i) [PRIOR AUTHORIZATION REQUIRED IN FOSTER CARE SETTING.] Home care services provided in an adult or child foster care setting must receive prior authorization by the department according to the limits established in paragraph (a).

The commissioner may not authorize:

(1) home care services that are the responsibility of the foster care provider under the terms of the foster care placement agreement and administrative rules;

(2) personal care 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; or

(4) personal care assistant and private duty nursing services when the number of foster care residents is greater than four unless the county responsible for the recipient's foster placement made the placement prior to April 1, 1992, requests that personal care assistant and private duty nursing services be provided, and case management is provided as required in section 256B.0625, subdivision 19a.

Sec. 22. Minnesota Statutes 2000, section 256B.0627, subdivision 7, is amended to read:

Subd. 7. [NONCOVERED HOME CARE SERVICES.] The following home care services are not eligible for payment under medical assistance:

- (1) skilled nurse visits for the sole purpose of supervision of the home health aide;
- (2) a skilled nursing visit:
 - (i) only for the purpose of monitoring medication compliance with an established medication program for a recipient; or
 - (ii) to administer or assist with medication administration, including injections, prefilling syringes for injections, or oral medication set-up of an adult recipient, when as determined and documented by the registered nurse, the need can be met by an available pharmacy or the recipient is physically and mentally able to self-administer or prefill a medication;
- (3) home care services to a recipient who is eligible for covered services ~~including hospice, if elected by the recipient~~, under the Medicare program or any other insurance held by the recipient;
- (4) services to other members of the recipient's household;
- (5) a visit made by a skilled nurse solely to train other home health agency workers;
- (6) any home care service included in the daily rate of the community-based residential facility where the recipient is residing;
- (7) nursing and rehabilitation therapy services that are reasonably accessible to a recipient outside the recipient's place of residence, excluding the assessment, counseling and education, and personal assistant care;
- (8) any home health agency service, excluding personal care assistant services and private duty nursing services, which are performed in a place other than the recipient's residence; and
- (9) Medicare evaluation or administrative nursing visits on dual-eligible recipients that do not qualify for Medicare visit billing.

Sec. 23. Minnesota Statutes 2000, section 256B.0627, subdivision 8, is amended to read:

Subd. 8. [SHARED PERSONAL CARE ASSISTANT SERVICES.] (a) Medical assistance payments for shared personal care assistance services shall be limited according to this subdivision.

(b) Recipients of personal care assistant services may share staff and the commissioner shall provide a rate system for shared personal care assistant services. For two persons sharing services, the rate paid to a provider shall not exceed 1-1/2 times the rate paid for serving a single individual, and for three persons sharing services, the rate paid to a provider shall not exceed twice the rate paid for serving a single individual. These rates apply only to situations in which all recipients were present and received shared services on the date for which the service is billed. No more than three persons may receive shared services from a personal care assistant in a single setting.

(c) Shared service is the provision of personal care services by a personal care assistant to two or three recipients at the same time and in the same setting. For the purposes of this subdivision, "setting" means:

- (1) the home or foster care home of one of the individual recipients; or

(2) a child care program in which all recipients served by one personal care assistant are participating, which is licensed under chapter 245A or operated by a local school district or private school; or

(3) outside the home or foster care home of one of the recipients when normal life activities take the recipients outside the home.

The provisions of this subdivision do not apply when a personal care assistant is caring for multiple recipients in more than one setting.

(d) The recipient or the recipient's responsible party, in conjunction with the county public health nurse, shall determine:

(1) whether shared personal care assistant services is an appropriate option based on the individual needs and preferences of the recipient; and

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

The recipient or the responsible party, in conjunction with the supervising qualified professional, if a qualified professional is requested by any one of the recipients or responsible parties, shall arrange the setting and grouping of shared services based on the individual needs and preferences of the recipients. Decisions on the selection of recipients to share services must be based on the ages of the recipients, compatibility, and coordination of their care needs.

(e) The following items must be considered by the recipient or the responsible party and the supervising qualified professional, if a qualified professional has been requested by any one of the recipients or responsible parties, and documented in the recipient's health service record:

(1) the additional qualifications needed by the personal care assistant to provide care to several recipients in the same setting;

(2) the additional training and supervision needed by the personal care assistant to ensure that the needs of the recipient are met appropriately and safely. The provider must provide on-site supervision by a qualified professional within the first 14 days of shared services, and monthly thereafter, if supervision by a qualified provider has been requested by any one of the recipients or responsible parties;

(3) the setting in which the shared services will be provided;

(4) the ongoing monitoring and evaluation of the effectiveness and appropriateness of the service and process used to make changes in service or setting; and

(5) a contingency plan which accounts for absence of the recipient in a shared services setting due to illness or other circumstances and staffing contingencies.

(f) The provider must offer the recipient or the responsible party the option of shared or one-on-one personal care assistant services. The recipient or the responsible party can withdraw from participating in a shared services arrangement at any time.

(g) In addition to documentation requirements under Minnesota Rules, part 9505.2175, a personal care provider must meet documentation requirements for shared personal care assistant services and must document the following in the health service record for each individual recipient sharing services:

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

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

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

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

(5) supervision of the shared personal care assistant services by the qualified professional, if a qualified professional is requested by one of the recipients or responsible parties, including the date, time of day, number of hours spent supervising the provision of shared services, whether the supervision was face-to-face or another method of supervision, changes in the recipient's condition, shared services scheduling issues and recommendations;

(6) documentation by the qualified professional, if a qualified professional is requested by one of the recipients or responsible parties, of telephone calls or other discussions with the personal care assistant regarding services being provided to the recipient who has requested the supervision; and

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

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

(ii) the setting for the shared services, including the starting and ending times that the recipient received shared services; and

(iii) notes by the personal care assistant regarding changes in the recipient's condition, problems that may arise from the sharing of services, scheduling issues, care issues, and other notes as required by the qualified professional, if a qualified professional is requested by one of the recipients or responsible parties.

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

(i) In the event that supervision by a qualified professional has been requested by one or more recipients, but not by all of the recipients, the supervision duties of the qualified professional shall be limited to only those recipients who have requested the supervision.

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

Sec. 24. Minnesota Statutes 2000, section 256B.0627, subdivision 10, is amended to read:

Subd. 10. ~~[FISCAL AGENT INTERMEDIARY OPTION AVAILABLE FOR PERSONAL CARE ASSISTANT SERVICES.]~~ (a) "Fiscal agent option" is an option that allows the recipient to:

~~(1) use a fiscal agent instead of a personal care provider organization;~~

~~(2) supervise the personal care assistant; and~~

~~(3) use a consulting professional.~~

The commissioner may allow a recipient of personal care assistant services to use a fiscal ~~agent~~ intermediary to assist the recipient in paying and accounting for medically necessary covered personal care assistant services authorized in subdivision 4 and within the payment parameters of subdivision 5. Unless otherwise provided in this subdivision, all other statutory and regulatory provisions relating to personal care services apply to a recipient using the fiscal ~~agent~~ intermediary option.

(b) The recipient or responsible party shall:

~~(1) hire, and terminate the personal care assistant and consulting professional, with the fiscal agent recruit, hire, and terminate a qualified professional, if a qualified professional is requested by the recipient or responsible party;~~

~~(2) recruit the personal care assistant and consulting professional and orient and train the personal care assistant in areas that do not require professional delegation as determined by the county public health nurse verify and document the credentials of the qualified professional, if a qualified professional is requested by the recipient or responsible party;~~

~~(3) supervise and evaluate the personal care assistant in areas that do not require professional delegation as determined in the assessment;~~

~~(4) cooperate with a consulting develop a plan of care based on physician orders and public health nurse assessment with the assistance of a qualified professional and implement recommendations pertaining to the health and safety of the recipient, if a qualified professional is requested by the recipient or responsible party, that addresses the health and safety of the recipient;~~

~~(5) hire a qualified professional to train and supervise the performance of delegated tasks done by (4) recruit, hire, and terminate the personal care assistant;~~

~~(6) monitor services and verify in writing the hours worked by the personal care assistant and the consulting (5) orient and train the personal care assistant with assistance as needed from the qualified professional;~~

~~(7) develop and revise a care plan with assistance from a consulting (6) supervise and evaluate the personal care assistant with assistance as needed from the recipient's physician or the qualified professional;~~

~~(8) verify and document the credentials of the consulting (7) monitor and verify in writing and report to the fiscal intermediary the number of hours worked by the personal care assistant and the qualified professional; and~~

~~(9) (8) enter into a written agreement, as specified in paragraph (f).~~

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

(1) bill the medical assistance program for personal care assistant and ~~consulting~~ qualified professional services;

(2) request and secure background checks on personal care assistants and ~~consulting~~ qualified professionals according to section 245A.04;

(3) pay the personal care assistant and ~~consulting~~ qualified professional based on actual hours of services provided;

(4) withhold and pay all applicable federal and state taxes;

(5) verify and ~~document~~ keep records of hours worked by the personal care assistant and ~~consulting~~ qualified professional;

(6) make the arrangements and pay unemployment insurance, taxes, workers' compensation, liability insurance, and other benefits, if any;

(7) enroll in the medical assistance program as a fiscal ~~agent~~ intermediary; and

(8) enter into a written agreement as specified in paragraph (f) before services are provided.

(d) The fiscal ~~agent~~ intermediary:

(1) may not be related to the recipient, ~~consulting~~ qualified professional, or the personal care assistant;

(2) must ensure arm's length transactions with the recipient and personal care assistant; and

(3) shall be considered a joint employer of the personal care assistant and ~~consulting~~ qualified professional to the extent specified in this section.

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

(e) ~~If the recipient or responsible party requests a qualified professional, the consulting qualified professional providing assistance to the recipient shall meet the qualifications specified in section 256B.0625, subdivision 19c. The consulting qualified professional shall assist the recipient in developing and revising a plan to meet the recipient's assessed needs, and supervise the performance of delegated tasks, as determined by the public health nurse as assessed by the public health nurse. In performing this function, the consulting qualified professional must visit the recipient in the recipient's home at least once annually. The consulting qualified professional must report to the local county public health nurse concerns relating to the health and safety of the recipient, and any suspected abuse, neglect, or financial exploitation of the recipient to the appropriate authorities.~~

(f) The fiscal ~~agent~~ intermediary, recipient or responsible party, personal care assistant, and ~~consulting~~ qualified professional shall enter into a written agreement before services are started. The agreement shall include:

(1) the duties of the recipient, qualified professional, personal care assistant, and fiscal agent based on paragraphs (a) to (e);

(2) the salary and benefits for the personal care assistant and ~~those providing professional consultation~~ the qualified professional;

(3) the administrative fee of the fiscal ~~agent~~ intermediary and services paid for with that fee, including background check fees;

(4) procedures to respond to billing or payment complaints; and

(5) procedures for hiring and terminating the personal care assistant and ~~those providing professional consultation~~ the qualified professional.

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

(h) As part of the assessment defined in subdivision 1, the following conditions must be met to use or continue use of a fiscal agent intermediary:

(1) the recipient must be able to direct the recipient's own care, or the responsible party for the recipient must be readily available to direct the care of the personal care assistant;

(2) the recipient or responsible party must be knowledgeable of the health care needs of the recipient and be able to effectively communicate those needs;

(3) a face-to-face assessment must be conducted by the local county public health nurse at least annually, or when there is a significant change in the recipient's condition or change in the need for personal care assistant services: ~~The county public health nurse shall determine the services that require professional delegation, if any, and the amount and frequency of related supervision;~~

(4) the recipient cannot select the shared services option as specified in subdivision 8; and

(5) parties must be in compliance with the written agreement specified in paragraph (f).

(i) The commissioner shall deny, revoke, or suspend the authorization to use the fiscal agent intermediary option if:

(1) it has been determined by the consulting qualified professional or local county public health nurse that the use of this option jeopardizes the recipient's health and safety;

(2) the parties have failed to comply with the written agreement specified in paragraph (f); or

(3) the use of the option has led to abusive or fraudulent billing for personal care assistant services.

The recipient or responsible party may appeal the commissioner's action according to section 256.045. The denial, revocation, or suspension to use the fiscal agent intermediary option shall not affect the recipient's authorized level of personal care assistant services as determined in subdivision 5.

Sec. 25. Minnesota Statutes 2000, section 256B.0627, subdivision 11, is amended to read:

Subd. 11. [SHARED PRIVATE DUTY NURSING CARE OPTION.] (a) Medical assistance payments for shared private duty nursing services by a private duty nurse shall be limited according to this subdivision. For the purposes of this section, "private duty nursing agency" means an agency licensed under chapter 144A to provide private duty nursing services.

(b) Recipients of private duty nursing services may share nursing staff and the commissioner shall provide a rate methodology for shared private duty nursing. For two persons sharing nursing care, the rate paid to a provider shall not exceed 1.5 times the ~~nonwaived~~ regular private duty nursing rates paid for serving a single individual ~~who is not ventilator dependent~~, by a registered nurse or licensed practical nurse. These rates apply only to situations in which both recipients are present and receive shared private duty nursing care on the date for which the service is billed. No more than two persons may receive shared private duty nursing services from a private duty nurse in a single setting.

(c) Shared private duty nursing care is the provision of nursing services by a private duty nurse to two recipients at the same time and in the same setting. For the purposes of this subdivision, "setting" means:

(1) the home or foster care home of one of the individual recipients; or

(2) a child care program licensed under chapter 245A or operated by a local school district or private school; or

(3) an adult day care service licensed under chapter 245A; or

(4) outside the home or foster care home of one of the recipients when normal life activities take the recipients outside the home.

This subdivision does not apply when a private duty nurse is caring for multiple recipients in more than one setting.

(d) The recipient or the recipient's legal representative, and the recipient's physician, in conjunction with the home health care agency, shall determine:

(1) whether shared private duty nursing care is an appropriate option based on the individual needs and preferences of the recipient; and

(2) the amount of shared private duty nursing services authorized as part of the overall authorization of nursing services.

(e) The recipient or the recipient's legal representative, in conjunction with the private duty nursing agency, shall approve the setting, grouping, and arrangement of shared private duty nursing care based on the individual needs and preferences of the recipients. Decisions on the selection of recipients to share services must be based on the ages of the recipients, compatibility, and coordination of their care needs.

(f) The following items must be considered by the recipient or the recipient's legal representative and the private duty nursing agency, and documented in the recipient's health service record:

(1) the additional training needed by the private duty nurse to provide care to two recipients in the same setting and to ensure that the needs of the recipients are met appropriately and safely;

(2) the setting in which the shared private duty nursing care will be provided;

(3) the ongoing monitoring and evaluation of the effectiveness and appropriateness of the service and process used to make changes in service or setting;

(4) a contingency plan which accounts for absence of the recipient in a shared private duty nursing setting due to illness or other circumstances;

(5) staffing backup contingencies in the event of employee illness or absence; and

(6) arrangements for additional assistance to respond to urgent or emergency care needs of the recipients.

(g) The provider must offer the recipient or responsible party the option of shared or one-on-one private duty nursing services. The recipient or responsible party can withdraw from participating in a shared service arrangement at any time.

(h) The private duty nursing agency must document the following in the health service record for each individual recipient sharing private duty nursing care:

(1) permission by the recipient or the recipient's legal representative for the maximum number of shared nursing care hours per week chosen by the recipient;

(2) permission by the recipient or the recipient's legal representative for shared private duty nursing services provided outside the recipient's residence;

(3) permission by the recipient or the recipient's legal representative for others to receive shared private duty nursing services in the recipient's residence;

(4) revocation by the recipient or the recipient's legal representative of the shared private duty nursing care authorization, or the shared care to be provided to others in the recipient's residence, or the shared private duty nursing services to be provided outside the recipient's residence; and

(5) daily documentation of the shared private duty nursing services provided by each identified private duty nurse, including:

(i) the names of each recipient receiving shared private duty nursing services together;

(ii) the setting for the shared services, including the starting and ending times that the recipient received shared private duty nursing care; and

(iii) notes by the private duty nurse regarding changes in the recipient's condition, problems that may arise from the sharing of private duty nursing services, and scheduling and care issues.

(i) Unless otherwise provided in this subdivision, all other statutory and regulatory provisions relating to private duty nursing services apply to shared private duty nursing services.

Nothing in this subdivision shall be construed to reduce the total number of private duty nursing hours authorized for an individual recipient under subdivision 5.

Sec. 26. Minnesota Statutes 2000, section 256B.0627, is amended by adding a subdivision to read:

Subd. 13. [CONSUMER-DIRECTED HOME CARE DEMONSTRATION PROJECT.] (a) The commissioner of human services after receiving federal waiver authority shall implement a consumer-directed home care demonstration project. The consumer-directed home care demonstration project must demonstrate and evaluate the outcomes of a consumer-directed service delivery alternative to improve access, increase consumer control and accountability over available resources, and enable the use of supports that are more individualized and cost-effective for eligible medical assistance recipients receiving certain medical assistance home care services. The consumer-directed home care demonstration project will be administered locally by county agencies, tribal governments, or administrative entities under contract with the state in regions where counties choose not to provide this service.

(b) Grant awards for persons who have been receiving medical assistance covered personal care, home health aide, or private duty nursing services for a period of 12 consecutive months or more prior to enrollment in the consumer-directed home care demonstration project will be established on a case-by-case basis using historical service expenditure data. An average monthly expenditure for each continuing enrollee will be calculated based on historical expenditures made on behalf of the enrollee for personal care, home health aide, or private duty nursing services during the 12 month period directly prior to enrollment in the project. The grant award will equal 90 percent of the average monthly expenditure.

(c) Grant awards for project enrollees who have been receiving medical assistance covered personal care, home health aide, or private duty nursing services for a period of less than 12 consecutive months prior to project enrollment will be calculated on a case-by-case basis using the service authorization in place at the time of enrollment. The total number of units of personal care, home health aide, or private duty nursing services the enrollee has been authorized to receive will be converted to the total cost of the authorized services in a given month using the statewide average service payment rates. To determine an estimated monthly expenditure, the total authorized monthly personal care, home health aide or private duty nursing service costs will be reduced by a percentage rate equivalent to the difference between the statewide average service authorization and the statewide average utilization rate for each of the services by medical assistance eligibles during the most recent fiscal year for which 12 months of data is available. The grant award will equal 90 percent of the estimated monthly expenditure.

Sec. 27. Minnesota Statutes 2000, section 256B.0627, is amended by adding a subdivision to read:

Subd. 14. [TELEHOMECARE; SKILLED NURSE VISITS.] Medical assistance covers skilled nurse visits according to section 256B.0625, subdivision 6a, provided via telehomecare, for services which do not require hands-on care between the home care nurse and recipient. The provision of telehomecare must be made via live, two-way interactive audiovisual technology and may be augmented by utilizing store-and-forward technologies. Store-and-forward technology includes telehomecare services that do not occur in real time via synchronous transmissions, and that do not require a face-to-face encounter with the recipient for all or any part of any such telehomecare visit. A communication between the home care nurse and recipient that consists solely of a telephone conversation, facsimile, electronic mail, or a consultation between two health care practitioners, is not to be considered a telehomecare visit. Multiple daily skilled nurse visits provided via telehomecare are allowed. Coverage of telehomecare is limited to two visits per day. All skilled nurse visits provided via telehomecare must be prior authorized by the commissioner or the commissioner's designee and will be covered at the same allowable rate as skilled nurse visits provided in-person.

Sec. 28. Minnesota Statutes 2000, section 256B.0627, is amended by adding a subdivision to read:

Subd. 15. [THERAPIES THROUGH HOME HEALTH AGENCIES.] (a) [PHYSICAL THERAPY.] Medical assistance covers physical therapy and related services, including specialized maintenance therapy. Services provided by a physical therapy assistant shall be reimbursed at the same rate as services performed by a physical therapist when the services of the physical therapy assistant are provided under the direction of a physical therapist who is on the premises. Services provided by a physical therapy assistant that are provided under the direction of a physical therapist who is not on the premises shall be reimbursed at 65 percent of the physical therapist rate. Direction of the physical therapy assistant must be provided by the physical therapist as described in Minnesota Rules, part 9505.0390, subpart 1, item B. The physical therapist and physical therapist assistant may not both bill for services provided to a recipient on the same day.

(b) [OCCUPATIONAL THERAPY.] Medical assistance covers occupational therapy and related services, including specialized maintenance therapy. Services provided by an occupational therapy assistant shall be reimbursed at the same rate as services performed by an occupational therapist when the services of the occupational therapy assistant are provided under the direction of the occupational therapist who is on the premises. Services provided by an occupational therapy assistant under the direction of an occupational therapist who is not on the premises shall be reimbursed at 65 percent of the occupational therapist rate. Direction of the occupational therapy assistant must be provided by the occupational therapist as described in Minnesota Rules, part 9505.0390, subpart 1, item B. The occupational therapist and occupational therapist assistant may not both bill for services provided to a recipient on the same day.

Sec. 29. Minnesota Statutes 2000, section 256B.0627, is amended by adding a subdivision to read:

Subd. 16. [HARDSHIP CRITERIA; PRIVATE DUTY NURSING.] (a) Payment is allowed for extraordinary services that require specialized nursing skills and are provided by parents of minor children, spouses, and legal guardians who are providing private duty nursing care, when the provision of these services is not legally required of the parents, spouses, or legal guardians, to a recipient under the state plan home care or under a home and community waiver in order to prevent hospitalization of the recipient if one of the following hardship criteria are met:

(1) the parent, spouse, or legal guardian resigns from a part-time or full-time job to provide nursing care for the recipient; or

(2) the parent, spouse, or legal guardian goes from a full-time to a part-time job with less compensation to provide nursing care for the recipient; or

(3) the parent, spouse, or legal guardian takes a leave of absence without pay to provide nursing care for the recipient; or

(4) because of labor conditions, special language needs, or intermittent hours of care needed, the parent, spouse, or legal guardian is needed in order to provide adequate private duty nursing services to meet the medical needs of the recipient.

(b) Private duty nursing may be provided by a parent, spouse, or legal guardian who is a nurse licensed in Minnesota. Private duty nursing services provided by a parent, spouse, or legal guardian cannot be used in lieu of nursing services covered and available under liable third-party payors including Medicare. The private duty nursing provided by a parent, spouse, or legal guardian must be included in the plan of care. Authorized skilled nursing services provided by the parent, spouse, or legal guardian may not exceed 50 percent of the total approved nursing hours, or eight hours per day, whichever is less, up to a maximum of 40 hours per week. Nothing in this subdivision precludes the parent's, spouse's, or legal guardian's obligation of assuming the nonreimbursed family responsibilities of emergency backup caregiver and primary caregiver.

(c) A parent or a spouse may not be paid to provide private duty nursing care if the parent or spouse fails to pass a criminal background check according to section 245A.04, or if it has been determined by the home health agency, the case manager, or the physician that the private duty nursing care provided by the parent, spouse, or legal guardian is unsafe.

Sec. 30. Minnesota Statutes 2000, section 256B.0627, is amended by adding a subdivision to read:

Subd. 17. [QUALITY ASSURANCE PLAN FOR PERSONAL CARE ASSISTANT SERVICES.] The commissioner shall establish a quality assurance plan for personal care services that includes:

(1) performance-based provider agreements;

(2) meaningful consumer input, which may include consumer surveys, that measure the extent to which participants receive the services and supports described in the individual plan and participant satisfaction with such services and supports;

(3) ongoing monitoring of the health and well-being of consumers; and

(4) an ongoing public process for development, implementation, and review of the quality assurance plan.

Sec. 31. Minnesota Statutes 2000, section 256B.0911, is amended by adding a subdivision to read:

Subd. 4a. [PREADMISSION SCREENING OF INDIVIDUALS UNDER 65 YEARS OF AGE.] (a) It is the policy of the state of Minnesota to ensure that individuals with disabilities or chronic illness are served in the most integrated setting appropriate to their needs and have the necessary information to make informed choices about home and community-based service options.

(b) Individuals under 65 years of age who are admitted to a nursing facility from a hospital must be screened prior to admission as outlined in subdivision 4.

(c) Individuals under 65 years of age who are admitted to nursing facilities with only a telephone screening must receive a face-to-face assessment from the long-term care consultation team member of the county in which the facility is located or from the recipient's county case manager within 20 working days of admission.

(d) At the face-to-face assessment, the long-term care consultation team member or county case manager must perform the activities required under subdivision 3.

(e) For individuals under 21 years of age, the screening or assessment which recommends nursing facility admission must be approved by the commissioner before the individual is admitted to the nursing facility.

(f) In the event that an individual under 65 years of age is admitted to a nursing facility on an emergency basis, the county must be notified of the admission on the next working day, and a face-to-face assessment as described in paragraph (c) must be conducted within 20 working days of admission.

(g) At the face-to-face assessment, the long-term care consultation team member or the case manager must present information about home and community-based options so the individual can make informed choices. If the individual chooses home and community-based services, the long-term care consultation team member or case manager must initiate the development of a written relocation plan within 30 working days of the visit. The plan shall ensure a smooth transition to the individual's home and community.

(h) An individual under 65 years of age residing in a nursing facility shall receive a face-to-face assessment at least every 12 months to review the person's service choices and available alternatives unless the individual indicates, in writing, that annual visits are not desired. In this case, the individual must receive a face-to-face assessment at least once every 36 months for the same purposes.

(i) Notwithstanding the provisions of subdivision 6, the commissioner may pay county agencies directly for face-to-face assessments for individuals who are eligible for medical assistance, under 65 years of age, and being considered for placement or residing in a nursing facility.

Sec. 32. Minnesota Statutes 2000, section 256B.093, subdivision 3, is amended to read:

Subd. 3. [TRAUMATIC BRAIN INJURY PROGRAM DUTIES.] The department shall fund administrative case management under this subdivision using medical assistance administrative funds. The traumatic brain injury program duties include:

(1) recommending to the commissioner in consultation with the medical review agent according to Minnesota Rules, parts 9505.0500 to 9505.0540, the approval or denial of medical assistance funds to pay for out-of-state placements for traumatic brain injury services and in-state traumatic brain injury services provided by designated Medicare long-term care hospitals;

(2) coordinating the traumatic brain injury home and community-based waiver;

~~(3) approving traumatic brain injury waiver eligibility or care plans or both;~~

~~(4) providing ongoing technical assistance and consultation to county and facility case managers to facilitate care plan development for appropriate, accessible, and cost-effective medical assistance services;~~

~~(5) (4) providing technical assistance to promote statewide development of appropriate, accessible, and cost-effective medical assistance services and related policy;~~

~~(6) (5) providing training and outreach to facilitate access to appropriate home and community-based services to prevent institutionalization;~~

~~(7) (6) facilitating appropriate admissions, continued stay review, discharges, and utilization review for neurobehavioral hospitals and other specialized institutions;~~

~~(8) (7) providing technical assistance on the use of prior authorization of home care services and coordination of these services with other medical assistance services;~~

~~(9) (8) developing a system for identification of nursing facility and hospital residents with traumatic brain injury to assist in long-term planning for medical assistance services. Factors will include, but are not limited to, number of individuals served, length of stay, services received, and barriers to community placement; and~~

(10) (9) providing information, referral, and case consultation to access medical assistance services for recipients without a county or facility case manager. Direct access to this assistance may be limited due to the structure of the program.

Sec. 33. Minnesota Statutes 2000, section 256B.095, is amended to read:

256B.095 [THREE-YEAR QUALITY ASSURANCE PILOT PROJECT ESTABLISHED.]

Effective July 1, 1998, an alternative quality assurance licensing system pilot project for programs for persons with developmental disabilities is established in Dodge, Fillmore, Freeborn, Goodhue, Houston, Mower, Olmsted, Rice, Steele, Wabasha, and Winona counties for the purpose of improving the quality of services provided to persons with developmental disabilities. A county, at its option, may choose to have all programs for persons with developmental disabilities located within the county licensed under chapter 245A using standards determined under the alternative quality assurance licensing system pilot project or may continue regulation of these programs under the licensing system operated by the commissioner. The pilot project expires on June 30, 2001 2003.

Sec. 34. Minnesota Statutes 2000, section 256B.0951, subdivision 1, is amended to read:

Subdivision 1. [MEMBERSHIP.] The region 10 quality assurance commission is established. The commission consists of at least 14 but not more than 21 members as follows: at least three but not more than five members representing advocacy organizations; at least three but not more than five members representing consumers, families, and their legal representatives; at least three but not more than five members representing service providers; at least three but not more than five members representing counties; and the commissioner of human services or the commissioner's designee. Initial membership of the commission shall be recruited and approved by the region 10 stakeholders group. Prior to approving the commission's membership, the stakeholders group shall provide to the commissioner a list of the membership in the stakeholders group, as of February 1, 1997, a brief summary of meetings held by the group since July 1, 1996, and copies of any materials prepared by the group for public distribution. The first commission shall establish membership guidelines for the transition and recruitment of membership for the commission's ongoing existence. Members of the commission who do not receive a salary or wages from an employer for time spent on commission duties may receive a per diem payment when performing commission duties and functions. All members may be reimbursed for expenses related to commission activities. Notwithstanding the provisions of section 15.059, subdivision 5, the commission expires on June 30, 2001 2003.

Sec. 35. Minnesota Statutes 2000, section 256B.0951, subdivision 3, is amended to read:

Subd. 3. [COMMISSION DUTIES.] (a) By October 1, 1997, the commission, in cooperation with the commissioners of human services and health, shall do the following: (1) approve an alternative quality assurance licensing system based on the evaluation of outcomes; (2) approve measurable outcomes in the areas of health and safety, consumer evaluation, education and training, providers, and systems that shall be evaluated during the alternative licensing process; ~~and~~ (3) establish variable licensure periods not to exceed three years based on outcomes achieved. For purposes of this subdivision, "outcome" means the behavior, action, or status of a person that can be observed or measured and can be reliably and validly determined; and (4) explore applications of the project to other populations or geographic areas and describe efforts, including barriers to expansion, in a report to the commissioner of human services by January 15, 2003.

(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. Based upon these recommendations, the project will be extended to June 30, 2003.

Sec. 36. Minnesota Statutes 2000, section 256B.0951, subdivision 4, is amended to read:

Subd. 4. [COMMISSION'S AUTHORITY TO RECOMMEND VARIANCES OF LICENSING STANDARDS.] The commission may recommend to the commissioners of human services and health variances from the standards governing licensure of programs for persons with developmental disabilities in order to improve the quality of services by implementing an alternative developmental disabilities licensing system if the commission determines that the alternative licensing system does not negatively affect the health or safety of persons being served by the licensed program nor compromise the qualifications of staff to provide services.

Sec. 37. Minnesota Statutes 2000, section 256B.0951, subdivision 5, is amended to read:

Subd. 5. [VARIANCE OF CERTAIN STANDARDS PROHIBITED.] The safety standards, rights, or procedural protections under sections 245.825; 245.91 to 245.97; 245A.04, subdivisions 3, 3a, 3b, and 3c; 245A.09, subdivision 2, paragraph (c), clauses (2) and (5); 245A.12; 245A.13; 252.41, subdivision 9; 256B.092, subdivisions 1b, clause (7), and 10; 626.556; 626.557, and procedures for the monitoring of psychotropic medications shall not be varied under the alternative licensing system pilot project. The commission may make recommendations to the commissioners of human services and health or to the legislature regarding alternatives to or modifications of the rules and procedures referenced in this subdivision.

Sec. 38. Minnesota Statutes 2000, section 256B.0951, subdivision 6, is amended to read:

Subd. 6. [PROGRESS REPORT.] The commission shall submit a progress report to the legislature on ~~pilot~~ project development by January 15, 1998. The report shall include recommendations on any legislative changes necessary to improve cooperation between the commission and the commissioners of human services and health.

Sec. 39. Minnesota Statutes 2000, section 256B.0951, subdivision 7, is amended to read:

Subd. 7. [WAIVER OF RULES.] ~~The commissioner of health may exempt residents of intermediate care facilities for persons with mental retardation (ICFs/MR) who participate in the three-year quality assurance pilot project established in section 256B.095 from the requirements of Minnesota Rules, chapter 4665, upon approval by the federal government of a waiver of federal certification requirements for ICFs/MR. The commissioners of health and human services shall apply for any necessary waivers as soon as practicable and shall submit the concept paper to the federal government by June 1, 1998.~~

Sec. 40. Minnesota Statutes 2000, section 256B.0951, is amended by adding a subdivision to read:

Subd. 8. [FEDERAL WAIVER.] The commissioner of human services shall seek federal authority to waive provisions of intermediate care facilities for persons with mental retardation (ICFs/MR) regulations to enable the demonstration and evaluation of the alternative quality assurance system for ICFs/MR under the project.

Sec. 41. Minnesota Statutes 2000, section 256B.0952, subdivision 1, is amended to read:

Subdivision 1. [NOTIFICATION.] ~~By January 15, 1998, each affected county shall notify the commission and the commissioners of human services and health as to whether it chooses to implement on July 1, 1998, the alternative licensing system for the pilot project. A county that does not implement the alternative licensing system on July 1, 1998, may give notice to the commission and the commissioners by January 15, 1999, or January 15, 2000; that it will implement the alternative licensing system on the following July 1. Region 10 counties may give notice to the commission and commissioners of human services and health by March 15 to join or terminate participation in the quality assurance alternative licensing system on July 1 of that year for each year of the project. A county that implements choosing to participate in the alternative licensing system commits to participate until June 30, 2001+ 2003. Counties that choose to participate in the quality assurance alternative licensing system prior to March 15, 2001, will need to notify the commission and commissioners of human services and health of continued participation. Counties who continue to participate must commit to participate until June 30, 2003.~~

Sec. 42. Minnesota Statutes 2000, section 256B.0952, subdivision 4, is amended to read:

Subd. 4. [APPOINTMENT OF QUALITY ASSURANCE MANAGER.] (a) A county or group of counties that chooses to participate in the alternative licensing system shall designate a quality assurance manager and shall establish quality assurance teams in accordance with subdivision 5. The manager shall recruit, train, and assign duties to the quality assurance team members. In assigning team members to conduct the quality assurance process at a facility, program, or service, the manager shall take into account the size of the service provider, the number of services to be reviewed, the skills necessary for team members to complete the process, and other relevant factors. The manager shall ensure that no team member has a financial, personal, or family relationship with the facility, program, or service being reviewed or with any clients of the facility, program, or service.

(b) Quality assurance teams shall report the findings of their quality assurance reviews to the quality assurance manager. The quality assurance manager shall provide the report from the quality assurance team to the county and, upon request, commissioners of human services and health and a summary of the report to the quality assurance review council.

Sec. 43. Minnesota Statutes 2000, 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.

Sec. 44. Minnesota Statutes 2000, section 256B.49, is amended by adding a subdivision to read:

Subd. 11. [AUTHORITY.] (a) The commissioner is authorized to apply for home and community-based service waivers, as authorized under section 1915(c) of the Social Security Act to serve persons under the age of 65 who are determined to require the level of care provided in a nursing home and persons who require the level of care provided

in a hospital. The commissioner shall apply for the home and community-based waivers in order to: (i) promote the support of persons with disabilities in the most integrated settings; (ii) expand the availability of services for persons who are eligible for medical assistance; (iii) promote cost-effective options to institutional care; and (iv) obtain federal financial participation.

(b) The provision of waived services to medical assistance recipients with disabilities shall comply with the requirements outlined in the federally approved applications for home and community-based services and subsequent amendments, including provision of services according to a service plan designed to meet the needs of the individual. For purposes of this section, the approved home and community-based application is considered the necessary federal requirement.

(c) The commissioner shall provide interested persons serving on agency advisory committees and task forces, and others upon request, with notice of, and an opportunity to comment on, any changes or amendments to the federally approved applications for home and community-based waivers, prior to their submission to the federal health care financing administration.

Sec. 45. Minnesota Statutes 2000, section 256B.49, is amended by adding a subdivision to read:

Subd. 12. [INFORMED CHOICE.] Persons who are determined likely to require the level of care provided in a nursing facility or hospital shall be informed of the home and community-based support alternatives to the provision of inpatient hospital services or nursing facility services. Each person must be given the choice of either institutional or home and community-based services, using the provisions described in section 256B.77, subdivision 2, paragraph (p).

Sec. 46. Minnesota Statutes 2000, section 256B.49, is amended by adding a subdivision to read:

Subd. 13. [CASE MANAGEMENT.] (a) Each recipient of a home and community-based waiver shall be provided case management services by qualified vendors as described in the federally approved waiver application. The case management service activities provided will include:

- (1) developing the written individual plan of care;
- (2) informing the recipient or the recipient's legal guardian or conservator of service options;
- (3) assisting the recipient in the identification of potential service providers;
- (4) assisting the recipient to access services;
- (5) coordinating, evaluating, and monitoring of the services identified in the plan of care; and
- (6) completing the annual reviews of the plan of care.

(b) The case manager may delegate certain aspects of the case management service activities to another individual provided there is oversight by the case manager. The case manager may not delegate those aspects which require professional judgment including assessments, reassessments, and care plan development.

Sec. 47. Minnesota Statutes 2000, section 256B.49, is amended by adding a subdivision to read:

Subd. 14. [ASSESSMENT AND REASSESSMENT.] (a) Assessments of each recipient's strengths, informal support systems, and need for services shall occur as indicated in the federally approved waiver plan. Reassessment of each recipient's strengths, support systems, and need for services shall be conducted at least every 12 months and at other times when there has been a significant change in the recipient's functioning.

(b) Persons with mental retardation or a related condition who apply for services under the nursing facility level waiver programs shall be screened for the appropriate level of care according to section 256B.092.

(c) Recipients who are found eligible for home and community-based services under this section before their 65th birthday may remain eligible for these services after their 65th birthday if they continue to meet all other eligibility factors.

Sec. 48. Minnesota Statutes 2000, section 256B.49, is amended by adding a subdivision to read:

Subd. 15. [INDIVIDUALIZED PLAN OF CARE.] Each recipient of home and community-based waived services shall have a written plan of care which:

(1) reasonably ensures the health and safety of the recipient;

(2) promotes independence;

(3) allows for services to be provided in the most integrated settings; and

(4) provides for an informed choice, as defined in section 256B.77, subdivision 2, paragraph (p), of service and support providers.

Sec. 49. Minnesota Statutes 2000, section 256B.49, is amended by adding a subdivision to read:

Subd. 16. [SERVICES AND SUPPORTS.] Services and supports included in the home and community-based waivers for persons with disabilities shall meet the requirements set out in United States Code, title 42, section 1396n. The services and supports, which are offered as alternatives to institutional care, shall promote consumer choice, community inclusion, self-sufficiency, and self-determination. Beginning January 1, 2003, the commissioner shall simplify and improve access to home and community-based waived services, to the extent possible, through the establishment of a common service menu that is available to eligible recipients regardless of age, disability type, or waiver program. Consumer directed community support services shall be offered as an option to all persons eligible for services under section 256B.49, subdivision 11, by January 1, 2002. Services and supports shall be arranged and provided consistent with individualized written plans of care for eligible waiver recipients.

Sec. 50. Minnesota Statutes 2000, section 256B.49, is amended by adding a subdivision to read:

Subd. 17. [COST OF SERVICES AND SUPPORTS.] (a) The commissioner shall ensure that the average per capita expenditures estimated in any fiscal year for home and community-based waiver recipients does not exceed the average per capita expenditures that would have been made to provide institutional services for recipients in the absence of the waiver.

(b) The commissioner shall implement on January 1, 2002, one or more aggregate, need-based methods for allocating to local agencies the home and community-based waived service resources available to support recipients with disabilities in need of the level of care provided in a nursing facility or a hospital. The commissioner shall allocate resources to single counties and county partnerships in a manner that reflects consideration of: (i) an incentive-based payment process for achieving outcomes; (ii) a state-level risk pool; (iii) the need for retention of management responsibility at the state agency level; and (iv) a phase-in strategy as appropriate.

(c) Until the allocation methods described in paragraph (b) are implemented, the annual allowable reimbursement level of home and community-based waiver services shall be the greater of:

(1) The statewide average payment amount which the recipient is assigned under the waiver reimbursement system in place on June 30, 2001, modified by the percentage of any provider rate increase appropriated for home and community-based services.

(2) An amount approved by the commissioner based on the recipient's extraordinary needs that cannot be met within the current allowable reimbursement level. The increased reimbursement level must be necessary to allow the recipient to be discharged from an institution or to prevent imminent placement in an institution. The additional reimbursement may be used to secure environmental modifications; assistive technology and equipment; and increased costs for supervision, training, and support services necessary to address the recipient's extraordinary needs. The commissioner may approve an increased reimbursement level for up to one year of the recipient's relocation from an institution or up to six months of a determination that a current waiver recipient is at imminent risk of being placed in an institution.

(d) Beginning July 1, 2001, medically necessary private duty nursing services will be authorized under this section as complex and regular care according to section 256B.0627. The rate established by the commissioner for registered nurse or licensed practical nurse services under any home and community-based waiver as of January 1, 2001, shall not be reduced.

Sec. 51. Minnesota Statutes 2000, section 256B.49, is amended by adding a subdivision to read:

Subd. 18. [PAYMENTS.] The commissioner shall reimburse approved vendors from the medical assistance account for the costs of providing home and community-based services to eligible recipients using the invoice processing procedures of the Medicaid management information system (MMIS). Recipients will be screened and authorized for services according to the federally approved waiver application and its subsequent amendments.

Sec. 52. Minnesota Statutes 2000, section 256B.49, is amended by adding a subdivision to read:

Subd. 19. [HEALTH AND WELFARE.] The commissioner of human services shall take the necessary safeguards to protect the health and welfare of individuals provided services under the waiver.

Sec. 53. Minnesota Statutes 2000, section 256B.49, is amended by adding a subdivision to read:

Subd. 20. [TRAUMATIC BRAIN INJURY AND RELATED CONDITIONS.] The commissioner shall seek to amend the traumatic brain injury waiver to include, as eligible persons, individuals with an acquired or degenerative disease diagnosis where cognitive impairment is present, such as multiple sclerosis.

Sec. 54. Minnesota Statutes 2000, section 256B.5012, is amended by adding a subdivision to read:

Subd. 4. [FACILITY RATE INCREASES EFFECTIVE JANUARY 1, 2003.] For the rate year beginning January 1, 2003, for intermediate care facilities reimbursed under this section, the commissioner shall increase the total payment rate in effect for each facility on December 31, 2002, by 2.0 percent. This increase shall be incorporated into ongoing facility per diems as part of the permanent total payment rate.

Sec. 55. Minnesota Statutes 2000, section 256D.35, is amended by adding a subdivision to read:

Subd. 11a. [INSTITUTION.] "Institution" means: a hospital, consistent with Code of Federal Regulations, title 42, section 440.10; regional treatment center inpatient services; a nursing facility; and an intermediate care facility for persons with mental retardation.

Sec. 56. Minnesota Statutes 2000, section 256D.35, is amended by adding a subdivision to read:

Subd. 18a. [SHELTER COSTS.] "Shelter costs" means: rent, manufactured home lot rentals; monthly principal, interest, insurance premiums, and property taxes due for mortgages or contract for deed costs; costs for utilities, including heating, cooling, electricity, water, and sewerage; garbage collection fees; and the basic service fee for one telephone.

Sec. 57. Minnesota Statutes 2000, section 256D.44, subdivision 5, is amended to read:

Subd. 5. [SPECIAL NEEDS.] In addition to the state standards of assistance established in subdivisions 1 to 4, payments are allowed for the following special needs of recipients of Minnesota supplemental aid who are not residents of a nursing home, a regional treatment center, or a group residential housing facility.

(a) The county agency shall pay a monthly allowance for medically prescribed diets payable under the Minnesota family investment program if the cost of those additional dietary needs cannot be met through some other maintenance benefit.

(b) Payment for nonrecurring special needs must be allowed for necessary home repairs or necessary repairs or replacement of household furniture and appliances using the payment standard of the AFDC program in effect on July 16, 1996, for these expenses, as long as other funding sources are not available.

(c) A fee for guardian or conservator service is allowed at a reasonable rate negotiated by the county or approved by the court. This rate shall not exceed five percent of the assistance unit's gross monthly income up to a maximum of \$100 per month. If the guardian or conservator is a member of the county agency staff, no fee is allowed.

(d) The county agency shall continue to pay a monthly allowance of \$68 for restaurant meals for a person who was receiving a restaurant meal allowance on June 1, 1990, and who eats two or more meals in a restaurant daily. The allowance must continue until the person has not received Minnesota supplemental aid for one full calendar month or until the person's living arrangement changes and the person no longer meets the criteria for the restaurant meal allowance, whichever occurs first.

(e) A fee of ten percent of the recipient's gross income or \$25, whichever is less, is allowed for representative payee services provided by an agency that meets the requirements under SSI regulations to charge a fee for representative payee services. This special need is available to all recipients of Minnesota supplemental aid regardless of their living arrangement.

(f) Notwithstanding the language in this subdivision, an amount equal to the maximum allotment authorized by the federal Food Stamp Program for a single individual which is in effect on the first day of January of the previous year will be added to the standards of assistance established in subdivisions 1 to 4 for individuals under the age of 65 who are relocating from an institution and who are shelter needy. An eligible individual who receives this benefit prior to age 65 may continue to receive the benefit after the age of 65.

"Shelter needy" means that the assistance unit incurs monthly shelter costs that exceed 40 percent of the assistance unit's gross income before the application of this special needs standard. "Gross income" for the purposes of this section is the applicant's or recipient's income as defined in section 256D.35, subdivision 10, or the standard specified in subdivision 3, whichever is greater. A recipient of a federal or state housing subsidy, that limits shelter costs to a percentage of gross income, shall not be considered shelter needy for purposes of this paragraph."

Delete the title and insert:

"A bill for an act relating to human services; changing provisions to improve access to home and community-based options for individuals with disabilities; modifying provisions for consumer control in some services; creating a consumer-directed home care demonstration project; amending Minnesota Statutes 2000, sections 245A.13, subdivision 7, 8; 252.275, subdivision 4b; 254B.03, subdivision 1; 254B.09, by adding a subdivision; 256.01, by adding a subdivision; 256.476, subdivisions 1, 2, 3, 4, 5, 8; 256B.0625, subdivisions 7, 19a, 19c, 20, by adding a subdivision; 256B.0627, subdivisions 1, 2, 4, 5, 7, 8, 10, 11, by adding subdivisions; 256B.0911, by adding

a subdivision; 256B.093, subdivision 3; 256B.095; 256B.0951, subdivisions 1, 3, 4, 5, 6, 7, by adding a subdivision; 256B.0952, subdivisions 1, 4; 256B.0955; 256B.49, by adding subdivisions; 256B.5012, by adding a subdivision; 256D.35, by adding subdivisions; 256D.44, subdivision 5."

With the recommendation that when so amended the bill pass and be re-referred to the Committee on Health and Human Services Finance.

The report was adopted.

Davids from the Committee on Commerce, Jobs and Economic Development to which was referred:

H. F. No. 1219, A bill for an act relating to insurance; removing certain state involvement with the state fund mutual insurance company; repealing Minnesota Statutes 2000, sections 79.371; 176A.01; 176A.02; 176A.03; 176A.04; 176A.05; 176A.06; 176A.07; 176A.08; 176A.09; 176A.10; 176A.11; and 176A.12.

Reported the same back with the recommendation that the bill pass.

The report was adopted.

Dempsey from the Committee on Local Government and Metropolitan Affairs to which was referred:

H. F. No. 1233, A bill for an act relating to Brooklyn Park; providing for the city economic development authority use of tax increment for qualified redevelopment.

Reported the same back with the following amendments:

Page 2, delete lines 17 to 23

Page 2, line 24, delete "qualified redevelopment district." and insert:

"Costs described in clauses (1) to (9) shall constitute creek improvement costs if such improvements are contained within a qualified redevelopment district. Costs described in clauses (1), (2), (5), (7), and (8) shall also constitute creek improvements costs if incurred with respect to improvements located outside a qualified redevelopment district, so long as such improvements are located within the project area and upstream from the qualified redevelopment district."

Page 3, line 32, after the period, insert "The authority may expend tax increments derived from a qualified redevelopment district for qualified costs for 25 years from the date of the establishment of the qualified redevelopment district."

With the recommendation that when so amended the bill be re-referred to the Committee on Taxes without further recommendation.

The report was adopted.

Dempsey from the Committee on Local Government and Metropolitan Affairs to which was referred:

H. F. No. 1340, A bill for an act relating to Wright county; permitting the appointment of the county recorder.

Reported the same back with the following amendments:

Page 1, line 16, delete "section 3" and insert "sections 3 and 4"

Page 2, after line 5, insert:

"Sec. 4. [FOUR-FIFTHS VOTE; REVERSE REFERENDUM.]

The county board may provide for the appointment of the county recorder as permitted in this act without an affirmative vote of the voters of the county if the resolution to make the office appointed is approved by 80 percent of the members of the county board. Before the adoption of the resolution, the county board must publish a resolution notifying the public of its intent to consider adopting the option once each week for two consecutive weeks in the official publication of the county. Following the publication, the county board shall provide an opportunity at its next regular meeting for public comment relating to the option, prior to formally adopting the option. The option may be implemented without the submission of the question of its implementation to the voters of the county, unless within 30 days after the second publication of the resolution, a petition requesting a referendum, signed by at least ten percent of the registered voters of the county, is filed with the county auditor. If a petition is filed, the option may be implemented unless disapproved by a majority of the voters of the county voting on the question at a regular or special election."

Renumber the sections in sequence

With the recommendation that when so amended the bill pass.

The report was adopted.

Smith from the Committee on Civil Law to which was referred:

H. F. No. 1360, A bill for an act relating to public safety; enacting the Minnesota Citizens' Personal Protection Act of 2001; recognizing the inherent right of law-abiding citizens to self-protection through the lawful use of self-defense; providing a system under which responsible, competent adults can exercise their right to self-protection by authorizing them to obtain a permit to carry a pistol; providing criminal penalties; amending Minnesota Statutes 2000, section 624.714, subdivisions 2, 3, 4, 6, 7, 8, 10, 12, by adding subdivisions; repealing Minnesota Statutes 2000, section 624.714, subdivisions 1, 5.

Reported the same back with the following amendments:

Page 12, line 16, after the period, insert "Notwithstanding section 138.163,"

Page 13, line 1, after "agencies" insert ", including prosecutors carrying out their duties under subdivision 8a,"

Page 14, line 11, after the period, insert "Sheriffs may submit data classified as private to the department of public safety under this paragraph."

With the recommendation that when so amended the bill pass and be re-referred to the Committee on Judiciary Finance.

The report was adopted.

Davids from the Committee on Commerce, Jobs and Economic Development to which was referred:

H. F. No. 1408, A bill for an act relating to rural economic development; providing funding for the rural policy and development center at Minnesota State University, Mankato; appropriating money.

Reported the same back with the recommendation that the bill be re-referred to the Committee on Jobs and Economic Development Finance without further recommendation.

The report was adopted.

Smith from the Committee on Civil Law to which was referred:

H. F. No. 1446, A bill for an act relating to family law; reforming and recodifying the law relating to marriage dissolution, child custody, child support, maintenance, and property division; making style and form changes; amending Minnesota Statutes 2000, sections 518.002; 518.003, subdivisions 1 and 3; 518.005; 518.01; 518.02; 518.03; 518.04; 518.05; 518.055; 518.06; 518.07; 518.09; 518.10; 518.11; 518.12; 518.13; 518.131; 518.14, subdivision 1; 518.148; 518.155; 518.156; 518.157, subdivisions 1, 2, 3, 5, and 6; 518.158, subdivisions 2 and 4; 518.165; 518.166; 518.167, subdivisions 3, 4, and 5; 518.168; 518.1705, subdivision 6; 518.175, subdivisions 1, 1a, 2, 3, 5, 6, 7, and 8; 518.1751, subdivisions 1b, 2, 2a, 2b, 2c, and 3; 518.176; 518.177; 518.178; 518.179, subdivision 1; 518.18; 518.24; 518.25; 518.54, subdivisions 1, 5, 6, 7, and 8; 518.55; 518.552; 518.58; 518.581; 518.582; 518.612; 518.619; 518.62; 518.64, subdivisions 1 and 2; 518.641; 518.642; 518.646; and 518.65; proposing coding for new law in Minnesota Statutes, chapters 517A; and 518; proposing coding for new law as Minnesota Statutes, chapters 517B; and 517C; repealing Minnesota Statutes 2000, sections 518.111; 518.17; 518.171; 518.185; 518.255; 518.54, subdivisions 2, 4a, 13, and 14; 518.551; 518.5513; 518.553; 518.57; 518.575; 518.585; 518.5851; 518.5852; 518.5853; 518.61; 518.6111; 518.614; 518.615; 518.616; 518.617; 518.618; 518.6195; 518.64, subdivisions 4, 4a, and 5; and 518.66.

Reported the same back with the following amendments:

Page 2, line 2, after "whether" insert "child"

Page 2, after line 4, insert:

"(b) At the six-month hearing, the obligor has the burden to present evidence to establish that child support payments are current. A party may request that the public authority provide information to the parties and court regarding child support payments. A party must request the information from the public authority at least 14 days before the hearing. The commissioner of human services must develop a form to be used by the public authority to submit child support payment information to the parties and court."

Page 2, line 5, delete "(b)" and insert "(c)"

Page 2, line 7, after "that" insert "child"

Page 2, line 10, delete "(c)" and insert "(d)" and after "for" insert "child"

Page 2, after line 12 insert:

"(e) At least one month before the six-month hearing, a court administrator must send the parties written notice of the hearing. The written notice must include a statement that an obligor has the burden to present evidence at the hearing to establish that child support payments are current. The written notice also must include a statement that a hearing will not be held if both parties submit an affidavit to the court administrator before the hearing date indicating that child support is current and that the parties are in compliance with parenting time provisions."

Page 66, delete lines 34 to 36

Page 67, delete lines 1 to 6 and insert:

"(a) An obligor may not assert as a defense to failure to pay child support that the obligee interfered with parenting time or removed the child from the state without permission of the obligor or the court.

(b) An obligee may not assert as a defense to interference with parenting time or removing the child from the state without permission of the obligor or the court, that the obligor failed to pay child support."

Page 71, line 19, delete the second "or"

Page 71, line 20, delete the period and insert "; or

(3) support ordered under chapter 518B or 518C."

Page 72, line 2, after the first comma, insert "child care support."

Page 72, line 12, before the period, insert "or the child support enforcement division of the department of human services"

Page 72, line 29, after "257." insert "518B."

Page 73, delete lines 29 to 31 and insert:

"Subd. 5. [PREFERENCE FOR MONTHLY PAYMENT.] There is a presumption in favor of ordering child support in an amount that reflects an obligor's monthly obligation."

Page 73, line 33, before "support" insert "child"

Page 74, delete lines 3 to 25 and insert "Upon the motion of an obligor, a court may order an obligee to account for the use or disposition of child support received. The motion must assert the specific allegations of abuse or misapplication of child support received and that a child's needs are not being met. If the court orders a hearing, the court may order an accounting only if the obligor establishes the specific allegations of abuse or misapplication of child support received and that the child's needs are not being met.

(b) If the court orders an accounting under paragraph (a), the obligee must provide documentation that breaks down monthly expenditures of child support received into the following categories:

(1) housing and utilities;

(2) food;

(3) transportation;

(4) clothing;

(5) health care;

(6) child care and education; and

(7) miscellaneous.

An obligee may account for expenditures on housing, utilities, food, and transportation that are attributable to multiple household members on a per capita basis.

(c) If the court finds that an obligee does not make the accounting required under paragraph (b) or the obligee does not spend the entire child support payment on behalf of the child, the court may:

(1) hold the obligee in contempt of court;

(2) reduce or eliminate the obligor's child support obligation;

(3) order the obligee to make future expenditures on behalf of the child, whether in whole or in part, in a manner that documents the transaction; or

(4) make any other appropriate order to ensure that the needs of the child are met.

(d) If the court determines that an obligor's motion under this section is brought in bad faith, the court may award reasonable attorney fees to the obligee."

Page 77, after line 30, insert:

"Subd. 5. [FAILURE OF NOTICE.] If the court in a dissolution, legal separation, or determination of parentage proceeding, finds before issuing the order for judgment and decree, that notification has not been given to the public authority, the court must set child support according to the guidelines in this chapter. In those proceedings in which no notification has been made pursuant to this section and in which the public authority determines that the judgment is lower than the child support required by the guidelines in this chapter, it must move the court for a redetermination of the support payments ordered so that the support payments comply with the guidelines."

Page 82, line 4, delete "120" and insert "150"

Page 82, line 22, delete "total" and after "monthly" insert "basic needs obligation in a"

Page 82, line 29, delete "child support" and insert "a basic needs obligation in a child support order"

Page 83, line 29, delete "518.175" and insert "517B.27"

Page 83, line 30, delete "518.175" and insert "517B.27"

Page 84, delete lines 8 to 13 and insert:

"(c) If each parent provides, or is responsible for providing, care at least 45 percent of the days in a year, the obligor's basic needs obligation on line 5 of the presumptive child support worksheet under section 517C.16, is 50 percent of the difference between the obligor's and obligee's basic needs obligations. The court must make specific written findings in support of a parenting time adjustment.

(d) If the obligor exercises substantial parenting time, the obligor and obligee may stipulate to reserve or reduce the amount of the child support obligation under section 517C.16. The stipulation must be reviewed and approved by the court."

Pages 84 to 91, delete section 13 and insert:

"Sec. 13. [517C.15] [MEDICAL SUPPORT.]

Subdivision 1. [DEFINITIONS.] The definitions in this subdivision apply to this chapter.

(a) "Health care coverage" means health care benefits that are provided by a health plan. Health care coverage does not include any form of medical assistance under chapter 256B or MinnesotaCare under chapter 256L.

(b) "Health carrier" means a carrier as defined in sections 62A.011, subdivision 2, and 62L.02, subdivision 16.

(c) "Health plan" means a plan meeting the definition under section 62A.011, subdivision 3, or a policy, contract, or certificate issued by a community integrated service network licensed under chapter 62N, and includes plans: (1) provided on an individual and group basis, (2) provided by an employer or union, (3) purchased in the private market, (4) available to a person eligible to carry insurance for the child, and (5) provided through a health plan governed under the federal Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, section 1169(a). "Health plan" includes a plan providing for dependent-only, dental, or vision coverage and a plan provided through a party's spouse or parent.

(d) "Medical support" means providing health care coverage for a child by carrying health care coverage for the child or by contributing to the cost of health care coverage, public coverage, unreimbursed medical expenses, and uninsured medical expenses of the child.

(e) "National medical support notice" is an administrative notice issued by the public authority to enforce medical support provisions of a support order in accordance with Code of Federal Regulations, title 45, section 303.32.

(f) "Public coverage" means health care benefits provided by any form of medical assistance under chapter 256B or MinnesotaCare under chapter 256L.

(g) "Uninsured medical expenses" means a child's reasonable and necessary health-related expenses if the child is not covered by a health plan or public coverage when the expenses are incurred.

(h) "Unreimbursed medical expenses" means a child's reasonable and necessary health-related expenses if a child is covered by a health plan or public coverage and the plan or coverage does not pay for the total cost of the expenses when the expenses are incurred. Unreimbursed medical expenses do not include the cost of premiums. Unreimbursed medical expenses include, but are not limited to, deductibles, co-payments, and expenses for orthodontia, prescription eye glasses and contact lenses, and over-the-counter medicine.

Subd. 2. [ORDER.] (a) A completed national medical support notice issued by the public authority or a court order that complies with this section is a qualified medical child support order under the federal Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, section 1169(a).

(b) Every order addressing child support must state:

(1) the names, last known addresses, and social security numbers of the parents and the child that is a subject of the order unless the court prohibits the inclusion of an address or social security number and orders the parent to provide the address and social security number to the administrator of the health plan;

(2) whether appropriate health care coverage for the child is available and, if so, state:

(i) which party must carry health care coverage;

(ii) the cost of premiums and how the cost is allocated between the parties;

(iii) how unreimbursed expenses will be allocated and collected by the parties; and

(iv) the circumstances, if any, under which the obligation to provide health care coverage for the child will shift from one party to the other; and

(3) if appropriate health care coverage is not available for the child, whether a contribution for medical support is required.

(c) The amount ordered for medical support is subject to a cost-of-living adjustment under section 517C.31.

Subd. 3. [DETERMINATION OF APPROPRIATE COVERAGE.] (a) In determining whether a party has appropriate health care coverage for the child, the court must evaluate the health plan using the following factors:

(1) accessible coverage. Dependent health care coverage is accessible if the covered child can obtain services from a health plan provider with reasonable effort by the custodial parent. Health care coverage is presumed accessible if:

(i) primary care coverage is available within 30 minutes or 30 miles of the child's residence and specialty care coverage is available within 60 minutes or 60 miles of the child's residence;

(ii) the coverage is available through an employer and the employee can be expected to remain employed for a reasonable amount of time; and

(iii) no preexisting conditions exist to delay coverage unduly;

(2) comprehensive coverage. Dependent health care coverage is comprehensive if it includes, at a minimum, medical and hospital coverage and provides for preventive, emergency, acute, and chronic care. If both parties have health care coverage that meets the minimum requirements, the court must determine which health care coverage is more comprehensive by considering whether the coverage includes:

(i) basic dental coverage;

(ii) orthodontics;

(iii) eyeglasses;

(iv) contact lenses;

(v) mental health services; or

(vi) substance abuse treatment;

(3) affordable coverage. Dependent health care coverage is affordable if a party's gross income is 150 percent of the federal poverty guidelines or more and the party's contribution to the health care coverage premium does not exceed five percent of the party's gross income. If a party's gross income is less than 150 percent of the federal poverty guidelines, it is presumed that the party is unable to contribute to the cost of health care coverage unless health care is available at no or low cost to that party; and

(4) the child's special medical needs, if any.

Subd. 4. [COVERAGE.] (a) If a child is presently enrolled in health care coverage, the court must order that the parent who currently has the child enrolled continue that enrollment unless the parties agree otherwise or a party requests a change in coverage and the court determines that other health care coverage is more appropriate.

(b) If a child is not presently enrolled in health care coverage, upon motion of a party or the public authority, the court must determine whether one or both parties have appropriate health care coverage for the child and order the party with appropriate health care coverage available to carry the coverage for the child.

(c) If only one party has appropriate health care coverage available, the court must order that party to carry the coverage for the child.

(d) If both parties have appropriate health care coverage available, the court must order the custodial parent to carry the coverage for the child, unless:

(1) either party expresses a preference for coverage available through the noncustodial parent;

(2) the noncustodial parent is already carrying dependent health care coverage for other children and the cost of contributing to the premiums of the custodial parent's coverage would cause the noncustodial parent extreme hardship; or

(3) both parents agree to provide coverage and agree on the allocation of costs.

If the exception in clause (1) or (2) applies, the court must determine which party has the most appropriate coverage available based on the best interests of the child and order that party to carry coverage for the child.

(e) If neither party has appropriate health care coverage available, the court must order the noncustodial parent to contribute toward the cost of public coverage for the child or the child's uninsured medical expenses in an amount equal to the lesser of:

(1) five percent of gross income; or

(2) the monthly amount the noncustodial parent would pay for the child's premiums if the parent's income meets the eligibility requirements for public coverage. For purposes of determining the premium amount, a parent's household size is equal to the parent plus the child who is the subject of the child support order. The court may order the custodial party to apply for public coverage for the child.

Subd. 5. [CALCULATING MEDICAL SUPPORT; UNREIMBURSED MEDICAL EXPENSES.] (a) The court must calculate the cost of medical support on line 7 of the presumptive child support worksheet under section 517C.16. Unless otherwise agreed by the parties and approved by the court, the court must order that the cost of health care coverage be divided between the obligor and obligee based on their proportionate share of the parties' combined gross income.

(b) If a party's obligation for health care coverage premiums is greater than five percent of the party's gross income, the court may order the other party to contribute more for the cost of the premiums, if doing so would not result in extreme hardship to that party. If an additional contribution causes a party extreme hardship, the court must order the obligor to contribute the lesser of the two amounts under subdivision 4, paragraph (e).

(c) The court must order that all unreimbursed medical expenses be divided between the obligor and obligee based on their proportionate share of the parties' combined gross income.

Subd. 6. [ALLOCATING MEDICAL SUPPORT COSTS.] (a) If the party ordered to carry health care coverage for the child already carries dependent health care coverage for other dependents and would incur no additional premium costs to add the child to the existing coverage, the court must not order the other party to contribute to the premium costs for coverage of the child.

(b) If a party ordered to carry health care coverage for the child does not already carry dependent health care coverage but has other dependents who may be added to the ordered coverage, the full premium costs of the dependent health care coverage must be allocated between the parties in proportion to the party's share of the parties' combined income available for child support, unless the parties agree otherwise.

(c) If a party ordered to carry health care coverage for the child is required to enroll in a health plan so that the child can be enrolled in dependent health care coverage under the plan, the court must allocate the costs of the dependent health care coverage between the parties. The costs of the health care coverage for the party ordered to carry the coverage for the child must not be allocated between the parties.

Subd. 7. [NOTICE TO EMPLOYER BY PUBLIC AUTHORITY OR COURT.] (a) A copy of the national medical support notice or court order for health care coverage must be forwarded by the public authority to the employer within two business days after the date an employee is entered into the work reporting system under section 256.998.

(b) If a party is ordered to carry health care coverage for the child and the public authority provides support enforcement services, the public authority must forward a copy of the national medical support notice or notice of medical support withholding to the party's employer or union and to the health carrier when the conditions under paragraph (d) are met or when ordered by the court.

(c) If the public authority does not provide support enforcement services, the party seeking to enforce the order may forward a copy of the court order for health care coverage for the child to the employer or union of the party ordered to carry coverage and to the health carrier when the conditions under paragraph (d) are met or when ordered by the court.

(d) The public authority or party seeking to enforce the order must forward a copy of the national medical support notice or court order for health care coverage to the employer under paragraphs (b) and (c) if:

(1) the party ordered to carry health care coverage for the child fails to provide written proof to the other party or the public authority, within 30 days of the effective date of the court order, that health care coverage has been obtained for the child;

(2) the other party or the public authority gives written notice to the party ordered to carry health care coverage for the child of intent to enforce medical support. The other party or public authority must mail the written notice to the last known address of the party ordered to carry health care coverage for the child; and

(3) the party ordered to carry health care coverage for the child fails, within 15 days after the date on which the written notice under clause (2) was mailed, to provide written proof to the other party or the public authority that the party has obtained health care coverage for the child.

Subd. 8. [EFFECT OF ORDER.] (a) A new employer or union of a party who is ordered to provide health care coverage for the child must enroll the child in the party's health plan as required by a national medical support notice or court order.

(b) If a health plan administrator receives a completed national medical support notice, the plan administrator must notify the public authority within 40 business days after the date of the notice of the following:

(1) whether coverage is available to the child under the terms of the health plan;

(2) whether the child is covered under the health plan;

(3) the effective date of the child's coverage under the health plan; and

(4) what steps, if any, are required to effectuate the child's coverage under the health plan.

(c) The plan administrator must also provide the public authority and the parties with a notice of enrollment of the child, description of the coverage, and any documents necessary to effectuate coverage.

Subd. 9. [CONTESTING ENROLLMENT.] (a) A party may contest the enrollment of a child in a health plan on the limited grounds that the enrollment is improper due to mistake of fact or that the enrollment meets the requirements of section 517C.26. If the party chooses to contest the enrollment, the party must do so no later than 15 days after the employer notifies the party of the enrollment by doing the following:

- (1) filing a request for hearing according to section 484.702;
 - (2) serving a copy of the request for hearing upon the public authority and the other party; and
 - (3) securing a date for the matter to be heard no later than 45 days after the notice of enrollment.
- (b) The enrollment must remain in place while the party contests the enrollment.

Subd. 10. [EMPLOYER OR UNION REQUIREMENTS.] (a) An employer must send the national medical support notice to its health plan within 20 business days after the date on the national medical support notice.

(b) An employer or union that is included under the federal Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, section 1169(a), may not deny enrollment to the child or to the parent if necessary to enroll the child based on exclusionary clauses described in section 62A.048.

(c) Upon application of the party, or if a court orders a party to carry health insurance coverage for a child, the employer or union and its health plan must enroll the child as a beneficiary in the health plan and withhold any required premiums from the income or wages of the party ordered to carry health care coverage for the child.

(d) If more than one plan is offered by the employer or union and the national medical support notice or court order does not specify the plan to be carried, the plan administrator must notify the parents and the public authority.

(e) If the party ordered to carry health care coverage for the child is not enrolled in the health plan, the employer or union must also enroll the party in the chosen plan if enrollment of the party is necessary to obtain dependent health care coverage under the plan.

(f) Enrollment of dependents and, if necessary, the party ordered to carry health care coverage for the child must be immediate and not dependent upon open enrollment periods. Enrollment is not subject to the underwriting policies under section 62A.048.

(g) Failure of the party ordered to carry health care coverage for the child to execute any documents necessary to enroll the dependent in the health plan does not affect the obligation of the employer or union and health plan to enroll the dependent in a plan. Information and authorization provided by the public authority, or by a party or guardian, is valid for the purposes of meeting enrollment requirements of the health plan.

Subd. 11. [EMPLOYER LIABILITY.] An employer or union that willfully fails to comply with the order is liable for any uninsured medical expenses incurred by the dependents while the dependents were eligible to be enrolled in the health plan and for any other premium costs incurred because the employer or union willfully failed to comply with the order. An employer or union that fails to comply with the order is subject to a finding of contempt and a \$250 civil penalty under section 517C.57 and is also subject to a civil penalty of \$500 to be paid to the party entitled to reimbursement or the public authority. Penalties paid to the public authority are designated for child support enforcement services.

Subd. 12. [DISENROLLMENT; CONTINUATION OF COVERAGE; OPTIONS IN COVERAGE.] (a) A child for whom a party is required to provide health care coverage under this section must be covered as a dependent of the party until the child is emancipated, until further order of the court, or as consistent with the terms of the coverage.

(b) The health carrier, employer, or union may not disenroll or eliminate coverage for the child unless:

(1) the health carrier, employer, or union is provided satisfactory written evidence that the court order is no longer in effect;

(2) the child is or will be enrolled in comparable health care coverage through another health plan that will take effect no later than the effective date of the disenrollment;

(3) the employee is no longer eligible for dependent coverage; or

(4) the required premium has not been paid by or on behalf of the child.

(c) If disenrollment or elimination of coverage of a child under this subdivision is based upon nonpayment of premiums, the health plan must provide 30 days' written notice to the child's parents and the public authority, if the public authority is providing support enforcement services, prior to the disenrollment or elimination of coverage.

(d) A child enrolled in health care coverage under a qualified medical child support order, including a national medical support notice, under this section is a dependent and a qualified beneficiary under the Consolidated Omnibus Budget and Reconciliation Act of 1985 (COBRA), Public Law Number 99-272. Upon expiration of the order, the child is entitled to the opportunity to elect continued coverage that is available under the health plan. Notice must be provided by the employer or union to the parties and the public authority, if it provides child support services, within ten days of the termination date.

(e) If the public authority provides support enforcement services and a plan administrator reports to the public authority that there is more than one coverage option available under the health plan, the public authority, in consultation with the parents, must promptly select coverage from the available options. If the parents fail to cooperate in a reasonable period of time, the public authority must select coverage from the available health plan options.

Subd. 13. [SPOUSAL OR FORMER SPOUSAL COVERAGE.] The court must require a noncustodial parent to provide dependent health care coverage for the benefit of a custodial parent if the noncustodial parent is ordered to provide dependent health care coverage for the parties' child and adding the custodial parent to the coverage results in no additional premium cost to the noncustodial parent.

Subd. 14. [PLAN REIMBURSEMENT.] The signature of a parent of the insured child is a valid authorization to a health plan for purposes of processing an insurance reimbursement payment to the provider of the medical services or to the parent if medical services have been prepaid by that parent.

Subd. 15. [CORRESPONDENCE AND NOTICE.] The health plan must send copies of all correspondence regarding the health care coverage to both parents.

Subd. 16. [DISCLOSURE OF INFORMATION.] (a) Parties must provide the public authority with the following information when support enforcement services are provided:

(1) information relating to dependent health care coverage or public coverage available for the benefit of the child for whom support is sought, including all information required to be included in a medical support order under this section;

(2) verification that application for court-ordered health care coverage was made within 30 days of the court's order; and

(3) the reason that a child is not enrolled in court-ordered health care coverage, if a child is not enrolled in coverage or subsequently loses coverage.

(b) Upon request from the public authority under section 256.978, an employer, union, or plan administrator, including an employer subject to the federal Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, section 1169(a), must provide the public authority the following information:

(1) information relating to dependent health care coverage available to a party for the benefit of the child for whom support is sought, including all information required to be included in a medical support order under this section; and

(2) information that will enable the public authority to determine whether a health plan is appropriate for a child, including, but not limited to, all available plan options, any geographic service restrictions, and the location of service providers.

(c) The employer, union, or plan administrator must not release information regarding one party to the other party. The employer, union, or plan administrator must provide both parties with insurance identification cards and all necessary written information to enable the parties to utilize the insurance benefits for the covered dependents.

(d) The public authority is authorized to release to a party's employer, union, or health plan information necessary to obtain or enforce medical support.

(e) An employee must disclose to an employer if medical support is required to be withheld under this section and the employer must begin withholding according to the terms of the order and under section 517C.52. If an employee discloses an obligation to obtain health care coverage and coverage is available through the employer, the employer must make all application processes known to the individual and enroll the employee and dependent in the plan under subdivision 10.

Subd. 17. [APPLICATION FOR CHILD SUPPORT ENFORCEMENT SERVICES.] The public authority must take necessary steps to establish and enforce an order for medical support if the child receives public assistance or a party completes an application for services from the public authority.

Subd. 18. [ENFORCEMENT.] (a) Remedies available for the collection and enforcement of child support apply to medical support. For the purpose of enforcement, the costs of individual or group health or hospitalization coverage, dental coverage, all medical costs ordered by the court to be paid by either party, including health and dental insurance premiums paid by the obligee because of the obligor's failure to obtain coverage as ordered, or liabilities established under this subdivision, are additional support.

(b) If a party owes a basic support obligation for a child and is ordered to carry health care coverage for the child, and the other party is ordered to contribute to the carrying party's cost for coverage, the carrying party's basic support payment must be reduced by the amount of the contributing party's contribution.

(c) If a party owes a basic support obligation for a child and is ordered to contribute to the other party's cost for carrying health care coverage for the child, the contributing party's basic support payment must be increased by the amount of the contribution.

(d) If a party owes no basic support obligation for a child and is ordered to contribute to the other party's cost for carrying health care coverage for the child, the contributing party is subject to income withholding under section 517C.52 for the amount of the contribution to the carrying party's cost for health care coverage for the child.

(e) If a party's court-ordered health care coverage for the child terminates and the child is not enrolled in other health care coverage or public coverage, and a modification motion is not pending, the public authority may remove the offset to the basic support obligation or terminate income withholding instituted against a custodial party under section 517C.52. The public authority must provide notice to the parties of the action taken.

(f) A party may contest the action of the public authority to remove the offset to the basic support obligation or terminate income withholding if the party makes a written request for a hearing within 30 days after receiving written notice. If a party makes a timely request for a hearing, the public authority must schedule a hearing and give written notice of the hearing to the parties at least 14 days before the hearing. The written notice of the hearing must be sent by mail to the parties' last known addresses. The hearing must be conducted in district court or in the expedited child support process if section 484.702 applies. The district court or child support magistrate must determine whether removal of the offset or termination of income withholding is appropriate and, if appropriate, the effective date for the removal or termination. If the party does not request a hearing, the court must order the offset or termination effective the first day of the month following termination of the child's health care coverage.

(g) A party who fails to carry court-ordered dependent health care coverage is liable for the child's uninsured medical expenses unless a court order provides otherwise. A party's failure to carry court-ordered coverage, or to provide other medical support as ordered, is a basis for modification of a support order under section 517C.28.

(h) Payments by the health carrier or employer for services rendered to the dependents that are directed to a party not owed reimbursement must be endorsed over to and forwarded to the vendor or appropriate party or the public authority. A party retaining insurance reimbursement not owed to the party is liable for the amount of the reimbursement.

Subd. 19. [COLLECTING UNREIMBURSED AND UNINSURED MEDICAL EXPENSES.] (a) A request for reimbursement of unreimbursed and uninsured medical expenses must be initiated within two years of the date that the unreimbursed or uninsured medical expenses were incurred. The time period in this paragraph does not apply if the location of the other parent is unknown.

(b) A party seeking reimbursement of unreimbursed and uninsured medical expenses must mail the other party written notice of intent to collect the expenses and an affidavit of health care expenses to the other party at the party's last known address. The affidavit of health care expenses must itemize and document the child's unreimbursed or uninsured medical expenses. A copy of the bills, receipts, and the insurance company's explanation of the benefits must be attached to the affidavit. The written notice must include a statement that the party has 30 days from the date of mailing the notice to pay in full, enter a payment agreement, or file a motion requesting a hearing contesting the matter. If the public authority provides support enforcement services, the written notice also must include a statement that the requesting party must submit the amount due to the public authority for collection.

(c) If, after 30 days, the other party has not paid in full, the parties are unable to enter a payment agreement, or the other party has not filed a motion contesting the matter, and:

(1) if the public authority provides support enforcement services, the requesting party must send the original affidavit, a copy of the written notice, and copies of the bills, receipts, and the insurance company's explanation of the benefits to the public authority. The public authority must serve the other party with a notice of intent to enforce unreimbursed and uninsured medical expenses and file an affidavit of service by mail with the district court administrator. The notice must provide that, unless the other party pays in full, enters into a payment agreement, or files a motion contesting the matter within 14 days of service of the notice, the public authority will commence enforcement under subdivision 20; or

(2) if the public authority does not provide support enforcement services, the requesting party may move the court for enforcement.

(d) If the party who receives notice under paragraph (b) or (c), clause (1), files a timely motion for a hearing contesting the requested reimbursement, a hearing must be scheduled in district court or in the expedited child support process if section 484.702 applies. The contesting party must provide the party seeking reimbursement and the public authority, if the public authority provides support enforcement services, with written notice of the hearing at least 14 days before the hearing by mailing notice of the hearing to the public authority and the party at the party's last known address. The party seeking reimbursement must file the original affidavit of health care expenses with the court at least five days before the hearing. Based upon the evidence presented, the court must determine liability for the expenses and order that the liable party is subject to enforcement of the expenses as medical support arrears under subdivision 20.

Subd. 20. [ENFORCING AN ORDER FOR MEDICAL SUPPORT ARREARS.] (a) If a party liable for unreimbursed and uninsured medical expenses under subdivision 19 owes a basic support obligation to the party seeking reimbursement of the expenses, the expenses must be collected as medical support arrears as follows:

(1) if income withholding under section 517C.52 is available, medical support arrears must be withheld from a liable party's income or wages pursuant to section 517C.60; or

(2) if income withholding under section 517C.52 is not available, a liable party must pay medical support arrears under the terms of a payment agreement under section 517C.71. If a liable party fails to enter into or comply with a payment agreement, the party seeking reimbursement or the public authority, if it provides support enforcement services, may schedule a hearing to have a court order payment. The party seeking reimbursement or the public authority must provide the liable party with written notice of the hearing at least 14 days before the hearing.

(b) If a party liable for unreimbursed and uninsured medical expenses does not owe a basic support obligation to the party seeking reimbursement, and the party seeking reimbursement owes the liable party child support arrears, the liable party's medical support arrears under subdivision 19 must be deducted from the amount of the child support arrears. If a liable party owes medical support arrears after deducting the amount owed from the amount of the child support arrears owed by the party seeking reimbursement, it must be collected as follows:

(1) if the party seeking reimbursement owes a basic support obligation to the liable party, the basic support obligation must be reduced by 20 percent until the medical support arrears are satisfied;

(2) if the party seeking reimbursement does not owe a basic support obligation to the liable party, the liable party's income must be subject to income withholding under section 517C.52 for an amount required under section 517C.71 until the medical support arrears are satisfied; or

(3) if the party seeking reimbursement does not owe a basic support obligation, and income withholding under section 517C.52 is not available, payment of the medical support arrears must be required under a payment agreement under section 517C.71."

Page 92, line 20, delete everything before the colon

Page 92, line 21, delete "a."

Page 92, delete lines 27 to 33

Page 93, line 2, after "care" insert "or obligor's income exceeds eligibility requirements for basic sliding fee child care"

Page 93, line 10, delete "insurance" and insert "care coverage"

Page 93, line 11, delete "insurance" and insert "health care coverage"

Page 93, line 12, delete "insurance" and insert "care coverage"

Page 93, line 13, delete "insurance" and insert "health care coverage"

Page 93, delete lines 14 to 17 and insert:

"c. Obligor and obligee do not have appropriate health care coverage: obligor must pay the lesser of the following amounts:

(i) the monthly premium amount obligor would pay if obligor's income meets the income eligibility requirements for public coverage: or

(ii) five percent of obligor's monthly gross income, if obligor's income does not meet the eligibility requirements for public coverage:"

Page 94, line 1, delete "and"

Page 94, line 4, delete the period and insert "; and

(7) the obligor exercises a substantial amount of parenting time pursuant to a court order or with the consent of the obligee."

Page 96, delete lines 1 to 12

Page 96, line 21, before "GENERAL" insert "MODIFICATION;"

Page 96, line 36, delete "department of human services" and insert "state court administrator"

Page 98, delete lines 15 to 18

Page 98, line 19, delete "4" and insert "3"

Page 113, line 13, delete "or"

Page 113, after line 13, insert:

"(2) the public authority provides child support enforcement services to a party; or"

Page 113, line 14, delete "(2)" and insert "(3)"

Page 130, line 30, delete "leave"

Page 131, line 6, after "establishes" insert "child"

Page 134, line 10, delete "maintenance or"

Page 134, line 14, delete "maintenance or"

Page 134, line 21, delete "maintenance or"

Page 134, line 22, delete "or maintenance"

Page 150, line 30, delete "January 1, 2003" and insert "July 1, 2001"

With the recommendation that when so amended the bill pass and be re-referred to the Committee on Health and Human Services Policy.

The report was adopted.

Dempsey from the Committee on Local Government and Metropolitan Affairs to which was referred:

H. F. No. 1465, A bill for an act relating to police civil service examinations; permitting periodic examinations; clarifying that qualified applicants may be added to eligible registers after inception; amending Minnesota Statutes 2000, section 419.10.

Reported the same back with the recommendation that the bill pass.

The report was adopted.

Bradley from the Committee on Health and Human Services Policy to which was referred:

H. F. No. 1522, A bill for an act relating to health; modifying requirements for full-time nursing home administrators; amending Minnesota Statutes 2000, section 144A.04, subdivision 5; repealing Minnesota Statutes 2000, section 144A.04, subdivision 5a; and Minnesota Rules, part 4658.0055, subpart 2.

Reported the same back with the following amendments:

Page 2, line 4, before "Each" insert "(a)"

Page 2, line 7, after the period, insert "The nursing home may share the services of a licensed administrator."

Page 2, line 9, delete "and ensure that needs of the residents are met" and insert "in compliance with applicable rules and regulations"

Page 2, line 10, delete "shall" and insert "must"

Page 2, line 12, after the period, insert "Each nursing home must have posted at all times the name of the administrator and the name of the person in charge on the premises in the absence of the licensed administrator."

(b) Notwithstanding sections 144A.18 to 144A.27, a nursing home with a director of nursing serving as an unlicensed nursing home administrator as of March 1, 2001, may continue to have a director of nursing serve in that capacity, provided the director of nursing has passed the state law and rules examination administered by the board of examiners for nursing home administrators and maintains evidence of completion of 20 hours of continuing education each year on topics pertinent to nursing home administration." and strike "The"

Page 2, lines 13 to 16, delete the new language and strike the old language

With the recommendation that when so amended the bill pass.

The report was adopted.

Dempsey from the Committee on Local Government and Metropolitan Affairs to which was referred:

H. F. No. 1589, A bill for an act relating to changing certain bid and performance bond thresholds; amending Minnesota Statutes 2000, section 469.015, subdivisions 1, 2, 3, and 5.

Reported the same back with the following amendments:

Page 2, delete section 3

Page 2, line 33, delete "4" and insert "3"

Amend the title as follows:

Page 1, line 4, delete "3, and"

With the recommendation that when so amended the bill pass and be re-referred to the Committee on Jobs and Economic Development Finance.

The report was adopted.

Bradley from the Committee on Health and Human Services Policy to which was referred:

H. F. No. 1658, A bill for an act relating to human services; providing a 3.5 percent rate increase for nursing facilities, intermediate care facilities for persons with mental retardation, and community-based providers; amending Minnesota Statutes 2000, sections 256B.431, by adding a subdivision; 256B.434, subdivision 4; 256B.501, by adding a subdivision.

Reported the same back with the following amendments:

Delete everything after the enacting clause and insert:

"ARTICLE 1

CONSUMER INFORMATION AND ASSISTANCE AND COMMUNITY-BASED CARE

Section 1. [144A.35] [EXPANSION OF BED DISTRIBUTION STUDY AND CREATION OF CRITICAL ACCESS SITES.]

Subdivision 1. [OLDER ADULT SERVICES DISTRIBUTION STUDY.] The commissioner of health, in coordination with the commissioner of human services, shall monitor and analyze the distribution of older adult services, including, but not limited to, nursing home beds, senior housing, housing with services units, and home and community-based services in the different geographic areas of the state. The study shall include an analysis of the impact of amendments to the nursing home moratorium law which would allow for transfers of nursing home beds within the state. The commissioner of health shall submit to the legislature, beginning January 15, 2002, and each January 15 thereafter, an assessment of the distribution of long-term health care services by geographic area, with particular attention to service deficits or problems, the designation of critical access service sites, and corrective action plans.

Subd. 2. [CRITICAL ACCESS SERVICE SITE.] "Critical access service site" shall include nursing homes, senior housing, housing with services, and home and community-based services that are certified by the state as necessary providers of health care services to a specific geographic area. For purposes of this requirement, a "necessary provider of health care services" is a provider that is:

(1) located more than 20 miles, defined as official mileage as reported by the Minnesota department of transportation, from the next nearest long-term health care provider;

(2) the sole long-term health care provider in the county; or

(3) a long-term health care provider located in a medically underserved area or health professional shortage area.

Subd. 3. [IDENTIFICATION OF CRITICAL ACCESS SERVICE SITES.] Based on the results of the analysis completed in subdivision 1, the commissioners of health and human services shall identify and designate long-term health care providers as critical access service sites.

Subd. 4. [CRITICAL ACCESS SERVICE SITES.] The commissioner of health, in consultation with the commissioner of human services, shall:

(1) develop and implement specific waivers to regulations governing health care personnel scope of duties, physical plant requirements, and location of community-based services, to address critical access service site older adult service needs;

(2) identify payment barriers to the continued operation of older adult services in critical access service sites, and provide recommendations on changes to reimbursement rates to facilitate the continued operation of these services.

Sec. 2. Minnesota Statutes 2000, section 256.975, is amended by adding a subdivision to read:

Subd. 7. [CONSUMER INFORMATION AND ASSISTANCE; SENIOR LINKAGE.] (a) The Minnesota board on aging shall operate a statewide information and assistance service to aid older Minnesotans and their families in making informed choices about long-term care options and health care benefits. Language services to persons with limited English language skills must be made available. The service, known as Senior LinkAge Line, must be available during business hours through a statewide toll-free number and must also be available through the Internet.

(b) The service must assist older adults, caregivers, and providers in accessing information about choices in long-term care services that are purchased through private providers or available through public options. The service must:

(1) develop a comprehensive database that includes detailed listings in both consumer- and provider-oriented formats;

(2) make the database accessible on the Internet and through other telecommunication and media-related tools;

(3) link callers to interactive long-term care screening tools and make these tools available through the Internet by integrating the tools with the database;

(4) develop community education materials with a focus on planning for long-term care and evaluating independent living, housing, and service options;

(5) conduct an outreach campaign to assist older adults and their caregivers in finding information on the Internet and through other means of communication;

(6) implement a messaging system for overflow callers and respond to these callers by the next business day;

(7) link callers with county human services and other providers to receive more in-depth assistance and consultation related to long-term care options; and

(8) link callers with quality profiles for nursing facilities and other providers developed by the commissioner of health.

(c) The Minnesota board on aging shall conduct an evaluation of the effectiveness of the statewide information and assistance, and submit this evaluation to the legislature by December 1, 2002. The evaluation must include an analysis of funding adequacy, gaps in service delivery, continuity in information between the service and identified linkages, and potential use of private funding to enhance the service.

Sec. 3. [256.9754] [COMMUNITY SERVICES DEVELOPMENT GRANTS PROGRAM.]

Subdivision 1. [DEFINITIONS.] For purposes of this section, the following terms have the meanings given.

(a) "Community" means a town, township, city, or targeted neighborhood within a city, or a consortium of towns, townships, cities, or targeted neighborhoods within cities.

(b) "Older adult services" means any services available under the elderly waiver program or alternative care grant programs; nursing facility services; transportation services; respite services; and other community-based services identified as necessary either to maintain lifestyle choices for older Minnesotans, or to promote independence.

(c) "Older adult" refers to individuals 65 years of age and older.

Subd. 2. [CREATION.] The community services development grants program is created under the administration of the commissioner of human services.

Subd. 3. [PROVISION OF GRANTS.] The commissioner shall make grants available to communities, providers of older adult services identified in subdivision 1, or to a consortium of providers of older adult services, to establish new older adult services. Grants may be provided for capital and other costs including, but not limited to, start-up and training costs, equipment, and supplies related to the establishment of new older adult services or other residential or service alternatives to nursing facility care. Grants may also be made to renovate current buildings, provide transportation services, or expand state-funded programs in the area.

Subd. 4. [ELIGIBILITY.] Grants may be awarded only to communities and providers or to a consortium of providers that have a local match of 50 percent of the costs for the project in the form of donations, local tax dollars, in-kind donations, fundraising, or other local matches.

Subd. 5. [GRANT PREFERENCE.] The commissioner of human services may award grants to the extent grant funds are available and to the extent applications are approved by the commissioner. Denial of approval of an application in one year does not preclude submission of an application in a subsequent year. The maximum grant amount is limited to \$750,000.

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

Subd. 4. [INCOME.] To be eligible for medical assistance, a person eligible under section 256B.055, subdivision 7, not receiving supplemental security income program payments, may have an income up to 100 percent of the federal poverty guidelines, and families and children may have an income up to 133-1/3 percent of the AFDC income standard in effect under the July 16, 1996, AFDC state plan. Effective July 1, 2000, the base AFDC standard in effect on July 16, 1996, shall be increased by three percent. Effective January 1, 2000, and each successive January, recipients of supplemental security income may have an income up to the supplemental security income standard in effect on that date. In computing income to determine eligibility of persons who are not residents of long-term care facilities, the commissioner shall disregard increases in income as required by Public Law Numbers 94-566, section 503; 99-272; and 99-509. Veterans aid and attendance benefits and Veterans Administration unusual medical expense payments are considered income to the recipient.

Sec. 5. Minnesota Statutes 2000, section 256B.0911, subdivision 1, is amended to read:

Subdivision 1. [PURPOSE AND GOAL.] (a) ~~The purpose of the preadmission screening program~~ long-term care consultation services is to assist persons with long-term or chronic care needs in making long-term care decisions and selecting options that meet their needs and reflect their preferences. ~~The availability of, and access to, information and other types of assistance is also intended to prevent or delay certified nursing facility placements by assessing applicants and residents and offering cost-effective alternatives appropriate for the person's needs and to provide transition assistance after admission.~~ Further, the goal of ~~the program~~ these services is to contain costs associated with unnecessary certified nursing facility admissions. The commissioners of human services and health shall seek to maximize use of available federal and state funds and establish the broadest program possible within the funding available.

(b) These services must be coordinated with services provided under sections 256.975, subdivision 7, and 256.9772, and with services provided by other public and private agencies in the community to offer a variety of cost-effective alternatives to persons with disabilities and elderly persons. The county agency providing long-term care consultation services shall encourage the use of volunteers from families, religious organizations, social clubs, and similar civic and service organizations to provide community-based services.

Sec. 6. Minnesota Statutes 2000, section 256B.0911, is amended by adding a subdivision to read:

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

(a) "Long-term care consultation services" means:

(1) providing information and education to the general public regarding availability of the services authorized under this section;

(2) an intake process that provides access to the services described in this section;

(3) assessment of the health, psychological, and social needs of referred individuals;

(4) assistance in identifying services needed to maintain an individual in the least restrictive environment;

(5) providing recommendations on cost-effective community services that are available to the individual;

(6) development of an individual's community support plan;

(7) providing information regarding eligibility for Minnesota health care programs;

(8) preadmission screening to determine the need for a nursing facility level of care;

(9) preliminary determination of Minnesota health care programs eligibility for individuals who need a nursing facility level of care, with appropriate referrals for final determination;

(10) providing recommendations for nursing facility placement when there are no cost-effective community services available; and

(11) assistance to transition people back to community settings after facility admission.

(b) "Minnesota health care programs" means the medical assistance program under chapter 256B, the alternative care program under section 256B.0913, and the prescription drug program under section 256.955.

Sec. 7. Minnesota Statutes 2000, section 256B.0911, subdivision 3, is amended to read:

Subd. 3. ~~[PERSONS RESPONSIBLE FOR CONDUCTING THE PREADMISSION SCREENING LONG-TERM CARE CONSULTATION TEAM.]~~ (a) A ~~local screening~~ long-term care consultation team shall be established by the county board of commissioners. Each ~~local screening~~ consultation team shall consist of ~~screeners who are a~~ at least one social worker and ~~a~~ at least one public health nurse from their respective county agencies. ~~The board may designate public health or social services as the lead agency for long-term care consultation services.~~ If a county does not have a public health nurse available, it may request approval from the commissioner to assign a county registered nurse with at least one year experience in home care to participate on the team. ~~The screening team members must confer regarding the most appropriate care for each individual screened.~~ Two or more counties may collaborate to establish a joint local screening consultation team or teams.

(b) ~~In assessing a person's needs, screeners shall have a physician available for consultation and shall consider the assessment of the individual's attending physician, if any. The individual's physician shall be included if the physician chooses to participate. Other personnel may be included on the team as deemed appropriate by the county agencies. The team is responsible for providing long-term care consultation services to all persons located in the county who request the services, regardless of eligibility for Minnesota health care programs.~~

Sec. 8. Minnesota Statutes 2000, section 256B.0911, is amended by adding a subdivision to read:

Subd. 3a. [ASSESSMENT AND SUPPORT PLANNING.] (a) Persons requesting assessment, services planning, or other assistance intended to support community-based living must be visited by a long-term care consultation team within ten working days after the date on which an assessment was requested or recommended. Assessments must be conducted according to paragraphs (b) to (g).

(b) The county may utilize a team of either the social worker or public health nurse, or both, to conduct the assessment in a face-to-face interview. The screening consultation team members must confer regarding the most appropriate care for each individual screened or assessed.

(c) The long-term care consultation team must assess the health and social needs of the person, using an assessment form provided by the commissioner of human services.

(d) The team must conduct the assessment in a face-to-face interview with the person being assessed and the person's legal representative, if applicable.

(e) The team must provide the person, or the person's legal representative, with written recommendations for facility- or community-based services. The team must document that the most cost-effective alternatives available were offered to the individual. For purposes of this requirement, "cost-effective alternatives" means community services and living arrangements that cost the same as or less than nursing facility care.

(f) If the person chooses to use community-based services, the team must provide the person or the person's legal representative with a written community support plan, regardless of whether the individual is eligible for Minnesota health care programs. The person may request assistance in developing a community support plan without participating in a complete assessment.

(g) The team must give the person receiving assessment or support planning, or the person's legal representative, materials supplied by the commissioner of human services containing the following information:

- (1) the purpose of preadmission screening and assessment;
- (2) information about Minnesota health care programs;
- (3) the person's freedom to accept or reject the recommendations of the team;

- (4) the person's right to confidentiality under the Minnesota Government Data Practices Act, chapter 13; and
- (5) the person's right to appeal the decision regarding the need for nursing facility level of care or the county's final decisions regarding public programs eligibility according to section 256.045, subdivision 3.

Sec. 9. Minnesota Statutes 2000, section 256B.0911, is amended by adding a subdivision to read:

Subd. 3b. [TRANSITION ASSISTANCE.] (a) A long-term care consultation team shall provide assistance to persons residing in a nursing facility, hospital, regional treatment center, or intermediate care facility for persons with mental retardation who request or are referred for such assistance. Transition assistance must include assessment, community support plan development, referrals to Minnesota health care programs, and referrals to programs that provide assistance with housing.

(b) The county shall develop transition processes with institutional social workers and discharge planners to ensure that:

- (1) persons admitted to facilities receive information about transition assistance that is available;
- (2) the assessment is completed for persons within ten working days of the date of request or recommendation for assessment; and
- (3) there is a plan for transition and follow-up for the individual's return to the community. The plan must require notification of other local agencies when a person who may require assistance is screened by one county for admission to a facility located in another county.

(c) If a person who is eligible for a Minnesota health care program is admitted to a nursing facility, the nursing facility must include a consultation team member or the case manager in the discharge planning process.

Sec. 10. Minnesota Statutes 2000, section 256B.0911, is amended by adding a subdivision to read:

Subd. 4a. [PREADMISSION SCREENING ACTIVITIES RELATED TO NURSING FACILITY ADMISSIONS.] (a) All applicants to Medicaid certified nursing facilities, including certified boarding care facilities, must be screened prior to admission regardless of income, assets, or funding sources for nursing facility care, except as described in subdivision 4b. The purpose of the screening is to determine the need for nursing facility level of care as described in paragraph (d) and to complete activities required under federal law related to mental illness and mental retardation as outlined in paragraph (b).

(b) A person who has a diagnosis or possible diagnosis of mental illness, mental retardation, or a related condition must receive a preadmission screening before admission regardless of the exemptions outlined in subdivision 4b, paragraph (b), to identify the need for further evaluation and specialized services, unless the admission prior to screening is authorized by the local mental health authority or the local developmental disabilities case manager, or unless authorized by the county agency according to Public Law Number 100-508.

The following criteria apply to the preadmission screening:

- (1) the county must use forms and criteria developed by the commissioner of human services to identify persons who require referral for further evaluation and determination of the need for specialized services; and
- (2) the evaluation and determination of the need for specialized services must be done by:
- (i) a qualified independent mental health professional, for persons with a primary or secondary diagnosis of a serious mental illness; or

(ii) a qualified mental retardation professional, for persons with a primary or secondary diagnosis of mental retardation or related conditions. For purposes of this requirement, a qualified mental retardation professional must meet the standards for a qualified mental retardation professional under Code of Federal Regulations, title 42, section 483.430.

(c) The local county mental health authority or the state mental retardation authority under Public Laws Numbers 100-203 and 101-508 may prohibit admission to a nursing facility if the individual does not meet the nursing facility level of care criteria or needs specialized services as defined in Public Laws Numbers 100-203 and 101-508. For purposes of this section, "specialized services" for a person with mental retardation or a related condition means active treatment as that term is defined under Code of Federal Regulations, title 42, section 483.440, paragraph (a), clause (1).

(d) The determination of the need for nursing facility level of care must be made according to criteria developed by the commissioner of human services. In assessing a person's needs, consultation team members shall have a physician available for consultation and shall consider the assessment of the individual's attending physician, if any. The individual's physician must be included if the physician chooses to participate. Other personnel may be included on the team as deemed appropriate by the county.

Sec. 11. Minnesota Statutes 2000, section 256B.0911, is amended by adding a subdivision to read:

Subd. 4b. [EXEMPTIONS AND EMERGENCY ADMISSIONS.] (a) Exemptions from the federal screening requirements outlined in subdivision 4a, paragraphs (b) and (c), are limited to:

(1) a person who, having entered an acute care facility from a certified nursing facility, is returning to a certified nursing facility; and

(2) a person transferring from one certified nursing facility in Minnesota to another certified nursing facility in Minnesota.

(b) Persons who are exempt from preadmission screening for purposes of level of care determination include:

(1) persons described in paragraph (a);

(2) an individual who has a contractual right to have nursing facility care paid for indefinitely by the veterans' administration;

(3) an individual enrolled in a demonstration project under section 256B.69, subdivision 8, at the time of application to a nursing facility;

(4) an individual currently being served under the alternative care program or under a home and community-based services waiver authorized under section 1915(c) of the federal Social Security Act; and

(5) individuals admitted to a certified nursing facility for a short-term stay, which is expected to be 14 days or less in duration based upon a physician's certification, and who have been assessed and approved for nursing facility admission within the previous six months. This exemption applies only if the consultation team member determines at the time of the initial assessment of the six-month period that it is appropriate to use the nursing facility for short-term stays and that there is an adequate plan of care for return to the home or community-based setting. If a stay exceeds 14 days, the individual must be referred no later than the first county working day following the 14th resident day for a screening, which must be completed within five working days of the referral. The payment limitations in subdivision 7 apply to an individual found at screening to not meet the level of care criteria for admission to a certified nursing facility.

(c) Persons admitted to a Medicaid-certified nursing facility from the community on an emergency basis as described in paragraph (d) or from an acute care facility on a nonworking day must be screened the first working day after admission.

(d) Emergency admission to a nursing facility prior to screening is permitted when all of the following conditions are met:

(1) a person is admitted from the community to a certified nursing or certified boarding care facility during county nonworking hours;

(2) a physician has determined that delaying admission until preadmission screening is completed would adversely affect the person's health and safety;

(3) there is a recent precipitating event that precludes the client from living safely in the community, such as sustaining an injury, sudden onset of acute illness, or a caregiver's inability to continue to provide care;

(4) the attending physician has authorized the emergency placement and has documented the reason that the emergency placement is recommended; and

(5) the county is contacted on the first working day following the emergency admission.

Transfer of a patient from an acute care hospital to a nursing facility is not considered an emergency except for a person who has received hospital services in the following situations: hospital admission for observation, care in an emergency room without hospital admission, or following hospital 24-hour bed care.

Sec. 12. Minnesota Statutes 2000, section 256B.0911, is amended by adding a subdivision to read:

Subd. 4c. [SCREENING REQUIREMENTS.] (a) A person may be screened for nursing facility admission by telephone or in a face-to-face screening interview. Consultation team members shall identify each individual's needs using the following categories:

(1) the person needs no face-to-face screening interview to determine the need for nursing facility level of care based on information obtained from other health care professionals;

(2) the person needs an immediate face-to-face screening interview to determine the need for nursing facility level of care and complete activities required under subdivision 4a; or

(3) the person may be exempt from screening requirements as outlined in subdivision 4b, but will need transitional assistance after admission or in-person follow-along after a return home.

(b) Persons admitted on a nonemergency basis to a Medicaid-certified nursing facility must be screened prior to admission.

(c) The long-term care consultation team shall recommend a case mix classification for persons admitted to a certified nursing facility when sufficient information is received to make that classification. The nursing facility is authorized to conduct all case mix assessments for persons who have been screened prior to admission for whom the county did not recommend a case mix classification. The nursing facility is authorized to conduct all case mix assessments for persons admitted to the facility prior to a preadmission screening. The county retains the responsibility of distributing appropriate case mix forms to the nursing facility.

(d) The county screening or intake activity must include processes to identify persons who may require transition assistance as described in subdivision 3b.

Sec. 13. Minnesota Statutes 2000, section 256B.0911, subdivision 5, is amended to read:

Subd. 5. [~~SIMPLIFICATION OF FORMS ADMINISTRATIVE ACTIVITY.~~] The commissioner shall minimize the number of forms required in the preadmission screening process provision of long-term care consultation services and shall limit the screening document to items necessary for care community support plan approval, reimbursement, program planning, evaluation, and policy development.

Sec. 14. Minnesota Statutes 2000, section 256B.0911, subdivision 6, is amended to read:

Subd. 6. [~~PAYMENT FOR PREADMISSION SCREENING LONG-TERM CARE CONSULTATION SERVICES.~~] (a) The total screening payment for each county must be paid monthly by certified nursing facilities in the county. The monthly amount to be paid by each nursing facility for each fiscal year must be determined by dividing the county's annual allocation for screenings long-term care consultation services by 12 to determine the monthly payment and allocating the monthly payment to each nursing facility based on the number of licensed beds in the nursing facility. Payments to counties in which there is no certified nursing facility must be made by increasing the payment rate of the two facilities located nearest to the county seat.

(b) The commissioner shall include the total annual payment for screening determined under paragraph (a) for each nursing facility according to section 256B.431, subdivision 2b, paragraph (g), or 256B.435.

(c) Payments for screening activities long-term care consultation services are available to the county or counties to cover staff salaries and expenses to provide the screening function services described in subdivision 1a. The lead agency county shall employ, or contract with other agencies to employ, within the limits of available funding, sufficient personnel to conduct the preadmission screening activity provide long-term care consultation services while meeting the state's long-term care outcomes and objectives as defined in section 256B.0917, subdivision 1. The local agency county shall be accountable for meeting local objectives as approved by the commissioner in the CSSA biennial plan.

(d) Notwithstanding section 256B.0641, overpayments attributable to payment of the screening costs under the medical assistance program may not be recovered from a facility.

(e) The commissioner of human services shall amend the Minnesota medical assistance plan to include reimbursement for the local screening consultation teams.

(f) The county may bill, as case management services, assessments, support planning, and follow-along provided to persons determined to be eligible for case management under Minnesota health care programs. No individual or family member shall be charged for an initial assessment or initial support plan development provided under subdivision 3a or 3b.

Sec. 15. Minnesota Statutes 2000, section 256B.0911, subdivision 7, is amended to read:

Subd. 7. [~~REIMBURSEMENT FOR CERTIFIED NURSING FACILITIES.~~] (a) Medical assistance reimbursement for nursing facilities shall be authorized for a medical assistance recipient only if a preadmission screening has been conducted prior to admission or the local county agency has authorized an exemption. Medical assistance reimbursement for nursing facilities shall not be provided for any recipient who the local screener has determined does not meet the level of care criteria for nursing facility placement or, if indicated, has not had a level II PASARR OBRA evaluation as required under the federal Omnibus Reconciliation Act of 1987 completed unless an admission for a recipient with mental illness is approved by the local mental health authority or an admission for a recipient with mental retardation or related condition is approved by the state mental retardation authority.

(b) The nursing facility must not bill a person who is not a medical assistance recipient for resident days that preceded the date of completion of screening activities as required under subdivisions 4a, 4b, and 4c. The nursing facility must include unreimbursed resident days in the nursing facility resident day totals reported to the commissioner.

(c) The commissioner shall make a request to the health care financing administration for a waiver allowing screening team approval of Medicaid payments for certified nursing facility care. An individual has a choice and makes the final decision between nursing facility placement and community placement after the screening team's recommendation, except as provided in ~~paragraphs (b) and (c)~~ subdivision 4a, paragraph (c).

~~(c) The local county mental health authority or the state mental retardation authority under Public Law Numbers 100-203 and 101-508 may prohibit admission to a nursing facility, if the individual does not meet the nursing facility level of care criteria or needs specialized services as defined in Public Law Numbers 100-203 and 101-508. For purposes of this section, "specialized services" for a person with mental retardation or a related condition means "active treatment" as that term is defined in Code of Federal Regulations, title 42, section 483.440(a)(1).~~

~~(e) Appeals from the screening team's recommendation or the county agency's final decision shall be made according to section 256.045, subdivision 3.~~

Sec. 16. Minnesota Statutes 2000, section 256B.0913, subdivision 1, is amended to read:

Subdivision 1. [PURPOSE AND GOALS.] The purpose of the alternative care program is to provide funding for ~~or access to~~ home and community-based services for ~~frail~~ elderly persons, in order to limit nursing facility placements. The program is designed to support ~~frail~~ elderly persons in their desire to remain in the community as independently and as long as possible and to support informal caregivers in their efforts to provide care for ~~frail~~ elderly people. Further, the goals of the program are:

(1) to contain medical assistance expenditures by providing funding care in the community ~~at a cost the same or less than nursing facility costs~~; and

(2) to maintain the moratorium on new construction of nursing home beds.

Sec. 17. Minnesota Statutes 2000, section 256B.0913, subdivision 2, is amended to read:

Subd. 2. [ELIGIBILITY FOR SERVICES.] Alternative care services are available to ~~all frail older~~ Minnesotans: ~~This includes:~~

~~(1) persons who are receiving medical assistance and served under the medical assistance program or the Medicaid waiver program;~~

~~(2) persons age 65 or older who are not eligible for medical assistance without a spenddown or waiver obligation but who would be eligible for medical assistance within 180 days of admission to a nursing facility and served under subject to subdivisions 4 to 13; and~~

~~(3) persons who are paying for their services out-of-pocket.~~

Sec. 18. Minnesota Statutes 2000, section 256B.0913, subdivision 4, is amended to read:

Subd. 4. [ELIGIBILITY FOR FUNDING FOR SERVICES FOR NONMEDICAL ASSISTANCE RECIPIENTS.] (a) Funding for services under the alternative care program is available to persons who meet the following criteria:

~~(1) the person has been screened by the county screening team or, if previously screened and served under the alternative care program, assessed by the local county social worker or public health nurse determined by a~~

community assessment under section 256B.0911, to be a person who would require the level of care provided in a nursing facility, but for the provision of services under the alternative care program;

(2) the person is age 65 or older;

(3) the person would be ~~financially~~ eligible for medical assistance within 180 days of admission to a nursing facility;

(4) ~~the person meets the asset transfer requirements of is not ineligible for the medical assistance program due to an asset transfer penalty;~~

(5) ~~the screening team would recommend nursing facility admission or continued stay for the person if alternative care services were not available;~~

(6) ~~the person needs services that are not available at that time in the county funded through other county, state, or federal funding sources; and~~

(7) (6) ~~the monthly cost of the alternative care services funded by the program for this person does not exceed 75 percent of the statewide average monthly medical assistance payment for nursing facility care at the individual's case mix classification weighted average monthly nursing facility rate of the case mix resident class to which the individual alternative care client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, less the recipient's maintenance needs allowance as described in section 256B.0915, subdivision 1d, paragraph (a), until the first day of the state fiscal year in which the resident assessment system, under section 256B.437, for nursing home rate determination is implemented. Effective on the first day of the state fiscal year in which a resident assessment system, under section 256B.437, for nursing home rate determination is implemented and the first day of each subsequent state fiscal year, the monthly cost of alternative care services for this person shall not exceed the alternative care monthly cap for the case mix resident class to which the alternative care client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, which was in effect on the last day of the previous state fiscal year, and adjusted by the greater of any legislatively adopted home and community-based services cost-of-living percentage increase or any legislatively adopted statewide percent rate increase for nursing facilities. This monthly limit does not prohibit the alternative care client from payment for additional services, but in no case may the cost of additional services purchased under this section exceed the difference between the client's monthly service limit defined under section 256B.0915, subdivision 3, and the alternative care program monthly service limit defined in this paragraph. If medical supplies and equipment or adaptations environmental modifications are or will be purchased for an alternative care services recipient, the costs may be prorated on a monthly basis throughout the year in which they are purchased for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's other alternative care services exceeds the monthly limit established in this paragraph, the annual cost of the alternative care services shall be determined. In this event, the annual cost of alternative care services shall not exceed 12 times the monthly limit calculated described in this paragraph.~~

(b) ~~Individuals who meet the criteria in paragraph (a) and who have been approved for alternative care funding are called 180-day eligible clients.~~

(c) ~~The statewide average payment for nursing facility care is the statewide average monthly nursing facility rate in effect on July 1 of the fiscal year in which the cost is incurred, less the statewide average monthly income of nursing facility residents who are age 65 or older and who are medical assistance recipients in the month of March of the previous fiscal year. This monthly limit does not prohibit the 180-day eligible client from paying for additional services needed or desired.~~

(d) ~~In determining the total costs of alternative care services for one month, the costs of all services funded by the alternative care program, including supplies and equipment, must be included.~~

~~(e)~~ Alternative care funding under this subdivision is not available for a person who is a medical assistance recipient or who would be eligible for medical assistance without a spenddown, ~~unless authorized by the commissioner or waiver obligation.~~ A person whose initial application for medical assistance is being processed may be served under the alternative care program for a period up to 60 days. If the individual is found to be eligible for medical assistance, ~~the county must bill~~ medical assistance must be billed for services payable under the federally approved elderly waiver plan and delivered from the date the individual was found eligible for ~~services reimbursable under the federally approved elderly waiver program plan.~~ Notwithstanding this provision, alternative care funds may not be used to pay for any service the cost of which is payable by medical assistance or which is used by a recipient to meet a medical assistance income spenddown or waiver obligation.

~~(f)~~ (c) Alternative care funding is not available for a person who resides in a licensed nursing home ~~or, certified~~ boarding care home, hospital, or intermediate care facility, except for case management services which are ~~being~~ provided in support of the discharge planning process to a nursing home resident or certified boarding care home resident who is ineligible for case management funded by medical assistance.

Sec. 19. Minnesota Statutes 2000, section 256B.0913, subdivision 5, is amended to read:

Subd. 5. [SERVICES COVERED UNDER ALTERNATIVE CARE.] (a) Alternative care funding may be used for payment of costs of:

- (1) adult foster care;
- (2) adult day care;
- (3) home health aide;
- (4) homemaker services;
- (5) personal care;
- (6) case management;
- (7) respite care;
- (8) assisted living;
- (9) residential care services;
- (10) care-related supplies and equipment;
- (11) meals delivered to the home;
- (12) transportation;
- (13) skilled nursing;
- (14) chore services;
- (15) companion services;
- (16) nutrition services;
- (17) training for direct informal caregivers;

(18) telemedicine devices to monitor recipients in their own homes as an alternative to hospital care, nursing home care, or home visits; ~~and~~

(19) other services ~~including which includes discretionary funds and~~ direct cash payments to clients, ~~approved by the county agency following approval by the commissioner,~~ subject to the provisions of paragraph ~~(m)~~ (j). Total annual payments for "other services" for all clients within a county may not exceed either ten percent of that county's annual alternative care program base allocation or \$5,000, whichever is greater. In no case shall this amount exceed the county's total annual alternative care program base allocation; ~~and~~

(20) environmental modifications.

(b) The county agency must ensure that the funds are not used only to supplement and not to supplant services available through other public assistance or services programs.

(c) Unless specified in statute, the service definitions and standards for alternative care services shall be the same as the service definitions and standards ~~defined specified~~ in the federally approved elderly waiver plan. Except for the county agencies' approval of direct cash payments to clients as described in paragraph (j) or for a provider of supplies and equipment when the monthly cost of the supplies and equipment is less than \$250, persons or agencies must be employed by or under a contract with the county agency or the public health nursing agency of the local board of health in order to receive funding under the alternative care program. Supplies and equipment may be purchased from a non-Medicaid certified vendor if the cost for the item is less than that of a Medicaid vendor.

(d) The adult foster care rate shall be considered a difficulty of care payment and shall not include room and board. The adult foster care ~~daily~~ rate shall be negotiated between the county agency and the foster care provider. ~~The rate established under this section shall not exceed 75 percent of the state average monthly nursing home payment for the case mix classification to which the individual receiving foster care is assigned, and it must allow for other alternative care services to be authorized by the case manager.~~ The alternative care payment for the foster care service in combination with the payment for other alternative care services, including case management, must not exceed the limit specified in subdivision 4, paragraph (a), clause (6).

(e) Personal care services ~~may be provided by a personal care provider organization; must meet the service standards defined in the federally approved elderly waiver plan, except that a county agency may contract with a client's relative of the client who meets the relative hardship waiver requirement as defined in section 256B.0627, subdivision 4, paragraph (b), clause (10), to provide personal care services; but must ensure nursing if the county agency ensures supervision of this service by a registered nurse or mental health practitioner.~~ Covered personal care services defined in section 256B.0627, subdivision 4, must meet applicable standards in Minnesota Rules, part 9505.0335.

(f) A county may use alternative care funds to purchase medical supplies and equipment without prior approval from the commissioner when: (1) there is no other funding source; (2) the supplies and equipment are specified in the individual's care plan as medically necessary to enable the individual to remain in the community according to the criteria in Minnesota Rules, part 9505.0210, item A; and (3) the supplies and equipment represent an effective and appropriate use of alternative care funds. ~~A county may use alternative care funds to purchase supplies and equipment from a non-Medicaid certified vendor if the cost for the items is less than that of a Medicaid vendor. A county is not required to contract with a provider of supplies and equipment if the monthly cost of the supplies and equipment is less than \$250.~~

(g) For purposes of this section, residential care services are services which are provided to individuals living in residential care homes. Residential care homes are currently licensed as board and lodging establishments and are registered with the department of health as providing special services under section 157.17 and are not subject to registration under chapter 144D. Residential care services are defined as "supportive services" and "health-related services." "Supportive services" means the provision of up to 24-hour supervision and oversight. Supportive services includes: (1) transportation, when provided by the residential care ~~center~~ home only; (2) socialization, when

socialization is part of the plan of care, has specific goals and outcomes established, and is not diversional or recreational in nature; (3) assisting clients in setting up meetings and appointments; (4) assisting clients in setting up medical and social services; (5) providing assistance with personal laundry, such as carrying the client's laundry to the laundry room. Assistance with personal laundry does not include any laundry, such as bed linen, that is included in the room and board rate. "Health-related services" are limited to minimal assistance with dressing, grooming, and bathing and providing reminders to residents to take medications that are self-administered or providing storage for medications, if requested. Individuals receiving residential care services cannot receive homemaking services funded under this section.

(g) For the purposes of this section, "assisted living" refers to supportive services provided by a single vendor to clients who reside in the same apartment building of three or more units which are not subject to registration under chapter 144D and are licensed by the department of health as a class A home care provider or a class E home care provider. Assisted living services are defined as up to 24-hour supervision, and oversight, supportive services as defined in clause (1), individualized home care aide tasks as defined in clause (2), and individualized home management tasks as defined in clause (3) provided to residents of a residential center living in their units or apartments with a full kitchen and bathroom. A full kitchen includes a stove, oven, refrigerator, food preparation counter space, and a kitchen utensil storage compartment. Assisted living services must be provided by the management of the residential center or by providers under contract with the management or with the county.

(1) Supportive services include:

(i) socialization, when socialization is part of the plan of care, has specific goals and outcomes established, and is not diversional or recreational in nature;

(ii) assisting clients in setting up meetings and appointments; and

(iii) providing transportation, when provided by the residential center only.

~~Individuals receiving assisted living services will not receive both assisted living services and homemaking services. Individualized means services are chosen and designed specifically for each resident's needs, rather than provided or offered to all residents regardless of their illnesses, disabilities, or physical conditions.~~

(2) Home care aide tasks means:

(i) preparing modified diets, such as diabetic or low sodium diets;

(ii) reminding residents to take regularly scheduled medications or to perform exercises;

(iii) household chores in the presence of technically sophisticated medical equipment or episodes of acute illness or infectious disease;

(iv) household chores when the resident's care requires the prevention of exposure to infectious disease or containment of infectious disease; and

(v) assisting with dressing, oral hygiene, hair care, grooming, and bathing, if the resident is ambulatory, and if the resident has no serious acute illness or infectious disease. Oral hygiene means care of teeth, gums, and oral prosthetic devices.

(3) Home management tasks means:

(i) housekeeping;

(ii) laundry;

(iii) preparation of regular snacks and meals; and

(iv) shopping.

Individuals receiving assisted living services shall not receive both assisted living services and homemaking services. Individualized means services are chosen and designed specifically for each resident's needs, rather than provided or offered to all residents regardless of their illnesses, disabilities, or physical conditions. Assisted living services as defined in this section shall not be authorized in boarding and lodging establishments licensed according to sections 157.011 and 157.15 to 157.22.

~~(h)~~ (h) For establishments registered under chapter 144D, assisted living services under this section means either the services described ~~and licensed in paragraph (g) and delivered by a class E home care provider licensed by the department of health or the services described under section 144A.4605 and delivered by an assisted living home care provider or a class A home care provider licensed by the commissioner of health.~~

~~(j)~~ For the purposes of this section, reimbursement (i) Payment for assisted living services and residential care services shall be a monthly rate negotiated and authorized by the county agency based on an individualized service plan for each resident and may not cover direct rent or food costs. ~~The rate~~

(1) The individualized monthly negotiated payment for assisted living services as described in subdivision 5, paragraph (g) or (h), and residential care services as described in subdivision 5, paragraph (f), shall not exceed the nonfederal share in effect on July 1 of the state fiscal year for which the rate limit is being calculated of the greater of either the statewide or any of the geographic groups' weighted average monthly medical assistance nursing facility payment rate of the case mix resident class to which the 180-day alternative care eligible client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, unless the less the maintenance needs allowance as described in subdivision 1d, paragraph (a), until the first day of the state fiscal year in which a resident assessment system, under section 256B.437, of nursing home rate determination is implemented. Effective on the first day of the state fiscal year in which a resident assessment system, under section 256B.437, of nursing home rate determination is implemented and the first day of each subsequent state fiscal year, the individualized monthly negotiated payment for the services described in this clause shall not exceed the limit described in this clause which was in effect on the last day of the previous state fiscal year and which has been adjusted by the greater of any legislatively adopted home and community-based services cost-of-living percentage increase or any legislatively adopted statewide percent rate increase for nursing facilities.

(2) The individualized monthly negotiated payment for assisted living services are provided by a home care described under section 144A.4605 and delivered by a provider licensed by the department of health as a class A home care provider or an assisted living home care provider and are provided in a building that is registered as a housing with services establishment under chapter 144D and that provides 24-hour supervision in combination with the payment for other alternative care services, including case management, must not exceed the limit specified in subdivision 4, paragraph (a), clause (6).

(k) For purposes of this section, companion services are defined as nonmedical care, supervision and oversight, provided to a functionally impaired adult. Companions may assist the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on medical care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the recipient. This service must be approved by the case manager as part of the care plan. Companion services must be provided by individuals or organizations who are under contract with the local agency to provide the service. Any person related to the waiver recipient by blood, marriage or adoption cannot be reimbursed under this service. Persons providing companion services will be monitored by the case manager.

~~(l) For purposes of this section, training for direct informal caregivers is defined as a classroom or home course of instruction which may include: transfer and lifting skills, nutrition, personal and physical cares, home safety in a home environment, stress reduction and management, behavioral management, long-term care decision making, care coordination and family dynamics. The training is provided to an informal unpaid caregiver of a 180-day eligible client which enables the caregiver to deliver care in a home setting with high levels of quality. The training must be approved by the case manager as part of the individual care plan. Individuals, agencies, and educational facilities which provide caregiver training and education will be monitored by the case manager.~~

~~(m)~~ (j) A county agency may make payment from their alternative care program allocation for "other services" provided to an alternative care program recipient if those services prevent, shorten, or delay institutionalization. These services may which include use of "discretionary funds" for services that are not otherwise defined in this section and direct cash payments to the recipient client for the purpose of purchasing the recipient's services. The following provisions apply to payments under this paragraph:

(1) a cash payment to a client under this provision cannot exceed 80 percent of the monthly payment limit for that client as specified in subdivision 4, paragraph (a), clause ~~(7)~~ (6);

(2) a county may not approve any cash payment for a client who meets either of the following:

(i) has been assessed as having a dependency in orientation, unless the client has an authorized representative under section 256.476, subdivision 2, paragraph (g), or for a client who. An "authorized representative" means an individual who is at least 18 years of age and is designated by the person or the person's legal representative to act on the person's behalf. This individual may be a family member, guardian, representative payee, or other individual designated by the person or the person's legal representative, if any, to assist in purchasing and arranging for supports; or

(ii) is concurrently receiving adult foster care, residential care, or assisted living services;

(3) any service approved under this section must be a service which meets the purpose and goals of the program as listed in subdivision 1;

~~(4) cash payments must also meet the criteria of and are governed by the procedures and liability protection established in section 256.476, subdivision 4, paragraphs (b) through (h), and recipients of cash grants must meet the requirements in section 256.476, subdivision 10; and cash payments to a person or a person's family will be provided through a monthly payment and be in the form of cash, voucher, or direct county payment to vendor. Fees or premiums assessed to the person for eligibility for health and human services are not reimbursable through this service option. Services and goods purchased through cash payments must be identified in the person's individualized care plan and must meet all of the following criteria:~~

~~(i) they must be over and above the normal cost of caring for the person if the person did not have functional limitations;~~

~~(ii) they must be directly attributable to the person's functional limitations;~~

~~(iii) they must have the potential to be effective at meeting the goals of the program;~~

~~(iv) they must be consistent with the needs identified in the individualized service plan. The service plan shall specify the needs of the person and family, the form and amount of payment, the items and services to be reimbursed, and the arrangements for management of the individual grant; and~~

~~(v) the person, the person's family, or the legal representative shall be provided sufficient information to ensure an informed choice of alternatives. The local agency shall document this information in the person's care plan, including the type and level of expenditures to be reimbursed;~~

(4) the county, lead agency under contract, or tribal government under contract to administer the alternative care program shall not be liable for damages, injuries, or liabilities sustained through the purchase of direct supports or goods by the person, the person's family, or the authorized representative with funds received through the cash payments under this section. Liabilities include, but are not limited to, workers' compensation, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA);

(5) persons receiving grants under this section shall have the following responsibilities:

(i) spend the grant money in a manner consistent with their individualized service plan with the local agency;

(ii) notify the local agency of any necessary changes in the grant-expenditures;

(iii) arrange and pay for supports; and

(iv) inform the local agency of areas where they have experienced difficulty securing or maintaining supports; and

~~(5)~~ (6) the county shall report client outcomes, services, and costs under this paragraph in a manner prescribed by the commissioner.

(k) Upon implementation of direct cash payments to clients under this section, any person determined eligible for the alternative care program who chooses a cash payment approved by the county agency shall receive the cash payment under this section and not under section 256.476 unless the person was receiving a consumer support grant under section 256.476 before implementation of direct cash payments under this section.

Sec. 20. Minnesota Statutes 2000, section 256B.0913, subdivision 6, is amended to read:

Subd. 6. [ALTERNATIVE CARE PROGRAM ADMINISTRATION.] The alternative care program is administered by the county agency. This agency is the lead agency responsible for the local administration of the alternative care program as described in this section. However, it may contract with the public health nursing service to be the lead agency. The commissioner may contract with federally recognized Indian tribes with a reservation in Minnesota to serve as the lead agency responsible for the local administration of the alternative care program as described in the contract.

Sec. 21. Minnesota Statutes 2000, section 256B.0913, subdivision 7, is amended to read:

Subd. 7. [CASE MANAGEMENT.] Providers of case management services for persons receiving services funded by the alternative care program must meet the qualification requirements and standards specified in section 256B.0915, subdivision 1b. The case manager must ensure the health and safety of the individual client and must not approve alternative care funding for a client in any setting in which the case manager cannot reasonably ensure the client's health and safety. The case manager is responsible for the cost-effectiveness of the alternative care individual care plan and must not approve any care plan in which the cost of services funded by alternative care and client contributions exceeds the limit specified in section 256B.0915, subdivision 3, paragraph (b). The county may allow a case manager employed by the county to delegate certain aspects of the case management activity to another individual employed by the county provided there is oversight of the individual by the case manager. The case manager may not delegate those aspects which require professional judgment including assessments, reassessments, and care plan development.

Sec. 22. Minnesota Statutes 2000, section 256B.0913, subdivision 8, is amended to read:

Subd. 8. [REQUIREMENTS FOR INDIVIDUAL CARE PLAN.] (a) The case manager shall implement the plan of care for each ~~180-day~~ eligible alternative care client and ensure that a client's service needs and eligibility are reassessed at least every 12 months. The plan shall include any services prescribed by the individual's attending physician as necessary to allow the individual to remain in a community setting. In developing the individual's care

plan, the case manager should include the use of volunteers from families and neighbors, religious organizations, social clubs, and civic and service organizations to support the formal home care services. The county shall be held harmless for damages or injuries sustained through the use of volunteers under this subdivision including workers' compensation liability. ~~The lead agency shall provide documentation to the commissioner verifying that the individual's alternative care is not available at that time through any other public assistance or service program.~~ The lead agency shall provide documentation in each individual's plan of care and, if requested, to the commissioner that the most cost-effective alternatives available have been offered to the individual and that the individual was free to choose among available qualified providers, both public and private. The case manager must give the individual a ten-day written notice of any decrease in or termination of alternative care services.

(b) If the county administering alternative care services is different than the county of financial responsibility, the care plan may be implemented without the approval of the county of financial responsibility.

Sec. 23. Minnesota Statutes 2000, section 256B.0913, subdivision 9, is amended to read:

Subd. 9. [CONTRACTING PROVISIONS FOR PROVIDERS.] ~~The lead agency shall document to the commissioner that the agency made reasonable efforts to inform potential providers of the anticipated need for services under the alternative care program or waiver programs under sections 256B.0915 and 256B.49, including a minimum of 14 days' written advance notice of the opportunity to be selected as a service provider and an annual public meeting with providers to explain and review the criteria for selection. The lead agency shall also document to the commissioner that the agency allowed potential providers an opportunity to be selected to contract with the county agency. Funds reimbursed to counties under this subdivision~~ Alternative care funds paid to service providers are subject to audit by the commissioner for fiscal and utilization control.

The lead agency must select providers for contracts or agreements using the following criteria and other criteria established by the county:

- (1) the need for the particular services offered by the provider;
- (2) the population to be served, including the number of clients, the length of time services will be provided, and the medical condition of clients;
- (3) the geographic area to be served;
- (4) quality assurance methods, including appropriate licensure, certification, or standards, and supervision of employees when needed;
- (5) rates for each service and unit of service exclusive of county administrative costs;
- (6) evaluation of services previously delivered by the provider; and
- (7) contract or agreement conditions, including billing requirements, cancellation, and indemnification.

The county must evaluate its own agency services under the criteria established for other providers. ~~The county shall provide a written statement of the reasons for not selecting providers.~~

Sec. 24. Minnesota Statutes 2000, section 256B.0913, subdivision 10, is amended to read:

Subd. 10. [ALLOCATION FORMULA.] (a) The alternative care appropriation for fiscal years 1992 and beyond shall cover only ~~180-day~~ alternative care eligible clients. Prior to July 1 of each year, the commissioner shall allocate to county agencies the state funds available for alternative care for persons eligible under subdivision 2.

(b) Prior to July 1 of each year, the commissioner shall allocate to county agencies the state funds available for alternative care for persons eligible under subdivision 2. The allocation for fiscal year 1992 shall be calculated using a base that is adjusted to exclude the medical assistance share of alternative care expenditures. The adjusted base is calculated by multiplying each county's allocation for fiscal year 1991 by the percentage of county alternative care expenditures for 180-day eligible clients. The percentage is determined based on expenditures for services rendered in fiscal year 1989 or calendar year 1989, whichever is greater. The adjusted base for each county is the county's current fiscal year base allocation plus any targeted funds approved during the current fiscal year. Calculations for paragraphs (c) and (d) are to be made as follows: for each county, the determination of alternative care program expenditures shall be based on payments for services rendered from April 1 through March 31 in the base year, to the extent that claims have been submitted and paid by June 1 of that year.

(c) If the county alternative care program expenditures for 180-day eligible clients as defined in paragraph (b) are 95 percent or more of its the county's adjusted base allocation, the allocation for the next fiscal year is 100 percent of the adjusted base, plus inflation to the extent that inflation is included in the state budget.

(d) If the county alternative care program expenditures for 180-day eligible clients as defined in paragraph (b) are less than 95 percent of its the county's adjusted base allocation, the allocation for the next fiscal year is the adjusted base allocation less the amount of unspent funds below the 95 percent level.

(e) ~~For fiscal year 1992 only, a county may receive an increased allocation if annualized service costs for the month of May 1991 for 180-day eligible clients are greater than the allocation otherwise determined. A county may apply for this increase by reporting projected expenditures for May to the commissioner by June 1, 1991. The amount of the allocation may exceed the amount calculated in paragraph (b). The projected expenditures for May must be based on actual 180-day eligible client caseload and the individual cost of clients' care plans. If a county does not report its expenditures for May, the amount in paragraph (c) or (d) shall be used.~~

(f) ~~Calculations for paragraphs (c) and (d) are to be made as follows: for each county, the determination of expenditures shall be based on payments for services rendered from April 1 through March 31 in the base year, to the extent that claims have been submitted by June 1 of that year. Calculations for paragraphs (c) and (d) must also include the funds transferred to the consumer support grant program for clients who have transferred to that program from April 1 through March 31 in the base year.~~

(g) ~~For the biennium ending June 30, 2001, the allocation of state funds to county agencies shall be calculated as described in paragraphs (c) and (d). If the annual legislative appropriation for the alternative care program is inadequate to fund the combined county allocations for fiscal year 2000 or 2001 a biennium, the commissioner shall distribute to each county the entire annual appropriation as that county's percentage of the computed base as calculated in ~~paragraph (f)~~ paragraphs (c) and (d).~~

Sec. 25. Minnesota Statutes 2000, section 256B.0913, subdivision 11, is amended to read:

Subd. 11. [TARGETED FUNDING.] (a) The purpose of targeted funding is to make additional money available to counties with the greatest need. Targeted funds are not intended to be distributed equitably among all counties, but rather, allocated to those with long-term care strategies that meet state goals.

(b) The funds available for targeted funding shall be the total appropriation for each fiscal year minus county allocations determined under subdivision 10 as adjusted for any inflation increases provided in appropriations for the biennium.

(c) The commissioner shall allocate targeted funds to counties that demonstrate to the satisfaction of the commissioner that they have developed feasible plans to increase alternative care spending. In making targeted funding allocations, the commissioner shall use the following priorities:

(1) counties that received a lower allocation in fiscal year 1991 than in fiscal year 1990. Counties remain in this priority until they have been restored to their fiscal year 1990 level plus inflation;

(2) counties that sustain a base allocation reduction for failure to spend 95 percent of the allocation if they demonstrate that the base reduction should be restored;

(3) counties that propose projects to divert community residents from nursing home placement or convert nursing home residents to community living; and

(4) counties that can otherwise justify program growth by demonstrating the existence of waiting lists, demographically justified needs, or other unmet needs.

(d) Counties that would receive targeted funds according to paragraph (c) must demonstrate to the commissioner's satisfaction that the funds would be appropriately spent by showing how the funds would be used to further the state's alternative care goals as described in subdivision 1, and that the county has the administrative and service delivery capability to use them.

(e) The commissioner shall request applications ~~by June 1 each year, for county agencies to apply~~ for targeted funds by November 1 of each year. The counties selected for targeted funds shall be notified of the amount of their additional funding ~~by August 1 of each year~~. Targeted funds allocated to a county agency in one year shall be treated as part of the county's base allocation for that year in determining allocations for subsequent years. No reallocations between counties shall be made.

~~(f) The allocation for each year after fiscal year 1992 shall be determined using the previous fiscal year's allocation, including any targeted funds, as the base and then applying the criteria under subdivision 10, paragraphs (c), (d), and (f), to the current year's expenditures.~~

Sec. 26. Minnesota Statutes 2000, section 256B.0913, subdivision 12, is amended to read:

Subd. 12. [CLIENT PREMIUMS.] (a) A premium is required for all ~~180-day~~ alternative care eligible clients to help pay for the cost of participating in the program. The amount of the premium for the alternative care client shall be determined as follows:

(1) when the alternative care client's income less recurring and predictable medical expenses is greater than the ~~medical assistance income standard~~ recipient's maintenance needs allowance as defined in section 256B.0915, subdivision 1d, paragraph (a), but less than 150 percent of the federal poverty guideline effective on July 1 of the state fiscal year in which the premium is being computed, and total assets are less than \$10,000, the fee is zero;

(2) when the alternative care client's income less recurring and predictable medical expenses is greater than 150 percent of the federal poverty guideline effective on July 1 of the state fiscal year in which the premium is being computed, and total assets are less than \$10,000, the fee is 25 percent of the cost of alternative care services or the difference between 150 percent of the federal poverty guideline effective on July 1 of the state fiscal year in which the premium is being computed and the client's income less recurring and predictable medical expenses, whichever is less; and

(3) when the alternative care client's total assets are greater than \$10,000, the fee is 25 percent of the cost of alternative care services.

For married persons, total assets are defined as the total marital assets less the estimated community spouse asset allowance, under section 256B.059, if applicable. For married persons, total income is defined as the client's income less the monthly spousal allotment, under section 256B.058.

All alternative care services except case management shall be included in the estimated costs for the purpose of determining 25 percent of the costs.

The monthly premium shall be calculated based on the cost of the first full month of alternative care services and shall continue unaltered until the next reassessment is completed or at the end of 12 months, whichever comes first. Premiums are due and payable each month alternative care services are received unless the actual cost of the services is less than the premium.

(b) The fee shall be waived by the commissioner when:

- (1) a person who is residing in a nursing facility is receiving case management only;
- (2) a person is applying for medical assistance;
- (3) a married couple is requesting an asset assessment under the spousal impoverishment provisions;
- (4) ~~a person is a medical assistance recipient, but has been approved for alternative care-funded assisted living services;~~
- ~~(5)~~ (5) a person is found eligible for alternative care, but is not yet receiving alternative care services; or
- ~~(6)~~ (5) a person's fee under paragraph (a) is less than \$25.

(c) The county agency must collect the premium from the client and forward the amounts collected to the commissioner in the manner and at the times prescribed by the commissioner. Money collected must be deposited in the general fund and is appropriated to the commissioner for the alternative care program. The client must supply the county with the client's social security number at the time of application. If a client fails or refuses to pay the premium due, the county shall supply the commissioner with the client's social security number and other information the commissioner requires to collect the premium from the client. The commissioner shall collect unpaid premiums using the Revenue Recapture Act in chapter 270A and other methods available to the commissioner. The commissioner may require counties to inform clients of the collection procedures that may be used by the state if a premium is not paid.

(d) The commissioner shall begin to adopt emergency or permanent rules governing client premiums within 30 days after July 1, 1991, including criteria for determining when services to a client must be terminated due to failure to pay a premium.

Sec. 27. Minnesota Statutes 2000, section 256B.0913, subdivision 13, is amended to read:

Subd. 13. [COUNTY BIENNIAL PLAN.] The county biennial plan for ~~the preadmission screening program long-term care consultation under section 256B.0911, the alternative care program under this section, and~~ waivers for the elderly under section 256B.0915, and waivers for the disabled under section 256B.49; shall be incorporated into the biennial Community Social Services Act plan and shall meet the regulations and timelines of that plan. ~~This county biennial plan shall include:~~

- ~~(1) information on the administration of the preadmission screening program;~~
- ~~(2) information on the administration of the home and community-based services waivers for the elderly under section 256B.0915, and for the disabled under section 256B.49; and~~
- ~~(3) information on the administration of the alternative care program.~~

Sec. 28. Minnesota Statutes 2000, section 256B.0913, subdivision 14, is amended to read:

Subd. 14. [REIMBURSEMENT PAYMENT AND RATE ADJUSTMENTS.] (a) Reimbursement Payment for ~~expenditures for the provided~~ alternative care services as approved by the client's case manager shall be through the invoice processing procedures of the department's Medicaid Management Information System (MMIS). To receive

reimbursement payment, the county or vendor must submit invoices within 12 months following the date of service. The county agency and its vendors under contract shall not be reimbursed for services which exceed the county allocation.

(b) If a county collects less than 50 percent of the client premiums due under subdivision 12, the commissioner may withhold up to three percent of the county's final alternative care program allocation determined under subdivisions 10 and 11.

(c) The county shall negotiate individual rates with vendors and may ~~be reimbursed~~ authorize service payment for actual costs up to ~~the greater of the county's current approved rate or 60 percent of the maximum rate in fiscal year 1994 and 65 percent of the maximum rate in fiscal year 1995 for each alternative care service.~~ Notwithstanding any other rule or statutory provision to the contrary, the commissioner shall not be authorized to increase rates by an annual inflation factor, unless so authorized by the legislature.

(d) ~~On July 1, 1993, the commissioner shall increase the maximum rate for home delivered meals to \$4.50 per meal.~~ To improve access to community services and eliminate payment disparities between the alternative care program and the elderly waiver program, the commissioner shall establish statewide maximum service rate limits and eliminate county-specific service rate limits.

(1) Effective July 1, 2001, for service rate limits, except those in subdivision 5, paragraphs (d) and (j), the rate limit for each service shall be the greater of the alternative care statewide maximum rate or the elderly waiver statewide maximum rate.

(2) Counties may negotiate individual service rates with vendors for actual costs up to the statewide maximum service rate limit.

Sec. 29. Minnesota Statutes 2000, section 256B.0915, subdivision 1d, is amended to read:

Subd. 1d. [POSTELIGIBILITY TREATMENT OF INCOME AND RESOURCES FOR ELDERLY WAIVER.]
(a) Notwithstanding the provisions of section 256B.056, the commissioner shall make the following amendment to the medical assistance elderly waiver program effective July 1, 1999, or upon federal approval, whichever is later.

A recipient's maintenance needs will be an amount equal to the Minnesota supplemental aid equivalent rate as defined in section 256I.03, subdivision 5, plus the medical assistance personal needs allowance as defined in section 256B.35, subdivision 1, paragraph (a), when applying posteligibility treatment of income rules to the gross income of elderly waiver recipients, except for individuals whose income is in excess of the special income standard according to Code of Federal Regulations, title 42, section 435.236. Recipient maintenance needs shall be adjusted under this provision each July 1.

(b) ~~The commissioner of human services shall secure approval of additional elderly waiver slots sufficient to serve persons who will qualify under the revised income standard described in paragraph (a) before implementing section 256B.0913, subdivision 16.~~

(c) ~~In implementing this subdivision, the commissioner shall consider allowing persons who would otherwise be eligible for the alternative care program but would qualify for the elderly waiver with a spenddown to remain on the alternative care program.~~

Sec. 30. Minnesota Statutes 2000, section 256B.0915, subdivision 3, is amended to read:

Subd. 3. [LIMITS OF CASES, RATES, ~~REIMBURSEMENT PAYMENTS~~, AND FORECASTING.] (a) The number of medical assistance waiver recipients that a county may serve must be allocated according to the number of medical assistance waiver cases open on July 1 of each fiscal year. Additional recipients may be served with the approval of the commissioner.

(b) The monthly limit for the cost of waived services to an individual elderly waiver client shall be the statewide average payment weighted average monthly nursing facility rate of the case mix resident class to which the elderly waiver client would be assigned under the medical assistance case mix reimbursement system. Minnesota Rules, parts 9549.0050 to 9549.0059, less the recipient's maintenance needs allowance as described in subdivision 1d, paragraph (a), until the first day of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented. Effective on the first day of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented and the first day of each subsequent state fiscal year, the monthly limit for the cost of waived services to an individual elderly waiver client shall be the rate of the case mix resident class to which the waiver client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, in effect on the last day of the previous state fiscal year, adjusted by the greater of any legislatively adopted home and community-based services cost-of-living percentage increase or any legislatively adopted statewide percent rate increase for nursing facilities.

(c) If extended medical supplies and equipment or adaptations environmental modifications are or will be purchased for an elderly waiver services recipient client, the costs may be prorated on a monthly basis throughout the year in which they are purchased for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's other waived services exceeds the monthly limit established in this paragraph (b), the annual cost of the all waived services shall be determined. In this event, the annual cost of all waived services shall not exceed 12 times the monthly limit calculated in this paragraph. The statewide average payment rate is calculated by determining the statewide average monthly nursing home rate, effective July 1 of the fiscal year in which the cost is incurred, less the statewide average monthly income of nursing home residents who are age 65 or older, and who are medical assistance recipients in the month of March of the previous state fiscal year. The annual cost divided by 12 of elderly or disabled waived services of waived services as described in paragraph (b).

(d) For a person who is a nursing facility resident at the time of requesting a determination of eligibility for elderly or disabled waived services shall be the greater of the monthly payment for: (i), a monthly conversion limit for the cost of elderly waived services may be requested. The monthly conversion limit for the cost of elderly waiver services shall be the resident class assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, for that resident in the nursing facility where the resident currently resides; or (ii) the statewide average payment of the case mix resident class to which the resident would be assigned under the medical assistance case mix reimbursement system, provided that until July 1 of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented. Effective on July 1 of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented, the monthly conversion limit for the cost of elderly waiver services shall be the per diem nursing facility rate as determined by the resident assessment system as described in section 256B.437 for that resident in the nursing facility where the resident currently resides multiplied by 365 and divided by 12, less the recipient's maintenance needs allowance as described in subdivision 1d. The limit under this clause only applies to persons discharged from a nursing facility after a minimum 30-day stay and found eligible for waived services on or after July 1, 1997. The following costs must be included in determining the total monthly costs for the waiver client:

(1) cost of all waived services, including extended medical supplies and equipment and environmental modifications; and

(2) cost of skilled nursing, home health aide, and personal care services reimbursable by medical assistance.

(e) (e) Medical assistance funding for skilled nursing services, private duty nursing, home health aide, and personal care services for waiver recipients must be approved by the case manager and included in the individual care plan.

(d) For both the elderly waiver and the nursing facility disabled waiver, a county may purchase extended supplies and equipment without prior approval from the commissioner when there is no other funding source and the supplies and equipment are specified in the individual's care plan as medically necessary to enable the individual to remain

in the community according to the criteria in Minnesota Rules, part 9505.0210, items A and B: (f) A county is not required to contract with a provider of supplies and equipment if the monthly cost of the supplies and equipment is less than \$250.

~~(e)~~ (g) The adult foster care daily rate for the elderly and disabled waivers shall be considered a difficulty of care payment and shall not include room and board. The adult foster care service rate shall be negotiated between the county agency and the foster care provider. The rate established under this section shall not exceed the state average monthly nursing home payment for the case mix classification to which the individual receiving foster care is assigned; the rate must allow for other waiver and medical assistance home care services to be authorized by the case manager. The elderly waiver payment for the foster care service in combination with the payment for all other elderly waiver services, including case management, must not exceed the limit specified in paragraph (b).

~~(f) The assisted living and residential care service rates for elderly and community alternatives for disabled individuals (CADI) waivers shall be made to the vendor as a monthly rate negotiated with the county agency based on an individualized service plan for each resident. The rate shall not exceed the nonfederal share of the greater of either the statewide or any of the geographic groups' weighted average monthly medical assistance nursing facility payment rate of the case mix resident class to which the elderly or disabled client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, unless the services are provided by a home care provider licensed by the department of health and are provided in a building that is registered as a housing with services establishment under chapter 144D and that provides 24-hour supervision. For alternative care assisted living projects established under Laws 1988, chapter 689, article 2, section 256, monthly rates may not exceed 65 percent of the greater of either the statewide or any of the geographic groups' weighted average monthly medical assistance nursing facility payment rate for the case mix resident class to which the elderly or disabled client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059. The rate may not cover direct rent or food costs.~~

(h) Payment for assisted living service shall be a monthly rate negotiated and authorized by the county agency based on an individualized service plan for each resident and may not cover direct rent or food costs.

(1) The individualized monthly negotiated payment for assisted living services as described in section 256B.0913, subdivision 5, paragraph (g) or (h), and residential care services as described in section 256B.0913, subdivision 5, paragraph (f), shall not exceed the nonfederal share, in effect on July 1 of the state fiscal year for which the rate limit is being calculated, of the greater of either the statewide or any of the geographic groups' weighted average monthly nursing facility rate of the case mix resident class to which the elderly waiver eligible client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, less the maintenance needs allowance as described in subdivision 1d, paragraph (a), until the July 1 of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented. Effective on July 1 of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented and July 1 of each subsequent state fiscal year, the individualized monthly negotiated payment for the services described in this clause shall not exceed the limit described in this clause which was in effect on June 30 of the previous state fiscal year and which has been adjusted by the greater of any legislatively adopted home and community-based services cost-of-living percentage increase or any legislatively adopted statewide percent rate increase for nursing facilities.

(2) The individualized monthly negotiated payment for assisted living services described in section 144A.4605 and delivered by a provider licensed by the department of health as a class A home care provider or an assisted living home care provider and provided in a building that is registered as a housing with services establishment under chapter 144D and that provides 24-hour supervision in combination with the payment for other elderly waiver services, including case management, must not exceed the limit specified in paragraph (b).

~~(g)~~ (i) The county shall negotiate individual service rates with vendors and may be reimbursed authorize payment for actual costs up to the greater of the county's current approved rate or 60 percent of the maximum rate in fiscal year 1994 and 65 percent of the maximum rate in fiscal year 1995 for each service within each program. Persons

or agencies must be employed by or under a contract with the county agency or the public health nursing agency of the local board of health in order to receive funding under the elderly waiver program, except as a provider of supplies and equipment when the monthly cost of the supplies and equipment is less than \$250.

~~(h) On July 1, 1993, the commissioner shall increase the maximum rate for home-delivered meals to \$4.50 per meal.~~

~~(i) (j) Reimbursement for the medical assistance recipients under the approved waiver shall be made from the medical assistance account through the invoice processing procedures of the department's Medicaid Management Information System (MMIS), only with the approval of the client's case manager. The budget for the state share of the Medicaid expenditures shall be forecasted with the medical assistance budget, and shall be consistent with the approved waiver.~~

(k) To improve access to community services and eliminate payment disparities between the alternative care program and the elderly waiver, the commissioner shall establish statewide maximum service rate limits and eliminate county-specific service rate limits.

(1) Effective July 1, 2001, for service rate limits, except those described or defined in paragraphs (g) and (h), the rate limit for each service shall be the greater of the alternative care statewide maximum rate or the elderly waiver statewide maximum rate.

(2) Counties may negotiate individual service rates with vendors for actual costs up to the statewide maximum service rate limit.

~~(j) (l) Beginning July 1, 1991, the state shall reimburse counties according to the payment schedule in section 256.025 for the county share of costs incurred under this subdivision on or after January 1, 1991, for individuals who are receiving medical assistance.~~

~~(k) For the community alternatives for disabled individuals waiver, and nursing facility disabled waivers, county may use waiver funds for the cost of minor adaptations to a client's residence or vehicle without prior approval from the commissioner if there is no other source of funding and the adaptation:~~

~~(1) is necessary to avoid institutionalization;~~

~~(2) has no utility apart from the needs of the client; and~~

~~(3) meets the criteria in Minnesota Rules, part 9505.0210, items A and B.~~

~~For purposes of this subdivision, "residence" means the client's own home, the client's family residence, or a family foster home. For purposes of this subdivision, "vehicle" means the client's vehicle, the client's family vehicle, or the client's family foster home vehicle.~~

~~(l) The commissioner shall establish a maximum rate unit for baths provided by an adult day care provider that are not included in the provider's contractual daily or hourly rate. This maximum rate must equal the home health aide extended rate and shall be paid for baths provided to clients served under the elderly and disabled waivers.~~

Sec. 31. Minnesota Statutes 2000, section 256B.0915, subdivision 5, is amended to read:

Subd. 5. [REASSESSMENTS FOR WAIVER CLIENTS.] A reassessment of a client served under the elderly ~~or disabled~~ waiver must be conducted at least every 12 months and at other times when the case manager determines that there has been significant change in the client's functioning. This may include instances where the client is discharged from the hospital.

Sec. 32. [256B.0918] [ESTABLISHMENT AND PURPOSE OF MEDICAL ASSISTANCE PILOT PROJECT ON SENIOR SERVICES.]

Subdivision 1. [ESTABLISHMENT AND PURPOSE.] The commissioner of human services shall establish a medical assistance pilot project on senior services to determine how converting the delivery of housing, supportive services, and health care for seniors into a flexible voucher program will impact public expenditures for older adult service care and provide an alternative way to purchase services based on consumer choice.

Subd. 2. [FEDERAL WAIVER AUTHORITY.] The commissioner shall apply for any necessary federal waivers or approvals to implement this pilot project. The commissioner shall submit the waiver request no later than April 15, 2002. The medical assistance pilot project on senior services shall be implemented January 1, 2003, or upon federal approval, whichever is later.

Subd. 3. [REPORT.] Participating communities and the commissioner of human services shall collaborate to prepare and issue an annual report December 1, 2003, and each December 1 thereafter, to the appropriate committee chairs in the senate and house on: (1) the use of state resources, including other funds leveraged for this initiative; (2) the status of individuals being served in the pilot project; and (3) the cost-effectiveness of the pilot project. The commissioner shall provide data that may be needed to evaluate the pilot project to communities that request the data.

Subd. 4. [SUNSET.] This section sunsets June 30, 2008.

Sec. 33. Minnesota Statutes 2000, section 256D.35, is amended by adding a subdivision to read:

Subd. 18a. [SHELTER COSTS.] "Shelter costs" means rent; manufactured home lot rentals; monthly principal, interest, insurance premiums, and property taxes due for mortgages or contracts for deed costs; costs for utilities, including heating, cooling, electricity, water, and sewage; garbage collection fees; and the basic service fee for one telephone.

Sec. 34. Minnesota Statutes 2000, section 256D.35, is amended by adding a subdivision to read:

Subd. 18b. [SHELTER NEEDY.] "Shelter needy" means that the assistance unit incurs monthly shelter costs that exceed 40 percent of the assistance unit's gross income.

Sec. 35. Minnesota Statutes 2000, section 256D.44, subdivision 5, is amended to read:

Subd. 5. [SPECIAL NEEDS.] In addition to the state standards of assistance established in subdivisions 1 to 4, payments are allowed for the following special needs of recipients of Minnesota supplemental aid who are not residents of a nursing home, a regional treatment center, or a group residential housing facility.

(a) The county agency shall pay a monthly allowance for medically prescribed diets payable under the Minnesota family investment program if the cost of those additional dietary needs cannot be met through some other maintenance benefit.

(b) Payment for nonrecurring special needs must be allowed for necessary home repairs or necessary repairs or replacement of household furniture and appliances using the payment standard of the AFDC program in effect on July 16, 1996, for these expenses, as long as other funding sources are not available.

(c) A fee for guardian or conservator service is allowed at a reasonable rate negotiated by the county or approved by the court. This rate shall not exceed five percent of the assistance unit's gross monthly income up to a maximum of \$100 per month. If the guardian or conservator is a member of the county agency staff, no fee is allowed.

(d) The county agency shall continue to pay a monthly allowance of \$68 for restaurant meals for a person who was receiving a restaurant meal allowance on June 1, 1990, and who eats two or more meals in a restaurant daily. The allowance must continue until the person has not received Minnesota supplemental aid for one full calendar month or until the person's living arrangement changes and the person no longer meets the criteria for the restaurant meal allowance, whichever occurs first.

(e) A fee of ten percent of the recipient's gross income or \$25, whichever is less, is allowed for representative payee services provided by an agency that meets the requirements under SSI regulations to charge a fee for representative payee services. This special need is available to all recipients of Minnesota supplemental aid regardless of their living arrangement.

(f) Notwithstanding the language in this subdivision, an amount equal to the maximum allotment authorized by the federal Food Stamp Program for a single individual which is in effect on the first day of January of the previous state fiscal year will be added to the standard of assistance established in subdivisions 1 to 4 for recipients of the elderly waiver program under section 256B.0915, who are shelter needy. A recipient of a federal or state housing subsidy that limits shelter costs to a percentage of gross income shall not be considered shelter needy for purposes of this provision.

Sec. 36. [INTEGRATED SERVICE ACCESS STUDY.]

By February 15, 2002, the commissioner of human services shall submit to the legislature recommendations for creating integrated service access at the county agency level for both publicly subsidized and nonsubsidized long-term care services and housing options. The report must:

(1) include a plan to integrate public funding streams to allow low-income, privately paying consumers to purchase services through a sliding fee scale; and

(2) evaluate the feasibility of statewide implementation, based upon an evaluation of public cost, consumer preferences and satisfaction, and other relevant factors.

Sec. 37. [RESPITE CARE.]

The Minnesota board on aging shall report to the legislature by February 1, 2002, on the provision of in-home and out-of-home respite care services on a sliding scale basis under the federal Older Americans Act.

Sec. 38. [APPROPRIATION.]

Subdivision 1. [SENIOR LINKAGE.] \$..... is appropriated from the general fund to the commissioner of human services for the biennium ending June 30, 2003, for the board on aging to expand services provided through Senior LinkAge.

Subd. 2. [LONG-TERM CARE CONSULTATION SERVICES.] \$..... is appropriated from the general fund to the commissioner of human services for the biennium ending June 30, 2003, to increase county allocations for long-term care consultation services.

Subd. 3. [ALTERNATIVE CARE AND ELDERLY WAIVER PROGRAMS.] \$..... is appropriated from the general fund to the commissioner of human services for the biennium ending June 30, 2003, to eliminate county-specific rates and serve additional individuals under the alternative care and elderly waiver programs.

Subd. 4. [MEDICAL ASSISTANCE PILOT PROJECT.] \$..... is appropriated from the general fund to the commissioner of human services for the biennium ending June 30, 2003, to administer the medical assistance pilot project under section 32.

Subd. 5. [IDENTIFICATION OF CRITICAL ACCESS SERVICE SITES.] \$..... is appropriated from the general fund to the commissioner of health for the biennium ending June 30, 2003, to implement section 1.

Sec. 39. [REPEALER.]

Minnesota Statutes 2000, sections 256B.0911, subdivisions 2, 2a, 4, 8, and 9; 256B.0913, subdivisions 3, 15a, 15b, 15c, and 16; and 256B.0915, subdivisions 3a, 3b, and 3c, and Minnesota Rules, parts 9505.2390, 9505.2395, 9505.2396, 9505.2400, 9505.2405, 9505.2410, 9505.2413, 9505.2415, 9505.2420, 9505.2425, 9505.2426, 9505.2430, 9505.2435, 9505.2440, 9505.2445, 9505.2450, 9505.2455, 9505.2458, 9505.2460, 9505.2465, 9505.2470, 9505.2473, 9505.2475, 9505.2480, 9505.2485, 9505.2486, 9505.2490, 9505.2495, 9505.2496, and 9505.2500, are repealed.

ARTICLE 2

LONG-TERM CARE SYSTEM REFORM AND REIMBURSEMENT

Section 1. [16A.88] [ESTABLISHMENT OF LONG-TERM CARE REVOLVING FUND.]

At the end of each state fiscal year, any unspent and unencumbered state general fund appropriations for long-term care for the elderly, including nursing facility, elderly waiver, alternative care, and home care services, must be deposited by the commissioner of finance in the long-term care enhancement fund, which is established. Money in the long-term care enhancement fund may be used only to enhance long-term care services in the state through capital or other one-time investment projects or through provider rate increases that are greater than the rate of inflation, measured by the Data Resources, Inc. forecast of the nursing home market basket index in the fourth quarter of the calendar year preceding the rate year, based on the 12-month period from the midpoint of the last rate year to the midpoint of the rate year for which funds are being appropriated. Each year that the long-term care enhancement fund is forecast to have a balance, the legislature shall designate the use of the funds.

Sec. 2. Minnesota Statutes 2000, section 144A.071, subdivision 1, is amended to read:

Subdivision 1. [FINDINGS.] The legislature declares that a moratorium on the licensure and medical assistance certification of new nursing home beds and construction projects that exceed ~~\$750,000~~ \$1,000,000 is necessary to control nursing home expenditure growth and enable the state to meet the needs of its elderly by providing high quality services in the most appropriate manner along a continuum of care.

Sec. 3. Minnesota Statutes 2000, section 144A.071, subdivision 1a, is amended to read:

Subd. 1a. [DEFINITIONS.] For purposes of sections 144A.071 to 144A.073, the following terms have the meanings given them:

- (a) "attached fixtures" has the meaning given in Minnesota Rules, part 9549.0020, subpart 6.
- (b) "buildings" has the meaning given in Minnesota Rules, part 9549.0020, subpart 7.
- (c) "capital assets" has the meaning given in section 256B.421, subdivision 16.

(d) "commenced construction" means that all of the following conditions were met: the final working drawings and specifications were approved by the commissioner of health; the construction contracts were let; a timely construction schedule was developed, stipulating dates for beginning, achieving various stages, and completing construction; and all zoning and building permits were applied for.

(e) "completion date" means the date on which a certificate of occupancy is issued for a construction project, or if a certificate of occupancy is not required, the date on which the construction project is available for facility use.

(f) "construction" means any erection, building, alteration, reconstruction, modernization, or improvement necessary to comply with the nursing home licensure rules.

(g) "construction project" means:

(1) a capital asset addition to, or replacement of a nursing home or certified boarding care home that results in new space or the remodeling of or renovations to existing facility space;

(2) the remodeling or renovation of existing facility space the use of which is modified as a result of the project described in clause (1). This existing space and the project described in clause (1) must be used for the functions as designated on the construction plans on completion of the project described in clause (1) for a period of not less than 24 months; or

(3) capital asset additions or replacements that are completed within 12 months before or after the completion date of the project described in clause (1).

(h) "new licensed" or "new certified beds" means:

(1) newly constructed beds in a facility or the construction of a new facility that would increase the total number of licensed nursing home beds or certified boarding care or nursing home beds in the state; or

(2) newly licensed nursing home beds or newly certified boarding care or nursing home beds that result from remodeling of the facility that involves relocation of beds but does not result in an increase in the total number of beds, except when the project involves the upgrade of boarding care beds to nursing home beds, as defined in section 144A.073, subdivision 1. "Remodeling" includes any of the type of conversion, renovation, replacement, or upgrading projects as defined in section 144A.073, subdivision 1.

(i) "project construction costs" means the cost of the facility capital asset additions, replacements, renovations, or remodeling projects, construction site preparation costs, and related soft costs. Project construction costs ~~also~~ include the cost of any remodeling or renovation of existing facility space which is modified as a result of the construction project. Project construction costs also includes the cost of new technology implemented as part of the construction project.

(j) "technology" means information systems or devices that make documentation, charting, and staff time more efficient or encourage and allow for care through alternative settings including, but not limited to, touch screens, monitors, hand-helds, swipe cards, motion detectors, pagers, telemedicine, medication dispensers, and equipment to monitor vital signs and self-injections, and to observe skin and other conditions.

Sec. 4. Minnesota Statutes 2000, section 144A.071, subdivision 2, is amended to read:

Subd. 2. [MORATORIUM.] The commissioner of health, in coordination with the commissioner of human services, shall deny each request for new licensed or certified nursing home or certified boarding care beds except as provided in subdivision 3 or 4a, or section 144A.073. "Certified bed" means a nursing home bed or a boarding care bed certified by the commissioner of health for the purposes of the medical assistance program, under United States Code, title 42, sections 1396 et seq.

The commissioner of human services, in coordination with the commissioner of health, shall deny any request to issue a license under section 252.28 and chapter 245A to a nursing home or boarding care home, if that license would result in an increase in the medical assistance reimbursement amount.

In addition, the commissioner of health must not approve any construction project whose cost exceeds ~~\$750,000~~ \$1,000,000 unless:

(a) any construction costs exceeding ~~\$750,000~~ \$1,000,000 are not added to the facility's appraised value and are not included in the facility's payment rate for reimbursement under the medical assistance program; or

(b) the project:

(1) has been approved through the process described in section 144A.073;

(2) meets an exception in subdivision 3 or 4a;

(3) is necessary to correct violations of state or federal law issued by the commissioner of health;

(4) is necessary to repair or replace a portion of the facility that was damaged by fire, lightning, groundshifts, or other such hazards, including environmental hazards, provided that the provisions of subdivision 4a, clause (a), are met;

(5) as of May 1, 1992, the facility has submitted to the commissioner of health written documentation evidencing that the facility meets the "commenced construction" definition as specified in subdivision 1a, clause (d), or that substantial steps have been taken prior to April 1, 1992, relating to the construction project. "Substantial steps" require that the facility has made arrangements with outside parties relating to the construction project and include the hiring of an architect or construction firm, submission of preliminary plans to the department of health or documentation from a financial institution that financing arrangements for the construction project have been made; or

(6) is being proposed by a licensed nursing facility that is not certified to participate in the medical assistance program and will not result in new licensed or certified beds.

Prior to the final plan approval of any construction project, the commissioner of health shall be provided with an itemized cost estimate for the project construction costs. If a construction project is anticipated to be completed in phases, the total estimated cost of all phases of the project shall be submitted to the commissioner and shall be considered as one construction project. Once the construction project is completed and prior to the final clearance by the commissioner, the total project construction costs for the construction project shall be submitted to the commissioner. If the final project construction cost exceeds the dollar threshold in this subdivision, the commissioner of human services shall not recognize any of the project construction costs or the related financing costs in excess of this threshold in establishing the facility's property-related payment rate.

The dollar thresholds for construction projects are as follows: for construction projects other than those authorized in clauses (1) to (6), the dollar threshold is ~~\$750,000~~ \$1,000,000. For projects authorized after July 1, 1993, under clause (1), the dollar threshold is the cost estimate submitted with a proposal for an exception under section 144A.073, plus inflation as calculated according to section 256B.431, subdivision 3f, paragraph (a). For projects authorized under clauses (2) to (4), the dollar threshold is the itemized estimate project construction costs submitted to the commissioner of health at the time of final plan approval, plus inflation as calculated according to section 256B.431, subdivision 3f, paragraph (a).

The commissioner of health shall adopt rules to implement this section or to amend the emergency rules for granting exceptions to the moratorium on nursing homes under section 144A.073.

Sec. 5. Minnesota Statutes 2000, section 144A.071, subdivision 4a, is amended to read:

Subd. 4a. [EXCEPTIONS FOR REPLACEMENT BEDS.] It is in the best interest of the state to ensure that nursing homes and boarding care homes continue to meet the physical plant licensing and certification requirements by permitting certain construction projects. Facilities should be maintained in condition to satisfy the physical and emotional needs of residents while allowing the state to maintain control over nursing home expenditure growth.

The commissioner of health in coordination with the commissioner of human services, may approve the renovation, replacement, upgrading, or relocation of a nursing home or boarding care home, under the following conditions:

(a) to license or certify beds in a new facility constructed to replace a facility or to make repairs in an existing facility that was destroyed or damaged after June 30, 1987, by fire, lightning, or other hazard provided:

(i) destruction was not caused by the intentional act of or at the direction of a controlling person of the facility;

(ii) at the time the facility was destroyed or damaged the controlling persons of the facility maintained insurance coverage for the type of hazard that occurred in an amount that a reasonable person would conclude was adequate;

(iii) the net proceeds from an insurance settlement for the damages caused by the hazard are applied to the cost of the new facility or repairs;

(iv) the new facility is constructed on the same site as the destroyed facility or on another site subject to the restrictions in section 144A.073, subdivision 5;

(v) the number of licensed and certified beds in the new facility does not exceed the number of licensed and certified beds in the destroyed facility; and

(vi) the commissioner determines that the replacement beds are needed to prevent an inadequate supply of beds.

Project construction costs incurred for repairs authorized under this clause shall not be considered in the dollar threshold amount defined in subdivision 2;

(b) to license or certify beds that are moved from one location to another within a nursing home facility, provided the total costs of remodeling performed in conjunction with the relocation of beds does not exceed ~~\$750,000~~ \$1,000,000;

(c) to license or certify beds in a project recommended for approval under section 144A.073;

(d) to license or certify beds that are moved from an existing state nursing home to a different state facility, provided there is no net increase in the number of state nursing home beds;

(e) to certify and license as nursing home beds boarding care beds in a certified boarding care facility if the beds meet the standards for nursing home licensure, or in a facility that was granted an exception to the moratorium under section 144A.073, and if the cost of any remodeling of the facility does not exceed ~~\$750,000~~ \$1,000,000. If boarding care beds are licensed as nursing home beds, the number of boarding care beds in the facility must not increase beyond the number remaining at the time of the upgrade in licensure. The provisions contained in section 144A.073 regarding the upgrading of the facilities do not apply to facilities that satisfy these requirements;

(f) to license and certify up to 40 beds transferred from an existing facility owned and operated by the Amherst H. Wilder Foundation in the city of St. Paul to a new unit at the same location as the existing facility that will serve persons with Alzheimer's disease and other related disorders. The transfer of beds may occur gradually or in stages, provided the total number of beds transferred does not exceed 40. At the time of licensure and certification of a bed or beds in the new unit, the commissioner of health shall delicense and decertify the same number of beds in the existing facility. As a condition of receiving a license or certification under this clause, the facility must make a written commitment to the commissioner of human services that it will not seek to receive an increase in its property-related payment rate as a result of the transfers allowed under this paragraph;

(g) to license and certify nursing home beds to replace currently licensed and certified boarding care beds which may be located either in a remodeled or renovated boarding care or nursing home facility or in a remodeled, renovated, newly constructed, or replacement nursing home facility within the identifiable complex of health care facilities in which the currently licensed boarding care beds are presently located, provided that the number of boarding care beds in the facility or complex are decreased by the number to be licensed as nursing home beds and further provided that, if the total costs of new construction, replacement, remodeling, or renovation exceed ten percent of the appraised value of the facility or \$200,000, whichever is less, the facility makes a written commitment to the commissioner of human services that it will not seek to receive an increase in its property-related payment rate by reason of the new construction, replacement, remodeling, or renovation. The provisions contained in section 144A.073 regarding the upgrading of facilities do not apply to facilities that satisfy these requirements;

(h) to license as a nursing home and certify as a nursing facility a facility that is licensed as a boarding care facility but not certified under the medical assistance program, but only if the commissioner of human services certifies to the commissioner of health that licensing the facility as a nursing home and certifying the facility as a nursing facility will result in a net annual savings to the state general fund of \$200,000 or more;

(i) to certify, after September 30, 1992, and prior to July 1, 1993, existing nursing home beds in a facility that was licensed and in operation prior to January 1, 1992;

(j) to license and certify new nursing home beds to replace beds in a facility acquired by the Minneapolis community development agency as part of redevelopment activities in a city of the first class, provided the new facility is located within three miles of the site of the old facility. Operating and property costs for the new facility must be determined and allowed under section 256B.431 or 256B.434;

(k) to license and certify up to 20 new nursing home beds in a community-operated hospital and attached convalescent and nursing care facility with 40 beds on April 21, 1991, that suspended operation of the hospital in April 1986. The commissioner of human services shall provide the facility with the same per diem property-related payment rate for each additional licensed and certified bed as it will receive for its existing 40 beds;

(l) to license or certify beds in renovation, replacement, or upgrading projects as defined in section 144A.073, subdivision 1, so long as the cumulative total costs of the facility's remodeling projects do not exceed ~~\$750,000~~ \$1,000,000;

(m) to license and certify beds that are moved from one location to another for the purposes of converting up to five four-bed wards to single or double occupancy rooms in a nursing home that, as of January 1, 1993, was county-owned and had a licensed capacity of 115 beds;

(n) to allow a facility that on April 16, 1993, was a 106-bed licensed and certified nursing facility located in Minneapolis to layaway all of its licensed and certified nursing home beds. These beds may be relicensed and recertified in a newly-constructed teaching nursing home facility affiliated with a teaching hospital upon approval by the legislature. The proposal must be developed in consultation with the interagency committee on long-term care planning. The beds on layaway status shall have the same status as voluntarily delicensed and decertified beds, except that beds on layaway status remain subject to the surcharge in section 256.9657. This layaway provision expires July 1, 1998;

(o) to allow a project which will be completed in conjunction with an approved moratorium exception project for a nursing home in southern Cass county and which is directly related to that portion of the facility that must be repaired, renovated, or replaced, to correct an emergency plumbing problem for which a state correction order has been issued and which must be corrected by August 31, 1993;

(p) to allow a facility that on April 16, 1993, was a 368-bed licensed and certified nursing facility located in Minneapolis to layaway, upon 30 days prior written notice to the commissioner, up to 30 of the facility's licensed and certified beds by converting three-bed wards to single or double occupancy. Beds on layaway status shall have

the same status as voluntarily delicensed and decertified beds except that beds on layaway status remain subject to the surcharge in section 256.9657, remain subject to the license application and renewal fees under section 144A.07 and shall be subject to a \$100 per bed reactivation fee. In addition, at any time within three years of the effective date of the layaway, the beds on layaway status may be:

(1) relicensed and recertified upon relocation and reactivation of some or all of the beds to an existing licensed and certified facility or facilities located in Pine River, Brainerd, or International Falls; provided that the total project construction costs related to the relocation of beds from layaway status for any facility receiving relocated beds may not exceed the dollar threshold provided in subdivision 2 unless the construction project has been approved through the moratorium exception process under section 144A.073;

(2) relicensed and recertified, upon reactivation of some or all of the beds within the facility which placed the beds in layaway status, if the commissioner has determined a need for the reactivation of the beds on layaway status.

The property-related payment rate of a facility placing beds on layaway status must be adjusted by the incremental change in its rental per diem after recalculating the rental per diem as provided in section 256B.431, subdivision 3a, paragraph (c). The property-related payment rate for a facility relicensing and recertifying beds from layaway status must be adjusted by the incremental change in its rental per diem after recalculating its rental per diem using the number of beds after the relicensing to establish the facility's capacity day divisor, which shall be effective the first day of the month following the month in which the relicensing and recertification became effective. Any beds remaining on layaway status more than three years after the date the layaway status became effective must be removed from layaway status and immediately delicensed and decertified;

(q) to license and certify beds in a renovation and remodeling project to convert 12 four-bed wards into 24 two-bed rooms, expand space, and add improvements in a nursing home that, as of January 1, 1994, met the following conditions: the nursing home was located in Ramsey county; had a licensed capacity of 154 beds; and had been ranked among the top 15 applicants by the 1993 moratorium exceptions advisory review panel. The total project construction cost estimate for this project must not exceed the cost estimate submitted in connection with the 1993 moratorium exception process;

(r) to license and certify up to 117 beds that are relocated from a licensed and certified 138-bed nursing facility located in St. Paul to a hospital with 130 licensed hospital beds located in South St. Paul, provided that the nursing facility and hospital are owned by the same or a related organization and that prior to the date the relocation is completed the hospital ceases operation of its inpatient hospital services at that hospital. After relocation, the nursing facility's status under section 256B.431, subdivision 2j, shall be the same as it was prior to relocation. The nursing facility's property-related payment rate resulting from the project authorized in this paragraph shall become effective no earlier than April 1, 1996. For purposes of calculating the incremental change in the facility's rental per diem resulting from this project, the allowable appraised value of the nursing facility portion of the existing health care facility physical plant prior to the renovation and relocation may not exceed \$2,490,000;

(s) to license and certify two beds in a facility to replace beds that were voluntarily delicensed and decertified on June 28, 1991;

(t) to allow 16 licensed and certified beds located on July 1, 1994, in a 142-bed nursing home and 21-bed boarding care home facility in Minneapolis, notwithstanding the licensure and certification after July 1, 1995, of the Minneapolis facility as a 147-bed nursing home facility after completion of a construction project approved in 1993 under section 144A.073, to be laid away upon 30 days' prior written notice to the commissioner. Beds on layaway status shall have the same status as voluntarily delicensed or decertified beds except that they shall remain subject to the surcharge in section 256.9657. The 16 beds on layaway status may be relicensed as nursing home beds and recertified at any time within five years of the effective date of the layaway upon relocation of some or all of the beds to a licensed and certified facility located in Watertown, provided that the total project construction costs related to the relocation of beds from layaway status for the Watertown facility may not exceed the dollar threshold provided in subdivision 2 unless the construction project has been approved through the moratorium exception process under section 144A.073.

The property-related payment rate of the facility placing beds on layaway status must be adjusted by the incremental change in its rental per diem after recalculating the rental per diem as provided in section 256B.431, subdivision 3a, paragraph (c). The property-related payment rate for the facility relicensing and recertifying beds from layaway status must be adjusted by the incremental change in its rental per diem after recalculating its rental per diem using the number of beds after the relicensing to establish the facility's capacity day divisor, which shall be effective the first day of the month following the month in which the relicensing and recertification became effective. Any beds remaining on layaway status more than five years after the date the layaway status became effective must be removed from layaway status and immediately delicensed and decertified;

(u) to license and certify beds that are moved within an existing area of a facility or to a newly constructed addition which is built for the purpose of eliminating three- and four-bed rooms and adding space for dining, lounge areas, bathing rooms, and ancillary service areas in a nursing home that, as of January 1, 1995, was located in Fridley and had a licensed capacity of 129 beds;

(v) to relocate 36 beds in Crow Wing county and four beds from Hennepin county to a 160-bed facility in Crow Wing county, provided all the affected beds are under common ownership;

(w) to license and certify a total replacement project of up to 49 beds located in Norman county that are relocated from a nursing home destroyed by flood and whose residents were relocated to other nursing homes. The operating cost payment rates for the new nursing facility shall be determined based on the interim and settle-up payment provisions of Minnesota Rules, part 9549.0057, and the reimbursement provisions of section 256B.431, except that subdivision 26, paragraphs (a) and (b), shall not apply until the second rate year after the settle-up cost report is filed. Property-related reimbursement rates shall be determined under section 256B.431, taking into account any federal or state flood-related loans or grants provided to the facility;

(x) to license and certify a total replacement project of up to 129 beds located in Polk county that are relocated from a nursing home destroyed by flood and whose residents were relocated to other nursing homes. The operating cost payment rates for the new nursing facility shall be determined based on the interim and settle-up payment provisions of Minnesota Rules, part 9549.0057, and the reimbursement provisions of section 256B.431, except that subdivision 26, paragraphs (a) and (b), shall not apply until the second rate year after the settle-up cost report is filed. Property-related reimbursement rates shall be determined under section 256B.431, taking into account any federal or state flood-related loans or grants provided to the facility;

(y) to license and certify beds in a renovation and remodeling project to convert 13 three-bed wards into 13 two-bed rooms and 13 single-bed rooms, expand space, and add improvements in a nursing home that, as of January 1, 1994, met the following conditions: the nursing home was located in Ramsey county, was not owned by a hospital corporation, had a licensed capacity of 64 beds, and had been ranked among the top 15 applicants by the 1993 moratorium exceptions advisory review panel. The total project construction cost estimate for this project must not exceed the cost estimate submitted in connection with the 1993 moratorium exception process;

(z) to license and certify up to 150 nursing home beds to replace an existing 285 bed nursing facility located in St. Paul. The replacement project shall include both the renovation of existing buildings and the construction of new facilities at the existing site. The reduction in the licensed capacity of the existing facility shall occur during the construction project as beds are taken out of service due to the construction process. Prior to the start of the construction process, the facility shall provide written information to the commissioner of health describing the process for bed reduction, plans for the relocation of residents, and the estimated construction schedule. The relocation of residents shall be in accordance with the provisions of law and rule;

(aa) to allow the commissioner of human services to license an additional 36 beds to provide residential services for the physically handicapped under Minnesota Rules, parts 9570.2000 to 9570.3400, in a 198-bed nursing home located in Red Wing, provided that the total number of licensed and certified beds at the facility does not increase;

(bb) to license and certify a new facility in St. Louis county with 44 beds constructed to replace an existing facility in St. Louis county with 31 beds, which has resident rooms on two separate floors and an antiquated elevator that creates safety concerns for residents and prevents nonambulatory residents from residing on the second floor. The project shall include the elimination of three- and four-bed rooms;

(cc) to license and certify four beds in a 16-bed certified boarding care home in Minneapolis to replace beds that were voluntarily delicensed and decertified on or before March 31, 1992. The licensure and certification is conditional upon the facility periodically assessing and adjusting its resident mix and other factors which may contribute to a potential institution for mental disease declaration. The commissioner of human services shall retain the authority to audit the facility at any time and shall require the facility to comply with any requirements necessary to prevent an institution for mental disease declaration, including delicensure and decertification of beds, if necessary; ~~or~~

(dd) to license and certify 72 beds in an existing facility in Mille Lacs county with 80 beds as part of a renovation project. The renovation must include construction of an addition to accommodate ten residents with beginning and midstage dementia in a self-contained living unit; creation of three resident households where dining, activities, and support spaces are located near resident living quarters; designation of four beds for rehabilitation in a self-contained area; designation of 30 private rooms; and other improvements; or

(ee) to license and certify beds in a facility that has undergone remodeling as part of a planned closure under section 256B.437.

Sec. 6. Minnesota Statutes 2000, section 144A.073, subdivision 2, is amended to read:

Subd. 2. [REQUEST FOR PROPOSALS.] At the authorization by the legislature of additional medical assistance expenditures for exceptions to the moratorium on nursing homes, the interagency committee shall publish in the State Register a request for proposals for nursing home projects to be licensed or certified under section 144A.071, subdivision 4a, clause (c). The public notice of this funding and the request for proposals must specify how the approval criteria will be prioritized by the advisory review panel, the interagency long-term care planning committee, and the commissioner. The notice must describe the information that must accompany a request and state that proposals must be submitted to the interagency committee within 90 days of the date of publication. The notice must include the amount of the legislative appropriation available for the additional costs to the medical assistance program of projects approved under this section. If no money is appropriated for a year, the interagency committee shall publish a notice to that effect, and no proposals shall be requested. If money is appropriated, the interagency committee shall initiate the application and review process described in this section at least twice each biennium and up to four times each biennium, according to dates established by rule. Authorized funds shall be allocated proportionally to the number of processes. Funds not encumbered by an earlier process within a biennium shall carry forward to subsequent iterations of the process. ~~Authorization for expenditures does not carry forward into the following biennium.~~ To be considered for approval, a proposal must include the following information:

- (1) whether the request is for renovation, replacement, upgrading, conversion, or relocation;
- (2) a description of the problem the project is designed to address;
- (3) a description of the proposed project;

(4) an analysis of projected costs of the nursing facility proposal, which are not required to exceed the cost threshold referred to in section 144A.071, subdivision 1, to be considered under this section, including initial construction and remodeling costs; site preparation costs; ~~technology costs~~; financing costs, including the current estimated long-term financing costs of the proposal, which consists of estimates of the amount and sources of money, reserves if required under the proposed funding mechanism, annual payments schedule, interest rates, length of term, closing costs and fees, insurance costs, and any completed marketing study or underwriting review; and estimated operating costs during the first two years after completion of the project;

- (5) for proposals involving replacement of all or part of a facility, the proposed location of the replacement facility and an estimate of the cost of addressing the problem through renovation;
- (6) for proposals involving renovation, an estimate of the cost of addressing the problem through replacement;
- (7) the proposed timetable for commencing construction and completing the project;
- (8) a statement of any licensure or certification issues, such as certification survey deficiencies;
- (9) the proposed relocation plan for current residents if beds are to be closed so that the department of human services can estimate the total costs of a proposal; and
- (10) other information required by permanent rule of the commissioner of health in accordance with subdivisions 4 and 8.

Sec. 7. Minnesota Statutes 2000, section 144A.073, subdivision 4, is amended to read:

Subd. 4. [CRITERIA FOR REVIEW.] The following criteria shall be used in a consistent manner to compare, evaluate, and rank all proposals submitted. Except for the criteria specified in clause (3), the application of criteria listed under this subdivision shall not reflect any distinction based on the geographic location of the proposed project:

(1) the extent to which the proposal furthers state long-term care goals, ~~including the goals stated in section 144A.31, and~~ including the goal of enhancing the availability and use of alternative care services and the goal of reducing the number of long-term care resident rooms with more than two beds;

(2) the proposal's long-term effects on state costs including the cost estimate of the project according to section 144A.071, subdivision 5a;

(3) the extent to which the proposal promotes equitable access to long-term care services in nursing homes through redistribution of the nursing home bed supply, as measured by the number of beds relative to the population 85 or older, projected to the year 2000 by the state demographer, and according to items (i) to (iv):

(i) reduce beds in counties where the supply is high, relative to the statewide mean, and increase beds in counties where the supply is low, relative to the statewide mean;

(ii) adjust the bed supply so as to create the greatest benefits in improving the distribution of beds;

(iii) adjust the existing bed supply in counties so that the bed supply in a county moves toward the statewide mean; and

(iv) adjust the existing bed supply so that the distribution of beds as projected for the year 2020 would be consistent with projected need, based on the methodology outlined in the interagency long-term care committee's ~~1993~~ nursing home bed distribution study;

(4) the extent to which the project improves conditions that affect the health or safety of residents, such as narrow corridors, narrow door frames, unenclosed fire exits, and wood frame construction, and similar provisions contained in fire and life safety codes and licensure and certification rules;

(5) the extent to which the project improves conditions that affect the comfort or quality of life of residents in a facility or the ability of the facility to provide efficient care, such as a relatively high number of residents in a room; inadequate lighting or ventilation; poor access to bathing or toilet facilities; a lack of available ancillary space for dining rooms, day rooms, or rooms used for other activities; problems relating to heating, cooling, or energy efficiency; inefficient location of nursing stations; narrow corridors; or other provisions contained in the licensure and certification rules;

(6) the extent to which the applicant demonstrates the delivery of quality care, as defined in state and federal statutes and rules, to residents as evidenced by the two most recent state agency certification surveys and the applicants' response to those surveys;

(7) the extent to which the project removes the need for waivers or variances previously granted by either the licensing agency, certifying agency, fire marshal, or local government entity; ~~and~~

(8) the extent to which the project increases the number of private or single bed rooms; and

(9) other factors that may be developed in permanent rule by the commissioner of health that evaluate and assess how the proposed project will further promote or protect the health, safety, comfort, treatment, or well-being of the facility's residents.

Sec. 8. Minnesota Statutes 2000, section 144A.073, is amended by adding a subdivision to read:

Subd. 9a. [CARRYFORWARD.] Funds appropriated for the nursing home moratorium exception process that are not authorized or have expired or are unused by the end of the biennium are carried forward to the next biennium.

Sec. 9. Minnesota Statutes 2000, section 144A.16, is amended to read:

144A.16 [CESSATION OF OPERATIONS.]

If a nursing home voluntarily plans to cease operations or to curtail operations to the extent that relocation of residents is necessary, the controlling persons of the facility shall notify the commissioner of health at least 90 days prior to the scheduled cessation or curtailment. ~~The commissioner of health shall cooperate with and advise the controlling persons of the nursing home in the resettlement of residents.~~ The commissioner of health shall notify the commissioner of human services of a nursing home's intention to cease or curtail operations. Failure to comply with this section shall be a violation of section 144A.10.

Sec. 10. [144A.185] [DEFINITIONS.]

Subdivision 1. [APPLICABILITY.] For purposes of sections 144A.185 to 144A.1889, the terms defined in this section have the meanings given them.

Subd. 2. [CLOSURE.] "Closure" means the cessation of operations of a nursing home and the delicensure or decertification of all beds within the facility.

Subd. 3. [CURTAILMENT, REDUCTION, OR CHANGE IN OPERATIONS.] "Curtailment, reduction, or change in operations" means any change in operations or services that would result in or encourage the relocation of residents.

Subd. 4. [FACILITY.] "Facility" means a licensed nursing home or a certified boarding care home licensed according to sections 144.50 to 144.56.

Subd. 5. [LICENSEE.] "Licensee" means the owner of the facility or the owner's designee or the commissioner of health for a facility in receivership.

Subd. 6. [LOCAL AGENCY.] "Local agency" means a county or a multicounty social service agency authorized under section 393.01 as the agency responsible for providing social services.

Subd. 7. [PLAN.] "Plan" means a process that has been agreed upon by the parties identified in section 144A.1855, subdivision 1, for the closure or curtailment, reduction, or change in operations of a facility and for the subsequent discharge or transfer of residents.

Subd. 8. [RELOCATION.] "Relocation" means the discharge of a resident and movement of the resident to another facility or living arrangement as a result of a closure or curtailment, reduction, or change in operations of a facility.

Subd. 9. [TRANSFER.] "Transfer" means the movement of a resident within a nursing facility from one assigned room to another.

Sec. 11. [144A.1852] [APPLICABILITY.]

Subdivision 1. [FUNDING MUST BE AVAILABLE.] Sections 144A.185 to 144A.1889 apply only when funding is made available by an appropriation of the legislature.

Subd. 2. [COORDINATION WITH OTHER LAW.] The relocation plan required under section 144A.186, subdivision 2, must be completed before a nursing home gives notice to the commissioner of health under section 144A.16.

Sec. 12. [144A.1855] [INITIAL NOTICE.]

Subdivision 1. [NOTIFICATION; PARTIES.] A licensee shall notify the following parties in writing when there is an intent to close or curtail, reduce, or change operations:

- (1) the commissioner of health;
- (2) the commissioner of human services;
- (3) the local agency;
- (4) the office of the ombudsman for older Minnesotans; and
- (5) the office of the ombudsman for mental health and mental retardation.

Subd. 2. [NOTICE REQUIREMENTS.] The written notice shall include the names, telephone numbers, fax numbers, and e-mail addresses of the persons in the facility who are responsible for coordinating the facility's efforts in the planning process and the number of residents potentially affected by the closure or curtailment, reduction, or change in operations.

Sec. 13. [144A.186] [PLANNING PROCESS.]

Subdivision 1. [LOCAL AGENCY REQUIREMENTS.] (a) A local agency, within five working days of receiving an initial notice from a licensee according to section 144A.1855, shall provide all parties identified in section 144A.1855, subdivision 1, with the names, telephone numbers, fax numbers, and e-mail addresses of those persons who are responsible for coordinating local agency efforts in the planning process.

(b) Within ten working days of receipt of the notice under paragraph (a), the local agency and licensee shall convene a meeting with representatives from the departments of health and human services, the office of the ombudsman for older Minnesotans, and the office of the ombudsman for mental health and mental retardation to develop the relocation plan under subdivision 2. The relocation plan must be completed within 45 days.

Subd. 2. [RELOCATION PLAN.] (a) The plan shall:

- (1) identify the expected date of closure or curtailment, reduction, or change in operations;
- (2) outline the process for public notification of the closure or curtailment, reduction, or change in operations;

(3) outline the process to ensure 60-day advance written notice to residents, family members, and designated representatives of residents;

(4) present an aggregate description of the resident population remaining to be transferred or relocated and the population's needs;

(5) outline the individual resident assessment process to be used;

(6) identify an inventory of available transfer or relocation options, including home and community-based services;

(7) identify a timeline for submission of the list required under section 144A.1865, subdivision 3;

(8) identify a schedule for each element of the plan; and

(9) estimate the relocation costs to the local agency and the licensee.

(b) All parties to the plan shall refrain from any public notification of the intent to close or curtail, reduce, or change operations until a relocation plan has been established.

Sec. 14. [144A.1865] [REQUIREMENTS OF LICENSEE.]

Subdivision 1. [TRANSFER AND RELOCATION.] The licensee shall provide for the safe, orderly, and appropriate transfer and relocation of residents. The licensee and facility staff shall cooperate with representatives from the local agency, the departments of health and human services, the office of the ombudsman for older Minnesotans, and the office of the ombudsman for mental health and mental retardation in planning for and implementing the transfer or relocation of residents.

Subd. 2. [INTERDISCIPLINARY TEAM.] The licensee shall establish an interdisciplinary team responsible for coordinating and implementing the plan under section 144A.186, subdivision 2. The interdisciplinary team shall include representatives from the local agency, the office of the ombudsman for older Minnesotans, facility staff who provide direct care services to the residents, and the facility administration.

Subd. 3. [RESIDENT LISTS.] The licensee shall provide a list to the local agency that includes the following information on each resident to be transferred or relocated:

(1) name;

(2) date of birth;

(3) social security number;

(4) medical assistance ID number;

(5) all diagnoses; and

(6) name of and contact information for the resident's family or other designated representative.

Subd. 4. [CONSULTATION WITH LOCAL AGENCY.] The licensee shall consult with the local agency on the availability and development of resources and in the resident transfer or relocation process.

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

Sec. 15. [144A.187] [RESIDENT AND PHYSICIAN NOTICE.]

Subdivision 1. [RESIDENT NOTICE REQUIRED.] (a) At least 60 days before the proposed date of closure or curtailment, reduction, or change in operations as agreed to in the plan under section 144A.186, the licensee shall send a written notice of closure or curtailment, reduction, or change in operations to each resident being transferred or relocated, the resident's family member or designated representative, and the resident's attending physician.

(b) The notice must include:

(1) the date of the proposed closure or curtailment, reduction, or change in operations;

(2) the name, address, telephone number, fax number, and e-mail address of the individuals in the facility responsible for providing assistance and information;

(3) a notice of upcoming meetings for residents, families, designated representatives, and resident councils to discuss the transfer or relocation of residents;

(4) the name, address, and telephone number of the local agency contact person;

(5) the name, address, and telephone number of the office of the ombudsman for older Minnesotans and the office of the ombudsman for mental health and mental retardation; and

(6) a notice of resident rights during transfer and relocation.

(c) The notice to residents must comply with all applicable state and federal requirements for notice of transfer or discharge of nursing home residents.

Subd. 2. [MEDICAL INFORMATION REQUEST.] The licensee shall request the attending physician to furnish the licensee with, or arrange for the release of, any medical information needed to update a resident's medical records and to prepare transfer forms and discharge summaries.

Sec. 16. [144A.1875] [RELOCATION OF RESIDENTS.]

Subdivision 1. [PREPARATION; PLACEMENT INFORMATION.] A licensee shall provide sufficient preparation to residents to ensure safe, orderly, and appropriate discharge and relocation. The facility is responsible for assisting residents in finding placement within the resident's desired geographic location using the Senior LinkAge database of the department of human services. The list from Senior LinkAge must contain the name, address, and telephone and fax numbers of each facility with available beds, the certification level of the available beds, the types of services available, and the number of beds that are available. The list must include home and community-based placements, services and settings, and other options for individuals with special needs. The list must be made available to residents, their families or designated representatives, the office of the ombudsman for older Minnesotans, the office of the ombudsman for mental health and mental retardation, and the local agency.

Subd. 2. [RESIDENT AND FAMILY MEETINGS.] After preparing the plan according to section 144A.186, the licensee shall conduct meetings with residents, families, designated representatives, and resident and family councils to notify them of the process for resident transfer or relocation. Representatives from the local agency, the office of the ombudsman for older Minnesotans, and the office of the ombudsman for mental health and mental retardation shall receive advance notice of these meetings.

Subd. 3. [PERSONAL PROPERTY.] (a) The licensee shall update the inventory of residents' personal possessions and provide a copy of the final inventory to each resident and the resident's family or designated representative prior to the relocation of the resident. The licensee is responsible for the timely transfer of a resident's possessions for all relocations within the state and within a 50-mile radius of the facility for relocations outside the state.

(b) The licensee shall complete a final accounting of personal funds held in trust by the licensee and provide a copy of the accounting to each resident and the resident's family or designated representative. The licensee is responsible for the timely transfer of all personal funds held in trust by the licensee.

Subd. 4. [SITE VISITS.] The licensee is responsible for assisting residents in making site visits to facilities or other placements to which the resident may be relocated, unless it is medically inadvisable, as documented by the attending physician in the resident's care record. The licensee shall provide transportation for site visits to facilities or other placements within a 50-mile radius.

Subd. 5. [FINAL NOTICE OF RELOCATION.] (a) Before relocating a resident, the licensee shall provide a final written notice to the resident, the resident's family or designated representative, and the resident's attending physician.

(b) The final written notice shall:

(1) be provided seven days before the relocation of a resident, unless the resident agrees to waive the resident's right to advance notice; and

(2) identify the date of the anticipated relocation and the location to which the resident is being transferred.

Subd. 6. [ADMINISTRATIVE DUTIES.] (a) All administrative duties of the licensee under subdivisions 1, 2, 4, and 5 must be completed before relocation of a resident.

(b) The licensee is responsible for providing the receiving facility or other health, housing, or care entity with a complete and accurate resident record, including information on family members, designated representatives, guardians, social service caseworkers, and other contact information. The record must also include all information necessary to provide appropriate medical care and social services, including, but not limited to, information on preadmission screening, Level I and Level II screening, minimum data set and all other assessments, resident diagnosis, behavior, and medication.

(c) For residents with special care needs, the licensee shall consult with the receiving facility or other placement entity and provide staff training or other preparation as needed to assist in providing for the special needs.

(d) The licensee shall assist residents with the transfer or reconnection of telephone service. The licensee shall bear all costs associated with reestablishing telephone service.

Subd. 7. [TRANSPORTATION; CONTINUITY OF CARE.] The licensee shall make arrangements or provide for the transportation of residents to the new facility or placement within the state or within a 50-mile radius for relocations outside the state. The licensee shall provide a staff person to accompany the resident during transportation, upon request of the resident, the resident's family, or designated representative. The discharge and relocation of residents must comply with all applicable state and federal requirements and must be conducted in a safe, orderly, and appropriate manner. The licensee must ensure that there is no disruption in providing meals, medications, or treatments of a resident during the relocation process.

Sec. 17. [144A.188] [TRANSFER OF RESIDENTS.]

(a) The licensee shall provide for the safe, orderly, and appropriate transfer of residents. The licensee and facility staff shall cooperate with representatives from the local agency, the departments of health and human services, the office of the ombudsman for older Minnesotans, and the office of the ombudsman for mental health and mental retardation in planning for and implementing the transfer of residents when a change in facility operation could result in or encourage multiple intrafacility transfers of individual residents.

(b) The licensee shall comply with all provisions of sections 144A.1865; 144A.187, subdivision 1; and 144A.1875, subdivision 2, applicable to residents being transferred.

Sec. 18. [144A.1885] [RELOCATION REPORTS.]

(a) Beginning the week following development of the initial relocation plan under section 144A.186, the licensee shall submit weekly status reports to the commissioners of health and human services and to the local agency.

(b) The first status report must identify the relocation plan developed under section 144A.186, the interdisciplinary team members, and the number of residents to be relocated.

(c) Subsequent status reports must note any modifications to the relocation plan, any change of interdisciplinary team members or number of residents relocated, the placement destination to which residents have been relocated, and the number of residents remaining to be relocated. Subsequent status reports must also identify issues or problems encountered during the relocation process and the resolution of these issues.

Sec. 19. [144A.1886] [REQUIREMENTS OF LOCAL AGENCY.]

Subdivision 1. [MEETING; REPRESENTATION.] (a) The local agency with the licensee shall convene a meeting to develop a plan according to section 144A.186, subdivision 1, paragraph (b).

(b) The local agency shall designate a representative to the interdisciplinary team established by the licensee responsible for coordinating the relocation efforts.

Subd. 2. [RESOURCE.] (a) The local agency shall serve as a resource in the transfer or relocation process.

(b) Concurrent with the notice sent to residents from the licensee according to section 144A.187, subdivision 1, the local agency shall provide written notice to residents, family members, and designated representatives describing:

(1) the local agency's role in the transfer or relocation process and in the follow-up to relocation;

(2) a local agency contact name, address, and telephone number; and

(3) the name, address, and telephone number of the office of the ombudsman for older Minnesotans and the office of the ombudsman for mental health and mental retardation.

(c) The local agency is responsible for the safe and orderly relocation of residents in cases where an emergent need arises or when the licensee has abrogated the licensee's responsibilities under the relocation plan.

Subd. 3. [COORDINATION; OVERSIGHT.] (a) The local agency shall meet with appropriate facility staff to coordinate any assistance. Coordination shall include participating in group meetings with residents, family members, and designated representatives to explain the transfer or relocation process.

(b) The local agency shall monitor compliance with all components of the relocation plan. When the licensee is not in compliance, the local agency shall notify the commissioners of health and human services.

(c) Except as requested by the resident, family member, or designated representative and within the parameters of the Vulnerable Adults Act, the local agency may halt a relocation that it deems inappropriate or dangerous to the health or safety of a resident.

Subd. 4. [FOLLOW-UP REVIEW.] (a) A member of the local agency staff shall visit residents within 30 days after a transfer or relocation. Local agency staff shall interview the resident and family member or designated representative or shall observe the resident on-site, or both, and review and discuss pertinent medical or social records with appropriate facility staff to assess the adjustment of the resident to the new placement, recommend services or methods to meet any special needs of the resident, and identify residents at risk.

(b) The local agency may conduct subsequent follow-up visits in cases where the adjustment of the resident to the new placement is in question.

(c) Within 60 days of the completion of the follow-up visits, the local agency shall submit a written summary of the follow-up work to the commissioners of health and human services, in a manner approved by the commissioners.

(d) The local agency shall submit a report of any issues that may require further review or monitoring to the commissioner of health.

Sec. 20. [144A.1887] [FUNDING.]

(a) Within 60 days of a nursing home ceasing operations, the commissioner of human services shall reimburse nursing homes that are reimbursed under sections 256B.431, 256B.434, and 256B.435 for operating costs incurred by the nursing home during the closure process. The amount to be reimbursed to the nursing home shall be determined by applying paragraphs (b) to (f).

(b) The facility shall provide the commissioner of human services with the nursing home's operating costs for the time period of 30 days prior to the notice specified under section 144A.16, to 30 days after the nursing home's closure.

(c) The nursing home shall provide the commissioner of human services with the number of medical assistance, Medicare, private pay, and other resident days for the period referenced in paragraph (b) by the 11 case mix categories.

(d) The commissioner of human services shall calculate a nursing home closure rate by dividing the facility operating costs in paragraph (b) by the total resident days in paragraph (c).

(e) The total closure costs attributable to medical assistance shall be determined by multiplying the nursing home closure rate in paragraph (d) by the medical assistance days provided by the nursing facility in paragraph (c).

(f) The amount to be reimbursed to the nursing home is equal to the total closure costs in paragraph (e) minus the sum of the nursing facility's 11 operating rates times their respective number of medical assistance days by case mix as referenced in paragraph (c).

Sec. 21. [144A.36] [TRANSITION PLANNING GRANTS.]

Subdivision 1. [DEFINITIONS.] "Eligible nursing home" means any nursing home licensed under sections 144A.01 to 144A.16 and certified by the appropriate authority under United States Code, title 42, sections 1396-1396p, to participate as a vendor in the medical assistance program established under chapter 256B.

Subd. 2. [GRANTS AUTHORIZED.] (a) The commissioner shall establish a program of transition planning grants to assist eligible nursing homes in implementing the provisions in paragraphs (b) to (d).

(b) Transition planning grants may be used by nursing homes to develop strategic plans which identify the appropriate institutional and noninstitutional settings necessary to meet the older adult service needs of the community.

(c) At a minimum, a strategic plan must consist of:

- (1) a needs assessment to determine what older adult services are needed and desired by the community;
- (2) an assessment of the appropriate settings in which to provide needed older adult services;
- (3) an assessment identifying currently available services and their settings in the community; and
- (4) a transition plan to achieve the needed outcome identified by the assessment.

Subd. 3. [ALLOCATION OF GRANTS.] (a) Eligible nursing homes must apply to the commissioner no later than September 1 of each fiscal year for grants awarded in that fiscal year. A grant shall be awarded upon signing of a grant contract.

(b) The commissioner must make a final decision on the funding of each application within 60 days of the deadline for receiving applications.

Subd. 4. [EVALUATION.] The commissioner shall evaluate the overall effectiveness of the grant program. The commissioner may collect, from the nursing homes receiving grants, the information necessary to evaluate the grant program. Information related to the financial condition of individual nursing homes shall be classified as nonpublic data.

Sec. 22. [144A.37] [ALTERNATIVE NURSING HOME SURVEY PROCESS.]

Subdivision 1. [ALTERNATIVE NURSING HOME SURVEY SCHEDULES.] (a) The commissioner of health shall implement alternative procedures for the nursing home survey process as authorized under this section.

(b) These alternative survey process procedures seek to: (1) use department resources more effectively and efficiently to target problem areas; (2) use other existing or new mechanisms to provide objective assessments of quality and to measure quality improvement; (3) provide for frequent collaborative interaction of facility staff and surveyors rather than a punitive approach; and (4) reward a nursing home that has performed very well by extending intervals between full surveys.

(c) The commissioner shall pursue changes in federal law necessary to accomplish this process and shall apply for any necessary federal waivers or approval. If a federal waiver is required, the commissioner shall submit a formal waiver request no later than June 15, 2001. The commissioner shall also pursue any necessary federal law changes during the 107th Congress.

(d) The alternative nursing home survey schedule shall be implemented January 1, 2002, or upon federal approval.

Subd. 2. [SURVEY INTERVALS.] The commissioner of health must extend the time period between standard surveys up to 30 months based on the criteria established in subdivision 4. In using the alternative survey schedule, the requirement for the statewide average to not exceed 12 months does not apply.

Subd. 3. [COMPLIANCE HISTORY.] The commissioner shall develop a process for identifying the survey cycles for skilled nursing facilities based upon the compliance history of the facility. This process can use a range of months for survey intervals. At a minimum, the process must be based on information from the last two survey cycles and shall take into consideration any deficiencies issued as the result of a survey or a complaint investigation during the interval. A skilled nursing facility with a finding of substandard quality of care or a finding of immediate jeopardy is not entitled to a survey interval greater than 12 months. The commissioner shall alter the survey cycle for a specific skilled nursing facility based on findings identified through the completion of a survey, a monitoring visit, or a complaint investigation. The commissioner must also take into consideration information other than the facility's compliance history.

Subd. 4. [CRITERIA FOR SURVEY INTERVAL CLASSIFICATION.] (a) The commissioner shall provide public notice of the classification process and shall identify the selected survey cycles for each skilled nursing facility. The classification system must be based on an analysis of the findings made during the past two standard survey intervals, but it only takes one survey or complaint finding to modify the interval.

(b) The commissioner shall also take into consideration information obtained from residents and family members in each skilled nursing facility and from other sources such as employees and ombudsmen in determining the appropriate survey intervals for facilities.

Subd. 5. [REQUIRED MONITORING.] (a) The commissioner shall conduct at least one monitoring visit on an annual basis for every skilled nursing facility which has been selected for a survey cycle greater than 12 months. The commissioner shall develop protocols for the monitoring visits which shall be less extensive than the requirements for a standard survey. The commissioner shall use the criteria in paragraph (b) to determine whether additional monitoring visits to a facility will be required.

(b) The criteria shall include, but not be limited to, the following:

(1) changes in ownership, administration of the facility, or direction of the facility's nursing service;

(2) changes in the facility's quality indicators which might evidence a decline in the facility's quality of care;

(3) reductions in staffing or an increase in the utilization of temporary nursing personnel; and

(4) complaint information or other information that identifies potential concerns for the quality of the care and services provided in the skilled nursing facility.

Subd. 6. [SURVEY REQUIREMENTS FOR FACILITIES NOT APPROVED FOR EXTENDED SURVEY INTERVALS.] The commissioner shall establish a process for surveying and monitoring of facilities which require a survey interval of less than 15 months. This information shall identify the steps that the commissioner must take to monitor the facility in addition to the standard survey.

Subd. 7. [IMPACT ON SURVEY AGENCY'S BUDGET.] The implementation of an alternative survey process for the state must not result in any reduction of funding that would have been provided to the state survey agency for survey and enforcement activity based upon the completion of full standard surveys for each skilled nursing facility in the state.

Subd. 8. [EDUCATIONAL ACTIVITIES.] The commissioner shall expand the state survey agency's ability to conduct training and educational efforts for skilled nursing facilities, residents and family members, residents and family councils, long-term care ombudsman programs, and the general public.

Subd. 9. [EVALUATION.] The commissioner shall develop a process for the evaluation of the effectiveness of an alternative survey process conducted under this section.

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

Sec. 23. [144A.38] [INNOVATIONS IN QUALITY DEMONSTRATION GRANTS.]

Subdivision 1. [PROGRAM ESTABLISHED.] The commissioner of health and the commissioner of human services shall establish a long-term care grant program that demonstrates best practices and innovation for long-term care service delivery and housing. The grants must fund demonstrations that create new means and models for serving the elderly or demonstrate creativity in service provision through the scope of their program or service.

Subd. 2. [ELIGIBILITY.] Grants may only be made to those who provide direct service or housing to the elderly within the state. Grants may only be made for projects that show innovations and measurable improvement in resident care, quality of life, use of technology, or customer satisfaction.

Subd. 3. [AWARDING OF GRANTS.] (a) Applications for grants must be made to the commissioner on forms prescribed by the commissioner.

(b) The commissioner shall review applications and award grants based on the following criteria:

- (1) improvement in direct care to residents;
- (2) increase in efficiency through the use of technology;
- (3) increase in quality of care through the use of technology;
- (4) increase in the access and delivery of service;
- (5) enhancement of nursing staff training;
- (6) the effectiveness of the project as a demonstration; and
- (7) the immediate transferability of the project to scale.

(c) In reviewing applications and awarding grants, the commissioner shall consult with long-term care providers, consumers of long-term care, long-term care researchers, and staff of other state agencies.

(d) Grants for eligible projects may not exceed \$100,000.

Sec. 24. [144A.39] [LONG-TERM CARE QUALITY PROFILES.]

Subdivision 1. [DEVELOPMENT AND IMPLEMENTATION OF QUALITY PROFILES.] (a) The commissioner of health and the commissioner of human services shall develop and implement a quality profile system for nursing facilities and, beginning not later than July 1, 2003, other providers of long-term care services, except when the quality profile system would duplicate requirements under sections 256B.5011 and 256B.5013. The system must be developed and implemented to the extent possible without the collection of significant amounts of new data. The system must be designed to provide information on quality:

- (1) to consumers and their families to facilitate informed choices of service providers;
- (2) to providers to enable them to measure the results of their quality improvement efforts and compare quality achievements with other service providers; and
- (3) to public and private purchasers of long-term care services to enable them to purchase high-quality care.

(b) The system must be developed in consultation with the long-term care task force and representatives of consumers, providers, and labor unions. Within the limits of available appropriations, the commissioner may employ consultants to assist with this project.

Subd. 2. [QUALITY MEASUREMENT TOOLS.] The commissioners shall identify and apply existing quality measurement tools to:

- (1) emphasize quality of care and its relationship to quality of life; and

(2) address the needs of various users of long-term care services, including, but not limited to, short-stay residents, persons with behavioral problems, persons with dementia, and persons who are members of minority groups.

The tools must be identified and applied, to the extent possible, without requiring providers to supply information beyond current state and federal requirements.

Subd. 3. [CONSUMER SURVEYS.] Following identification of the quality measurement tool, the commissioners shall conduct surveys of long-term care service consumers to develop quality profiles of providers. To the extent possible, surveys must be conducted face-to-face by state employees or contractors. At the discretion of the commissioners, surveys may be conducted by telephone or by provider staff. Surveys must be conducted periodically to update quality profiles of individual service providers.

Subd. 4. [DISSEMINATION OF QUALITY PROFILES.] By July 1, 2002, the commissioners shall implement a system to disseminate the quality profiles developed from consumer surveys using the quality measurement tool. Profiles must be disseminated to the Senior LinkAge line and to consumers, providers, and purchasers of long-term care services through all feasible printed and electronic outlets. The commissioners shall conduct a public awareness campaign to inform potential users regarding profile contents and potential uses.

Sec. 25. Minnesota Statutes 2000, section 256B.431, subdivision 2e, is amended to read:

Subd. 2e. [CONTRACTS FOR SERVICES FOR VENTILATOR DEPENDENT PERSONS.] The commissioner may contract with a nursing facility eligible to receive medical assistance payments to provide services to a ventilator-dependent person identified by the commissioner according to criteria developed by the commissioner, including:

- (1) nursing facility care has been recommended for the person by a preadmission screening team;
- (2) the person has been assessed at case mix classification K;
- ~~(3)~~ the person has been hospitalized for at least six months and no longer requires inpatient acute care hospital services; and
- ~~(4)~~ (3) the commissioner has determined that necessary services for the person cannot be provided under existing nursing facility rates.

The commissioner may issue a request for proposals to provide services to a ventilator-dependent person to nursing facilities eligible to receive medical assistance payments and shall select nursing facilities from among respondents according to criteria developed by the commissioner, including:

- (1) the cost-effectiveness and appropriateness of services;
- (2) the nursing facility's compliance with federal and state licensing and certification standards; and
- (3) the proximity of the nursing facility to a ventilator-dependent person identified by the commissioner who requires nursing facility placement.

The commissioner may negotiate an adjustment to the operating cost payment rate for a nursing facility selected by the commissioner from among respondents to the request for proposals. The negotiated adjustment must reflect only the actual additional cost of meeting the specialized care needs of a ventilator-dependent person identified by the commissioner for whom necessary services cannot be provided under existing nursing facility rates and which are not otherwise covered under Minnesota Rules, parts 9549.0010 to 9549.0080 or 9505.0170 to 9505.0475. For persons initially admitted to a nursing facility before July 1, 2001, the negotiated payment rate must not exceed 200 percent of the highest multiple bedroom payment rate for a Minnesota nursing the facility, as initially established

by the commissioner for the rate year for case mix classification K. For persons initially admitted to a nursing facility on or after July 1, 2001, the negotiated payment rate must not exceed 300 percent of the facility's multiple bedroom payment rate for case mix classification K. The negotiated adjustment shall not affect the payment rate charged to private paying residents under the provisions of section 256B.48, subdivision 1.

Sec. 26. Minnesota Statutes 2000, section 256B.431, subdivision 17, is amended to read:

Subd. 17. [SPECIAL PROVISIONS FOR MORATORIUM EXCEPTIONS.] (a) Notwithstanding Minnesota Rules, part 9549.0060, subpart 3, for rate periods beginning on October 1, 1992, and for rate years beginning after June 30, 1993, a nursing facility that (1) has completed a construction project approved under section 144A.071, subdivision 4a, clause (m); (2) has completed a construction project approved under section 144A.071, subdivision 4a, and effective after June 30, 1995; or (3) has completed a renovation, replacement, or upgrading project approved under the moratorium exception process in section 144A.073 shall be reimbursed for costs directly identified to that project as provided in subdivision 16 and this subdivision.

(b) Notwithstanding Minnesota Rules, part 9549.0060, subparts 5, item A, subitems (1) and (3), and 7, item D, allowable interest expense on debt shall include:

(1) interest expense on debt related to the cost of purchasing or replacing depreciable equipment, excluding vehicles, not to exceed six percent of the total historical cost of the project; and

(2) interest expense on debt related to financing or refinancing costs, including costs related to points, loan origination fees, financing charges, legal fees, and title searches; and issuance costs including bond discounts, bond counsel, underwriter's counsel, corporate counsel, printing, and financial forecasts. Allowable debt related to items in this clause shall not exceed seven percent of the total historical cost of the project. To the extent these costs are financed, the straight-line amortization of the costs in this clause is not an allowable cost; and

(3) interest on debt incurred for the establishment of a debt reserve fund, net of the interest earned on the debt reserve fund.

(c) Debt incurred for costs under paragraph (b) is not subject to Minnesota Rules, part 9549.0060, subpart 5, item A, subitem (5) or (6).

(d) The incremental increase in a nursing facility's rental rate, determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section, resulting from the acquisition of allowable capital assets, and allowable debt and interest expense under this subdivision shall be added to its property-related payment rate and shall be effective on the first day of the month following the month in which the moratorium project was completed.

(e) Notwithstanding subdivision 3f, paragraph (a), for rate periods beginning on October 1, 1992, and for rate years beginning after June 30, 1993, the replacement-costs-new per bed limit to be used in Minnesota Rules, part 9549.0060, subpart 4, item B, for a nursing facility that has completed a renovation, replacement, or upgrading project that has been approved under the moratorium exception process in section 144A.073, or that has completed an addition to or replacement of buildings, attached fixtures, or land improvements for which the total historical cost exceeds the lesser of \$150,000 or ten percent of the most recent appraised value, must be \$47,500 per licensed bed in multiple-bed rooms and \$71,250 per licensed bed in a single-bed room. These amounts must be adjusted annually as specified in subdivision 3f, paragraph (a), beginning January 1, 1993.

(f) For purposes of this paragraph, a total replacement means the complete replacement of the nursing facility's physical plant through the construction of a new physical plant, the transfer of the nursing facility's license from one physical plant location to another, or a new building addition to relocate beds from three- and four-bed wards. For total replacement projects completed on or after July 1, 1992, the commissioner shall compute the incremental change in the nursing facility's rental per diem, for rate years beginning on or after July 1, 1995, by replacing its appraised value, including the historical capital asset costs, and the capital debt and interest costs with the new

nursing facility's allowable capital asset costs and the related allowable capital debt and interest costs. If the new nursing facility has decreased its licensed capacity, the aggregate investment per bed limit in subdivision 3a, paragraph (c), shall apply. If the new nursing facility has retained a portion of the original physical plant for nursing facility usage, then a portion of the appraised value prior to the replacement must be retained and included in the calculation of the incremental change in the nursing facility's rental per diem. For purposes of this part, the original nursing facility means the nursing facility prior to the total replacement project. The portion of the appraised value to be retained shall be calculated according to clauses (1) to (3):

(1) The numerator of the allocation ratio shall be the square footage of the area in the original physical plant which is being retained for nursing facility usage.

(2) The denominator of the allocation ratio shall be the total square footage of the original nursing facility physical plant.

(3) Each component of the nursing facility's allowable appraised value prior to the total replacement project shall be multiplied by the allocation ratio developed by dividing clause (1) by clause (2).

In the case of either type of total replacement as authorized under section 144A.071 or 144A.073, the provisions of this subdivision shall also apply. For purposes of the moratorium exception authorized under section 144A.071, subdivision 4a, paragraph (s), if the total replacement involves the renovation and use of an existing health care facility physical plant, the new allowable capital asset costs and related debt and interest costs shall include first the allowable capital asset costs and related debt and interest costs of the renovation, to which shall be added the allowable capital asset costs of the existing physical plant prior to the renovation, and if reported by the facility, the related allowable capital debt and interest costs.

(g) Notwithstanding Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2), for a total replacement, as defined in paragraph (f), authorized under section 144A.071 or 144A.073 after July 1, 1999, or any building project that is a relocation, renovation, upgrading, or conversion ~~authorized under section 144A.073; complete on or after July 1, 2001,~~ the replacement-costs-new per bed limit shall be \$74,280 per licensed bed in multiple-bed rooms, \$92,850 per licensed bed in semiprivate rooms with a fixed partition separating the resident beds, and \$111,420 per licensed bed in single rooms. Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2), does not apply. These amounts must be adjusted annually as specified in subdivision 3f, paragraph (a), beginning January 1, 2000.

(h) For a total replacement, as defined in paragraph (f), authorized under section 144A.073 for a 96-bed nursing home in Carlton county, the replacement-costs-new per bed limit shall be \$74,280 per licensed bed in multiple-bed rooms, \$92,850 per licensed bed in semiprivate rooms with a fixed partition separating the resident's beds, and \$111,420 per licensed bed in a single room. Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2), does not apply. The resulting maximum allowable replacement-costs-new multiplied by 1.25 shall constitute the project's dollar threshold for purposes of application of the limit set forth in section 144A.071, subdivision 2. The commissioner of health may waive the requirements of section 144A.073, subdivision 3b, paragraph (b), clause (2), on the condition that the other requirements of that paragraph are met.

(i) For a renovation authorized under section 144A.073 for a 65-bed nursing home in St. Louis county, the incremental increase in rental rate for purposes of paragraph (d) shall be \$8.16, and the total replacement cost, allowable appraised value, allowable debt, and allowable interest shall be increased according to the incremental increase.

(j) For a total replacement, as defined in paragraph (f), authorized under section 144A.073 involving a new building addition that relocates beds from three-bed wards for an 80-bed nursing home in Redwood county, the replacement-costs-new per bed limit shall be \$74,280 per licensed bed for multiple-bed rooms; \$92,850 per licensed bed for semiprivate rooms with a fixed partition separating the beds; and \$111,420 per licensed bed for single rooms. These amounts shall be adjusted annually, beginning January 1, 2001. Minnesota Rules,

part 9549.0060, subpart 11, item C, subitem (2), does not apply. The resulting maximum allowable replacement-costs-new multiplied by 1.25 shall constitute the project's dollar threshold for purposes of application of the limit set forth in section 144A.071, subdivision 2. The commissioner of health may waive the requirements of section 144A.073, subdivision 3b, paragraph (b), clause (2), on the condition that the other requirements of that paragraph are met.

Sec. 27. Minnesota Statutes 2000, section 256B.431, is amended by adding a subdivision to read:

Subd. 31. [NURSING FACILITY RATE INCREASES BEGINNING JULY 1, 2001, AND JULY 1, 2002.] (a) For the rate years beginning July 1, 2001, and July 1, 2002, the commissioner shall provide each nursing facility reimbursed under this section or section 256B.434 with an adjustment to the total operating payment rates in effect on June 30, 2001, and June 30, 2002, respectively, after any increases required by section 256B.434, subdivision 4. The operating payment rate in effect on June 30, 2001, must include the adjustment in subdivision 2i, paragraph (c).

(b) The adjustment is calculated according to clauses (1) to (4):

(1) the commissioner shall calculate the arithmetic mean of all June 30, 2001, and June 30, 2002, operating rates for each facility;

(2) the commissioner shall construct an array of nursing facilities from highest to lowest according to the arithmetic mean calculated in clause (1). A numerical rank must be assigned to each facility in the array. The facility with the highest mean must be assigned a numerical rank of one. The facility with the lowest mean must be assigned a numerical rank equal to the total number of nursing facilities in the array. All other facilities must be assigned a numerical rank according to their position in the array;

(3) the amount of this rate increase for the rate year beginning July 1, 2001, is \$1 plus an amount equal to \$6.11 multiplied by the ratio of the facility's numerical rank divided by the number of facilities in the array; and

(4) the amount of this rate increase for the rate year beginning July 1, 2002, is \$1 plus an amount equal to \$6.40 multiplied by the ratio of the facility's numerical rank divided by the number of facilities in the array.

Sec. 28. Minnesota Statutes 2000, section 256B.431, is amended by adding a subdivision to read:

Subd. 32. [ADDITIONAL INCREASES FOR LOW RATE FACILITIES.] Before the calculation of the increases in subdivision 31, the commissioner must provide for special increases to facilities determined to be the lowest rate facilities in the state. The commissioner shall place all nursing facilities under section 256B.431 or 256B.434 into one of the state development regions designated under section 462.385. Within each of the development regions, the commissioner shall identify the median nursing facility rates by case mix category. Nursing home rates that are below the median must be adjusted to the greater of their current rates or 98 percent of the region median. Certified boarding care home rates that are below the median must be adjusted to the greater of their current rates or 90 percent of the region median.

Sec. 29. Minnesota Statutes 2000, section 256B.434, subdivision 4, is amended to read:

Subd. 4. [ALTERNATE RATES FOR NURSING FACILITIES.] (a) For nursing facilities which have their payment rates determined under this section rather than section 256B.431, the commissioner shall establish a rate under this subdivision. The nursing facility must enter into a written contract with the commissioner.

(b) A nursing facility's case mix payment rate for the first rate year of a facility's contract under this section is the payment rate the facility would have received under section 256B.431.

(c) A nursing facility's case mix payment rates for the second and subsequent years of a facility's contract under this section are the previous rate year's contract payment rates plus an inflation adjustment. The index for the inflation adjustment must be based on the change in the Consumer Price Index-All Items (United States City average) (CPI-U) forecasted by Data Resources, Inc., as forecasted in the fourth quarter of the calendar year preceding the rate year. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined. For the rate years beginning on July 1, 1999, ~~and July 1, 2000, July 1, 2001, and July 1, 2002,~~ this paragraph shall apply only to the property-related payment rate. In determining the amount of the property-related payment rate adjustment under this paragraph, the commissioner shall determine the proportion of the facility's rates that are property-related based on the facility's most recent cost report.

(d) The commissioner shall develop additional incentive-based payments of up to five percent above the standard contract rate for achieving outcomes specified in each contract. The specified facility-specific outcomes must be measurable and approved by the commissioner. The commissioner may establish, for each contract, various levels of achievement within an outcome. After the outcomes have been specified the commissioner shall assign various levels of payment associated with achieving the outcome. Any incentive-based payment cancels if there is a termination of the contract. In establishing the specified outcomes and related criteria the commissioner shall consider the following state policy objectives:

- (1) improved cost effectiveness and quality of life as measured by improved clinical outcomes;
- (2) successful diversion or discharge to community alternatives;
- (3) decreased acute care costs;
- (4) improved consumer satisfaction;
- (5) the achievement of quality; or
- (6) any additional outcomes proposed by a nursing facility that the commissioner finds desirable.

Sec. 30. Minnesota Statutes 2000, section 256B.434, subdivision 10, is amended to read:

Subd. 10. [EXEMPTIONS.] (a) To the extent permitted by federal law, (1) a facility that has entered into a contract under this section is not required to file a cost report, as defined in Minnesota Rules, part 9549.0020, subpart 13, for any year after the base year that is the basis for the calculation of the contract payment rate for the first rate year of the alternative payment demonstration project contract; and (2) a facility under contract is not subject to audits of historical costs or revenues, or paybacks or retroactive adjustments based on these costs or revenues, except audits, paybacks, or adjustments relating to the cost report that is the basis for calculation of the first rate year under the contract.

~~(b) A facility that is under contract with the commissioner under this section is not subject to the moratorium on licensure or certification of new nursing home beds in section 144A.071, unless the project results in a net increase in bed capacity or involves relocation of beds from one site to another. Contract payment rates must not be adjusted to reflect any additional costs that a nursing facility incurs as a result of a construction project undertaken under this paragraph. In addition, as a condition of entering into a contract under this section, a nursing facility must agree that any future medical assistance payments for nursing facility services will not reflect any additional costs attributable to the sale of a nursing facility under this section and to construction undertaken under this paragraph that otherwise would not be authorized under the moratorium in section 144A.073. Nothing in this section prevents a nursing facility participating in the alternative payment demonstration project under this section from seeking approval of an exception to the moratorium through the process established in section 144A.073, and if approved the facility's rates shall be adjusted to reflect the cost of the project. Nothing in this section prevents a nursing~~

facility participating in the alternative payment demonstration project from seeking legislative approval of an exception to the moratorium under section 144A.071, and, if enacted, the facility's rates shall be adjusted to reflect the cost of the project.

(e) Notwithstanding section 256B.48, subdivision 6, paragraphs (c), (d), and (e), and pursuant to any terms and conditions contained in the facility's contract, a nursing facility that is under contract with the commissioner under this section is in compliance with section 256B.48, subdivision 6, paragraph (b), if the facility is Medicare certified.

(d) Notwithstanding paragraph (a), if by April 1, 1996, the health care financing administration has not approved a required waiver, or the health care financing administration otherwise requires cost reports to be filed prior to the waiver's approval, the commissioner shall require a cost report for the rate year.

(d) A facility that is under contract with the commissioner under this section shall be allowed to change therapy arrangements from an unrelated vendor to a related vendor during the term of the contract. The commissioner may develop reasonable requirements designed to prevent an increase in therapy utilization for residents enrolled in the medical assistance program.

Sec. 31. [256B.4351] [CONSTRUCTION PROJECTS FOR ALTERNATIVE PAYMENT SYSTEM NURSING FACILITIES.]

(a) Beginning July 1, 2001, facilities reimbursed under section 256B.434 shall receive reimbursement for projects completed on or after July 1, 2001, as provided in this section.

(b) Facilities reimbursed under section 256B.434 that complete a project as defined in section 256B.431, subdivision 17, paragraph (e), shall receive an add-on to the total payment rate as defined in Minnesota Rules, part 9549.0070, subpart 1.

(c) The department of human services shall use the facility's most recently submitted cost report, project cost information, and rate setting processes used for projects defined in section 256B.431, subdivision 17, paragraph (e), to calculate the rate add-on.

(d) For the rate year beginning July 1, 2001, the replacement-cost-new per bed limit must be \$59,570 per licensed bed in multiple bedrooms and \$89,354 per licensed bed in a single bedroom. The replacement-cost-new per bed limits must be adjusted annually as specified in Minnesota Rules, part 9549.0060, subpart 4, item A, subitem (1), except that the index that must be used is the Bureau of the Census: Composite Fixed-Weighted Price Index as published in the C30 Report, Value of New Construction Put in Place plus ten percent.

Sec. 32. [256B.4352] [PRIVATE ROOMS.]

Subdivision 1. [FEDERAL WAIVER.] The commissioner of human services shall apply for any necessary waiver of federal Medicaid regulations or change in state plan to allow the state to cover the payment for a private or single bed room for medical assistance recipients, regardless of the medical necessity status of the recipient.

Subd. 2. [PRIVATE ROOM RATE.] Effective July 1, 2001, a private room payment rate of 130 percent of the established total payment rate for a resident must be allowed if the resident is a medical assistance recipient, subject to any limits determined under subdivision 1. Nursing facilities are prohibited from discharging residents in order to provide single bed rooms. Single bed rooms established through layaway under section 144A.071 shall not receive rate adjustments under section 256B.431, subdivision 30. Single bed rooms established through planned partial closure shall not receive rate adjustments under section 256B.437, subdivision 3, paragraph (b).

Sec. 33. [256B.437] [NURSING FACILITY VOLUNTARY CLOSURES AND PLANNING AND DEVELOPMENT OF COMMUNITY-BASED ALTERNATIVES.]

Subdivision 1. [DEFINITIONS.] (a) The definitions in this subdivision apply to subdivisions 2 to 9.

(b) "Closure" means the cessation of operations of a nursing facility and delicensure and decertification of all beds within the facility.

(c) "Commencement of closure" means the date on which the commissioner of health is notified of a planned closure according to section 144A.16 as part of an approved closure plan.

(d) "Completion of closure" means the date on which the final resident of the nursing facility or facilities designated for closure in an approved closure plan is discharged from the facility or facilities.

(e) "Closure plan" means a plan to close one or more nursing facilities and reallocate the resulting savings to provide special rate adjustments at other facilities.

(f) "Partial closure" means the delicensure and decertification of a portion of the beds within the facility.

(g) "Planned closure rate adjustment" means an increase in a nursing facility's operating rates under this section.

Subd. 2. [REGIONAL LONG-TERM CARE PLANNING AND DEVELOPMENT.] (a) The commissioner of human services shall establish a process to adjust the capacity and distribution of long-term care services to equalize the supply and demand for different types of services. The process must include community and regional planning, expansion or establishment of needed services, and voluntary nursing facility closures.

(b) The commissioner shall issue a request for proposals to contract with regional long-term care planning groups. Each group must:

(1) consist of county health and social services agencies, consumers, housing agencies, a representative of nursing facilities, a representative of home and community-based services providers, and area agencies on aging in the geographic area; and

(2) serve an area that has at least 2,000 people who are 85 years of age or older.

In awarding contracts, the commissioner shall give preference to groups that represent an entire area agency on aging region where there is not already a planning and development group established under section 256B.0917. An area not included in a proposal must be included in a group convened by the area agency on aging of that planning and service area through a contract negotiated by the commissioner.

(c) Each regional long-term care planning group shall:

(1) conduct a detailed assessment of the region's long-term care services system. This assessment must be completed within 90 days of the contract award and must evaluate the adequacy of nursing facility beds and the impact of potential nursing facility closures. The commissioner of health and the commissioner of human services, as appropriate, shall provide data to the group on nursing facility bed distribution, housing-with-service options, the closure of nursing facilities in the planning area that occur outside of the planned closure process, the approval of planned closures in the planning area, the addition of new community long-term care services in the area, the closure of existing community long-term care services in the area, and other available data;

(2) plan options for increasing community capacity to provide more home and community-based services to reduce reliance on nursing facility services;

(3) respond to a notice from a nursing facility of its intent to propose voluntary bed closures under this section. This response must consist of reviewing, assessing, and providing recommendations to the commissioner of human services, the interagency long-term care planning committee, and the nursing facility about the impact of a nursing facility closure; and

(4) develop community services alternatives to ensure that sufficient community-based services are available to meet demand.

Subd. 3. [REQUEST FOR APPLICATIONS FOR PLANNED CLOSURE OF NURSING FACILITIES.] (a) By July 15, 2001, the commissioner of human services shall publish a request for applications for closure or partial closure of nursing facilities. The request for applications must specify:

(1) the criteria that will be used by the interagency long-term care planning committee established under section 144A.31 and the commissioner to approve or reject applications;

(2) a requirement for the submission of a letter of intent before the submission of an application;

(3) the information that must accompany an application;

(4) a schedule for letters of intent, applications, and consideration of applications for a minimum of four review processes to be conducted before June 30, 2003; and

(5) that applications may combine planned closure rate adjustments with moratorium exception funding, in which case a single application may serve both purposes.

Between October 1, 2001, and June 30, 2003, the commissioner may approve planned closures of up to 4,000 nursing facility beds, with no more than 2,000 approved for closure prior to July 1, 2002.

(b) A facility or facilities reimbursed under section 256B.431, 256B.434, or 256B.435 with a closure plan approved by the commissioner under subdivision 6 may assign a planned closure rate adjustment to another facility that is not closing. The planned closure rate adjustment must be calculated under subdivision 7. A planned closure rate adjustment under this section is effective on the first day of the month following completion of closure of all facilities designated for closure in the application and becomes part of the nursing facility's total operating payment rate.

Applicants may use the planned closure rate adjustment to allow for a property payment for a new nursing facility or an addition to an existing nursing facility. Applications approved under this paragraph are exempt from other requirements for moratorium exceptions under section 144A.073, subdivisions 2 and 3.

(c) To be considered for approval, an application must include:

(1) a description of the proposed closure plan, which must include identification of the facility or facilities to receive a planned closure rate adjustment and the amount and timing of a planned closure rate adjustment proposed for each facility;

(2) the proposed timetable for any proposed closure, including the proposed dates for announcement to residents, commencement of closure, and completion of closure;

(3) the proposed relocation plan for current residents of any facility designated for closure. The proposed relocation plan must be designed to comply with all applicable state and federal statutes and regulations, including, but not limited to, section 144A.16 and Minnesota Rules, parts 4655.6810 to 4655.6830, 4658.1600 to 4658.1690, and 9546.0010 to 9546.0060;

(4) a description of the relationship between the nursing facility that is proposed for closure and the nursing facility or facilities proposed to receive the planned closure rate adjustment. If these facilities are not under common ownership, copies of any contracts, purchase agreements, or other documents establishing a relationship or proposed relationship must be provided;

(5) documentation, in a format approved by the commissioner, that all the nursing facilities receiving a planned closure rate adjustment under the plan have accepted joint and several liability for recovery of overpayments under section 256B.0641, subdivision 2, for the facilities designated for closure under the plan; and

(6) a detailed plan developed by the facility submitting the application and by:

(i) a regional long-term care planning group established under subdivision 2;

(ii) a seniors' agenda for independent living (SAIL) project under section 256B.0917; or

(iii) if a grantee under item (i) or (ii) has not been established, a group similar to the group described in subdivision 2 that is coordinated by the area agency on aging and is engaged in regional planning.

The plan must address how services will be established or expanded in the community to meet the needs of people who require long-term care or demonstrate that adequate services are already available in the community.

(d) The application must address the criteria listed in subdivision 4.

Subd. 4. [CRITERIA FOR REVIEW OF APPLICATION.] In reviewing and approving closure proposals, the commissioner of human services shall consider, but not be limited to, the following criteria:

(1) improved quality of care and quality of life for consumers;

(2) closure of a nursing facility that has a poor physical plant;

(3) the existence of excess nursing facility beds, measured in terms of beds per thousand persons aged 85 or older. The excess must be measured in reference to:

(i) the county in which the facility is located;

(ii) the county and all contiguous counties;

(iii) the region in which the facility is located; or

(iv) the facility's service area.

The facility shall indicate in its proposal the area it believes is appropriate for this measurement. A facility in a county that is in the lowest quartile of counties with reference to beds per thousand persons aged 85 or older is not in an area of excess capacity;

(4) low-occupancy rates, provided that the unoccupied beds are not the result of a personnel shortage. In analyzing occupancy rates, the commissioner shall examine waiting lists in the applicant facility and at facilities in the surrounding area, as determined under clause (3);

(5) evidence of a community planning process to determine what services are needed and ensure that needed services are established;

(6) innovative use of reinvestment funds;

(7) innovative use planned for the closed facility's physical plant;

(8) evidence that the proposal serves the interests of the state; and

(9) evidence of other factors that affect the viability of the facility, including excessive nursing pool costs.

Subd. 5. [CERTIFICATION.] Upon receipt of an application for planned closure, the commissioner of human services shall provide a copy of the application to the commissioner of health. The commissioner of health shall certify to the commissioner of human services within 30 days whether the application, if implemented, will satisfy the requirements of section 144A.16 and Minnesota Rules, parts 4655.6810 to 4655.6830 and 4658.1600 to 4658.1690. The commissioner of human services shall reject all applications for which the commissioner of health does not make the certification required under this subdivision.

Subd. 6. [REVIEW AND APPROVAL OF PROPOSALS.] (a) The interagency long-term care planning committee may recommend that the commissioner of human services grant approval, within the limits established in subdivision 3, paragraph (a), to applications that satisfy the requirements of this section. The interagency committee may appoint an advisory review panel composed of representatives of counties, SAIL projects, consumers, and providers to review proposals and provide comments and recommendations to the committee. The commissioners of human services and health shall provide staff and technical assistance to the committee for the review and analysis of proposals. The commissioners of human services and health shall jointly approve or disapprove an application within 30 days after receiving the committee's recommendations.

(b) Approval of a planned closure expires 18 months after approval by the commissioner of human services, unless commencement of closure has begun.

(c) The commissioner of human services may change any provision of the application to which all parties agree.

Subd. 7. [PLANNED CLOSURE RATE ADJUSTMENT.] The commissioner of human services shall calculate the amount of the planned closure rate adjustment available under subdivision 3, paragraph (b), according to clauses (1) to (4):

(1) the amount available is the net reduction of nursing facility beds multiplied by \$2,080;

(2) the total number of beds in the nursing facility receiving the planned closure rate adjustment must be identified;

(3) capacity days are determined by multiplying the number determined under clause (2) by 365; and

(4) the planned closure rate adjustment is the amount available in clause (1), divided by capacity days determined under clause (3).

Subd. 8. [OTHER RATE ADJUSTMENTS.] Facilities subject to this section remain eligible for any applicable rate adjustments provided under section 256B.431, 256B.434, or any other section.

Subd. 9. [COUNTY COSTS.] The commissioner of human services may allocate up to \$400 per nursing facility bed that is closing, within the limits of the appropriation specified for this purpose, to be used for relocation costs incurred by counties for planned closures under this section or resident relocation under section 144A.16. To be eligible for this allocation, a county in which a nursing facility closes must provide to the commissioner a detailed statement in a form provided by the commissioner of additional costs, not to exceed \$400 per bed closed, that are directly incurred related to the county's required role in the relocation process.

Sec. 34. Minnesota Statutes 2000, 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 that~~ a 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)(1) Charging, soliciting, accepting, or receiving from an applicant for admission to the facility, or from anyone acting in behalf of the applicant, as a condition of admission, expediting the admission, or as a requirement for the individual's continued stay, any fee, deposit, gift, money, donation, or other consideration not otherwise required as payment under the state plan;

(2) requiring an individual, or anyone acting in behalf of the individual, to loan any money to the nursing facility;

(3) requiring an individual, or anyone acting in behalf of the individual, to promise to leave all or part of the individual's estate to the facility; or

(4) requiring a third-party guarantee of payment to the facility as a condition of admission, expedited admission, or continued stay in the facility.

Nothing in this paragraph would prohibit discharge for nonpayment of services in accordance with state and federal regulations.

(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 approved by the Minnesota board of pharmacy, and may require a resident to use pharmacies that are able to meet the federal regulations 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. Notwithstanding the provisions of this paragraph, nursing facilities shall not restrict a resident's choice of pharmacy because the pharmacy utilizes a specific system of unit dose drug packing.

(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.

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. 35. Minnesota Statutes 2000, section 256B.501, is amended by adding a subdivision to read:

Subd. 14. [ICF/MR RATE INCREASES BEGINNING JULY 1, 2001, AND JULY 1, 2002.] (a) For the rate periods beginning July 1, 2001, and July 1, 2002, the commissioner shall make available to each facility reimbursed under this section, section 256B.5011, and Laws 1993, First Special Session chapter 1, article 4, section 11, an adjustment to the total operating payment rate of 3.5 percent.

(b) For each facility, the commissioner shall make available an adjustment using the percentage specified in paragraph (a) multiplied by the total payment rate, excluding the property-related payment rate in effect on the preceding June 30. The total operating payment rate shall include the adjustment provided in subdivision 12.

(c) Notwithstanding paragraph (a), for the rate increase effective July 1, 2001, the adjustment applied to the increase provided under section 256B.501, subdivision 12, shall be 6.125 percent.

(d) Any facility whose payment rates are governed by closure agreements, receivership agreements, or Minnesota Rules, part 9553.0075, is not eligible for an adjustment otherwise granted under this subdivision.

Sec. 36. Laws 1999, chapter 245, article 3, section 45, as amended by Laws 2000, chapter 312, section 3, is amended to read:

Sec. 45. [STATE LICENSURE CONFLICTS WITH FEDERAL REGULATIONS.]

(a) Notwithstanding the provisions of Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval.

(b) This section expires July 1, ~~2001~~ 2003.

Sec. 37. [PROVIDER RATE INCREASES.]

(a) The commissioner shall increase reimbursement rates by 3.5 percent each year of the biennium for the providers listed in paragraph (b). The increases shall be effective for services rendered on or after July 1 of each year.

(b) The rate increases described in this section shall be provided to home and community-based waived services for persons with mental retardation or related conditions under Minnesota Statutes, section 256B.501; home and community-based waived services for the elderly under Minnesota Statutes, section 256B.0915; waived services under community alternatives for disabled individuals under Minnesota Statutes, section 256B.49; community alternative care waived services under Minnesota Statutes, section 256B.49; traumatic brain injury waived services under Minnesota Statutes, section 256B.49; nursing services and home health services under Minnesota Statutes, section 256B.0625, subdivision 6a; personal care services and nursing supervision of personal care services under Minnesota Statutes, section 256B.0625, subdivision 19a; private-duty nursing services under Minnesota Statutes, section 256B.0625, subdivision 7; day training and habilitation services for adults with mental retardation or related conditions under Minnesota Statutes, sections 252.40 to 252.46; alternative care services under Minnesota Statutes, section 256B.0913; adult residential program grants under Minnesota Rules, parts 9535.2000 to 9535.3000; adult and family community support grants under Minnesota Rules, parts 9535.1700 to 9535.1760; the group residential housing supplementary service rate under Minnesota Statutes, section 256I.05, subdivision 1a; semi-independent living services under Minnesota Statutes, section 252.275, including SILS funding under county social services grants formerly funded under Minnesota Statutes, chapter 256I; community support services for deaf and hard-of-hearing adults with mental illness who use or wish to use sign language as their primary means of communication; and living skills training programs for persons with intractable epilepsy who need assistance in the transition to independent living.

Sec. 38. [DEVELOPMENT OF NEW NURSING FACILITY REIMBURSEMENT SYSTEM.]

(a) The commissioner of human services shall develop and report to the legislature by January 15, 2003, a system to replace the current nursing facility reimbursement system established under Minnesota Statutes, sections 256B.431, 256B.434, and 256B.435.

(b) The system must be developed in consultation with the long-term care task force and with representatives of consumers, providers, and labor unions. Within the limits of available appropriations, the commissioner may employ consultants to assist with this project.

(c) The new reimbursement system must:

(1) provide incentives to enhance quality of life and quality of care;

(2) recognize cost differences in the care of different types of populations, including subacute care and dementia care;

(3) establish rates that are sufficient without being excessive;

(4) be affordable for the state and for private-pay residents;

(5) be sensitive to changing conditions in the long-term care environment;

(6) avoid creating access problems related to insufficient funding;

(7) allow providers maximum flexibility in their business operations;

(8) recognize the need for capital investment to improve physical plants; and

(9) provide incentives for the development and use of private rooms.

(d) Notwithstanding Minnesota Statutes, section 256B.435, the commissioner must not implement a performance-based contracting system for nursing facilities prior to July 1, 2003. The commissioner shall continue to reimburse nursing facilities under Minnesota Statutes, section 256B.431 or 256B.434, until otherwise directed by law.

(e) The commissioner of human services, in consultation with the commissioner of health, shall conduct or contract for a time study to determine staff time being spent on various case mix categories; recommend adjustments to the case mix weights based on the time study data; and determine whether current staffing standards are adequate for providing quality care based on professional best practice and consumer experience. If the commissioner determines the current standards are inadequate, the commissioner shall determine an appropriate staffing standard for the various case mix categories and the financial implications of phasing into this standard over the next four years.

Sec. 39. [REPORT ON STANDARDS FOR SUBACUTE CARE FACILITY LICENSURE.]

By January 15, 2003, the commissioner of health shall submit a report to the legislature on implementation of a licensure program for subacute care. This report must include:

(1) definitions of subacute care and applicability of the proposed licensure program to various types of licensed facilities;

(2) an analysis of whether specific standards for subacute levels of care need to be developed and the potential for increased costs for existing providers of subacute care;

(3) recommendations on the applicability of the nursing home moratorium law to the licensure of subacute care facilities or programs;

(4) identification of federal regulations guiding the provision of subacute care and whether further state standards are needed; and

(5) identification of current and potential reimbursement for subacute care under Medicare, Medicaid, or managed care programs.

Sec. 40. [REGULATORY FLEXIBILITY.]

(a) By July 1, 2001, the commissioners of health and human services shall:

(1) develop a summary of federal nursing facility and community long-term care regulations that hamper state flexibility and place burdens on the goal of achieving high-quality care and optimum outcomes for consumers of services; and

(2) share this summary with the legislature, other states, national groups that advocate for state interests with Congress, and the Minnesota congressional delegation.

(b) The commissioners shall conduct ongoing follow-up with the entities to which this summary is provided and with the health care financing administration to achieve maximum regulatory flexibility, including the possibility of pilot projects to demonstrate regulatory flexibility on less than a statewide basis.

Sec. 41. [REPORT.]

By January 15, 2003, the commissioner of health and the commissioner of human services shall report to the senate health and family security committee and the house health and human services policy committee on the number of closures that have taken place under Minnesota Statutes, section 256B.437, and any other nursing facility closures that may have taken place, alternatives to nursing facility care that have been developed, any problems with access to long-term care services that have resulted, and any recommendations for continuation of the regional long-term care planning process and the closure process after June 30, 2003.

Sec. 42. [NURSING ASSISTANT; HOME HEALTH AIDE CURRICULUM.]

By January 1, 2003, the commissioner of health, in consultation with long-term care consumers, advocates, unions, and trade associations, shall present to the chairs of the legislative committees dealing with health care policy recommendations for updating the nursing assistant and home health aide curriculum (1998 edition) to help students learn front-line survival skills that support job motivation and satisfaction. These skills include, but are not limited to, working with challenging behaviors, communication skills, stress management including the impact of personal life stress in the work setting, building relationships with families, cultural competencies, and working with death and dying.

Sec. 43. [REPORT ON WAGE AND BENEFIT INCREASES.]

The commissioner of human services shall report to the chairs of the house and senate committees with jurisdiction over health and human services policy and finance by February 1, 2002, on the wage and benefit increases provided at each long-term care facility and long-term care provider as a result of reimbursement increases provided by the 2001 legislature.

Sec. 44. [EVALUATION OF REPORTING REQUIREMENTS.]

The commissioners of human services and health, in consultation with interested parties, shall evaluate long-term care provider reporting requirements, balancing the need for public accountability with the need to reduce unnecessary paperwork, and shall eliminate unnecessary reporting requirements, seeking any necessary changes in federal and state law. The commissioner shall present a progress report by February 1, 2002, to the chairs of the house and senate committees with jurisdiction over health and human services policy and finance.

Sec. 45. [APPROPRIATIONS.]

(a) The following amounts are appropriated from the general fund to the commissioner of human services for the biennium beginning July 1, 2001, for the purposes indicated:

(1) \$..... for the following purposes related to the nursing facility planned closure process:

(i) \$..... for incentive payments to nursing facilities;

(ii) \$..... for state and county administrative costs; and

(iii) \$..... for transition planning grants to nursing facilities;

(2) \$..... to develop and disseminate quality measures in nursing facilities and other long-term care settings;

(3) \$..... to develop a new nursing facility reimbursement system; and

(4) \$..... to implement the transition grant program.

(b) \$..... is appropriated from the general fund to the commissioner of health for the biennium beginning July 1, 2001, for the purposes indicated:

(1) \$..... to develop different regulatory standards for the licensure of subacute care facilities; and

(2) \$..... for implementation of an alternative survey schedule.

ARTICLE 3

WORK FORCE

Section 1. Minnesota Statutes 2000, section 116L.11, subdivision 4, is amended to read:

Subd. 4. [QUALIFYING CONSORTIUM.] "Qualifying consortium" means an entity that ~~may include~~ includes a public or private institution of higher education, ~~work force center, county,~~ and one ~~or more~~ eligible employers, ~~but must include a public or private institution of higher education and one or more eligible employers~~ employer.

Sec. 2. Minnesota Statutes 2000, section 116L.12, subdivision 4, is amended to read:

Subd. 4. [GRANTS.] Within the limits of available appropriations, the board shall make grants not to exceed \$400,000 each to qualifying consortia to operate local, regional, or statewide training and retention programs. Grants may be made from TANF funds, general fund appropriations, and any other funding sources available to the board, provided the requirements of those funding sources are satisfied. Grant awards must establish specific, measurable outcomes and timelines for achieving those outcomes.

Sec. 3. Minnesota Statutes 2000, section 116L.12, subdivision 5, is amended to read:

Subd. 5. [LOCAL MATCH REQUIREMENTS.] A consortium must ~~provide at least a 50 percent match from local resources for money appropriated under this section. The local match requirement must be satisfied on an overall program basis but need not be satisfied for each particular client. The local match requirement may be reduced for consortia that include a relatively large number of small employers whose financial contribution has been reduced in accordance with section 116L.15. In-kind services and expenditures under section 116L.13, subdivision 2, may be used to meet this local match requirement. The grant application must specify the financial contribution from each member of the consortium~~ satisfy the match requirements established in section 116L.02, paragraph (a).

Sec. 4. Minnesota Statutes 2000, section 116L.13, subdivision 1, is amended to read:

Subdivision 1. [MARKETING AND RECRUITMENT.] A qualifying consortium must implement a marketing and outreach strategy to recruit into the health care and human services fields persons from one or more of the potential employee target groups. Recruitment strategies must include:

(1) a screening process to evaluate whether potential employees may be disqualified as the result of a required background check or are otherwise unlikely to succeed in the position for which they are being recruited; and

(2) a process for modifying course work to meet the training needs of non-English-speaking persons, when appropriate.

Sec. 5. [116L.146] [EXPEDITED GRANT PROCESS.]

(a) The board may authorize grants not to exceed \$50,000 each through an expedited grant approval process to:

(1) eligible employers to provide training programs for up to 50 workers; or

(2) a public or private institution of higher education to:

(i) provide predevelopment or curriculum development for training programs prior to submission for program funding under section 116L.12;

(ii) convert an existing curriculum for distance learning through interactive television or other communication methods; or

(iii) enable a training program to be offered when it would otherwise be canceled due to an enrollment shortfall of one or two students when the program is offered in a health-related field with a documented worker shortage and is part of a training program not exceeding two years in length.

(b) The board shall develop application procedures and evaluation policies for grants made under this section.

Sec. 6. Minnesota Statutes 2000, section 144.1464, is amended to read:

144.1464 [SUMMER HEALTH CARE INTERNS.]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 7. Minnesota Statutes 2000, section 144.1496, subdivision 3, is amended to read:

Subd. 3. [LOAN FORGIVENESS.] The commissioner may accept up to ~~ten~~ 170 applicants a year. Applicants are responsible for securing their own loans. For each year of nursing education, for up to two years, applicants accepted into the loan forgiveness program may designate an agreed amount, not to exceed \$3,000, as a qualified loan. For each year that a participant practices nursing in a nursing home or intermediate care facility for persons

with mental retardation or related conditions, up to a maximum of two years, the commissioner shall annually repay an amount equal to one year of qualified loans. Participants who move from one nursing home or intermediate care facility for persons with mental retardation or related conditions to another remain eligible for loan repayment.

Sec. 8. [144.1499] [PROMOTION OF HEALTH CARE AND LONG-TERM CARE CAREERS.]

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

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

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

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

Sec. 9. [144.15] [LOAN FORGIVENESS PROGRAM FOR LICENSED PROFESSIONAL STAFF.]

Subdivision 1. [COORDINATION OF EXISTING PROGRAMS.] (a) The commissioner of health shall coordinate all loan forgiveness, grant, tuition waiver programs, and training programs available for licensed and unlicensed health care workers who work or pledge to work in long-term health care settings.

(b) Loan forgiveness, grant, tuition waiver programs, and training programs include, but are not limited to:

(1) national health services corps state loan repayment program;

(2) state rural health network reform initiative;

(3) nursing grant program;

(4) rural physicians loan forgiveness loan program;

(5) rural midlevel practitioner loan forgiveness program;

(6) nurses in nursing homes or ICFs/MRs program;

(7) rural clinic sites for nurse practitioner education;

(8) health care and human services worker training and retention program;

(9) health care and human services tuition waiver program;

(10) worker development fund; and

(11) tuition payback program established under subdivision 2.

(c) The department of health shall also serve as a clearinghouse on available programs through the dissemination of information to interested individuals and through the development and performance of public education activities and outreach.

Subd. 2. [ESTABLISHMENT OF TUITION PAYBACK PROGRAM.] The commissioner of health shall establish a health care worker tuition payback program, with grants made available to health care facilities for the purpose of: (1) reimbursing employees' cost of tuition for education needed to perform their current job functions; (2) reimbursing employees' cost of tuition to further their career development in the long-term care field; or (3) payment for past tuition debts in exchange for pledges to work within the facility for a specified period of time.

Sec. 10. Minnesota Statutes 2000, section 144A.62, subdivision 1, is amended to read:

Subdivision 1. [ASSISTANCE WITH EATING AND DRINKING.] (a) Upon federal approval, a nursing home may employ resident attendants to assist with the activities authorized under subdivision 2. The resident attendant ~~will not~~ shall be counted in the minimum staffing requirements under section 144A.04, subdivision 7.

(b) The commissioner shall submit by ~~May~~ July 15, ~~2000~~ 2001, a new request for a federal waiver necessary to implement this section.

Sec. 11. Minnesota Statutes 2000, section 144A.62, subdivision 2, is amended to read:

Subd. 2. [DEFINITION.] (a) "Resident attendant" means an individual who assists residents ~~in a nursing home~~ with ~~the one or more of the following activities of eating and drinking:~~

(1) eating and drinking; and

(2) transporting.

(b) A resident attendant does not include an individual who:

(1) is a licensed health professional or a registered dietitian;

(2) volunteers without monetary compensation; or

(3) is a registered nursing assistant.

Sec. 12. Minnesota Statutes 2000, section 144A.62, subdivision 3, is amended to read:

Subd. 3. [REQUIREMENTS.] (a) A nursing home may not use on a full-time or other paid basis any individual as a resident attendant in the nursing home unless the individual:

(1) has completed a training and competency evaluation program encompassing the ~~tasks~~ activities in subdivision 2 that the individual provides;

(2) is competent to provide ~~feeding and hydration services~~ those activities; and

(3) is under the supervision of the director of nursing.

(b) A nursing home may not use a current employee as a resident attendant unless the employee satisfies the requirements of paragraph (a) and volunteers to be used in that capacity.

Sec. 13. Minnesota Statutes 2000, section 144A.62, subdivision 4, is amended to read:

Subd. 4. [EVALUATION.] The training and competency evaluation program may be facility based. It must include, at a minimum, the training and competency standards for ~~eating and drinking assistance~~ the specific activities the attendant will be conducting contained in the nursing assistant training curriculum.

Sec. 14. [APPROPRIATIONS.]

Subdivision 1. [SUMMER HEALTH CARE INTERN PROGRAM.] \$..... is appropriated from the health care access fund to the commissioner of health for the biennium ending June 30, 2003, to expand eligibility for the summer health care intern program and to increase the number of internships funded.

Subd. 2. [NURSE LOAN FORGIVENESS PROGRAM.] \$..... is appropriated from the health care access fund to the commissioner of health for the biennium ending June 30, 2003, to expand the nurse loan forgiveness program.

Subd. 3. [MINNESOTA JOB SKILLS.] \$..... is appropriated from the general fund to the Minnesota job skills partnership board for the biennium ending June 30, 2003, to fund the health care and human services worker training program.

Sec. 15. [REPEALER.]

Minnesota Statutes 2000, sections 116L.10; and 116L.12, subdivisions 2 and 7, are repealed.

ARTICLE 4

REGULATION OF SUPPLEMENTAL NURSING SERVICES AGENCIES

Section 1. Minnesota Statutes 2000, section 144.057, is amended to read:

144.057 [BACKGROUND STUDIES ON LICENSEES AND SUPPLEMENTAL NURSING SERVICES AGENCY PERSONNEL.]

Subdivision 1. [BACKGROUND STUDIES REQUIRED.] The commissioner of health shall contract with the commissioner of human services to conduct background studies of:

(1) individuals providing services which have direct contact, as defined under section 245A.04, subdivision 3, with patients and residents in hospitals, boarding care homes, outpatient surgical centers licensed under sections 144.50 to 144.58; nursing homes and home care agencies licensed under chapter 144A; residential care homes licensed under chapter 144B, and board and lodging establishments that are registered to provide supportive or health supervision services under section 157.17; ~~and~~

(2) beginning July 1, 1999, all other employees in nursing homes licensed under chapter 144A, and boarding care homes licensed under sections 144.50 to 144.58. A disqualification of an individual in this section shall disqualify the individual from positions allowing direct contact or access to patients or residents receiving services;

(3) individuals employed by a supplemental nursing services agency, as defined under section 144A.70, who are providing services in health care facilities; and

(4) controlling persons of a supplemental nursing services agency, as defined under section 144A.70.

If a facility or program is licensed by the department of human services and subject to the background study provisions of chapter 245A and is also licensed by the department of health, the department of human services is solely responsible for the background studies of individuals in the jointly licensed programs.

Subd. 2. [RESPONSIBILITIES OF DEPARTMENT OF HUMAN SERVICES.] The department of human services shall conduct the background studies required by subdivision 1 in compliance with the provisions of chapter 245A and Minnesota Rules, parts 9543.3000 to 9543.3090. For the purpose of this section, the term "residential program" shall include all facilities described in subdivision 1. The department of human services shall provide necessary forms and instructions, shall conduct the necessary background studies of individuals, and shall provide notification of the results of the studies to the facilities, supplemental nursing services agencies, individuals, and the commissioner of health. Individuals shall be disqualified under the provisions of chapter 245A and Minnesota Rules, parts 9543.3000 to 9543.3090. If an individual is disqualified, the department of human services shall notify the facility, the supplemental nursing services agency, and the individual and shall inform the individual of the right to request a reconsideration of the disqualification by submitting the request to the department of health.

Subd. 3. [RECONSIDERATIONS.] The commissioner of health shall review and decide reconsideration requests, including the granting of variances, in accordance with the procedures and criteria contained in chapter 245A and Minnesota Rules, parts 9543.3000 to 9543.3090. The commissioner's decision shall be provided to the individual and to the department of human services. The commissioner's decision to grant or deny a reconsideration of disqualification is the final administrative agency action.

Subd. 4. [RESPONSIBILITIES OF FACILITIES AND AGENCIES.] Facilities and agencies described in subdivision 1 shall be responsible for cooperating with the departments in implementing the provisions of this section. The responsibilities imposed on applicants and licensees under chapter 245A and Minnesota Rules, parts 9543.3000 to 9543.3090, shall apply to these facilities and supplemental nursing services agencies. The provision of section 245A.04, subdivision 3, paragraph (e), shall apply to applicants, licensees, registrants, or an individual's refusal to cooperate with the completion of the background studies. Supplemental nursing services agencies subject to the registration requirements in section 144A.71 must maintain records verifying compliance with the background study requirements under this section.

Sec. 2. [144A.70] [REGISTRATION OF SUPPLEMENTAL NURSING SERVICES AGENCIES; DEFINITIONS.]

Subdivision 1. [SCOPE.] As used in sections 144A.70 to 144A.74, the terms defined in this section have the meanings given them.

Subd. 2. [COMMISSIONER.] "Commissioner" means the commissioner of health.

Subd. 3. [CONTROLLING PERSON.] "Controlling person" means a business entity, officer, program administrator, or director whose responsibilities include the direction of the management or policies of a supplemental nursing services agency. Controlling person also means an individual who, directly or indirectly, beneficially owns an interest in a corporation, partnership, or other business association that is a controlling person.

Subd. 4. [HEALTHCARE FACILITY.] "Health care facility" means a hospital, boarding care home, or outpatient surgical center licensed under sections 144.50 to 144.58, a nursing home or home care agency licensed under this chapter, a residential care home, or a board and lodging establishment that is registered to provide supportive or health supervision services under section 157.17.

Subd. 5. [PERSON.] "Person" includes an individual, firm, corporation, partnership, or association.

Subd. 6. [SUPPLEMENTAL NURSING SERVICES AGENCY.] "Supplemental nursing services agency" means a person, firm, corporation, partnership, or association engaged for hire in the business of providing or procuring temporary employment in health care facilities for nurses, nursing assistants, nurse aides, and orderlies. Supplemental nursing services agency does not include an individual who only engages in providing the individual's services on a temporary basis to health care facilities. Supplemental nursing services agency also does not include any nursing services agency that is limited to providing temporary nursing personnel solely to one or more health care facilities owned or operated by the same person, firm, corporation, or partnership.

Sec. 3. [144A.71] [SUPPLEMENTAL NURSING SERVICES AGENCY REGISTRATION.]

Subdivision 1. [DUTY TO REGISTER.] A person who operates a supplemental nursing services agency shall register the agency with the commissioner. Each separate location of the business of a supplemental nursing services agency shall register the agency with the commissioner. Each separate location of the business of a supplemental nursing services agency shall have a separate registration.

Subd. 2. [APPLICATION INFORMATION AND FEE.] The commissioner shall establish forms and procedures for processing each supplemental nursing services agency registration application. An application for a supplemental nursing services agency registration must include at least the following:

- (1) the names and addresses of the owner or owners of the supplemental nursing services agency;
- (2) if the owner is a corporation, copies of its articles of incorporation and current bylaws, together with the names and addresses of its officers and directors;
- (3) any other relevant information that the commissioner determines is necessary to properly evaluate an application for registration; and
- (4) the annual registration fee for a supplemental nursing services agency, which is \$.....

Subd. 3. [REGISTRATION NOT TRANSFERABLE.] A registration issued by the commissioner according to this section is effective for a period of one year from the date of its issuance unless the registration is revoked or suspended under section 144A.72, subdivision 2, or unless the supplemental nursing services agency is sold or ownership or management is transferred. When a supplemental nursing services agency is sold or ownership or management is transferred, the registration of the agency must be voided and the new owner or operator may apply for a new registration.

Sec. 4. [144A.72] [REGISTRATION REQUIREMENTS.]

The commissioner shall require that, as a condition of registration:

- (1) the supplemental nursing services agency shall document that each temporary employee provided to health care facilities currently meets the minimum licensing, training, and continuing education standards for the position in which the employee will be working;
- (2) the supplemental nursing services agency shall comply with all pertinent requirements relating to the health and other qualifications of personnel employed in health care facilities;
- (3) the supplemental nursing services agency must not restrict in any manner the employment opportunities of its employees;
- (4) the supplemental nursing services agency, when supplying temporary employees to a health care facility, and when requested by the facility to do so, shall agree that at least 30 percent of the total personnel hours supplied are during night, holiday, or weekend shifts;
- (5) the supplemental nursing services agency shall carry medical malpractice insurance to insure against the loss, damage, or expense incident to a claim arising out of the death or injury of any person as the result of negligence or malpractice in the provision of health care services by the supplemental nursing services agency or by any employee of the agency; and
- (6) the supplemental nursing services agency must not, in any contract with any employee or health care facility, require the payment of liquidated damages, employment fees, or other compensation should the employee be hired as a permanent employee of a health care facility.

Sec. 5. [144A.73] [COMPLAINT SYSTEM.]

The commissioner shall establish a system for reporting complaints against a supplemental nursing services agency or its employees. Complaints may be made by any member of the public. Written complaints must be forwarded to the employer of each person against whom a complaint is made. The employer shall promptly report to the commissioner any corrective action taken.

Sec. 6. [144A.74] [MAXIMUM CHARGES.]

A supplemental nursing services agency must not bill or receive payments from a nursing home licensed under this chapter at a rate higher than 150 percent of the weighted average wage rate for the applicable employee classification for the geographic group to which the nursing home is assigned under chapter 256B. The weighted average wage rates must be determined by the commissioner of human services and reported to the commissioner of health on an annual basis. Facilities shall provide information necessary to determine weighted average wage rates to the commissioner of human services in a format requested by the commissioner. The maximum rate must include all charges for administrative fees, contract fees, or other special charges in addition to the hourly rates for the temporary nursing pool personnel supplied to a nursing home.

Sec. 7. Minnesota Statutes 2000, section 245A.04, subdivision 3, is amended to read:

Subd. 3. [BACKGROUND STUDY OF THE APPLICANT; DEFINITIONS.] (a) Before the commissioner issues a license, the commissioner shall conduct a study of the individuals specified in paragraph ~~(e)~~ (d), clauses (1) to (5), according to rules of the commissioner.

Beginning January 1, 1997, the commissioner shall also conduct a study of employees providing direct contact services for nonlicensed personal care provider organizations described in paragraph ~~(e)~~ (d), clause (5).

The commissioner shall recover the cost of these background studies through a fee of no more than \$12 per study charged to the personal care provider organization.

Beginning August 1, 1997, the commissioner shall conduct all background studies required under this chapter for adult foster care providers who are licensed by the commissioner of human services and registered under chapter 144D. The commissioner shall conduct these background studies in accordance with this chapter. The commissioner shall initiate a pilot project to conduct up to 5,000 background studies under this chapter in programs with joint licensure as home and community-based services and adult foster care for people with developmental disabilities when the license holder does not reside in the foster care residence.

(b) Beginning July 1, 1998, the commissioner shall conduct a background study on individuals specified in paragraph ~~(e)~~ (d), clauses (1) to (5), who perform direct contact services in a nursing home or a home care agency licensed under chapter 144A or a boarding care home licensed under sections 144.50 to 144.58, when the subject of the study resides outside Minnesota; the study must be at least as comprehensive as that of a Minnesota resident and include a search of information from the criminal justice data communications network in the state where the subject of the study resides.

(c) Beginning August 1, 2001, the commissioner shall conduct all background studies required under this chapter and initiated by supplemental nursing services agencies registered under chapter 144A. Studies for the agencies must be initiated annually by each agency. The commissioner shall conduct the background studies according to this chapter. The commissioner shall recover the cost of the background studies through a fee of no more than \$..... per study, charged to the supplemental nursing services agency.

(d) The applicant, license holder, ~~the registrant~~, bureau of criminal apprehension, ~~the~~ commissioner of health, and county agencies, after written notice to the individual who is the subject of the study, shall help with the study by giving the commissioner criminal conviction data and reports about the maltreatment of adults substantiated under section 626.557 and the maltreatment of minors in licensed programs substantiated under section 626.556.

The individuals to be studied shall include:

- (1) the applicant;
- (2) persons over the age of 13 living in the household where the licensed program will be provided;
- (3) current employees or contractors of the applicant who will have direct contact with persons served by the facility, agency, or program;
- (4) volunteers or student volunteers who have direct contact with persons served by the program to provide program services, if the contact is not directly supervised by the individuals listed in clause (1) or (3); and
- (5) any person who, as an individual or as a member of an organization, exclusively offers, provides, or arranges for personal care assistant services under the medical assistance program as authorized under sections 256B.04, subdivision 16, and 256B.0625, subdivision 19a.

The juvenile courts shall also help with the study by giving the commissioner existing juvenile court records on individuals described in clause (2) relating to delinquency proceedings held within either the five years immediately preceding the application or the five years immediately preceding the individual's 18th birthday, whichever time period is longer. The commissioner shall destroy juvenile records obtained pursuant to this subdivision when the subject of the records reaches age 23.

For purposes of this section and Minnesota Rules, part 9543.3070, a finding that a delinquency petition is proven in juvenile court shall be considered a conviction in state district court.

For purposes of this subdivision, "direct contact" means providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by a program. For purposes of this subdivision, "directly supervised" means an individual listed in clause (1), (3), or (5) is within sight or hearing of a volunteer to the extent that the individual listed in clause (1), (3), or (5) is capable at all times of intervening to protect the health and safety of the persons served by the program who have direct contact with the volunteer.

A study of an individual in clauses (1) to (5) shall be conducted at least upon application for initial license or registration and reapplication for a license or registration. The commissioner is not required to conduct a study of an individual at the time of reapplication for a license or if the individual has been continuously affiliated with a foster care provider licensed by the commissioner of human services and registered under chapter 144D, other than a family day care or foster care license, if: (i) a study of the individual was conducted either at the time of initial licensure or when the individual became affiliated with the license holder; (ii) the individual has been continuously affiliated with the license holder since the last study was conducted; and (iii) the procedure described in paragraph ~~(d)~~ (e) has been implemented and was in effect continuously since the last study was conducted. For the purposes of this section, a physician licensed under chapter 147 is considered to be continuously affiliated upon the license holder's receipt from the commissioner of health or human services of the physician's background study results. For individuals who are required to have background studies under clauses (1) to (5) and who have been continuously affiliated with a foster care provider that is licensed in more than one county, criminal conviction data may be shared among those counties in which the foster care programs are licensed. A county agency's receipt of criminal conviction data from another county agency shall meet the criminal data background study requirements of this section.

The commissioner may also conduct studies on individuals specified in clauses (3) and (4) when the studies are initiated by:

- (i) personnel pool agencies;
- (ii) temporary personnel agencies;

- (iii) educational programs that train persons by providing direct contact services in licensed programs; and
- (iv) professional services agencies that are not licensed and which contract with licensed programs to provide direct contact services or individuals who provide direct contact services.

Studies on individuals in items (i) to (iv) must be initiated annually by these agencies, programs, and individuals. Except for personal care provider organizations and supplemental nursing services agencies, no applicant, license holder, or individual who is the subject of the study shall pay any fees required to conduct the study.

(1) At the option of the licensed facility, rather than initiating another background study on an individual required to be studied who has indicated to the licensed facility that a background study by the commissioner was previously completed, the facility may make a request to the commissioner for documentation of the individual's background study status, provided that:

- (i) the facility makes this request using a form provided by the commissioner;
- (ii) in making the request the facility informs the commissioner that either:
 - (A) the individual has been continuously affiliated with a licensed facility since the individual's previous background study was completed, or since October 1, 1995, whichever is shorter; or
 - (B) the individual is affiliated only with a personnel pool agency, a temporary personnel agency, an educational program that trains persons by providing direct contact services in licensed programs, or a professional services agency that is not licensed and which contracts with licensed programs to provide direct contact services or individuals who provide direct contact services; and
- (iii) the facility provides notices to the individual as required in paragraphs (a) to ~~(d)~~ (e), and that the facility is requesting written notification of the individual's background study status from the commissioner.

(2) The commissioner shall respond to each request under paragraph (1) with a written or electronic notice to the facility and the study subject. If the commissioner determines that a background study is necessary, the study shall be completed without further request from a licensed agency or notifications to the study subject.

(3) When a background study is being initiated by a licensed facility or a foster care provider that is also registered under chapter 144D, a study subject affiliated with multiple licensed facilities may attach to the background study form a cover letter indicating the additional facilities' names, addresses, and background study identification numbers. When the commissioner receives such notices, each facility identified by the background study subject shall be notified of the study results. The background study notice sent to the subsequent agencies shall satisfy those facilities' responsibilities for initiating a background study on that individual.

~~(d)~~ (e) If an individual who is affiliated with a program or facility regulated by the department of human services or department of health or who is affiliated with a nonlicensed personal care provider organization, is convicted of a crime constituting a disqualification under subdivision 3d, the probation officer or corrections agent shall notify the commissioner of the conviction. The commissioner, in consultation with the commissioner of corrections, shall develop forms and information necessary to implement this paragraph and shall provide the forms and information to the commissioner of corrections for distribution to local probation officers and corrections agents. The commissioner shall inform individuals subject to a background study that criminal convictions for disqualifying crimes will be reported to the commissioner by the corrections system. A probation officer, corrections agent, or corrections agency is not civilly or criminally liable for disclosing or failing to disclose the information required by this paragraph. Upon receipt of disqualifying information, the commissioner shall provide the notifications required in subdivision 3a, as appropriate to agencies on record as having initiated a background study or making a request for documentation of the background study status of the individual. This paragraph does not apply to family day care and child foster care programs.

~~(e)~~ (f) The individual who is the subject of the study must provide the applicant or license holder with sufficient information to ensure an accurate study including the individual's first, middle, and last name; home address, city, county, and state of residence for the past five years; zip code; sex; date of birth; and driver's license number. The applicant or license holder shall provide this information about an individual in paragraph ~~(e)~~ (d), clauses (1) to (5), on forms prescribed by the commissioner. By January 1, 2000, for background studies conducted by the department of human services, the commissioner shall implement a system for the electronic transmission of: (1) background study information to the commissioner; and (2) background study results to the license holder. The commissioner may request additional information of the individual, which shall be optional for the individual to provide, such as the individual's social security number or race.

~~(f)~~ (g) Except for child foster care, adult foster care, and family day care homes, a study must include information related to names of substantiated perpetrators of maltreatment of vulnerable adults that has been received by the commissioner as required under section 626.557, subdivision 9c, paragraph (i), and the commissioner's records relating to the maltreatment of minors in licensed programs, information from juvenile courts as required in paragraph ~~(e)~~ (d) for persons listed in paragraph ~~(e)~~ (d), clause (2), and information from the bureau of criminal apprehension. For child foster care, adult foster care, and family day care homes, the study must include information from the county agency's record of substantiated maltreatment of adults, and the maltreatment of minors, information from juvenile courts as required in paragraph ~~(e)~~ (d) for persons listed in paragraph ~~(e)~~ (d), clause (2), and information from the bureau of criminal apprehension. The commissioner may also review arrest and investigative information from the bureau of criminal apprehension, the commissioner of health, a county attorney, county sheriff, county agency, local chief of police, other states, the courts, or the Federal Bureau of Investigation if the commissioner has reasonable cause to believe the information is pertinent to the disqualification of an individual listed in paragraph ~~(e)~~ (d), clauses (1) to (5). The commissioner is not required to conduct more than one review of a subject's records from the Federal Bureau of Investigation if a review of the subject's criminal history with the Federal Bureau of Investigation has already been completed by the commissioner and there has been no break in the subject's affiliation with the license holder who initiated the background studies.

When the commissioner has reasonable cause to believe that further pertinent information may exist on the subject, the subject shall provide a set of classifiable fingerprints obtained from an authorized law enforcement agency. For purposes of requiring fingerprints, the commissioner shall be considered to have reasonable cause under, but not limited to, the following circumstances:

- (1) information from the bureau of criminal apprehension indicates that the subject is a multistate offender;
- (2) information from the bureau of criminal apprehension indicates that multistate offender status is undetermined; or
- (3) the commissioner has received a report from the subject or a third party indicating that the subject has a criminal history in a jurisdiction other than Minnesota.

~~(g)~~ (h) An applicant's ~~or~~ license holder's, ~~or~~ registrant's failure or refusal to cooperate with the commissioner is reasonable cause to disqualify a subject, deny a license application or immediately suspend, suspend, or revoke a license or registration. Failure or refusal of an individual to cooperate with the study is just cause for denying or terminating employment of the individual if the individual's failure or refusal to cooperate could cause the applicant's application to be denied or the license holder's license to be immediately suspended, suspended, or revoked.

~~(h)~~ (i) The commissioner shall not consider an application to be complete until all of the information required to be provided under this subdivision has been received.

~~(i)~~ (j) No person in paragraph ~~(e)~~ (d), clause (1), (2), (3), (4), or (5), who is disqualified as a result of this section may be retained by the agency in a position involving direct contact with persons served by the program.

~~(j)~~ (k) Termination of persons in paragraph ~~(c)~~ (d), clause (1), (2), (3), (4), or (5), made in good faith reliance on a notice of disqualification provided by the commissioner shall not subject the applicant or license holder to civil liability.

~~(k)~~ (l) The commissioner may establish records to fulfill the requirements of this section.

~~(l)~~ (m) The commissioner may not disqualify an individual subject to a study under this section because that person has, or has had, a mental illness as defined in section 245.462, subdivision 20.

~~(m)~~ (n) An individual subject to disqualification under this subdivision has the applicable rights in subdivision 3a, 3b, or 3c.

~~(n)~~ (o) For the purposes of background studies completed by tribal organizations performing licensing activities otherwise required of the commissioner under this chapter, after obtaining consent from the background study subject, tribal licensing agencies shall have access to criminal history data in the same manner as county licensing agencies and private licensing agencies under this chapter.

Sec. 8. Minnesota Statutes 2000, section 245A.04, subdivision 3a, is amended to read:

Subd. 3a. [NOTIFICATION TO SUBJECT AND LICENSE HOLDER OF STUDY RESULTS; DETERMINATION OF RISK OF HARM.] (a) The commissioner shall notify the applicant ~~or~~ license holder, or registrant and the individual who is the subject of the study, in writing or by electronic transmission, of the results of the study. When the study is completed, a notice that the study was undertaken and completed shall be maintained in the personnel files of the program. For studies on individuals pertaining to a license to provide family day care or group family day care, foster care for children in the provider's own home, or foster care or day care services for adults in the provider's own home, the commissioner is not required to provide a separate notice of the background study results to the individual who is the subject of the study unless the study results in a disqualification of the individual.

The commissioner shall notify the individual studied if the information in the study indicates the individual is disqualified from direct contact with persons served by the program. The commissioner shall disclose the information causing disqualification and instructions on how to request a reconsideration of the disqualification to the individual studied. An applicant or license holder who is not the subject of the study shall be informed that the commissioner has found information that disqualifies the subject from direct contact with persons served by the program. However, only the individual studied must be informed of the information contained in the subject's background study unless the only basis for the disqualification is failure to cooperate, the Data Practices Act provides for release of the information, or the individual studied authorizes the release of the information.

(b) If the commissioner determines that the individual studied has a disqualifying characteristic, the commissioner shall review the information immediately available and make a determination as to the subject's immediate risk of harm to persons served by the program where the individual studied will have direct contact. The commissioner shall consider all relevant information available, including the following factors in determining the immediate risk of harm: the recency of the disqualifying characteristic; the recency of discharge from probation for the crimes; the number of disqualifying characteristics; the intrusiveness or violence of the disqualifying characteristic; the vulnerability of the victim involved in the disqualifying characteristic; and the similarity of the victim to the persons served by the program where the individual studied will have direct contact. The commissioner may determine that the evaluation of the information immediately available gives the commissioner reason to believe one of the following:

(1) The individual poses an imminent risk of harm to persons served by the program where the individual studied will have direct contact. If the commissioner determines that an individual studied poses an imminent risk of harm to persons served by the program where the individual studied will have direct contact, the individual and the license

holder must be sent a notice of disqualification. The commissioner shall order the license holder to immediately remove the individual studied from direct contact. The notice to the individual studied must include an explanation of the basis of this determination.

(2) The individual poses a risk of harm requiring continuous supervision while providing direct contact services during the period in which the subject may request a reconsideration. If the commissioner determines that an individual studied poses a risk of harm that requires continuous supervision, the individual and the license holder must be sent a notice of disqualification. The commissioner shall order the license holder to immediately remove the individual studied from direct contact services or assure that the individual studied is within sight or hearing of another staff person when providing direct contact services during the period in which the individual may request a reconsideration of the disqualification. If the individual studied does not submit a timely request for reconsideration, or the individual submits a timely request for reconsideration, but the disqualification is not set aside for that license holder, the license holder will be notified of the disqualification and ordered to immediately remove the individual from any position allowing direct contact with persons receiving services from the license holder.

(3) The individual does not pose an imminent risk of harm or a risk of harm requiring continuous supervision while providing direct contact services during the period in which the subject may request a reconsideration. If the commissioner determines that an individual studied does not pose a risk of harm that requires continuous supervision, only the individual must be sent a notice of disqualification. The license holder must be sent a notice that more time is needed to complete the individual's background study. If the individual studied submits a timely request for reconsideration, and if the disqualification is set aside for that license holder, the license holder will receive the same notification received by license holders in cases where the individual studied has no disqualifying characteristic. If the individual studied does not submit a timely request for reconsideration, or the individual submits a timely request for reconsideration, but the disqualification is not set aside for that license holder, the license holder will be notified of the disqualification and ordered to immediately remove the individual from any position allowing direct contact with persons receiving services from the license holder.

(c) County licensing agencies performing duties under this subdivision may develop an alternative system for determining the subject's immediate risk of harm to persons served by the program, providing the notices under paragraph (b), and documenting the action taken by the county licensing agency. Each county licensing agency's implementation of the alternative system is subject to approval by the commissioner. Notwithstanding this alternative system, county licensing agencies shall complete the requirements of paragraph (a).

Sec. 9. Minnesota Statutes 2000, section 245A.04, subdivision 3b, is amended to read:

Subd. 3b. [RECONSIDERATION OF DISQUALIFICATION.] (a) The individual who is the subject of the disqualification may request a reconsideration of the disqualification.

The individual must submit the request for reconsideration to the commissioner in writing. A request for reconsideration for an individual who has been sent a notice of disqualification under subdivision 3a, paragraph (b), clause (1) or (2), must be submitted within 30 calendar days of the disqualified individual's receipt of the notice of disqualification. A request for reconsideration for an individual who has been sent a notice of disqualification under subdivision 3a, paragraph (b), clause (3), must be submitted within 15 calendar days of the disqualified individual's receipt of the notice of disqualification. Removal of a disqualified individual from direct contact shall be ordered if the individual does not request reconsideration within the prescribed time, and for an individual who submits a timely request for reconsideration, if the disqualification is not set aside. The individual must present information showing that:

(1) the information the commissioner relied upon is incorrect or inaccurate. If the basis of a reconsideration request is that a maltreatment determination or disposition under section 626.556 or 626.557 is incorrect, and the commissioner has issued a final order in an appeal of that determination or disposition under section 256.045, the commissioner's order is conclusive on the issue of maltreatment; or

(2) the subject of the study does not pose a risk of harm to any person served by the applicant or license holder, or registrant.

(b) The commissioner may set aside the disqualification under this section if the commissioner finds that the information the commissioner relied upon is incorrect or the individual does not pose a risk of harm to any person served by the applicant or license holder, or registrant. In determining that an individual does not pose a risk of harm, the commissioner shall consider the consequences of the event or events that lead to disqualification, whether there is more than one disqualifying event, the vulnerability of the victim at the time of the event, the time elapsed without a repeat of the same or similar event, documentation of successful completion by the individual studied of training or rehabilitation pertinent to the event, and any other information relevant to reconsideration. In reviewing a disqualification under this section, the commissioner shall give preeminent weight to the safety of each person to be served by the license holder or applicant, or registrant over the interests of the license holder or applicant, or registrant.

(c) Unless the information the commissioner relied on in disqualifying an individual is incorrect, the commissioner may not set aside the disqualification of an individual in connection with a license to provide family day care for children, foster care for children in the provider's own home, or foster care or day care services for adults in the provider's own home if:

(1) less than ten years have passed since the discharge of the sentence imposed for the offense; and the individual has been convicted of a violation of any offense listed in sections 609.20 (manslaughter in the first degree), 609.205 (manslaughter in the second degree), criminal vehicular homicide under 609.21 (criminal vehicular homicide and injury), 609.215 (aiding suicide or aiding attempted suicide), felony violations under 609.221 to 609.2231 (assault in the first, second, third, or fourth degree), 609.713 (terroristic threats), 609.235 (use of drugs to injure or to facilitate crime), 609.24 (simple robbery), 609.245 (aggravated robbery), 609.25 (kidnapping), 609.255 (false imprisonment), 609.561 or 609.562 (arson in the first or second degree), 609.71 (riot), burglary in the first or second degree under 609.582 (burglary), 609.66 (dangerous weapon), 609.665 (spring guns), 609.67 (machine guns and short-barreled shotguns), 609.749 (harassment; stalking), 152.021 or 152.022 (controlled substance crime in the first or second degree), 152.023, subdivision 1, clause (3) or (4), or subdivision 2, clause (4) (controlled substance crime in the third degree), 152.024, subdivision 1, clause (2), (3), or (4) (controlled substance crime in the fourth degree), 609.224, subdivision 2, paragraph (c) (fifth-degree assault by a caregiver against a vulnerable adult), 609.228 (great bodily harm caused by distribution of drugs), 609.23 (mistreatment of persons confined), 609.231 (mistreatment of residents or patients), 609.2325 (criminal abuse of a vulnerable adult), 609.233 (criminal neglect of a vulnerable adult), 609.2335 (financial exploitation of a vulnerable adult), 609.234 (failure to report), 609.265 (abduction), 609.2664 to 609.2665 (manslaughter of an unborn child in the first or second degree), 609.267 to 609.2672 (assault of an unborn child in the first, second, or third degree), 609.268 (injury or death of an unborn child in the commission of a crime), 617.293 (disseminating or displaying harmful material to minors), a gross misdemeanor offense under 609.324, subdivision 1 (other prohibited acts), a gross misdemeanor offense under 609.378 (neglect or endangerment of a child), a gross misdemeanor offense under 609.377 (malicious punishment of a child), 609.72, subdivision 3 (disorderly conduct against a vulnerable adult); or an attempt or conspiracy to commit any of these offenses, as each of these offenses is defined in Minnesota Statutes; or an offense in any other state, the elements of which are substantially similar to the elements of any of the foregoing offenses;

(2) regardless of how much time has passed since the discharge of the sentence imposed for the offense, the individual was convicted of a violation of any offense listed in sections 609.185 to 609.195 (murder in the first, second, or third degree), 609.2661 to 609.2663 (murder of an unborn child in the first, second, or third degree), a felony offense under 609.377 (malicious punishment of a child), a felony offense under 609.324, subdivision 1 (other prohibited acts), a felony offense under 609.378 (neglect or endangerment of a child), 609.322 (solicitation, inducement, and promotion of prostitution), 609.342 to 609.345 (criminal sexual conduct in the first, second, third, or fourth degree), 609.352 (solicitation of children to engage in sexual conduct), 617.246 (use of minors in a sexual performance), 617.247 (possession of pictorial representations of a minor), 609.365 (incest), a felony offense under sections 609.2242 and 609.2243 (domestic assault), a felony offense of spousal abuse, a felony offense of child abuse

or neglect, a felony offense of a crime against children, or an attempt or conspiracy to commit any of these offenses as defined in Minnesota Statutes, or an offense in any other state, the elements of which are substantially similar to any of the foregoing offenses;

(3) within the seven years preceding the study, the individual committed an act that constitutes maltreatment of a child under section 626.556, subdivision 10e, and that resulted in substantial bodily harm as defined in section 609.02, subdivision 7a, or substantial mental or emotional harm as supported by competent psychological or psychiatric evidence; or

(4) within the seven years preceding the study, the individual was determined under section 626.557 to be the perpetrator of a substantiated incident of maltreatment of a vulnerable adult that resulted in substantial bodily harm as defined in section 609.02, subdivision 7a, or substantial mental or emotional harm as supported by competent psychological or psychiatric evidence.

In the case of any ground for disqualification under clauses (1) to (4), if the act was committed by an individual other than the applicant or license holder, or registrant residing in the applicant's or license holder's, or registrant's home, the applicant or license holder, or registrant may seek reconsideration when the individual who committed the act no longer resides in the home.

The disqualification periods provided under clauses (1), (3), and (4) are the minimum applicable disqualification periods. The commissioner may determine that an individual should continue to be disqualified from licensure or registration because the license holder or registrant, or applicant poses a risk of harm to a person served by that individual after the minimum disqualification period has passed.

(d) The commissioner shall respond in writing or by electronic transmission to all reconsideration requests for which the basis for the request is that the information relied upon by the commissioner to disqualify is incorrect or inaccurate within 30 working days of receipt of a request and all relevant information. If the basis for the request is that the individual does not pose a risk of harm, the commissioner shall respond to the request within 15 working days after receiving the request for reconsideration and all relevant information. If the disqualification is set aside, the commissioner shall notify the applicant or license holder in writing or by electronic transmission of the decision.

(e) Except as provided in subdivision 3c, the commissioner's decision to disqualify an individual, including the decision to grant or deny a rescission or set aside a disqualification under this section, is the final administrative agency action and shall not be subject to further review in a contested case under chapter 14 involving a negative licensing appeal taken in response to the disqualification or involving an accuracy and completeness appeal under section 13.04.

Sec. 10. Minnesota Statutes 2000, section 245A.04, subdivision 3d, is amended to read:

Subd. 3d. [DISQUALIFICATION.] (a) Except as provided in paragraph (b), when a background study completed under subdivision 3 shows any of the following: a conviction of one or more crimes listed in clauses (1) to (4); the individual has admitted to or a preponderance of the evidence indicates the individual has committed an act or acts that meet the definition of any of the crimes listed in clauses (1) to (4); or an administrative determination listed under clause (4), the individual shall be disqualified from any position allowing direct contact with persons receiving services from the license holder or registrant:

(1) regardless of how much time has passed since the discharge of the sentence imposed for the offense, and unless otherwise specified, regardless of the level of the conviction, the individual was convicted of any of the following offenses: sections 609.185 (murder in the first degree); 609.19 (murder in the second degree); 609.195 (murder in the third degree); 609.2661 (murder of an unborn child in the first degree); 609.2662 (murder of an unborn child in the second degree); 609.2663 (murder of an unborn child in the third degree); 609.322 (solicitation, inducement, and promotion of prostitution); 609.342 (criminal sexual conduct in the first degree); 609.343 (criminal sexual conduct in the second degree); 609.344 (criminal sexual conduct in the third degree); 609.345 (criminal sexual

conduct in the fourth degree); 609.352 (solicitation of children to engage in sexual conduct); 609.365 (incest); felony offense under 609.377 (malicious punishment of a child); a felony offense under 609.378 (neglect or endangerment of a child); a felony offense under 609.324, subdivision 1 (other prohibited acts); 617.246 (use of minors in sexual performance prohibited); 617.247 (possession of pictorial representations of minors); a felony offense under sections 609.2242 and 609.2243 (domestic assault), a felony offense of spousal abuse, a felony offense of child abuse or neglect, a felony offense of a crime against children; or attempt or conspiracy to commit any of these offenses as defined in Minnesota Statutes, or an offense in any other state or country, where the elements are substantially similar to any of the offenses listed in this clause;

(2) if less than 15 years have passed since the discharge of the sentence imposed for the offense; and the individual has received a felony conviction for a violation of any of these offenses: sections 609.20 (manslaughter in the first degree); 609.205 (manslaughter in the second degree); 609.21 (criminal vehicular homicide and injury); 609.215 (suicide); 609.221 to 609.2231 (assault in the first, second, third, or fourth degree); repeat offenses under 609.224 (assault in the fifth degree); repeat offenses under 609.3451 (criminal sexual conduct in the fifth degree); 609.713 (terroristic threats); 609.235 (use of drugs to injure or facilitate crime); 609.24 (simple robbery); 609.245 (aggravated robbery); 609.25 (kidnapping); 609.255 (false imprisonment); 609.561 (arson in the first degree); 609.562 (arson in the second degree); 609.563 (arson in the third degree); repeat offenses under 617.23 (indecent exposure; penalties); repeat offenses under 617.241 (obscene materials and performances; distribution and exhibition prohibited; penalty); 609.71 (riot); 609.66 (dangerous weapons); 609.67 (machine guns and short-barreled shotguns); 609.749 (harassment; stalking; penalties); 609.228 (great bodily harm caused by distribution of drugs); 609.2325 (criminal abuse of a vulnerable adult); 609.2664 (manslaughter of an unborn child in the first degree); 609.2665 (manslaughter of an unborn child in the second degree); 609.267 (assault of an unborn child in the first degree); 609.2671 (assault of an unborn child in the second degree); 609.268 (injury or death of an unborn child in the commission of a crime); 609.52 (theft); 609.2335 (financial exploitation of a vulnerable adult); 609.521 (possession of shoplifting gear); 609.582 (burglary); 609.625 (aggravated forgery); 609.63 (forgery); 609.631 (check forgery; offering a forged check); 609.635 (obtaining signature by false pretense); 609.27 (coercion); 609.275 (attempt to coerce); 609.687 (adulteration); 260C.301 (grounds for termination of parental rights); and chapter 152 (drugs; controlled substance). An attempt or conspiracy to commit any of these offenses, as each of these offenses is defined in Minnesota Statutes; or an offense in any other state or country, the elements of which are substantially similar to the elements of the offenses in this clause. If the individual studied is convicted of one of the felonies listed in this clause, but the sentence is a gross misdemeanor or misdemeanor disposition, the lookback period for the conviction is the period applicable to the disposition, that is the period for gross misdemeanors or misdemeanors;

(3) if less than ten years have passed since the discharge of the sentence imposed for the offense; and the individual has received a gross misdemeanor conviction for a violation of any of the following offenses: sections 609.224 (assault in the fifth degree); 609.2242 and 609.2243 (domestic assault); violation of an order for protection under 518B.01, subdivision 14; 609.3451 (criminal sexual conduct in the fifth degree); repeat offenses under 609.746 (interference with privacy); repeat offenses under 617.23 (indecent exposure); 617.241 (obscene materials and performances); 617.243 (indecent literature, distribution); 617.293 (harmful materials; dissemination and display to minors prohibited); 609.71 (riot); 609.66 (dangerous weapons); 609.749 (harassment; stalking; penalties); 609.224, subdivision 2, paragraph (c) (assault in the fifth degree by a caregiver against a vulnerable adult); 609.23 (mistreatment of persons confined); 609.231 (mistreatment of residents or patients); 609.2325 (criminal abuse of a vulnerable adult); 609.233 (criminal neglect of a vulnerable adult); 609.2335 (financial exploitation of a vulnerable adult); 609.234 (failure to report maltreatment of a vulnerable adult); 609.72, subdivision 3 (disorderly conduct against a vulnerable adult); 609.265 (abduction); 609.378 (neglect or endangerment of a child); 609.377 (malicious punishment of a child); 609.324, subdivision 1a (other prohibited acts; minor engaged in prostitution); 609.33 (disorderly house); 609.52 (theft); 609.582 (burglary); 609.631 (check forgery; offering a forged check); 609.275 (attempt to coerce); or an attempt or conspiracy to commit any of these offenses, as each of these offenses is defined in Minnesota Statutes; or an offense in any other state or country, the elements of which are substantially similar to the elements of any of the offenses listed in this clause. If the defendant is convicted of one of the gross misdemeanors listed in this clause, but the sentence is a misdemeanor disposition, the lookback period for the conviction is the period applicable to misdemeanors; or

(4) if less than seven years have passed since the discharge of the sentence imposed for the offense; and the individual has received a misdemeanor conviction for a violation of any of the following offenses: sections 609.224 (assault in the fifth degree); 609.2242 (domestic assault); violation of an order for protection under 518B.01 (Domestic Abuse Act); violation of an order for protection under 609.3232 (protective order authorized; procedures; penalties); 609.746 (interference with privacy); 609.79 (obscene or harassing phone calls); 609.795 (letter, telegram, or package; opening; harassment); 617.23 (indecent exposure; penalties); 609.2672 (assault of an unborn child in the third degree); 617.293 (harmful materials; dissemination and display to minors prohibited); 609.66 (dangerous weapons); 609.665 (spring guns); 609.2335 (financial exploitation of a vulnerable adult); 609.234 (failure to report maltreatment of a vulnerable adult); 609.52 (theft); 609.27 (coercion); or an attempt or conspiracy to commit any of these offenses, as each of these offenses is defined in Minnesota Statutes; or an offense in any other state or country, the elements of which are substantially similar to the elements of any of the offenses listed in this clause; failure to make required reports under section 626.556, subdivision 3, or 626.557, subdivision 3, for incidents in which: (i) the final disposition under section 626.556 or 626.557 was substantiated maltreatment, and (ii) the maltreatment was recurring or serious; or substantiated serious or recurring maltreatment of a minor under section 626.556 or of a vulnerable adult under section 626.557 for which there is a preponderance of evidence that the maltreatment occurred, and that the subject was responsible for the maltreatment.

For the purposes of this section, "serious maltreatment" means sexual abuse; maltreatment resulting in death; or maltreatment resulting in serious injury which reasonably requires the care of a physician whether or not the care of a physician was sought; or abuse resulting in serious injury. For purposes of this section, "abuse resulting in serious injury" means: bruises, bites, skin laceration or tissue damage; fractures; dislocations; evidence of internal injuries; head injuries with loss of consciousness; extensive second-degree or third-degree burns and other burns for which complications are present; extensive second-degree or third-degree frostbite, and others for which complications are present; irreversible mobility or avulsion of teeth; injuries to the eyeball; ingestion of foreign substances and objects that are harmful; near drowning; and heat exhaustion or sunstroke. For purposes of this section, "care of a physician" is treatment received or ordered by a physician, but does not include diagnostic testing, assessment, or observation. For the purposes of this section, "recurring maltreatment" means more than one incident of maltreatment for which there is a preponderance of evidence that the maltreatment occurred, and that the subject was responsible for the maltreatment.

(b) If the subject of a background study is licensed by a health-related licensing board, the board shall make the determination regarding a disqualification under this subdivision based on a finding of substantiated maltreatment under section 626.556 or 626.557. The commissioner shall notify the health-related licensing board if a background study shows that a licensee would be disqualified because of substantiated maltreatment and the board shall make a determination under section 214.104.

Sec. 11. [REPORT ON SUPPLEMENTAL NURSING SERVICES AGENCY USE.]

Beginning July 1, 2001, through June 30, 2003, the commissioner of human services shall require nursing facilities and other providers of long-term care services to report semiannually on the use of supplemental nursing services, in the form and manner specified by the commissioner. The information reported must include, but is not limited to:

- (1) number of hours worked by supplemental nursing services personnel, by job classification, for each month;
- (2) payments to supplemental nursing services agencies, on a per hour worked basis, by job classification, for each month; and
- (3) percentage of total monthly work hours provided by supplemental nursing services agency personnel, by job classification, for each shift and for weekdays and weekends.

Sec. 12. [APPROPRIATION.]

\$..... is appropriated from the general fund to the commissioner of health for the biennium beginning July 1, 2001, to regulate supplemental nursing services agencies.

ARTICLE 5

LONG-TERM CARE INSURANCE

Section 1. Minnesota Statutes 2000, section 62A.48, subdivision 4, is amended to read:

Subd. 4. [LOSS RATIO.] The anticipated loss ratio for long-term care policies must not be less than 65 percent for policies issued on a group basis or 60 percent for policies issued on an individual or mass-market basis. This subdivision does not apply to policies issued on or after January 1, 2002, that comply with sections 62S.021 and 62S.081.

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

Sec. 2. Minnesota Statutes 2000, section 62A.48, is amended by adding a subdivision to read:

Subd. 10. [REGULATION OF PREMIUMS AND PREMIUM INCREASES.] Policies issued under sections 62A.46 to 62A.56 on or after January 1, 2002, must comply with sections 62S.021, 62S.081, 62S.265, and 62S.266 to the same extent as policies issued under chapter 62S.

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

Sec. 3. Minnesota Statutes 2000, section 62A.48, is amended by adding a subdivision to read:

Subd. 11. [NONFORFEITURE BENEFITS.] Policies issued under sections 62A.46 to 62A.56 on or after January 1, 2002, must comply with section 62S.02, subdivision 2, to the same extent as policies issued under chapter 62S.

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

Sec. 4. Minnesota Statutes 2000, section 62S.01, is amended by adding a subdivision to read:

Subd. 13a. [EXCEPTIONAL INCREASE.] (a) "Exceptional increase" means only those increases filed by an insurer as exceptional for which the commissioner determines the need for the premium rate increase is justified due to changes in laws or rules applicable to long-term care coverage in this state, or due to increased and unexpected utilization that affects the majority of insurers of similar products.

(b) Except as provided in section 62S.265, exceptional increases are subject to the same requirements as other premium rate schedule increases. The commissioner may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase. The commissioner, in determining that the necessary basis for an exceptional increase exists, shall also determine any potential offsets to higher claims costs.

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

Sec. 5. Minnesota Statutes 2000, section 62S.01, is amended by adding a subdivision to read:

Subd. 17a. [INCIDENTAL.] "Incidental," as used in section 62S.265, subdivision 10, means that the value of the long-term care benefits provided is less than ten percent of the total value of the benefits provided over the life of the policy. These values shall be measured as of the date of issue.

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

Sec. 6. Minnesota Statutes 2000, section 62S.01, is amended by adding a subdivision to read:

Subd. 23a. [QUALIFIED ACTUARY.] "Qualified actuary" means a member in good standing of the American Academy of Actuaries.

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

Sec. 7. Minnesota Statutes 2000, section 62S.01, is amended by adding a subdivision to read:

Subd. 25a. [SIMILAR POLICY FORMS.] "Similar policy forms" means all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition in section ... are not considered similar to certificates or policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: institutional long-term care benefits only, noninstitutional long-term care benefits only, or comprehensive long-term care benefits.

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

Sec. 8. [62S.021] [LONG-TERM CARE INSURANCE; INITIAL FILING.]

Subdivision 1. [APPLICABILITY.] This section applies to any long-term care policy issued in this state on or after January 1, 2002, under this chapter or sections 62A.46 to 62A.56.

Subd. 2. [REQUIRED SUBMISSION TO COMMISSIONER.] An insurer shall provide the following information to the commissioner 30 days prior to making a long-term care insurance form available for sale:

(1) a copy of the disclosure documents required in section 62S.081; and

(2) an actuarial certification consisting of at least the following:

(i) a statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;

(ii) a statement that the policy design and coverage provided have been reviewed and taken into consideration;

(iii) a statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration; and

(iv) a complete description of the basis for contract reserves that are anticipated to be held under the form, to include:

(A) sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;

(B) a statement that the assumptions used for reserves contain reasonable margins for adverse experience;

(C) a statement that the net valuation premium for renewal years does not increase, except for attained-age rating where permitted;

(D) a statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses, or if such a statement cannot be made, a complete description of the situations where this does not occur. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship. If the gross premiums for certain age groups appear to be inconsistent with this requirement, the commissioner may request a demonstration under item (i) based on a standard age distribution; and

(E) either a statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits, or a comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.

Subd. 3. [ACTUARIAL DEMONSTRATION.] The commissioner may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both. If the commissioner asks for additional information under this subdivision, the 30-day time limit in subdivision 2 does not include the time during which the insurer is preparing the requested information.

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

Sec. 9. [62S.081] [REQUIRED DISCLOSURE OF RATING PRACTICES TO CONSUMERS.]

Subdivision 1. [APPLICATION.] This section shall apply as follows:

(a) Except as provided in paragraph (b), this section applies to any long-term care policy or certificate issued in this state on or after January 1, 2002.

(b) For certificates issued on or after the effective date of this section under a policy of group long-term care insurance as defined in section 62S.01, subdivision 15, that was in force on the effective date of this section, this section applies on the policy anniversary following June 30, 2002.

Subd. 2. [REQUIRED DISCLOSURES.] Other than policies for which no applicable premium rate or rate schedule increases can be made, insurers shall provide all of the information listed in this subdivision to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that time; in this case, an insurer shall provide all of the information listed in this subdivision to the applicant no later than at the time of delivery of the policy or certificate:

(1) a statement that the policy may be subject to rate increases in the future;

(2) an explanation of potential future premium rate revisions and the policyholder's or certificate holder's option in the event of a premium rate revision;

(3) the premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase;

(4) a general explanation for applying premium rate or rate schedule adjustments that must include:

(i) a description of when premium rate or rate schedule adjustments will be effective, for example the next anniversary date or the next billing date; and

(ii) the right to a revised premium rate or rate schedule as provided in clause (3) if the premium rate or rate schedule is changed; and

(5)(i) information regarding each premium rate increase on this policy form or similar policy forms over the past ten years for this state or any other state that, at a minimum, identifies:

(A) the policy forms for which premium rates have been increased;

(B) the calendar years when the form was available for purchase; and

(C) the amount or percent of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics;

(ii) the insurer may, in a fair manner, provide additional explanatory information related to the rate increases;

(iii) an insurer has the right to exclude from the disclosure premium rate increases that apply only to blocks of business acquired from other nonaffiliated insurers or the long-term care policies acquired from other nonaffiliated insurers when those increases occurred prior to the acquisition;

(iv) if an acquiring insurer files for a rate increase on a long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers on or before the later of the effective date of this section, or the end of a 24-month period following the acquisition of the block of policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling company must include the disclosure of that rate increase according to item (i); and

(v) if the acquiring insurer in item (iv) files for a subsequent rate increase, even within the 24-month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers referenced in item (iv), the acquiring insurer shall make all disclosures required by this subdivision, including disclosure of the earlier rate increase referenced in item (iv).

Subd. 3. [ACKNOWLEDGMENT.] An applicant shall sign an acknowledgment at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required under subdivision 2. If, due to the method of application, the applicant cannot sign an acknowledgment at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

Subd. 4. [FORMS.] An insurer shall use the forms in Appendices B and F of the Long-term Care Insurance Model Regulation adopted by the National Association of Insurance Commissioners to comply with the requirements of subdivisions 1 and 2.

Subd. 5. [NOTICE OF INCREASE.] An insurer shall provide notice of an upcoming premium rate schedule increase, after the increase has been approved by the commissioner, to all policyholders or certificate holders, if applicable, at least 45 days prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by subdivision 2 when the rate increase is implemented.

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

Sec. 10. Minnesota Statutes 2000, section 62S.26, is amended to read:

62S.26 [LOSS RATIO.]

(a) The minimum loss ratio must be at least 60 percent, calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, the commissioner shall give consideration to all relevant factors, including:

- (1) statistical credibility of incurred claims experience and earned premiums;
- (2) the period for which rates are computed to provide coverage;
- (3) experienced and projected trends;
- (4) concentration of experience within early policy duration;
- (5) expected claim fluctuation;
- (6) experience refunds, adjustments, or dividends;
- (7) renewability features;
- (8) all appropriate expense factors;
- (9) interest;
- (10) experimental nature of the coverage;
- (11) policy reserves;
- (12) mix of business by risk classification; and
- (13) product features such as long elimination periods, high deductibles, and high maximum limits.

(b) This section does not apply to policies or certificates that are subject to sections 62S.021, 62S.081, and 62S.265, and that comply with those sections.

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

Sec. 11. [62S.265] [PREMIUM RATE SCHEDULE INCREASES.]

Subdivision 1. [APPLICABILITY.] (a) Except as provided in paragraph (b), this section applies to any long-term care policy or certificate issued in this state on or after January 1, 2002, under this chapter or sections 62A.46 to 62A.56.

(b) For certificates issued on or after the effective date of this section under a group long-term care insurance policy as defined in section 62S.01, subdivision 15, or as described in section 62A.46, subdivision 2, that was in force on the effective date of this section, this section applies on the policy anniversary following June 30, 2002.

Subd. 2. [NOTICE.] An insurer shall file a requested premium rate schedule increase, including an exceptional increase, to the commissioner for prior approval at least 60 days prior to the notice to the policyholders and shall include:

- (1) all information required by section 62S.081;

(2) certification by a qualified actuary that:

(i) if the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated; and

(ii) the premium rate filing complies with this section;

(3) an actuarial memorandum justifying the rate schedule change request that includes:

(i) lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale;

(A) annual values for the five years preceding and the three years following the valuation date shall be provided separately;

(B) the projections must include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;

(C) the projections must demonstrate compliance with subdivision 3; and

(D) for exceptional increases, the projected experience must be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase and, if the commissioner determines that offsets to higher claim costs may exist, the insurer shall use appropriate net projected experience;

(ii) disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;

(iii) disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied upon by the actuary;

(iv) a statement that policy design, underwriting, and claims adjudication practices have been taken into consideration; and

(v) if it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer shall file composite rates reflecting projections of new certificates;

(4) a statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commissioner; and

(5) sufficient information for review and approval of the premium rate schedule increase by the commissioner.

Subd. 3. [REQUIREMENTS PERTAINING TO RATE INCREASES.] All premium rate schedule increases must be determined according to the following requirements:

(1) exceptional increases shall provide that 70 percent of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

(2) premium rate schedule increases must be calculated so that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

- (i) the accumulated value of the initial earned premium times 58 percent;
 - (ii) 85 percent of the accumulated value of prior premium rate schedule increases on an earned basis;
 - (iii) the present value of future projected initial earned premiums times 58 percent; and
 - (iv) 85 percent of the present value of future projected premiums not in item (iii) on an earned basis;
- (3) if a policy form has both exceptional and other increases, the values in clause (2), items (ii) and (iv), must also include 70 percent for exceptional rate increase amounts; and
- (4) all present and accumulated values used to determine rate increases must use the maximum valuation interest rate for contract reserves permitted for valuation of whole life insurance policies issued in this state on the same date. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

Subd. 4. [PROJECTIONS.] For each rate increase that is implemented, the insurer shall file for approval by the commissioner updated projections, as defined in subdivision 2, clause (3), item (i), annually for the next three years and include a comparison of actual results to projected values. The commissioner may extend the period to greater than three years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in subdivision 11, the projections required by this subdivision must be provided to the policyholder in lieu of filing with the commissioner.

Subd. 5. [LIFETIME PROJECTIONS.] If any premium rate in the revised premium rate schedule is greater than 200 percent of the comparable rate in the initial premium schedule, lifetime projections, as defined in subdivision 2, clause (3), item (i), must be filed for approval by the commissioner every five years following the end of the required period in subdivision 4. For group insurance policies that meet the conditions in subdivision 11, the projections required by this subdivision must be provided to the policyholder in lieu of filing with the commissioner.

Subd. 6. [EFFECT OF ACTUAL EXPERIENCE.] (a) If the commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in subdivision 3, the commissioner may require the insurer to implement any of the following:

- (1) premium rate schedule adjustments; or
- (2) other measures to reduce the difference between the projected and actual experience.

(b) In determining whether the actual experience adequately matches the projected experience, consideration should be given to subdivision 2, clause (3), item (v), if applicable.

Subd. 7. [CONTINGENT BENEFIT UPON LAPSE.] If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:

(1) a plan, subject to commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or a demonstration that appropriate administration and claims processing have been implemented or are in effect; otherwise, the commissioner may impose the condition in subdivision 8, paragraph (b); and

(2) the original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to subdivision 3 had the greater of the original anticipated lifetime loss ratio or 58 percent been used in the calculations described in subdivision 3, clause (2), items (i) and (iii).

Subd. 8. [PROJECTED LAPSE RATES.] (a) For a rate increase filing that meets the following criteria, the commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the 12 months following each increase to determine if significant adverse lapsation has occurred or is anticipated:

(1) the rate increase is not the first rate increase requested for the specific policy form or forms;

(2) the rate increase is not an exceptional increase; and

(3) the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

(b) If significant adverse lapsation has occurred, is anticipated in the filing, or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the commissioner may determine that a rate spiral exists. Following the determination that a rate spiral exists, the commissioner may require the insurer to offer, without underwriting, to all in-force insureds subject to the rate increase, the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates. The offer must:

(1) be subject to the approval of the commissioner;

(2) be based upon actuarially sound principles, but not be based upon attained age; and

(3) provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.

(c) The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase must be limited to the lesser of the maximum rate increase determined based on the combined experience and the maximum rate increase determined based only upon the experience of the insureds originally issued the form plus ten percent.

Subd. 9. [PERSISTENT PRACTICE OF INADEQUATE INITIAL RATES.] If the commissioner determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the commissioner may, in addition to the provisions of subdivision 8, prohibit the insurer from either of the following:

(1) filing and marketing comparable coverage for a period of up to five years; or

(2) offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

Subd. 10. [INCIDENTAL LONG-TERM CARE BENEFITS.] Subdivisions 1 to 9 do not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in section 62S.01, subdivision 17a, if the policy complies with all of the following provisions:

(1) the interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

(2) the portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following:

(i) for life insurance, section 61A.25;

(ii) for individual deferred annuities, section 61A.245; and

(iii) for variable annuities, section 61A.21;

(3) the policy meets the disclosure requirements of sections 62S.10 and 62S.11 if the policy is governed by chapter 62S and of section 62A.50 if the policy is governed by sections 62A.46 to 62A.56;

(4) the portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements as applicable in the following:

(i) policy illustrations to the extent required by state law applicable to life insurance;

(ii) disclosure requirements in state law applicable to annuities; and

(iii) disclosure requirements applicable to variable annuities; and

(5) an actuarial memorandum is filed with the commissioner that includes:

(i) a description of the basis on which the long-term care rates were determined;

(ii) a description of the basis for the reserves;

(iii) a summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(iv) a description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

(v) a description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(vi) the estimated average annual premium per policy and the average issue age;

(vii) a statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(viii) a description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values, and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

Subd. 11. [LARGE GROUP POLICIES.] Subdivisions 6 and 9 do not apply to group long-term care insurance policies as defined in section 62S.01, subdivision 15, where:

(1) the policies insure 250 or more persons, and the policyholder has 5,000 or more eligible employees of a single employer; or

(2) the policyholder, and not the certificate holders, pays a material portion of the premium, which is not less than 20 percent of the total premium for the group in the calendar year prior to the year in which a rate increase is filed.

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

Sec. 12. [62S.266] [NONFORFEITURE BENEFIT REQUIREMENT.]

Subdivision 1. [APPLICABILITY.] This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

Subd. 2. [REQUIREMENT.] An insurer must offer each prospective policyholder a nonforfeiture benefit in compliance with the following requirements:

(1) a policy or certificate offered with nonforfeiture benefits must have coverage elements, eligibility, benefit triggers, and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer must be the benefit described in subdivision 5; and

(2) the offer must be in writing if the nonforfeiture benefit is not otherwise described in the outline of coverage or other materials given to the prospective policyholder.

Subd. 3. [EFFECT OF REJECTION OF OFFER.] If the offer required to be made under subdivision 2 is rejected, the insurer shall provide the contingent benefit upon lapse described in this section.

Subd. 4. [CONTINGENT BENEFIT UPON LAPSE.] (a) After rejection of the offer required under subdivision 2, for individual and group policies without nonforfeiture benefits issued after the effective date of this section, the insurer shall provide a contingent benefit upon lapse.

(b) If a group policyholder elects to make the nonforfeiture benefit an option to the certificate holder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

(c) The contingent benefit on lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium based on the insured's issue age, and the policy or certificate lapses within 120 days of the due date of the premium increase. Unless otherwise required, policyholders shall be notified at least 30 days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase

<u>Issue Age</u>	<u>Percent Increase Over Initial Premium</u>
<u>29 and Under</u>	<u>200</u>
<u>30-34</u>	<u>190</u>
<u>35-39</u>	<u>170</u>
<u>40-44</u>	<u>150</u>
<u>45-49</u>	<u>130</u>
<u>50-54</u>	<u>110</u>
<u>55-59</u>	<u>90</u>
<u>60</u>	<u>70</u>
<u>61</u>	<u>66</u>
<u>62</u>	<u>62</u>
<u>63</u>	<u>58</u>
<u>64</u>	<u>54</u>
<u>65</u>	<u>50</u>
<u>66</u>	<u>48</u>
<u>67</u>	<u>46</u>
<u>68</u>	<u>44</u>
<u>69</u>	<u>42</u>

<u>70</u>	<u>40</u>
<u>71</u>	<u>38</u>
<u>72</u>	<u>36</u>
<u>73</u>	<u>34</u>
<u>74</u>	<u>32</u>
<u>75</u>	<u>30</u>
<u>76</u>	<u>28</u>
<u>77</u>	<u>26</u>
<u>78</u>	<u>24</u>
<u>79</u>	<u>22</u>
<u>80</u>	<u>20</u>
<u>81</u>	<u>19</u>
<u>82</u>	<u>18</u>
<u>83</u>	<u>17</u>
<u>84</u>	<u>16</u>
<u>85</u>	<u>15</u>
<u>86</u>	<u>14</u>
<u>87</u>	<u>13</u>
<u>88</u>	<u>12</u>
<u>89</u>	<u>11</u>
<u>90 and over</u>	<u>10</u>

(d) On or before the effective date of a substantial premium increase as defined in paragraph (c), the insurer shall:

(1) offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(2) offer to convert the coverage to a paid-up status with a shortened benefit period according to the terms of subdivision 5. This option may be elected at any time during the 120-day period referenced in paragraph (c); and

(3) notify the policyholder or certificate holder that a default or lapse at any time during the 120-day period referenced in paragraph (c) shall be deemed to be the election of the offer to convert in clause (2).

Subd. 5. [NONFORFEITURE BENEFITS; REQUIREMENTS.] (a) Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse, must be as described in this subdivision.

(b) For purposes of this subdivision, "attained age rating" is defined as a schedule of premiums starting from the issue date which increases with age at least one percent per year prior to age 50, and at least three percent per year beyond age 50.

(c) For purposes of this subdivision, the nonforfeiture benefit shall be of a shortened benefit period providing paid-up, long-term care insurance coverage after lapse. The same benefits, amounts, and frequency in effect at the time of lapse, but not increased thereafter, will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in paragraph (d).

(d) The standard nonforfeiture credit will be equal to 100 percent of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit must not be less than 30 times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of this subdivision.

(e) The nonforfeiture benefit must begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse must be effective during the first three years as well as thereafter.

(f) Notwithstanding paragraph (e), for a policy or certificate with attained age rating, the nonforfeiture benefit must begin on the earlier of:

(1) the end of the tenth year following the policy or certificate issue date; or

(2) the end of the second year following the date the policy or certificate is no longer subject to attained age rating.

(g) Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

Subd. 6. [BENEFIT LIMIT.] All benefits paid by the insurer while the policy or certificate is in premium-paying status and in the paid-up status will not exceed the maximum benefits which would be payable if the policy or certificate had remained in premium-paying status.

Subd. 7. [MINIMUM BENEFITS; INDIVIDUAL AND GROUP POLICIES.] There shall be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.

Subd. 8. [APPLICATION; EFFECTIVE DATES.] This section becomes effective January 1, 2002, and applies as follows:

(a) Except as provided in paragraph (b), this section applies to any long-term care policy issued in this state on or after the effective date of this section.

(b) For certificates issued on or after the effective date of this section, under a group long-term care insurance policy that was in force on the effective date of this section, the provisions of this section do not apply.

Subd. 9. [EFFECT ON LOSS RATIO.] Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse are subject to the loss ratio requirements of section 62A.48, subdivision 4, or 62S.26, treating the policy as a whole, except for policies or certificates that are subject to sections 62S.021, 62S.081, and 62S.265 and that comply with those sections.

Subd. 10. [PURCHASED BLOCKS OF BUSINESS.] To determine whether contingent nonforfeiture upon lapse provisions are triggered under subdivision 4, paragraph (c), a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

Subd. 11. [LEVEL PREMIUM CONTRACTS.] A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts shall be offered that meets the following requirements:

(1) the nonforfeiture provision shall be appropriately captioned;

(2) the nonforfeiture provision shall provide a benefit available in the event of a default in the payment of any premiums and shall state that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying contracts approved by the commissioner for the same contract form; and

(3) the nonforfeiture provision shall provide at least one of the following:

(i) reduced paid-up insurance;

(ii) extended term insurance;

(iii) shortened benefit period; or

(iv) other similar offerings approved by the commissioner.

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

Sec. 13. Minnesota Statutes 2000, section 256.975, is amended by adding a subdivision to read:

Subd. 8. [PROMOTION OF LONG-TERM CARE INSURANCE.] The Minnesota board on aging, either directly or through contract, shall promote the provision of employer-sponsored, long-term care insurance. The board shall encourage private and public sector employers to make long-term care insurance available to employees, provide interested employers with information on the long-term care insurance product offered to state employees, and provide technical assistance to employers in designing long-term care insurance products and contacting health plan companies offering long-term care insurance products.

Sec. 14. [256B.0571] [LONG-TERM CARE PARTNERSHIP.]

Subdivision 1. [DEFINITIONS.] For purposes of this section, the following terms have the meanings given them.

(a) "Home care service" means care described in section 144A.43.

(b) "Long-term care insurance" means a policy described in section 62S.01.

(c) "Medical assistance" means the program of medical assistance established under section 256B.01.

(d) "Nursing home" means nursing home as described in section 144A.01.

(e) "Partnership policy" means a long-term care insurance policy that meets the requirements under chapter 62S.

(f) "Partnership program" means the Minnesota partnership for long-term care program established under this section.

Subd. 2. [PARTNERSHIP PROGRAM.] (a) Subject to federal waiver approval, the commissioner of human services, along with the commissioner of commerce, shall establish the Minnesota partnership for long-term care program to provide for the financing of long-term care through a combination of private insurance and medical assistance.

(b) An individual who meets the requirements in paragraph (c) is eligible to participate in the partnership program.

(c) The individual must:

(1) be a Minnesota resident;

(2) purchase a partnership policy that is delivered, issued for delivery, or renewed on or after the effective date of this section, and maintains the partnership policy in effect throughout the period of participation in the partnership program; and

(3) exhaust the minimum benefits under the partnership policy as described in this section. Benefits received under a long-term care insurance policy before the effective date of this section do not count toward the exhaustion of benefits required in this subdivision.

Subd. 3. [MEDICAL ASSISTANCE ELIGIBILITY.] (a) Upon application of an individual who meets the requirements described in subdivision 2, the commissioner of human services shall determine the individual's eligibility for medical assistance according to paragraphs (b) and (c).

(b) After disregarding financial assets exempted under medical assistance eligibility requirements, the department shall disregard an additional amount of financial assets equal to the dollar amount of coverage under the partnership policy.

(c) The department shall consider the individual's income according to medical assistance eligibility requirements.

Subd. 4. [FEDERAL APPROVAL.] (a) The commissioner of human services shall seek appropriate amendments to the medical assistance state plan and shall apply for any necessary waiver of medical assistance requirements by the federal Health Care Financing Administration to implement the partnership program. The state shall not implement the partnership program unless the provisions in paragraphs (b) and (c) apply.

(b) The commissioner shall seek any necessary federal waiver of medical assistance requirements.

(c) Individuals who receive medical assistance under this section are exempt from estate recovery requirements under section 1917, title XIX of the federal Social Security Act, United States Code, title 42, section 1396p.

Subd. 5. [APPROVED POLICIES.] (a) A partnership policy must meet all of the requirements in paragraphs (b) to (h).

(b) Minimum coverage shall be for a period of not less than three years and for a dollar amount equal to 36 months of nursing home care at the minimum daily benefit rate determined and adjusted under paragraph (c). The policy shall provide for home health care benefits to be substituted for nursing home care benefits on the basis of two home health care days for one nursing home care day.

(c) Minimum daily benefits shall be \$130 for nursing home care or \$65 for home care. These minimum daily benefit amounts shall be adjusted by the department on October 1 of each year, based on the health care index used under medical assistance for nursing home rate setting. Adjusted minimum daily benefit amounts shall be rounded to the nearest whole dollar.

(d) A third party designated by the insured shall be entitled to receive notice if the policy is about to lapse for nonpayment of premium, and an additional 30-day grace period for payment of premium shall be granted following notification to that person.

(e) The policy must cover all of the following services:

(1) nursing home stay;

(2) home care service;

(3) care management; and

(4) up to 14 days of nursing care in a hospital while the individual is waiting for long-term care placement.

(f) Payment for service under paragraph (e), clause (4), must not exceed the daily benefit amount for nursing home care.

(g) A partnership policy must offer both options in paragraph (h) for an adjusted premium.

(h) The options are:

(1) an elimination period of not more than 100 days; and

(2) nonforfeiture benefits for applicants between the ages of 18 and 75.

Sec. 15. [APPROPRIATION.]

Subdivision 1. [BOARD ON AGING.] \$..... is appropriated from the general fund to the commissioner of human services for the biennium ending June 30, 2003, for the board on aging to promote employer-sponsored long-term care insurance as required under section 13.

Subd. 2. [LONG-TERM CARE PARTNERSHIP PROGRAM.] \$..... is appropriated from the general fund to the commissioner of human services for the biennium ending June 30, 2003, for federal waiver development and application under section 14."

Amend the title accordingly

With the recommendation that when so amended the bill pass and be re-referred to the Committee on Commerce, Jobs and Economic Development.

The report was adopted.

McElroy from the Committee on Jobs and Economic Development Finance to which was referred:

S. F. No. 142, A bill for an act relating to state government; increasing the membership of the state council on Black Minnesotans; amending Minnesota Statutes 2000, section 3.9225, subdivisions 1 and 2.

Reported the same back with the recommendation that the bill pass.

The report was adopted.

Bradley from the Committee on Health and Human Services Policy to which was referred:

S. F. No. 456, A bill for an act relating to human services; allowing mental retardation and related conditions waiver recipients access to respite care in intermediate care facilities for persons with mental retardation and related conditions; amending Minnesota Statutes 2000, section 256B.501, by adding a subdivision.

Reported the same back with the following amendments:

Page 1, line 17, after "care" insert "as available"

With the recommendation that when so amended the bill pass.

The report was adopted.

Bishop from the Committee on Ways and Means to which was referred:

House Resolution No. 8, A house resolution setting the maximum limit on general fund expenditures for the biennium.

Reported the same back with the following amendments:

Page 1, line 6, delete "\$....." and insert "\$25,872,400,000"

Page 1, line 7, after "fund" insert ", excluding expenditures for tax reduction and relief,"

Page 1, line 10, delete "\$....." and insert "\$350,000,000"

Page 1, line 11, delete "\$....." and insert "\$622,000,000"

With the recommendation that when so amended the resolution be adopted.

The report was adopted.

SECOND READING OF HOUSE BILLS

H. F. Nos. 118, 570, 610, 894, 995, 1069, 1219, 1340, 1465 and 1522 were read for the second time.

SECOND READING OF SENATE BILLS

S. F. Nos. 142 and 456 were read for the second time.

INTRODUCTION AND FIRST READING OF HOUSE BILLS

The following House Files were introduced:

Johnson, J.; Sykora; Wolf; Erickson and Buesgens introduced:

H. F. No. 2031, A bill for an act relating to labor relations; providing that the term of a master contract between a school board and an exclusive representative of teachers may be for up to five years; amending Minnesota Statutes 2000, section 179A.20, subdivision 3.

The bill was read for the first time and referred to the Committee on Governmental Operations and Veterans Affairs Policy.

Seifert, Pelowski, Erickson, Kielkucki and Anderson, B., introduced:

H. F. No. 2032, A bill for an act relating to education; allowing school districts to expend reasonable funds to transmit relevant facts about a ballot measure or other government initiative; requiring a school district policy on reasonable expenditures for transmitting information on government-proposed initiatives; requiring school districts to inform voters on district lobbying expenditures; amending Minnesota Statutes 2000, sections 123B.10, subdivision 1; 275.065, subdivision 5a; proposing coding for new law in Minnesota Statutes, chapter 123B.

The bill was read for the first time and referred to the Committee on Education Policy.

Workman and Holberg introduced:

H. F. No. 2033, A bill for an act relating to public employment labor relations; defining radio communications operators as "essential employees"; creating the radio communications operators unit; amending Minnesota Statutes 2000, sections 179A.03, subdivision 7; 179A.10, subdivision 2.

The bill was read for the first time and referred to the Committee on Governmental Operations and Veterans Affairs Policy.

Fuller introduced:

H. F. No. 2034, A bill for an act relating to state lands; authorizing the commissioner of transportation to exercise the power of eminent domain for acquisition of certain trust fund land bordering public waters.

The bill was read for the first time and referred to the Committee on Environment and Natural Resources Policy.

Westerberg introduced:

H. F. No. 2035, A bill for an act relating to transportation; allocating proceeds from sales tax on motor vehicles to highway user tax distribution fund; proposing an amendment to the Minnesota Constitution, article XIV, section 5, and by adding a section; amending Minnesota Statutes 2000, sections 174.32, subdivision 2; 297B.09, subdivision 1.

The bill was read for the first time and referred to the Committee on Transportation Policy.

Dempsey and Ozment introduced:

H. F. No. 2036, A bill for an act relating to Goodhue county; permitting the appointment of the auditor-treasurer.

The bill was read for the first time and referred to the Committee on Local Government and Metropolitan Affairs.

Abrams, McElroy and Lenczewski introduced:

H. F. No. 2037, A bill for an act relating to public finance; updating and making technical changes to public finance provisions related to debt obligations, sales and use tax exemptions, county capital financing of certain equipment and hardware and software; extending a sunset date for certain county capital improvement bonds; removing election requirements as preconditions for issuance of certain obligations; authorizing some flexibility in stating certain ballot questions; amending Minnesota Statutes 2000, sections 103B.555, by adding a subdivision;

165.10, subdivision 2; 275.60; 297A.70, subdivisions 4 and 7; 297A.71, subdivision 6; 373.01, subdivision 3; 373.40, subdivision 7; 373.45, subdivision 3; 376.08, subdivisions 1, 3, and by adding a subdivision; 410.32; 412.301; 426.19, subdivision 2; 429.091, subdivision 7a; 444.075, subdivision 1a; 475.54, subdivision 1; 475.58, subdivision 1; and 475.59.

The bill was read for the first time and referred to the Committee on Taxes.

Milbert and Pugh introduced:

H. F. No. 2038, A bill for an act relating to waste management; increasing the amount of the waste disposal fee that cities or towns may collect within the metropolitan area; amending Minnesota Statutes 2000, section 115A.921, subdivision 1.

The bill was read for the first time and referred to the Committee on Environment and Natural Resources Policy.

Gunther introduced:

H. F. No. 2039, A bill for an act relating to agriculture; repealing obsolete or unnecessary provisions; repealing Minnesota Statutes 2000, sections 17.039; 17.042; 17.06; 17.07; 17.108; 17.139; 17.45; 17.4996; 17.76; 17.861; 17A.091, subdivision 1; 17B.21; 17B.23; 17B.24; 17B.25; 17B.26; 17B.27; 18.205; 24.001; 24.002; 24.12; 24.131; 24.135; 24.141; 24.145; 24.151; 24.155; 24.161; 24.171; 24.175; 24.18; 24.181; 25.47; 27.185; 29.025; 29.049; 30.50; 30.51; 31.185; 31.73; 31B.07; 32.11; 32.12; 32.18; 32.19; 32.20; 32.203; 32.204; 32.206; 32.208; 32.70; 32.71; 32.72; 32.74; 32.745; 33.001; 33.002; 33.01; 33.011; 33.02; 33.03; 33.031; 33.032; 33.06; 33.07; 33.08; 33.09; 33.091; 33.111; 35.04; 35.14; and 35.84.

The bill was read for the first time and referred to the Committee on Agriculture Policy.

Penas introduced:

H. F. No. 2040, A bill for an act relating to public safety; eliminating provisions relating to the registration of certain intoxicating liquor brand labels, the hiring of subversives in emergency management organizations, public service announcements, the use of waste burners, flammable liquids and explosives, fire drills in schools, fire extinguishers in certain buildings, fire alarm systems, and the reporting of malicious false fire alarms; amending Minnesota Statutes 2000, sections 299F.18; 340A.311; repealing Minnesota Statutes 2000, sections 12.43; 169.219; 299F.015; 299F.19; 299F.30; 299F.361; 299F.451; 299F.452.

The bill was read for the first time and referred to the Committee on Crime Prevention.

Cassell, Greiling, Davnie, Ness, Mares and McGuire introduced:

H. F. No. 2041, A bill for an act relating to education; appropriating money for the commission on national and community service for the service learning program.

The bill was read for the first time and referred to the Committee on K-12 Education Finance.

Abrams introduced:

H. F. No. 2042, A bill for an act relating to taxation; reducing the rate of the insurance premiums tax; amending Minnesota Statutes 2000, section 297I.05, subdivisions 1, 4, 9, 10, 12.

The bill was read for the first time and referred to the Committee on Taxes.

Hausman, Lieder and Marko introduced:

H. F. No. 2043, A bill for an act relating to transportation; directing commissioner of transportation to study feasibility of assuming or sharing jurisdiction of major river crossings in Minnesota.

The bill was read for the first time and referred to the Committee on Transportation Policy.

Krinkie, Mahoney, Dawkins and Mariani introduced:

H. F. No. 2044, A bill for an act relating to state procurement; authorizing the commissioner to enter into agreements to acquire cooling services; amending Minnesota Statutes 2000, section 16C.22.

The bill was read for the first time and referred to the Committee on Governmental Operations and Veterans Affairs Policy.

Dawkins, Gunther and Mariani introduced:

H. F. No. 2045, A bill for an act relating to taxation; exempting machinery and other personal property of a biomass electrical generating facility from the property tax; amending Minnesota Statutes 2000, section 272.02, by adding a subdivision.

The bill was read for the first time and referred to the Committee on Taxes.

Walker, Mariani, Huntley, Gray and Clark, K., introduced:

H. F. No. 2046, A bill for an act relating to human services; modifying provisions for family and adult self-sufficiency; amending Minnesota Statutes 2000, sections 256D.053, subdivision 1; 256J.11, subdivision 3; 256J.21, subdivision 2; 256J.24, subdivision 10; 256J.37, subdivision 9; 256J.39, subdivision 2; 256J.42, subdivisions 1, 3, 4, by adding subdivisions; 256J.46, subdivisions 1, 2a; 256J.48, subdivision 2; 256J.50, subdivisions 1, 7; 256J.52, subdivision 2; 256J.53, subdivision 1; 256J.62, subdivision 9; 256J.625, subdivisions 1, 2, 4; proposing coding for new law in Minnesota Statutes, chapter 256J; repealing Minnesota Statutes 2000, sections 256.01, subdivision 18; 256J.32, subdivision 7a; 256J.46, subdivision 1a; 256J.53, subdivision 4.

The bill was read for the first time and referred to the Committee on Health and Human Services Policy.

Ozment and Tingelstad introduced:

H. F. No. 2047, A bill for an act relating to the environment; providing direction to public entities for developing bid specifications and procurement of commodities and services to promote recycled materials; amending Minnesota Statutes 2000, sections 16B.121; 16B.122, subdivision 3.

The bill was read for the first time and referred to the Committee on Governmental Operations and Veterans Affairs Policy.

Ness; Finseth; Penas; Dorman; Harder; Juhnke; Clark, K.; Wenzel; Otremba; Winter; Kahn; Leighton; Gunther; Mulder; Westrom; Tuma; Swenson; Kuisle; Erickson; Dehler; Marquart; Skoe and Holsten introduced:

H. F. No. 2048, A bill for an act relating to agriculture; providing environmental compliance grants for feedlot upgrades; appropriating money.

The bill was read for the first time and referred to the Committee on Agriculture and Rural Development Finance.

Davids introduced:

H. F. No. 2049, A bill for an act relating to insurance; providing qualifications and procedures for the licensing of insurance producers; prescribing a criminal penalty; amending Minnesota Statutes 2000, sections 13.7191, subdivision 6; 43A.317, subdivision 12; 60A.02, subdivision 7; 60A.14; 60A.198, subdivision 3; 62A.41, subdivision 4; 62C.17, subdivision 5; 62D.22, subdivision 8; 62H.10, subdivision 4; 62L.12, subdivision 3; 62S.30; 64B.33; 65B.09, subdivision 1; 72A.07; 72A.125, subdivision 2; 72A.201, subdivision 3; and 270B.07, subdivision 1; proposing coding for new law in Minnesota Statutes, chapters 60K; repealing Minnesota Statutes 2000, sections 60K.01; 60K.02; 60K.03; 60K.04; 60K.05; 60K.06; 60K.07; 60K.081; 60K.09; 60K.10; 60K.11; 60K.12; 60K.13; 60K.14; 60K.15; 60K.16; 60K.17; 60K.18; 60K.19; and 60K.20.

The bill was read for the first time and referred to the Committee on Commerce, Jobs and Economic Development.

Molnau introduced:

H. F. No. 2050, A bill for an act relating to human services; providing for a rate increase for a nursing facility in Carver county; amending Minnesota Statutes 2000, section 256B.431, by adding a subdivision.

The bill was read for the first time and referred to the Committee on Health and Human Services Finance.

Ozment introduced:

H. F. No. 2051, A bill for an act relating to taxes; sales and use; exempting purchase of construction materials and equipment used in construction of a water treatment facility and improvement of a utility facility in the city of Cannon Falls; amending Minnesota Statutes 2000, sections 297A.71, by adding a subdivision; 297A.75.

The bill was read for the first time and referred to the Committee on Taxes.

Ness introduced:

H. F. No. 2052, A bill for an act relating to agricultural trade; providing funding for an agricultural trade specialist position; appropriating money.

The bill was read for the first time and referred to the Committee on Agriculture and Rural Development Finance.

Ness introduced:

H. F. No. 2053, A bill for an act relating to agriculture; establishing a program to promote the production and sale of E-85 motor fuel; amending Minnesota Statutes 2000, section 41A.09, subdivision 2a; proposing coding for new law in Minnesota Statutes, chapter 41A.

The bill was read for the first time and referred to the Committee on Environment and Natural Resources Policy.

Holberg, Stanek, Fuller and Paymar introduced:

H. F. No. 2054, A bill for an act relating to public safety; establishing a grant program; appropriating money.

The bill was read for the first time and referred to the Committee on Crime Prevention.

Mares introduced:

H. F. No. 2055, A bill for an act relating to education finance; authorizing a grant for junior achievement programs; appropriating money.

The bill was read for the first time and referred to the Committee on K-12 Education Finance.

Larson and Mulder introduced:

H. F. No. 2056, A bill for an act relating to health occupations; establishing requirements for orthopedic physician assistant practice; protecting certain titles; establishing a ground for disciplinary action for physician assistants; amending Minnesota Statutes 2000, sections 147A.01, by adding subdivisions; 147A.03, subdivisions 3 and 4, and by adding a subdivision; and 147A.13, subdivision 1; proposing coding for new law in Minnesota Statutes, chapter 147A.

The bill was read for the first time and referred to the Committee on Health and Human Services Policy.

Kielkucki, Pelowski, Krinkie, Fuller, Buesgens, Olson, Schumacher and Anderson, B., introduced:

H. F. No. 2057, A bill for an act relating to education; repealing the profile of learning; establishing local academic achievement testing; establishing local testing revenue; appropriating money; amending Minnesota Statutes 2000, sections 120B.02; 120B.30, subdivision 1; 120B.31, subdivision 3; 120B.35; proposing coding for new law in Minnesota Statutes, chapter 120B; repealing Minnesota Statutes 2000, sections 120B.031; 120B.31, subdivisions 1, 2, 4; Minnesota Rules, parts 3501.0300; 3501.0310; 3501.0320; 3501.0330; 3501.0340; 3501.0350; 3501.0370; 3501.0380; 3501.0390; 3501.0400; 3501.0410; 3501.0420; 3501.0440; 3501.0441; 3501.0442; 3501.0443; 3501.0444; 3501.0445; 3501.0446; 3501.0447; 3501.0448; 3501.0449; 3501.0450; 3501.0460; 3501.0461; 3501.0462; 3501.0463; 3501.0464; 3501.0465; 3501.0466; 3501.0467; 3501.0468; 3501.0469.

The bill was read for the first time and referred to the Committee on Education Policy.

Bernardy, Greiling and McGuire introduced:

H. F. No. 2058, A bill for an act relating to ethics in government; requiring electronic filing of certain reports to the campaign finance and public disclosure board and publication of reports on the board's web site; amending Minnesota Statutes 2000, sections 10A.02, subdivision 11a; 10A.04, subdivision 1; 10A.05; 10A.09, subdivision 3; and 10A.20, by adding a subdivision.

The bill was read for the first time and referred to the Committee on Governmental Operations and Veterans Affairs Policy.

Bernardy, Greiling, McGuire and Wasiluk introduced:

H. F. No. 2059, A bill for an act relating to crime prevention; notifying schools of student delinquency; amending Minnesota Statutes 2000, section 121A.28.

The bill was read for the first time and referred to the Committee on Crime Prevention.

McGuire and Sykora introduced:

H. F. No. 2060, A bill for an act relating to appropriations; appropriating money for child care improvement grants.

The bill was read for the first time and referred to the Committee on Family and Early Childhood Education Finance.

Abrams introduced:

H. F. No. 2061, A bill for an act relating to counties; repealing the sunset of county capital improvement bonding authority; repealing Minnesota Statutes 2000, section 373.40, subdivision 7.

The bill was read for the first time and referred to the Committee on Local Government and Metropolitan Affairs.

Tuma, Stanek, Sykora, Skoglund, McGuire, Pugh and Smith introduced:

H. F. No. 2062, A bill for an act relating to corrections; establishing a parole board; prescribing its membership, duties, and powers; prescribing when an individual is eligible for parole; appropriating money; proposing coding for new law as Minnesota Statutes, chapter 244A.

The bill was read for the first time and referred to the Committee on Crime Prevention.

Osskopp and Kubly introduced:

H. F. No. 2063, A bill for an act relating to appropriations; appropriating money for managed grazing systems.

The bill was read for the first time and referred to the Committee on Environment and Natural Resources Finance.

Buesgens, Pelowski, Seagren, Marquart, Erickson and Schumacher introduced:

H. F. No. 2064, A bill for an act relating to education; establishing a task force to oversee revision of the profile of learning and develop statewide testing consistent with the revised profile of learning; appropriating money.

The bill was read for the first time and referred to the Committee on Education Policy.

Finseth introduced:

H. F. No. 2065, A bill for an act relating to natural resources; appropriating money for a hydraulic study of the Red river north of the city of East Grand Forks.

The bill was read for the first time and referred to the Committee on Environment and Natural Resources Finance.

Finseth introduced:

H. F. No. 2066, A bill for an act relating to education; providing for a nontraditional agriculture magnet program; appropriating money.

The bill was read for the first time and referred to the Committee on K-12 Education Finance.

McGuire, Skoglund, Paymar, Jaros and Wagenius introduced:

H. F. No. 2067, A bill for an act relating to crime prevention; requiring firearms to comply with certain safety requirements; imposing criminal penalties; proposing coding for new law in Minnesota Statutes, chapter 624.

The bill was read for the first time and referred to the Committee on Crime Prevention.

Kelliher, Entenza and Leighton introduced:

H. F. No. 2068, A bill for an act relating to health occupations; expanding the scope of practice for pharmacists; amending Minnesota Statutes 2000, sections 151.01, subdivision 27; 151.37, by adding a subdivision.

The bill was read for the first time and referred to the Committee on Health and Human Services Policy.

Dawkins introduced:

H. F. No. 2069, A bill for an act relating to housing; appropriating money to the housing finance agency for Section 8 home ownership programs.

The bill was read for the first time and referred to the Committee on Jobs and Economic Development Finance.

Gunther introduced:

H. F. No. 2070, A bill for an act relating to economic security; modifying and repealing various statutory provisions in the area of economic security; amending Minnesota Statutes 2000, sections 119A.46, subdivision 3; 268.0111, subdivision 4; 268.0122, subdivision 3; 268.665, subdivision 3; 268.871, subdivisions 1, 1a; repealing Minnesota Statutes 2000, sections 268.0111, subdivision 9; 268.6715; 268.672; 268.673; 268.6751; 268.677; 268.681; 268.6811; 268.682; 268.85; 268.86, subdivision 8; 268.871, subdivisions 2, 4; 268.88; 268.90; 268.971.

The bill was read for the first time and referred to the Committee on Commerce, Jobs and Economic Development.

Murphy and Mares introduced:

H. F. No. 2071, A bill for an act relating to retirement; establishing a normal retirement age for the Minneapolis and St. Paul teachers retirement fund associations; modifying the computation of the retirement annuity formula for Minneapolis and St. Paul teachers retirement fund associations coordinated and basic plan members by allowing a partial postretirement adjustment; amending Minnesota Statutes 2000, sections 354A.011, subdivision 15a; 354A.29, by adding a subdivision.

The bill was read for the first time and referred to the Committee on Governmental Operations and Veterans Affairs Policy.

Biernat, Thompson and Kahn introduced:

H. F. No. 2072, A bill for an act relating to elections; making it easier to vote by absentee ballot; prohibiting certain activities; providing for rules; amending Minnesota Statutes 2000, sections 203B.02, subdivision 1; 203B.04, subdivisions 1 and 4; 203B.06, subdivision 3; and 203B.07, subdivision 2; proposing coding for new law in Minnesota Statutes, chapter 203B.

The bill was read for the first time and referred to the Committee on Governmental Operations and Veterans Affairs Policy.

Evans, Slawik, Ozment and Greiling introduced:

H. F. No. 2073, A resolution memorializing the President and Congress to promptly provide aid to the victims of the January 26 earthquake in India.

The bill was read for the first time and referred to the Committee on Commerce, Jobs and Economic Development.

Clark, J.; Buesgens; Pawlenty; McElroy and Smith introduced:

H. F. No. 2074, A bill for an act relating to contracts; regulating public works contracts; proposing coding for new law in Minnesota Statutes, chapter 15.

The bill was read for the first time and referred to the Committee on Governmental Operations and Veterans Affairs Policy.

Kelliher, Dibble, Swapinski and Wagenius introduced:

H. F. No. 2075, A bill for an act relating to the environment; providing for limitations in the use and sale of phosphorous lawn fertilizers; requiring rulemaking; appropriating money; amending Minnesota Statutes 2000, section 115.01, by adding a subdivision; proposing coding for new law in Minnesota Statutes, chapter 115.

The bill was read for the first time and referred to the Committee on Environment and Natural Resources Policy.

Larson, Wilkin, Lenczewski, Pawlenty and Pugh introduced:

H. F. No. 2076, A bill for an act relating to the metropolitan airports commission; adding mayors to the commissioner membership; amending Minnesota Statutes 2000, sections 473.604, subdivision 1; 473.605, subdivision 2; 473.622; repealing Minnesota Statutes 2000, section 473.601, subdivisions 3, 6.

The bill was read for the first time and referred to the Committee on Local Government and Metropolitan Affairs.

Lenczewski, Abrams, Workman, Hilstrom, Seagren, Gray and Kelliher introduced:

H. F. No. 2077, A bill for an act relating to Hennepin county; providing for design-build contracts; proposing coding for new law in Minnesota Statutes, chapter 383B.

The bill was read for the first time and referred to the Committee on Local Government and Metropolitan Affairs.

Lieder introduced:

H. F. No. 2078, A bill for an act relating to education; providing for a fund transfer for independent school district No. 593, Crookston.

The bill was read for the first time and referred to the Committee on K-12 Education Finance.

Lieder introduced:

H. F. No. 2079, A bill for an act relating to education; providing for a grant to independent school district No. 600, Fisher; appropriating money.

The bill was read for the first time and referred to the Committee on K-12 Education Finance.

Mariani, Hausman, Paymar and Entenza introduced:

H. F. No. 2080, A bill for an act relating to liquor; authorizing the city of St. Paul to issue on-sale wine and malt liquor licenses to the Great American History Theater and Flanagan's Wake at the Palace Theatre; amending Minnesota Statutes 2000, section 340A.404, subdivision 2b.

The bill was read for the first time and referred to the Committee on Commerce, Jobs and Economic Development.

Biernat introduced:

H. F. No. 2081, A bill for an act relating to education finance; specifying the calculation to determine an excess in the debt redemption fund; authorizing certain fund transfers; amending Minnesota Statutes 2000, sections 123B.80, subdivision 1; 475.61, subdivision 3.

The bill was read for the first time and referred to the Committee on K-12 Education Finance.

Mulder introduced:

H. F. No. 2082, A bill for an act relating to taxes; sales and use; exempting purchase of construction materials and equipment used in construction of a school in independent school district No. 2689, Pipestone-Jasper; amending Minnesota Statutes 2000, sections 297A.71, by adding a subdivision; 297A.75.

The bill was read for the first time and referred to the Committee on Taxes.

Mulder introduced:

H. F. No. 2083, A bill for an act relating to education; allowing school districts to employ licensed teachers to teach in fields other than the fields in which they are licensed; proposing coding for new law in Minnesota Statutes, chapter 122A.

The bill was read for the first time and referred to the Committee on Education Policy.

Kubly introduced:

H. F. No. 2084, A bill for an act relating to motor vehicles; providing for single license plate for a registered vehicle; amending Minnesota Statutes 2000, sections 168.012, subdivision 1c; 168.013, subdivision 3; 168.021; 168.041, subdivision 6; 168.10, subdivisions 1g and 1i; 168.12, subdivision 1; 168.123, subdivisions 1 and 4; 168.125, subdivision 2; 168.129, subdivision 1; 168.1296, subdivision 1; and 169.79.

The bill was read for the first time and referred to the Committee on Transportation Policy.

Knoblach introduced:

H. F. No. 2085, A bill for an act relating to taxation; providing for payment of a sales tax rebate; providing for an automatic rebate under certain circumstances; providing for transfer of unclaimed rebates to be used to fund education; appropriating money; amending Minnesota Statutes 2000, section 16A.1522, subdivisions 2, 5.

The bill was read for the first time and referred to the Committee on Taxes.

Abrams, Jennings, Lenczewski, Wolf and Dorman introduced:

H. F. No. 2086, A bill for an act relating to taxes; sales and use taxes; exempting certain energy efficient products; amending Minnesota Statutes 2000, sections 297A.67, by adding subdivisions; 297B.03.

The bill was read for the first time and referred to the Committee on Taxes.

Pelowski, Cassell, Seifert, Carlson and Dorn introduced:

H. F. No. 2087, A bill for an act relating to higher education; authorizing a feasibility study of restructuring the central office of the Minnesota state colleges and universities.

The bill was read for the first time and referred to the Committee on Higher Education Finance.

Kubly, Skoe, Lieder, Juhnke, Huntley, Winter, Mulder, Sertich, Cassell, Westrom, Marquart, Swenson, Ness, Gunther, Otremba and Schumacher introduced:

H. F. No. 2088, A bill for an act relating to rural health; establishing a loan forgiveness program for health professionals practicing in rural hospitals or rural nursing homes; appropriating money; proposing coding for new law in Minnesota Statutes, chapter 144.

The bill was read for the first time and referred to the Committee on Health and Human Services Policy.

Dibble introduced:

H. F. No. 2089, A bill for an act relating to human services; providing a rate increase for a 60-bed board and care facility located in Minneapolis; amending Minnesota Statutes 2000, section 256B.431, by adding a subdivision.

The bill was read for the first time and referred to the Committee on Health and Human Services Finance.

Howes and Lieder introduced:

H. F. No. 2090, A bill for an act relating to highways; appropriating money to the commissioner of transportation for additional line personnel and related equipment and supplies in highway maintenance and program delivery.

The bill was read for the first time and referred to the Committee on Transportation Finance.

Olson, Rukavina, Fuller, Juhnke, Schumacher and Kubly introduced:

H. F. No. 2091, A bill for an act relating to natural resources; modifying registration of all-terrain vehicles; amending Minnesota Statutes 2000, section 84.922, subdivision 1a.

The bill was read for the first time and referred to the Committee on Environment and Natural Resources Policy.

Olson, Dehler, Gray, Kubly and Juhnke introduced:

H. F. No. 2092, A bill for an act relating to natural resources; modifying state park fees; requiring state campsites to remain open as scheduled; requiring a report; amending Minnesota Statutes 2000, section 85.055, subdivision 1; proposing coding for new law in Minnesota Statutes, chapter 85.

The bill was read for the first time and referred to the Committee on Environment and Natural Resources Policy.

Wenzel introduced:

H. F. No. 2093, A bill for an act relating to highway traffic regulations; authorizing religious organizations to operate buses painted school bus glossy yellow or golden orange and equipped with stop arm and flashing lights under certain circumstances; amending Minnesota Statutes 2000, section 169.448, by adding a subdivision.

The bill was read for the first time and referred to the Committee on Transportation Policy.

Dorman introduced:

H. F. No. 2094, A bill for an act relating to capital improvements; authorizing a grant to the Albert Lea Port Authority to remodel a building for use as a business incubator; authorizing issuance of bonds; appropriating money.

The bill was read for the first time and referred to the Committee on Jobs and Economic Development Finance.

Dorman introduced:

H. F. No. 2095, A bill for an act relating to economic development; appropriating money for a grant to the Albert Lea Port Authority to remodel a building for use as a business incubator.

The bill was read for the first time and referred to the Committee on Jobs and Economic Development Finance.

Mariani, Osthoff, Mares, Mahoney, Paymar, Dawkins, Entenza, Wasiluk, Hausman and Johnson, S., introduced:

H. F. No. 2096, A bill for an act relating to amateur athletics; providing for a St. Paul soccer exhibition center; appropriating money.

The bill was read for the first time and referred to the Committee on State Government Finance.

Slawik introduced:

H. F. No. 2097, A bill for an act relating to agriculture; regulating pesticide application on golf courses; proposing coding for new law in Minnesota Statutes, chapter 18B.

The bill was read for the first time and referred to the Committee on Agriculture Policy.

Murphy and Huntley introduced:

H. F. No. 2098, A bill for an act relating to human services; modifying the group residential housing supplementary service rate for certain facilities serving persons with mental illness or chemical dependency; amending Minnesota Statutes 2000, section 256I.05, by adding a subdivision.

The bill was read for the first time and referred to the Committee on Health and Human Services Policy.

Kelliher introduced:

H. F. No. 2099, A bill for an act relating to liquor; authorizing the city of Minneapolis to issue an on-sale wine and malt liquor license for the Brave New Institute; amending Minnesota Statutes 2000, section 340A.404, subdivision 2.

The bill was read for the first time and referred to the Committee on Commerce, Jobs and Economic Development.

Workman introduced:

H. F. No. 2100, A bill for an act relating to highways; advancing construction projects on I-494; temporarily suspending construction of I-35W/trunk highway No. 62 improvement project; requiring redesign of construction projects; redirecting available funds to I-494 project; appropriating money; authorizing issuance of trunk highway bonds.

The bill was read for the first time and referred to the Committee on Transportation Policy.

Workman introduced:

H. F. No. 2101, A bill for an act proposing an amendment to the Minnesota Constitution, article IV, section 12; prohibiting regular sessions in even-numbered years.

The bill was read for the first time and referred to the Committee on Governmental Operations and Veterans Affairs Policy.

Workman, Finseth and Westrom introduced:

H. F. No. 2102, A bill for an act relating to drivers' licenses; providing that speeding violation less than 18 percent greater than the lawful speed not be recorded on the violator's driving record; amending Minnesota Statutes 2000, section 171.12, subdivision 6.

The bill was read for the first time and referred to the Committee on Transportation Policy.

Hilty and Kalis introduced:

H. F. No. 2103, A bill for an act relating to energy; establishing cold weather protection for consumers of delivered fuels; proposing coding for new law in Minnesota Statutes, chapter 216B.

The bill was read for the first time and referred to the Committee on Regulated Industries.

Finseth introduced:

H. F. No. 2104, A bill for an act relating to agriculture; providing for a second-generation ethanol development program; providing grants for certain research and demonstration projects; appropriating money; amending Minnesota Statutes 2000, section 41A.09, subdivision 2a; proposing coding for new law in Minnesota Statutes, chapter 41A.

The bill was read for the first time and referred to the Committee on Agriculture Policy.

Greiling introduced:

H. F. No. 2105, A bill for an act relating to campaign finance and public disclosure; increasing the public's right to know; requiring disclosure of economic interests of independent contractors and consultants; changing certain definitions; requiring full disclosure of the total costs of lobbying; requiring certain reports; amending Minnesota Statutes 2000, sections 10A.01, subdivisions 5, 21, and 33; and 10A.04, subdivisions 4, 5, and 6.

The bill was read for the first time and referred to the Committee on Governmental Operations and Veterans Affairs Policy.

McElroy introduced:

H. F. No. 2106, A bill for an act relating to taxation; transferring the legal incidence of the mortgage registry tax from the mortgagee to the mortgagor; amending Minnesota Statutes 2000, sections 287.035; 287.08; 287.13, by adding a subdivision.

The bill was read for the first time and referred to the Committee on Taxes.

Johnson, J.; Mullery; Fuller; Thompson; Howes; Jacobson; Dehler; Wilkin; Ruth; Cassell; Marquart; Anderson, B.; Goodno; Penas and Erickson introduced:

H. F. No. 2107, A bill for an act relating to education; specifying student conduct as grounds for dismissal or removal from class; amending Minnesota Statutes 2000, sections 121A.45, subdivision 2; 121A.61, subdivision 2.

The bill was read for the first time and referred to the Committee on Education Policy.

Greiling and McGuire introduced:

H. F. No. 2108, A bill for an act relating to elections; limiting independent expenditures by political parties on behalf of their own candidates as a condition of receiving a public subsidy; amending Minnesota Statutes 2000, sections 10A.01, subdivision 18; 10A.25, subdivision 1, and by adding a subdivision; 10A.28, subdivision 1; 10A.31, subdivisions 3 and 5; 10A.322; and 290.06, subdivision 23.

The bill was read for the first time and referred to the Committee on Governmental Operations and Veterans Affairs Policy.

Johnson, J.; Daggett; Bernardy; Penas; Kubly and Boudreau introduced:

H. F. No. 2109, A bill for an act relating to children; child care assistance; allowing child care assistance payments to be used for all day kindergarten tuition payments; amending Minnesota Statutes 2000, sections 119B.011, subdivision 7; 119B.13, subdivision 1.

The bill was read for the first time and referred to the Committee on Family and Early Childhood Education Finance.

Howes, Winter, Knoblach, Pelowski and Hilstrom introduced:

H. F. No. 2110, A bill for an act relating to local government; providing a limited exemption for attendees at a national or international conference or event; amending Minnesota Statutes 2000, section 471.895, subdivision 3.

The bill was read for the first time and referred to the Committee on Local Government and Metropolitan Affairs.

Greiling introduced:

H. F. No. 2111, A bill for an act relating to openness in government; expanding the legislative open meeting law to cover caucuses and conference committee negotiations; amending Minnesota Statutes 2000, section 3.055, subdivision 1.

The bill was read for the first time and referred to the Committee on Governmental Operations and Veterans Affairs Policy.

Smith, Stanek, Walker, Davnie and Rhodes introduced:

H. F. No. 2112, A bill for an act relating to retirement; providing local government correctional service retirement plan coverage for Hennepin county medical center protection officers; amending Minnesota Statutes 2000, sections 353.01, subdivision 2b; 353E.02, subdivision 1.

The bill was read for the first time and referred to the Committee on Governmental Operations and Veterans Affairs Policy.

Gunther introduced:

H. F. No. 2113, A bill for an act relating to education; appropriating money for interactive television for independent school district No. 2752, Fairmont area schools.

The bill was read for the first time and referred to the Committee on K-12 Education Finance.

Greiling introduced:

H. F. No. 2114, A bill for an act relating to elections; providing for "clean money" campaigns funded without special interest money; expanding certain definitions; requiring certain campaign finance reports to be filed and published electronically; requiring notice of independent expenditures; requiring reports of excess spending by candidates who do not agree to limit spending; reducing certain contribution limits and spending limits; limiting independent expenditures by political parties on behalf of their own candidates as a condition of receiving a public subsidy; imposing campaign contribution and spending limits on political party caucuses as a condition of receiving a public subsidy; limiting multicandidate expenditures by political parties; increasing public subsidies for candidates who agree to lower contribution limits; increasing spending limits and public subsidies to respond to independent expenditures and excess spending by nonparticipating candidates; repealing the income tax checkoff for election campaigns; increasing the maximum political contribution refund from \$50 to \$100; imposing criminal penalties; appropriating money; amending Minnesota Statutes 2000, sections 10A.01, subdivisions 18, 21, and by adding a subdivision; 10A.02, subdivision 11a; 10A.14, subdivision 2; 10A.20, subdivisions 2, 6b, and by adding subdivisions; 10A.25, subdivisions 1, 2, 2a, 10, and by adding subdivisions; 10A.257, subdivision 1; 10A.27, subdivisions 1, 11, and by adding subdivisions; 10A.275, subdivision 1; 10A.28, subdivisions 1 and 2; 10A.315; 10A.322; 200.02, subdivision 7, and by adding a subdivision; and 290.06, subdivision 23; proposing coding for new law in Minnesota Statutes, chapter 10A; repealing Minnesota Statutes 2000, sections 10A.25, subdivision 6; and 10A.31.

The bill was read for the first time and referred to the Committee on Governmental Operations and Veterans Affairs Policy.

CONSENT CALENDAR

H. F. No. 323, A bill for an act relating to motor vehicle fuel franchises; extending an expiration date; amending Minnesota Statutes 2000, section 80C.147.

The bill was read for the third time and placed upon its final passage.

The question was taken on the passage of the bill and the roll was called. There were 131 yeas and 0 nays as follows:

Those who voted in the affirmative were:

Abeler	Dawkins	Gunther	Kahn	Mares	Ozment
Abrams	Dehler	Haas	Kalis	Mariani	Paulsen
Anderson, B.	Dempsey	Hackbarth	Kelliher	Marko	Pawlenty
Anderson, I.	Dibble	Harder	Kielkucki	Marquart	Paymar
Bakk	Dorman	Hausman	Knobloch	McElroy	Pelowski
Bernardy	Dorn	Hilstrom	Koskinen	McGuire	Penas
Biernat	Eastlund	Hilty	Krinkie	Milbert	Peterson
Bishop	Entenza	Holberg	Kubly	Molnau	Pugh
Boudreau	Erhardt	Holsten	Kuisele	Mulder	Rhodes
Bradley	Erickson	Howes	Larson	Mullery	Rifenberg
Buesgens	Evans	Huntley	Leighton	Murphy	Rukavina
Carlson	Finseth	Jacobson	Lenczewski	Ness	Ruth
Cassell	Folliard	Jaros	Leppik	Nornes	Schumacher
Clark, J.	Fuller	Jennings	Lieder	Olson	Seagren
Clark, K.	Gerlach	Johnson, J.	Lindner	Opatz	Seifert
Daggett	Gleason	Johnson, R.	Lipman	Osskopp	Sertich
Davids	Goodno	Johnson, S.	Luther	Osthoff	Skoe
Davnie	Greiling	Juhnke	Mahoney	Otremba	Skoglund

Slawik	Stang	Thompson	Walker	Westerberg	Wolf
Smith	Swapinski	Tingelstad	Walz	Westrom	Workman
Solberg	Swenson	Vanderveer	Wasiluk	Wilkin	Spk. Sviggum
Stanek	Sykora	Wagenius	Wenzel	Winter	

The bill was passed and its title agreed to.

CALENDAR FOR THE DAY

Pawlenty moved that the Calendar for the Day be continued. The motion prevailed.

MOTIONS AND RESOLUTIONS

Peterson moved that his name be stricken as an author on H. F. No. 150. The motion prevailed.

Pawlenty moved that the name of Knoblach be added as an author on H. F. No. 400. The motion prevailed.

Pawlenty moved that the name of Leighton be added as an author on H. F. No. 402. The motion prevailed.

Pawlenty moved that the name of Rifenberg be added as an author on H. F. No. 503. The motion prevailed.

Westrom moved that the names of Kubly, Mares, Koskinen and Kahn be added as authors on H. F. No. 594. The motion prevailed.

Sykora moved that the names of Dempsey and Rifenberg be added as authors on H. F. No. 646. The motion prevailed.

Lindner moved that the name of Sertich be added as an author on H. F. No. 679. The motion prevailed.

Daggett moved that the name of Johnson, R., be added as an author on H. F. No. 756. The motion prevailed.

Johnson, R., moved that the name of Murphy be added as an author on H. F. No. 944. The motion prevailed.

Gunther moved that the names of Dehler and Johnson, R., be added as authors on H. F. No. 1003. The motion prevailed.

Walker moved that the name of Biernat be added as an author on H. F. No. 1017. The motion prevailed.

Tingelstad moved that the name of Gray be added as an author on H. F. No. 1196. The motion prevailed.

Tingelstad moved that her name be stricken as an author on H. F. No. 1551. The motion prevailed.

Gerlach moved that the names of Haas, Rifenberg, Cassell and Krinkie be added as authors on H. F. No. 1614. The motion prevailed.

Abrams moved that the name of Lipman be added as an author on H. F. No. 1765. The motion prevailed.

Otremba moved that the name of Rhodes be added as an author on H. F. No. 1796. The motion prevailed.

Larson moved that the name of Leppik be added as an author on H. F. No. 1829. The motion prevailed.

Seifert moved that his name be stricken as an author on H. F. No. 1868. The motion prevailed.

Howes moved that the names of Fuller, Walz, Solberg, Skoe and Wenzel be added as authors on H. F. No. 1873. The motion prevailed.

Wilkin moved that the name of Holberg be added as an author on H. F. No. 1875. The motion prevailed.

Workman moved that the name of Holberg be added as an author on H. F. No. 1891. The motion prevailed.

Tuma moved that the names of Murphy; Hilstrom; Anderson, B.; Sykora; Gunther and Stanek be added as authors on H. F. No. 1911. The motion prevailed.

Penas moved that the name of Harder be added as an author on H. F. No. 1919. The motion prevailed.

Holberg moved that the names of Wilkin, Jacobson, McElroy and Paulsen be added as authors on H. F. No. 1944. The motion prevailed.

Kuisle moved that the name of Harder be added as an author on H. F. No. 1954. The motion prevailed.

Koskinen moved that the name of Tingelstad be added as an author on H. F. No. 1972. The motion prevailed.

Kuisle moved that the name of Rifenberg be added as an author on H. F. No. 2023. The motion prevailed.

Hackbarth moved that H. F. No. 691 be recalled from the Committee on Environment and Natural Resources Policy and be re-referred to the Committee on Environment and Natural Resources Finance. The motion prevailed.

Koskinen moved that H. F. No. 1095 be recalled from the Committee on Taxes and be re-referred to the Committee on Commerce, Jobs and Economic Development. The motion prevailed.

Gunther moved that H. F. No. 1219, now on the General Register, be re-referred to the Committee on Governmental Operations and Veterans Affairs Policy. The motion prevailed.

Mahoney moved that H. F. No. 1504 be recalled from the Committee on Governmental Operations and Veterans Affairs Policy and be re-referred to the Committee on Commerce, Jobs and Economic Development. The motion prevailed.

Mahoney moved that H. F. No. 1634 be recalled from the Committee on Health and Human Services Policy and be re-referred to the Committee on Civil Law. The motion prevailed.

Kahn moved that H. F. No. 1938 be recalled from the Committee on Commerce, Jobs and Economic Development and be re-referred to the Committee on Governmental Operations and Veterans Affairs Policy. The motion prevailed.

Mahoney moved that H. F. No. 690 be returned to its author. The motion prevailed.

Kahn moved that H. F. No. 2004 be returned to its author. The motion prevailed.

Molnau introduced:

House Resolution No. 10, A house resolution commending Chaska Police Officers Brady Juell and Mike Kleber.

The resolution was referred to the Committee on Crime Prevention.

ADJOURNMENT

Pawlenty moved that when the House adjourns today it adjourn until 3:00 p.m., Thursday, March 22, 2001. The motion prevailed.

Pawlenty moved that the House adjourn. The motion prevailed, and Speaker pro tempore Dehler declared the House stands adjourned until 3:00 p.m., Thursday, March 22, 2001.

EDWARD A. BURDICK, Chief Clerk, House of Representatives