

## STATE OF MINNESOTA

## EIGHTY-SECOND SESSION — 2001

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 FIFTY-FIRST DAY

SAINT PAUL, MINNESOTA, THURSDAY, MAY 10, 2001

The House of Representatives convened at 9:00 a.m. and was called to order by Steve Sviggum, Speaker of the House.

The colors were presented by the Minnesota Law Enforcement Memorial Association Honor Guard.

The Law Enforcement Memorial Prayer was offered by Captain Larry Klink of the Anoka County Sheriff's Office.

Prayer was offered by Father Terrence Hayes, Minneapolis Police Department Chaplain, Minneapolis, Minnesota.

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

A quorum was present.

Walker was excused.

Mahoney was excused until 9:50 a.m. Osthoff was excused until 10:10 a.m. Clark, K., was excused until 10:30 a.m.

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

#### REPORTS OF CHIEF CLERK

S. F. No. 1495 and H. F. No. 1547, which had been referred to the Chief Clerk for comparison, were examined and found to be identical with certain exceptions.

#### SUSPENSION OF RULES

Finseth moved that the rules be so far suspended that S. F. No. 1495 be substituted for H. F. No. 1547 and that the House File be indefinitely postponed. The motion prevailed.

S. F. No. 1721 and H. F. No. 1886, which had been referred to the Chief Clerk for comparison, were examined and found to be identical with certain exceptions.

#### SUSPENSION OF RULES

Kahn moved that the rules be so far suspended that S. F. No. 1721 be substituted for H. F. No. 1886 and that the House File be indefinitely postponed. The motion prevailed.

### REPORTS OF STANDING COMMITTEES

Pawlenty from the Committee on Rules and Legislative Administration to which was referred:

H. F. No. 281, A bill for an act relating to civil commitment; modifying a definition; specifying certain patient rights and examination requirements; expanding voluntary consent procedures; modifying the standard for and collection of information for an emergency hold; requiring certain hearings on neuroleptic medications to be combined with a civil commitment proceeding; amending Minnesota Statutes 2000, sections 253B.02, subdivision 13; 253B.03, subdivisions 5, 10, by adding a subdivision; 253B.04, subdivisions 1, 1a, by adding a subdivision; 253B.05, subdivision 1; 253B.066, subdivision 1; 253B.07, subdivisions 1, 2; 253B.09, subdivision 1.

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

Joint Rule 2.03 and Senate Concurrent Resolution No. 5 have been waived for subsequent committee action on this bill.

The report was adopted.

Bishop from the Committee on Ways and Means to which was referred:

H. F. No. 1807, A bill for an act relating to children; providing for measures to improve child support collection and enforcement; providing civil penalties; amending Minnesota Statutes 2000, sections 13B.06, subdivision 7; 256.741, subdivisions 1, 5, and 8; 256.979, subdivisions 5 and 6; 393.07, by adding a subdivision; 518.5513,

subdivision 5; 518.575, subdivision 1; 518.5851, by adding a subdivision; 518.5853, by adding a subdivision; 518.6195; 518.64, subdivision 2; 518.641, subdivisions 1, 2, 3, and by adding a subdivision; and 548.091, subdivision 1a; repealing Minnesota Statutes 2000, section 518.641, subdivisions 4 and 5.

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

The report was adopted.

Abrams from the Committee on Taxes to which was referred:

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.

Reported the same back with the following amendments:

Delete everything after the enacting clause and insert:

"Section 1. Minnesota Statutes 2000, section 103B.555, is amended by adding a subdivision to read:

Subd. 4. [DISTRICT OBLIGATIONS.] The district, with approval of the county board or joint county authority, expressed in a resolution identifying each specific improvement to which the approval applies, may exercise the powers of a city under chapter 429 and section 444.075, including, but not limited to:

(1) the levy of special assessments;

(2) the imposition of rates and charges; and

(3) the issuance of bonds

to finance improvements that the district may undertake.

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

Sec. 2. Minnesota Statutes 2000, section 165.10, subdivision 2, is amended to read:

Subd. 2. [BONDS ISSUED, SOLD, AND RETIRED.] Such bonds shall be general obligations of the county and issued, sold, and retired in the manner provided in chapter 475.

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

Sec. 3. Minnesota Statutes 2000, section 275.60, is amended to read:

275.60 [LEVY OR BOND REFERENDUM; BALLOT NOTICE.]

(a) Notwithstanding any general or special law or any charter provisions, but subject to section 126C.17, subdivision 9, any question submitted to the voters by any local governmental subdivision at a general or special

election after June 8, 1995, authorizing a property tax levy or tax rate increase, including the issuance of debt obligations payable in whole or in part from property taxes, must include on the ballot the following notice in boldface type:

"BY VOTING "YES" ON THIS BALLOT QUESTION, YOU ARE VOTING FOR A PROPERTY TAX INCREASE."

(b) For purposes of this section and section 275.61, "local governmental subdivision" includes counties, home rule and statutory cities, towns, school districts, and all special taxing districts. This statement is in addition to any general or special laws or any charter provisions that govern the contents of a ballot question and, in the case of a question on the issuance of debt obligations, may be supplemented by a description of revenues pledged to payment of the obligations that are intended as the primary source of payment.

(c) This section does not apply to a school district bond election if the debt service payments are to be made entirely from transfers of revenue from the capital fund to the debt service fund.

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

Sec. 4. Minnesota Statutes 2000, section 373.40, subdivision 1, is amended to read:

Subdivision 1. [DEFINITIONS.] For purposes of this section, the following terms have the meanings given.

(a) "Bonds" means an obligation as defined under section 475.51.

(b) "Capital improvement" means acquisition or betterment of public lands, development rights in the form of conservation easements under chapter 84C, buildings, or other improvements within the county for the purpose of a county courthouse, administrative building, health or social service facility, correctional facility, jail, law enforcement center, hospital, morgue, library, park, qualified indoor ice arena, and roads and bridges. An improvement must have an expected useful life of five years or more to qualify. "Capital improvement" does not include light rail transit, commuter rail, busway, or any activity related to ~~it~~ any of them, or a recreation or sports facility building (such as, but not limited to, a gymnasium, ice arena, racquet sports facility, swimming pool, exercise room or health spa), unless the building is part of an outdoor park facility and is incidental to the primary purpose of outdoor recreation.

(c) "Commissioner" means the commissioner of trade and economic development.

(d) "Metropolitan county" means a county located in the seven-county metropolitan area as defined in section 473.121 or a county with a population of 90,000 or more.

(e) "Population" means the population established by the most recent of the following (determined as of the date the resolution authorizing the bonds was adopted):

(1) the federal decennial census,

(2) a special census conducted under contract by the United States Bureau of the Census, or

(3) a population estimate made either by the metropolitan council or by the state demographer under section 4A.02.

(f) "Qualified indoor ice arena" means a facility that meets the requirements of section 373.43.

(g) "Tax capacity" means total taxable market value, but does not include captured market value.

Sec. 5. Minnesota Statutes 2000, section 373.40, subdivision 7, is amended to read:

Subd. 7. [REPEALER.] This section is repealed effective for bonds issued after July 1, ~~2003~~ 2008, but continues to apply to bonds issued before that date.

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

Sec. 6. Minnesota Statutes 2000, section 373.45, subdivision 3, is amended to read:

Subd. 3. [AGREEMENT.] (a) ~~In order~~ For specified debt obligations of a county to be covered by ~~the provisions of~~ this section, the county must enter an agreement with the authority obligating the county to be bound by ~~the provisions of~~ this section.

(b) This agreement must be in a form prescribed by the authority and contain any provisions required by the authority, including, at least, an obligation to:

(1) deposit with the paying agent three days before the date on which the payment is due an amount sufficient to make that payment;

(2) notify the authority, if the county will be unable to make all or a portion of the payment; and

(3) include a provision in the bond resolution and county's agreement with the paying agent for the debt obligation that requires the paying agent to inform the commissioner if it becomes aware of a default or potential default in the payment of principal or interest on that issue or if, on the day two business days before the date a payment is due on that issue, there are insufficient funds to make the payment on deposit with the paying agent.

(c) Funds invested in a refunding escrow account established under section 475.67 that are to become available to the paying agent on a principal or interest payment date are deemed to be on deposit with the paying agent three business days before the payment date.

~~(b)~~ (d) The provisions of an agreement under this subdivision are binding as to an issue as long as any debt obligation of the issue remains outstanding.

~~(c)~~ (e) This section is a contract with bondholders and may not be amended or repealed for the covered bonds so long as the covered bonds are outstanding and the obligations of the state under this section are not a public debt of the state under article XI, section 4, of the Minnesota Constitution, and the legislature may, at any time, choose not to appropriate amounts under subdivision 4, paragraph (b).

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

Sec. 7. Minnesota Statutes 2000, section 376.06, subdivision 1, is amended to read:

Subdivision 1. [PROCEDURE, POWERS, PAY, ELECTION.] A county board which has purchased and constructed buildings for hospital purposes may operate these buildings as a hospital and may appoint a superintendent. The board shall set the superintendent's salary, term of employment, and powers and duties; provide for the management and operation of the hospital; and operate, control, and manage the hospital. The superintendent shall serve at the pleasure of the board. If the board determines that it is in the public interest, it may appoint a hospital board of at least three, but not more than nine members, who ~~must be county residents and landowners, to serve~~ may include some or all of the county commissioners except as otherwise provided in subdivision 2. Persons appointed to the hospital board must reside in the hospital's service area and 80 percent of the board members, including any commissioners appointed to serve on the hospital board, must be residents of the county. The hospital board serves without compensation unless the county board authorizes the payment of compensation and reimbursement of expenses for service on the hospital board. Notwithstanding section 375.44, if compensation and reimbursement are authorized, they shall be the same as authorized for service on the local

social services agency. Subject to its supervision, the county board may commit the care, management, and operation of the hospital to the hospital board. The county board may provide for the organization and regulation of the hospital board, its duties and the duties of the members, and regulations for the management, operation, and control of the hospital. The county board may lease the hospital grounds and buildings to a ~~hospital association nonprofit or governmental hospital organization~~ for terms it considers advisable. ~~Sections 376.01 to 376.06 do not permit any county board to purchase and construct any hospital buildings or to pay for them without first submitting the question to the vote of the people. No purchase or construction of buildings or payment may be made unless a majority of the electors voting upon the proposition vote in favor.~~

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

Sec. 8. Minnesota Statutes 2000, section 376.07, is amended to read:

376.07 [ADDITION TO COUNTY HOSPITAL.]

~~When the county board of a county has been authorized by the voters to construct an addition to the county hospital of the county under sections 376.01 to 376.06, whether or not also authorized to equip the addition, and the board has determined that the addition, whether with or without equipment, cannot be completed within the cost authorized, or has determined that, to complete the improvement, certain alterations should be made, or fixtures or equipment added, either in the original building, or in the addition, or both, the board may be authorized to spend a specified additional amount for any of the purposes mentioned in this chapter, either by vote of the people of the county at a general or special election or by petition. If an election is held, the proposition shall be submitted and disposed of in the same manner as provided by sections 376.01 to 376.06. If by petition, the petition must be signed by a majority of those voting at the last preceding general election. The petition may be in the form of one document or of several documents in the same form, and shall be filed with the county auditor. A special election may be called in the manner provided for calling special county elections. When authority is granted by the voters, in either manner provided, the board may proceed accordingly. If the board made or attempted to make a contract or contracts for more than the authority first granted, it may ratify and carry out the contracts. The county board, hospital board, or board of directors of a nonprofit or governmental hospital organization that has leased a county hospital may authorize the remodeling, improvement, alteration, or construction of an addition to the county hospital or of another building on the county hospital's existing premises by a majority vote of the board. Financing for any project under this section is governed by other law, including sections 373.40 and 447.45 and chapter 475.~~

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

Sec. 9. Minnesota Statutes 2000, section 376.08, subdivision 1, is amended to read:

Subdivision 1. [APPROPRIATIONS.] ~~Except as provided in subdivision subdivisions 2 and 4,~~ the board of county commissioners in any county with a population of 50,000 or less may appropriate up to \$65,000 annually from the general revenue fund of the county for the acquisition of lands for hospital purposes, and the construction, improvement, alterations, equipment and maintenance of hospitals within the county, including public or nonprofit hospitals that are not county hospitals. The board may also appropriate up to \$25,000 from the general revenue fund of the county for the acquisition of land and construction of municipally owned nursing homes within the county.

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

Sec. 10. Minnesota Statutes 2000, section 376.08, subdivision 2, is amended to read:

Subd. 2. [REMODELING OR ADDITIONS.] A county hospital may by majority vote of its board of commissioners, or if the hospital has been leased to another entity under section 376.06, subdivision 1, or 447.47, by majority vote of the board of directors of that entity, enter into projects for the construction of an addition or remodeling to its presently existing facility or the acquisition of equipment as described in this subdivision without complying with the dollar limitation of subdivision 1 or the election requirements of section 376.03. This subdivision applies ~~only~~ to projects in which the funds for the project are derived from dedicated, restricted, or other

designated accounts ~~or, from~~ the hospital's depreciation fund ~~and do not require incurring debt by the county through, or from~~ the issuance of bonds ~~or otherwise authorized under other law~~. An addition to a current hospital under this subdivision may include construction of buildings physically separate from the present hospital building, as well as additions to the present building, if the new buildings are constructed on the hospital's existing premises.

This subdivision does not affect the ability of the hospital board to approve funds for improvements or remodeling of a hospital facility under other law.

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

Sec. 11. Minnesota Statutes 2000, section 376.08, subdivision 3, is amended to read:

Subd. 3. [LIMITATION ON HOSPITAL CAPACITY.] Section 144.551 applies to any project authorized by subdivision 2 ~~or 4~~. ~~Subdivision 2 does and 4 do not~~ authorize an increase in the license capacity of the hospital or the licensing, relocation, or redistribution of hospital beds except as provided by section 144.551, subdivision 1, paragraph (b).

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

Sec. 12. Minnesota Statutes 2000, section 376.08, is amended by adding a subdivision to read:

Subd. 4. [NO ELECTION FOR EXPENDITURE OF CERTAIN BOND PROCEEDS.] Notwithstanding section 376.03, a county may by vote of the majority of the board of county commissioners acquire, construct, remodel, renovate, and equip hospital facilities to the extent of money derived from general obligation bonds authorized for that purpose by an election under section 475.58, capital improvement bonds issued under a capital improvement plan approved in accordance with section 373.40, or revenue bonds issued under sections 447.45 to 447.50.

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

Sec. 13. Minnesota Statutes 2000, section 376.09, is amended to read:

376.09 [AID TO HOSPITALS IN COUNTIES HAVING NO COUNTY HOSPITAL.]

In any county in which there is no county hospital, or a county hospital is leased to a nonprofit or governmental hospital organization pursuant to section 376.06, subdivision 1, or 447.47, the county board may appropriate and pay money from the general fund of the county, for the construction, maintenance, and operation of a private, nonprofit, or public hospital in the county for the treatment of sick, diseased, and injured persons. Admission preference shall always be given to patients who are, in whole or in part, public charges, and are sent to the hospital by the county board.

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

Sec. 14. Minnesota Statutes 2000, section 383B.79, is amended by adding a subdivision to read:

Subd. 5. [FINANCING.] Hennepin county may appropriate funds for any of the activities described in subdivision 1, whether or not state funds are appropriated for the activity. Hennepin county may include any part of the costs of a project described in section 469.002, subdivision 12, in a capital improvement plan adopted under section 373.40, and may issue bonds for such purposes pursuant to and subject to the procedures and limitations set forth in section 373.40, whether or not the capital improvement to be financed is to be owned by the county or any other governmental entity. Such purposes are in addition to the capital improvements described in section 373.40, but shall not include light rail transit, commuter rail, or any activity related to either of those, or a sports facility building designed or used primarily for professional sports. No funds appropriated under this subdivision may be used to pay operating expenses.

Sec. 15. Minnesota Statutes 2000, section 473.39, is amended by adding a subdivision to read:

Subd. 1h. [OBLIGATIONS.] After July 1, 2001, in addition to the authority in subdivisions 1a, 1b, 1c, 1d, 1e, and 1g, the council may issue certificates of indebtedness, bonds, or other obligations under this section in an amount not exceeding \$45,000,000 for capital expenditures as prescribed in the council's regional transit master plan and transit capital improvement program and for related costs, including the costs of issuance and sale of the obligations, but not for construction, maintenance, or operation of light rail transit, commuter rail, or busways.

**[EFFECTIVE DATE; APPLICATION.]** This section is effective the day following final enactment and applies in the counties of Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington.

Sec. 16. Minnesota Statutes 2000, section 474A.02, subdivision 8, is amended to read:

Subd. 8. [FEDERAL TAX LAW.] "Federal tax law" means those provisions of the Internal Revenue Code of 1986, as amended ~~through December 31, 1990~~, that limit the aggregate amount of obligations of a specified type or types which may be issued by an issuer during a calendar year whose interest is excluded from gross income for purposes of federal income taxation.

Sec. 17. Minnesota Statutes 2000, section 474A.02, subdivision 13a, is amended to read:

Subd. 13a. [SMALL ISSUE POOL.] "Small issue pool" means the amount of the annual volume cap allocated under section 474A.061, that is available for the issuance of enterprise zone facility bonds authorized under Public Law Number 103-66, section 13301, small issue bonds to finance manufacturing projects, ~~and~~ the agricultural development bond beginning farmer and agricultural business enterprise loan program authorized in sections 41C.01 to 41C.13, and student loan bonds issued by the Minnesota higher education services office.

Sec. 18. Minnesota Statutes 2000, section 474A.02, subdivision 22a, is amended to read:

Subd. 22a. [PUBLIC FACILITIES POOL.] "Public facilities pool" means the amount of the annual volume cap allocated under section 474A.061, which is available for the issuance of public facility bonds ~~or student loan bonds.~~

Sec. 19. Minnesota Statutes 2000, section 474A.02, subdivision 22b, is amended to read:

Subd. 22b. [PUBLIC FACILITIES PROJECT.] "Public facilities project" means any publicly owned facility, or facility owned by a nonprofit organization that is used for district heating or cooling, that is eligible to be financed with the proceeds of public facilities bonds as defined under section 474A.02, subdivision 23a.

Sec. 20. Minnesota Statutes 2000, section 474A.02, subdivision 23a, is amended to read:

Subd. 23a. [QUALIFIED BONDS.] "Qualified bonds" means the specific type or types of obligations that are subject to the annual volume cap. Qualified bonds include the following types of obligations as defined in federal tax law:

(a) "public facility bonds" means "exempt facility bonds" as defined in federal tax law, except for residential rental project bonds, which are those obligations issued to finance airports, docks and wharves, mass commuting facilities, facilities for the furnishing of water, sewage facilities, solid waste disposal facilities, facilities for the local furnishing of electric energy or gas, local district heating or cooling facilities, and qualified hazardous waste facilities. New bonds and other obligations are ineligible to receive state allocations or entitlement authority for public facility projects under this section if they have been issued:

- (1) for the purpose of refinancing, refunding, or otherwise defeasing existing debt; and
- (2) more than one calendar year prior to the date of application;



(b) "residential rental project bonds" which are those obligations issued to finance qualified residential rental projects;

(c) "mortgage bonds";

(d) "small issue bonds" issued to finance manufacturing projects and the acquisition or improvement of agricultural real or personal property under sections 41C.01 to 41C.13;

(e) "student loan bonds" issued by or on behalf of the Minnesota higher education services office;

(f) "redevelopment bonds";

(g) "governmental bonds" with a nonqualified amount in excess of \$15,000,000 as set forth in section 141(b)5 of federal tax law; and

(h) "enterprise zone facility bonds" issued to finance facilities located within empowerment zones or enterprise communities, as authorized under Public Law Number 103-66, section 13301.

Sec. 21. Minnesota Statutes 2000, section 474A.03, subdivision 1, is amended to read:

Subdivision 1. [UNDER FEDERAL TAX LAW; ALLOCATIONS.] At the beginning of each calendar year after December 31, ~~1997~~ 2001, the commissioner shall determine the aggregate dollar amount of the annual volume cap under federal tax law for the calendar year, and of this amount the commissioner shall make the following allocation:

(1) ~~\$63,000,000~~ \$74,530,000 to the small issue pool;

(2) ~~\$59,000,000~~ \$122,060,000 to the housing pool, ~~\$37,000,000~~ of which 31 percent of the adjusted allocation is reserved until the ~~day after the first~~ last Monday in ~~February~~ July for single-family housing programs;

(3) ~~\$10,500,000~~ \$12,750,000 to the public facilities pool; and

(4) amounts to be allocated as provided in subdivision 2a.

If the annual volume cap is greater or less than the amount of bonding authority allocated under clauses (1) to (4) and subdivision 2a, paragraph (a), clauses (1) to (4), the allocation must be adjusted so that each adjusted allocation is the same percentage of the annual volume cap as each original allocation is of the total bonding authority originally allocated.

Sec. 22. Minnesota Statutes 2000, section 474A.03, subdivision 2a, is amended to read:

Subd. 2a. [ENTITLEMENT ISSUER ALLOCATION.] (a) The commissioner shall make the following allocation to the Minnesota housing finance agency and the following cities and county:

(1) ~~\$53,750,000~~ \$84,940,000 per year to the Minnesota housing finance agency, ~~less any amount received in the previous year under section 474A.091, subdivision 6~~;

(2) ~~\$21,000,000~~ \$33,190,000 per year to the city of Minneapolis;

(3) ~~\$15,750,000~~ \$24,890,000 per year to the city of Saint Paul; and

(4) ~~\$10,500,000~~ \$16,600,000 per year to the Dakota county community development agency for the county of Dakota and all political subdivisions located within the county.

(b) Entitlement allocations provided under this subdivision must be used for mortgage bonds, mortgage credit certificates, public facility bonds, or residential rental project bonds, except that entitlement issuers ~~may also use their allocations for public facility bonds, and~~ may carry forward their allocations for any qualified bond as defined under section 474A.02, subdivision 23a.

(c) Data on the home purchase price amount, mortgage amount, income, household size, and race of the households served with the proceeds of mortgage revenue bonds and mortgage credit certificates in the previous year must be submitted by each entitlement issuer to the Minnesota housing finance agency by December 31 of each year. Compliance by the Minnesota housing finance agency with the provisions of section 462A.073, subdivision 5, shall be deemed compliance with the reporting requirements of this subdivision.

Sec. 23. Minnesota Statutes 2000, section 474A.03, subdivision 4, is amended to read:

Subd. 4. [APPLICATION FEE.] Every entitlement issuer and other issuer shall pay to the commissioner a nonrefundable application fee to offset the state cost of program administration. The application fee is \$20 for each \$100,000 of entitlement or allocation requested, with the request rounded to the nearest \$100,000. The minimum fee is \$20. Fees received by the commissioner must be credited to the general fund. ~~Application fees for projects of entitlement issuers must be submitted to the commissioner with the notice of issuance of bonds, notice of use of mortgage credit certificates, and notice of carry forward.~~ Each entitlement issuer must pay its application fee in full for that calendar year to the commissioner no later than when the first notice of issuance of bonds, notice of use of mortgage credit certificates, or notice of carry forward is submitted to the commissioner by that issuer.

Sec. 24. Minnesota Statutes 2000, section 474A.04, subdivision 1a, is amended to read:

Subd. 1a. [ENTITLEMENT RESERVATIONS; CARRYFORWARD; DEDUCTION.] Any amount returned by an entitlement issuer before July 15 shall be reallocated through the housing pool. Any amount returned on or after July 15 shall be reallocated through the unified pool. An amount returned after the last Monday in November shall be reallocated to the Minnesota housing finance agency. Any amount of bonding authority that an entitlement issuer carries forward under federal tax law that is not permanently issued or for which the governing body of the entitlement issuer has not enacted a resolution electing to use the authority for mortgage credit certificates ~~by July 15 and has not provided a notice of issue to the commissioner before 4:30 p.m. on the last business day in December~~ of the succeeding calendar year shall be deducted from the entitlement allocation for that entitlement issuer ~~for the current calendar year. Any amount deducted from an entitlement issuer's allocation under this subdivision shall be reallocated through the unified pool. An entitlement issuer must permanently issue all carryforward authority or enact a resolution electing to use all carryforward authority for mortgage credit certificates prior to issuing any current year authority of that entitlement issuer in the next succeeding calendar year. Any amount deducted from an entitlement issuer's allocation under this subdivision shall be reallocated to other entitlement issuers, the housing pool, the small issue pool, and the public facilities pool on a proportional basis consistent with section 474A.03.~~

Sec. 25. Minnesota Statutes 2000, section 474A.04, subdivision 5, is amended to read:

Subd. 5. [NOTICE OF ENTITLEMENT ALLOCATION.] As soon as possible in each calendar year, the commissioner shall ~~provide to each entitlement issuer a written notice of the amount of its~~ post on the department's Web site the amount of each entitlement allocation.

Sec. 26. Minnesota Statutes 2000, section 474A.045, is amended to read:

474A.045 [SCORING SYSTEM FOR ENTERPRISE ZONE FACILITY PROJECTS AND MANUFACTURING PROJECTS.]

The following criteria must be used in determining the allocation of enterprise zone facility bonds and small issue bonds for manufacturing projects. The issuer must prepare and submit to the commissioner a public purpose scoring worksheet that presents the data and methods used in determining the total score under this section. The total score is the sum of the following:

(1) the number of direct new jobs in the state generated by the proposed project for the next two years per \$100,000 of proposed allocation multiplied by 15;

(2) the number of direct existing jobs in the state multiplied by .625 due to the proposed project for the next two years per \$100,000 of proposed allocation multiplied by 15;

(3) the average hourly wage paid to employees by the proposed project for the next two years, exclusive of benefits mandated by law, based on the following scale:

Wages paid per hour	\$ 8	\$10	\$12	\$15
Non-Metro area points awarded	10	15	20	20
Seven-County Metro Area points awarded	0	10	15	20

For purposes of this section, the seven-county metropolitan area includes Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington counties;

(4) the quotient of the estimated total net increase in property taxes generated in the state by the project in the first full year of operation divided by the proposed bond allocation, multiplied by 500; ~~and~~

(5) the seasonally unadjusted unemployment rate in the community where the proposed project is located measured as a percent of the state's unemployment rate, multiplied by ten.

The community seasonally unadjusted unemployment rate used in determining the points under clause (5) must be the most recent rate for the city or county in which the proposed project is located, as provided by the commissioner of economic security.

(6) 20 points for projects that locate in an incorporated area or a planned urban growth area as defined by section 462.352, subdivision 18;

(7) 20 points for brownfield projects located in a state or federal Superfund site, a voluntary investigation and cleanup site, or a brownfield site, all as defined by the Minnesota pollution control agency; and

(8) 20 points for projects with favorable environmental citizenship as evidenced by no nonforgivable or combination administrative penalty orders, stipulation agreements, consent decrees, or other enforcement orders containing a monetary penalty by the Minnesota pollution control agency over the past three years or pending at the time of application.

Sec. 27. Minnesota Statutes 2000, section 474A.047, subdivision 1, is amended to read:

Subdivision 1. [ELIGIBILITY.] (a) An issuer may only use the proceeds from residential rental bonds if the proposed project meets ~~one of the following requirements~~:

~~(1) the proposed project is a single room occupancy project and all the units of the project will be occupied by individuals whose incomes at the time of their initial residency in the project are 50 percent or less of the greater of the statewide or county median income adjusted for household size as determined by the federal Department of Housing and Urban Development;~~

~~(2) the proposed project is a multifamily project where at least 75 percent of the units have two or more bedrooms and at least one-third of the 75 percent have three or more bedrooms; or~~

~~(3) the proposed project is a multifamily project that meets the following requirements:~~

~~(i) the proposed project is the rehabilitation of an existing building which meets the requirements for minimum rehabilitation expenditures in sections 42(e)(2) and 42(e)(3)(A) of the Internal Revenue Code;~~

~~(ii) the proposed project involves participation by the Minnesota housing finance agency or a local unit of government in the financing of the acquisition or rehabilitation of the project. For purposes of this subdivision, "participation" means an activity other than the issuance of the bonds; and~~

~~(iii) the proposed project must be occupied by individuals or families whose incomes at the time of their initial residency in the project meet the requirements of section 42(g) of the Internal Revenue Code.~~

(1) the proposed residential rental project meets the requirements of section 142(d) of the Internal Revenue Code regarding the incomes of the occupants of the housing; and

(2) the maximum rent for at least 20 percent of the units in the proposed residential rental project do not exceed the area fair market rent or exception fair market rents for existing housing, if applicable, as established by the federal Department of Housing and Urban Development.

~~(b) The maximum rent for a proposed single room occupancy unit under paragraph (a), clause (1), is 30 percent of the amount equal to 30 percent of the greater of the statewide or county median income for a one-member household as determined by the federal Department of Housing and Urban Development. The maximum rent for at least 75 percent of the units of a multifamily project under paragraph (a), clause (2), is 30 percent of the amount equal to 50 percent of the greater of the statewide or county median income as determined by the federal Department of Housing and Urban Development based on a household size with 1.5 persons per bedroom.~~

~~(c) The proceeds from residential rental bonds may be used for a project for which project-based federal rental assistance payments are made only if:~~

~~(1) the owner of the project enters into a binding agreement with the Minnesota housing finance agency under which the owner is obligated to extend any existing low-income affordability restrictions and any contract or agreement for rental assistance payments for the maximum term permitted, including any renewals thereof; and~~

~~(2) the Minnesota housing finance agency certifies that project reserves will be maintained at closing of the bond issue and budgeted in future years at the lesser of:~~

~~(i) the level described in Minnesota Rules, part 4900.0010, subpart 7, item A, subitem (2), effective May 1, 1997; or~~

~~(ii) the level of project reserves available prior to the bond issue, provided that additional money is available to accomplish repairs and replacements needed at the time of bond issue.~~

Sec. 28. Minnesota Statutes 2000, section 474A.047, subdivision 2, is amended to read:

Subd. 2. [15-YEAR AGREEMENT.] Prior to the issuance of residential rental bonds, the developer of the project for which the bond proceeds will be used must enter into a 15-year agreement with the issuer that specifies the maximum rental rates of the rent-restricted units in the project and the income levels of the residents of the project occupying income-restricted units. ~~The Such~~ rental rates and income levels must be within the limitations established under subdivision 1. The developer must annually certify to the issuer over the term of the agreement that the rental rates for the rent-restricted units are within the limitations under subdivision 1. The issuer may request individual certification of the income of ~~all~~ residents of the project income-restricted units. The commissioner may request from the issuer a copy of the annual certification prepared by the developer. The commissioner may require the issuer to request individual certification of all residents of the project income-restricted units.

Sec. 29. Minnesota Statutes 2000, section 474A.061, subdivision 1, is amended to read:

Subdivision 1. [APPLICATION.] (a) An issuer may apply for an allocation under this section by submitting to the department an application on forms provided by the department, accompanied by (1) a preliminary resolution, (2) a statement of bond counsel that the proposed issue of obligations requires an allocation under this chapter and

the Internal Revenue Code, (3) the type of qualified bonds to be issued, (4) an application deposit in the amount of one percent of the requested allocation before the last Monday in July, or in the amount of two percent of the requested allocation on or after the last Monday in July, (5) a public purpose scoring worksheet for manufacturing project and enterprise zone facility project applications, and (6) for residential rental projects, a statement from the applicant or bond counsel as to whether the project preserves existing federally subsidized housing for residential rental project applications and whether the project is restricted to persons who are 55 years of age or older. The issuer must pay the application deposit by a check made payable to the department of finance. The Minnesota housing finance agency, the Minnesota rural finance authority, and the Minnesota higher education services office may apply for and receive an allocation under this section without submitting an application deposit.

(b) An entitlement issuer may not apply for an allocation from the housing pool or from the public facilities pool unless it has either permanently issued bonds equal to the amount of its entitlement allocation for the current year plus any amount of bonding authority carried forward from previous years or returned for reallocation all of its unused entitlement allocation. For purposes of this subdivision, its entitlement allocation includes an amount obtained under section 474A.04, subdivision 6. This paragraph does not apply to an application from the Minnesota housing finance agency for an allocation under subdivision 2a for cities who choose to have the agency issue bonds on their behalf.

(c) If an application is rejected under this section, the commissioner must notify the applicant and return the application deposit to the applicant within 30 days unless the applicant requests in writing that the application be resubmitted. The granting of an allocation of bonding authority under this section must be evidenced by a certificate of allocation.

Sec. 30. Minnesota Statutes 2000, section 474A.061, subdivision 2a, is amended to read:

Subd. 2a. [HOUSING POOL ALLOCATION.] (a) ~~On the first business day that falls on a Monday of the calendar year and the first Monday in February~~ Commencing on the second Tuesday in January and continuing on each Monday through July 15, the commissioner shall allocate available bonding authority ~~in from~~ the housing pool to applications received ~~by on or before~~ the Monday of the ~~previous preceding~~ week for residential rental projects ~~that are not restricted to persons who are 55 years of age or older and that meet the eligibility criteria under section 474A.047, except that allocations may be made to projects that are restricted to persons who are 55 years of age or older, if the project preserves existing federally subsidized housing. Projects that preserve existing federally subsidized housing shall be allocated available bonding authority in the housing pool for residential rental projects prior to the allocation of available bonding authority to other eligible residential rental projects. Allocations of available bonding authority from the housing pool for eligible residential rental projects shall be awarded in the following order of priority: (1) projects that preserve existing federally subsidized housing; (2) projects that are not restricted to persons who are 55 years of age or older; and (3) other residential rental projects. Prior to May 15, no allocation shall be made to a project restricted to persons who are 55 years of age or older.~~ that are not restricted to persons who are 55 years of age or older and that meet the eligibility criteria under section 474A.047, except that allocations may be made to projects that are restricted to persons who are 55 years of age or older, if the project preserves existing federally subsidized housing. Projects that preserve existing federally subsidized housing shall be allocated available bonding authority in the housing pool for residential rental projects prior to the allocation of available bonding authority to other eligible residential rental projects. Allocations of available bonding authority from the housing pool for eligible residential rental projects shall be awarded in the following order of priority: (1) projects that preserve existing federally subsidized housing; (2) projects that are not restricted to persons who are 55 years of age or older; and (3) other residential rental projects. Prior to May 15, no allocation shall be made to a project restricted to persons who are 55 years of age or older. If an issuer that receives an allocation under this paragraph does not issue obligations equal to all or a portion of the allocation received within 120 days of the allocation or returns the allocation to the commissioner, the amount of the allocation is canceled and returned for reallocation through the housing pool or to the unified pool after July 15.

(b) After ~~February~~ January 1, and through ~~February~~ January 15, the Minnesota housing finance agency may accept applications from cities for single-family housing programs which meet program requirements as follows:

(1) the housing program must meet a locally identified housing need and be economically viable;

(2) the adjusted income of home buyers may not exceed 80 percent of the greater of statewide or area median income as published by the Department of Housing and Urban Development, adjusted for household size;

(3) house price limits may not exceed the federal price limits established for mortgage revenue bond programs. Data on the home purchase price amount, mortgage amount, income, household size, and race of the households served in the previous year's single-family housing program, if any, must be included in each application; and

(4) for applicants who choose to have the agency issue bonds on their behalf, an application fee pursuant to section 474A.03, subdivision 4, and an application deposit equal to one percent of the requested allocation must be submitted to the Minnesota housing finance agency before the agency forwards the list specifying the amounts allocated to the commissioner under paragraph (e) (d). The agency shall submit the city's application fee and application deposit to the commissioner when requesting an allocation from the housing pool.

Applications by a consortium shall include the name of each member of the consortium and the amount of allocation requested by each member.

~~The Minnesota housing finance agency may accept applications from June 15 through June 30 from cities for single-family housing programs which meet program requirements specified under clauses (1) to (4) if bonding authority is available in the housing pool. Applications will be accepted from June 15 to June 30 only from cities that received an allotment in the same calendar year and used at least 75 percent of their allotment by June 1.~~

(c) Any amounts remaining in the housing pool after July 15 are available for single-family housing programs for cities that applied in January and received an allocation under this section in the same calendar year. For a city that chooses to issue bonds on its own behalf or pursuant to a joint powers agreement, the agency must allot available bonding authority based on the formula in paragraphs (d) and (f). Allocations will be made loan by loan, on a first come, first served basis among applicant cities on whose behalf the Minnesota housing finance agency issues bonds. The agency must allot available bonding authority.

Any city that received an allocation pursuant to paragraph (f) in the same calendar year that wishes to issue bonds on its own behalf or pursuant to a joint powers agreement for an amount becoming available for single-family housing programs after July 15 shall notify the Minnesota housing finance agency by July 15. The Minnesota housing finance agency shall notify each city making a request of the amount of its allocation within three business days after July 15. The city must comply with paragraph (f).

For purposes of paragraphs (a) to ~~(g)~~ (h), "city" means a county or a consortium of local government units that agree through a joint powers agreement to apply together for single-family housing programs, and has the meaning given it in section 462C.02, subdivision 6. "Agency" means the Minnesota housing finance agency.

~~(e)~~ (d) The total amount of allocation for mortgage bonds for one city is limited to the lesser of: (i) the amount requested, or (ii) the product of the total amount available for mortgage bonds from the housing pool, multiplied by the ratio of each applicant's population as determined by the most recent estimate of the city's population released by the state demographer's office to the total of all the applicants' population, except that each applicant shall be allocated a minimum of \$100,000 regardless of the amount requested or the amount determined under the formula in clause (ii). If a city applying for an allocation is located within a county that has also applied for an allocation, the city's population will be deducted from the county's population in calculating the amount of allocations under this paragraph.

Upon determining the amount of each applicant's allocation, the agency shall forward to the commissioner a list specifying the amounts allotted to each application ~~and application deposit checks to the commissioner with all application fees and deposits from applicants who choose to have the agency issue bonds on their behalf.~~

Total allocations from the housing pool for single-family housing programs may not exceed 31 percent of the adjusted allocation to the housing pool until after July 15.

~~(d)~~ (e) The agency may issue bonds on behalf of participating cities. The agency shall request an allocation from the commissioner for all applicants who choose to have the agency issue bonds on their behalf and the commissioner shall allocate the requested amount to the agency. The agency may request an allocation at any time after the ~~first Monday second Tuesday in February~~ January and through the last Monday in July, ~~but may request an allocation no later than the last Monday in July. After awarding an allocation and receiving a notice of issuance for the mortgage bonds issued on behalf of the participating cities, the commissioner shall transfer the application deposits~~

to the Minnesota housing finance agency to be returned to the participating cities. The commissioner Minnesota housing finance agency shall return any application deposit to a city that paid an application deposit under paragraph (b), clause (4), but was not part of the list forwarded to the commissioner under paragraph (e) (d).

~~(e)~~ (f) A city may choose to issue bonds on its own behalf or through a joint powers agreement ~~or may use bonding authority for mortgage credit certificates~~ and may request an allocation from the commissioner by forwarding an application with an application fee pursuant to section 474A.03, subdivision 4, and a one percent application deposit to the commissioner no later than the Monday of the week preceding an allocation. If the total amount requested by all applicants exceeds the amount available in the pool, the city may not receive a greater allocation than the amount it would have received under the list forwarded by the Minnesota housing finance agency to the commissioner. No city may request or receive an allocation from the commissioner until the list under paragraph ~~(e)~~ (d) has been forwarded to the commissioner. A city must request an allocation from the commissioner no later than ~~14 days before the unified pool is created pursuant to section 474A.091, subdivision 1~~ the last Monday in July. ~~On and after the first Monday in February and through the last Monday in July,~~ No city may receive an allocation from the housing pool for mortgage bonds which has not first applied to the Minnesota housing finance agency. The commissioner shall allocate the requested amount to the city or cities subject to the limitations under this paragraph.

If a city issues mortgage bonds from an allocation received under this paragraph, the issuer must provide for the recycling of funds into new loans. If the issuer is not able to provide for recycling, the issuer must notify the commissioner in writing of the reason that recycling was not possible and the reason the issuer elected not to have the Minnesota housing finance agency issue the bonds. "Recycling" means the use of money generated from the repayment and prepayment of loans for further eligible loans or for the redemption of bonds and the issuance of current refunding bonds.

~~(f)~~ (g) No entitlement city or county or city in an entitlement county may apply for or be allocated authority to issue mortgage bonds or use mortgage credit certificates from the housing pool. No city in an entitlement county may apply for or be allocated authority to issue residential rental bonds from the housing pool or the unified pool.

~~(g)~~ (h) A city that does not use at least 50 percent of its allotment by the date applications are due for the first allocation that is made from the housing pool for single-family housing programs in the immediately succeeding calendar year may not apply to the housing pool for a single-family mortgage bond or mortgage credit certificate program allocation that exceeds the amount of its allotment for the preceding year that was used by the city in the immediately preceding year or receive an allotment from the housing pool in the succeeding calendar year that exceeds the amount of its allotment for the preceding year that was used in the preceding year. The minimum allotment is \$100,000 for an allocation made prior to July 15, regardless of the amount used in the preceding calendar year, except that a city whose allocation in the preceding year was the minimum amount of \$100,000 and who did not use at least 50 percent of its allocation from the preceding year is ineligible for an allocation in the immediate succeeding calendar year. Each local government unit in a consortium must meet the requirements of this paragraph.

Sec. 31. Minnesota Statutes 2000, section 474A.061, subdivision 2b, is amended to read:

Subd. 2b. [SMALL ISSUE POOL ALLOCATION.] ~~On the first Monday in January that is a business day through the last Monday in July~~ Commencing on the second Tuesday in January and continuing on each Monday through the last Monday in July, the commissioner shall allocate available bonding authority from the small issue pool ~~on Monday of each week~~ to applications received on or before the Monday of the preceding week for manufacturing projects and enterprise zone facility projects. From the ~~first Monday in January that is a business day~~ second Tuesday in January through the last Monday in July, the commissioner shall reserve \$5,000,000 of the available bonding authority from the small issue pool for applications for agricultural development bond loan projects of the Minnesota rural finance authority.

Beginning in calendar year 2002, on the second Tuesday in January through the last Monday in July, the commissioner shall reserve \$10,000,000 of available bonding authority in the small issue pool for applications for student loan bonds of or on behalf of the Minnesota higher education services office. The total amount of allocations for student loan bonds from the small issue pool may not exceed \$10,000,000 per year.

The commissioner shall reserve \$10,000,000 until the day after the last Monday in February, \$10,000,000 until the day after the last Monday in April, and \$10,000,000 until the day after the last Monday in June in the small issue pool for enterprise zone facility projects and manufacturing projects. The amount of allocation provided to an issuer for a specific enterprise zone facility project or manufacturing project will be based on the number of points received for the proposed project under the scoring system under section 474A.045. ~~Proposed projects that receive 50 points or more are eligible for all of the proposed allocation. Proposed projects that receive less than 50 points are eligible to receive a proportionally reduced share of the proposed authority, based upon the number of points received.~~

If there are two or more applications for manufacturing and enterprise zone facility projects from the small issue pool and there is insufficient bonding authority to provide allocations for all projects in any one week, the available bonding authority shall be awarded based on the number of points awarded a project under section 474A.045, with those projects receiving the greatest number of points receiving allocation first. If two or more applications receive an equal number of points, available bonding authority shall be awarded by lot unless otherwise agreed to by the respective issuers.

Sec. 32. Minnesota Statutes 2000, section 474A.061, subdivision 2c, is amended to read:

Subd. 2c. [PUBLIC FACILITIES POOL ALLOCATION.] From the beginning of the calendar year and continuing for a period of 120 days, the commissioner shall reserve ~~\$5,000,000~~ \$3,000,000 of the available bonding authority from the public facilities pool for applications for public facilities projects to be financed by the Western Lake Superior Sanitary District. ~~On the first Monday in January that is a business day through the last Monday in July~~ Commencing on the second Tuesday in January and continuing on each Monday through the last Monday in July, the commissioner shall allocate available bonding authority from the public facilities pool ~~on Monday of each week~~ to applications for eligible public facilities projects received on or before the Monday of the preceding week. If there are two or more applications for public facilities projects from the pool and there is insufficient available bonding authority to provide allocations for all projects in any one week, the available bonding authority shall be awarded by lot unless otherwise agreed to by the respective issuers.

Sec. 33. Minnesota Statutes 2000, section 474A.061, subdivision 4, is amended to read:

Subd. 4. [RETURN OF ALLOCATION; DEPOSIT REFUND.] (a) If an issuer that receives an allocation under this section determines that it will not issue obligations equal to all or a portion of the allocation received under this section within 120 days of allocation or within the time period permitted by federal tax law, whichever is less, the issuer must notify the department. If the issuer notifies the department or the 120-day period since allocation has expired prior to the last Monday in July, the amount of allocation is canceled and returned for reallocation through the pool from which it was originally allocated. If the issuer notifies the department or the 120-day period since allocation has expired on or after the last Monday in July, the amount of allocation is canceled and returned for reallocation through the unified pool. If the issuer notifies the department after the last Monday in November, the amount of allocation is canceled and returned for reallocation to the Minnesota housing finance agency. To encourage a competitive application process, the commissioner shall reserve, for new applications, the amount of allocation that is canceled and returned for reallocation under this section for a minimum of seven calendar days.

(b) An issuer that returns for reallocation all or a portion of an allocation received under this section within 120 days of allocation shall receive within 30 days a refund equal to:

(1) one-half of the application deposit for the amount of bonding authority returned within 30 days of receiving allocation;

(2) one-fourth of the application deposit for the amount of bonding authority returned between 31 and 60 days of receiving allocation; and

(3) one-eighth of the application deposit for the amount of bonding authority returned between 61 and 120 days of receiving allocation.



(c) No refund shall be available for allocations returned 120 or more days after receiving the allocation or beyond the last Monday in November. ~~This subdivision does not apply to the Minnesota housing finance agency or the Minnesota rural finance authority.~~

Sec. 34. [474A.062] [HESO 120-DAY ISSUANCE EXEMPTION.]

The Minnesota higher education services office is exempt from the 120-day issuance requirements in this chapter and may carry forward allocations for student loan bonds into three successive calendar years, subject to carryforward notice requirements of section 474A.131, subdivision 2. The maximum cumulative carryforward is limited to \$25,000,000.

Sec. 35. Minnesota Statutes 2000, section 474A.091, subdivision 2, is amended to read:

Subd. 2. [APPLICATION.] Issuers may apply for an allocation under this section by submitting to the department an application on forms provided by the department accompanied by (1) a preliminary resolution, (2) a statement of bond counsel that the proposed issue of obligations requires an allocation under this chapter and the Internal Revenue Code, (3) the type of qualified bonds to be issued, (4) an application deposit in the amount of two percent of the requested allocation, ~~and~~ (5) a public purpose scoring worksheet for manufacturing and enterprise zone applications, and (6) for residential rental projects, a statement from the applicant or bond counsel as to whether the project preserves existing federally subsidized housing and whether the project is restricted to persons who are 55 years of age or older. The issuer must pay the application deposit by check. An entitlement issuer may not apply for an allocation for public facility bonds, residential rental project bonds, or mortgage bonds under this section unless it has either permanently issued bonds equal to the amount of its entitlement allocation for the current year plus any amount carried forward from previous years or returned for reallocation all of its unused entitlement allocation. For purposes of this subdivision, its entitlement allocation includes an amount obtained under section 474A.04, subdivision 6.

Notwithstanding the restrictions imposed on entitlement issuers under this subdivision, the Minnesota housing finance agency may not apply for receive an allocation for mortgage bonds under this section until after prior to the last first Monday in August. Notwithstanding the restrictions imposed on unified pool allocations after September 1 under subdivision 3, paragraph (c)(2), the Minnesota housing finance agency October, but may be awarded allocations for mortgage bonds from the unified pool on or after September 1 the first Monday in October. The Minnesota housing finance agency, the Minnesota higher education services office, and the Minnesota rural finance authority may apply for and receive an allocation under this section without submitting an application deposit.

Sec. 36. Minnesota Statutes 2000, section 474A.091, subdivision 3, is amended to read:

Subd. 3. [ALLOCATION PROCEDURE.] (a) The commissioner shall allocate available bonding authority under this section on the Monday of every other week beginning with the first Monday in August through and on the last Monday in November. Applications for allocations must be received by the department by 4:30 p.m. on the Monday preceding the Monday on which allocations are to be made. If a Monday falls on a holiday, the allocation will be made or the applications must be received by the next business day after the holiday.

~~(b) On or before September 1, allocations shall be awarded from the unified pool in the following order of priority:~~

- ~~(1) applications for enterprise zone facility bonds;~~
- ~~(2) applications for small issue bonds for manufacturing projects;~~
- ~~(3) applications for small issue bonds for agricultural development bond loan projects;~~
- ~~(4) applications for residential rental project bonds;~~
- ~~(5) applications for public facility projects funded by public facility bonds;~~

(6) applications for redevelopment bonds;

(7) applications for mortgage bonds; and

(8) applications for governmental bonds.

~~Allocations for residential rental projects may only be made during the first allocation in August. The amount of allocation provided to an issuer for a specific manufacturing project will be based on the number of points received for the proposed project under the scoring system under section 474A.045. Proposed manufacturing projects that receive 50 points or more are eligible for all of the proposed allocation. Proposed manufacturing projects that receive less than 50 points under section 474A.045 are only eligible to receive a proportionally reduced share of the proposed authority, based upon the number of points received.~~

(b) Prior to October 1, only the following applications shall be awarded allocations from the unified pool. Allocations shall be awarded in the following order of priority:

(1) applications for residential rental project bonds;

(2) applications for small issue bonds for manufacturing projects; and

(3) applications for small issue bonds for agricultural development bond loan projects.

(c) On the first Monday in October through the last Monday in November, allocations shall be awarded from the unified pool in the following order of priority:

(1) applications for student loan bonds issued by or on behalf of the Minnesota higher education services office;

(2) applications for mortgage bonds;

(3) applications for public facility projects funded by public facility bonds;

(4) applications for small issue bonds for manufacturing projects;

(5) applications for small issue bonds for agricultural development bond loan projects;

(6) applications for residential rental project bonds;

(7) applications for enterprise zone facility bonds;

(8) applications for governmental bonds; and

(9) applications for redevelopment bonds.

(d) If there are two or more applications for manufacturing projects from the unified pool and there is insufficient bonding authority to provide allocations for all manufacturing projects in any one allocation period, the available bonding authority shall be awarded based on the number of points awarded a project under section 474A.045 with those projects receiving the greatest number of points receiving allocation first. If two or more applications for manufacturing projects receive an equal amount of points, available bonding authority shall be awarded by lot unless otherwise agreed to by the respective issuers.

(e) If there are two or more applications for enterprise zone facility projects from the unified pool and there is insufficient bonding authority to provide allocations for all enterprise zone facility projects in any one allocation period, the available bonding authority shall be awarded based on the number of points awarded a project under

section 474A.045 with those projects receiving the greatest number of points receiving allocation first. If two or more applications for enterprise zone facility projects receive an equal amount of points, available bonding authority shall be awarded by lot unless otherwise agreed to by the respective issuers.

(f) If there are two or more applications for residential rental projects from the unified pool and there is insufficient bonding authority to provide allocations for all residential rental projects in any one allocation period, the available bonding authority shall be awarded in the following order of priority: (1) projects that preserve existing federally subsidized housing; (2) projects that are not restricted to persons who are 55 years of age or older; and (3) other residential rental projects.

~~(e)(+)~~ (g) From the first Monday in August through the last Monday in November, \$20,000,000 of bonding authority or an amount equal to the total annual amount of bonding authority allocated to the small issue pool under section 474A.03, subdivision 1, less the amount allocated to issuers from the small issue pool for that year, whichever is less, is reserved within the unified pool for small issue bonds to the extent such amounts are available within the unified pool. ~~On the first Monday in September through the last Monday in November, \$2,500,000 of bonding authority or an amount equal to the total annual amount of bonding authority allocated to the public facilities pool under section 474A.03, subdivision 1, less the amount allocated to issuers from the public facilities pool for that year, whichever is less, is reserved within the unified pool for public facility bonds to the extent such amounts are available within the unified pool.~~

~~(2)~~ (h) The total amount of allocations for mortgage bonds from the housing pool and the unified pool may not exceed:

(i) (1) \$10,000,000 for any one city; or

(ii) (2) \$20,000,000 for any number of cities in any one county.

~~An allocation for mortgage bonds may be used for mortgage credit certificates.~~

~~(d) After September 1, allocations shall be awarded from the unified pool only for the following types of qualified bonds: small issue bonds, public facility bonds to finance publicly owned facility projects, residential rental project bonds, and enterprise zone facility bonds.~~

(i) The total amount of allocations for student loan bonds from the unified pool may not exceed \$10,000,000 per year.

(j) If there is insufficient bonding authority to fund all projects within any qualified bond category other than enterprise zone facility projects, manufacturing projects, and residential rental projects, allocations shall be awarded by lot unless otherwise agreed to by the respective issuers.

(k) If an application is rejected, the commissioner must notify the applicant and return the application deposit to the applicant within 30 days unless the applicant requests in writing that the application be resubmitted.

(l) The granting of an allocation of bonding authority under this section must be evidenced by issuance of a certificate of allocation.

Sec. 37. Minnesota Statutes 2000, section 474A.091, is amended by adding a subdivision to read:

Subd. 3a. [MORTGAGE BONDS.] (a) Bonding authority remaining in the unified pool on October 1 is available for single-family housing programs for cities that applied in January and received an allocation under section 474A.061, subdivision 2a, in the same calendar year. The Minnesota housing finance agency shall receive an allocation for mortgage bonds pursuant to this section, minus any amounts for a city or consortium that intends to issue bonds on its own behalf under paragraph (c).

(b) The agency may issue bonds on behalf of participating cities. The agency shall request an allocation from the commissioner for all applicants who choose to have the agency issue bonds on their behalf and the commissioner shall allocate the requested amount to the agency. Allocations shall be awarded by the commissioner each Monday commencing on the first Monday in October through the last Monday in November for applications received by 4:30 p.m. on the Monday of the week preceding an allocation.

For cities who choose to have the agency issue bonds on their behalf, allocations will be made loan by loan, on a first come, first served basis among the cities. The agency shall submit an application fee pursuant to section 474A.03, subdivision 4, and an application deposit equal to two percent of the requested allocation to the commissioner when requesting an allocation from the unified pool. After awarding an allocation and receiving a notice of issuance for mortgage bonds issued on behalf of the participating cities, the commissioner shall transfer the application deposit to the Minnesota housing finance agency.

For purposes of paragraphs (a) to (d), "city" means a county or a consortium of local government units that agree through a joint powers agreement to apply together for single-family housing programs, and has the meaning given it in section 462C.02, subdivision 6. "Agency" means the Minnesota housing finance agency.

(c) Any city that received an allocation pursuant to section 474A.061, subdivision 2a, paragraph (f), in the current year that wishes to receive an additional allocation from the unified pool and issue bonds on its own behalf or pursuant to a joint powers agreement shall notify the Minnesota housing finance agency by the third Monday in September. The total amount of allocation for mortgage bonds for a city choosing to issue bonds on its own behalf or through a joint powers agreement is limited to the lesser of: (i) the amount requested, or (ii) the product of the total amount available for mortgage bonds from the unified pool, multiplied by the ratio of the population of each city that applied in January and received an allocation under section 474A.061, subdivision 2a, in the same calendar year, as determined by the most recent estimate of the city's population released by the state demographer's office to the total of the population of all the cities that applied in January and received an allocation under section 474A.061, subdivision 2a, in the same calendar year. If a city choosing to issue bonds on its own behalf or through a joint powers agreement is located within a county that has also chosen to issue bonds on its own behalf or through a joint powers agreement, the city's population will be deducted from the county's population in calculating the amount of allocations under this paragraph.

The Minnesota housing finance agency shall notify each city choosing to issue bonds on its own behalf or pursuant to a joint powers agreement of the amount of its allocation by October 15. Upon determining the amount of the allocation of each choosing to issue bonds on its own behalf or through a joint powers agreement, the agency shall forward a list specifying the amounts allotted to each city.

A city that chooses to issue bonds on its own behalf or through a joint powers agreement may request an allocation from the commissioner by forwarding an application with an application fee pursuant to section 474A.03, subdivision 4, and an application deposit equal to two percent of the requested amount to the commissioner no later than 4:30 p.m. on the Monday of the week preceding an allocation. Allocations to cities that choose to issue bonds on their own behalf shall be awarded by the commissioner on the first Monday after October 15 through the last Monday in November. No city may receive an allocation from the commissioner after the last Monday in November. The commissioner shall allocate the requested amount to the city or cities subject to the limitations under this subdivision.

If a city issues mortgage bonds from an allocation received under this paragraph, the issuer must provide for the recycling of funds into new loans. If the issuer is not able to provide for recycling, the issuer must notify the commissioner in writing of the reason that recycling was not possible and the reason the issuer elected not to have the Minnesota housing finance agency issue the bonds. "Recycling" means the use of money generated from the repayment and prepayment of loans for further eligible loans or for the redemption of bonds and the issuance of current refunding bonds.

(d) No entitlement city or county or city in an entitlement county may apply for or be allocated authority to issue mortgage bonds or use mortgage credit certificates from the unified pool.

(e) An allocation awarded to the agency for mortgage bonds under this section may be carried forward by the agency into the next succeeding calendar year subject to notice requirements under section 474A.131 and is available until the last business day in December of that succeeding calendar year.

Sec. 38. Minnesota Statutes 2000, section 474A.091, subdivision 4, is amended to read:

Subd. 4. [~~MORTGAGE BONDS REMAINING BONDING AUTHORITY.~~] All remaining bonding authority available for allocation under this section on December 1, is allocated to the Minnesota housing finance agency.

Sec. 39. Minnesota Statutes 2000, section 474A.091, subdivision 5, is amended to read:

Subd. 5. [RETURN OF ALLOCATION; DEPOSIT REFUND.] (a) If an issuer that receives an allocation under this section determines that it will not issue obligations equal to all or a portion of the allocation received under this section within 120 days of the allocation or within the time period permitted by federal tax law, whichever is less, the issuer must notify the department. If the issuer notifies the department or the 120-day period since allocation has expired prior to the last Monday in November, the amount of allocation is canceled and returned for reallocation through the unified pool. If the issuer notifies the department on or after the last Monday in November, the amount of allocation is canceled and returned for reallocation to the Minnesota housing finance agency. To encourage a competitive application process, the commissioner shall reserve, for new applications, the amount of allocation that is canceled and returned for reallocation under this section for a minimum of seven calendar days.

(b) An issuer that returns for reallocation all or a portion of an allocation received under this section within 120 days of the allocation shall receive within 30 days a refund equal to:

(1) one-half of the application deposit for the amount of bonding authority returned within 30 days of receiving the allocation;

(2) one-fourth of the application deposit for the amount of bonding authority returned between 31 and 60 days of receiving the allocation; and

(3) one-eighth of the application deposit for the amount of bonding authority returned between 61 and 120 days of receiving the allocation.

(c) No refund of the application deposit shall be available for allocations returned on or after the last Monday in November. ~~This subdivision does not apply to the Minnesota housing finance agency, or the Minnesota rural finance authority.~~

Sec. 40. Minnesota Statutes 2000, section 474A.091, subdivision 6, is amended to read:

Subd. 6. [FINAL ALLOCATION; CARRYFORWARD.] Notwithstanding the notice requirements of section 474A.131, subdivision 2, any bonding authority remaining unissued by the Minnesota housing finance agency on the last business day in December shall be carried forward into the next calendar year by the commissioner for the Minnesota housing finance agency in accordance with section 474A.131, subdivision 2.

Sec. 41. Minnesota Statutes 2000, section 474A.131, subdivision 1, is amended to read:

Subdivision 1. [NOTICE OF ISSUE.] Each issuer that issues bonds with an allocation received under this chapter shall provide a notice of issue to the department on forms provided by the department stating:

(1) the date of issuance of the bonds;

(2) the title of the issue;

(3) the principal amount of the bonds;

(4) the type of qualified bonds under federal tax law; ~~and~~

(5) the dollar amount of the bonds issued that were subject to the annual volume cap; and

(6) for entitlement issuers, whether the allocation is from current year entitlement authority or is from carry forward authority.

For obligations that are issued as a part of a series of obligations, a notice must be provided for each series. A penalty of one-half of the amount of the application deposit not to exceed \$5,000 shall apply to any issue of obligations for which a notice of issue is not provided to the department within five business days after issuance or before the last Monday in December, whichever occurs first. Within 30 days after receipt of a notice of issue the department shall refund a portion of the application deposit equal to one percent of the amount of the bonding authority actually issued if a one percent application deposit was made, or equal to two percent of the amount of the bonding authority actually issued if a two percent application deposit was made, less any penalty amount.

Sec. 42. Minnesota Statutes 2000, section 474A.131, is amended by adding a subdivision to read:

Subd. 1b. [DEADLINE FOR ISSUANCE OF QUALIFIED BONDS.] If an issuer fails to notify the department before 4:30 p.m. on the last business day in December of issuance of obligations pursuant to an allocation received for any qualified bond project or issuance of an entitlement allocation, the allocation is canceled and the bonding authority is allocated to the Minnesota housing finance agency for carryforward by the commissioner under section 474A.091, subdivision 6.

Sec. 43. Minnesota Statutes 2000, section 474A.131, subdivision 2, is amended to read:

Subd. 2. [CARRYFORWARD NOTICE.] If an issuer intends to carry forward an allocation received under this chapter, it must notify the department in writing before 4:30 p.m. on the last Monday of business day in December. This notice requirement does not apply to the Minnesota housing finance agency for the carryforward of unallocated unified pool balances.

Sec. 44. Minnesota Statutes 2000, section 474A.14, is amended to read:

474A.14 [NOTICE OF AVAILABLE AUTHORITY.]

The department shall ~~publish in the State Register a~~ provide at its official Web site a written notice of the amount of bonding authority in the housing, small issue, and public facilities pools as soon after January 1 as possible. The department shall ~~publish in the State Register a~~ provide at its official Web site a written notice of the amount of bonding authority available for allocation in the unified pool as soon after August 1 as possible.

Sec. 45. Minnesota Statutes 2000, section 475.54, subdivision 1, is amended to read:

Subdivision 1. [IN INSTALLMENTS; EXCEPTION; ANNUAL LIMIT.] Except as provided in subdivision 3, 5a, 15, or 17, or as expressly authorized in another law, all obligations of each issue shall mature or be subject to mandatory sinking fund redemption in installments, the first not later than three years and the last not later than 30 years from the date of the issue; or 40 years or the useful life of the asset, whichever is less, for municipal water and wastewater treatment systems and essential community facilities financed or guaranteed by the United States Department of Agriculture. No amount of principal of the issue payable in any calendar year shall exceed ~~five times the an amount of equal to~~ the smallest amount payable in any preceding calendar year ending three years or more after the issue date multiplied:

(1) by five, in the case of obligations maturing not later than 25 years from the date of issue; and

(2) by six, in the case of obligations maturing 25 years or later from the date of issue.

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

Sec. 46. Minnesota Statutes 2000, section 475.58, subdivision 1, is amended to read:

Subdivision 1. [APPROVAL BY ELECTORS; EXCEPTIONS.] Obligations authorized by law or charter may be issued by any municipality upon obtaining the approval of a majority of the electors voting on the question of issuing the obligations, but an election shall not be required to authorize obligations issued:

(1) to pay any unpaid judgment against the municipality;

(2) for refunding obligations;

(3) for an improvement or improvement program, which obligation is payable wholly or partly from the proceeds of special assessments levied upon property specially benefited by the improvement or by an improvement within the improvement program, or of taxes levied upon the increased value of property within a district for the development of which the improvement is undertaken, including obligations which are the general obligations of the municipality, if the municipality is entitled to reimbursement in whole or in part from the proceeds of such special assessments or taxes and not less than 20 percent of the cost of the improvement or the improvement program is to be assessed against benefited property or is to be paid from the proceeds of federal grant funds or a combination thereof, or is estimated to be received from such taxes within the district;

(4) payable wholly from the income of revenue producing conveniences;

(5) under the provisions of a home rule charter which permits the issuance of obligations of the municipality without election;

(6) under the provisions of a law which permits the issuance of obligations of a municipality without an election, subject to the reverse referendum requirement in subdivision 1b;

(7) to fund pension or retirement fund liabilities pursuant to section 475.52, subdivision 6;

(8) under a capital improvement plan under section 373.40;

(9) to fund facilities as provided in subdivision 3; and

(10) under sections 469.1813 to 469.1815 (property tax abatement authority bonds).

Sec. 47. Minnesota Statutes 2000, section 475.58, subdivision 1a, is amended to read:

Subd. 1a. [RESUBMISSION LIMITATION.] If the electors do not approve the issuing of obligations at an election required by subdivision 1 or subdivision 1b, the question of authorizing the obligations for the same purpose and in the same amount may not be submitted to the electors within a period of 180 days from the date the election was held. If the question of authorizing the obligations for the same purpose and in the same amount is not approved a second time it may not be submitted to the electors within a period of one year after the second election.

Sec. 48. Minnesota Statutes 2000, section 475.58, is amended by adding a subdivision to read:

Subd. 1b. [REVERSE REFERENDUM REQUIRED.] Any authority given to a statutory or home rule charter city, county, or town in general or special law to issue general obligation bonds under this chapter that is exempt from the election requirement under subdivision 1, clause (6), is subject to the reverse referendum requirement in this subdivision. The city, county, or town must publish a notice of its intention to issue the bonds and the date and time of a hearing to obtain public comment on the matter. The notice must be published in the official newspaper of the local government unit or in a newspaper of general circulation in the local government's jurisdiction. The notice must be published at least 14 but not more than 28 days before the date of the hearing. The local government unit may issue the bonds only upon obtaining approval of a majority of the voters voting on the question of issuing the obligations, if a petition requesting a vote on the issuance is signed by voters equal to five percent of the votes cast

in the local government's last general election and is filed with the chief clerical officer of the city, county, or town within 30 days after the public hearing. The commissioner of revenue shall prepare a suggested form of the question to be presented at election.

Sec. 49. Laws 1974, chapter 473, is amended to read:

Section 1. [SCOTT COUNTY; HOUSING AND REDEVELOPMENT AUTHORITY.]

(a) There is hereby created in Scott county a public body corporate and politic, to be known as the Scott county housing and redevelopment authority, having all the powers and duties of a housing and redevelopment authority under the provisions of ~~the municipal housing and redevelopment act~~, Minnesota Statutes, sections ~~462.411 to 462.711~~, and acts amendatory thereof, which act applies to the county of Scott ~~469.001 to 469.047~~, and having those powers of an economic development authority under the provisions of Minnesota Statutes, sections 469.090 to 469.180, as are granted to it by Scott county as provided below. For the purposes of applying the provisions of ~~the municipal housing and redevelopment act~~ Minnesota Statutes, sections 469.001 to 469.047 and 469.090 to 469.180, to Scott county, the county has all the powers and duties of a municipality, the county board has all of the powers and duties of a governing body, the chairman of the county board has all of the powers and duties of a mayor, and the area of operation includes the area within the territorial boundaries of the county.

Sec. 2. [APPLICATION.]

Subdivision 1. This act shall not limit or restrict any existing housing and redevelopment authority or prevent a municipality from creating an authority. ~~The county shall not exercise jurisdiction in any municipality where a municipal housing and redevelopment authority is established.~~

Subd. 2. A municipal housing and redevelopment authority may request the Scott county housing and redevelopment authority to handle the housing duties of the authority and, in such an event, the Scott county housing and redevelopment authority shall act and have exclusive jurisdiction for housing in the municipality pursuant to the provisions of ~~the municipal housing and redevelopment act~~, Minnesota Statutes, sections ~~462.411 to 462.711~~, and acts amendatory thereof 469.001 to 469.047. A transfer of duties relating to housing shall not transfer any duties relating to redevelopment.

Sec. 3. [MUNICIPAL APPROVAL.]

If any housing or redevelopment project is undertaken in Scott county pursuant to this authorization, and such project is within the boundaries of any incorporated village, city, or township, the location of such project shall be approved by the governing body of such village, city, or township.

Sec. 4. [ECONOMIC DEVELOPMENT AUTHORITY POWERS.]

The Scott county housing and redevelopment authority may exercise any of the powers of an economic development authority (EDA) granted to it by resolution by the Scott county board of commissioners, except for the authority to levy the tax described in Minnesota Statutes, section 469.107. With the prior approval of the Scott county board, the authority may increase its levy of the special tax described in Minnesota Statutes, section 469.033, subdivision 6, to an amount not exceeding 0.01813 percent of taxable market value, or any higher limit from time to time authorized under Minnesota Statutes, section 469.033, subdivision 6, or 469.107.

~~Sec. 4.~~ Sec. 5. [EFFECTIVE DATE; LOCAL APPROVAL.]

This act takes effect when approved by a majority of the board of county commissioners of Scott county and upon compliance with Minnesota Statutes, Section 645.021. This act is effective the day after the governing body of Scott county and its chief clerical officer timely complete their compliance with Minnesota Statutes, section 645.021, subdivisions 2 and 3.



Sec. 50. Laws 1980, chapter 482, is amended to read:

Section 1. [CARVER COUNTY; HOUSING AND REDEVELOPMENT.]

Subdivision 1. There is created in the county of Carver a public body corporate and politic, to be known as the Carver county housing and redevelopment authority, having all of the powers and duties of a housing and redevelopment authority under the provisions of ~~the municipal housing and redevelopment act~~, Minnesota Statutes, ~~Section 462.411 to 462.711~~ sections 469.001 to 469.047, and having those powers of an economic development authority under the provisions of Minnesota Statutes, sections 469.090 to 469.180, as are granted to it by Carver county as provided below. For the purposes of applying the provisions of ~~the municipal housing and redevelopment act~~ Minnesota Statutes, sections 469.001 to 469.047 and 469.090 to 469.180, to Carver county, the county has all of the powers and duties of a municipality, the county board has all of the powers and duties of a governing body, the chairman of the county board has all of the powers and duties of a mayor, and the area of operation includes the area within the territorial boundaries of the county.

Subd. 2. This section shall not limit or restrict any existing housing and redevelopment authority or prevent a municipality from creating an authority. ~~The county shall not exercise jurisdiction in any municipality where a municipal housing and redevelopment authority is established.~~ If a municipal housing and redevelopment authority requests the Carver county housing and redevelopment authority to handle the housing duties of the municipal authority, the Carver county housing and redevelopment authority shall act and have exclusive jurisdiction for housing in the municipality. A transfer of duties relating to housing shall not transfer any duties relating to redevelopment.

Sec. 2. [EDA POWERS.]

The Carver county housing and redevelopment authority may exercise any of the powers of an economic development authority granted to it by resolution by the Carver county board of commissioners, except for the authority to levy the tax described in Minnesota Statutes, section 469.107. With the prior approval of the Carver county board, the authority may increase its levy of the special tax described in Minnesota Statutes, section 469.033, subdivision 6, to an amount not exceeding 0.01813 percent of taxable market value, or any higher limit from time to time authorized under Minnesota Statutes, section 469.033, subdivision 6, or 469.107.

Sec. 3. [LOCAL APPROVAL.]

Before a housing or redevelopment project of the Carver county housing and redevelopment authority is undertaken, the project shall be approved by the local governing body with jurisdiction over all or any part of the area in which the proposed project is located.

~~Sec. 3.~~ Sec. 4. [EFFECTIVE DATE DATES; LOCAL APPROVAL.]

~~This act is effective upon the day of compliance with Minnesota Statutes, Section 645.021, Subdivision 3. This act is effective the day after the governing body of Carver county and its chief clerical officer timely complete their compliance with Minnesota Statutes, section 645.021, subdivisions 2 and 3.~~

Sec. 51. [CHISAGO LAKES JOINT SEWAGE TREATMENT COMMISSION BONDING AUTHORITY.]

Subdivision 1. [AUTHORITY.] Notwithstanding Minnesota Statutes, section 471.59, subdivision 11, the Chisago lakes joint sewage treatment commission, a joint powers board established by the county of Chisago, and the cities of Lindstrom, Chisago City, and Center City, to own and operate wastewater treatment facilities for the member local governments, may issue and sell general obligation bonds pursuant to Minnesota Statutes, sections 115.46 and 444.075, and chapter 475, to acquire land for, construct, expand, furnish, equip, and modify its wastewater treatment facilities, and pledge the full faith and credit and taxing power of the governmental units that are members of the joint powers board. Bonds issued under this section are not subject to Minnesota Statutes, section 475.58. The joint powers board is a municipality within the meaning of Minnesota Statutes, chapter 475. Each government unit that is a member of the joint powers board must adopt a resolution authorizing the joint powers board to issue and sell the bonds.

Subd. 2. [EFFECTIVE DATE; NO LOCAL APPROVAL.] This section is effective the day following final enactment and does not require local approval, as provided in Minnesota Statutes, section 645.023, subdivision 1, paragraph (a).

Sec. 52. [HASSAN TOWNSHIP; ECONOMIC DEVELOPMENT AUTHORITY; ESTABLISHMENT AND POWERS.]

Subdivision 1. [ESTABLISHMENT.] The board of township supervisors of Hassan township may establish an economic development authority in the manner provided in Minnesota Statutes, sections 469.090 to 469.1081, and may impose limits on the authority enumerated in Minnesota Statutes, section 469.092. The economic development authority has all of the powers and duties granted to or imposed upon economic development authorities under Minnesota Statutes, sections 469.090 to 469.1081. The township economic development authority may create and define the boundaries of economic development districts at any place or places within the township, provided that a project as recommended by the township authority that is to be located within the corporate limits of a city may not be commenced without the approval of the governing body of the city. Minnesota Statutes, section 469.174, subdivision 10, and the contiguity requirement specified under Minnesota Statutes, section 469.101, subdivision 1, do not apply to limit the areas that may be designated as township economic development districts.

Subd. 2. [POWERS.] If an economic development authority is established as provided in subdivision 1, the township may exercise all of the powers relating to an economic development authority granted to a city under Minnesota Statutes, sections 469.090 to 469.1081, or other law, including the power to levy a tax to support the activities of the authority.

Subd. 3. [LOCAL APPROVAL.] This section is effective the day after the town board of supervisors of Hassan township and its chief clerical officer timely complete their compliance with Minnesota Statutes, section 645.021, subdivisions 2 and 3.

Sec. 53. [REPEALER.]

Minnesota Statutes 2000, section 474A.061, subdivision 6, is repealed.

Sec. 54. [EFFECTIVE DATE.]

Sections 16 to 44 are effective the day after final enactment except that section 22, paragraph (c), is effective to require submissions by December 31, 2002, and annually thereafter."

Delete the title and insert:

"A bill for an act relating to public finance; updating and making technical changes to public finance and related provisions related to county and county-supported hospitals, municipally-owned nursing homes, lake improvement districts, and the metropolitan council; extending a sunset date for certain county capital improvement bonds and limiting the inclusiveness of capital improvements; removing election requirements as preconditions for issuance of certain obligations; requiring reverse referenda in certain cases; clarifying the effect of a state guaranty as not creating constitutional public debt of the state; authorizing some flexibility in stating certain ballot questions; authorizing Scott and Carver counties to grant certain economic development powers to their housing and redevelopment authorities; authorizing the Chisago Lakes joint sewage treatment commission to issue bonds; authorizing expanded funding by the county for certain multijurisdictional program activities in Hennepin county; authorizing Hassan township to create and empower an economic development authority; updating and changing the Minnesota Bond Allocation Act; amending Minnesota Statutes 2000, sections 103B.555, by adding a subdivision; 165.10, subdivision 2; 275.60; 373.40, subdivisions 1, 7; 373.45, subdivision 3; 376.06, subdivision 1; 376.07; 376.08, subdivisions 1, 2, 3, by adding a subdivision; 376.09; 383B.79, by adding a subdivision; 473.39, by adding a subdivision; 474A.02, subdivisions 8, 13a, 22a, 22b, 23a; 474A.03, subdivisions 1, 2a, 4; 474A.04, subdivisions 1a, 5; 474A.045; 474A.047, subdivisions 1, 2; 474A.061, subdivisions 1, 2a, 2b, 2c, 4; 474A.091, subdivisions 2, 3, 4, 5, 6, by adding a subdivision; 474A.131, subdivisions 1, 2, by adding a subdivision; 474A.14; 475.54, subdivision 1;

475.58, subdivisions 1, 1a, by adding a subdivision; Laws 1974, chapter 473; Laws 1980, chapter 482; proposing coding for new law in Minnesota Statutes, chapter 474A; repealing Minnesota Statutes 2000, section 474A.061, subdivision 6."

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

The report was adopted.

Krinkie from the Committee on State Government Finance to which was referred:

S. F. No. 722, A bill for an act relating to energy; providing for comprehensive energy conservation, production, and regulatory changes; amending Minnesota Statutes 2000, sections 16B.32, subdivision 2; 116C.52, subdivisions 4, 10; 116C.53, subdivisions 2, 3; 116C.57, subdivisions 1, 2, 4, by adding subdivisions; 116C.58; 116C.59, subdivisions 1, 4; 116C.60; 116C.61, subdivisions 1, 3; 116C.62; 116C.63, subdivision 2; 116C.645; 116C.65; 116C.66; 116C.69; 216B.095; 216B.097, subdivision 1; 216B.16, subdivision 15; 216B.241, subdivisions 1, 1a, 1b, 1c, 2; 216B.2421, subdivision 2; 216B.243, subdivisions 3, 4, 8; 216B.62, subdivision 5; 216C.41; proposing coding for new law in Minnesota Statutes, chapters 16B; 116C; 216B; 452; repealing Minnesota Statutes 2000, sections 116C.55, subdivisions 2, 3; 116C.57, subdivisions 3, 5, 5a; 116C.67; 216B.2421, subdivision 3.

Reported the same back with the following amendments:

Delete everything after the enacting clause and insert:

## "ARTICLE 1

### ENERGY PLANNING

Section 1. [TITLE.]

This act shall be known as the Minnesota Energy Security and Reliability Act.

Sec. 2. [216B.012] [STATE TRANSMISSION PLAN.]

Subdivision 1. [PLAN.] The commission shall maintain a state transmission plan, consisting of a list of certified high voltage transmission line projects.

Subd. 2. [PLAN DEVELOPMENT.] (a) By November 1 of each odd-numbered year, each public utility, municipal utility, and cooperative electric association, or the generation and transmission organization that serves each utility or association, that owns or operates electric transmission lines in Minnesota shall jointly or individually submit a transmission projects report to the commission. The report must:

(1) list specific present and reasonably foreseeable future inadequacies in the transmission system in Minnesota;

(2) identify alternative means of addressing each inadequacy listed;

(3) identify general economic, environmental, and social issues associated with each alternative; and

(4) provide a summary of public input the utilities and associations have gathered related to the list of inadequacies and the role of local government officials and other interested persons in assisting to develop the list and analyze alternatives.

(b) To meet the requirements of this subdivision, entities may rely on available information and analysis developed by a regional transmission organization or any subgroup of a regional transmission organization and may develop and include additional information as necessary. A regional energy infrastructure planning report issued under section 216B.019 and submitted under this subdivision satisfies the requirements of this subdivision for the member utilities.

Subd. 3. [COMMISSION APPROVAL.] By June 1 of each even-numbered year, the commission shall adopt a state transmission plan and shall certify, certify as modified, or deny certification of the projects proposed under subdivision 2. The commission may only certify a project that is a high voltage transmission line as defined in section 216B.2421, subdivision 2, that the commission finds is:

- (1) necessary to maintain or enhance the reliability of electric service to Minnesota consumers;
- (2) needed, applying the criteria in section 216B.241, subdivision 3;
- (3) a public purpose project, applying the considerations in section 216B.241, subdivision 2a; and
- (4) in the public interest, taking into account electric energy system needs and economic, environmental, and social interests affected by the project.

Projects certified as part of the state transmission plan need no further review by the commission under section 216B.243. The reliability administrator shall provide technical assistance to the commissioner and the commission in reviewing the proposed projects.

Subd. 4. [CONTINUING OBLIGATION.] Each public utility, municipal utility, and cooperative electric association that operates and provides electric service in this state has an existing and continuing obligation to provide reliable, affordable, safe, and efficient services to their customers in the state; to plan to meet the resource and infrastructure needs of those customers; and to ensure that those resources and infrastructure are sited and constructed, or otherwise acquired.

### Sec. 3. [216B.013] [EXISTING GENERATION FACILITIES.]

In order to continue the low-maintenance and low-cost service that the existing base-load generation facilities in Minnesota have provided to Minnesota consumers, and to provide power to meet the growing demand for electricity by Minnesota consumers and businesses, it is the policy of the state that these facilities be maintained and upgraded consistent with energy policy goals established pursuant to this chapter. The public utilities commission, department, and other state agencies with regulatory jurisdiction over the operation of these facilities shall take all steps necessary to incorporate this state policy into the regulatory decisions made by each respective agency.

### Sec. 4. [216B.014] [ENERGY SECURITY AND RELIABILITY.]

(a) It is a fundamental goal of Minnesota's energy and utility policy that state policymakers maximize the state's energy security.

(b) "Energy security" means, among other things, ensuring that the state's energy sources are:

(1) diverse, including (i) traditional sources such as coal, natural gas, waste-to-energy, and nuclear facilities, (ii) renewable sources such as wind, biomass, and agricultural waste generation, and (iii) high-efficiency, low-emissions distributed generation sources such as fuel cells and microturbines;

(2) to the extent feasible, produced in the state utilizing Minnesota's resources;

(3) environmentally sustainable;

(4) available to consumers at affordable and stable rates or prices; and

(5) above all, reliable. "Reliable" means, among other things, that adequate resources and infrastructure are in place, and are planned for, to provide efficient, dependable, and secure energy services to Minnesota consumers.

Sec. 5. [216B.015] [ENERGY SECURITY BLUEPRINT.]

(a) The commissioner shall develop a draft energy security blueprint by December 15, 2001, and every four years thereafter. The blueprint must:

(1) identify important trends and issues in energy supply, consumption, conservation, and costs;

(2) set energy goals; and

(3) develop strategies to meet the goals.

(b) For the purposes of sections 216B.012 to 216B.019, the terms:

(1) "electric utility" means an entity that is a public utility; a cooperative electric association providing generation, transmission, or distribution services; a municipal utility; or a municipal power agency; and

(2) "energy utility" means an electric utility, or an entity providing natural gas to retail consumers.

Sec. 6. [216B.016] [ENERGY BLUEPRINT CONTENTS.]

The energy blueprint must include:

(1) the amount and type of projected statewide energy consumption over the next ten years;

(2) a determination of whether and the extent to which existing and anticipated energy production and transportation facilities will or will not be able to supply needed energy;

(3) a determination of the potential for conservation to meet some or all of the projected need for energy;

(4) an assessment of the environmental impact of projected energy consumption over the next ten years, prepared by the commissioner of the pollution control agency in consultation with other state agencies and other interested persons, with strategies to mitigate those impacts; and

(5) benchmarks to measure and monitor supply adequacy and infrastructure capacity, and to assess the overall reliability of the state's electric system.

Sec. 7. [216B.017] [ENERGY GOALS.]

(a) The blueprint must recommend statewide goals and recommend strategies to accomplish the following goals for:

(1) energy conservation and recovery;

(2) limiting adverse environmental emissions from the generation of electric energy consumed in the state;

(3) production of electric energy consumed in the state from renewable energy sources;

(4) deployment of distributed electric generation technologies;

(5) ensuring that energy service is affordable and available to all consumers in the state;

(6) minimizing the imposition of social costs on energy consumers through energy rates or prices; and

(7) increasing the efficiency of the regulatory infrastructure and reducing regulatory and administrative costs.

(b) The goals adopted in the blueprint may be onetime goals or a series of goals to meet overall objectives. The commissioner shall present these goals, and any associated strategies that require changes to state law, to the legislature for modification and approval.

Sec. 8. [216B.018] [BLUEPRINT DEVELOPMENT.]

Subdivision 1. [PUBLIC PARTICIPATION.] The commissioner shall:

(1) invite public and stakeholder comment and participation during blueprint development; and

(2) hold at least one public meeting on the proposed blueprint in each energy infrastructure planning region of the state after at least 30 days' public notice in the region.

Subd. 2. [NOTICE AND COMMENT; BLUEPRINT ISSUANCE.] The commissioner shall provide notice of all public meetings to discuss the proposed blueprint and allow opportunity for written comment prior to issuing the final blueprint. After review by the administrator, the commissioner shall publish the final energy blueprint in the State Register within four months of issuing the draft blueprint.

Sec. 9. [216B.019] [REGIONAL ENERGY INFRASTRUCTURE PLANNING.]

Subdivision 1. [ESTABLISHING PLANNING REGIONS.] The commission, after notice and opportunity for written comment, shall establish geographic regional energy infrastructure planning regions in the state by August 1, 2001. Planning regions may coincide with existing subregional planning areas used by the regional electric reliability or regional transmission organization serving Minnesota. The commission shall also request comments on and approve, or approve as modified, each group's organizational, administrative, planning, and voting structures.

Subd. 2. [PLANNING GROUP.] Each energy utility that operates in an identified region shall participate in the regional energy infrastructure planning group. Each regional group must include as voting members an equal number of representatives of energy utilities, and representatives from counties in the identified region, appointed by the county board.

Subd. 3. [PUBLIC MEETINGS.] Each regional energy infrastructure planning group shall hold public meetings within the region on a regular basis, not less than twice a year, and provide public notice at least 14 calendar days in advance of a meeting.

Subd. 4. [REPORT.] By November 1, 2001, and every two years thereafter, each regional energy infrastructure planning group shall submit a report to the commissioner that:

(1) identifies inadequacies in electric generation and transmission within the region including any deficiencies as defined in subdivision 5;

(2) lists alternative ways to address identified inadequacies, taking into account the provisions of the state energy security blueprint;

(3) identifies potential general and, to the extent known, specific economic, environmental, and social issues associated with each alternative; and

(4) recommends alternatives to address identified inadequacies and deficiencies that ensure the reliability and security of the energy system in the region, while minimizing environmental and social impacts. In making recommendations, the planning group shall identify critical needs. For the purposes of this clause, "critical needs" are those projects that are necessary to maintain reliable electric service to Minnesota consumers that meet or exceed the most stringent applicable state or regional reliability standards. A regional planning group may satisfy the requirement to issue an initial report under this section by submitting the portion of the Mid-Continent Area Power Pool transmission plan that affects the region, with any analysis, comment, or narrative that the group deems important.

Subd. 5. [DEFICIENCY.] (a) "Deficiency" means a condition, or set of conditions, that, based on the utility's most recent forecast or consistent with the transmission expansion plan of a federally approved regional transmission organization or regional reliability entity, may materially limit the adequacy of electric supply, efficiency of electric service, or reliability of electric service to an electric utility's customers in the state that may require construction of a generation or transmission project.

(b) Within 90 days of identifying a deficiency in its system, an electric utility shall give notice of the deficiency to at least:

- (1) the members of affected regional energy infrastructure planning groups;
- (2) officials of potentially affected local governments; and
- (3) the commissioner and the independent reliability administrator.

(c) Notice of deficiency must be made before submitting (1) an application for a certificate of need under section 216B.243 or (2) a request for environmental review of an energy project to any governmental entity.

Sec. 10. Minnesota Statutes 2000, section 216C.051, subdivision 9, is amended to read:

Subd. 9. [EXPIRATION.] This section is repealed ~~March 15, 2001~~ June 30, 2003.

Sec. 11. [216C.052] [RELIABILITY ADMINISTRATOR.]

Subdivision 1. [POSITION ESTABLISHED IN DEPARTMENT.] Recognizing the critical importance of adequate, reliable, and environmentally sound energy services to the state's economy and the well being of its citizens, and that independent and expert technical analysis is necessary to ensure the reliability of the energy system, the position of reliability administrator is established within the department of commerce.

Subd. 2. [RESPONSIBILITIES.] (a) The administrator shall provide technical advice and assistance to the department, the commission, and regional energy infrastructure planning groups. In addition, the administrator shall provide technical and administrative assistance to the legislative electric energy task force. In conducting its work, the administrator shall:

(1) model and monitor the use and operation of the energy infrastructure in the state, including generation facilities, transmission lines, natural gas pipelines, and other energy infrastructure;

(2) develop and present to the commission and parties technical analyses of proposed infrastructure projects, and provide technical advice to the commission;

(3) assist the regional energy infrastructure planning groups in analyzing assertions of need for additional infrastructure;

(4) develop and present the reliability status report required under subdivision 4 and the state reliability plan under section 216B.012; and

(5) present independent, factual, expert, and technical information on infrastructure proposals at public meetings hosted by the task force, the environmental quality board, or the commission.

(b) Upon request and subject to resource constraints, the administrator shall provide technical assistance regarding matters unrelated to applications for infrastructure improvements to the task force, the department, or the commission.

Subd. 3. [ADMINISTRATIVE ISSUES.] (a) The commissioner may select the administrator whose term shall be concurrent with that of the governor. The administrator may be removed only for cause. The commissioner shall oversee and direct the work of the administrator, annually review the expenses of the administrator, and biennially approve the budget of the administrator. The administrator may utilize existing commission or department staff at the discretion of the chair or the commissioner, may hire staff, and may contract for technical expertise in performing duties when existing state resources are required for other state responsibilities or when special expertise is required. The salary of the administrator is governed by section 15A.0815, subdivision 2.

(b) The administrator shall certify its administrative costs to the commission on a monthly basis, and shall specify those costs that are general in nature and those that were incurred on a specific application or with regard to a specific utility.

(c) The legislative energy task force shall make assessments for the general administrative costs of the administrator pursuant to the assessment authority of the legislative electric energy task force under section 216C.051, subdivision 6. If sufficient funds are not available under that section, the administrator must not incur additional costs and the position of administrator must be vacated. In no event shall the general fund of the state treasury be responsible for any costs of the administrator. Additional amounts for general administrative costs may be incurred and recovered above this amount if the commissioner and chair of the commission deem the additional amounts to be necessary. Costs that are of a general nature must be apportioned among all energy utilities in proportion to their respective gross operating revenues from retail sales of gas or electric service within the state during the last calendar year.

(d) Costs relating to a specific proceeding, analysis, or project are not general administrative costs and must be billed directly. The commission shall review those costs, and shall order payment within 30 days of commission review. The department shall render a bill to the utility or utilities, either at the conclusion of a particular proceeding, analysis, or project, or from time to time during the course of the proceeding, analysis, or project. The bill constitutes notice of the assessment and a demand for payment. The amount of the bills so rendered by the department must be paid by the public utility into a special revenue fund in the state treasury within 30 days from the date of billing and are appropriated to the administrator for the purposes provided in this section. Appeals may be handled by the commission as provided in section 216B.62. The commission shall approve or approve as modified a rate schedule providing for the automatic adjustment of charges to recover amounts paid by utilities under this section. The administrator shall provide a detailed accounting of finances to the commissioner and to the chairs of the house of representatives and senate finance committees with jurisdiction over the department's budget. All amounts assessed under this section are in addition to amounts appropriated to the commission and the department by other law.

Subd. 4. [RELIABILITY STATUS REPORT.] The commission shall require all electric utilities to report to the administrator on operating and planning reserves, available transmission capacity, outages of major generation units and feeders of distribution and transmissions facilities, the adequacy of stock and equipment, and any other information necessary to assess the current and future reliability of energy service in this state. By January 1 of each odd-numbered year beginning in 2003, the administrator shall assess and report the status of the reliability of electric service in the state to the commissioner, with copies to the commission and the legislative electric energy task force.

Sec. 12. [EFFECTIVE DATE.]

Article 1 is effective the day following final enactment.



## ARTICLE 2

## ESSENTIAL ENERGY INFRASTRUCTURE

Section 1. Minnesota Statutes 2000, section 116.07, subdivision 4a, is amended to read:

Subd. 4a. [PERMITS.] (a) The pollution control agency may issue, continue in effect, or deny permits, under ~~such~~ conditions ~~as~~ it may prescribe for the prevention of pollution, for (1) the emission of air contaminants ~~except for emissions from electric generation stations,~~ or for (2) the installation or operation of any emission facility, air contaminant treatment facility, treatment facility, potential air contaminant storage facility, or storage facility, or any part thereof, or for (3) the sources or emissions of noise pollution:

~~The pollution control agency may also issue, continue in effect or deny permits, under such conditions as it may prescribe for the prevention of pollution, for, (4) the storage, collection, transportation, processing, or disposal of waste, or for (5) the installation or operation of any system or facility, or any part thereof, related to the storage, collection, transportation, processing, or disposal of waste. The commissioner, rather than the agency, may issue, continue in effect, or deny permits, under conditions the commissioner may prescribe for the prevention of pollution, for the emissions of air contaminants from electric generation stations.~~

The pollution control agency may revoke or modify any permit issued under this subdivision and section 116.081 whenever it is necessary, in the opinion of the agency, to prevent or abate pollution.

(b) The pollution control agency has the authority for approval over the siting, expansion, or operation of a solid waste facility with regard to environmental issues. However, the agency's issuance of a permit does not release the permittee from any liability, penalty, or duty imposed by any applicable county ordinances. Nothing in this chapter precludes, or shall be construed to preclude, a county from enforcing land use controls, regulations, and ordinances existing at the time of the permit application and adopted pursuant to sections 366.10 to 366.181, 394.21 to 394.37, or 462.351 to 462.365, with regard to the siting, expansion, or operation of a solid waste facility.

Sec. 2. Minnesota Statutes 2000, section 116C.52, subdivision 10, is amended to read:

Subd. 10. [UTILITY.] "Utility" shall mean any entity engaged or intending to engage in this state in the generation, transmission or distribution of electric energy including, but not limited to, a private investor owned utility, cooperatively owned utility, and a public or municipally owned utility.

Sec. 3. Minnesota Statutes 2000, section 116C.53, subdivision 2, is amended to read:

Subd. 2. [JURISDICTION.] The board is hereby given the authority to provide for site and route selection for large electric power facilities. The board shall issue permits for large electric power facilities in a timely fashion. When the public utilities commission has determined the need for the project under section 216B.012 or 216B.243, questions of need, including size, type, and timing; alternative system configurations; and voltage, are not within the board's siting and routing authority and must not be included in the scope of environmental review conducted under sections 116C.51 to 116C.69.

Sec. 4. Minnesota Statutes 2000, section 116C.53, subdivision 3, is amended to read:

Subd. 3. [INTERSTATE ROUTES.] (a) If a route is proposed in two or more states, the board shall attempt to reach agreement with affected states on the entry and exit points prior to ~~authorizing the construction of the designating~~ a route. The board, in discharge of its duties pursuant to sections 116C.51 to 116C.69 may make joint investigations, hold joint hearings within or without the state, and issue joint or concurrent orders in conjunction or concurrence with any official or agency of any state or of the United States. The board may negotiate and enter into any agreements or compacts with agencies of other states, pursuant to any consent of Congress, for cooperative efforts in certifying the construction, operation, and maintenance of large electric power facilities in accord with the purposes of sections 116C.51 to 116C.69 and for the enforcement of the respective state laws regarding such facilities.

(b) The board may not issue a route permit for the Minnesota portion of an interstate high voltage transmission line unless the applicant has received a certificate of need from the public utilities commission.

Sec. 5. Minnesota Statutes 2000, section 116C.57, subdivision 1, is amended to read:

Subdivision 1. [~~DESIGNATION OF SITES SUITABLE FOR SPECIFIC FACILITIES; REPORTS SITE PERMIT.~~] A utility must apply to the board in a form and manner prescribed by the board for designation of a specific site for a specific size and type of facility. The application shall contain at least two proposed sites. In the event a utility proposes a site not included in the board's inventory of study areas, the utility shall specify the reasons for the proposal and shall make an evaluation of the proposed site based upon the planning policies, criteria and standards specified in the inventory. Pursuant to sections 116C.57 to 116C.60, the board shall study and evaluate any site proposed by a utility and any other site the board deems necessary which was proposed in a manner consistent with rules adopted by the board concerning the form, content, and timeliness of proposals for alternate sites. No site designation shall be made in violation of the site selection standards established in section 116C.55. The board shall indicate the reasons for any refusal and indicate changes in size or type of facility necessary to allow site designation. Within a year after the board's acceptance of a utility's application, the board shall decide in accordance with the criteria specified in section 116C.55, subdivision 2, the responsibilities, procedures and considerations specified in section 116C.57, subdivision 4, and the considerations in chapter 116D which proposed site is to be designated. The board may extend for just cause the time limitation for its decision for a period not to exceed six months. When the board designates a site, it shall issue a certificate of site compatibility to the utility with any appropriate conditions. The board shall publish a notice of its decision in the State Register within 30 days of site designation. No person may construct a large electric power generating plant shall be constructed except on without a site designated by permit from the board or a county. A large electric generating plant may be constructed only on either (1) a site approved by the board under this section or section 116C.575, or (2) a site designated by a county using terms, conditions, procedures, and standards no less stringent than those imposed and used by the board. If the proposed project is under the jurisdiction of the board, the board must incorporate into one proceeding the route selection for a high voltage transmission line that is directly associated with and necessary to interconnect the large electric generation plant to the transmission system and whose need is certified as part of the generation plant project by the public utilities commission.

Sec. 6. Minnesota Statutes 2000, section 116C.57, subdivision 2, is amended to read:

Subd. 2. [~~DESIGNATION OF ROUTES; PROCEDURE ROUTE PERMIT.~~] A utility shall apply to the board in a form and manner prescribed by the board for a permit for the construction of a high voltage transmission line. The application shall contain at least two proposed routes. Pursuant to sections 116C.57 to 116C.60, the board shall study, and evaluate the type, design, routing, right-of-way preparation and facility construction of any route proposed in a utility's application and any other route the board deems necessary which was proposed in a manner consistent with rules adopted by the board concerning the form, content, and timeliness of proposals for alternate routes provided, however, that the board shall identify the alternative routes prior to the commencement of public hearings thereon pursuant to section 116C.58. Within one year after the board's acceptance of a utility's application, the board shall decide in accordance with the criteria and standards specified in section 116C.55, subdivision 2, and the considerations specified in section 116C.57, subdivision 4, which proposed route is to be designated. The board may extend for just cause the time limitation for its decision for a period not to exceed 90 days. When the board designates a route, it shall issue a permit for the construction of a high voltage transmission line specifying the type, design, routing, right-of-way preparation and facility construction it deems necessary and with any other appropriate conditions. The board may order the construction of high voltage transmission line facilities which are capable of expansion in transmission capacity through multiple circuiting or design modifications. The board shall publish a notice of its decision in the state register within 30 days of issuance of the permit. No person may construct a high voltage transmission line shall be constructed except on without a route designated by permit from the board, unless it was exempted pursuant to subdivision 5. A high voltage transmission line may be constructed only along a route approved by the board.

Sec. 7. Minnesota Statutes 2000, section 116C.57, is amended by adding a subdivision to read:

Subd. 2a. [APPLICATION.] (a) A person seeking to construct a large electric power generating plant or a high voltage transmission line shall apply to the board for a site permit or route permit. The application must contain any information required by the board and must specify:

(1) whether the applicant is required to receive a certificate of need for the proposed project;

(2) whether the applicant is required to comply with section 216B.019, subdivision 5, and has complied; and

(3) whether the proposed project was identified, discussed, and considered by the relevant regional energy infrastructure planning group and the result of that consideration.

(b) The applicant shall propose at least two sites for a large electric power generating plant and two routes for a high voltage transmission line.

(c) The chair of the board shall determine whether an application is complete and advise the applicant of any deficiencies. An application is not incomplete if information not in the application can be obtained from the applicant during the first phase of the process and that information is not essential for notice and initial public meetings.

Sec. 8. Minnesota Statutes 2000, section 116C.57, is amended by adding a subdivision to read:

Subd. 2b. [NOTICE OF APPLICATION.] Within 15 days after submitting an application to the board, the applicant shall publish notice of the application in a legal newspaper of general circulation in each county in which the site or route is proposed and send a copy of the application by certified mail to any regional development commission, county, incorporated municipality, and town in which the site or route is proposed. Within the same 15 days, the applicant shall also send a notice of the submission of the application and description of the proposed project to each owner whose property is adjacent to any of the proposed sites for the power plant or along any of the proposed routes for the transmission line. The notice must identify a location where a copy of the application can be reviewed. For the purpose of giving mailed notice under this subdivision, owners are those shown on the records of the county auditor or, in any county where tax statements are mailed by the county treasurer, on the records of the county treasurer, but other appropriate records may be used for this purpose. The failure to give mailed notice to a property owner, or defects in the notice, does not invalidate the proceedings, provided a bona fide attempt to comply with this subdivision has been made. Within the same 15 days, the applicant shall also send the same notice of the submission of the application and description of the proposed project to those persons who have requested to be placed on a list maintained by the board for receiving notice of proposed large electric generating power plants and high voltage transmission lines.

Sec. 9. Minnesota Statutes 2000, section 116C.57, is amended by adding a subdivision to read:

Subd. 2c. [ENVIRONMENTAL REVIEW.] The board shall prepare an environmental impact statement on each proposed large electric generating plant or high voltage transmission line for which a complete application has been submitted. For any project that has obtained a certificate of need from the public utilities commission, the board shall not consider whether or not the project is needed. No other state environmental review documents are required. The board shall study and evaluate any site or route proposed by an applicant and any other site or route the board deems necessary that was proposed in a manner consistent with rules adopted by the board concerning the form, content, and timeliness of proposals for alternate sites or routes.

Sec. 10. Minnesota Statutes 2000, section 116C.57, is amended by adding a subdivision to read:

Subd. 2d. [PUBLIC HEARING.] The board shall hold a public hearing on an application for a site permit for a large electric power generating plant or a route permit for a high voltage transmission line. A hearing held for designating a site or route must be conducted by an administrative law judge from the office of administrative

hearings under the contested case procedures of chapter 14. Notice of the hearing must be given by the board at least ten days in advance but no earlier than 45 days prior to the commencement of the hearing. Notice must be by publication in a legal newspaper of general circulation in the county in which the public hearing is to be held and by certified mail to chief executives of the regional development commissions, counties, organized towns, townships, and the incorporated municipalities in which a site or route is proposed. A person may appear at the hearing and offer testimony and exhibits without the necessity of intervening as a formal party to the proceeding. The administrative law judge may allow a person to ask questions of other witnesses. The administrative law judge shall hold a portion of the hearing in the area where the power plant or transmission line is proposed to be located.

Sec. 11. Minnesota Statutes 2000, section 116C.57, subdivision 4, is amended to read:

Subd. 4. [CONSIDERATIONS IN DESIGNATING SITES AND ROUTES.] (a) To facilitate the study, research, evaluation, and designation of sites and routes, the board shall be guided by, but not limited to, the following responsibilities, procedures, and considerations:

(1) evaluation of research and investigations relating to the effects on land, water, and air resources of large electric power generating plants and high voltage transmission line routes and the effects of water and air discharges and electric fields resulting from such facilities on public health and welfare, vegetation, animals, materials, and aesthetic values, including base line studies, predictive modeling, and monitoring of the water and air mass at proposed and operating sites and routes, evaluation of new or improved methods for minimizing adverse impacts of water and air discharges and other matters pertaining to the effects of power plants on the water and air environment;

(2) environmental evaluation of sites and routes proposed for future development and expansion and their relationship to the land, water, air, and human resources of the state;

(3) evaluation of the effects of new electric power generation and transmission technologies and systems related to power plants designed to minimize adverse environmental effects;

(4) evaluation of the potential for beneficial uses of waste energy from proposed large electric power generating plants;

(5) analysis of the direct and indirect economic impact of proposed sites and routes including, but not limited to, productive agricultural land lost or impaired;

(6) evaluation of adverse direct and indirect environmental effects ~~which~~ that cannot be avoided should the proposed site and route be accepted;

(7) evaluation of alternatives to the applicant's proposed site or route proposed pursuant to subdivisions 1 and 2;

(8) evaluation of potential routes ~~which~~ that would use or parallel existing railroad and highway rights-of-way;

(9) evaluation of governmental survey lines and other natural division lines of agricultural land so as to minimize interference with agricultural operations;

(10) evaluation of the future needs for additional high voltage transmission lines in the same general area as any proposed route, and the advisability of ordering the construction of structures capable of expansion in transmission capacity through multiple circuiting or design modifications;

(11) evaluation of irreversible and irretrievable commitments of resources should the proposed site or route be approved; and

(12) ~~where~~ when appropriate, consideration of problems raised by other state and federal agencies and local entities.

~~(13)~~ (b) If the board's rules are substantially similar to existing ~~rules and~~ regulations of a federal agency to which the utility in the state is subject, the federal ~~rules and~~ regulations ~~shall~~ must be applied by the board.

~~(14)~~ (c) No site or route ~~shall~~ may be designated ~~which violates if to do so would violate~~ state agency rules.

Sec. 12. Minnesota Statutes 2000, section 116C.57, is amended by adding a subdivision to read:

Subd. 7. [TIMING.] The board shall make a final decision on an application within 60 days after receipt of the report of the administrative law judge. A final decision on the request for a site permit or route permit shall be made within one year after the chair's determination that an application is complete. The time for the final decision may be extended for up to 90 days for good cause and if all parties agree.

Sec. 13. Minnesota Statutes 2000, section 116C.57, is amended by adding a subdivision to read:

Subd. 8. [FINAL DECISION.] (a) A site permit may not be issued in violation of the site selection standards and criteria established in this section and in rules adopted by the board. The board shall indicate the reasons for any refusal and indicate changes in size or type of facility necessary to allow site designation. When the board designates a site, it shall issue a site permit to the applicant with any appropriate conditions. The board shall publish a notice of its decision in the State Register within 30 days of issuing the site permit.

(b) A route permit may not be issued in violation of the route selection standards and criteria established in this section and in rules adopted by the board. When the route is designated, the permit issued for the construction of the facility must specify the type, design, routing, right-of-way preparation, and facility construction deemed necessary and any other appropriate conditions. The board may order the construction of high voltage transmission line facilities that are capable of expansion in transmission capacity through multiple circuiting or design modifications. The board shall publish a notice of its decision in the State Register within 30 days of issuing the permit.

Sec. 14. [116C.575] [ALTERNATIVE REVIEW OF APPLICATIONS.]

Subdivision 1. [ALTERNATIVE REVIEW.] An applicant who seeks a site permit or route permit for one of the projects identified in this section may petition the board to be allowed to follow the procedures in this section rather than the procedures in section 116C.57. The board shall grant the petition within 30 days unless the board finds good cause for denial.

Subd. 2. [APPLICABLE PROJECTS.] The requirements and procedures in this section may apply to the following projects:

- (1) large electric power generating plants with a capacity of less than 80 megawatts;
- (2) large electric power generating plants fueled by natural gas;
- (3) projects to retrofit or repower an existing large electric power generating plant to one burning primarily natural gas or other similar clean fuel;
- (4) any natural gas peaking facility designed for or capable of storing on a single site more than 100,000 gallons of liquefied natural gas or synthetic gas;
- (5) high voltage transmission lines in excess of 200 kilovolts less than five miles in length in Minnesota; and
- (6) high voltage transmission lines in excess of 200 kilovolts if at least 80 percent of the distance of the line in Minnesota will be located along existing high voltage transmission line right-of-way.

Subd. 3. [APPLICATION.] The applicant for a site certificate or route permit for any of the projects listed in subdivision 2 who chooses to follow these procedures shall submit information the board may require, but the applicant is not required to propose a second site or route for the project. The applicant shall identify in the application any other sites or routes that were rejected by the applicant and the board may identify additional sites or routes to consider during the processing of the application. The chair of the board shall determine whether an application is complete and advise the applicant of any deficiencies.

Subd. 4. [NOTICE OF APPLICATION.] On submitting an application under this section, the applicant shall provide the same notice as required by section 116C.57, subdivision 2b.

Subd. 5. [ENVIRONMENTAL REVIEW.] For the projects identified in subdivision 2 and following these procedures, the board shall prepare an environmental assessment worksheet. The board shall include as part of the environmental assessment worksheet alternative sites or routes identified by the board and shall address mitigating measures for all of the sites or routes considered. The environmental assessment worksheet is the only state environmental review document required to be prepared on the project.

Subd. 6. [PUBLIC MEETING.] The board shall hold a public meeting in the area where the facility is proposed to be located. The board shall give notice of the public meeting in the same manner as notice for a public hearing. The board shall provide opportunity at the public meeting for any person to present comments and to ask questions of the applicant and board staff. The board shall also afford interested persons an opportunity to submit written comments into the record.

Subd. 7. [TIMING.] The board shall make a final decision on an application within 60 days after completion of the public meeting. A final decision on the request for a site permit or route permit under this section must be made within six months after the chair's determination that an application is complete. The time for the final decision may be extended for up to 45 days for good cause and if all parties agree.

Subd. 8. [CONSIDERATIONS.] The considerations in section 116C.57, subdivision 4, apply to any projects subject to this section.

Subd. 9. [FINAL DECISION.] (a) A site permit may not be issued in violation of the site selection standards and criteria established in this section and in rules adopted by the board. The board shall indicate the reasons for any refusal and indicate changes in size or type of facility necessary to allow site designation. When the board designates a site, it shall issue a site permit to the applicant with any appropriate conditions. The board shall publish a notice of its decision in the State Register within 30 days of issuance of the site permit.

(b) A route designation may not be made in violation of the route selection standards and criteria established in this section and in rules adopted by the board. When the board designates a route, it shall issue a permit for the construction of a high voltage transmission line specifying the type, design, routing, right-of-way preparation, and facility construction it deems necessary and specifying any other appropriate conditions. The board may order the construction of high voltage transmission line facilities that are capable of expansion in transmission capacity through multiple circuiting or design modifications. The board shall publish a notice of its decision in the State Register within 30 days of issuance of the permit.

Sec. 15. [116C.57] [EMERGENCY PERMIT.]

(a) Any utility whose electric power system requires the immediate construction of a large electric power generating plant or high voltage transmission line due to a major unforeseen event may apply to the board for an emergency permit after providing notice in writing to the public utilities commission of the major unforeseen event and the need for immediate construction. The permit must be issued in a timely manner, no later than 195 days after the board's acceptance of the application and upon a finding by the board that (1) a demonstrable emergency exists, (2) the emergency requires immediate construction, and (3) adherence to the procedures and time schedules specified in section 116C.57 would jeopardize the utility's electric power system or would jeopardize the utility's ability to meet the electric needs of its customers in an orderly and timely manner.

(b) A public hearing to determine if an emergency exists must be held within 90 days of the application. The board, after notice and hearing, shall adopt rules specifying the criteria for emergency certification.

Sec. 16. Minnesota Statutes 2000, section 116C.58, is amended to read:

116C.58 [~~PUBLIC HEARINGS; NOTICE~~ ANNUAL HEARING.]

The board shall hold an annual public hearing at a time and place prescribed by rule in order to afford interested persons an opportunity to be heard regarding ~~its inventory of study areas and any other aspects of the board's activities and duties or policies specified in sections 116C.51 to 116C.69.~~ The board shall hold at least one public hearing in each county where a site or route is being considered for designation pursuant to section 116C.57. ~~Notice and agenda of public hearings and public meetings of the board held in each county shall be given by the board at least ten days in advance but no earlier than 45 days prior to such hearings or meetings. Notice shall be by publication in a legal newspaper of general circulation in the county in which the public hearing or public meeting is to be held and by certified mailed notice to chief executives of the regional development commissions, counties, organized towns and the incorporated municipalities in which a site or route is proposed. All hearings held for designating a site or route or for exempting a route shall be conducted by an administrative law judge from the office of administrative hearings pursuant to the contested case procedures of chapter 14. Any person may appear at the hearings and present testimony and exhibits and may question witnesses without the necessity of intervening as a formal party to the proceedings.~~ any matters relating to the siting of large electric generating power plants and routing of high voltage transmission lines. At the meeting, the board shall advise the public of the permits issued by the board in the past year. The board shall provide at least ten days' notice, but no more than 45 days' notice, of the annual meeting by mailing notice to those persons who have requested notice and by publication in the board's "EQB Monitor."

Sec. 17. Minnesota Statutes 2000, section 116C.59, subdivision 1, is amended to read:

Subdivision 1. [~~ADVISORY TASK FORCE.~~] The board may appoint one or more advisory task forces to assist it in carrying out its duties. Task forces appointed to evaluate sites or routes considered for designation shall be comprised of as many persons as may be designated by the board, but at least one representative from each of the following: Regional development commissions, counties and municipal corporations and one town board member from each county in which a site or route is proposed to be located. No officer, agent, or employee of a utility shall serve on an advisory task force. Reimbursement for expenses incurred shall be made pursuant to the rules governing state employees. The task forces expire as provided in section 15.059, subdivision 6. At the time the task force is appointed, the board shall specify the charge to the task force. The task force shall expire upon completion of its charge, upon designation by the board of alternative sites or routes to be included in the environmental impact statement, or upon the specific date identified by the board in the charge, whichever occurs first.

Sec. 18. Minnesota Statutes 2000, section 116C.59, subdivision 4, is amended to read:

Subd. 4. [~~SCIENTIFIC ADVISORY TASK FORCE.~~] The board may appoint one or more advisory task forces composed of technical and scientific experts to conduct research and make recommendations concerning generic issues such as health and safety, underground routes, double circuiting and long-range route and site planning. Reimbursement for expenses incurred shall be made pursuant to the rules governing reimbursement of state employees. The task forces expire as provided in section 15.059, subdivision 6. The time allowed for completion of a specific site or route procedure may not be extended to await the outcome of these generic investigations.

Sec. 19. Minnesota Statutes 2000, section 116C.60, is amended to read:

116C.60 [~~PUBLIC MEETINGS; TRANSCRIPT OF PROCEEDINGS; WRITTEN RECORDS.~~]

Meetings of the board, including hearings, ~~shall~~ must be open to the public. Minutes ~~shall~~ must be kept of board meetings and a complete record of public hearings ~~shall be~~ kept. All books, records, files, and correspondence of the board ~~shall~~ must be available for public inspection at any reasonable time. ~~The council shall board is~~ also be subject to chapter 13D.

Sec. 20. Minnesota Statutes 2000, section 216B.2421, subdivision 2, is amended to read:

Subd. 2. [LARGE ENERGY FACILITY.] "Large energy facility" means:

(1) any electric power generating plant or combination of plants at a single site with a combined capacity of 80,000 kilowatts or more, ~~or any facility of 50,000 kilowatts or more which requires oil, natural gas, or natural gas liquids as a fuel and for which an installation permit has not been applied for by May 19, 1977 pursuant to Minn. Reg. APC 3(a) and transmission lines directly associated with the plant that are necessary to interconnect the plant to the transmission system;~~

(2) any high voltage transmission line with a capacity of ~~200~~ 100 kilovolts or more and (i) with more than ~~50~~ ten miles of its length in Minnesota, ~~or (ii) any of its length in Minnesota and that crosses the state line; or, any high voltage transmission line with a capacity of 300 kilovolts or more with more than 25 miles of its length in Minnesota;~~

(3) any pipeline greater than six inches in diameter and having more than 50 miles of its length in Minnesota used for the transportation of coal, crude petroleum or petroleum fuels or oil or their derivatives;

(4) any pipeline for transporting natural or synthetic gas at pressures in excess of 200 pounds per square inch with more than 50 miles of its length in Minnesota;

(5) any facility designed for or capable of storing on a single site more than 100,000 gallons of liquefied natural gas or synthetic gas;

(6) any underground gas storage facility requiring permit pursuant to section 103I.681;

(7) any nuclear fuel processing or nuclear waste storage or disposal facility; and

(8) any facility intended to convert any material into any other combustible fuel and having the capacity to process in excess of 75 tons of the material per hour.

Sec. 21. Minnesota Statutes 2000, section 216B.2421, is amended by adding a subdivision to read:

Subd. 4. [MODIFYING EXISTING LARGE ENERGY FACILITY.] Refurbishing or upgrading an existing large energy facility through the replacement or addition of facility components does not require a certificate of need under section 216B.243, unless the changes lead to (1) a capacity increase of more than 100 megawatts, or ten percent of existing capacity, whichever is greater, or (2) operation at more than 50 percent higher voltage.

Sec. 22. Minnesota Statutes 2000, section 216B.243, subdivision 2, is amended to read:

Subd. 2. [CERTIFICATE REQUIRED.] (a) Except as provided in paragraph (b), no large energy facility shall may be sited or constructed in Minnesota without the issuance of a certificate of need by the commission pursuant to sections 216C.05 to 216C.30 and this section and consistent with the criteria for assessment of need.

(b) Notwithstanding paragraph (a), a large energy facility that is a generation facility of 500 megawatts or less or a natural gas peaking facility not owned by a public or municipal utility or cooperative electric association and that is not to be included in the utility's or association's rate base does not need a certificate of need under this section.

(c) The commission may not issue a certificate of need for a generation facility with coal as its primary fuel, unless the commission finds that the facility implements the most stringent technology and processes technically achievable, to ensure the least impact on the state's environment from the facility.



Sec. 23. Minnesota Statutes 2000, section 216B.243, is amended by adding a subdivision to read:

Subd. 2a. [PUBLIC PURPOSE DESIGNATION.] (a) When filing for a certificate of need under this section, an applicant may also petition the commission to designate the proposed large energy facility a public purpose project. The commission shall approve or reject the petition at the same time the commission renders its decision under subdivision 5. Notwithstanding section 116C.63 or any other law to the contrary, eminent domain authority may not be used in constructing a large energy facility unless the commission designates the facility a public purpose project. The value paid for property in the exercise of eminent domain authority may be structured so as to provide for the payment of a portion of the revenue derived from the large energy facility over a period of years, rather than a lump sum payment at the time the property is taken.

(b) In deciding whether to designate a proposed large energy facility as a public purpose project, the commission shall consider whether the proposed facility:

(1) remedies a condition, or set of conditions, that, based on the utility's most recent forecast or consistent with the transmission expansion plan of a federally approved regional transmission organization or regional reliability entity, may materially limit the adequacy of electric supply, efficiency of electric service, or reliability of electric service to Minnesota consumers;

(2) was identified as a critical need by the relevant regional energy infrastructure planning group;

(3) is consistent with all relevant state goals and strategies approved by the legislature under section 216B.017; and

(4) is otherwise in the public interest.

Sec. 24. Minnesota Statutes 2000, section 216B.243, subdivision 3, is amended to read:

~~Subd. 3. [SHOWING REQUIRED FOR CONSTRUCTION.] No (a) A proposed large energy facility shall may not be certified for construction unless the applicant can show that demand for electricity cannot be met more cost-effectively through energy conservation and load-management measures and unless the applicant has otherwise justified its need.~~

(b) In assessing need, the commission shall evaluate:

(1) the accuracy of the long-range energy demand forecasts on which the necessity for the facility is based;

(2) the effect of existing or possible energy conservation programs under sections 216C.05 to 216C.30 and this section or other federal or state legislation on long-term energy demand;

(3) the relationship of the proposed facility to overall state and regional energy needs, as described in the most recent state energy policy and conservation report prepared under section 216C.18 including consideration of (i) the most recent state energy security blueprint under section 216B.015, (ii) the most recent relevant regional energy infrastructure planning group report under section 216B.019, and (iii) information from federal and regional reliability organizations, regional transmission organizations, and other relevant sources;

(4) promotional activities that may have given rise to the demand for this facility;

(5) socially beneficial uses of the output (3) environmental and socioeconomic benefits of this facility, including its uses to protect or enhance environmental quality, to increase reliability of energy supply in Minnesota and the region, and to induce future development;

(6) the effects of the facility in inducing future development;

~~(7)~~ (4) possible alternatives for satisfying the energy demand or transmission needs including but not limited to potential for increased efficiency and upgrading of existing energy generation and transmission facilities, load management programs, and distributed generation;

~~(8)~~ (5) the policies, rules, and regulations of other state and federal agencies and local governments; ~~and~~

~~(9)~~ any (6) feasible ~~combination~~ of energy conservation improvements, required under section 216B.241, sections 216C.05 to 216C.30, or other available conservation programs that can (i) reasonably replace a significant part or all of the energy to be provided by the proposed facility, and (ii) compete with it economically and in terms of reliability; and

(7) whether the proposed large energy facility was recommended for construction by the relevant regional energy infrastructure planning group.

Sec. 25. Minnesota Statutes 2000, section 216B.243, subdivision 4, is amended to read:

Subd. 4. [APPLICATION FOR CERTIFICATE; HEARING.] Any person proposing to construct a large energy facility shall apply for a certificate of need prior to construction of the facility. The application ~~shall~~ must be on forms and in a manner established by the commission. In reviewing each application the commission shall hold at least one public hearing pursuant to chapter 14. The public hearing ~~shall~~ must be held at a location and hour reasonably calculated to be convenient for the public. An objective of the public hearing ~~shall~~ must be to obtain public opinion on the necessity of granting a certificate of need. The commission shall designate a commission employee whose duty shall be to facilitate citizen participation in the hearing process. If the commission and the environmental quality board determine that a joint hearing on siting and need under this subdivision and section 116C.57, subdivision 2d, is feasible, more efficient, and may further the public interest, a joint hearing under those subdivisions may be held.

Sec. 26. [INSTRUCTION TO REVISOR.]

The revisor of statutes shall renumber Minnesota Statutes, section 116C.57, subdivision 6, as section 116C.57, subdivision 9.

Sec. 27. [REPEALER.]

Minnesota Statutes 2000, sections 116C.55; 116C.57, subdivisions 3, 5, and 5a; and 116C.67, are repealed.

Sec. 28. [EFFECTIVE DATE.]

This article is effective the day following final enactment.

## ARTICLE 3

### REGULATORY FLEXIBILITY

Section 1. Minnesota Statutes 2000, section 216B.16, subdivision 7, is amended to read:

Subd. 7. [ENERGY COST ADJUSTMENT.] (a) Notwithstanding any other provision of this chapter, the commission may permit a public utility to file rate schedules containing provisions for the automatic adjustment of charges for public utility service in direct relation to changes in: (1) federally regulated wholesale rates for energy delivered through interstate facilities; (2) direct costs for natural gas delivered; or (3) costs for fuel used in generation of electricity or the manufacture of gas.

(b) In reviewing utility fuel purchases under this or any other provision, the commission shall allow and encourage a utility to have a combination of measures to manage price volatility and risk, including but not limited to having an appropriate share of the utility's supply come from long-term and medium-term contracts, in order to minimize consumer exposure to fuel price volatility.

Sec. 2. [216B.169] [RENEWABLE AND HIGH EFFICIENCY ENERGY RATE OPTIONS.]

(a) Each public utility, cooperative association, and municipal utility shall offer its customers, and shall advertise the offer at least annually, one or more options that allow a customer to determine that a certain amount of the electricity generated or purchased on behalf of the customer is (1) renewable energy as defined in section 216B.2422, subdivision 1, paragraph (c), or (2) high-efficiency, low-emissions, distributed generation such as fuel cells and microturbines fueled by a renewable fuel.

(b) Each public utility shall file an implementation plan within 90 days of the effective date of this section to implement paragraph (a).

(c) Rates charged to customers must be calculated using the utility's or association's cost of acquiring the energy for the customer and must be (1) the difference between the cost of generating or purchasing the renewable energy and the cost of generating or purchasing the same amount of nonrenewable energy; and (2) distributed on a per kilowatt-hour basis among all customers who choose to participate in the program. Implementation of these rate options may reflect a reasonable amount of lead time necessary to arrange acquisition of the energy.

(d) If a utility is not able to arrange an adequate supply of renewable or high-efficiency energy to meet its customers' demand under this section, the utility must file a report with the commission detailing its efforts and reasons for its failure.

(e) The commission, by order, may establish a program for tradeable credits for renewable energy under this section.

Sec. 3. [216B.2411] [CONSERVATION INVESTMENT PROGRAM.]

Subdivision 1. [DEFINITIONS.] For purposes of this section and section 216B.16, subdivision 6b, the terms defined in this subdivision have the meanings given them.

(a) "Commission" means the public utilities commission.

(b) "Commissioner" means the commissioner of commerce.

(c) "Customer facility" means all buildings, structures, equipment, and installations at a single site.

(d) "Department" means the department of commerce.

(e) "Energy conservation improvement" means the purchase or installation of a device, method, material, or project:

(1) that reduces consumption of or increases efficiency in the use of electricity or natural gas, including but not limited to insulation and ventilation, storm or thermal doors or windows, caulking and weatherstripping, furnace efficiency modifications, thermostat or lighting controls, awnings, or systems to turn off or vary the delivery of energy;

(2) that either (i) creates, converts, or actively uses energy from renewable sources such as solar, wind, and biomass, or (ii) recovers energy for reuse, from air or water or other similar material, provided that the device or method conforms with national or state performance and quality standards whenever applicable;

(3) that seeks to provide energy savings through reclamation or recycling and that is used as part of the infrastructure of an electric generation, transmission, or distribution system within the state or a natural gas distribution system within the state;

(4) that provides research or development of new means of increasing energy efficiency or conserving energy or research or development of improvement of existing means of increasing energy efficiency or conserving energy; or

(5) that either (i) is a renewable energy facility, such as a facility utilizing agricultural wastes as biomass fuel, or a methane digester facility associated with livestock feedlots for the production of energy, the grants for which should be coordinated with loans under the shared savings loan program established in section 17.115 to the extent feasible; (ii) increases a customer's ability to control the amount and scheduling of energy purchased from a utility, such as through the installation of a distributed generation facility as described in section 216B.169; or (iii) allows the utility or the customer to manage customer load if doing so reduces the demand for or increases the efficiency of electric services.

(f) "Investments and expenses of a public utility" includes the investments and expenses incurred by a public utility in connection with an energy conservation improvement, including but not limited to:

(1) the differential in interest cost between the market rate and the rate charged on a no-interest or below-market interest loan made by a public utility to a customer for the purchase or installation of an energy conservation improvement; and

(2) the difference between the utility's cost of purchase or installation of energy conservation improvements and any price charged by a public utility to a customer for those improvements.

(g) "Large electric customer facility" means a customer facility that imposes a peak electrical demand on an electric utility's system of not less than 10,000 kilowatts, measured in the same way as the utility that serves the customer facility measures electrical demand for billing purposes, and for which electric services are provided at retail on a single bill by a utility operating in the state.

(h) "Utility" means a public utility, municipal utility, electric cooperative association, or any combination of these authorized under Minnesota law.

Subd. 2. [INVESTMENT, EXPENDITURE, AND CONTRIBUTION; PUBLIC UTILITY.] (a) Each public utility shall spend and invest for energy conservation improvements under this subdivision the following amounts:

(1) for a public utility that furnishes gas service, 0.5 percent of its annual average gross operating revenues over the previous five years from service provided in the state;

(2) for a public utility that furnishes electric service, 1.5 percent of its annual average gross operating revenues over the previous five years from service provided in the state; and

(3) for a public utility that furnishes electric service and that operates a nuclear-powered electric generating plant within the state, 2.0 percent of its annual average gross operating revenues over the previous five years from service provided in the state.

(b) Load management may only be used to meet the requirements for energy conservation improvements under this section if it results in a demonstrable reduction in consumption of energy. However, up to five percent of the total amount required to be spent under this section may be spent on conservation improvements described in subdivision 1, paragraph (e), clause (5). Each public utility subject to this subdivision may spend and invest annually up to 15 percent of the total amount required to be spent and invested on energy conservation improvements under this section by the utility on research and development projects that meet the definition of energy conservation improvement in subdivision 1 and that are funded directly by the public utility.

Subd. 3. [CONSERVATION IMPROVEMENT BY COOPERATIVE ASSOCIATION OR MUNICIPALITY.] (a) This subdivision applies to:

(1) a cooperative electric association that generates and transmits electricity to associations that provide electricity at retail including a cooperative electric association not located in this state that serves associations or others in the state;

(2) a municipality that provides electric service to retail customers; and

(3) a municipality with gross operating revenues in excess of \$5,000,000 from sales of natural gas to retail customers.

(b) Each cooperative electric association and municipality subject to this subdivision shall spend and invest for energy conservation improvements under this subdivision the following amounts:

(1) for a municipality, 0.5 percent of its annual average gross operating revenues over the previous five years from the sale of gas and 1.0 percent of its annual average gross operating revenues over the previous five years from the sale of electricity; and

(2) for a cooperative electric association, 1.5 percent of its annual average gross operating revenues over the previous five years from service provided in the state.

(c) Each municipality and cooperative association subject to this subdivision shall identify and implement energy conservation improvement spending and investments that are appropriate for the municipality or association. Municipal utilities and electric cooperative associations may agree to form associations or organizations to aggregate their conservation spending obligations and to jointly provide energy conservation services to the customers of the municipal utilities or associations, and shall notify the commissioner in writing of the formation of such an association or organization.

(d) Each municipality and cooperative electric association subject to this subdivision may spend and invest annually up to 15 percent of the total amount required to be spent and invested on energy conservation improvements under this subdivision on research and development projects that meet the definition of energy conservation improvement in subdivision 1 and that are funded directly by the municipality or cooperative electric association.

(e) Load management may only be used to meet the requirements of this subdivision if it reduces the demand for or increases the efficiency of electric services.

(f) Up to five percent of the total amount required to be spent under this section may be spent on conservation improvements described in subdivision 1, paragraph (e), clause (5).

(g) A generation and transmission cooperative electric association may include as spending and investment required under this subdivision conservation improvement spending and investment by cooperative electric associations that provide electric service at retail to consumers and that are served by the generation and transmission association.

Subd. 4. [PROGRAMS.] (a) The commissioner may by rule as resources allow, or by order, establish standards and criteria for the provision of energy conservation improvements, including standard programs, to efficiently and effectively provide energy conservation services to each utility's energy consumers on a nondiscriminatory basis and cost-effective manner and to provide certainty to utilities and associations as to what constitutes an acceptable energy conservation improvement under this section. The list of standard programs may include rebates for high-efficiency appliances, rebates or subsidies for high-efficiency lamps, small business energy audits, and building recommissioning. A utility may adhere to this list of programs or may offer other conservation programs not on the list.

(b) Each public utility shall ensure that a portion of the money spent on residential conservation improvement programs is devoted to programs that directly address the needs of renters and low-income persons unless an insufficient number of appropriate programs is available.

(c) A utility, a political subdivision, or a nonprofit or community organization that has suggested an energy conservation improvement program to a public utility, the attorney general acting on behalf of consumers and small business interests, or a utility customer that has suggested a program and is not represented by the attorney general under section 8.33 may petition the commission to modify or discontinue a utility energy conservation improvement program, and the commission may do so if it determines that the program is not sufficiently cost effective, does not adequately address the residential conservation improvement needs of low-income persons, has a long-range negative effect on one or more classes of customers, or is otherwise not in the public interest. The person petitioning for commission review has the burden of proof. The commission shall reject a petition that, on its face, fails to make a reasonable argument that a program is not in the public interest.

Subd. 5. [ENERGY SAVINGS GOALS.] (a) By August 1, 2001, and every three years thereafter, the commissioner shall develop energy savings goals:

(1) in kilowatts and kilowatt-hours that each public utility providing retail electric service in this state can reasonably be expected to achieve at the level of energy conservation improvement expenditures required under this section; and

(2) in cubic feet of natural gas that each public utility providing retail natural gas service in this state can reasonably be expected to achieve at the level of conservation improvement expenditures required under this section.

(b) In consultation with the commissioner, municipal utilities and cooperative electric associations shall develop and submit energy savings goals to the commissioner by August 1, 2001, and every three years thereafter.

(c) Municipal utilities and electric cooperative associations that agree to aggregate their energy conservation obligations and resources by forming associations or organizations to provide energy conservation services to their customers may develop goals for the association or organization, in lieu of goals for individual members.

Subd. 6. [OVERVIEW; REVIEW AND AUDIT; PUBLIC UTILITIES.] (a) By January 1, 2002, and every three years thereafter, each public utility shall provide the commissioner with a prospective overview of the utility's planned conservation activities and the anticipated energy savings on a triennial basis. This overview must include a description of the types of activities, the consumer sectors targeted by each activity, and the anticipated energy savings and costs of each activity. This overview must also indicate, for each type of activity, how much additional cost-effective conservation is likely to be achieved in subsequent years. A public utility may request the commissioner to approve or reject the utility's plan prior to implementing the plan. The commissioner may do so if resources permit.

(b) By April 1, 2005, and every three years thereafter, each public utility shall provide a report to the commissioner, acting on behalf of the commission, summarizing the utility's conservation activities and energy savings resulting from those activities under this section. The public utility shall include in the report the results of an independent audit performed by the department or an auditor with experience in the provision of energy conservation and energy efficiency services approved by the commissioner and chosen by the utility. The audit must specify the actual energy savings or increased efficiency in the use of energy within the service territory of the utility that is the result of the spending and investments. Annually beginning by April 1, 2003, except for those years a full audit is due, each utility shall submit a report to the commissioner detailing the utility's energy conservation activities for the previous year and provide information regarding the cost effectiveness of those activities.

(c) The audit provided under paragraph (b) shall evaluate the cost effectiveness of the utility's conservation programs. In making this evaluation, the audit shall consider whether the utility's programs:

(1) fairly address each of the utility's consumer classes and market sectors;

- (2) use accurate and complete data in calculating costs and energy savings;
- (3) identify and target investments and improvements that have a high potential for saving energy;
- (4) indicate an adequate commitment to implementing highly cost-effective conservation programs; and
- (5) comply with the provisions of this section and associated rules and orders.

An audit must give a negative evaluation if it finds the utility's overall energy conservation program has not been cost effective or has failed to satisfy any of the criteria. Up to five percent of a utility's conservation spending obligation under this section may be used for program pre-evaluation, research and testing, monitoring, and program audit and evaluation.

(d) Following each submittal of an annual report or a triennial audit, the commissioner shall issue a report to the commission as to whether:

(1) the utility's overall conservation program is cost effective and is in compliance with this section and all applicable rules or orders; and

(2) the utility has been successful in achieving the energy savings goals for that utility under subdivision 5.

(e) Following two or more negative evaluations under paragraph (b), the commission may determine that a utility is not implementing adequate energy conservation programs. In that event, the commission may order the utility to pay into the energy and conservation account under subdivision 10, up to 50 percent of the utility's or association's conservation spending obligation under this section. The commissioner shall select a third party other than the utility by competitive bid to provide conservation improvements in the utility's service territory.

Subd. 7. [OVERVIEW AND PROGRAM EVALUATION; MUNICIPAL AND COOPERATIVE UTILITIES.]

(a) By January 1, 2002, and every three years thereafter, each municipal utility and electric cooperative association shall provide the commissioner with a prospective overview of the utility's or association's planned conservation activities and the anticipated energy savings on a triennial basis. This overview must include a description of the types of activities, the consumer sectors targeted by each, and the anticipated energy savings and costs of each activity. This overview must also indicate, for each type of activity, how much additional cost-effective conservation is likely to be achieved in subsequent years.

(b) By February 2, 2002, and every three years thereafter, each municipal utility or cooperative association shall provide an evaluation to the commission summarizing the utility's or association's conservation activities and energy savings resulting from those activities under this section. In consultation with the commissioner, the municipal utility or cooperative association shall evaluate its energy and capacity conservation programs, develop plans for future programs, and report its findings to the commission. The evaluation must develop program and performance goals that recognize customer class, utility service area demographics, cost of program delivery, regional economic indicators, and utility load shape. The program evaluation must address:

(1) whether the utility or association has implemented or is implementing cost-effective energy conservation programs and specify the energy and capacity savings within the service territory or association that is the result of conservation improvement programs, using a list of baseline energy and capacity savings assumptions developed in consultation with the department of commerce;

(2) the availability of basic conservation services and programs to customers;

(3) methodologies that best quantify energy savings, cost effectiveness, and the potential for cost-effective conservation improvements;

(4) the value of local administration of conservation programs in meeting local and statewide needs;

(5) the effect on customer bills;

(6) the role of capacity conservation in meeting utility planning needs and state energy goals;

(7) the ability of energy conservation programs to avoid the need for construction of generation facilities and transmission lines;

(8) whether the utility's or association's programs address all of the following consumer market sectors: farm, residential, commercial, and industrial; and

(9) whether the utility's or association's programs use accurate and auditable data in calculating costs and energy savings.

(c) Municipal utilities and electric cooperative associations that aggregate their energy conservation obligations and resources by forming associations or organizations to provide energy conservation services to their customers may submit overviews, program evaluations, and annual reports jointly.

Subd. 8. [ADDITIONAL CONSERVATION SPENDING.] (a) Nothing in this section prohibits any utility from spending or investing more for energy conservation improvements than is required in this section.

(b) The commission may require a public utility to invest or spend more than is required under this section if the commission finds that additional investments would be cost effective, and the utility's most recent forecast projects a significant supply deficit to meet demand and energy requirements. If the commission orders the utility to make additional conservation investments under this section, the commission shall provide for financial incentives for these investments under section 216B.16.

Subd. 9. [LARGE CUSTOMER OPT-OUT.] (a) The owner of a large electric customer facility may petition the commissioner to exempt both electric and gas utilities serving the large energy customer facility from the investment and expenditure requirements of subdivision 2 with respect to retail revenues attributable to the facility. The petition must contain an audit by a consultant registered with the department and selected by the customer, certifying that the customer has implemented all energy conservation improvements with a ten-year simple payback or less. Within five business days of receipt of a petition that contains this audit, the commissioner shall either:

(1) grant the petition exempting both electric and gas utilities serving the large energy customer facility from the investment and expenditure requirements of this section with respect to all of the retail revenues attributable to the facility; or

(2) order a confirming audit of the customer.

(b) The decision to grant the petition or order a confirming audit is entirely within the discretion of the commissioner. The cost of the initial audit must be borne by the customer.

(c) If the commissioner orders a confirming audit, the commissioner shall select a contractor from the list maintained by the department and notify the customer.

(d) If the confirming audit supports the initial audit:

(1) the commissioner shall issue an order granting the petition within five business days; and

(2) the cost of the confirming audit must be borne by the electric and gas utilities serving the customer, in relative proportion to the total retail revenues attributable to the customer, and deducted from the utility's conservation spending obligation under this section.



(e) If the confirming audit does not support the initial audit:

(1) the cost of the confirming audit must be borne by the customer; and

(2) the commissioner may suspend the consultant that conducted the initial audit from the list maintained by the department.

(f) The commissioner shall create, maintain, and publish on the department's Web site a list of contractors available to conduct audits under this subdivision. The commissioner may spend no more than \$20,000 per biennium under this subdivision.

(g) If a petition is filed on or before October 1 of any year, the order of the commissioner to exempt revenues attributable to the facility can be effective no earlier than January 1 of the following year. The commissioner may, after investigation, recommend that any exemption granted under this paragraph be rescinded upon a determination that additional energy conservation improvements with a simple payback of ten years or less are available at the large electric customer facility. For the purposes of investigations by the commissioner under this paragraph, the owner of any large electric customer facility shall, upon request, provide the commissioner with updated information comparable to that originally supplied in or with the owner's original petition under paragraph (a).

(h) For purposes of this section, "gross operating revenues" do not include revenues from large electric customer facilities exempted by the commissioner under this subdivision. A public utility may not spend for or invest in energy conservation improvements that directly benefit a large electric customer facility for which the commissioner has issued an exemption pursuant to this subdivision.

Subd. 10. [ENERGY AND CONSERVATION ACCOUNT.] (a) Money in the account is appropriated to the department for programs designed to meet the energy conservation needs of low-income persons and to make energy conservation improvements in areas not adequately served including research and development projects included in the definition of energy conservation improvement in subdivision 1. Interest on money in the account accrues to the account.

(b) Using information collected under section 216C.02, subdivision 1, paragraph (b), the commissioner must, to the extent possible, allocate enough money to programs for low-income persons to assure that their needs are being adequately addressed. The commissioner must request the commissioner of finance to transfer money from the account to the commissioner of economic security for an energy conservation program for low-income persons. In establishing programs under this paragraph, the commissioner must consult political subdivisions and nonprofit and community organizations, especially organizations engaged in providing energy and weatherization assistance to low-income persons. At least one program must address the need for energy conservation improvements in areas in which a high percentage of residents use fuel oil or propane to fuel their source of home heating.

(c) The commissioner may contract with a political subdivision, a nonprofit or community organization, a public utility, a municipality, or a cooperative electric association to implement its programs under this section. The commissioner may provide grants to any person to conduct research and development projects in accordance with this section.

Subd. 11. [RECOVERY OF EXPENSES.] (a) The commission shall allow a public utility to recover expenses resulting from a conservation improvement program consistent with the requirements of this section and contributions to the energy and conservation account, unless the recovery would be inconsistent with a financial incentive proposal approved by the commission. In addition, a utility may file annually, or the public utilities commission may require the utility to file, and the commission may approve, rate schedules containing provisions for the automatic adjustment of charges for utility service in direct relation to changes in the expenses of the utility for real and personal property taxes, fees, and permits, the amounts of which the utility cannot control.

(b) A public utility is eligible to file for adjustment for real and personal property taxes, fees, and permits under this subdivision only if, in the year previous to the year in which it files for adjustment, it has spent or invested at least 2.25 percent of its gross revenues from provision of electric service, excluding gross operating revenues from electric service provided in the state to large electric customer facilities for which the commissioner has issued an exemption under subdivision 9, and 0.75 percent of its gross revenues from provision of gas service, excluding gross operating revenues from gas services provided in the state to large electric customer facilities for which the commissioner has issued an exemption under subdivision 9, for that year for energy conservation improvements under this section.

Subd. 12. [OWNERSHIP OF ENERGY CONSERVATION IMPROVEMENT.] An energy conservation improvement made to or installed in a building in accordance with this section, except systems owned by the utility and designed to turn off, limit, or vary the delivery of energy, are the exclusive property of the owner of the building except to the extent that the improvement is subjected to a security interest in favor of the utility in case of a loan to the building owner. The utility has no liability for loss, damage, or injury caused directly or indirectly by an energy conservation improvement except for negligence by the utility in purchase, installation, or modification of the product.

Subd. 13. [FEDERAL LAW PROHIBITIONS.] If investments by public utilities in energy conservation improvements are in any manner prohibited or restricted by federal law and there is a provision under which the prohibition or restriction may be waived, then the commissioner, the governor, or any other necessary state agency or officer shall take all necessary and appropriate steps to secure a waiver with respect to those public utility investments in energy conservation improvements included in this section.

Subd. 14. [EFFICIENT LIGHTING PROGRAM.] (a) Each public utility, cooperative electric association, and municipal utility that provides electric service to retail customers shall include as part of its conservation improvement activities a program to strongly encourage the use of fluorescent and high intensity discharge lamps. The program must include at least a public information campaign to encourage use of the lamps and proper management of spent lamps by all customer classifications.

(b) A public utility that provides electric service at retail to 200,000 or more customers shall establish, either directly or through contracts with other persons, including lamp manufacturers, distributors, wholesalers, and retailers and local government units, a system to collect for delivery to a reclamation or recycling facility spent fluorescent and high-intensity discharge lamps from households and from small businesses as defined in section 645.445 that generate an average of fewer than ten spent lamps per year.

(c) A collection system must include establishing reasonably convenient locations for collecting spent lamps from households and financial incentives sufficient to encourage spent lamp generators to take the lamps to the collection locations. Financial incentives may include coupons for purchase of new fluorescent or high-intensity discharge lamps, a cash-back system, or any other financial incentive or group of incentives designed to collect the maximum number of spent lamps from households and small businesses that is reasonably feasible.

(d) A public utility that provides electric service at retail to fewer than 200,000 customers, a cooperative electric association, or a municipal utility that provides electric service at retail to customers may establish a collection system under paragraphs (b) and (c) as part of conservation improvement activities required under this section.

(e) The commissioner of the pollution control agency may not, unless clearly required by federal law, require a public utility, cooperative electric association, or municipality that establishes a household fluorescent and high-intensity discharge lamp collection system under this section to manage the lamps as hazardous waste as long as the lamps are managed to avoid breakage and are delivered to a recycling or reclamation facility that removes mercury and other toxic materials contained in the lamps prior to placement of the lamps in solid waste.

(f) If a utility contracts with a local government unit to provide a collection system under this subdivision, the contract must provide for payment to the local government unit of all the unit's incremental costs of collecting and managing spent lamps.

(g) All the costs incurred by a public utility, cooperative electric association, or municipal utility for promotion and collection of fluorescent and high-intensity discharge lamps under this subdivision constitute conservation improvement spending under this section.

Sec. 4. Minnesota Statutes 2000, section 216B.2422, subdivision 2, is amended to read:

Subd. 2. [RESOURCE PLAN FILING AND APPROVAL.] A utility shall file a resource plan with the commission periodically in accordance with rules adopted by the commission. ~~The commission shall approve, reject, or modify the plan of a public utility, as defined in section 216B.02, subdivision 4, consistent with the public interest.~~ In the resource plan proceedings of all ~~other~~ utilities, ~~the commission's utility may request the commission to approve or reject the resource plan, and the commission may do so if the resources of both the commission and the department permit. Otherwise, the filing of the plan is informational only. If the utility requests the commissioner to waive the need for a certificate of need under subdivision 6 or to approve a bidding schedule under subdivision 5, the commission's order is binding. Otherwise, the commission's order shall be~~ is advisory and the order's findings and conclusions ~~shall~~ constitute prima facie evidence ~~which that~~ may be rebutted by substantial evidence in all other proceedings. With respect to utilities other than those defined in section 216B.02, subdivision 4, the commission shall consider the filing requirements and decisions in any comparable proceedings in another jurisdiction. As a part of its resource plan filing, a utility shall include the least cost plan for meeting 50 and 75 percent of all new and refurbished capacity needs through a combination of conservation and renewable energy resources.

Sec. 5. [452.25] [JOINT VENTURES BY UTILITIES.]

Subdivision 1. [APPLICABILITY.] This section applies to all home rule charter and statutory cities, except as provided in section 6.

Subd. 2. [DEFINITIONS.] For purposes of this section:

(a) "City" means a statutory or home rule charter city, section 410.015 to the contrary notwithstanding.

(b) "Cooperative association" means a cooperative association organized under chapter 308A.

(c) "Governing body" means (1) the city council in a city that operates a municipal utility, or (2) a board, commission, or body empowered by law, city charter, or ordinance or resolution of the city council to control and operate the municipal utility.

(d) "Investor-owned utility" means an entity that provides utility services to the public under chapter 216B and that is owned by private persons.

(e) "Municipal power agency" means an organization created under sections 453.51 to 453.62.

(f) "Municipal utility" means a utility owned, operated, or controlled by a city to provide utility services.

(g) "Public utility" or "utility" means a provider of electric or water facilities or services or an entity engaged in other similar or related operations authorized by law or charter.

Subd. 3. [AUTHORITY.] (a) Upon the approval of its elected utilities commission or, if there be none, its city council, a municipal utility may enter into a joint venture with other municipal utilities, municipal power agencies, cooperative associations, or investor-owned utilities to provide utility services. Retail electric utility services provided by a joint venture must be within the boundaries of each utility's exclusive electric service territory as shown on the map of service territories maintained by the department of commerce. The terms and conditions of the joint venture are subject to ratification by the governing bodies of the respective utilities and may include the formation of a corporate or other separate legal entity with an administrative and governance structure independent of the respective utilities.

(b) A corporate or other separate legal entity, if formed:

(1) has the authority and legal capacity and, in the exercise of the joint venture, the powers, privileges, responsibilities, and duties authorized by this section;

(2) is subject to the laws and rules applicable to the organization, internal governance, and activities of the entity;

(3) in connection with its property and affairs and in connection with property within its control, may exercise any and all powers that may be exercised by a natural person or a private corporation or other private legal entity in connection with similar property and affairs; and

(4) a joint venture that does not include an investor-owned utility may elect to be deemed a municipal utility or a cooperative association for purposes of chapter 216B or other federal or state law regulating utility operations; and

(5) a joint venture that includes an investor-owned utility must notify the public utilities commission 30 days in advance of offering services. Upon a finding by the commission, such joint venture will be subject to regulation under chapter 216B.

(c) Any corporation, if formed, must comply with section 465.719, subdivisions 9, 10, 11, 12, 13, and 14. The term "political subdivision," as it is used in section 465.719, shall refer to the city council of a city.

Subd. 4. [RETAIL CUSTOMERS.] Unless the joint venture's retail electric rates, as defined in section 216B.02, subdivision 5, of a joint venture that does not include an investor-owned utility, are approved by the governing body of each municipal utility or municipal power agency and the board of directors of each cooperative association that is party to the joint venture, the retail electric customers of the joint venture, if their number be more than 25, may elect to become subject to electric rate regulation by the public utilities commission as provided in chapter 216B. The election is subject to and must be carried out according to the procedures in section 216B.026 and, for these purposes, each retail electric customer of the joint venture is deemed a member or stockholder as referred to in section 216B.026.

Subd. 5. [POWERS.] (a) A joint venture under this section has the powers, privileges, responsibilities, and duties of the separate utilities entering into the joint venture as the joint venture agreement may provide, including the powers under paragraph (b), except that:

(1) with respect to retail electric utility services, a joint venture shall not enlarge or extend the service territory served by the joint venture by virtue of the authority granted in sections 216B.44, 216B.45, and 216B.47;

(2) a joint venture may extend service to an existing connected load of 2,000 kilowatts or more, pursuant to section 216B.42, when the load is outside of the assigned service area of the joint venture, or of the electric utilities party to the joint venture, only if the load is already being served by one of the electric utilities party to the joint venture; and

(3) a privately owned utility, as defined in section 216B.02, may extend service to an existing connected load of 2,000 kilowatts or more, pursuant to section 216B.42, when the load is located within the assigned service territory of the joint venture, or of the electric utilities party to the joint venture, only if the load is already being served by that privately owned utility.

The limitations of clauses (1) to (3) do not apply if written consent to the action is obtained from the electric utility assigned to and serving the affected service territory or connected load.

(b) Joint venture powers include, but are not limited to, the authority to:

(1) finance, own, acquire, construct, and operate facilities necessary to provide utility services to retail customers of the joint venture, including generation, transmission, and distribution facilities, and like facilities used in other utility services;

(2) combine assigned service territories, in whole or in part, upon notice to, hearing by, and approval of the public utilities commission;

(3) serve customers in the utilities' service territories or in the combined service territory;

(4) combine, share, or employ administrative, managerial, operational, or other staff if combining or sharing will not degrade safety, reliability, or customer service standards;

(5) provide for joint administrative functions, such as meter reading and billings;

(6) purchase or sell utility services at wholesale for resale to customers;

(7) provide conservation programs, other utility programs, and public interest programs, such as cold weather shut-off protection and conservation spending programs, as required by law and rule; and

(8) participate as the parties deem necessary in providing utility services with other municipal utilities, cooperative utilities, investor-owned utilities, or other entities, public or private.

(c) Notwithstanding any contrary provision within this section, a joint venture formed under this section may engage in wholesale utility services unless the municipal utility, municipal power agency, cooperative association, or investor-owned utility party to the joint venture is prohibited under current law from conducting that activity; but, in any case, the joint venture may provide wholesale services to a municipal utility, a cooperative association, or an investor-owned utility that is party to the joint venture.

(d) This subdivision does not limit the authority of a joint venture to exercise rights of eminent domain for other utility purposes to the same extent as is permitted of those utilities party to the joint venture.

Subd. 6. [CONSTRUCTION.] (a) The powers conferred by this section are in addition to the powers conferred by other law or charter. A joint venture under this section, and a municipal utility with respect to any joint venture under this section, have the powers necessary to effect the intent and purpose of this section, including, but not limited to, the expenditure of public funds and the transfer of real or personal property in accordance with the terms and conditions of the joint venture and the joint venture agreement. This section is complete in itself with respect to the formation and operation of a joint venture under this section and with respect to a municipal utility, a cooperative association, or an investor-owned utility party to a joint venture related to their creation of and dealings with the joint venture, without regard to other laws or city charter provisions that do not specifically address or refer to this section or a joint venture created under this section.

(b) This section must not be construed to supersede or modify:

(1) the power of a city council conferred by charter to overrule or override any action of a governing body other than the actions of the joint venture;

(2) chapter 216B;

(3) any referendum requirements applicable to the creation of a new electric utility by a municipality under section 216B.46 or 216B.465; or

(4) any powers, privileges, or authority or any duties or obligations of a municipal utility, municipal power agency, or cooperative association acting as a separate legal entity without reference to a joint venture created under this section.

Sec. 6. [EXCEPTION.]

Laws 1996, chapter 300, section 1, as amended by Laws 1997, chapter 232, section 1, govern joint ventures created under it and those joint ventures are not governed by this section.

## Sec. 7. [EXEMPTION EXTENDED.]

The commissioner of commerce shall not review the exemption under Minnesota Statutes, section 216B.241, subdivision 1a, paragraph (b), of a large electric customer facility, as defined in Minnesota Statutes, section 216B.241, subdivision 1, paragraph (g), from the investment and expenditure requirements of Minnesota Statutes, section 216B.241, subdivision 1a, paragraph (b), for five years from the date the exemption was granted, provided the exemption was granted before April 15, 2001. This provision does not apply if the customer facility's peak electrical demand exceeds ten percent of the peak electrical demand of the facility as of the date the exemption was granted.

## Sec. 8. [EFFECTIVE DATE.]

This article is effective the day following final enactment.

## ARTICLE 4

## INTERCONNECTION OF DISTRIBUTED RESOURCES

## Section 1. [216B.68] [DEFINITIONS.]

Subdivision 1. [SCOPE.] The words and terms used in sections 216B.68 to 216B.75 have the meanings given them in this section.

Subd. 2. [APPLICATION FOR INTERCONNECTION AND PARALLEL OPERATION.] "Application for interconnection and parallel operation" with the utility system or application means a standard form of application developed by the commissioner and approved by the commission.

Subd. 3. [COMPANY.] "Company" means an electric utility operating a distribution system.

Subd. 4. [ELECTRIC UTILITY.] "Electric utility" means all electric utilities that own and operate equipment in the state for furnishing electric service at retail.

Subd. 5. [CUSTOMER.] "Customer" means any individual person or entity interconnected to the company's utility system for the purpose of receiving or exporting electric power from or to the company's utility system.

Subd. 6. [DISTRIBUTED GENERATION OR ON-SITE DISTRIBUTED GENERATION.] "Distributed generation" or "on-site distributed generation" means an electrical generating facility located at a customer's point of delivery or point of common coupling of ten megawatts or less and connected at a voltage less than or equal to 60 kilovolts that may be connected in parallel operation to the utility system.

Subd. 7. [FACILITY.] "Facility" means an electrical generating installation consisting of one or more on-site distributed generation units. The total capacity of a facility's individual on-site distributed generation units may exceed ten megawatts; however, no more than ten megawatts of a facility's capacity will be interconnected at any point in time at the point of common coupling under this section.

Subd. 8. [INTERCONNECTION.] "Interconnection" means the physical connection of distributed generation to the utility system in accordance with the requirements of this section so that parallel operation can occur.

Subd. 9. [INTERCONNECTION AGREEMENT.] "Interconnection agreement" means the standard form of agreement, developed and approved by the commission. The interconnection agreement sets forth the contractual conditions under which a company and a customer agree that one or more facilities may be interconnected with the company's utility system.

Subd. 10. [PARALLEL OPERATION.] "Parallel operation" means the operation of on-site distributed generation by a customer while the customer is connected to the company's utility system.

Subd. 11. [POINT OF COMMON COUPLING.] "Point of common coupling" means the point where the electrical conductors of the company utility system are connected to the customer's conductors and where any transfer of electric power between the customer and the utility system takes place, such as switchgear near the meter.

Subd. 12. [PRECERTIFIED EQUIPMENT.] "Precertified equipment" means a specific generating and protective equipment system or systems that have been certified as meeting the applicable parts of this section relating to safety and reliability by an entity approved by the commission.

Subd. 13. [PRE-INTERCONNECTION STUDY.] "Pre-interconnection study" means a study or studies that may be undertaken by a company in response to its receipt of a completed application for interconnection and parallel operation with the utility system. Pre-interconnection studies may include, but are not limited to, service studies, coordination studies, and utility system impact studies.

Sec. 2. [216B.69] [INTERCONNECTION OF ON-SITE DISTRIBUTED GENERATION.]

Subdivision 1. [PURPOSE.] The purpose of this section is to:

(1) establish the terms and conditions that govern the interconnection and parallel operation of on-site distributed generation;

(2) provide cost savings and reliability benefits to customers;

(3) establish technical requirements that will promote the safe and reliable parallel operation of on-site distributed generation resources;

(4) enhance both the reliability of electric service and economic efficiency in the production and consumption of electricity; and

(5) promote the use of distributed resources in order to provide electric system benefits during periods of capacity constraints.

Subd. 2. [DISTRIBUTED GENERATION; GENERIC PROCEEDING.] (a) The commission shall initiate a proceeding within 30 days of the effective date of this section, to establish, by order, generic standards for utility tariffs for the interconnection and parallel operation of distributed generation of no more than ten megawatts of interconnected capacity. The commission shall ensure that these standards are, and continue to be, consistent with federal requirements and any distributed generation interconnection operational and safety standards adopted by the institute of electrical and electronics engineers, and must:

(1) provide for the low-cost, safe, and standardized interconnection of facilities fueled by natural gas, by a renewable fuel, by another similarly clean fuel, or by a combination of these fuels, which may include, but are not limited to, fuel cells, microturbines, wind turbines, or solar modules;

(2) take into account differing system requirements and hardware, as well as the overall demand load requirements of individual utilities;

(3) encourage and compensate for the addition of distributed generation power resources while reducing the cost to the utility's customers for energy, capacity, transmission, and distribution;

(4) minimize and avoid increases in the rates of other customers on the utility's system;

(5) allow for reasonable terms and conditions, consistent with the cost and operating characteristics of the various technologies, so that a utility can reasonably be assured of the reliable, safe, and efficient operation of the interconnected equipment;

(6) ensure that backup power, supplemental power, and maintenance power are available to all customers and customer classes that desire this service;

(7) establish a standard interconnection agreement that sets forth the contractual conditions under which a company and a customer agree that one or more facilities may be interconnected with the company's utility system; and

(8) establish a standard application for interconnection and parallel operation with the utility system.

(b) The commission may develop financial incentives based on a public utility's performance in encouraging residential and small business customers to participate in on-site generation.

Subd. 3. [DISTRIBUTED GENERATION TARIFF.] Within 90 days of the issuance of an order under subdivision 2:

(1) each public utility providing electric service at retail shall file a distributed generation tariff consistent with that order, for commission approval or approval with modification; and

(2) each municipal utility and cooperative electric association shall adopt a distributed generation tariff that addresses the issues included in the commission's order.

Sec. 3. [216B.70] [DISCONNECTION AND RECONNECTION.]

Subdivision 1. [WHEN DISCONNECTION ALLOWED.] A utility may disconnect a distributed generation unit from the utility system if:

(1) the interconnection agreement with a customer expires or terminates, in accordance with the terms of the agreement;

(2) the facility is not in compliance with the technical requirements specified by the commissioner;

(3) continued interconnection will endanger persons or property; or

(4) written notice is provided at least seven business days prior to a service interruption for routine maintenance, repairs, and utility system modifications.

Subd. 2. [INCREMENTAL DEMAND CHARGES.] During the term of an interconnection agreement, a utility may require that a customer disconnect its distributed generation unit or take it off-line as a result of utility system conditions. The company may not assess the customer incremental demand charges arising from disconnecting the distributed generator as directed by the company during these periods.

Sec. 4. [216B.71] [PRE-INTERCONNECTION STUDIES FOR NONNETWORK INTERCONNECTION OF DISTRIBUTED GENERATION.]

Subdivision 1. [STUDIES.] A utility may conduct a service study, coordination study, or utility system impact study prior to interconnection of a distributed generation facility. When a study is deemed necessary, the scope of the study must be based on the characteristics of the particular distributed generation facility to be interconnected and the utility's system at the specific proposed location. At the customer's choice, a study related to interconnection of distributed generation on the customer's premises may be conducted by a qualified third party jointly selected by the utility and the customer.



Subd. 2. [CUSTOMER FEE.] A utility generation facility not described in subdivision 1 may charge a customer a fee to offset its costs incurred in the conduct of a pre-interconnection study.

Subd. 3. [WHEN UTILITY CONDUCTS STUDY.] When a utility conducts an interconnection study, paragraphs (a) to (d) apply:

(a) The conduct of the pre-interconnection study may not take more than four weeks.

(b) A utility shall prepare written reports of the study findings and make them available to the customer.

(c) The study must consider both the costs incurred and the benefits realized as a result of the interconnection of distributed generation to the company's utility system.

(d) The utility shall provide the customer with an estimate of the study cost before the utility initiates the study.

Sec. 5. [216B.72] [PRE-INTERCONNECTION STUDIES FOR NETWORK INTERCONNECTION OF DISTRIBUTED GENERATION.]

Subdivision 1. [NOTICE AND FEES.] Prior to charging a pre-interconnection study fee for a network interconnection of distributed generation, a utility shall first advise the customer of the potential problems associated with interconnection of distributed generation with its network system.

Subd. 2. [REQUIREMENTS WHEN UTILITY CONDUCTS STUDY.] When a utility conducts an interconnection study, paragraphs (a) to (d) apply:

(a) The conduct of a pre-interconnection study may not take more than four weeks.

(b) A utility shall prepare written reports of the study findings and make them available to the customer.

(c) The study must consider both the costs incurred and the benefits realized as a result of the interconnection of distributed generation to the utility's system.

(d) The utility shall provide the customer with an estimate of the study cost before the utility initiates the study.

Sec. 6. [216B.73] [EQUIPMENT PRECERTIFICATION.]

(a) The commissioner may approve one or more entities that shall precertify equipment as described under this section.

(b) Testing organizations or facilities capable of analyzing the function, control, and protective systems of distributed generation units may request to be certified as testing organizations.

(c) Distributed generation units that are certified to be in compliance by an approved testing facility or organization must be installed on a company utility system in accordance with an approved interconnection control and protection scheme without further review of their design by the utility.

Sec. 7. [216B.74] [TIME FOR PROCESSING APPLICATIONS FOR INTERCONNECTION.]

(a) The interconnection of distributed generation to the utility system must take place within the schedules described in paragraphs (b) to (f):

(b) For a facility with precertified equipment, interconnection must take place within four weeks of the utility's receipt of a completed interconnection application.

(c) For facilities without precertified equipment, connection must take place within six weeks of the utility's receipt of a completed application.

(d) If interconnection of a particular facility will require substantial capital upgrades to the utility system, the company shall provide the customer an estimate of the schedule and the customer's cost for the upgrade. If the customer desires to proceed with the upgrade, the customer and the company shall enter into a contract for the completion of the upgrade. The interconnection must take place no later than two weeks following the completion of the upgrade. The utility shall employ best reasonable efforts to complete the system upgrade in the shortest time reasonably practical.

(e) A utility shall use best reasonable efforts to interconnect facilities within the time frames described in this section. If in a particular instance, a utility determines that it cannot interconnect a facility within the time frames stated in this section, it must notify the applicant in writing of that fact. The notification must identify any reasons interconnection could not be performed in accordance with the schedule and provide an estimated date for interconnection.

(f) Applications for interconnection and parallel operation of distributed generation must be processed by the utility in a nondiscriminatory manner and in the order that they are received. It is recognized that certain applications may require minor modifications while they are being reviewed by the utility. These minor modifications to a pending application do not require that it be considered incomplete and treated as a new or separate application.

#### Sec. 8. [216B.75] [REPORTING REQUIREMENTS.]

(a) Each electric utility shall maintain records concerning applications received for interconnection and parallel operation of distributed generation. The records must include the date each application is received, documents generated in the course of processing each application, correspondence regarding each application, and the final disposition of each application.

(b) As part of the reporting requirement under section 216C.052, subdivision 4, every electric utility shall file with the reliability administrator a distributed generation interconnection report for the preceding calendar year that identifies each distributed generation facility interconnected with the utility's distribution system. The report must list the new distributed generation facilities interconnected with the system since the previous year's report, any distributed generation facilities no longer interconnected with the utility's system since the previous report, the capacity of each facility, and the feeder or other point on the company's utility system where the facility is connected. The annual report must also identify all applications for interconnection received during the previous one-year period, and the disposition of the applications.

#### Sec. 9. [EFFECTIVE DATE.]

This article is effective the day following final enactment.

### ARTICLE 5

#### CONFORMING AMENDMENTS

Section 1. Minnesota Statutes 2000, section 116C.61, subdivision 1, is amended to read:

Subdivision 1. ~~[REGIONAL, COUNTY AND LOCAL ORDINANCES, RULES, REGULATIONS, PRIMARY RESPONSIBILITY AND REGULATION OF SITE DESIGNATION, IMPROVEMENT, AND USE.]~~ To assure the paramount and controlling effect of the provisions herein in this section over other state agencies, regional, county, and local governments; and special purpose government districts, the issuance of a certificate of site compatibility permit or transmission line construction route permit and subsequent purchase and use of such site or route locations

for large electric power generating plant and high voltage transmission line purposes ~~shall be~~ is the sole site approval required to be obtained by the utility. ~~Such certificate or~~ The permit shall supersede ~~supersedes~~ and ~~preempt all~~ preempts any zoning, building, or land use rules, regulations, or ordinances promulgated by any regional, county, local, and special purpose government.

Sec. 2. Minnesota Statutes 2000, section 116C.62, is amended to read:

116C.62 [IMPROVEMENT OF SITES AND ROUTES.]

Utilities ~~which that~~ have acquired a site or route in accordance with sections 116C.51 to 116C.69 may proceed to construct or improve the site or route for the intended purposes at any time, subject to section 116C.61, subdivision 2; provided that, if the construction and improvement ~~commences more than~~ has not commenced within four years after a ~~certificate or~~ permit for the site or route has been issued, then the utility must certify to the board that the site or route continues to meet the conditions upon which the certificate of site compatibility or transmission line construction permit was issued.

Sec. 3. Minnesota Statutes 2000, section 116C.64, is amended to read:

116C.64 [FAILURE TO ACT.]

If the board fails to act within the times specified in section 116C.57, the applicant or any affected utility person may seek an order of the district court requiring the board to designate or refuse to designate a site or route.

Sec. 4. Minnesota Statutes 2000, section 116C.645, is amended to read:

116C.645 [REVOCAION OR SUSPENSION.]

A site ~~certificate permit or construction route~~ permit may be revoked or suspended by the board after adequate notice of the alleged grounds for revocation or suspension and a full and fair hearing in which the affected utility has an opportunity to confront any witness and respond to any evidence against it and to present rebuttal or mitigating evidence upon a finding by the board of:

(1) any false statement knowingly made in the application or in accompanying statements or studies required of the applicant, if a true statement would have warranted a change in the board's findings;

(2) failure to comply with material conditions of the site certificate or construction permit, or failure to maintain health and safety standards; or

(3) any material violation of the provisions of sections 116C.51 to 116C.69, any rule ~~promulgated pursuant thereto~~ adopted under these sections, or any order of the board.

Sec. 5. Minnesota Statutes 2000, section 116C.65, is amended to read:

116C.65 [JUDICIAL REVIEW.]

Any utility applicant, party, or person aggrieved by the issuance of a ~~certificate site or route permit~~ or emergency ~~certificate of site compatibility or transmission line construction~~ permit from the board or a certification of continuing suitability filed by a utility with the board or by a final order in accordance with any rules ~~promulgated~~ adopted by the board, may appeal to the court of appeals in accordance with chapter 14. The appeal ~~shall~~ must be filed within 60 days after the publication in the State Register of notice of the issuance of the certificate or permit by the board or certification filed with the board or the filing of any final order by the board.

Sec. 6. Minnesota Statutes 2000, section 116C.66, is amended to read:

116C.66 [RULES.]

(a) The board, in order to give effect to the purposes of sections 116C.51 to 116C.69, ~~shall prior to July 1, 1978, may~~ adopt rules consistent with sections 116C.51 to 116C.69, including ~~promulgation~~ adoption of site and route designation criteria; the description of the information to be furnished by the utilities; establishment of minimum guidelines for public participation in the development, revision, and enforcement of any rule, plan, or program established by the board; procedures for the revocation or suspension of a construction permit or a certificate of site compatibility; the procedure and timeliness for proposing alternative routes and sites; and route exemption criteria and procedures.

~~No~~ (b) A rule adopted by the board ~~shall~~ may not grant priority to state-owned wildlife management areas over agricultural lands in the designation of route-avoidance areas.

(c) The provisions of chapter 14 ~~shall~~ apply to the appeal of rules adopted by the board to the same extent as it applies to the review of rules adopted by any other agency of state government.

(d) The chief administrative law judge shall, ~~prior to January 1, 1978,~~ adopt procedural rules for public hearings relating to the site and route designation process and to the route exemption process. The rules ~~shall~~ must attempt to maximize citizen participation in these processes.

Sec. 7. Minnesota Statutes 2000, section 116C.69, is amended to read:

116C.69 [~~BIENNIAL REPORT; APPLICATION FEES; APPROPRIATION; FUNDING.~~]

Subdivision 1. [~~BIENNIAL REPORT.~~] Before November 15 of each even-numbered year the board shall prepare and submit to the legislature a report of its operations, activities, findings, and recommendations concerning sections 116C.51 to 116C.69. The report shall also contain information on the board's biennial expenditures, its proposed budget for the following biennium, and the amounts paid in ~~certificate and permit application fees pursuant to subdivisions 2 and 2a~~ and in assessments pursuant to ~~subdivision 3~~ this section. The proposed budget for the following biennium ~~shall be~~ is subject to legislative review.

Subd. 2. [~~SITE APPLICATION FEE.~~] Every applicant for a site ~~certificate~~ permit shall pay to the board a fee in an amount equal to \$500 for each \$1,000,000 of production plant investment in the proposed installation as defined in the Federal Power Commission Uniform System of Accounts. The board shall specify the time and manner of payment of the fee. If any single payment requested by the board is in excess of 25 percent of the total estimated fee, the board shall show that the excess is reasonably necessary. The applicant shall pay within 30 days of notification any additional fees reasonably necessary for completion of the site evaluation and designation process by the board. ~~In no event shall~~ The total fees required of the applicant under this subdivision must never exceed an amount equal to 0.001 of ~~said~~ the production plant investment ~~(, which equals \$1,000 for each \$1,000,000)~~. All money received ~~pursuant to~~ under this subdivision ~~shall~~ must be deposited in a special account. Money in the account is appropriated to the board to pay expenses incurred in processing applications for ~~certificates~~ site permits in accordance with sections 116C.51 to 116C.69 and ~~in the event,~~ if the expenses are less than the fee paid, to refund the excess to the applicant.

Subd. 2a. [~~ROUTE APPLICATION FEE.~~] Every applicant for a transmission line ~~construction~~ route permit shall pay to the board a base fee of \$35,000 plus a fee in an amount equal to \$1,000 per mile length of the longest proposed route. The board shall specify the time and manner of payment of the fee. If any single payment requested by the board is in excess of 25 percent of the total estimated fee, the board shall show that the excess is reasonably necessary. ~~In the event~~ If the actual cost of processing an application up to the board's final decision to designate a route exceeds ~~the above~~ this fee schedule, the board may assess the applicant any additional fees necessary to cover the actual costs, not to exceed an amount equal to \$500 per mile length of the longest proposed route. All money received ~~pursuant to~~ under this subdivision ~~shall~~ must be deposited in a special account. Money in the account is

appropriated to the board to pay expenses incurred in processing applications for ~~construction route~~ permits in accordance with sections 116C.51 to 116C.69 and ~~in the event, if~~ the expenses are less than the fee paid, to refund the excess to the applicant.

Subd. 3. [FUNDING; ASSESSMENT.] (a) The board shall finance its base line studies, general environmental studies, development of criteria, inventory preparation, monitoring of conditions placed on site ~~certificates and construction route~~ permits, and all other work, other than specific site and route designation, from an assessment made quarterly, at least 30 days before the start of each quarter, by the board against all utilities with annual retail kilowatt-hour sales greater than 4,000,000 kilowatt-hours in the previous calendar year.

(b) Each share ~~shall~~ must be determined as follows:

(1) the ratio that the annual retail kilowatt-hour sales in the state of each utility bears to the annual total retail kilowatt-hour sales in the state of all these utilities, multiplied by 0.667; plus

(2) the ratio that the annual gross revenue from retail kilowatt-hour sales in the state of each utility bears to the annual total gross revenues from retail kilowatt-hour sales in the state of all these utilities, multiplied by 0.333, as determined by the board.

(c) The assessment ~~shall~~ must be credited to the special revenue fund and ~~shall be~~ paid to the state treasury within 30 days after receipt of the bill, which shall constitute notice of ~~said~~ the assessment and its demand of payment ~~thereof~~.

(d) The total amount ~~which that~~ may be assessed to the several utilities under the authority of this subdivision ~~shall~~ may not exceed the sum of the annual budget of the board for carrying out the purposes of this subdivision.

(e) The assessment for the second quarter of each fiscal year ~~shall~~ must be adjusted to compensate for the amount by which actual expenditures by the board for the preceding fiscal year were more or less than the estimated expenditures previously assessed.

Sec. 8. [INSTRUCTION TO REVISOR.]

(a) The revisor of statutes shall renumber Minnesota Statutes, section 116C.69, subdivision 1, as Minnesota Statutes, section 116C.681.

(b) The revisor of statutes shall change all references as appropriate from Minnesota Statutes, section 216B.241 to Minnesota Statutes, section 216B.2411, including references to appropriate subdivisions, if known, in this act and in Minnesota Statutes, chapters 216A, 216B, and 216C, and in the Minnesota Rules associated with those chapters.

Sec. 9. [EFFECTIVE DATE.]

This article is effective the day following final enactment.

## ARTICLE 6

### MISCELLANEOUS PROVISIONS

Section 1. Minnesota Statutes 2000, section 216A.03, subdivision 3a, is amended to read:

Subd. 3a. [POWERS AND DUTIES OF CHAIR.] The chair ~~shall be~~ is the principal executive officer of the commission and shall preside at meetings of the commission. The responsibilities of the chair shall organize include:

(1) organizing the work of the commission ~~and may make;~~

- (2) making assignments to commission members, appoint committees and give as appropriate;
- (3) appointing subcommittees;
- (4) giving direction to the commission staff through the executive secretary subject to the approval of the commission;
- (5) supervising the work of the executive secretary; and
- (6) in coordination with the executive secretary, participating in employment and termination decisions, including representing the commission in grievance proceedings; addressing employee complaints and grievances; developing and implementing the agency budget; testifying before legislative committees and working with legislators as requested; determining agency-wide training needs and initiatives; implementing computer technology updates; administering and implementing relations with the department of commerce, the office of the attorney general, and other agencies; and developing and implementing strategies for the commission to adapt to rapid changes in the industries the commission oversees.

Sec. 2. Minnesota Statutes 2000, section 216B.095, is amended to read:

216B.095 [DISCONNECTION DURING COLD WEATHER.]

The commission shall amend its rules governing disconnection of residential utility customers who are unable to pay for utility service during cold weather to include the following:

- (1) coverage of customers whose household income is less than ~~185 percent of the federal poverty level~~ 50 percent of the state median income;
- (2) a requirement that a customer who pays the utility at least ten percent of the customer's income or the full amount of the utility bill, whichever is less, in a cold weather month cannot be disconnected during that month;
- (3) that the ten percent figure in clause (2) must be prorated between energy providers proportionate to each provider's share of the customer's total energy costs where the customer receives service from more than one provider;
- ~~(4) that a customer's household income does not include any amount received for energy assistance;~~
- ~~(5) (4) verification of income by the local energy assistance provider or the utility, unless the customer is automatically eligible for protection against disconnection as a recipient of any form of public assistance, including energy assistance, that uses income eligibility in an amount at or below the income eligibility in clause (1); and~~
- ~~(6) (5) a requirement that the customer receive, from the local energy assistance provider or other entity, budget counseling and referral referrals to energy assistance programs, weatherization, conservation, or other programs likely to reduce the customer's consumption of energy bills;~~
- (6) a requirement that customers who have demonstrated an inability to pay on forms for such purposes provided by the utility, and who make reasonably timely payments to the utility under a payment plan that considers the financial resources of the household, cannot be disconnected from utility services from October 15 to April 15. A customer who is receiving energy assistance is deemed to have demonstrated an inability to pay.

For the purpose of clause (2), the "customer's income" means the actual monthly income of the customer except ~~for a customer who is normally employed only on a seasonal basis and whose annual income is over 135 percent of the federal poverty level, in which case the customer's income is or~~ the average monthly income of the customer computed on an annual calendar year ~~basis, whichever is less, and does not include any amount received for energy assistance.~~

Sec. 3. Minnesota Statutes 2000, section 216B.097, subdivision 1, is amended to read:

Subdivision 1. [APPLICATION; NOTICE TO RESIDENTIAL CUSTOMER.] (a) A municipal utility or a cooperative electric association must not disconnect the utility service of a residential customer during the period between October 15 and April 15 if the disconnection affects the primary heat source for the residential unit when the following conditions are met:

~~(1) the disconnection would occur during the period between October 15 and April 15;~~

~~(2) (1) the customer has declared inability to pay on forms provided by the utility. For the purpose of this clause, a customer that is receiving energy assistance is deemed to have demonstrated an inability to pay;~~

~~(3) (2) the household income of the customer is less than 185 percent of the federal poverty level, as documented by the customer to the utility; and 50 percent of the state median income;~~

~~(3) verification of income may be conducted by the local energy assistance provider or the utility, unless the customer is automatically eligible for protection against disconnection as a recipient of any form of public assistance, including energy assistance, that uses income eligibility in an amount at or below the income eligibility in clause (2);~~

~~(4) the customer's a customer whose account is current for the billing period immediately prior to October 15 or the customer has entered who, at any time, enters into a payment schedule that considers the financial resources of the household and is reasonably current with payments under the schedule; and~~

~~(5) the customer receives referrals to energy assistance programs, and weatherization, conservation, or other programs to reduce the customer's energy bills.~~

(b) A municipal utility or a cooperative electric association must, between August 15 and October 15 of each year, notify all residential customers of the provisions of this section.

Sec. 4. [216B.098] [CUSTOMER PROTECTIONS.]

Subdivision 1. [APPLICABILITY.] This section applies to residential customers of public utilities, municipal utilities, and cooperative electric associations.

Subd. 2. [BUDGET BILLING PLANS.] A utility shall offer a customer a budget billing plan for payment of charges for service, including adequate notice to customers prior to changing budget payment amounts. Municipal utilities having 3,000 or fewer customers are exempt from this requirement. Municipal utilities having more than 3,000 customers shall implement this requirement within two years of the effective date of this chapter.

Subd. 3. [PAYMENT AGREEMENTS.] A utility shall offer a payment agreement for the payment of arrears.

Subd. 4. [UNDERCHARGES.] A utility shall offer a payment agreement to customers who have been undercharged if no culpable conduct by the customer or resident of the customer's household caused the undercharge. The agreement must cover a period equal to the time over which the undercharge occurred. No interest or delinquency fee may be charged under this agreement.

Subd. 5. [MEDICALLY NECESSARY EQUIPMENT.] A utility shall reconnect or continue service to a customer's residence where a medical emergency exists or where medical equipment requiring electricity is necessary to sustain life is in use, provided that the utility receives from a medical doctor written certification, or initial certification by telephone and written certification within five business days, that failure to reconnect or continue service will impair or threaten the health or safety of a resident of the customer's household. The customer must enter into a payment agreement.

Subd. 6. [COMMISSION AUTHORITY.] The commission, or staff designated by the commission, has the authority to order resolutions of disputes involving alleged violations of this chapter by a public utility or any other disputes involving public utilities coming within its jurisdiction.

Sec. 5. Minnesota Statutes 2000, section 216B.16, subdivision 15, is amended to read:

Subd. 15. [LOW-INCOME RATE PROGRAMS; REPORT.] (a) The commission may consider ability to pay as a factor in setting utility rates and may establish programs for low-income residential ratepayers in order to ensure affordable, reliable, and continuous service to low-income utility customers. ~~The commission shall order a pilot program for at least one utility. In ordering pilot programs, the commission shall consider the following:~~

~~(1) the potential for low-income programs to provide savings to the utility for all collection costs including but not limited to: costs of disconnecting and reconnecting residential ratepayers' service, all activities related to the utilities' attempt to collect past due bills, utility working capital costs, and any other administrative costs related to inability to pay programs and initiatives;~~

~~(2) the potential for leveraging federal low-income energy dollars to the state; and~~

~~(3) the impact of energy costs as a percentage of the total income of a low-income residential customer.~~

~~(b) In determining the structure of the pilot utility program, the commission shall:~~

~~(1) consult with advocates for and representatives of low-income utility customers, administrators of energy assistance and conservation programs, and utility representatives;~~

~~(2) coordinate eligibility for the program with the state and federal energy assistance program and low-income residential energy programs, including weatherization programs; and~~

~~(3) evaluate comprehensive low-income programs offered by utilities in other states.~~

~~(c) The commission shall implement at least one pilot project by January 1, 1995, and shall allow a utility required to implement a pilot project to recover the net costs of the project in the utility's rates.~~

~~(d) The commission, in conjunction with the commissioner of the department of public service and the commissioner of economic security, shall review low-income rate programs and shall report to the legislature by January 1, 1998. The report must include:~~

~~(1) the increase in federal energy assistance money leveraged by the state as a result of this program;~~

~~(2) the effect of the program on low-income customer's ability to pay energy costs;~~

~~(3) the effect of the program on utility customer bad debt and arrearages;~~

~~(4) the effect of the program on the costs and numbers of utility disconnections and reconnections and other costs incurred by the utility in association with inability to pay programs;~~

~~(5) the ability of the utility to recover the costs of the low-income program without a general rate change;~~

~~(6) how other ratepayers have been affected by this program;~~

~~(7) recommendations for continuing, eliminating, or expanding the low-income pilot program; and~~

~~(8) how general revenue funds may be utilized in conjunction with low-income programs.~~



(b) The purpose of the low-income programs is to lower the percentage of income that low-income households devote to energy bills, to increase customer payments, and to lower utility costs associated with customer account collection activities. In ordering low-income programs, the commission may require utilities to file program evaluations, including the effect of the program on participant household energy burdens, the coordination of other available low-income bill payment and conservation resources, the effect of the program on service disconnections, and the effect of the program on customer payment behavior, utility collection costs, arrearages, and bad debt.

Sec. 6. [216B.79] [PREVENTATIVE MAINTENANCE.]

(a) The commission has the authority to ensure that public utilities are making adequate infrastructure investments and undertaking sufficient preventative maintenance with regard to generation, transmission, and distribution facilities.

(b) The commission may make appropriate adjustments in a utility's rates through an automatic adjustment of charges under section 216B.16, accelerated depreciation of capital costs, or other appropriate mechanisms, or make a recommendation to the Federal Energy Regulatory Commission to make an appropriate adjustment in a utility's allowed rate of return on those utilities' transmission facilities, to provide incentive and offset the costs of new energy infrastructure facility construction.

Sec. 7. Minnesota Statutes 2000, section 216C.41, subdivision 5, is amended to read:

Subd. 5. [AMOUNT OF PAYMENT.] (a) An incentive payment is based on the number of kilowatt hours of electricity generated. The amount of the payment is 1.5 cents per kilowatt hour. For electricity generated by qualified wind energy conversion facilities, the incentive payment under this section is limited to no more than 100 megawatts of nameplate capacity. During any period in which qualifying claims for incentive payments exceed 100 megawatts of nameplate capacity, the payments must be made to producers in the order in which the production capacity was brought into production.

(b) Beginning January 1, 2002, the total size of a wind energy conversion system under this section must be determined according to this paragraph. Unless the systems are interconnected with different distribution systems, the nameplate capacity of one wind energy conversion system must be combined with the nameplate capacity of any other wind energy conversion system that is:

- (1) located within five miles of the wind energy conversion system;
- (2) constructed within the same calendar year as the wind energy conversion system; and
- (3) under common ownership.

In the case of a dispute, the commissioner of commerce shall determine the total size of the system, and shall draw all reasonable inferences in favor of combining the systems.

(c) In making a determination under paragraph (b), the commissioner of commerce may determine that two wind energy conversion systems are under common ownership when the underlying ownership structure contains similar persons or entities, even if the ownership shares differ between the two systems. Wind energy conversion systems are not under common ownership solely because the same person or entity provided equity financing for the systems.

Sec. 8. Minnesota Statutes 2000, section 216C.41, is amended by adding a subdivision to read:

Subd. 6. [OWNERSHIP; FINANCING; CURE.] (a) For the purposes of subdivision 1, paragraph (c), clause (2), a wind energy conversion facility qualifies if it is owned at least 51 percent by one or more of any combination of the entities listed in that clause.

(b) A subsequent owner of a qualified facility may continue to receive the incentive payment for the duration of the original payment period if the subsequent owner qualifies for the incentive under subdivision 1.

(c) Nothing in this section may be construed to deny incentive payment to an otherwise qualified facility that has obtained debt or equity financing for construction or operation as long as the ownership requirements of subdivision 1 and this subdivision are met. If, during the incentive payment period for a qualified facility, the owner of the facility is in default of a lending agreement and the lender takes possession of and operates the facility and makes reasonable efforts to transfer ownership of the facility to an entity other than the lender, the lender may continue to receive the incentive payment for electricity generated and sold by the facility for a period not to exceed 18 months. A lender who takes possession of a facility shall notify the commissioner immediately on taking possession and, at least quarterly, document efforts to transfer ownership of the facility.

(d) If, during the incentive payment period, a qualified facility loses the right to receive the incentive because of changes in ownership, the facility may regain the right to receive the incentive upon cure of the ownership structure that resulted in the loss of eligibility and may reapply for the incentive, but in no case may the payment period be extended beyond the original ten-year limit.

(e) A subsequent or requalifying owner under paragraph (b) or (d) retains the facility's original priority order for incentive payments as long as the ownership structure requalifies within two years from the date the facility became unqualified or two years from the date a lender takes possession.

Sec. 9. [REPEALER.]

Minnesota Statutes 2000, sections 216B.241 and 216C.18 are repealed.

Sec. 10. [EFFECTIVE DATE.]

This article is effective the day following final enactment.

## ARTICLE 7

### SAFETY AND SERVICE STANDARDS

Section 1. [216B.81] [DEFINITIONS.]

Subdivision 1. [SCOPE.] The terms used in this article have the meanings given them in this section.

Subd. 2. [AVERAGE NUMBER OF CUSTOMERS SERVED.] "Average number of customers served" means the number of active, metered, customer accounts available in a utility's interruption-reporting database on the day that an interruption occurs.

Subd. 3. [CIRCUIT.] "Circuit" means a set of conductors serving customer loads that are capable of being separated from the serving substation automatically by a recloser, fuse, sectionalizing equipment, and other devices.

Subd. 4. [COMPONENT.] "Component" means a piece of equipment, a line, a section of line, or a group of items that is an entity for purposes of reporting, analyzing, and predicting interruptions.

Subd. 5. [CUSTOMER.] "Customer" means a contiguous electrical service location, regardless of the number of meters at the location.

Subd. 6. [CUSTOMER INTERRUPTION.] "Customer interruption" means the loss of service due to a forced outage for more than five minutes, for one or more customers, which is the result of one or more component failures.

Subd. 7. [CUSTOMERS' INTERRUPTIONS CAUSED BY POWER RESTORATION PROCESS.] "Customers' interruptions caused by power restoration process" means when customers lose power as a result of the process of restoring power. The duration of these outages is included in the customer-minutes of interruption. Only the customers affected by the power restoration outages that were not affected by the original outage are added to the number of customer interruptions.

Subd. 8. [CUSTOMER-MINUTES OF INTERRUPTION.] "Customer-minutes of interruption" means the number of minutes of forced outage duration multiplied by the number of customers affected.

Subd. 9. [ELECTRIC DISTRIBUTION LINE.] "Electric distribution line" means circuits operating at less than 40,000 volts.

Subd. 10. [FORCED OUTAGE.] "Forced outage" means an outage that cannot be deferred.

Subd. 11. [MAJOR CATASTROPHIC EVENTS.] "Major catastrophic events" means events that are beyond the utility's control that result in widespread system damages causing customer interruptions that affect at least ten percent of the customers in the system or in an operating area or that result in customers being without electric service for durations of at least 24 hours.

Subd. 12. [MAJOR STORM.] "Major storm" means a period of severe adverse weather resulting in widespread system damage causing customer interruptions that affect at least ten percent of the customers on the system or in an operating area or that result in customers being without electric service for durations of at least 24 hours.

Subd. 13. [MOMENTARY INTERRUPTION.] "Momentary interruption" means an interruption of electric service with a duration shorter than the time necessary to be classified as a customer interruption.

Subd. 14. [OPERATING AREA.] "Operating area" means a geographical subdivision of each electric utility's service territory that functions under the direction of a company office and may be used for reporting interruptions under this article. These areas may also be referred to as regions, divisions, or districts.

Subd. 15. [OUTAGE.] "Outage" means the failure of a power system component that results in one or more customer interruptions.

Subd. 16. [OUTAGE DURATION.] "Outage duration" means the one minute or greater period from the initiation of an interruption to a customer until service has been restored to that customer.

Subd. 17. [PARTIAL CIRCUIT OUTAGE CUSTOMER COUNT.] "Partial circuit outage customer count" means when only part of a circuit experiences an outage, the number of customers affected is estimated, unless an actual count is available. When power is partially restored, the number of customers restored is also estimated. Most utilities use estimates based on the portion of the circuit restored.

Subd. 18. [PLANNED OUTAGES.] "Planned outages" means those outages scheduled by the utility. These interruptions are sometimes necessary to connect new customers or perform maintenance activities safely. They must not be included in the calculation of reliability indexes.

Subd. 19. [RELIABILITY.] "Reliability" means the degree to which electric service is supplied without interruption.

Subd. 20. [RELIABILITY INDEXES.] "Reliability indexes" include the following performance indices for measuring frequency and duration of service interruptions:

(a) The system average interruption frequency index is the average number of interruptions per customer per year. It is determined by dividing the total annual number of customer interruptions by the average number of customers served during the year.

(b) The system average interruption duration index is the average customer-minutes of interruption per customer. It is determined by dividing the annual sum of customer-minutes of interruption by the average number of customers served during the year.

(c) The customer average interruption duration index is the average customer-minutes of interruption per customer interruption. It approximates the average length of time required to complete service restoration. It is determined by dividing the annual sum of all customer-minutes of interruption durations by the annual number of customer interruptions.

Sec. 2. [216B.82] [RECORDING SERVICE INTERRUPTION INDEXES.]

Subdivision 1. [SYSTEM INTERRUPTION DATA.] Each electric utility with 10,000 retail customers or more shall keep a record of the necessary interruption data and calculate the system average interruption frequency index, system average interruption duration index, and customer average interruption duration index of its system, and of each operating area, if applicable, at the end of each calendar year for the previous 12-month period.

Subd. 2. [CIRCUIT INTERRUPTION DATA.] Unless a utility uses alternative criteria as provided in section 216B.83, subdivision 2, paragraph (d), each utility also shall, at the end of each calendar year, calculate the system average interruption frequency index, system average interruption duration index, and customer average interruption duration index for each circuit in each operating area. Each circuit in each operating area must then be listed in order separately according to its system average interruption frequency index, its system average interruption duration index, and its customer average interruption duration index, beginning with the highest values for each index.

Sec. 3. [216B.83] [ANNUAL REPORT.]

Subdivision 1. [SUMMARY REPORT GENERALLY.] Beginning on July 1, 2002, and by July 1 of every year thereafter, each electric utility with 10,000 retail customers or more shall file with the commission, or in the case of a cooperative electric association or municipal utility, with the local governing body of the utility or association a report summarizing various measures of reliability. The form of the report is subject to review and comment by the commission staff. Names and numbers used to identify operating areas or individual circuits may conform to the utility's practice, but should allow ready identification of the geographic location or the general area served. Electronic recording and reporting of the required data and information is encouraged.

Subd. 2. [INFORMATION REQUIRED.] (a) The report must include at least the information described in paragraphs (b) to (h).

(b) The report must provide an overall assessment of the reliability of performance including the aggregate system average interruption frequency index, system average interruption duration index, and customer average interruption duration index by system and each operating area, as applicable.

(c) The report must include a list of the worst performing circuits based on system average interruption frequency index, system average interruption duration index, and customer average interruption duration index for the calendar year. This portion of the report must describe the actions that the utility has taken or will take to remedy the conditions responsible for each listed circuit's unacceptable performance. The actions taken or planned should be briefly described. Target dates for corrective actions must be included in the report. When the utility determines that actions on its part are unwarranted, its report shall provide adequate justification for that conclusion.

(d) Utilities that use or prefer alternative criteria for measuring individual circuit performance to those described in paragraphs (b) and (c) and that are required by this section to submit an annual report of reliability data, shall submit their alternative listing of circuits along with the criteria used to rank circuit performance.

(e) Information must be included with respect to any report on the accomplishment of the improvements proposed in prior reports for which completion has not been previously reported.

(f) The report must describe any new reliability or power quality programs and changes that are made to existing programs.

(g) It must include a status report of any long-range electric distribution plans.

(h) In addition to the information included in paragraph (b), each utility that has the technical capability and administrative resources shall report the following additional service quality information:

(1) route miles of electric distribution line reconstructed during the year, with separate totals for single- and three-phase circuits provided;

(2) total route miles of electric distribution line in service at year's end, segregated by voltage level;

(3) monthly average speed of answer for telephone calls received regarding emergencies;

(4) the average number of calendar days a utility takes to install and energize service to a customer site once it is ready to receive service, with a separate average calculated for each month, including all extensions energized during the calendar month;

(5) the total number of written and telephone customer complaints received in the areas of safety, outages, power quality, customer property damage, and other areas, by month filed;

(6) total annual tree-trimming budget and actual expenses; and

(7) total annual projected and actual miles of tree-trimmed distribution line.

#### Sec. 4. [216B.84] [INITIAL HISTORICAL RELIABILITY PERFORMANCE REPORT.]

(a) Each electric utility with 10,000 retail customers or more that has historically used measures of system, operating area, and circuit reliability performance shall initially submit annual system average interruption frequency index, system average interruption duration index, and customer average interruption duration index data for the previous three years. Those utilities that have this data for some time period less than three years shall submit data for those years it is available.

(b) Those utilities whose historical reliability performance data is similar or related to those measures listed in paragraph (a), but differs due to how the parameters are defined or calculated, shall submit the data it has and explain any material differences from the prescribed indices. After the effective date of this section, utilities shall modify their reliability performance measures to conform to those specified in sections 216B.81 to 216B.87 for purposes of consistent reporting of comparable data in the future.

#### Sec. 5. [216B.85] [INTERRUPTIONS OF SERVICE; RECORDS; NOTICE.]

Subdivision 1. [RECORDS.] (a) Each utility shall keep records of all interruptions to service affecting the entire distribution system of any single community or an important division of a community, and include in the records each interruption's location, date and time, and duration; the approximate number of customers affected; the circuit or circuits involved; and, when known, the cause of each interruption.

(b) When complete distribution systems or portions of communities have service furnished from unattended stations, these records must be kept to the extent practicable. The record of unattended stations shall show interruptions that require attention to restore service, with the estimated time of interruption. Breaker or fuse operations affecting service should also be indicated even though duration of interruption may not be known.

Subd. 2. [NOTICE OF INTERRUPTIONS OF BULK POWER SUPPLY FACILITIES.] (a) Each utility owning or operating bulk power supply facilities shall record any event described in clauses (1) to (5) involving any generating unit or electric facilities operating at a nominal voltage of 69 kilovolts or higher, and shall make such records available to the commission semiannually or upon request of the commission:

(1) any interruption or loss of service to customers for 15 minutes or more to aggregate firm loads in excess of 200,000 kilowatts;

(2) any interruption or loss of service to customers for 15 minutes or more to aggregate firm loads exceeding the lesser of 100,000 kilowatts or one-half of the current annual system peak load and not required to be recorded under clause (1);

(3) any decision to issue a public request for reduction in use of electricity;

(4) an action to reduce firm customer loads by reduction of voltage for reasons of maintaining adequacy of bulk electric power supply; and

(5) any action to reduce firm customer loads by manual switching, operation of automatic load-shedding devices, or any other means for reasons of maintaining adequacy of bulk electric power supply.

Subd. 3. [NOTICE OF OTHER INTERRUPTIONS OF POWER.] Each utility shall record service interruptions of 60 minutes or more to an entire distribution substation bus or entire feeder serving either 500 or more customers or entire cities or villages having 200 or more customers.

Subd. 4. [INFORMATION REQUIRED.] The written records required in subdivisions 2 and 3 must include the date, time, duration, general location, approximate number of customers affected, identification of circuit or circuits involved, and, when known, the cause of the interruption. When extensive interruptions occur, as from a storm, a narrative record including the extent of the interruptions and system damage, estimated number of customers affected, and a list of entire communities interrupted may be recorded in lieu of records of individual interruptions. When customer service interruptions are necessary, the utility shall make reasonable efforts to notify affected customers in advance.

#### Sec. 6. [216B.86] [CUSTOMERS' COMPLAINTS.]

Each utility shall keep a record of complaints received by it from its customers in regard to safety or service, and the operation of its system, with appropriate response times designated for critical safety and monetary loss situations and shall investigate if appropriate. The record must show the name and address of the complainant, the date and nature of the complaint, the priority assigned to the assistance, and its disposition and the time and date of its disposition.

#### Sec. 7. [216B.87] [STANDARDS FOR DISTRIBUTION UTILITIES.]

(a) The commission and each cooperative electric association and municipal utility shall, only as resources allow, adopt standards for safety, reliability, and service quality for distribution utilities. Standards for cooperative electric associations and municipal utilities should be as consistent as possible with the commission standards.

(b) Reliability standards must be based on the system average interruption frequency index, system average interruption duration index, and customer average interruption duration index measurement indices. Service quality standards must specify, if technically and administratively feasible:

(1) average call center response time;

(2) customer disconnection rate;

(3) meter-reading frequency;

(4) complaint resolution response time; and

(5) service extension request response time.

(c) Minimum performance standards developed under this section must treat similarly situated distribution systems similarly and recognize differing characteristics of system design and hardware.

(d) Electric distribution utilities shall comply with all applicable governmental and industry standards required for the safety, design, construction, and operation of electric distribution facilities, including section 326.243.

Sec. 8. [COST BENEFIT ANALYSIS.]

The commissioner of commerce shall provide an analysis of the costs and benefits to consumers and utilities of the provisions of sections 1 to 7, including any recommended changes to those provisions, to the chairs of the house of representatives and senate policy and finance committees with jurisdiction over electric utility issues by February 1, 2002.

Sec. 9. [EFFECTIVE DATE.]

Sections 1 to 7 are effective July 1, 2003. Section 8 is effective the day following final enactment."

Delete the title and insert:

"A bill for an act relating to energy; enacting the Minnesota Energy Security and Reliability Act; requiring an energy security blueprint and a state transmission plan; establishing position of reliability administrator; providing for essential energy infrastructure; modifying provisions for siting, routing, and determining the need for large electric power facilities; regulating conservation expenditures by energy utilities and eliminating state pre-approval of conservation plans by public utilities; encouraging regulatory flexibility in supplying and obtaining energy; regulating interconnection of distributed utility resources; providing for safety and service standards from distribution utilities; clarifying the state cold weather disconnection requirements; authorizing municipal utilities, municipal power agencies, cooperative utilities, and investor-owned utilities to form joint ventures to provide utility services; eliminating the requirement for individual utility resource plans; requiring reports; making technical, conforming, and clarifying changes; amending Minnesota Statutes 2000, sections 116.07, subdivision 4a; 116C.52, subdivision 10; 116C.53, subdivisions 2, 3; 116C.57, subdivisions 1, 2, 4, by adding subdivisions; 116C.58; 116C.59, subdivisions 1, 4; 116C.60; 116C.61, subdivision 1; 116C.62; 116C.64; 116C.645; 116C.65; 116C.66; 116C.69; 216A.03, subdivision 3a; 216B.095; 216B.097, subdivision 1; 216B.16, subdivisions 7, 15; 216B.2421, subdivision 2, by adding a subdivision; 216B.2422, subdivision 2; 216B.243, subdivisions 2, 3, 4, by adding a subdivision; 216C.051, subdivision 9; 216C.41, subdivision 5, by adding a subdivision; proposing coding for new law in Minnesota Statutes, chapters 116C; 216B; 216C; 452; repealing Minnesota Statutes 2000, sections 116C.55; 116C.57, subdivisions 3, 5, 5a; 116C.67; 216B.241; 216C.18."

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

The report was adopted.

Pursuant to Senate Concurrent Resolution No. 5, S. F. No. 722 was re-referred to the Committee on Rules and Legislative Administration.

## SECOND READING OF HOUSE BILLS

H. F. Nos. 281 and 1807 were read for the second time.

## SECOND READING OF SENATE BILLS

S. F. Nos. 1495 and 1721 were read for the second time.

## INTRODUCTION AND FIRST READING OF HOUSE BILLS

The following House File was introduced:

Dawkins introduced:

H. F. No. 2522, A bill for an act relating to agriculture; requiring the commissioner of agriculture to stop payments to ethanol plants found by cities to be nuisances; amending Minnesota Statutes 2000, section 41A.09, by adding a subdivision.

The bill was read for the first time and referred to the Committee on Agriculture Policy.

## MESSAGES FROM THE SENATE

The following messages were received from the Senate:

Mr. Speaker:

I hereby announce that the Senate accedes to the request of the House for the appointment of a Conference Committee on the amendments adopted by the Senate to the following House File:

H. F. No. 2486, A bill for an act relating to state government; appropriating money for economic development, housing, and certain agencies of state government; establishing and modifying programs; transferring certain duties and funds; establishing an account; consolidating housing programs; regulating activities and practices; modifying fees; making conforming changes; requiring reports; revising certain provisions involving state regulation of private health coverage; transferring certain regulatory control; establishing requirements for managed care plans; codifying reorganization order No. 181; transferring the remaining duties of the commissioner of public service to the commissioner of commerce; instructing the revisor to change certain terms; modifying provisions of the Minnesota Electrical Act; providing for power limited technician licensing; amending Minnesota Statutes 2000, sections 3C.12, subdivision 2; 13.679; 15.01; 15.06, subdivision 1; 15A.0815, subdivision 2; 16B.32, subdivision 2; 16B.335, subdivision 4; 16B.56, subdivision 1; 16B.76, subdivision 1; 17.86, subdivision 3; 18.024, subdivision 1; 43A.08, subdivision 1a; 45.012; 62A.021, subdivision 1; 62A.041, subdivisions 1, 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, 8; 62D.12, subdivisions 1, 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, 2; 62J.75; 62L.02, subdivision 8; 62L.05, subdivision 12; 62L.08, subdivisions 10, 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, 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, 3; 62Q.71; 62Q.72; 62Q.73, subdivisions 3, 4, 5, 6; 62R.04, subdivision 5; 62R.06, subdivision 1; 62T.01, subdivision 4; 103F.325, subdivisions 2, 3; 115A.15, subdivision 5; 116J.8731, subdivision 1; 116L.03, subdivisions 2, 3, 5; 116O.06, subdivision 2; 123B.65, subdivisions 1, 3, 5; 138.664, by adding a subdivision; 161.45, subdivision 1; 168.61, subdivision 1; 169.073; 174.03, subdivision 7; 181.30; 184.29; 184.30, subdivision 1; 184.38, subdivisions 6, 8, 9, 10, 11, 17, 18, 20; 184.41; 216A.01; 216A.035; 216A.036; 216A.05, subdivision 1; 216A.07, subdivision 1; 216A.08; 216A.085, subdivision 3; 216B.02, subdivisions 1, 7, 8; 216B.16, subdivisions 1, 2, 6b, 15; 216B.162, subdivisions 7, 11; 216B.1675, subdivision 9; 216B.241, subdivisions 1a, 1b, 2b; 216C.01, subdivisions 1, 2, 3; 216C.051, subdivision 6; 216C.06, by adding a subdivision; 216C.37, subdivision 1; 216C.40, subdivision 4; 216C.41; 237.02; 237.075, subdivisions 2, 9; 237.082; 237.21; 237.30; 237.462, subdivision 6; 237.51, subdivisions 1, 5, 5a; 237.52, subdivisions 2, 4, 5; 237.54, subdivision 2; 237.55; 237.59, subdivision 1; 237.768; 239.01; 239.10; 256B.692, subdivisions 2, 7; 257.34, subdivision 1; 268.022, subdivisions 1, 2; 325E.11; 325E.115, subdivision 2; 326.01, subdivisions 5, 6g, by adding subdivisions; 326.241, subdivision 1; 326.242, subdivisions 1, 2, 3, 5, 6, 6a, 6b, 6c, 7, 8, 10, 12, by adding a subdivision; 326.2421, subdivisions 2, 9; 326.243; 326.244, subdivisions 1a, 2, 5, 6; 462A.01; 462A.03, subdivisions 1, 6, 10, by adding a subdivision; 462A.04, subdivision 6; 462A.05, subdivisions 14, 14a, 16, 22, 26; 462A.06, subdivisions 1, 4; 462A.07, subdivisions 10, 12; 462A.073, subdivision 1; 462A.15; 462A.17, subdivision 3; 462A.20, subdivision 3; 462A.201, subdivisions 2, 6; 462A.204, subdivision 3; 462A.205, subdivisions 4, 4a; 462A.209; 462A.2091, subdivision 3; 462A.2093, subdivision 1; 462A.2097; 462A.21, subdivisions 5, 10, by adding subdivisions; 462A.222, subdivision 1a; 462A.24; 462A.33, subdivisions 1, 2, 3, 5, by adding a subdivision; 484.50; Laws 1993, chapter 301, section 1, subdivision 4, as amended; Laws 1995, chapter 248, article 12, section 2, as amended; article 13, section 2, subdivision 2, as amended; Laws 2000, chapter 488, article 8, section 2, subdivision 6; proposing coding for new law in Minnesota Statutes, chapters 116L; 122A; 462A; 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, 14; 62C.142; 62D.09, subdivision 3; 62D.101; 62D.105; 62D.12, subdivision 19; 62D.123, subdivisions 2, 3, 4; 62D.124; 62Q.095, subdivisions 1, 2, 3, 4, 6; 62Q.45; 138A.01; 138A.02; 138A.03; 138A.04; 138A.05; 138A.06; 184.22, subdivisions 2, 3, 4, 5; 184.37, subdivision 2; 216A.06; 237.69, subdivision 3; 268.96; 268.975; 268.976; 268.9771; 268.978; 268.9781; 268.9782; 268.9783; 268.979; 268.98; 326.01, subdivision 6d; 326.2421, subdivisions 3, 4, 6, 8; 462A.201, subdivision 4; 462A.207; 462A.209, subdivision 4; 462A.21, subdivision 17; 462A.221, subdivision 4; 462A.30, subdivision 2; 462A.33, subdivisions 4, 6, 7; Minnesota Rules, parts 3800.3500, subpart 12; 4685.0801, subpart 7; 4685.1010; 4685.1300; 4685.1900; 4685.2000; 4685.2200, subpart 3; 4685.1105; 4685.1110; 4685.1115; 4685.1120; 4685.1125; 4685.1130.

The Senate has appointed as such committee:

Senators Anderson; Cohen; Johnson, Dave; Lesewski and Orfield.

Said House File is herewith returned to the House.

PATRICK E. FLAHAVEN, Secretary of the Senate

Mr. Speaker:

I hereby announce that the Senate refuses to concur in the House amendments to the following Senate File:

S. F. No. 103, A bill for an act relating to civil actions; providing civil remedies for receiving motor fuel from a motor fuel retail business without paying for it; proposing coding for new law in Minnesota Statutes, chapter 332.

The Senate respectfully requests that a Conference Committee be appointed thereon. The Senate has appointed as such committee:

Senators Larson, Marty and Scheid.

Said Senate File is herewith transmitted to the House with the request that the House appoint a like committee.

PATRICK E. FLAHAVEN, Secretary of the Senate

Nornes moved that the House accede to the request of the Senate and that the Speaker appoint a Conference Committee of 3 members of the House to meet with a like committee appointed by the Senate on the disagreeing votes of the two houses on S. F. No. 103. The motion prevailed.

The Speaker called Abrams to the Chair.

Mr. Speaker:

I hereby announce that the Senate refuses to concur in the House amendments to the following Senate File:

S. F. No. 1394, A bill for an act relating to human services; changing child placement provisions; modifying provisions governing child maltreatment investigations; classifying data and authorizing data sharing; amending Minnesota Statutes 2000, sections 13.319, by adding a subdivision; 13.32, subdivision 3; 13.43, by adding a subdivision; 13.46, subdivision 2; 119B.02, by adding a subdivision; 256.01, subdivision 2; 256.045, subdivision 3b; 260C.007, subdivisions 4, 14, and by adding subdivisions; 260C.141, subdivision 2; 260C.151, subdivision 6; 260C.178, subdivisions 1 and 7; 260C.193, subdivision 3; 260C.201, subdivisions 1, 2, 5, 6, 7, 10, 11, and by adding a subdivision; 260C.205; 260C.212, subdivisions 1, 2, 4, 5, 7, 8, and 9; 260C.215, subdivision 6; 260C.301, subdivisions 1, 4, and 8; 260C.312; 260C.317, subdivision 3; and 260C.325, subdivision 4; 626.556, subdivisions 2, 3, 4, 7, 10, 10b, 10d, 10e, 10i, 10j, 11; proposing coding for new law in Minnesota Statutes, chapter 256F; repealing Minnesota Statutes 2000, sections 260C.325, subdivision 2; and 626.5565.

The Senate respectfully requests that a Conference Committee be appointed thereon. The Senate has appointed as such committee:

Senators Kiscaden, Ranum and Knutson.

Said Senate File is herewith transmitted to the House with the request that the House appoint a like committee.

PATRICK E. FLAHAVEN, Secretary of the Senate

Tingelstad moved that the House accede to the request of the Senate and that the Speaker appoint a Conference Committee of 3 members of the House to meet with a like committee appointed by the Senate on the disagreeing votes of the two houses on S. F. No. 1394. The motion prevailed.

Mr. Speaker:

I hereby announce the passage by the Senate of the following House File, herewith returned, as amended by the Senate, in which amendments the concurrence of the House is respectfully requested:

H. F. No. 208, A resolution urging authorization of funding for modernization of waterways.

PATRICK E. FLAHAVEN, Secretary of the Senate

#### CONCURRENCE AND REPASSAGE

Workman moved that the House concur in the Senate amendments to H. F. No. 208 and that the bill be repassed as amended by the Senate.

A roll call was requested and properly seconded.

#### CALL OF THE HOUSE

On the motion of Workman and on the demand of 10 members, a call of the House was ordered. The following members answered to their names:

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

Seifert moved that further proceedings of the roll call be suspended and that the Sergeant at Arms be instructed to bring in the absentees. The motion prevailed and it was so ordered.

#### CALL OF THE HOUSE LIFTED

Workman moved that the call of the House be suspended. The motion prevailed and it was so ordered.

The question recurred on the Workman motion and the roll was called. There were 98 yeas and 31 nays as follows:

Those who voted in the affirmative were:

Abeler	Anderson, I.	Boudreau	Cassell	Dauids	Dorman
Abrams	Bakk	Bradley	Clark, J.	Dehler	Dorn
Anderson, B.	Bishop	Buesgens	Daggett	Dempsey	Eastlund

Erhardt	Jacobson	Leppik	Opatz	Schumacher	Tuma
Erickson	Jennings	Lieder	Osskopp	Seagren	Vandever
Finseth	Johnson, J.	Lindner	Otremba	Seifert	Walz
Fuller	Johnson, R.	Lipman	Ozment	Sertich	Wenzel
Gerlach	Juhnke	Mahoney	Paulsen	Skoe	Westerberg
Goodno	Kalis	Marko	Pawlenty	Slawik	Westrom
Gunther	Kielkucki	Marquart	Pelowski	Smith	Wilkin
Haas	Knoblach	McElroy	Penas	Solberg	Winter
Hackbarth	Krinkie	Milbert	Peterson	Stanek	Workman
Harder	Kubly	Molnau	Pugh	Stang	Spk. Sviggum
Holberg	Kuisle	Mulder	Rhodes	Swenson	
Holsten	Larson	Ness	Rifenberg	Sykora	
Howes	Leighton	Nornes	Rukavina	Thompson	
Huntley	Lenczewski	Olson	Ruth	Tingelstad	

Those who voted in the negative were:

Bernardy	Entenza	Greiling	Kelliher	Murphy	Wolf
Biernat	Evans	Hausman	Koskinen	Paymar	
Carlson	Folliard	Hilstrom	Luther	Skoglund	
Davnie	Gleason	Hilty	Mariani	Swapinski	
Dawkins	Goodwin	Johnson, S.	McGuire	Wagenius	
Dibble	Gray	Kahn	Mullery	Wasiluk	

The motion prevailed.

H. F. No. 208, A resolution urging authorization of funding for improvement and rehabilitation of waterways.

The bill was read for the third time, as amended by the Senate, and placed upon its repassage.

The question was taken on the repassage of the bill and the roll was called. There were 97 yeas and 32 nays as follows:

Those who voted in the affirmative were:

Abeler	Erickson	Johnson, R.	Marquart	Pugh	Thompson
Anderson, B.	Finseth	Juhnke	McElroy	Rhodes	Tingelstad
Anderson, I.	Fuller	Kalis	Milbert	Rifenberg	Tuma
Bakk	Gerlach	Kielkucki	Molnau	Rukavina	Vandever
Bishop	Goodno	Knoblach	Mulder	Ruth	Walz
Boudreau	Gunther	Krinkie	Ness	Schumacher	Wenzel
Bradley	Haas	Kubly	Nornes	Seagren	Westerberg
Buesgens	Hackbarth	Kuisle	Olson	Seifert	Westrom
Cassell	Harder	Larson	Opatz	Sertich	Wilkin
Clark, J.	Holberg	Leighton	Osskopp	Skoe	Winter
Daggett	Holsten	Leppik	Otremba	Slawik	Workman
Davids	Howes	Lieder	Ozment	Smith	Spk. Sviggum
Dehler	Huntley	Lindner	Paulsen	Solberg	
Dempsey	Jacobson	Lipman	Pawlenty	Stanek	
Dorman	Jaros	Mahoney	Pelowski	Stang	
Dorn	Jennings	Mares	Penas	Swenson	
Eastlund	Johnson, J.	Marko	Peterson	Sykora	

Those who voted in the negative were:

Bernardy	Entenza	Greiling	Kelliher	Mullery	Wasiluk
Biernat	Evans	Hausman	Koskinen	Murphy	Wolf
Carlson	Folliard	Hilstrom	Lenczewski	Paymar	
Davnie	Gleason	Hilty	Luther	Skoglund	
Dawkins	Goodwin	Johnson, S.	Mariani	Swapinski	
Dibble	Gray	Kahn	McGuire	Wagenius	

The bill was repassed, as amended by the Senate, and its title agreed to.

Mr. Speaker:

I hereby announce the passage by the Senate of the following House File, herewith returned, as amended by the Senate, in which amendments the concurrence of the House is respectfully requested:

H. F. No. 1266, A bill for an act relating to agriculture; providing funding for the department of agriculture, the board of animal health, the Minnesota horticultural society, and the agricultural utilization research institute; changing certain fees and charges; creating, extending, and expanding certain programs; establishing, changing, and clarifying terms and procedures; refunding certain fines; providing a civil penalty; appropriating money; amending Minnesota Statutes 2000, sections 17.102, subdivision 3; 17.1025; 17.117; 17.85; 18B.065, subdivision 5; 18E.04, subdivisions 2, 4, 5; 28A.04, subdivision 1; 32.394, subdivision 8e; 38.02, subdivision 1; 41A.09, subdivision 2a; 103B.3369, subdivision 5; 116.07, subdivision 7; 116O.09, subdivision 1a; 169.871, subdivision 1; 169.872, subdivision 1; proposing coding for new law in Minnesota Statutes, chapters 17; 41A; repealing Minnesota Statutes 2000, section 31.11, subdivision 2.

PATRICK E. FLAHAVEN, Secretary of the Senate

Ness moved that the House refuse to concur in the Senate amendments to H. F. No. 1266, that the Speaker appoint a Conference Committee of 5 members of the House, and that the House requests that a like committee be appointed by the Senate to confer on the disagreeing votes of the two houses. The motion prevailed.

Mr. Speaker:

I hereby announce the passage by the Senate of the following Senate File, herewith transmitted:

S. F. No. 2142.

PATRICE DWORAK, First Assistant Secretary of the Senate

### FIRST READING OF SENATE BILLS

S. F. No. 2142, A bill for an act relating to highways; allowing judicial review of public purpose and necessity for taking property for county highway or town road; amending Minnesota Statutes 2000, sections 163.12, subdivision 2, by adding subdivisions; 164.07, subdivisions 1, 2, 7, 10.

The bill was read for the first time.

Clark, J., moved that S. F. No. 2142 and H. F. No. 2203, now on the General Register, be referred to the Chief Clerk for comparison. The motion prevailed.

REPORT FROM THE COMMITTEE ON RULES AND  
LEGISLATIVE ADMINISTRATION

Pawlenty from the Committee on Rules and Legislative Administration, pursuant to rule 1.21, designated the following bill to be placed on the Calendar for the Day, immediately preceding the remaining bills on the Calendar for the Day, for Thursday, May 10, 2001:

S. F. No. 2005.

**CALENDAR FOR THE DAY**

S. F. No. 2005, A bill for an act relating to highways; designating the State Trooper Theodore "Ted" Foss Memorial Highway; amending Minnesota Statutes 2000, section 161.14, by adding a subdivision.

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

The bill was passed and its title agreed to.

Seifert moved that the remaining bills on the Calendar for the Day be continued. The motion prevailed.

**FISCAL CALENDAR**

Pursuant to rule 1.22, Bishop requested immediate consideration of S. F. No. 2361.

S. F. No. 2361 was reported to the House.

Goodno moved to amend S. F. No. 2361 as follows:

Delete everything after the enacting clause and insert the following language of H. F. No. 1832, the third engrossment:

**"ARTICLE 1****HEALTH DEPARTMENT**

Section 1. Minnesota Statutes 2000, section 103I.101, subdivision 6, is amended to read:

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

Sec. 2. Minnesota Statutes 2000, section 103I.112, is amended to read:

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

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

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

Sec. 3. Minnesota Statutes 2000, section 103I.208, subdivision 1, is amended to read:

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

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

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

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

Sec. 4. Minnesota Statutes 2000, section 103I.208, subdivision 2, is amended to read:

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

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

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

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

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

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

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

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

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

Sec. 5. Minnesota Statutes 2000, section 103I.235, subdivision 1, is amended to read:

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

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

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

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

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

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

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



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

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

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

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

(j) No new well disclosure certificate is required under this subdivision if the buyer or seller, or a person authorized to act on behalf of the buyer or seller, certifies on the deed or other instrument of conveyance that the status and number of wells on the property have not changed since the last previously filed well disclosure certificate. The following statement, if followed by the signature of the person making the statement, is sufficient to comply with the certification requirement of this paragraph: "I am familiar with the property described in this instrument and I certify that the status and number of wells on the described real property have not changed since the last previously filed well disclosure certificate." The certification and signature may be on the front or back of the deed or on an attached sheet and an acknowledgment of the statement is not required for the deed or other instrument of conveyance to be recordable.

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

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

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

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

Sec. 6. Minnesota Statutes 2000, section 103I.525, subdivision 2, is amended to read:

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

Sec. 7. Minnesota Statutes 2000, section 103I.525, subdivision 6, is amended to read:

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

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

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

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

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

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

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

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

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

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

Sec. 10. Minnesota Statutes 2000, section 103I.531, subdivision 2, is amended to read:

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

Sec. 11. Minnesota Statutes 2000, section 103I.531, subdivision 6, is amended to read:

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

Sec. 12. Minnesota Statutes 2000, section 103I.531, subdivision 8, is amended to read:

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

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

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

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

Sec. 13. Minnesota Statutes 2000, section 103I.531, subdivision 9, is amended to read:

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

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

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

Sec. 14. Minnesota Statutes 2000, section 103I.535, subdivision 2, is amended to read:

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

Sec. 15. Minnesota Statutes 2000, section 103I.535, subdivision 6, is amended to read:

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

Sec. 16. Minnesota Statutes 2000, section 103I.535, subdivision 8, is amended to read:

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

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

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

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

Sec. 17. Minnesota Statutes 2000, section 103I.535, subdivision 9, is amended to read:

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

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

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

Sec. 18. Minnesota Statutes 2000, section 103I.541, subdivision 2b, is amended to read:

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

Sec. 19. Minnesota Statutes 2000, section 103I.541, subdivision 4, is amended to read:

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

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

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

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

Sec. 20. Minnesota Statutes 2000, section 103I.541, subdivision 5, is amended to read:

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

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

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

Sec. 21. Minnesota Statutes 2000, section 103I.545, is amended to read:

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

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

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

(c) A registration is valid for one year.

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

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

(c) A registration is valid for one year.

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

Sec. 22. Minnesota Statutes 2000, section 121A.15, subdivision 6, is amended to read:

Subd. 6. [SUSPENSION OF IMMUNIZATION REQUIREMENT; MODIFICATION TO SCHEDULE.] (a) The commissioner of health, on finding that an immunization required pursuant to this section is not necessary to protect the public's health, may suspend for one year the requirement that children receive that immunization.

(b) During portions of the year in which the legislature is not meeting in regular or special session, the commissioner of health may modify the immunization requirements of this section. A modification made under this paragraph must be part of the current immunization recommendations of each of the following organizations: the United States Public Health Service's Advisory Committee on Immunization Practices, the American Academy of Family Physicians, and the American Academy of Pediatrics. The commissioner shall modify the immunization requirements through rulemaking using the expedited process in section 14.389. A rule adopted under this paragraph shall be in effect until the adjournment of the next regular legislative session held after the rule is adopted. The commissioner shall report to the legislature on any rules adopted under this paragraph during the previous calendar year. Such reports are due by January 15 of the year following the calendar year in which the rule is adopted, except that if a rule is adopted in January, a report on that rule is due by February 15 of that year.

Sec. 23. Minnesota Statutes 2000, section 135A.14, is amended by adding a subdivision to read:

Subd. 7. [MODIFICATIONS TO SCHEDULE.] During portions of the year in which the legislature is not meeting in regular or special session, the commissioner of health may modify the immunization requirements of this section. A modification made under this subdivision must be part of the current immunization recommendations of each of the following organizations: the United States Public Health Service's Advisory Committee on Immunization Practices, the American Academy of Family Physicians, and the American Academy of Pediatrics. The commissioner shall modify the immunization requirements through rulemaking using the expedited process in section 14.389. A rule adopted under this subdivision shall be in effect until the adjournment of the next regular legislative session held after the rule is adopted. The commissioner shall report to the legislature on any rules adopted under this subdivision during the previous calendar year. Such reports are due by January 15 of the year following the calendar year in which the rule is adopted, except that if a rule is adopted in January, a report on that rule is due by February 15 of that year.

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

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

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

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

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

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

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

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

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

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

<u>Irradiator - less than 10,000 Ci</u>	<u>\$7,500</u>	<u>Irradiators less than 10,000 curies</u>
<u>Irradiator - more than 10,000 Ci</u>	<u>\$11,500</u>	<u>Irradiators greater than 10,000 curies</u>
<u>Research and development, no distribution Radioactive material possession only</u>	<u>\$4,100</u>	<u>Research and development</u>
<u>Source material</u>	<u>\$1,000</u>	<u>By-product possession only</u>
<u>Special nuclear material, less than 200 grams</u>	<u>\$1,000</u>	<u>Source material shielding</u>
<u>Pacemaker manufacturing</u>	<u>\$1,000</u>	<u>Special nuclear material plutonium-neutron sources less than 200 grams</u>
<u>General license distribution</u>	<u>\$2,100</u>	<u>Pacemaker by-product and/or special nuclear material - medical institution</u>
<u>General license distribution, exempt</u>	<u>\$1,500</u>	<u>General license distribution</u>
<u>Academic, small</u>	<u>\$1,000</u>	<u>General license distribution - certain exempt items</u>
<u>Veterinary</u>	<u>\$2,000</u>	<u>Possession limit of ten radionuclides, not to exceed a total of one curie of activity</u>
<u>Well logging</u>	<u>\$5,000</u>	<u>Veterinary use</u>
		<u>Well logging</u>

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

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

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

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

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

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

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

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

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

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

144.122 [LICENSE, PERMIT, AND SURVEY FEES.]

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

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

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

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

Joint Commission on Accreditation of Healthcare

Organizations (JCAHO hospitals)	<del>\$1,017</del> <u>\$7,055</u>
Non-JCAHO hospitals	<del>\$762 plus \$34 per bed</del> <u>\$4,680 plus \$234 per bed</u>
Nursing home	<del>\$78 plus \$19 per bed</del> <u>\$183 plus \$91 per bed</u>



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

Outpatient surgical centers	<del>\$517</del> <u>\$1,512</u>
Boarding care homes	<del>\$78 plus \$19 per bed</del> <u>\$183 plus \$91 per bed</u>
Supervised living facilities	<del>\$78 plus \$19 per bed</del> <u>\$183 plus \$91 per bed.</u>

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

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

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

Sec. 27. Minnesota Statutes 2000, section 144.148, subdivision 2, is amended to read:

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

(b) A grant shall not exceed \$1,500,000 per eligible rural hospital that also satisfies the following criteria:

(1) is the only hospital in a county;

(2) has 25 or fewer licensed hospital beds with a net hospital operating margin not greater than an average of two percent over the three fiscal years prior to application;

(3) is located in a medically underserved community (MUC) or a health professional shortage area (HPSA);

(4) is located near a migrant worker employment site and regularly treats significant numbers of migrant workers and their families; and

(5) has not previously received a grant under this section prior to July 1, 1999.

Sec. 28. Minnesota Statutes 2000, section 144.226, subdivision 4, is amended to read:

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

Sec. 29. [144.585] [HOSPITAL CHARITY CARE AID.]

Subdivision 1. [PURPOSE.] The purpose of charity care aid is to help offset excess charity care burdens at Minnesota acute care, short-term hospitals.

Subd. 2. [DEFINITIONS.] (a) For purposes of this section, the terms in this subdivision have the meanings given to them.

(b) "Charity care" is the dollar amount of charity care adjustments as determined under subdivision 3.

(c) "Cost-to-charge ratio" means a hospital's total operating expenses over the sum of gross patient revenue and other operating revenue, as reported to the commissioner of health under rules adopted under sections 144.695 to 144.703. The commissioner shall use the most recently available data to calculate the cost-to-charge ratio.

Subd. 3. [CHARITY CARE REPORTING.] (a) For a hospital to report amounts as charity care adjustments, the hospital:

(1) must generate and record a charge;

(2) have a policy on the provision of charity care and must communicate the policy to the public;

(3) have made a reasonable effort to identify a third party payer, encourage the patient to enroll in public programs, and should, to the extent possible, aid the patient in the enrollment process; and

(4) ensure that the patient meets the charity care criteria of this subdivision, which must be consistent with statewide income standards set out in paragraph (c).

(b) In determining whether to classify care as charity care, the hospital must consider the following:

(1) charity care may include services which the provider is obligated to render independently of the ability to collect;

(2) charity care may include care provided to low-income patients who meet the charity care income standards under paragraph (c) and have partial coverage, but are unable to pay the remainder of their medical bills. This does not apply to that portion of the bill which has been determined to be the patient's responsibility after a partial charity care classification;

(3) charity care may include care provided to low-income patients who may qualify for a public health insurance program and meet the statewide eligibility criteria for charity care, but who do not complete the application process for public insurance despite the facility's best efforts;

(4) charity care may include care to individuals whose eligibility for charity care was determined through third party services employed by the hospital for information gathering purposes only;

(5) charity care may not include contractual allowances, which is the difference between gross charges and payments received under contractual arrangements with insurance companies and payers;

(6) charity care may not include bad debt;

(7) charity care may not include what may be perceived as underpayments for operating public programs;

(8) charity care may not include cases which are paid through a charitable contribution through a third party or facility-related foundation;

(9) charity care may not include unreimbursed costs of basic or clinical research and of professional education and training;

(10) charity care may not include professional courtesy discounts;

(11) charity care may not include community service or outreach activities; and

(12) charity care may not include services for patients against whom collection actions were taken which result in a credit report.

(c) The hospital must use the income standards in this paragraph for determining charity care eligibility for reporting purposes. The hospital does not need to make a patient asset determination in order to apply charity care income standards.

(1) Care to a patient with a family income at or below 150 percent of the Federal Poverty Guideline (FPG) may be reported as full charity care or free care.

(2) The hospital's share of discounted charges for care to a patient with family income below 275 percent of the FPG qualifies for classification as charity care. The following sliding fee schedules apply:

<u>income as % of FPG</u>	<u>charges paid by patient</u>	<u>corresponding charity care</u>
<u>151-200%</u>	<u>20%</u>	<u>80%</u>
<u>201-225%</u>	<u>40%</u>	<u>60%</u>
<u>226-250%</u>	<u>60%</u>	<u>40%</u>
<u>251-275%</u>	<u>80%</u>	<u>20%</u>

(3) Care to a patient is considered medical hardship when qualified medical expenses, as defined for the purposes of federal income tax deductibility, exceeds 30 percent of family income. Qualified medical expenses may be counted as charity care in the amount that exceeds 30 percent of family income. This clause applies even if the patient's family income exceeds the charity care income standards in clauses (1) and (2).

Subd. 4. [APPLICATION.] To be eligible for funds under this section, hospitals must submit an application to the commissioner of health by the deadline established by the commissioner. Applications must meet the criteria as established by the commissioner, but must contain:

(1) the dollar amount of charity care in the previous year, as defined in subdivision 3, paragraphs (b) and (c);

(2) a list with the most common diagnoses for which charity care is provided; and

(3) descriptive aggregate statistics of the characteristics of patients who receive charity care.

Subd. 5. [ALLOCATION OF FUNDS.] A hospital's share of the available charity care aid is equal to that hospital's share of charity care relative to the total charity care provided by applicants.

Sec. 30. Minnesota Statutes 2000, section 144.98, subdivision 3, is amended to read:

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

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

(2) test category certification fees:

Test Category	Certification Fee
<u>Clean water program</u> bacteriology	<del>\$200</del> <u>\$600</u>
<u>Safe drinking water program</u> bacteriology	<u>\$600</u>
<u>Clean water program</u> inorganic chemistry; fewer than four constituents	<del>\$100</del> <u>\$600</u>
<u>Safe drinking water program</u> inorganic chemistry; four or more constituents	<del>\$300</del> <u>\$600</u>
<u>Clean water program</u> chemistry metals; fewer than four constituents	<del>\$200</del> <u>\$800</u>
<u>Safe drinking water program</u> chemistry metals; four or more constituents	<del>\$500</del> <u>\$800</u>
<u>Resource conservation and recovery program</u> chemistry metals	<u>\$800</u>
<u>Clean water program</u> volatile organic compounds	<del>\$600</del> <u>\$1,200</u>
<u>Safe drinking water program</u> volatile organic compounds	<u>\$1,200</u>
<u>Resource conservation and recovery program</u> volatile organic compounds	<u>\$1,200</u>
<u>Underground storage tank program</u> volatile organic compounds	<u>\$1,200</u>
<u>Clean water program</u> other organic compounds	<del>\$600</del> <u>\$1,200</u>
<u>Safe drinking water program</u> other organic compounds	<u>\$1,200</u>
<u>Resource conservation and recovery program</u> other organic compounds	<u>\$1,200</u>

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

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

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

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

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

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

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

Sec. 31. Minnesota Statutes 2000, section 144A.44, subdivision 1, is amended to read:

Subdivision 1. [STATEMENT OF RIGHTS.] A person who receives home care services has these rights:

(1) the right to receive written information about rights in advance of receiving care or during the initial evaluation visit before the initiation of treatment, including what to do if rights are violated;

(2) the right to receive care and services according to a suitable and up-to-date plan, and subject to accepted medical or nursing standards, to take an active part in creating and changing the plan and evaluating care and services;

(3) the right to be told in advance of receiving care about the services that will be provided, the disciplines that will furnish care, the frequency of visits proposed to be furnished, other choices that are available, and the consequences of these choices including the consequences of refusing these services;

(4) the right to be told in advance of any change in the plan of care and to take an active part in any change;

(5) the right to refuse services or treatment;

(6) the right to know, in advance, any limits to the services available from a provider, and the provider's grounds for a termination of services;

(7) the right to know in advance of receiving care whether the services are covered by health insurance, medical assistance, or other health programs, the charges for services that will not be covered by Medicare, and the charges that the individual may have to pay;

(8) the right to know what the charges are for services, no matter who will be paying the bill;

(9) the right to know that there may be other services available in the community, including other home care services and providers, and to know where to go for information about these services;

(10) the right to choose freely among available providers and to change providers after services have begun, within the limits of health insurance, medical assistance, or other health programs;

(11) the right to have personal, financial, and medical information kept private, and to be advised of the provider's policies and procedures regarding disclosure of such information;

(12) the right to be allowed access to records and written information from records in accordance with section 144.335;

(13) the right to be served by people who are properly trained and competent to perform their duties;

(14) the right to be treated with courtesy and respect, and to have the patient's property treated with respect;

(15) the right to be free from physical and verbal abuse;

(16) the right to reasonable, advance notice of changes in services or charges, including at least ten days' advance notice of the termination of a service by a provider, except in cases where:

(i) the recipient of services engages in conduct that alters the conditions of employment as specified in the employment contract between the home care provider and the individual providing home care services, or creates an abusive or unsafe work environment for the individual providing home care services; or

(ii) an emergency for the informal caregiver or a significant change in the recipient's condition has resulted in service needs that exceed the current service provider agreement and that cannot be safely met by the home care provider;

(17) the right to a coordinated transfer when there will be a change in the provider of services;

(18) the right to voice grievances regarding treatment or care that is, or fails to be, furnished, or regarding the lack of courtesy or respect to the patient or the patient's property;

(19) the right to know how to contact an individual associated with the provider who is responsible for handling problems and to have the provider investigate and attempt to resolve the grievance or complaint;

(20) the right to know the name and address of the state or county agency to contact for additional information or assistance; and

(21) the right to assert these rights personally, or have them asserted by the patient's family or guardian when the patient has been judged incompetent, without retaliation.

Sec. 32. [145.4241] [DEFINITIONS.]

Subdivision 1. [APPLICABILITY.] As used in sections 145.4241 to 145.4246, the following terms have the meaning given them.

Subd. 2. [ABORTION.] "Abortion" means the use or prescription of any instrument, medicine, drug, or any other substance or device to intentionally terminate the pregnancy of a female known to be pregnant, with an intention other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove a dead fetus.

Subd. 3. [ATTEMPT TO PERFORM AN ABORTION.] "Attempt to perform an abortion" means an act, or an omission of a statutorily required act, that, under the circumstances as the actor believes them to be, constitutes a substantial step in a course of conduct planned to culminate in the performance of an abortion in Minnesota in violation of sections 145.4241 to 145.4246.

Subd. 4. [MEDICAL EMERGENCY.] "Medical emergency" means any condition that, on the basis of the physician's good faith clinical judgment, complicates the medical condition of a pregnant female to the extent that:

(1) an immediate abortion of her pregnancy is necessary to avert her death; or

(2) a 24-hour delay in performing an abortion creates a serious risk of substantial and irreversible impairment of a major bodily function.

Subd. 5. [PHYSICIAN.] "Physician" means a person licensed under chapter 147.

Subd. 6. [PROBABLE GESTATIONAL AGE OF THE UNBORN CHILD.] "Probable gestational age of the unborn child" means what will, in the judgment of the physician, with reasonable probability, be the gestational age of the unborn child at the time the abortion is planned to be performed.

## Sec. 33. [145.4242] [INFORMED CONSENT.]

No abortion shall be performed in this state except with the voluntary and informed consent of the female upon whom the abortion is to be performed. Except in the case of a medical emergency, consent to an abortion is voluntary and informed only if:

(1) the female is told the following, by telephone or in person, by the physician who is to perform the abortion or by a referring physician, at least 24 hours before the abortion:

(i) the name of the physician who will perform the abortion;

(ii) the particular medical risks associated with the particular abortion procedure to be employed including, when medically accurate, the risks of infection, hemorrhage, breast cancer, danger to subsequent pregnancies, and infertility;

(iii) the probable gestational age of the unborn child at the time the abortion is to be performed; and

(iv) the medical risks associated with carrying her child to term.

The information required by this clause may be provided by telephone without conducting a physical examination or tests of the patient, in which case the information required to be provided may be based on facts supplied the physician by the female and whatever other relevant information is reasonably available to the physician. It may not be provided by a tape recording, but must be provided during a consultation in which the physician is able to ask questions of the female and the female is able to ask questions of the physician. If a physical examination, tests, or the availability of other information to the physician subsequently indicate, in the medical judgment of the physician, a revision of the information previously supplied to the patient, that revised information may be communicated to the patient at any time prior to the performance of the abortion. Nothing in this section may be construed to preclude provision of required information in a language understood by the patient through a translator;

(2) the female is informed, by telephone or in person, by the physician who is to perform the abortion, by a referring physician, or by an agent of either physician at least 24 hours before the abortion:

(i) that medical assistance benefits may be available for prenatal care, childbirth, and neonatal care;

(ii) that the father is liable to assist in the support of her child, even in instances when the father has offered to pay for the abortion; and

(iii) that she has the right to review the printed materials described in section 145.4243. The physician or the physician's agent shall orally inform the female that the materials have been provided by the state of Minnesota and that they describe the unborn child and list agencies that offer alternatives to abortion. If the female chooses to view the materials, they shall either be given to her at least 24 hours before the abortion or mailed to her at least 72 hours before the abortion by certified mail, restricted delivery to addressee, which means the postal employee can only deliver the mail to the addressee.

The information required by this clause may be provided by a tape recording if provision is made to record or otherwise register specifically whether the female does or does not choose to review the printed materials;

(3) the female certifies in writing, prior to the abortion, that the information described in this section has been furnished her, and that she has been informed of her opportunity to review the information referred to in clause (2); and

(4) prior to the performance of the abortion, the physician who is to perform the abortion or the physician's agent receives a copy of the written certification prescribed by clause (3).

## Sec. 34. [145.4243] [PRINTED INFORMATION.]

(a) Within 90 days after the effective date of sections 145.4241 to 145.4246, the department of health shall cause to be published, in English and in each language that is the primary language of two percent or more of the state's population, the following printed materials in such a way as to ensure that the information is easily comprehensible:

(1) geographically indexed materials designed to inform the female of public and private agencies and services available to assist a female through pregnancy, upon childbirth, and while the child is dependent, including adoption agencies, which shall include a comprehensive list of the agencies available, a description of the services they offer, and a description of the manner, including telephone numbers, in which they might be contacted or, at the option of the department of health, printed materials including a toll-free, 24-hours-a-day telephone number that may be called to obtain, orally, such a list and description of agencies in the locality of the caller and of the services they offer; and

(2) materials designed to inform the female of the probable anatomical and physiological characteristics of the unborn child at two-week gestational increments from the time when a female can be known to be pregnant to full term, including any relevant information on the possibility of the unborn child's survival and pictures or drawings representing the development of unborn children at two-week gestational increments, provided that any such pictures or drawings must contain the dimensions of the fetus and must be realistic and appropriate for the stage of pregnancy depicted. The materials shall be objective, nonjudgmental, and designed to convey only accurate scientific information about the unborn child at the various gestational ages. The material shall also contain objective information describing the methods of abortion procedures commonly employed, the medical risks commonly associated with each procedure, the possible detrimental psychological effects of abortion, the medical risks commonly associated with each procedure, and the medical risks commonly associated with carrying a child to term.

(b) The materials referred to in this section must be printed in a typeface large enough to be clearly legible. The materials required under this section must be available at no cost from the department of health upon request and in appropriate number to any person, facility, or hospital.

## Sec. 35. [145.4244] [PROCEDURE IN CASE OF MEDICAL EMERGENCY.]

When a medical emergency compels the performance of an abortion, the physician shall inform the female, prior to the abortion if possible, of the medical indications supporting the physician's judgment that an abortion is necessary to avert her death or that a 24-hour delay in conformance with section 145.4242 creates a serious risk of substantial and irreversible impairment of a major bodily function.

## Sec. 36. [145.4245] [REMEDIES.]

Subdivision 1. [CIVIL REMEDIES.] Any person upon whom an abortion has been performed or the parent of a minor upon whom an abortion has been performed may maintain an action against the person who performed the abortion in knowing or reckless violation of sections 145.4241 to 145.4246 for actual and punitive damages. Any person upon whom an abortion has been attempted without complying with sections 145.4241 to 145.4246 may maintain an action against the person who attempted to perform the abortion in knowing or reckless violation of sections 145.4241 to 145.4246 for actual and punitive damages.

Subd. 2. [ATTORNEY FEES.] If judgment is rendered in favor of the plaintiff in any action described in this section, the court shall also render judgment for a reasonable attorney's fee in favor of the plaintiff against the defendant. If judgment is rendered in favor of the defendant and the court finds that the plaintiff's suit was frivolous and brought in bad faith, the court shall also render judgment for a reasonable attorney's fee in favor of the defendant against the plaintiff.

Subd. 3. [PROTECTION OF PRIVACY IN COURT PROCEEDINGS.] In every civil action brought under sections 145.4241 to 145.4246, the court shall rule whether the anonymity of any female upon whom an abortion has been performed or attempted shall be preserved from public disclosure if she does not give her consent to such



disclosure. The court, upon motion or sua sponte, shall make such a ruling and, upon determining that her anonymity should be preserved, shall issue orders to the parties, witnesses, and counsel and shall direct the sealing of the record and exclusion of individuals from courtrooms or hearing rooms to the extent necessary to safeguard her identity from public disclosure. Each order must be accompanied by specific written findings explaining why the anonymity of the female should be preserved from public disclosure, why the order is essential to that end, how the order is narrowly tailored to serve that interest, and why no reasonable, less restrictive alternative exists. In the absence of written consent of the female upon whom an abortion has been performed or attempted, anyone, other than a public official, who brings an action under subdivision 1, shall do so under a pseudonym. This section may not be construed to conceal the identity of the plaintiff or of witnesses from the defendant.

Sec. 37. [145.4246] [SEVERABILITY.]

If any one or more provision, section, subsection, sentence, clause, phrase, or word of sections 145.4241 to 145.4246 or the application thereof to any person or circumstance is found to be unconstitutional, the same is hereby declared to be severable and the balance of sections 145.4241 to 145.4246 shall remain effective notwithstanding such unconstitutionality. The legislature hereby declares that it would have passed sections 145.4241 to 145.4246, and each provision, section, subsection, sentence, clause, phrase, or word thereof, irrespective of the fact that any one or more provision, section, subsection, sentence, clause, phrase, or word be declared unconstitutional.

Sec. 38. Minnesota Statutes 2000, section 145.881, subdivision 2, is amended to read:

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

- (a) review and report on the health care needs of mothers and children throughout the state of Minnesota;
- (b) review and report on the type, frequency and impact of maternal and child health care services provided to mothers and children under existing maternal and child health care programs, including programs administered by the commissioner of health;
- (c) establish, review, and report to the commissioner a list of program guidelines and criteria which the advisory task force considers essential to providing an effective maternal and child health care program to low income populations and high risk persons and fulfilling the purposes defined in section 145.88;
- (d) review staff recommendations of the department of health regarding maternal and child health grant awards before the awards are made;
- (e) make recommendations to the commissioner for the use of other federal and state funds available to meet maternal and child health needs;
- (f) make recommendations to the commissioner of health on priorities for funding the following maternal and child health services: (1) prenatal, delivery and postpartum care, (2) comprehensive health care for children, especially from birth through five years of age, (3) adolescent health services, (4) family planning services, (5) preventive dental care, (6) special services for chronically ill and handicapped children and (7) any other services which promote the health of mothers and children; ~~and~~
- (g) make recommendations to the commissioner of health on the process to distribute, award and administer the maternal and child health block grant funds; and
- (h) review the measures that are used to define the variables of the funding distribution formula in section 145.882, subdivision 4a, every two years and make recommendations to the commissioner of health for changes based upon principles established by the advisory task force for this purpose.

Sec. 39. Minnesota Statutes 2000, section 145.882, is amended by adding a subdivision to read:

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

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

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

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

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

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

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

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

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

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

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

Sec. 40. Minnesota Statutes 2000, section 145.882, subdivision 7, is amended to read:

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

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

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

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

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

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

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

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

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

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

Sec. 41. Minnesota Statutes 2000, section 145.885, subdivision 2, is amended to read:

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

Sec. 42. Minnesota Statutes 2000, section 145.924, is amended to read:

145.924 [AIDS PREVENTION GRANTS.]

Subdivision 1. [GRANT AWARDS.] (a) The commissioner may award grants to boards of health as defined in section 145A.02, subdivision 2, state agencies, state councils, or nonprofit corporations to provide evaluation and counseling services to populations at risk for acquiring human immunodeficiency virus infection, including, but not limited to, minorities, adolescents, intravenous drug users, and homosexual men.

(b) The commissioner may award grants to agencies experienced in providing services to communities of color, for the design of innovative outreach and education programs for targeted groups within the community who may be at risk of acquiring the human immunodeficiency virus infection, including intravenous drug users and their partners, adolescents, gay and bisexual individuals and women. Grants shall be awarded on a request for proposal basis and shall include funds for administrative costs. Priority for grants shall be given to agencies or organizations that have experience in providing service to the particular community which the grantee proposes to serve; that have policymakers representative of the targeted population; that have experience in dealing with issues relating to HIV/AIDS; and that have the capacity to deal effectively with persons of differing sexual orientations. For purposes of this paragraph, the "communities of color" are: the American-Indian community; the Hispanic community; the African-American community; and the Asian-Pacific community.

(c) All state grants awarded under this ~~section~~ subdivision for programs targeted to adolescents shall include the promotion of abstinence from sexual activity and drug use.

Subd. 2. [OUTCOMES.] The commissioner, in consultation with boards of health, agencies, councils, and nonprofit organizations involved in human immunodeficiency virus infection prevention efforts shall establish measurable outcomes to determine the effectiveness of the grants provided under this section in reducing the number of people who acquire human immunodeficiency virus, the rates of infection, and average numbers of sexual partners for populations served by grants funded under this section.

Subd. 3. [EVALUATION.] (a) Using the outcomes established according to subdivision 2, the commissioner shall conduct a biennial evaluation of activities funded under this section. The evaluation must include:

(1) the effect of these activities on the number of people who acquire human immunodeficiency virus and the rates of infection;

(2) the effect of these activities on average numbers of sexual partners for populations served by grants funded under this section; and

(3) a longitudinal tracking of outcomes for targeted populations who are served under subdivision 1, paragraphs (a) and (b).

(b) Grant recipients shall cooperate with the commissioner in the evaluation and shall provide the commissioner with the information needed to conduct the evaluation. Beginning January 15, 2003, the results of each evaluation must be submitted to the chairs of the policy and finance committees in the house and senate with jurisdiction over health and human services.

Sec. 43. Minnesota Statutes 2000, section 145.925, subdivision 1, is amended to read:

Subdivision 1. [ELIGIBLE ORGANIZATIONS; PURPOSE.] The commissioner of health may make special grants to cities, counties, tribal governments, or groups of cities ~~or~~ counties, ~~or nonprofit corporations or tribal governments~~ to provide pre-pregnancy family planning services: targeted to low-income and minority populations. A city, county, tribal government, or group of cities, counties, or tribal governments that receives a grant is responsible for ensuring that the grant funds are used for services targeted to low-income and minority populations, and must establish a goal for reducing specific pregnancy rates in the service area. In determining populations to

serve and services to provide, a city, county, tribal government, or group of cities, counties, or tribal governments must consider the spacing of pregnancies in low-income and minority populations in the service area, teen birth rates in the service area, and the needs of populations of color in the service area. A city, county, tribal government, or group of cities, counties, or tribal governments may contract for the provision of pre-pregnancy family planning services using grant funds provided under this section only if the contract is specifically authorized by the governing body of the city, county, or tribal government that is contracting for the services.

Any organization or an affiliate of an organization which provides abortions, promotes abortions, or directly refers for abortions, shall be ineligible to receive funds under this subdivision.

Sec. 44. Minnesota Statutes 2000, section 145.925, subdivision 1a, is amended to read:

Subd. 1a. [FAMILY PLANNING SERVICES; DEFINED.] "Family planning services" means counseling by trained personnel regarding family planning; distribution of information relating to family planning, referral to licensed physicians or local health agencies for consultation, examination, medical treatment, genetic counseling, and prescriptions for the purpose of family planning; and the distribution of family planning products, such as charts, thermometers, drugs, medical preparations, and contraceptive devices. Family planning services do not include services that, directly or indirectly, encourage, counsel, refer, or provide abortions or abortion referrals. For purposes of sections 145A.01 to 145A.14, family planning shall mean voluntary action by individuals to prevent or aid conception but does not include ~~the performance, or make referrals for encouragement of voluntary termination of pregnancy services that, directly or indirectly, encourage, counsel, refer, or provide abortions or abortion referrals.~~

Sec. 45. [145.9257] [TEEN PREGNANCY PREVENTION.]

Subdivision 1. [GOAL.] It is the goal of the state to reduce teen pregnancy rates by 24 percent by 2006. To do so, the commissioner of health shall establish a grant program to reduce the rates of unintended teen pregnancies in the state. If this goal of reducing teen pregnancy rates by 24 percent is not met by December 31, 2006, this section expires June 30, 2007. No funds awarded under this section may be used for medical services or family planning services or for services that, directly or indirectly, encourage, counsel, refer, or provide abortions or abortion referrals.

Any organization or an affiliate of an organization which provides abortions, promotes abortions, or directly refers for abortions, shall be ineligible to receive funds under this section.

Subd. 2. [STATE-COMMUNITY PARTNERSHIPS; PLAN.] The commissioner, in consultation with the commissioner of children, families, and learning; the commissioner of human services; the maternal and child health advisory task force under section 145.881; the Indian affairs council under section 3.922; the council on affairs of Chicano/Latino people under section 3.9223; the council on Black Minnesotans under section 3.9225; the council on Asian-Pacific Minnesotans under section 3.9226; community health boards as defined in section 145A.02; tribal governments; nonprofit community organizations; and others interested in teen pregnancy prevention, shall develop and implement a comprehensive, coordinated plan to reduce the number of teen pregnancies.

Subd. 3. [MEASURABLE OUTCOMES.] The commissioner, in consultation with the commissioners and community partners listed in subdivision 2, shall establish measurable outcomes to achieve the goal specified in subdivision 1 and to determine the effectiveness of the grants provided under this section in reducing teen pregnancies. The development of measurable outcomes must be completed before any funds are distributed under this section.

Subd. 4. [STATEWIDE ASSESSMENT.] The commissioner shall use and enhance current statewide assessments of teen pregnancy risk behaviors and attitudes among youth to establish a baseline to measure the statewide effect of teen pregnancy prevention activities. To the extent feasible, the commissioner shall conduct the assessment so that the results may be compared to national data.

Subd. 5. [PROCESS.] The commissioner, in consultation with the commissioners and community partners listed in subdivision 2, shall develop the criteria and procedures used to allocate grants under this section. In developing the criteria, the commissioner shall establish an administrative cost limit for grant recipients. At the time a grant is awarded, the commissioner shall provide a grant recipient with information on the outcomes established according to subdivision 3.

Subd. 6. [TEEN PREGNANCY PREVENTION DISPARITY GRANTS.] (a) The commissioner shall award competitive grants to eligible applicants for projects to reduce disparities in unintended teen pregnancy rates for American Indians and populations of color, as compared with unintended teen pregnancy rates for whites.

(b) No funds awarded under this subdivision may be used for medical services or family planning services or for services that, directly or indirectly, encourage, counsel, refer, or provide abortions or abortion referrals.

Any organization or an affiliate of an organization which provides abortions, promotes abortions, or directly refers for abortions, shall be ineligible to receive funds under this subdivision.

(c) Eligible applicants may include, but are not limited to, nonprofit organizations, school districts, faith-based organizations, community health boards, and tribal governments. Applicants must submit proposals to the commissioner. A proposal must specify the strategies to be implemented and must take into account the need for a coordinated, statewide teen pregnancy prevention effort. Strategies may include youth development programs, after-school enrichment programs, youth mentoring programs, academic support programs, and abstinence until marriage education programs.

(d) The commissioner shall give priority to applicants who demonstrate that their proposed project:

(1) emphasizes abstinence until marriage;

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

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

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

(5) reflects racially and ethnically appropriate approaches; and

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

Subd. 7. [HIGH-RISK COMMUNITY TEEN PREGNANCY PREVENTION GRANTS.] (a) The commissioner shall award grants to communities that have significant risk factors for teen pregnancies, that currently have in place youth development programs, and that are interested in expanding existing efforts to prevent teen pregnancies.

(b) No funds awarded under this subdivision may be used for medical services or family planning services or for services that, directly or indirectly, encourage, counsel, refer, or provide abortions or abortion referrals.

Any organization or an affiliate of an organization which provides abortions, promotes abortions, or directly refers for abortions, shall be ineligible to receive funds under this subdivision.

(c) To be eligible for a grant under this subdivision, an applicant must be a tribal government or a community health board as defined in section 145A.02. Applicants must submit proposals to the commissioner. A proposal must specify the strategies to be implemented. Strategies may include, but are not limited to, youth development programs, youth mentoring programs, academic support programs, and abstinence until marriage education programs. Applicants must demonstrate that a proposed project:

(1) emphasizes abstinence until marriage;

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

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

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

(5) reflects racially and ethnically appropriate approaches; and

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

(d) Grants may be awarded to up to 15 community health boards and three tribal governments based on areas having the highest risk factors for teen pregnancies. The commissioner shall award grants based on the following risk factors:

(1) the proportion of teens in the applicant's service area who are sexually active;

(2) the proportion of births to teens in the applicant's service area; and

(3) the proportion of births to teens who are American Indian or of a population of color in the applicant's service area.

Subd. 8. [ADOLESCENT PARENT GRANTS.] The commissioner shall transfer funds to the commissioner of children, families, and learning to increase the number of adolescent parent grants currently provided by the commissioner of children, families, and learning under section 124D.33.

Subd. 9. [COORDINATION.] The commissioner shall coordinate the projects and initiatives funded under this section with other efforts at the local, state, and national levels to avoid duplication and promote complementary efforts.

Subd. 10. [EVALUATION.] Using the outcomes established according to subdivision 3, the commissioner shall conduct a biennial evaluation of the impact of each teen pregnancy prevention initiative in this section. Grant recipients and the commissioner of children, families, and learning shall cooperate with the commissioner in the evaluation and shall provide the commissioner with the information needed to conduct the evaluation.

Subd. 11. [REPORT.] By January 15, 2002, and January 15 of each even-numbered year thereafter, the commissioner shall submit a report to the legislature on the projects funded under this section and the results of the biennial evaluation.

Sec. 46. [145.9268] [COMMUNITY CLINIC GRANTS.]

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

(1) a clinic that provides services under conditions as defined in Minnesota Rules, part 9505.0255 or 9505.0380, and utilizes a sliding fee scale to determine eligibility for charity care;

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

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

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

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

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

- (1) a description of the project for which grant funds will be used;
- (2) a description of the problem the proposed project will address; and
- (3) a description of achievable objectives, a workplan, and a timeline for project completion.

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

(d) A grant awarded to an eligible community clinic may not exceed \$300,000 per eligible community clinic. For an applicant applying as a consortium of clinics, a grant may not exceed \$300,000 per clinic included in the consortium. The commissioner has discretion over the number of grants awarded.

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

- (1) establish, update, or improve information, data collection, or billing systems;
- (2) procure, modernize, remodel, or replace equipment used in the delivery of direct patient care at a clinic;
- (3) provide improvements for care delivery, such as increased translation and interpretation services;
- (4) provide a direct offset to expenses incurred for charity care services; or
- (5) other projects determined by the commissioner to improve the ability of applicants to provide care to the vulnerable populations they serve.

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

Sec. 47. [145.928] [ELIMINATING HEALTH DISPARITIES.]

Subdivision 1. [GOAL; ESTABLISHMENT.] It is the goal of the state, by 2010, to decrease by 50 percent the disparities in infant mortality rates and adult and child immunization rates for American Indians and populations of color, as compared with rates for whites. To do so and to achieve other measurable outcomes, the commissioner of health shall establish a program to close the gap in the health status of American Indians and populations of color as compared with whites in the following priority areas: infant mortality, breast and cervical cancer screening,



HIV/AIDS and sexually transmitted infections, adult and child immunizations, cardiovascular disease, diabetes, and accidental injuries and violence. If this goal of reducing disparities in infant mortality rates and adult and child immunization rates is not met by December 31, 2010, this section expires June 30, 2011.

Subd. 2. [STATE-COMMUNITY PARTNERSHIPS; PLAN.] The commissioner, in partnership with culturally-based community organizations; the Indian affairs council under section 3.922; the council on affairs of Chicano/Latino people under section 3.9223; the council on Black Minnesotans under section 3.9225; the council on Asian-Pacific Minnesotans under section 3.9226; community health boards as defined in section 145A.02; and tribal governments, shall develop and implement a comprehensive, coordinated plan to reduce health disparities in the health disparity priority areas identified in subdivision 1.

Subd. 3. [MEASURABLE OUTCOMES.] The commissioner, in consultation with the community partners listed in subdivision 2, shall establish measurable outcomes to achieve the goal specified in subdivision 1 and to determine the effectiveness of the grants and other activities funded under this section in reducing health disparities in the priority areas identified in subdivision 1. The development of measurable outcomes must be completed before any funds are distributed under this section.

Subd. 4. [STATEWIDE ASSESSMENT.] The commissioner shall enhance current data tools to ensure a statewide assessment of the risk behaviors associated with the health disparity priority areas identified in subdivision 1. The statewide assessment must be used to establish a baseline to measure the effect of activities funded under this section. To the extent feasible, the commissioner shall conduct the assessment so that the results may be compared to national data.

Subd. 5. [TECHNICAL ASSISTANCE.] The commissioner shall provide the necessary expertise to grant applicants to ensure that submitted proposals are likely to be successful in reducing the health disparities identified in subdivision 1. The commissioner shall provide grant recipients with guidance and training on best or most promising strategies to use to reduce the health disparities identified in subdivision 1. The commissioner shall also assist grant recipients in the development of materials and procedures to evaluate local community activities.

Subd. 6. [PROCESS.] (a) The commissioner, in consultation with the community partners listed in subdivision 2, shall develop the criteria and procedures used to allocate grants under this section. In developing the criteria, the commissioner shall establish an administrative cost limit for grant recipients. At the time a grant is awarded, the commissioner must provide a grant recipient with information on the outcomes established according to subdivision 3.

(b) A grant recipient must coordinate its activities to reduce health disparities with other entities receiving funds under this section that are in the grant recipient's service area.

Subd. 7. [COMMUNITY GRANT PROGRAM; IMMUNIZATION RATES AND INFANT MORTALITY RATES.] (a) The commissioner shall award grants to eligible applicants for local or regional projects and initiatives directed at reducing health disparities in one or both of the following priority areas:

- (1) decreasing racial and ethnic disparities in infant mortality rates; or
- (2) increasing adult and child immunization rates in nonwhite racial and ethnic populations.

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

(c) Eligible applicants may include, but are not limited to, faith-based organizations, social service organizations, community nonprofit organizations, community health boards, tribal governments, and community clinics. Applicants must submit proposals to the commissioner. A proposal must specify the strategies to be implemented to address one or both of the priority areas listed in paragraph (a) and must be targeted to achieve the outcomes established according to subdivision 3.

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

(1) is supported by the community the applicant will serve;

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

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

(4) utilizes strategies that positively impact both priority areas;

(5) reflects racially and ethnically appropriate approaches; and

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

Subd. 8. [COMMUNITY GRANT PROGRAM; OTHER HEALTH DISPARITIES.] (a) The commissioner shall award grants to eligible applicants for local or regional projects and initiatives directed at reducing health disparities in one or more of the following priority areas:

(1) decreasing racial and ethnic disparities in morbidity and mortality rates from breast and cervical cancer;

(2) decreasing racial and ethnic disparities in morbidity and mortality rates from HIV/AIDS and sexually transmitted infections;

(3) decreasing racial and ethnic disparities in morbidity and mortality rates from cardiovascular disease;

(4) decreasing racial and ethnic disparities in morbidity and mortality rates from diabetes; or

(5) decreasing racial and ethnic disparities in morbidity and mortality rates from accidental injuries or violence.

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

(c) Eligible applicants may include, but are not limited to, faith-based organizations, social service organizations, community nonprofit organizations, community health boards, tribal governments, and community clinics. Applicants shall submit proposals to the commissioner. A proposal must specify the strategies to be implemented to address one or more of the priority areas listed in paragraph (a) and must be targeted to achieve the outcomes established according to subdivision 3.

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

(1) is supported by the community the applicant will serve;

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

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

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

(5) reflects racially and ethnically appropriate approaches; and

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

Subd. 9. [REFUGEE AND IMMIGRANT HEALTH.] (a) The commissioner shall distribute funds to community health boards for health screening and follow-up services for tuberculosis for refugees. Funds shall be distributed based on the following formula:

- (1) \$1,500 per refugee with pulmonary tuberculosis in the community health board's service area;
- (2) \$500 per refugee with extrapulmonary tuberculosis in the community health board's service area;
- (3) \$500 per month of directly observed therapy provided by the community health board for each uninsured refugee with pulmonary or extrapulmonary tuberculosis; and
- (4) \$50 per refugee in the community health board's service area.

(b) Payments must be made at the end of each state fiscal year. The amount paid per tuberculosis case, per month of directly observed therapy, and per refugee must be proportionately increased or decreased to fit the actual amount appropriated for that fiscal year.

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

Subd. 11. [EVALUATION.] Using the outcomes established according to subdivision 3, the commissioner shall conduct a biennial evaluation of the community grant programs under subdivisions 7 and 8. Grant recipients shall cooperate with the commissioner in the evaluation and shall provide the commissioner with the information needed to conduct the evaluation.

Subd. 12. [REPORT.] By January 15, 2002, and January 15 of each even-numbered year thereafter, the commissioner shall submit a report to the legislature on the local community projects and community health board activities funded under this section. The report must include information on grant recipients, activities conducted using grant funds, and evaluation data and outcome measures if available.

Sec. 48. Minnesota Statutes 2000, section 145A.15, subdivision 1, is amended to read:

Subdivision 1. [ESTABLISHMENT.] (a) The commissioner of health shall expand the current grant program to fund additional projects designed to prevent child abuse and neglect and reduce juvenile delinquency by promoting positive parenting, resiliency in children, and a healthy beginning for children by providing early intervention services for families in need. Grant dollars shall be available to train paraprofessionals to provide in-home intervention services and to allow public health nurses to do case management of services. The grant program shall provide early intervention services for families in need and will include:

- (1) expansion of current public health nurse and family aide home visiting programs and public health home visiting projects which prevent child abuse and neglect, prevent juvenile delinquency, and build resiliency in children;
- (2) early intervention to promote a healthy and nurturing beginning;
- (3) distribution of educational and public information programs and materials in hospital maternity divisions, well-baby clinics, obstetrical clinics, and community clinics; and
- (4) training of home visitors in skills necessary for comprehensive home visiting which promotes a healthy and nurturing beginning for the child.

(b) No new grants shall be awarded under this section after June 30, 2001. Grant contracts awarded and in effect under this section as of July 1, 2001, shall continue until their expiration date.

Sec. 49. Minnesota Statutes 2000, section 145A.15, is amended by adding a subdivision to read:

Subd. 5. [EXPIRATION.] This section expires June 30, 2003.

Sec. 50. Minnesota Statutes 2000, section 145A.16, subdivision 1, is amended to read:

Subdivision 1. [ESTABLISHMENT.] The commissioner shall establish a grant program to fund universally offered home visiting programs designed to serve all live births in designated geographic areas. The commissioner shall designate the geographic area to be served by each program. At least one program must provide home visiting services to families within the seven-county metropolitan area, and at least one program must provide home visiting services to families outside the metropolitan area. The purpose of the program is to strengthen families and to promote positive parenting and healthy child development. No new grants shall be awarded under this section after June 30, 2001. Competitive grant contracts awarded and in effect under this section as of July 1, 2001, shall expire December 31, 2003.

Sec. 51. Minnesota Statutes 2000, section 145A.16, is amended by adding a subdivision to read:

Subd. 10. [EXPIRATION.] This section expires December 31, 2003.

Sec. 52. [145A.17] [FAMILY HOME VISITING PROGRAMS.]

Subdivision 1. [ESTABLISHMENT; GOALS.] The commissioner shall establish a program to fund family home visiting programs designed to foster a healthy beginning for children in families at or below 200 percent of the federal poverty guidelines, prevent child abuse and neglect, reduce juvenile delinquency, promote positive parenting and resiliency in children, and promote family health and economic self-sufficiency. A program funded under this section must serve families at or below 200 percent of the federal poverty guidelines, and other families determined to be at risk for child abuse, neglect, or juvenile delinquency. Programs must give priority for services to families considered to be in need of services, including but not limited to families with:

- (1) adolescent parents;
- (2) a history of alcohol or other drug abuse;
- (3) a history of child abuse, domestic abuse, or other types of violence;
- (4) a history of domestic abuse, rape, or other forms of victimization;
- (5) reduced cognitive functioning;
- (6) a lack of knowledge of child growth and development stages;
- (7) low resiliency to adversities and environmental stresses; or
- (8) insufficient financial resources to meet family needs.

Subd. 2. [ALLOCATION OF FUNDS.] The commissioner shall distribute funds available under this section to community health boards, as defined in section 145A.02, and to tribal governments. Funds shall be distributed to community health boards as follows: (1) each community health board shall receive an allocation of \$25,000 per year; and (2) remaining funds available to community health boards shall be distributed according to the formula in section 256J.625, subdivision 3. The commissioner, in consultation with tribal governments, shall establish a formula for distributing funds to tribal governments.

Subd. 3. [REQUIREMENTS FOR PROGRAMS; PROCESS.] (a) Before a community health board or tribal government may receive an allocation under subdivision 2, a community health board or tribal government must submit a proposal to the commissioner that includes identification, based on a community assessment, of the populations at or below 200 percent of the federal poverty guidelines that will be served and the other populations that will be served. Each program that receives funds must:

(1) use either a broad community-based or selective community-based strategy to provide preventive and early intervention home visiting services;

(2) offer a home visit by a trained home visitor. If a home visit is accepted, the first home visit must occur prenatally or as soon after birth as possible and must include a public health nursing assessment by a public health nurse;

(3) offer, at a minimum, information on infant care, child growth and development, positive parenting, preventing diseases, preventing exposure to environmental hazards, and support services available in the community;

(4) provide information on and referrals to health care services, if needed, including information on health care coverage for which the child or family may be eligible; and provide information on preventive services, developmental assessments, and the availability of public assistance programs as appropriate;

(5) recruit home visitors who will represent, to the extent possible, the races, cultures, and languages spoken by families that may be served;

(6) train and supervise home visitors in accordance with the requirements established under subdivision 4;

(7) maximize resources and minimize duplication by coordinating activities with local social and human services organizations, education organizations, and other appropriate governmental entities and community-based organizations and agencies; and

(8) utilize appropriate racial and ethnic approaches to providing home visiting services.

(b) Funds available under this section shall not be used for medical services. The commissioner shall establish an administrative cost limit for recipients of funds. The outcome measures established under subdivision 6 must be specified to recipients of funds at the time the funds are distributed.

Subd. 4. [TRAINING.] The commissioner shall establish training requirements for home visitors and minimum requirements for supervision by a public health nurse. The requirements for nurses must be consistent with chapter 148. Training must include child development, positive parenting techniques, and diverse cultural practices in child rearing and family systems.

Subd. 5. [TECHNICAL ASSISTANCE.] The commissioner shall provide administrative and technical assistance to each program, including assistance in data collection and other activities related to conducting short- and long-term evaluations of the programs as required under subdivision 7. The commissioner may request research and evaluation support from the University of Minnesota.

Subd. 6. [OUTCOME MEASURES.] The commissioner shall establish outcomes to determine the impact of family home visiting programs funded under this section on the following areas:

(1) appropriate utilization of preventive health care;

(2) rates of substantiated child abuse and neglect;

(3) rates of unintentional child injuries; and

(4) any additional qualitative goals and quantitative measures established by the commissioner.

Subd. 7. [EVALUATION.] Using the qualitative goals and quantitative outcome measures established under subdivisions 1 and 6, the commissioner shall conduct ongoing evaluations of the programs funded under this section. Community health boards and tribal governments shall cooperate with the commissioner in the evaluations and shall provide the commissioner with the information necessary to conduct the evaluations. As part of the ongoing evaluations, the commissioner shall rate the impact of the programs on the outcome measures listed in subdivision 6, and shall periodically determine whether home visiting programs are the best way to achieve the qualitative goals established in subdivision 1 and by the commissioner. If the commissioner determines that home visiting programs are not the best way to achieve these goals, the commissioner shall provide the legislature with alternative methods for achieving them.

Subd. 8. [REPORT.] By January 15, 2002, and January 15 of each even-numbered year thereafter, the commissioner shall submit a report to the legislature on the family home visiting programs funded under this section and on the results of the evaluations conducted under subdivision 7.

Subd. 9. [NO SUPPLANTING OF EXISTING FUNDS.] Funding available under this section may be used only to supplement, not to replace, nonstate funds being used for home visiting services as of July 1, 2001.

Sec. 53. Minnesota Statutes 2000, section 157.16, subdivision 3, is amended to read:

Subd. 3. [ESTABLISHMENT FEES; DEFINITIONS.] (a) The following fees are required for food and beverage service establishments, hotels, motels, lodging establishments, and resorts licensed under this chapter. Food and beverage service establishments must pay the highest applicable fee under paragraph (e), clause (1), (2), (3), or (4), and establishments serving alcohol must pay the highest applicable fee under paragraph (e), clause (6) or (7). The license fee for new operators previously licensed under this chapter for the same calendar year is one-half of the appropriate annual license fee, plus any penalty that may be required. The license fee for operators opening on or after October 1 is one-half of the appropriate annual license fee, plus any penalty that may be required. The fees in paragraphs (b), (c), and (d) effective until June 30, 2001, shall be phased up as specified in section 55 to the fee amounts effective beginning July 1, 2004. Notwithstanding section 16A.1285, in fiscal years 2002, 2003, and 2004, the commissioner shall regulate food and beverage service establishments, hotels, motels, lodging establishments, and resorts with the fees collected for that purpose.

(b) All food and beverage service establishments, except special event food stands, and all hotels, motels, lodging establishments, and resorts shall pay an annual base fee of \$100 until June 30, 2001. Effective July 1, 2004, the annual base fee shall be \$145.

(c) A special event food stand shall pay a flat fee of \$30 annually until June 30, 2001. Effective July 1, 2004, the annual flat fee shall be \$35. "Special event food stand" means a fee category where food is prepared or served in conjunction with celebrations, county fairs, or special events from a special event food stand as defined in section 157.15.

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

(1) Limited food menu selection, \$30 until June 30, 2001. Effective July 1, 2004, the annual fee shall be \$40. "Limited food menu selection" means a fee category that provides one or more of the following:

- (i) prepackaged food that receives heat treatment and is served in the package;
- (ii) frozen pizza that is heated and served;
- (iii) a continental breakfast such as rolls, coffee, juice, milk, and cold cereal;

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

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

(2) Small establishment, including boarding establishments, \$55 until June 30, 2001. Effective July 1, 2004, the annual fee shall be \$75. "Small establishment" means a fee category that has no salad bar and meets one or more of the following:

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

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

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

(iv) is a boarding establishment; or

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

(3) Medium establishment, \$150 until June 30, 2001. Effective July 1, 2004, the annual fee shall be \$210. "Medium establishment" means a fee category that meets one or more of the following:

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

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

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

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

(4) Large establishment, \$250 until June 30, 2001. Effective July 1, 2004, the annual fee shall be \$350. "Large establishment" means either:

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

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

(5) Other food and beverage service, including food carts, mobile food units, seasonal temporary food stands, and seasonal permanent food stands, \$30 until June 30, 2001. Effective July 1, 2004, the annual fee shall be \$40.

(6) Beer or wine table service, \$30 until June 30, 2001. Effective July 1, 2004, the annual fee shall be \$40. "Beer or wine table service" means a fee category where the only alcoholic beverage service is beer or wine, served to customers seated at tables.

(7) Alcoholic beverage service, other than beer or wine table service, \$75 until June 30, 2001. Effective July 1, 2004, the annual fee shall be \$105.

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

(8) Until June 30, 2001, lodging per sleeping accommodation unit, \$4, including hotels, motels, lodging establishments, and resorts, up to a maximum of \$400. Effective July 1, 2004, lodging per sleeping accommodation unit, \$6, including hotels, motels, lodging establishments, and resorts, up to a maximum of \$600. "Lodging per sleeping accommodation unit" means a fee category including the number of guest rooms, cottages, or other rental units of a hotel, motel, lodging establishment, or resort; or the number of beds in a dormitory.

(9) First public swimming pool, \$100 until June 30, 2001; each additional public swimming pool, \$50 until June 30, 2001. Effective July 1, 2004, first public swimming pool, \$140; each additional public swimming pool, \$80. "Public swimming pool" means a fee category that has the meaning given in Minnesota Rules, part 4717.0250, subpart 8.

(10) First spa, \$50 until June 30, 2001; each additional spa, \$25 until June 30, 2001. Effective July 1, 2004, first spa, \$80; each additional spa, \$40. "Spa pool" means a fee category that has the meaning given in Minnesota Rules, part 4717.0250, subpart 9.

(11) Private sewer or water, \$30 until June 30, 2001. Effective July 1, 2004, private sewer or water, \$40. "Individual private water" means a fee category with a water supply other than a community public water supply as defined in Minnesota Rules, chapter 4720. "Individual private sewer" means a fee category with an individual sewage treatment system which uses subsurface treatment and disposal.

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

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

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

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

Sec. 54. Minnesota Statutes 2000, section 157.22, is amended to read:

157.22 [EXEMPTIONS.]

This chapter shall not be construed to apply to:

- (1) interstate carriers under the supervision of the United States Department of Health and Human Services;
- (2) any building constructed and primarily used for religious worship;
- (3) any building owned, operated, and used by a college or university in accordance with health regulations promulgated by the college or university under chapter 14;
- (4) any person, firm, or corporation whose principal mode of business is licensed under sections 28A.04 and 28A.05, is exempt at that premises from licensure as a food or beverage establishment; provided that the holding of any license pursuant to sections 28A.04 and 28A.05 shall not exempt any person, firm, or corporation from the applicable provisions of this chapter or the rules of the state commissioner of health relating to food and beverage service establishments;
- (5) family day care homes and group family day care homes governed by sections 245A.01 to 245A.16;
- (6) nonprofit senior citizen centers for the sale of home-baked goods; ~~and~~



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

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

Sec. 55. [ESTABLISHMENT FEES DURING TRANSITION PERIOD.]

For fiscal years 2002, 2003, and 2004, the following fees shall apply to food and beverage service establishments, hotels, motels, lodging establishments, and resorts for which fees are established under Minnesota Statutes, section 157.16, subdivision 3, paragraphs (b), (c), and (d):

<u>Fee Category</u>	<u>Fiscal Year 2002</u>	<u>Fiscal Year 2003</u>	<u>Fiscal Year 2004</u>
<u>Annual base fee, all food and beverage service establishments except special event food stands and all hotels, motels, lodging establishments, and resorts</u>	<u>\$111.25</u>	<u>\$122.50</u>	<u>\$133.75</u>
<u>Special event food stand</u>	<u>\$ 31.25</u>	<u>\$ 32.50</u>	<u>\$ 33.75</u>
<u>Establishment with limited food menu selection</u>	<u>\$ 32.50</u>	<u>\$ 35.00</u>	<u>\$ 37.50</u>
<u>Small establishment</u>	<u>\$ 60.00</u>	<u>\$ 65.00</u>	<u>\$ 70.00</u>
<u>Medium establishment</u>	<u>\$165.00</u>	<u>\$180.00</u>	<u>\$195.00</u>
<u>Large establishment</u>	<u>\$275.00</u>	<u>\$300.00</u>	<u>\$325.00</u>
<u>Other food and beverage service</u>	<u>\$ 32.50</u>	<u>\$ 35.00</u>	<u>\$ 37.50</u>
<u>Beer or wine table service</u>	<u>\$ 32.50</u>	<u>\$ 35.00</u>	<u>\$ 37.50</u>
<u>Alcoholic beverage service other than beer or wine table service</u>	<u>\$ 82.50</u>	<u>\$ 90.00</u>	<u>\$ 97.50</u>
<u>Lodging per sleeping accommodation unit, up to a specified maximum</u>	<u>\$4.50 per unit, \$450 maximum</u>	<u>\$5.00 per unit, \$500 maximum</u>	<u>\$5.50 per unit, \$550 maximum</u>
<u>First public swimming pool</u>	<u>\$110.00</u>	<u>\$120.00</u>	<u>\$130.00</u>
<u>Each additional public swimming pool</u>	<u>\$ 57.50</u>	<u>\$ 65.00</u>	<u>\$ 72.50</u>
<u>First spa</u>	<u>\$ 57.50</u>	<u>\$ 65.00</u>	<u>\$ 72.50</u>
<u>Each additional spa</u>	<u>\$ 28.75</u>	<u>\$ 32.50</u>	<u>\$ 36.25</u>
<u>Private sewer or water</u>	<u>\$ 32.50</u>	<u>\$ 35.00</u>	<u>\$ 37.50</u>

Sec. 56. [REPEALER.]

(a) Minnesota Statutes 2000, sections 145.882, subdivisions 3 and 4; and 145.927, are repealed.

(b) Minnesota Statutes 2000, section 144.148, subdivision 8, is repealed.

**[EFFECTIVE DATE.]** Paragraph (b) of this section is effective the day following final enactment.

## ARTICLE 2

### HEALTH CARE

Section 1. Minnesota Statutes 2000, section 256.01, subdivision 2, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(12) Have the authority to conduct and administer experimental projects to test methods and procedures of administering assistance and services to recipients or potential recipients of public welfare. To carry out such experimental projects, it is further provided that the commissioner of human services is authorized to waive the enforcement of existing specific statutory program requirements, rules, and standards in one or more counties. The order establishing the waiver shall provide alternative methods and procedures of administration, shall not be in

conflict with the basic purposes, coverage, or benefits provided by law, and in no event shall the duration of a project exceed four years. It is further provided that no order establishing an experimental project as authorized by the provisions of this section shall become effective until the following conditions have been met:

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

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

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

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

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

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

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

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

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

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

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

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

(d) A county board that submits reports that are late, illegible, incomplete, or not in the required format for two out of three consecutive reporting periods is considered noncompliant. When a county board is found to be noncompliant, the commissioner shall notify the county board of the reason the county board is considered noncompliant and request that the county board develop a corrective action plan stating how the county board plans to correct the problem. The corrective action plan must be submitted to the commissioner within 45 days after the date the county board received notice of noncompliance.

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

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

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

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

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

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

(21) Have the authority to administer a drug rebate program for drugs purchased pursuant to the prescription drug program established under section 256.955 after the beneficiary's satisfaction of any deductible established in the program. The commissioner shall require a rebate agreement from all manufacturers of covered drugs as defined in section 256B.0625, subdivision 13. Rebate agreements for prescription drugs delivered on or after July 1, 2002, must include rebates for individuals covered under the prescription drug program who are under 65 years of age. For each drug, the amount of the rebate shall be equal to the basic rebate as defined for purposes of the federal rebate program in United States Code, title 42, section 1396r-8(c)(1). This basic rebate shall be applied to single-source

and multiple-source drugs. The manufacturers must provide full payment within 30 days of receipt of the state invoice for the rebate within the terms and conditions used for the federal rebate program established pursuant to section 1927 of title XIX of the Social Security Act. The manufacturers must provide the commissioner with any information necessary to verify the rebate determined per drug. The rebate program shall utilize the terms and conditions used for the federal rebate program established pursuant to section 1927 of title XIX of the Social Security Act.

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

~~(22)~~ (23) Operate the department's communication systems account established in Laws 1993, First Special Session chapter 1, article 1, section 2, subdivision 2, to manage shared communication costs necessary for the operation of the programs the commissioner supervises. A communications account may also be established for each regional treatment center which operates communications systems. Each account must be used to manage shared communication costs necessary for the operations of the programs the commissioner supervises. The commissioner may distribute the costs of operating and maintaining communication systems to participants in a manner that reflects actual usage. Costs may include acquisition, licensing, insurance, maintenance, repair, staff time and other costs as determined by the commissioner. Nonprofit organizations and state, county, and local government agencies involved in the operation of programs the commissioner supervises may participate in the use of the department's communications technology and share in the cost of operation. The commissioner may accept on behalf of the state any gift, bequest, devise or personal property of any kind, or money tendered to the state for any lawful purpose pertaining to the communication activities of the department. Any money received for this purpose must be deposited in the department's communication systems accounts. Money collected by the commissioner for the use of communication systems must be deposited in the state communication systems account and is appropriated to the commissioner for purposes of this section.

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

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

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

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

Subd. 2b. [ELIGIBILITY.] Effective July 1, 2002, an individual satisfying the following requirements and the requirements described in subdivision 2, paragraph (d), is eligible for the prescription drug program:

(1) is under 65 years of age; and

(2) is eligible as a qualified Medicare beneficiary according to section 256B.057, subdivision 3 or 3a, or is eligible under section 256B.057, subdivision 3 or 3a, and is also eligible for medical assistance or general assistance medical care with a spenddown as defined in section 256B.056, subdivision 5.

Sec. 3. [256.956] [PURCHASING ALLIANCE STOP-LOSS FUND.]

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

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

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

(c) "Health plan company" means:

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

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

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

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

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

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

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

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

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

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

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

(1) meets the requirements of chapter 62T;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 8. [REPORT.] The commissioner of commerce, in consultation with the office of rural health and the qualifying purchasing alliances, shall evaluate the extent to which the purchasing alliance stop-loss fund increases the availability of employer-subsidized health care coverage for residents residing in the geographic areas served by the qualifying purchasing alliances. A preliminary report must be submitted to the legislature by February 15, 2003, and a final report must be submitted by February 15, 2004.

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

Sec. 4. [256.958] [RETIRED DENTIST PROGRAM.]

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



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

- (1) documentation of service provided;
- (2) the cost of malpractice insurance for the 12-month period; and
- (3) the cost of the license.

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

Sec. 5. Minnesota Statutes 2000, section 256.9657, subdivision 2, is amended to read:

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

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

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

Sec. 6. Minnesota Statutes 2000, section 256.969, subdivision 2b, is amended to read:

Subd. 2b. [OPERATING PAYMENT RATES.] In determining operating payment rates for admissions occurring on or after the rate year beginning January 1, 1991, and every two years after, or more frequently as determined by the commissioner, the commissioner shall obtain operating data from an updated base year and, within the limits of available appropriations, establish operating payment rates per admission for each hospital based on the cost-finding methods and allowable costs of the Medicare program in effect during the base year. Rates under the general assistance medical care, medical assistance, and MinnesotaCare programs shall not be rebased to more current data on January 1, 1997. The base year operating payment rate per admission is standardized by the case mix index and adjusted by the hospital cost index, relative values, and disproportionate population adjustment. The cost and charge data used to establish operating rates shall only reflect inpatient services covered by medical assistance and shall not include property cost information and costs recognized in outlier payments.

Sec. 7. Minnesota Statutes 2000, section 256.969, is amended by adding a subdivision to read:

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

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

(2) the rate in clause (1) plus a proportion of the difference between the current average payment rate for that diagnostic category for hospitals located within the seven-county metropolitan area, exclusive of disproportionate population adjustments received under subdivision 9 and hospital payment adjustments received under subdivision 23, and the current rate in clause (1). This proportion shall be 12.5 percent for the fiscal year beginning July 1, 2001, and shall increase by 12.5 percentage points for each of the next seven fiscal years, such that the proportion is 100 percent for the fiscal year beginning July 1, 2008.

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

- (1) 370 C-section with complicating diagnosis;
- (2) 371 C-section without complicating diagnosis;
- (3) 372 vaginal delivery with complicating diagnosis;
- (4) 373 vaginal delivery without complicating diagnosis;
- (5) 386 extreme immaturity, weight greater than 1,500 grams;
- (6) 388 full-term neonates with other problems;
- (7) 390 prematurity without major problems;
- (8) 391 normal newborn case;
- (9) 385 neonate, died or transferred to another health care facility;
- (10) 425 acute adjustment reaction and psychosocial dysfunctioning;
- (11) 430 psychosis;
- (12) 431 childhood mental disorders; and
- (13) 164-167 appendectomy.

Sec. 8. Minnesota Statutes 2000, section 256B.04, is amended by adding a subdivision to read:

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

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

Sec. 9. Minnesota Statutes 2000, section 256B.055, subdivision 3a, is amended to read:

Subd. 3a. ~~[MFIP-S FAMILIES; FAMILIES ELIGIBLE UNDER PRIOR AFDC RULES.]~~ (a) Beginning January 1, 1998, or on the date that MFIP-S is implemented in counties, medical assistance may be paid for a person receiving public assistance under the MFIP-S program. Beginning July 1, 2002, medical assistance may be paid for a person who would have been eligible, but for excess income or assets, under the state's AFDC plan in effect as of July 16, 1996, with the base AFDC standard increased by three percent effective July 1, 2000.

(b) Beginning ~~January 1, 1998~~, July 1, 2002, medical assistance may be paid for a person who would have been eligible for public assistance under the income and ~~resource~~ assets standards, ~~or who would have been eligible but for excess income or assets~~, under the state's AFDC plan in effect as of July 16, 1996, ~~as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law Number 104-193 with the base AFDC rate increased by three percent effective July 1, 2000.~~

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

Sec. 10. Minnesota Statutes 2000, section 256B.056, subdivision 1a, is amended to read:

Subd. 1a. [INCOME AND ASSETS GENERALLY.] Unless specifically required by state law or rule or federal law or regulation, the methodologies used in counting income and assets to determine eligibility for medical assistance for persons whose eligibility category is based on blindness, disability, or age of 65 or more years, the methodologies for the supplemental security income program shall be used. Effective upon federal approval, for children eligible under section 256B.055, subdivision 12, or for home and community-based waiver services whose eligibility for medical assistance is determined without regard to parental income, child support payments, including any payments made by an obligor in satisfaction of or in addition to a temporary or permanent order for child support, social security payments, and other benefits for basic needs are not counted as income. For families and children, which includes all other eligibility categories, the methodologies under the state's AFDC plan in effect as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law Number 104-193, shall be used. Effective upon federal approval, in-kind contributions to, and payments made on behalf of, a recipient, by an obligor, in satisfaction of or in addition to a temporary or permanent order for child support or maintenance, shall be considered income to the recipient. For these purposes, a "methodology" does not include an asset or income standard, or accounting method, or method of determining effective dates.

Sec. 11. Minnesota Statutes 2000, section 256B.056, subdivision 3, is amended to read:

Subd. 3. [ASSET LIMITATIONS.] To be eligible for medical assistance, a person must not individually own more than \$3,000 in assets, or if a member of a household with two family members, husband and wife, or parent and child, the household must not own more than \$6,000 in assets, plus \$200 for each additional legal dependent. In addition to these maximum amounts, an eligible individual or family may accrue interest on these amounts, but they must be reduced to the maximum at the time of an eligibility redetermination. The accumulation of the clothing and personal needs allowance according to section 256B.35 must also be reduced to the maximum at the time of the eligibility redetermination. The value of assets that are not considered in determining eligibility for medical assistance is the value of those assets excluded under the AFDC state plan as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law Number 104-193, for families and children, and the supplemental security income program for aged, blind, and disabled persons, with the following exceptions:

(a) Household goods and personal effects are not considered.

(b) Capital and operating assets of a trade or business that the local agency determines are necessary to the person's ability to earn an income are not considered.

(c) Motor vehicles are excluded to the same extent excluded by the supplemental security income program.

(d) Assets designated as burial expenses are excluded to the same extent excluded by the supplemental security income program.

(e) Effective upon federal approval, for a person who no longer qualifies as an employed person with a disability due to loss of earnings, assets allowed while eligible for medical assistance under section 256B.057, subdivision 9, are not considered for 12 months, beginning with the first month of ineligibility as an employed person with a disability, to the extent that the person's total assets remain within the allowed limits of section 256B.057, subdivision 9, paragraph (b).

Sec. 12. Minnesota Statutes 2000, section 256B.056, subdivision 4, is amended to read:

Subd. 4. [INCOME.] (a) To be eligible for medical assistance, a person eligible under section 256B.055, subdivision subdivisions 7, 7a, and 12, not receiving supplemental security income program payments, and may have income up to the following specified percentages of the federal poverty guidelines for the family size effective on April 1 of each year:

(1) 80 percent, effective July 1, 2002;

(2) 90 percent, effective July 1, 2003;

(3) 100 percent, effective July 1, 2004.

Increases in benefits under title II of the Social Security Act shall not be counted as income for purposes of this subdivision until the first day of the second full month following publication of the change in the federal poverty guidelines.

(b) To be eligible for medical assistance, families and children may have an income up to 133-1/3 percent of the AFDC income standard in effect under the July 16, 1996, AFDC state plan. Effective July 1, 2000, the base AFDC standard in effect on July 16, 1996, shall be increased by three percent. Effective January 1, 2000, and each successive January, recipients of supplemental security income may have an income up to the supplemental security income standard in effect on that date.

(c) Effective July 1, 2002, to be eligible for medical assistance, families and children may have an income up to 100 percent of the federal poverty guidelines for the family size effective on April 1 of each year.

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

Sec. 13. Minnesota Statutes 2000, section 256B.056, subdivision 5, is amended to read:

Subd. 5. [EXCESS INCOME.] A person who has excess income is eligible for medical assistance if the person has expenses for medical care that are more than the amount of the person's excess income, computed by deducting incurred medical expenses from the excess income to reduce the excess to the income standard specified in subdivision 4, except that if federal authorization to use the standard in subdivision 4 is not obtained, the medically needy standard for purposes of a spenddown shall be 133 and 1/3 percent of the AFDC income standard in effect under the July 16, 1996, AFDC state plan, increased by three percent. The person shall elect to have the medical expenses deducted at the beginning of a one-month budget period or at the beginning of a six-month budget period. The commissioner shall allow persons eligible for assistance on a one-month spenddown basis under this subdivision to elect to pay the monthly spenddown amount in advance of the month of eligibility to the state agency in order to maintain eligibility on a continuous basis. If the recipient does not pay the spenddown amount on or before the 20th of the month, the recipient is ineligible for this option for the following month. The local agency shall code the Medicaid Management Information System (MMIS) to indicate that the recipient has elected this option. The state agency shall convey recipient eligibility information relative to the collection of the spenddown to providers through the Electronic Verification System (EVS). A recipient electing advance payment must pay the state agency the monthly spenddown amount on or before the 20th of the month in order to be eligible for this option in the following month.

Sec. 14. Minnesota Statutes 2000, section 256B.057, subdivision 9, is amended to read:

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

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

- (2) is at least 16 but less than 65 years of age;
- (3) meets the asset limits in paragraph (b); and
- (4) pays a premium, if required, under paragraph (c).

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

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

- (1) all assets excluded under section 256B.056;
- (2) retirement accounts, including individual accounts, 401(k) plans, 403(b) plans, Keogh plans, and pension plans; and
- (3) medical expense accounts set up through the person's employer.

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

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

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

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

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

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

Sec. 15. Minnesota Statutes 2000, section 256B.057, is amended by adding a subdivision to read:

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

(1) has been screened for breast or cervical cancer by the Minnesota breast and cervical cancer control program, and program funds have been used to pay for the person's screening;

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

(3) meets the income eligibility guidelines for the Minnesota breast and cervical cancer control program;

(4) is under age 65;

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

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

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

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

Sec. 16. Minnesota Statutes 2000, section 256B.0625, subdivision 3b, is amended to read:

Subd. 3b. [TELEMEDICINE CONSULTATIONS.] ~~(a)~~ Medical assistance covers telemedicine consultations. Telemedicine consultations must be made via two-way, interactive video or store-and-forward technology. Store-and-forward technology includes telemedicine consultations that do not occur in real time via synchronous transmissions, and that do not require a face-to-face encounter with the patient for all or any part of any such telemedicine consultation. The patient record must include a written opinion from the consulting physician providing the telemedicine consultation. A communication between two physicians that consists solely of a telephone conversation is not a telemedicine consultation. Coverage is limited to three telemedicine consultations per recipient per calendar week. Telemedicine consultations shall be paid at the full allowable rate.

~~(b) This subdivision expires July 1, 2001.~~

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

Subd. 5a. [INTENSIVE EARLY INTERVENTION BEHAVIOR THERAPY SERVICES FOR CHILDREN WITH AUTISM SPECTRUM DISORDERS.] (a) [COVERAGE.] Medical assistance covers home-based intensive early intervention behavior therapy for children with autism spectrum disorders. Children with autism spectrum disorder, and their custodial parents or foster parents, may access other covered services to treat autism spectrum disorder, and are not required to receive intensive early intervention behavior therapy services under this subdivision. Intensive early intervention behavior therapy does not include coverage for services to treat developmental disorders of language, early onset psychosis, Rett's disorder, selective mutism, social anxiety disorder, stereotypic movement disorder, dementia, obsessive compulsive disorder, schizoid personality disorder, avoidant personality disorder, or reactive attachment disorder. If a child with autism spectrum disorder is diagnosed to have one or more of these conditions, intensive early intervention behavior therapy includes coverage only for services necessary to treat the autism spectrum disorder.

(b) [PURPOSE OF INTENSIVE EARLY INTERVENTION BEHAVIOR THERAPY SERVICES (IEIBTS).] The purpose of IEIBTS is to improve the child's behavioral functioning, to prevent development of challenging behaviors, to eliminate autistic behaviors, to reduce the risk of out-of-home placement, and to establish independent typical functioning in language and social behavior. The procedures used to accomplish these goals are based upon research in applied behavior analysis.

(c) [ELIGIBLE CHILDREN.] A child is eligible to initiate IEIBTS if, the child meets the additional eligibility criteria in paragraph (d) and in a diagnostic assessment by a mental health professional who is not under the employ of the service provider, the child:

(1) is found to have an autism spectrum disorder;

- (2) has a current IQ of either untestable, or at least 30;
- (3) if nonverbal, initiated behavior therapy by 42 months of age;
- (4) if verbal, initiated behavior therapy by 48 months of age; or
- (5) if having an IQ of at least 50, initiated behavior therapy by 84 months of age.

To continue in IEIBTS, at least one of the child's custodial parents or foster parents must participate in an average of at least five hours of documented behavior therapy per week for six months, and consistently implement behavior therapy recommendations 24 hours a day. To continue after six-month individualized treatment plan (ITP) reviews, the child must show documented progress toward mastery of six-month benchmark behavior objectives. The maximum number of months during which services may be billed is 54. If significant progress towards treatment goals has not been achieved after 24 months of treatment, treatment must be discontinued.

(d) [ADDITIONAL ELIGIBILITY CRITERIA.] A child is eligible to initiate IEIBTS if:

(1) in medical and diagnostic assessments by medical and mental health professionals, it is determined that the child does not have severe or profound mental retardation;

(2) an accurate assessment of the child's hearing has been performed, including audiometry if the brain stem auditory evokes response;

(3) a blood lead test has been performed prior to initiation of treatment; and

(4) an EEG or neurologic evaluation is done, prior to initiation of treatment, if the child has a history of staring spells or developmental regression.

(e) [COVERED SERVICES.] The focus of IEIBTS must be to treat the principal diagnostic features of the autism spectrum disorder. All IEIBTS must be delivered by a team of practitioners under the consistent supervision of a single clinical supervisor. A mental health professional must develop the ITP for IEIBTS. The ITP must include six-month benchmark behavior objectives. All behavior therapy must be based upon research in applied behavior analysis, with an emphasis upon positive reinforcement of carefully task-analyzed skills for optimum rates of progress. All behavior therapy must be consistently applied and generalized throughout the 24-hour day and seven-day week by all of the child's regular care providers. When placing the child in school activities, a majority of the peers must have no mental health diagnosis, and the child must have sufficient social skills to succeed with 80 percent of the school activities. Reactive consequences, such as redirection, correction, positive practice, or time-out, must be used only when necessary to improve the child's success when proactive procedures alone have not been effective. IEIBTS must be delivered by a team of behavior therapy practitioners who are employed under the direction of the same agency. The team may deliver up to 200 billable hours per year of direct clinical supervisor services, up to 750 billable hours per year of senior behavior therapist services, and up to 1,800 billable hours per year of direct behavior therapist services. A one-hour clinical review meeting for the child, parents, and staff must be scheduled 50 weeks a year, at which behavior therapy is reviewed and planned. At least one-quarter of the annual clinical supervisor billable hours shall consist of on-site clinical meeting time. At least one-half of the annual senior behavior therapist billable hours shall consist of direct services to the child or parents. All of the behavioral therapist billable hours shall consist of direct on-site services to the child or parents. None of the senior behavior therapist billable hours or behavior therapist billable hours shall consist of clinical meeting time. If there is any regression of the autistic spectrum disorder after 12 months of therapy, a neurologic consultation must be performed.

(f) [PROVIDER QUALIFICATIONS.] The provider agency must be capable of delivering consistent applied behavior analysis (ABA)-based behavior therapy in the home. The site director of the agency must be a mental health professional certified as a behavior analyst by the Association for Behavior Analysis. Each clinical supervisor must be certified as a behavior analyst by the Association for Behavior Analysis.

(g) [SUPERVISION REQUIREMENTS.] (1) Each behavior therapist practitioner must be continuously supervised while in the home until the practitioner has mastered competencies for independent practice. Each behavior therapist must have mastered three credits of academic content and practice in an ABA sequence at an accredited university. A college degree or minimum hours of experience are not required. Each behavior therapist must continue training through weekly direct observation by the senior behavior therapist, through demonstrated performance in clinical meetings with the clinical supervisor, and annual training in ABA.

(2) Each senior behavior therapist practitioner must have mastered the senior behavior therapy competencies, completed one year of practice as a behavior therapist, and six months of co-therapy training with another senior behavior therapist or have an equivalent amount of experience in ABA. Each senior behavior therapist must have mastered 12 credits of academic content and practice in an ABA sequence at an accredited university. Each senior behavior therapist must continue training through demonstrated performance in clinical meetings with the clinical supervisor, and annual training in ABA.

(3) Each clinical supervisor practitioner must have mastered the clinical supervisor and family consultation competencies, completed two years of practice as a senior behavior therapist and one year of co-therapy training with another clinical supervisor, or equivalent experience in ABA. Each clinical supervisor must continue training through annual training in ABA.

(h) [PLACE OF SERVICE.] IEIBTS are provided primarily in the child's home and community. Services may be provided in the child's natural school or preschool classroom, home of a relative, natural recreational setting, or day care.

(i) [PRIOR AUTHORIZATION REQUIREMENTS.] Prior authorization shall be required for services provided after 200 hours of clinical supervisor, 750 hours of senior behavior therapist, or 1,800 hours of behavior therapist services per year.

(j) [PAYMENT RATES.] The following payment rates apply:

(1) for an IEIBTS clinical supervisor practitioner under supervision of a mental health professional, the lower of the submitted charge or \$137 per hour unit;

(2) for an IEIBTS senior behavior therapist practitioner under supervision of a mental health professional, the lower of the submitted charge or \$56 per hour unit; or

(3) for an IEIBTS behavior therapist practitioner under supervision of a mental health professional, the lower of the submitted charge or \$19 per hour unit.

An IEIBTS practitioner may receive payment for travel time which exceeds 50 minutes one-way. The maximum payment allowed will be \$0.51 per minute for up to a maximum of 300 hours per year.

For any week during which the above charges are made to medical assistance, payments for the following services are excluded: supervising mental health professional hours and personal care attendant, home-based mental health, family-community support, or mental health behavioral aide hours.

(k) [REPORT.] The commissioner shall collect evidence of the effectiveness of intensive early intervention behavior therapy services and present a report to the legislature by July 1, 2006.

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

Sec. 18. Minnesota Statutes 2000, section 256B.0625, subdivision 13, is amended to read:

Subd. 13. [DRUGS.] (a) Medical assistance covers drugs, except for fertility drugs when specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed by a licensed pharmacist, by a physician enrolled in the medical assistance program as a dispensing physician, or by a physician or a nurse practitioner



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

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

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

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

(3) the commissioner must provide information to the formulary committee on the impact that placing the drug on prior authorization will have on the quality of patient care and information regarding whether the drug is subject to clinical abuse or misuse. Prior authorization may be required by the commissioner before certain formulary drugs are eligible for payment. The formulary shall not include:

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

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

(iii) anorectics, except that medically necessary anorectics shall be covered for a recipient previously diagnosed as having pickwickian syndrome and currently diagnosed as having diabetes and being morbidly obese;

(iv) drugs for which medical value has not been established; and

(v) drugs from manufacturers who have not signed a rebate agreement with the Department of Health and Human Services pursuant to section 1927 of title XIX of the Social Security Act.

The commissioner shall publish conditions for prohibiting payment for specific drugs after considering the formulary committee's recommendations. An honorarium of \$100 per meeting and reimbursement for mileage shall be paid to each committee member in attendance.

(c) The basis for determining the amount of payment shall be the lower of the actual acquisition costs of the drugs plus a fixed dispensing fee; the maximum allowable cost set by the federal government or by the commissioner plus the fixed dispensing fee; or the usual and customary price charged to the public. The pharmacy dispensing fee shall be \$3.65, except that the dispensing fee for intravenous solutions which must be compounded by the pharmacist shall be \$8 per bag, \$14 per bag for cancer chemotherapy products, and \$30 per bag for total parenteral nutritional products dispensed in one liter quantities, or \$44 per bag for total parenteral nutritional products dispensed in quantities greater than one liter. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. The actual acquisition cost of a drug shall be estimated by the commissioner, at average wholesale price minus nine percent, except that where a drug has had its wholesale price reduced as a result of the actions of the National Association of Medicaid Fraud Control Units, the estimated actual acquisition cost shall be the reduced average wholesale price, without the nine percent deduction. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to, but no higher than, the maximum amount paid by other third-party payors in this state who have maximum allowable cost programs. The commissioner shall set maximum allowable costs for multisource drugs that are not on the federal upper limit list as described in United States Code, title 42, chapter 7, section 1396r-8(e), the Social Security Act, and Code of Federal Regulations, title 42, part 447, section 447.332. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act. An additional dispensing fee of \$.30 may be added to the dispensing fee paid to pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities when a unit dose blister card system, approved by the department, is used. Under this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister card must be identified on the claim to the department. The unit dose blister card containing the drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider will be required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse. Over-the-counter medications must be dispensed in the manufacturer's unopened package. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply. Whenever a generically equivalent product is available, payment shall be on the basis of the actual acquisition cost of the generic drug, unless the prescriber specifically indicates "dispense as written - brand necessary" on the prescription as required by section 151.21, subdivision 2.

(d) For purposes of this subdivision, "multisource drugs" means covered outpatient drugs, excluding innovator multisource drugs for which there are two or more drug products, which:

(1) are related as therapeutically equivalent under the Food and Drug Administration's most recent publication of "Approved Drug Products with Therapeutic Equivalence Evaluations";

(2) are pharmaceutically equivalent and bioequivalent as determined by the Food and Drug Administration; and

(3) are sold or marketed in Minnesota.

"Innovator multisource drug" means a multisource drug that was originally marketed under an original new drug application approved by the Food and Drug Administration.

(e) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider; the average wholesale price minus five percent; or the maximum allowable cost set by the federal government under United States Code, title 42, chapter 7, section 1396r-8(e) and Code of Federal Regulations, title 42, section 447.332, or by the commissioner under paragraph (c).

Sec. 19. Minnesota Statutes 2000, section 256B.0625, subdivision 13a, is amended to read:

Subd. 13a. [DRUG UTILIZATION REVIEW BOARD.] A nine-member drug utilization review board is established. The board is comprised of at least three but no more than four licensed physicians actively engaged in the practice of medicine in Minnesota; at least three licensed pharmacists actively engaged in the practice of

pharmacy in Minnesota; and one consumer representative; the remainder to be made up of health care professionals who are licensed in their field and have recognized knowledge in the clinically appropriate prescribing, dispensing, and monitoring of covered outpatient drugs. The board shall be staffed by an employee of the department who shall serve as an ex officio nonvoting member of the board. The members of the board shall be appointed by the commissioner and shall serve three-year terms. The members shall be selected from lists submitted by professional associations. The commissioner shall appoint the initial members of the board for terms expiring as follows: three members for terms expiring June 30, 1996; three members for terms expiring June 30, 1997; and three members for terms expiring June 30, 1998. Members may be reappointed once. The board shall annually elect a chair from among the members.

The commissioner shall, with the advice of the board:

(1) implement a medical assistance retrospective and prospective drug utilization review program as required by United States Code, title 42, section 1396r-8(g)(3);

(2) develop and implement the predetermined criteria and practice parameters for appropriate prescribing to be used in retrospective and prospective drug utilization review;

(3) develop, select, implement, and assess interventions for physicians, pharmacists, and patients that are educational and not punitive in nature;

(4) establish a grievance and appeals process for physicians and pharmacists under this section;

(5) publish and disseminate educational information to physicians and pharmacists regarding the board and the review program;

(6) adopt and implement procedures designed to ensure the confidentiality of any information collected, stored, retrieved, assessed, or analyzed by the board, staff to the board, or contractors to the review program that identifies individual physicians, pharmacists, or recipients;

(7) establish and implement an ongoing process to (i) receive public comment regarding drug utilization review criteria and standards, and (ii) consider the comments along with other scientific and clinical information in order to revise criteria and standards on a timely basis; and

(8) adopt any rules necessary to carry out this section.

The board may establish advisory committees. The commissioner may contract with appropriate organizations to assist the board in carrying out the board's duties. The commissioner may enter into contracts for services to develop and implement a retrospective and prospective review program.

The board shall report to the commissioner annually on the date the Drug Utilization Review Annual Report is due to the Health Care Financing Administration. This report is to cover the preceding federal fiscal year. The commissioner shall make the report available to the public upon request. The report must include information on the activities of the board and the program; the effectiveness of implemented interventions; administrative costs; and any fiscal impact resulting from the program. An honorarium of ~~\$50~~ \$100 per meeting and reimbursement for mileage shall be paid to each board member in attendance.

Sec. 20. Minnesota Statutes 2000, section 256B.0625, subdivision 17, is amended to read:

Subd. 17. [TRANSPORTATION COSTS.] (a) Medical assistance covers transportation costs incurred solely for obtaining emergency medical care or transportation costs incurred by nonambulatory persons in obtaining emergency or nonemergency medical care when paid directly to an ambulance company, common carrier, or other recognized providers of transportation services. For the purpose of this subdivision, a person who is incapable of transport by taxicab or bus shall be considered to be nonambulatory.

(b) Medical assistance covers special transportation, as defined in Minnesota Rules, part 9505.0315, subpart 1, item F, if the provider receives and maintains a current physician's order by the recipient's attending physician certifying that the recipient has a physical or mental impairment that would prohibit the recipient from safely accessing and using a bus, taxi, other commercial transportation, or private automobile. Special transportation includes driver-assisted service to eligible individuals. Driver-assisted service includes passenger pickup at and return to the individual's residence or place of business, assistance with admittance of the individual to the medical facility, and assistance in passenger securement or in securing of wheelchairs or stretchers in the vehicle. The commissioner shall establish maximum medical assistance reimbursement rates for special transportation services for persons who need a wheelchair ~~lift~~ accessible van or stretcher-equipped vehicle and for those who do not need a wheelchair ~~lift~~ accessible van or stretcher-equipped vehicle. The average of these two rates per trip must not exceed \$15 for the base rate and ~~\$1.20~~ \$1.50 per mile. Special transportation provided to ~~nonambulatory~~ ambulatory persons who do not need a wheelchair lift van or stretcher-equipped vehicle, may be reimbursed at a lower rate than special transportation provided to persons who need a wheelchair lift van or stretcher-equipped vehicle.

Sec. 21. Minnesota Statutes 2000, section 256B.0625, subdivision 17a, is amended to read:

Subd. 17a. [PAYMENT FOR AMBULANCE SERVICES.] Effective for services rendered on or after July 1, ~~1999~~ 2001, medical assistance payments for ambulance services shall be ~~increased by five percent paid at the greater of: (1) the medical assistance reimbursement rate in effect on June 30, 2000; or (2) the current Medicare reimbursement rate for ambulance services.~~

Sec. 22. Minnesota Statutes 2000, section 256B.0625, subdivision 18a, is amended to read:

Subd. 18a. [~~PAYMENT FOR MEALS AND LODGING~~ ACCESS TO MEDICAL SERVICES.] (a) Medical assistance reimbursement for meals for persons traveling to receive medical care may not exceed \$5.50 for breakfast, \$6.50 for lunch, or \$8 for dinner.

(b) Medical assistance reimbursement for lodging for persons traveling to receive medical care may not exceed \$50 per day unless prior authorized by the local agency.

(c) Medical assistance direct mileage reimbursement to the eligible person or the eligible person's driver may not exceed 20 cents per mile.

(d) Medical assistance covers oral language interpreter services when provided by an enrolled health care provider during the course of providing a direct, person-to-person covered health care service to an enrolled recipient with limited English proficiency.

Sec. 23. Minnesota Statutes 2000, section 256B.0625, subdivision 30, is amended to read:

Subd. 30. [OTHER CLINIC SERVICES.] (a) Medical assistance covers rural health clinic services, federally qualified health center services, nonprofit community health clinic services, public health clinic services, and the services of a clinic meeting the criteria established in rule by the commissioner. Rural health clinic services and federally qualified health center services mean services defined in United States Code, title 42, section 1396d(a)(2)(B) and (C). Payment for rural health clinic and federally qualified health center services shall be made according to applicable federal law and regulation.

(b) A federally qualified health center that is beginning initial operation shall submit an estimate of budgeted costs and visits for the initial reporting period in the form and detail required by the commissioner. A federally qualified health center that is already in operation shall submit an initial report using actual costs and visits for the initial reporting period. Within 90 days of the end of its reporting period, a federally qualified health center shall submit, in the form and detail required by the commissioner, a report of its operations, including allowable costs actually incurred for the period and the actual number of visits for services furnished during the period, and other information required by the commissioner. Federally qualified health centers that file Medicare cost reports shall provide the commissioner with a copy of the most recent Medicare cost report filed with the Medicare program intermediary for the reporting year which support the costs claimed on their cost report to the state.

(c) In order to continue cost-based payment under the medical assistance program according to paragraphs (a) and (b), a federally qualified health center or rural health clinic must apply for designation as an essential community provider within six months of final adoption of rules by the department of health according to section 62Q.19, subdivision 7. For those federally qualified health centers and rural health clinics that have applied for essential community provider status within the six-month time prescribed, medical assistance payments will continue to be made according to paragraphs (a) and (b) for the first three years after application. For federally qualified health centers and rural health clinics that either do not apply within the time specified above or who have had essential community provider status for three years, medical assistance payments for health services provided by these entities shall be according to the same rates and conditions applicable to the same service provided by health care providers that are not federally qualified health centers or rural health clinics.

(d) Effective July 1, 1999, the provisions of paragraph (c) requiring a federally qualified health center or a rural health clinic to make application for an essential community provider designation in order to have cost-based payments made according to paragraphs (a) and (b) no longer apply.

(e) Effective January 1, 2000, payments made according to paragraphs (a) and (b) shall be limited to the cost phase-out schedule of the Balanced Budget Act of 1997.

(f) Effective January 1, 2001, each federally qualified health center and rural health clinic may elect to be paid either under the prospective payment system established in United States Code, title 42, section 1396a, paragraph (a) or under an alternative payment methodology consistent with the requirements of United States Code, title 42, section 1392a, paragraph (a) and approved by the health care financing administration. The alternative payment methodology shall be 100 percent of cost as determined according to Medicare cost principles.

Sec. 24. Minnesota Statutes 2000, section 256B.0625, subdivision 34, is amended to read:

Subd. 34. [INDIAN HEALTH SERVICES FACILITIES.] Medical assistance payments and MinnesotaCare payments to facilities of the Indian health service and facilities operated by a tribe or tribal organization under funding authorized by United States Code, title 25, sections 450f to 450n, or title III of the Indian Self-Determination and Education Assistance Act, Public Law Number 93-638, for enrollees who are eligible for federal financial participation, shall be at the option of the facility in accordance with the rate published by the United States Assistant Secretary for Health under the authority of United States Code, title 42, sections 248(a) and 249(b). General assistance medical care payments to facilities of the Indian health services and facilities operated by a tribe or tribal organization for the provision of outpatient medical care services billed after June 30, 1990, must be in accordance with the general assistance medical care rates paid for the same services when provided in a facility other than a facility of the Indian health service or a facility operated by a tribe or tribal organization. MinnesotaCare payments for enrollees who are not eligible for federal financial participation at facilities of the Indian Health Service and facilities operated by a tribe or tribal organization for the provision of outpatient medical services must be in accordance with the medical assistance rates paid for the same services when provided in a facility other than a facility of the Indian Health Service or a facility operated by a tribe or tribal organization.

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

Sec. 25. Minnesota Statutes 2000, section 256B.0635, subdivision 1, is amended to read:

Subdivision 1. [INCREASED EMPLOYMENT.] ~~Beginning January 1, 1998 (a) Until June 30, 2002,~~ medical assistance may be paid for persons who received MFIP-S or medical assistance for families and children in at least three of six months preceding the month in which the person became ineligible for MFIP-S or medical assistance, if the ineligibility was due to an increase in hours of employment or employment income or due to the loss of an earned income disregard. In addition, to receive continued assistance under this section, persons who received medical assistance for families and children but did not receive MFIP-S must have had income less than or equal to the assistance standard for their family size under the state's AFDC plan in effect as of July 16, 1996, ~~as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law Number 104-193,~~ increased by three percent effective July 1, 2000, at the time medical assistance eligibility began.

A person who is eligible for extended medical assistance is entitled to six months of assistance without reapplication, unless the assistance unit ceases to include a dependent child. For a person under 21 years of age, medical assistance may not be discontinued within the six-month period of extended eligibility until it has been determined that the person is not otherwise eligible for medical assistance. Medical assistance may be continued for an additional six months if the person meets all requirements for the additional six months, according to title XIX of the Social Security Act, as amended by section 303 of the Family Support Act of 1988, Public Law Number 100-485.

(b) Beginning July 1, 2002, medical assistance for families and children may be paid for persons who were eligible under section 256B.055, subdivision 3a, paragraph (b), in at least three of six months preceding the month in which the person became ineligible under that section if the ineligibility was due to an increase in hours of employment or employment income or due to the loss of an earned income disregard. A person who is eligible for extended medical assistance is entitled to six months of assistance without reapplication, unless the assistance unit ceases to include a dependent child, except medical assistance may not be discontinued for that dependent child under 21 years of age within the six-month period of extended eligibility until it has been determined that the person is not otherwise eligible for medical assistance. Medical assistance may be continued for an additional six months if the person meets all requirements for the additional six months, according to title XIX of the Social Security Act, as amended by section 303 of the Family Support Act of 1988, Public Law Number 100-485.

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

Sec. 26. Minnesota Statutes 2000, section 256B.0635, subdivision 2, is amended to read:

Subd. 2. **[INCREASED CHILD OR SPOUSAL SUPPORT.]** Beginning January 1, 1998 (a) Until June 30, 2002, medical assistance may be paid for persons who received MFIP-S or medical assistance for families and children in at least three of the six months preceding the month in which the person became ineligible for MFIP-S or medical assistance, if the ineligibility was the result of the collection of child or spousal support under part D of title IV of the Social Security Act. In addition, to receive continued assistance under this section, persons who received medical assistance for families and children but did not receive MFIP-S must have had income less than or equal to the assistance standard for their family size under the state's AFDC plan in effect as of July 16, 1996, ~~as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law Number 104-193~~ increased by three percent effective July 1, 2000, at the time medical assistance eligibility began. A person who is eligible for extended medical assistance under this subdivision is entitled to four months of assistance without reapplication, unless the assistance unit ceases to include a dependent child. ~~For a person under 21 years of age,~~ except medical assistance may not be discontinued ~~for that dependent child under 21 years of age~~ within the four-month period of extended eligibility until it has been determined that the person is not otherwise eligible for medical assistance.

(b) Beginning July 1, 2002, medical assistance for families and children may be paid for persons who were eligible under section 256B.055, subdivision 3a, paragraph (b), in at least three of the six months preceding the month in which the person became ineligible under that section if the ineligibility was the result of the collection of child or spousal support under part D of title IV of the Social Security Act. A person who is eligible for extended medical assistance under this subdivision is entitled to four months of assistance without reapplication, unless the assistance unit ceases to include a dependent child, except medical assistance may not be discontinued for that dependent child under 21 years of age within the four-month period of extended eligibility until it has been determined that the person is not otherwise eligible for medical assistance.

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

Sec. 27. [256B.0637] **[PRESUMPTIVE ELIGIBILITY FOR CERTAIN PERSONS NEEDING TREATMENT FOR BREAST OR CERVICAL CANCER.]**

Medical assistance is available during a presumptive eligibility period for persons who meet the criteria in section 256B.057, subdivision 10. For purposes of this section, the presumptive eligibility period begins on the date on which an entity designated by the commissioner determines, based on preliminary information, that the person

meets the criteria in section 256B.057, subdivision 10. The presumptive eligibility period ends on the day on which a determination is made as to the person's eligibility, except that if an application is not submitted by the last day of the month following the month during which the determination based on preliminary information is made, the presumptive eligibility period ends on that last day of the month.

Sec. 28. [256B.195] [HEALTH CARE SAFETY NET PRESERVATION.]

Subdivision 1. [INTERGOVERNMENTAL TRANSFERS AND RELATED PAYMENTS.] (a) This section is contingent on federal approval of the intergovernmental transfers and payments to safety net hospitals authorized under this section.

(b) In addition to the percentage contribution paid by a county under section 256B.19, subdivision 1, the governmental units designated in this subdivision shall be responsible for an additional portion of the nonfederal share of medical assistance costs attributable to them. For purposes of this section, "designated governmental unit" means Hennepin county, Ramsey county, or the University of Minnesota. For purposes of this section, "nonstate, government hospital" means Hennepin County Medical Center, the successor or assignee to St. Paul-Ramsey Medical Center as described in section 383A.91, or Fairview University Medical Center.

(c) Effective July 1, 2001, the governmental units designated in paragraph (a) shall in total transfer \$2,833,333 on a monthly basis to the state Medicaid agency. The commissioner shall allocate this assessment between the governmental units based on the proportion of the Medicare upper payment limit for each nonstate, government hospital located within the governmental unit to the total Medicare upper payment limit of all participating hospitals in paragraph (b).

(d) The commissioner shall distribute the proceeds of this intergovernmental transfer, including the federal Medicaid match, as follows:

(1) Proceeds may be no less than the amount of the intergovernmental transfer in paragraph (c) multiplied by 1.75.

(2) The remaining proceeds provide funding for hospital charity care aid under section 144.585. The commissioner of human services shall work with the commissioner of health to assure that hospital charity care aid payments are administered in a manner that generates Medicaid matching funds.

(e) The successor or assignee to St. Paul-Ramsey Medical Center shall transfer on a monthly basis to Ramsey county an amount equal to the county assessment under paragraph (c).

Subd. 2. [DETERMINATION OF INTERGOVERNMENTAL TRANSFER AMOUNTS.] Medicaid rate changes, including those required to obtain federal financial participation under section 62J.692, subdivision 8, enacted prior to the effective date of this legislation, shall precede the determination of intergovernmental transfer amounts determined in this section. Participation in the intergovernmental transfer program shall not result in the offset of any nonstate, government hospital's receipt of Medicaid payment increases.

Subd. 3. [STATE PLAN AMENDMENTS.] The commissioner shall amend the state Medicaid plan as necessary to implement this section.

Subd. 4. [PROPORTIONATE ADJUSTMENTS.] (a) The commissioner shall adjust the intergovernmental transfers under subdivision 1, paragraph (c), and the payments under subdivision 1, paragraph (d), upon the approval of the designated governmental unit named in subdivision 1, paragraph (b), based on the commissioner's determination of Medicare upper payment limits, hospital-specific federal limitations on disproportionate share payments or to maximize additional federal reimbursements.

(b) In the event that: (i) federal approval is not received for the total intergovernmental transfer amount specified in subdivision 1, paragraph (d), or, (ii) federal rules regarding the establishment of the 150 percent Medicare upper payment limit, section 1102 of the Social Security Act, United States Code, title 42, section 1302, enacted on

March 13, 2001, are rescinded or, (iii) the federal 150 percent Medicare upper payment limit is reduced to 100 percent, the amount of the intergovernmental transfers and Medicaid payments to the nonstate, government hospitals named in subdivision 1, paragraph (b), shall be adjusted for each hospital based on the proportion of each hospital's Medicaid inpatient hospital days to the total Medicaid inpatient hospital days provided by all participating hospitals.

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

Sec. 29. Minnesota Statutes 2000, section 256B.69, subdivision 4, is amended to read:

Subd. 4. [LIMITATION OF CHOICE.] The commissioner shall develop criteria to determine when limitation of choice may be implemented in the experimental counties. The criteria shall ensure that all eligible individuals in the county have continuing access to the full range of medical assistance services as specified in subdivision 6. The commissioner shall exempt the following persons from participation in the project, in addition to those who do not meet the criteria for limitation of choice:

- (1) persons eligible for medical assistance according to section 256B.055, subdivision 1;
- (2) persons eligible for medical assistance due to blindness or disability as determined by the social security administration or the state medical review team, unless:
  - (i) they are 65 years of age or older; or
  - (ii) they reside in Itasca county or they reside in a county in which the commissioner conducts a pilot project under a waiver granted pursuant to section 1115 of the Social Security Act;
- (3) recipients who currently have private coverage through a health maintenance organization;
- (4) recipients who are eligible for medical assistance by spending down excess income for medical expenses other than the nursing facility per diem expense;
- (5) recipients who receive benefits under the Refugee Assistance Program, established under United States Code, title 8, section 1522(e);
- (6) children who are both determined to be severely emotionally disturbed and receiving case management services according to section 256B.0625, subdivision 20; ~~and~~
- (7) adults who are both determined to be seriously and persistently mentally ill and received case management services according to section 256B.0625, subdivision 20; and
- (8) persons eligible for medical assistance according to section 256B.057, subdivision 10.

Children under age 21 who are in foster placement may enroll in the project on an elective basis. Individuals excluded under clauses (6) and (7) may choose to enroll on an elective basis. The commissioner may allow persons with a one-month spenddown who are otherwise eligible to enroll to voluntarily enroll or remain enrolled, if they elect to prepay their monthly spenddown to the state. ~~Beginning on or after July 1, 1997,~~ The commissioner may require those individuals to enroll in the prepaid medical assistance program who otherwise would have been excluded under clauses (1) ~~and~~, (3), ~~and~~ (8), and under Minnesota Rules, part 9500.1452, subpart 2, items H, K, and L. Before limitation of choice is implemented, eligible individuals shall be notified and after notification, shall be allowed to choose only among demonstration providers. The commissioner may assign an individual with private coverage through a health maintenance organization, to the same health maintenance organization for medical assistance coverage, if the health maintenance organization is under contract for medical assistance in the individual's county of residence. After initially choosing a provider, the recipient is allowed to change that choice



only at specified times as allowed by the commissioner. If a demonstration provider ends participation in the project for any reason, a recipient enrolled with that provider must select a new provider but may change providers without cause once more within the first 60 days after enrollment with the second provider.

Sec. 30. Minnesota Statutes 2000, section 256B.69, subdivision 5, is amended to read:

Subd. 5. [PROSPECTIVE PER CAPITA PAYMENT.] The commissioner shall establish the method and amount of payments for services. The commissioner shall annually contract with demonstration providers to provide services consistent with these established methods and amounts for payment. Payment rates established by the commissioner must be within the limits of available appropriations.

If allowed by the commissioner, a demonstration provider may contract with an insurer, health care provider, nonprofit health service plan corporation, or the commissioner, to provide insurance or similar protection against the cost of care provided by the demonstration provider or to provide coverage against the risks incurred by demonstration providers under this section. The recipients enrolled with a demonstration provider are a permissible group under group insurance laws and chapter 62C, the Nonprofit Health Service Plan Corporations Act. Under this type of contract, the insurer or corporation may make benefit payments to a demonstration provider for services rendered or to be rendered to a recipient. Any insurer or nonprofit health service plan corporation licensed to do business in this state is authorized to provide this insurance or similar protection.

Payments to providers participating in the project are exempt from the requirements of sections 256.966 and 256B.03, subdivision 2. The commissioner shall complete development of capitation rates for payments before delivery of services under this section is begun. For payments made during calendar year 1990 and later years, the commissioner shall contract with an independent actuary to establish prepayment rates.

By January 15, 1996, the commissioner shall report to the legislature on the methodology used to allocate to participating counties available administrative reimbursement for advocacy and enrollment costs. The report shall reflect the commissioner's judgment as to the adequacy of the funds made available and of the methodology for equitable distribution of the funds. The commissioner must involve participating counties in the development of the report.

Sec. 31. Minnesota Statutes 2000, section 256B.69, subdivision 5b, is amended to read:

Subd. 5b. [PROSPECTIVE REIMBURSEMENT RATES.] (a) For prepaid medical assistance and general assistance medical care program contract rates set by the commissioner under subdivision 5 and effective on or after January 1, 1998, capitation rates for nonmetropolitan counties shall on a weighted average be no less than 88 percent of the capitation rates for metropolitan counties, excluding Hennepin county. The commissioner shall make a pro rata adjustment in capitation rates paid to counties other than nonmetropolitan counties in order to make this provision budget neutral.

(b) For prepaid medical assistance program contract rates set by the commissioner under subdivision 5 and effective on or after January 1, ~~2001~~ 2002, capitation rates for nonmetropolitan counties shall, on a weighted average, be no less than ~~89~~ 95 percent of the capitation rates for metropolitan counties, excluding Hennepin county. The commissioner shall make a pro rata adjustment in capitation rates paid to Hennepin county in order to make the portion of the increase between 89 and 95 percent budget neutral.

(c) This subdivision shall not affect the nongeographically based risk adjusted rates established under section 62Q.03, subdivision 5a, paragraph (f).

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

Sec. 32. Minnesota Statutes 2000, section 256B.69, is amended by adding a subdivision to read:

Subd. 6c. [DENTAL SERVICES DEMONSTRATION PROJECT.] The commissioner shall establish a dental services demonstration project in Crow Wing, Todd, Morrison, Wadena, and Cass counties for provision of dental services to medical assistance, general assistance medical care, and MinnesotaCare recipients. The commissioner may contract on a prospective per capita payment basis for these dental services with an organization licensed under chapter 62C, 62D, or 62N in accordance with section 256B.037 or may establish and administer a fee-for-service system for the reimbursement of dental services.

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

Sec. 33. Minnesota Statutes 2000, section 256B.75, is amended to read:

256B.75 [HOSPITAL OUTPATIENT REIMBURSEMENT.]

(a) For outpatient hospital facility fee payments for services rendered on or after October 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge, or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for which there is a federal maximum allowable payment. Effective for services rendered on or after January 1, 2000, payment rates for nonsurgical outpatient hospital facility fees and emergency room facility fees shall be increased by eight percent over the rates in effect on December 31, 1999, except for those services for which there is a federal maximum allowable payment. Services for which there is a federal maximum allowable payment shall be paid at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare upper limit. If it is determined that a provision of this section conflicts with existing or future requirements of the United States government with respect to federal financial participation in medical assistance, the federal requirements prevail. The commissioner may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial participation resulting from rates that are in excess of the Medicare upper limitations.

(b) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory surgery hospital facility fee services for critical access hospitals designated under section 144.1483, clause (11), shall be paid on a cost-based payment system that is based on the cost-finding methods and allowable costs of the Medicare program.

(c) Effective for services provided on or after July 1, 2002, rates that are based on the Medicare outpatient prospective payment system shall be replaced by a budget neutral prospective payment system that is derived using medical assistance data. The department shall provide a proposal to the 2002 legislature to define and implement this provision.

Sec. 34. Minnesota Statutes 2000, section 256B.76, is amended to read:

256B.76 [PHYSICIAN AND DENTAL REIMBURSEMENT.]

(a) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for physician services as follows:

(1) payment for level one Health Care Finance Administration's common procedural coding system (HCPCS) codes titled "office and other outpatient services," "preventive medicine new and established patient," "delivery, antepartum, and postpartum care," "critical care," ~~Caesarean~~ cesarean delivery and pharmacologic management provided to psychiatric patients, and HCPCS level three codes for enhanced services for prenatal high risk, shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992. If the rate on any procedure code within these categories is different than the rate that would have been paid under the methodology in section 256B.74, subdivision 2, then the larger rate shall be paid;

(2) payments for all other services shall be paid at the lower of (i) submitted charges, or (ii) 15.4 percent above the rate in effect on June 30, 1992;

(3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases except that payment rates for home health agency services shall be the rates in effect on September 30, 1992;

(4) effective for services rendered on or after January 1, 2000, payment rates for physician and professional services shall be increased by three percent over the rates in effect on December 31, 1999, except for home health agency and family planning agency services; and

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

(b) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for dental services as follows:

(1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992;

(2) dental rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases;

(3) effective for services rendered on or after January 1, 2000, payment rates for dental services shall be increased by three percent over the rates in effect on December 31, 1999;

(4) the commissioner shall award grants to community clinics or other nonprofit community organizations, political subdivisions, professional associations, or other organizations that demonstrate the ability to provide dental services effectively to public program recipients. Grants may be used to fund the costs related to coordinating access for recipients, developing and implementing patient care criteria, upgrading or establishing new facilities, acquiring furnishings or equipment, recruiting new providers, or other development costs that will improve access to dental care in a region. In awarding grants, the commissioner shall give priority to applicants that plan to serve areas of the state in which the number of dental providers is not currently sufficient to meet the needs of recipients of public programs or uninsured individuals. The commissioner shall consider the following in awarding the grants: (i) potential to successfully increase access to an underserved population; (ii) the ability to raise matching funds; (iii) the long-term viability of the project to improve access beyond the period of initial funding; (iv) the efficiency in the use of the funding; and (v) the experience of the proposers in providing services to the target population.

The commissioner shall monitor the grants and may terminate a grant if the grantee does not increase dental access for public program recipients. The commissioner shall consider grants for the following:

(i) implementation of new programs or continued expansion of current access programs that have demonstrated success in providing dental services in underserved areas;

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

(iii) a program that organizes a network of volunteer dentists, establishes a system to refer eligible individuals to volunteer dentists, and through that network provides donated dental care services to public program recipients or uninsured individuals.

(5) beginning October 1, 1999, the payment for tooth sealants and fluoride treatments shall be the lower of (i) submitted charge, or (ii) 80 percent of median 1997 charges; ~~and~~

(6) the increases listed in clauses (3) and (5) shall be implemented January 1, 2000, for managed care; and

(7) effective for services provided on or after October 1, 2001, payment for diagnostic examinations and dental x-rays provided to children under age 21 shall be the lower of (i) the submitted charge, or (ii) 85 percent of median 1999 charges.

(c) Effective for dental services rendered on or after July 1, 2001, the commissioner may increase reimbursements to dentists and dental clinics deemed by the commissioner to be critical access dental providers. Reimbursement to a critical access dental provider may be increased by not more than 50 percent above the reimbursement rate that would otherwise be paid to the provider. Payments to health plan companies shall be adjusted to reflect increased reimbursements to critical access dental providers as approved by the commissioner. In determining which dentists and dental clinics shall be deemed critical access dental providers, the commissioner shall review:

(1) the utilization rate in the service area in which the dentist or dental clinic operates for dental services to patients covered by medical assistance, general assistance medical care, or MinnesotaCare as their primary source of coverage;

(2) the level of services provided by the dentist or dental clinic to patients covered by medical assistance, general assistance medical care, or MinnesotaCare as their primary source of coverage; and

(3) whether the level of services provided by the dentist or dental clinic is critical to maintaining adequate levels of patient access within the service area.

In the absence of a critical access dental provider in a service area, the commissioner may designate a dentist or dental clinic as a critical access dental provider if the dentist or dental clinic is willing to provide care to patients covered by medical assistance, general assistance medical care, or MinnesotaCare at a level which significantly increases access to dental care in the service area.

(d) An entity that operates both a Medicare certified comprehensive outpatient rehabilitation facility and a facility which was certified prior to January 1, 1993, that is licensed under Minnesota Rules, parts 9570.2000 to 9570.3600, and for whom at least 33 percent of the clients receiving rehabilitation services in the most recent calendar year are medical assistance recipients, shall be reimbursed by the commissioner for rehabilitation services at rates that are 38 percent greater than the maximum reimbursement rate allowed under paragraph (a), clause (2), when those services are (1) provided within the comprehensive outpatient rehabilitation facility and (2) provided to residents of nursing facilities owned by the entity.

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

Sec. 35. [256B.78] [MEDICAL ASSISTANCE DEMONSTRATION PROJECT FOR FAMILY PLANNING SERVICES.]

(a) The commissioner of human services shall establish a medical assistance demonstration project to determine whether improved access to coverage of pre-pregnancy family planning services reduces medical assistance and MFIP costs.

(b) This section is effective upon federal approval of the demonstration project.

Sec. 36. Minnesota Statutes 2000, section 256D.03, subdivision 3, is amended to read:

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

(1) who is receiving assistance under section 256D.05, except for families with children who are eligible under Minnesota family investment program-statewide (MFIP-S), who is having a payment made on the person's behalf under sections 256I.01 to 256I.06, or who resides in group residential housing as defined in chapter 256I and can meet a spenddown using the cost of remedial services received through group residential housing; or

(2)(i) who is a resident of Minnesota; and whose equity in assets is not in excess of \$1,000 per assistance unit. Exempt assets, the reduction of excess assets, and the waiver of excess assets must conform to the medical assistance program in chapter 256B, with the following exception: the maximum amount of undistributed funds in a trust that could be distributed to or on behalf of the beneficiary by the trustee, assuming the full exercise of the trustee's discretion under the terms of the trust, must be applied toward the asset maximum; and

(ii) who has countable income ~~not in excess of the assistance standards established in section 256B.056, subdivision 4~~ that does not exceed 133 and 1/3 percent of the AFDC income standard in effect under the July 16, 1996, AFDC state plan, increased by three percent, or whose excess income is spent down according to section 256B.056, subdivision 5, using a six-month budget period. The method for calculating earned income disregards and deductions for a person who resides with a dependent child under age 21 shall follow section 256B.056, subdivision 1a. However, if a disregard of \$30 and one-third of the remainder has been applied to the wage earner's income, the disregard shall not be applied again until the wage earner's income has not been considered in an eligibility determination for general assistance, general assistance medical care, medical assistance, or MFIP-S for 12 consecutive months. The earned income and work expense deductions for a person who does not reside with a dependent child under age 21 shall be the same as the method used to determine eligibility for a person under section 256D.06, subdivision 1, except the disregard of the first \$50 of earned income is not allowed;

(3) who would be eligible for medical assistance except that the person resides in a facility that is determined by the commissioner or the federal Health Care Financing Administration to be an institution for mental diseases; or

(4) who is ineligible for medical assistance under chapter 256B or general assistance medical care under any other provision of this section, and is receiving care and rehabilitation services from a nonprofit center established to serve victims of torture. These individuals are eligible for general assistance medical care only for the period during which they are receiving services from the center. During this period of eligibility, individuals eligible under this clause shall not be required to participate in prepaid general assistance medical care.

(b) Beginning January 1, 2000, applicants or recipients who meet all eligibility requirements of MinnesotaCare as defined in sections 256L.01 to 256L.16, and are:

(i) adults with dependent children under 21 whose gross family income is equal to or less than 275 percent of the federal poverty guidelines; or

(ii) adults without children with earned income and whose family gross income is between 75 percent of the federal poverty guidelines and the amount set by section 256L.04, subdivision 7, shall be terminated from general assistance medical care upon enrollment in MinnesotaCare.

(c) For services rendered on or after July 1, 1997, eligibility is limited to one month prior to application if the person is determined eligible in the prior month. A redetermination of eligibility must occur every 12 months. Beginning January 1, 2000, Minnesota health care program applications completed by recipients and applicants who are persons described in paragraph (b), may be returned to the county agency to be forwarded to the department of human services or sent directly to the department of human services for enrollment in MinnesotaCare. If all other eligibility requirements of this subdivision are met, eligibility for general assistance medical care shall be available in any month during which a MinnesotaCare eligibility determination and enrollment are pending. Upon notification of eligibility for MinnesotaCare, notice of termination for eligibility for general assistance medical care shall be sent to an applicant or recipient. If all other eligibility requirements of this subdivision are met, eligibility for general assistance medical care shall be available until enrollment in MinnesotaCare subject to the provisions of paragraph (e).

(d) The date of an initial Minnesota health care program application necessary to begin a determination of eligibility shall be the date the applicant has provided a name, address, and social security number, signed and dated, to the county agency or the department of human services. If the applicant is unable to provide an initial application when health care is delivered due to a medical condition or disability, a health care provider may act on the person's behalf to complete the initial application. The applicant must complete the remainder of the application and provide

necessary verification before eligibility can be determined. The county agency must assist the applicant in obtaining verification if necessary. On the basis of information provided on the completed application, an applicant who meets the following criteria shall be determined eligible beginning in the month of application:

- (1) has gross income less than 90 percent of the applicable income standard;
- (2) has liquid assets that total within \$300 of the asset standard;
- (3) does not reside in a long-term care facility; and
- (4) meets all other eligibility requirements.

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

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

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

(g) General assistance medical care is not available for applicants or recipients who do not cooperate with the county agency to meet the requirements of medical assistance. General assistance medical care is limited to payment of emergency services only for applicants or recipients as described in paragraph (b), whose MinnesotaCare coverage is denied or terminated for nonpayment of premiums as required by sections 256L.06 and 256L.07.

(h) In determining the amount of assets of an individual, there shall be included any asset or interest in an asset, including an asset excluded under paragraph (a), that was given away, sold, or disposed of for less than fair market value within the 60 months preceding application for general assistance medical care or during the period of eligibility. Any transfer described in this paragraph shall be presumed to have been for the purpose of establishing eligibility for general assistance medical care, unless the individual furnishes convincing evidence to establish that the transaction was exclusively for another purpose. For purposes of this paragraph, the value of the asset or interest shall be the fair market value at the time it was given away, sold, or disposed of, less the amount of compensation received. For any uncompensated transfer, the number of months of ineligibility, including partial months, shall be calculated by dividing the uncompensated transfer amount by the average monthly per person payment made by the medical assistance program to skilled nursing facilities for the previous calendar year. The individual shall remain ineligible until this fixed period has expired. The period of ineligibility may exceed 30 months, and a reapplication for benefits after 30 months from the date of the transfer shall not result in eligibility unless and until the period of ineligibility has expired. The period of ineligibility begins in the month the transfer was reported to the county agency, or if the transfer was not reported, the month in which the county agency discovered the transfer, whichever comes first. For applicants, the period of ineligibility begins on the date of the first approved application.

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

(j)(1) An undocumented noncitizen or a nonimmigrant is ineligible for general assistance medical care other than emergency services. For purposes of this subdivision, a nonimmigrant is an individual in one or more of the classes listed in United States Code, title 8, section 1101(a)(15), and an undocumented noncitizen is an individual who resides in the United States without the approval or acquiescence of the Immigration and Naturalization Service.

(2) This paragraph does not apply to a child under age 18, to a Cuban or Haitian entrant as defined in Public Law Number 96-422, section 501(e)(1) or (2)(a), or to a noncitizen who is aged, blind, or disabled as defined in Code of Federal Regulations, title 42, sections 435.520, 435.530, 435.531, 435.540, and 435.541, or effective October 1, 1998, to an individual eligible for general assistance medical care under paragraph (a), clause (4), who cooperates with the Immigration and Naturalization Service to pursue any applicable immigration status, including citizenship, that would qualify the individual for medical assistance with federal financial participation.

(k) For purposes of paragraphs (g) and (j), "emergency services" has the meaning given in Code of Federal Regulations, title 42, section 440.255(b)(1), except that it also means services rendered because of suspected or actual pesticide poisoning.

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

Sec. 37. Minnesota Statutes 2000, section 256D.03, subdivision 4, is amended to read:

Subd. 4. [GENERAL ASSISTANCE MEDICAL CARE; SERVICES.] (a) For a person who is eligible under subdivision 3, paragraph (a), clause (3), general assistance medical care covers, except as provided in paragraph (c):

- (1) inpatient hospital services;
- (2) outpatient hospital services;
- (3) services provided by Medicare certified rehabilitation agencies;
- (4) prescription drugs and other products recommended through the process established in section 256B.0625, subdivision 13;
- (5) equipment necessary to administer insulin and diagnostic supplies and equipment for diabetics to monitor blood sugar level;
- (6) eyeglasses and eye examinations provided by a physician or optometrist;
- (7) hearing aids;
- (8) prosthetic devices;
- (9) laboratory and X-ray services;
- (10) physician's services;
- (11) medical transportation;
- (12) chiropractic services as covered under the medical assistance program;
- (13) podiatric services;
- (14) dental services;
- (15) outpatient services provided by a mental health center or clinic that is under contract with the county board and is established under section 245.62;
- (16) day treatment services for mental illness provided under contract with the county board;

(17) prescribed medications for persons who have been diagnosed as mentally ill as necessary to prevent more restrictive institutionalization;

(18) psychological services, medical supplies and equipment, and Medicare premiums, coinsurance and deductible payments;

(19) medical equipment not specifically listed in this paragraph when the use of the equipment will prevent the need for costlier services that are reimbursable under this subdivision;

(20) services performed by a certified pediatric nurse practitioner, a certified family nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse practitioner in independent practice, if (1) the service is otherwise covered under this chapter as a physician service, (2) the service provided on an inpatient basis is not included as part of the cost for inpatient services included in the operating payment rate, and (3) the service is within the scope of practice of the nurse practitioner's license as a registered nurse, as defined in section 148.171;

(21) services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic that is a department of, or that operates under the direct authority of, a unit of government, if the service is within the scope of practice of the public health nurse's license as a registered nurse, as defined in section 148.171; and

(22) telemedicine consultations, to the extent they are covered under section 256B.0625, subdivision 3b.

(b) Except as provided in paragraph (c), for a recipient who is eligible under subdivision 3, paragraph (a), clause (1) or (2), general assistance medical care covers the services listed in paragraph (a) with the exception of special transportation services.

(c) Gender reassignment surgery and related services are not covered services under this subdivision unless the individual began receiving gender reassignment services prior to July 1, 1995.

(d) In order to contain costs, the commissioner of human services shall select vendors of medical care who can provide the most economical care consistent with high medical standards and shall where possible contract with organizations on a prepaid capitation basis to provide these services. The commissioner shall consider proposals by counties and vendors for prepaid health plans, competitive bidding programs, block grants, or other vendor payment mechanisms designed to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided. Before implementing prepaid programs in counties with a county operated or affiliated public teaching hospital or a hospital or clinic operated by the University of Minnesota, the commissioner shall consider the risks the prepaid program creates for the hospital and allow the county or hospital the opportunity to participate in the program in a manner that reflects the risk of adverse selection and the nature of the patients served by the hospital, provided the terms of participation in the program are competitive with the terms of other participants considering the nature of the population served. Payment for services provided pursuant to this subdivision shall be as provided to medical assistance vendors of these services under sections 256B.02, subdivision 8, and 256B.0625. For payments made during fiscal year 1990 and later years, the commissioner shall consult with an independent actuary in establishing prepayment rates, but shall retain final control over the rate methodology. Payment rates established by the commissioner must be within the limits of available appropriations. Notwithstanding the provisions of subdivision 3, an individual who becomes ineligible for general assistance medical care because of failure to submit income reports or recertification forms in a timely manner, shall remain enrolled in the prepaid health plan and shall remain eligible for general assistance medical care coverage through the last day of the month in which the enrollee became ineligible for general assistance medical care.

(e) There shall be no copayment required of any recipient of benefits for any services provided under this subdivision. A hospital receiving a reduced payment as a result of this section may apply the unpaid balance toward satisfaction of the hospital's bad debts.

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



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

(h) The maximum payment for new vendors enrolled in the general assistance medical care program after the base year shall be determined from the average usual and customary charge of the same vendor type enrolled in the base year.

(i) The conditions of payment for services under this subdivision are the same as the conditions specified in rules adopted under chapter 256B governing the medical assistance program, unless otherwise provided by statute or rule.

Sec. 38. Minnesota Statutes 2000, section 256J.31, subdivision 12, is amended to read:

Subd. 12. [RIGHT TO DISCONTINUE CASH ASSISTANCE.] A participant who is not in vendor payment status may discontinue receipt of the cash assistance portion of the MFIP assistance grant and retain eligibility for child care assistance under section 119B.05 ~~and for medical assistance under sections 256B.055, subdivision 3a, and 256B.0635.~~ For the months a participant chooses to discontinue the receipt of the cash portion of the MFIP grant, the assistance unit accrues months of eligibility to be applied toward eligibility for child care under section 119B.05 ~~and for medical assistance under sections 256B.055, subdivision 3a, and 256B.0635.~~

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

Sec. 39. Minnesota Statutes 2000, section 256K.03, subdivision 1, is amended to read:

Subdivision 1. [NOTIFICATION OF PROGRAM.] Except for the provisions in this section, the provisions for the MFIP application process shall be followed. Within two days after receipt of a completed combined application form, the county agency must refer to the provider the applicant who meets the conditions under section 256K.02, and notify the applicant in writing of the program including the following provisions:

(1) notification that, as part of the application process, applicants are required to attend orientation, to be followed immediately by a job search;

(2) the program provider, the date, time, and location of the scheduled program orientation;

(3) the procedures for qualifying for and receiving benefits under the program;

(4) ~~the immediate availability of supportive services, including, but not limited to, child care, transportation, medical assistance, and other work-related aid; and~~

(5) the rights, responsibilities, and obligations of participants in the program, including, but not limited to, the grounds for exemptions and deferrals, the consequences for refusing or failing to participate fully, and the appeal process.

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

Sec. 40. Minnesota Statutes 2000, section 256K.07, is amended to read:

256K.07 [ELIGIBILITY FOR FOOD STAMPS; ~~MEDICAL ASSISTANCE;~~ AND CHILD CARE.]

The participant shall be treated as an MFIP recipient for food stamps, ~~medical assistance,~~ and child care eligibility purposes. The participant who leaves the program as a result of increased earnings from employment shall be eligible for ~~transitional medical assistance and~~ child care without regard to MFIP receipt in three of the six months preceding ineligibility.

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

Sec. 41. Minnesota Statutes 2000, section 256L.06, subdivision 3, is amended to read:

Subd. 3. [ADMINISTRATION AND COMMISSIONER'S DUTIES.] (a) Premiums are dedicated to the commissioner for MinnesotaCare.

(b) The commissioner shall develop and implement procedures to: (1) require enrollees to report changes in income; (2) adjust sliding scale premium payments, based upon changes in enrollee income; and (3) disenroll enrollees from MinnesotaCare for failure to pay required premiums. Failure to pay includes payment with a dishonored check, a returned automatic bank withdrawal, or a refused credit card or debit card payment. The commissioner may demand a guaranteed form of payment, including a cashier's check or a money order, as the only means to replace a dishonored, returned, or refused payment.

(c) Premiums are calculated on a calendar month basis and may be paid on a monthly, quarterly, or annual basis, with the first payment due upon notice from the commissioner of the premium amount required. The commissioner shall inform applicants and enrollees of these premium payment options. Premium payment is required before enrollment is complete and to maintain eligibility in MinnesotaCare.

(d) Nonpayment of the premium will result in disenrollment from the plan ~~within one calendar month after the due date effective for the calendar month for which the premium was due.~~ Persons disenrolled for nonpayment or who voluntarily terminate coverage from the program may not reenroll until four calendar months have elapsed. Persons disenrolled for nonpayment who pay all past due premiums as well as current premiums due, including premiums due for the period of disenrollment, within 20 days of disenrollment, shall be reenrolled retroactively to the first day of disenrollment. Persons disenrolled for nonpayment or who voluntarily terminate coverage from the program may not reenroll for four calendar months unless the person demonstrates good cause for nonpayment. Good cause does not exist if a person chooses to pay other family expenses instead of the premium. The commissioner shall define good cause in rule.

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

Sec. 42. Minnesota Statutes 2000, section 256L.12, subdivision 9, is amended to read:

Subd. 9. [RATE SETTING.] Rates will be prospective, per capita, where possible. The commissioner may allow health plans to arrange for inpatient hospital services on a risk or nonrisk basis. The commissioner shall consult with an independent actuary to determine appropriate rates. Rates established by the commissioner must be within the limits of available appropriations.

Sec. 43. Minnesota Statutes 2000, section 256L.12, is amended by adding a subdivision to read:

Subd. 11. [COVERAGE AT INDIAN HEALTH SERVICE FACILITIES.] For American Indian enrollees of MinnesotaCare, MinnesotaCare shall cover health care services provided at Indian Health Service facilities and facilities operated by a tribe or tribal organization under funding authorized by United States Code, title 25, sections 450f to 450n, or title III of the Indian Self-Determination and Education Act, Public Law Number 93-638, if those services would otherwise be covered under section 256L.03. Payments for services provided under this subdivision shall be made on a fee-for-service basis, and may, at the option of the tribe or organization, be made at the rates authorized under sections 256.969, subdivision 16, and 256B.0625, subdivision 34, for those MinnesotaCare enrollees eligible for coverage at medical assistance rates. For purposes of this subdivision, "American Indian" has the meaning given to persons to whom services will be provided for in the Code of Federal Regulations, title 42, section 36.12.

Sec. 44. Minnesota Statutes 2000, section 256L.16, is amended to read:

256L.16 [PAYMENT RATES; SERVICES FOR FAMILIES AND CHILDREN UNDER THE MINNESOTACARE HEALTH CARE REFORM WAIVER.]

Section 256L.11, subdivision 2, shall not apply to services provided to ~~children families with children~~ who are eligible to receive expanded services according to section ~~256L.03, subdivision 1a~~ 256L.04, subdivision 1, paragraph (a).

Sec. 45. Laws 1995, chapter 178, article 2, section 36, is amended to read:

Sec. 36. [EMPOWERMENT ZONES; ADMINISTRATIVE SIMPLIFICATION OF WELFARE LAWS.]

(a) The commissioner of human services shall make recommendations to effectuate the changes in federal laws and regulations, state laws and rules, and the state plan to improve the administrative efficiency of the aid to families with dependent children, general assistance, work readiness, family general assistance, medical assistance, general assistance medical care, and food stamp programs. At a minimum, the following administrative standards and procedures must be changed.

The commissioner shall:

(1) require income or eligibility reviews no more frequently than annually for cases in which income is normally invariant, as in aid to families with dependent children cases where the only source of household income is Supplemental Social Security Income;

(2) permit households to report income annually when the source of income is excluded, such as a minor's earnings;

~~(3) require income or eligibility reviews no more frequently than annually for extended medical assistance cases;~~

~~(4)~~ require income or eligibility reviews no more frequently than annually for a medical assistance postpartum client, where the client previously had eligibility under a different basis prior to pregnancy or if other household members have eligibility with the same income/basis that applies to the client;

~~(5)~~ (4) permit all income or eligibility reviews for foster care medical assistance cases to use the short application form; and

~~(6)~~ (5) make dependent care expenses declaratory for medical assistance; ~~and~~

~~(7) permit households to only report gifts worth \$100 or more per month.~~

(b) The county's administrative savings resulting from these changes may be allocated to fund any lawful purpose.

(c) The recommendations must be provided in a report to the chairs of the appropriate legislative committees by August 1, 1995. The recommendations must include a list of the administrative standards and procedures that require approval by the federal government before implementation, and also which administrative simplification standards and procedures may be implemented by a county prior to receiving a federal waiver.

(d) The commissioner shall seek the necessary waivers from the federal government as soon as possible to implement the administrative simplification standards and procedures.

Sec. 46. Laws 1999, chapter 245, article 4, section 110, is amended to read:

Sec. 110. [PROGRAMS FOR SENIOR CITIZENS.]

The commissioner of human services shall study the eligibility criteria of and benefits provided to persons age 65 and over through the array of cash assistance and health care programs administered by the department, and the extent to which these programs can be combined, simplified, or coordinated to reduce administrative costs and improve access. The commissioner shall also study potential barriers to enrollment for low-income seniors who would otherwise deplete resources necessary to maintain independent community living. At a minimum, the study must include an evaluation of asset requirements and enrollment sites. The commissioner shall report study findings and recommendations to the legislature by ~~June~~ September 30, 2001.

## Sec. 47. [NOTICE OF NEW PREMIUM SCHEDULE.]

The commissioner of human services shall provide medical assistance enrollees subject to premiums as employed persons with disabilities with prior notice of the new premium schedule established under the section 13 amendment to section 256B.057, subdivision 9, paragraph (c). This notice must be provided at least two months before the month in which the first premium payment under the new schedule is due.

## Sec. 48. [MEDICATION THERAPY MANAGEMENT PILOT PROGRAM.]

Subdivision 1. [ESTABLISHMENT.] The commissioner of human services, in consultation with the advisory committee established under subdivision 2, shall implement, beginning July 1, 2001, a two-year medication therapy management pilot program for medical assistance enrollees. Medication therapy management must be provided by teams of physicians and pharmacists working in collaborative practice, as defined in Minnesota Statutes, section 151.01, subdivision 27, clause (5), to help patients use medications safely and effectively. The commissioner may enroll individual pharmacists who participate in the pilot program as medical assistance providers and shall seek to ensure that participating pharmacists represent all geographic regions of the state.

Subd. 2. [ADVISORY COMMITTEE.] The commissioner shall establish a ten-member medication therapy management advisory committee, to advise the commissioner in the implementation and administration of the program and the development of eligibility criteria for enrollees and providers and requirements for collaborative practice agreements. The committee shall be comprised of: two licensed physicians; two licensed pharmacists; two consumer representatives; three members with expertise in the area of medication therapy management, who may be licensed physicians or licensed pharmacists; and a representative of the commissioner, who shall serve as an ex-officio nonvoting member. In appointing members who are not consumer representatives, the commissioner shall consider recommendations of associations representing pharmacy and medical practitioners. The committee is governed by section 15.059, except that committee members do not receive compensation or reimbursement for expenses.

Subd. 3. [EVALUATION.] The commissioner shall evaluate the cost-effectiveness of the pilot program and its effect on patient outcomes and quality of care, and shall report to the legislature by December 15, 2003. The commissioner may contract with a vendor to conduct the evaluation.

## Sec. 49. [REGULATORY SIMPLIFICATION FOR STATE HEALTH CARE PROGRAM PROVIDERS.]

The commissioner of human services, in consultation with providers participating in state health care programs, shall identify nonfinancial barriers to increased provider enrollment and provider retention in state health care programs, and shall implement procedures to address these barriers. Areas to be examined by the commissioner shall include, but are not limited to, regulatory complexity and inconsistencies between state health care programs, provider requirements, provision of technical assistance to providers, responsiveness to provider inquiries and complaints, claims processing turnaround times, and policies for rejecting provider claims. The commissioner shall report to the legislature by February 15, 2002, on any changes to the administration of state health care programs that will be implemented as a result of the study, and present recommendations for any necessary changes in state law.

## Sec. 50. [REPEALER.]

(a) Minnesota Statutes 2000, section 256B.037, subdivision 5, is repealed effective January 1, 2002.

(b) Minnesota Statutes 2000, section 256B.0635, subdivision 3, is repealed effective July 1, 2002.

## ARTICLE 3

## CONTINUING CARE AND HOME CARE

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

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

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

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

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

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

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

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

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

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

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

Sec. 4. Minnesota Statutes 2000, section 254B.02, subdivision 3, is amended to read:

Subd. 3. [RESERVE ACCOUNT.] The commissioner shall allocate money from the reserve account to counties that, during the current fiscal year, have met or exceeded the base level of expenditures for eligible chemical dependency services from local money. The commissioner shall establish the base level for fiscal year 1988 as the amount of local money used for eligible services in calendar year 1986. In later years, the base level must be increased in the same proportion as state appropriations to implement Laws 1986, chapter 394, sections 8 to 20, are increased. The base level must be decreased if the fund balance from which allocations are made under section 254B.02, subdivision 1, is decreased in later years. The local match rate for the reserve account is the same rate as applied to the initial allocation. Reserve account payments must not be included when calculating the county adjustments made according to subdivision 2. For counties providing medical assistance or general assistance medical care through managed care plans on January 1, 1996, the base year is fiscal year 1995. For counties beginning provision of managed care after January 1, 1996, the base year is the most recent fiscal year before enrollment in managed care begins. For counties providing managed care, the base level will be increased or decreased in proportion to changes in the fund balance from which allocations are made under subdivision 2, but will be additionally increased or decreased in proportion to the change in county adjusted population made in subdivision 1, paragraphs (b) and (c). Effective July 1, 2001, funds deposited in the reserve account in excess of those needed to meet obligations for services provided during the biennium under this section and sections 254B.06 and 254B.09 shall cancel to the general fund.

Sec. 5. Minnesota Statutes 2000, section 254B.03, subdivision 1, is amended to read:

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

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

(c) The calendar year ~~1998~~ 2002 rate for vendors may not increase more than ~~three~~ two percent above the rate approved in effect on January 1, ~~1997~~ 2001. The calendar year ~~1999~~ 2003 rate for vendors may not increase more than ~~three~~ two percent above the rate in effect on January 1, ~~1998~~ 2002. The calendar years 2004 and 2005 rates may not exceed the rate in effect on January 1, 2003.

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

Sec. 6. Minnesota Statutes 2000, section 254B.04, subdivision 1, is amended to read:

Subdivision 1. [ELIGIBILITY.] (a) Persons eligible for benefits under Code of Federal Regulations, title 25, part 20, persons eligible for medical assistance benefits under sections 256B.055, 256B.056, and 256B.057, subdivisions 1, 2, 5, and 6, or who meet the income standards of section 256B.056, subdivision 4, and persons eligible for general assistance medical care under section 256D.03, subdivision 3, are entitled to chemical dependency fund services. State money appropriated for this paragraph must be placed in a separate account established for this purpose.

Persons with dependent children who are determined to be in need of chemical dependency treatment pursuant to an assessment under section 626.556, subdivision 10, or a case plan under section 260C.201, subdivision 6, or 260C.212, shall be assisted by the local agency to access needed treatment services. Treatment services must be appropriate for the individual or family, which may include long-term care treatment or treatment in a facility that allows the dependent children to stay in the treatment facility. The county shall pay for out-of-home placement costs, if applicable.

(b) A person not entitled to services under paragraph (a), but with family income that is less than the 1997 federal poverty guidelines equivalent of 60 percent of the state median income for a family of like size and composition, shall be eligible to receive chemical dependency fund services within the limit of funds ~~available after persons entitled to services under paragraph (a) have been served~~ appropriated for this group for the fiscal year. If notified by the state agency of limited funds, a county must give preferential treatment to persons with dependent children who are in need of chemical dependency treatment pursuant to an assessment under section 626.556, subdivision 10, or a case plan under section 260C.201, subdivision 6, or 260C.212. A county may spend money from its own sources to serve persons under this paragraph. State money appropriated for this paragraph must be placed in a separate account established for this purpose.

(c) Persons whose income is between the 1997 federal poverty guidelines equivalent of 60 percent and 115 percent of the state median income shall be eligible for chemical dependency services on a sliding fee basis, within the limit of funds ~~available, after persons entitled to services under paragraph (a) and persons eligible for services under paragraph (b) have been served~~ appropriated for this group for the fiscal year. Persons eligible under this paragraph must contribute to the cost of services according to the sliding fee scale established under subdivision 3. A county may spend money from its own sources to provide services to persons under this paragraph. State money appropriated for this paragraph must be placed in a separate account established for this purpose.

Sec. 7. Minnesota Statutes 2000, section 254B.09, is amended by adding a subdivision to read:

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

Sec. 8. Minnesota Statutes 2000, section 256.01, is amended by adding a subdivision to read:

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

Sec. 9. Minnesota Statutes 2000, section 256.476, subdivision 1, is amended to read:

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

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

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

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

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

Sec. 10. Minnesota Statutes 2000, section 256.476, subdivision 2, is amended to read:

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

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

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

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

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

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

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

(3) refuse any or all alternatives.

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

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

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



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

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

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

Sec. 11. Minnesota Statutes 2000, section 256.476, subdivision 3, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

Sec. 12. Minnesota Statutes 2000, section 256.476, subdivision 4, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(h) The state of Minnesota, the county boards participating in the consumer support grant program, or the agencies acting on behalf of the county boards in the implementation and administration of the consumer support grant program shall not be liable for damages, injuries, or liabilities sustained through the purchase of support by

the individual, the individual's family, or the authorized representative under this section with funds received through the consumer support grant program. Liabilities include but are not limited to: workers' compensation liability, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA). For purposes of this section, participating county boards and agencies acting on behalf of county boards are exempt from the provisions of section 268.04.

Sec. 13. Minnesota Statutes 2000, section 256.476, subdivision 5, is amended to read:

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

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

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

(2) their eligibility for current program and services;

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

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

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

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

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

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

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

(h) Grant funds unexpended by consumers shall return to the state once a year. The annual return of unexpended grant funds shall occur in the quarter following the end of the state fiscal year.

Sec. 14. Minnesota Statutes 2000, section 256.476, subdivision 8, is amended to read:

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

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

Sec. 15. Minnesota Statutes 2000, section 256B.0625, subdivision 7, is amended to read:

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

Sec. 16. Minnesota Statutes 2000, section 256B.0625, subdivision 19a, is amended to read:

Subd. 19a. [PERSONAL CARE ASSISTANT SERVICES.] Medical assistance covers personal care assistant services in a recipient's home. To qualify for personal care assistant services, recipients or responsible parties must be able to identify the recipient's needs, direct and evaluate task accomplishment, and provide for health and safety. Approved hours may be used outside the home when normal life activities take them outside the home ~~and when, without the provision of personal care, their health and safety would be jeopardized.~~ To use personal care assistant services at school, the recipient or responsible party must provide written authorization in the care plan identifying the chosen provider and the daily amount of services to be used at school. Total hours for services, whether actually performed inside or outside the recipient's home, cannot exceed that which is otherwise allowed for personal care

assistant services in an in-home setting according to section 256B.0627. Medical assistance does not cover personal care assistant services for residents of a hospital, nursing facility, intermediate care facility, health care facility licensed by the commissioner of health, or unless a resident who is otherwise eligible is on leave from the facility and the facility either pays for the personal care assistant services or forgoes the facility per diem for the leave days that personal care assistant services are used. All personal care services must be provided according to section 256B.0627. Personal care assistant services may not be reimbursed if the personal care assistant is the spouse or legal guardian of the recipient or the parent of a recipient under age 18, or the responsible party or the foster care provider of a recipient who cannot direct the recipient's own care unless, in the case of a foster care provider, a county or state case manager visits the recipient as needed, but not less than every six months, to monitor the health and safety of the recipient and to ensure the goals of the care plan are met. Parents of adult recipients, adult children of the recipient or adult siblings of the recipient may be reimbursed for personal care assistant services ~~if they are not the recipient's legal guardian and, if they are granted a waiver under section 256B.0627. Until July 1, 2001, and~~ Notwithstanding the provisions of section 256B.0627, subdivision 4, paragraph (b), clause (4), the noncorporate legal guardian or conservator of an adult, who is not the responsible party and not the personal care provider organization, may be granted a hardship waiver under section 256B.0627, to be reimbursed to provide personal care assistant services to the recipient, and shall not be considered to have a service provider interest for purposes of participation on the screening team under section 256B.092, subdivision 7.

Sec. 17. Minnesota Statutes 2000, section 256B.0625, subdivision 19c, is amended to read:

Subd. 19c. [PERSONAL CARE.] Medical assistance covers personal care assistant services provided by an individual who is qualified to provide the services according to subdivision 19a and section 256B.0627, where the services are prescribed by a physician in accordance with a plan of treatment and are supervised by the recipient ~~under the fiscal agent option according to section 256B.0627, subdivision 10;~~ or a qualified professional. "Qualified professional" means a mental health professional as defined in section 245.462, subdivision 18, or 245.4871, subdivision 27; or a registered nurse as defined in sections 148.171 to 148.285. As part of the assessment, the county public health nurse will ~~consult with~~ assist the recipient or responsible party ~~and to~~ to identify the most appropriate person to provide supervision of the personal care assistant. The qualified professional shall perform the duties described in Minnesota Rules, part 9505.0335, subpart 4.

Sec. 18. Minnesota Statutes 2000, section 256B.0625, subdivision 20, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

- (1) the costs of developing and implementing this section; and
- (2) programming the information systems.

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 43. [TARGETED CASE MANAGEMENT.] For purposes of subdivisions 43a to 43h, the following terms have the meanings given them:

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

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

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

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

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

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

Subd. 43a. [ELIGIBILITY.] The following persons are eligible for relocation targeted case management or home care targeted case management:

(1) medical assistance eligible persons residing in institutions who choose to move into the community are eligible for relocation targeted case management services; and

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

Sec. 21. Minnesota Statutes 2000, section 256B.0625, is amended by adding a subdivision to read:

Subd. 43b. [RELOCATION TARGETED CASE MANAGEMENT PROVIDER QUALIFICATIONS.] The following qualifications and certification standards must be met by providers of relocation targeted case management:

(a) The commissioner must certify each provider of relocation targeted case management before enrollment. The certification process shall examine the provider's ability to meet the requirements in this subdivision and other federal and state requirements of this service. A certified relocation targeted case management provider may subcontract with another provider to deliver relocation targeted case management services. Subcontracted providers must demonstrate the ability to provide the services outlined in subdivision 43d.

(b) A relocation targeted case management provider is an enrolled medical assistance provider who is determined by the commissioner to have all of the following characteristics:

(1) the legal authority to provide public welfare under sections 393.01, subdivision 7; and 393.07, or a federally recognized Indian tribe;

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

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

(4) the legal authority to provide complete investigative and protective services under section 626.556, subdivision 10, and child welfare and foster care services under section 393.07, subdivisions 1 and 2, or a federally recognized Indian tribe;

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

(6) the capacity to document and maintain individual case records under state and federal requirements.

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



Sec. 22. Minnesota Statutes 2000, section 256B.0625, is amended by adding a subdivision to read:

Subd. 43c. [HOME CARE TARGETED CASE MANAGEMENT PROVIDER QUALIFICATIONS.] The following qualifications and certification standards must be met by providers of home care targeted case management.

(a) The commissioner must certify each provider of home care targeted case management before enrollment. The certification process shall examine the provider's ability to meet the requirements in this subdivision and other state and federal requirements of this service.

(b) A home care targeted case management provider is an enrolled medical assistance provider who has a minimum of a bachelor's degree or a license in a health or human services field, and is determined by the commissioner to have all of the following characteristics:

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

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

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

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

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

Sec. 23. Minnesota Statutes 2000, section 256B.0625, is amended by adding a subdivision to read:

Subd. 43d. [ELIGIBLE SERVICES.] Services eligible for medical assistance reimbursement as targeted case management include:

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

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

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

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

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

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

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

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

Sec. 24. Minnesota Statutes 2000, section 256B.0625, is amended by adding a subdivision to read:

Subd. 43e. [TIME LINES.] The following time lines must be met for assigning a case manager:

(1) for relocation targeted case management, an eligible recipient must be assigned a case manager who visits the person within 20 working days of requesting a case manager from their county of financial responsibility as determined under chapter 256G. If a county agency does not provide case management services as required, the recipient may, after written notice to the county agency, obtain targeted relocation case management services from a home care targeted case management provider, as defined in subdivision 43c; and

(2) for home care targeted case management, an eligible recipient must be assigned a case manager within 20 working days of requesting a case manager from a home care targeted case management provider, as defined in subdivision 43c.

Sec. 25. Minnesota Statutes 2000, section 256B.0625, is amended by adding a subdivision to read:

Subd. 43f. [EVALUATION.] The commissioner shall evaluate the delivery of targeted case management, including, but not limited to, access to case management services, consumer satisfaction with case management services, and quality of case management services.

Sec. 26. Minnesota Statutes 2000, section 256B.0625, is amended by adding a subdivision to read:

Subd. 43g. [CONTACT DOCUMENTATION.] The case manager must document each face-to-face and telephone contact with the recipient and others involved in the recipient's individual service plan.

Sec. 27. Minnesota Statutes 2000, section 256B.0625, is amended by adding a subdivision to read:

Subd. 43h. [PAYMENT RATES.] The commissioner shall set payment rates for targeted case management under this subdivision. Case managers may bill according to the following criteria:

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

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

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

Sec. 28. Minnesota Statutes 2000, section 256B.0627, subdivision 1, is amended to read:

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

(b) "Assessment" means a review and evaluation of a recipient's need for home care services conducted in person. Assessments for private duty nursing shall be conducted by a registered private duty nurse. Assessments for home health agency services shall be conducted by a home health agency nurse. Assessments for personal care assistant services shall be conducted by the county public health nurse or a certified public health nurse under contract with the county. A face-to-face assessment must include: documentation of health status, determination of need, evaluation of service effectiveness, identification of appropriate services, service plan development or modification, coordination of services, referrals and follow-up to appropriate payers and community resources, completion of required reports, recommendation of service authorization, and consumer education. Once the need for personal care assistant services is determined under this section, the county public health nurse or certified public health nurse

under contract with the county is responsible for communicating this recommendation to the commissioner and the recipient. A face-to-face assessment for personal care assistant services is conducted on those recipients who have never had a county public health nurse assessment. A face-to-face assessment must occur at least annually or when there is a significant change in the recipient's condition or when there is a change in the need for personal care assistant services. A service update may substitute for the annual face-to-face assessment when there is not a significant change in recipient condition or a change in the need for personal care assistant service. A service update or review for temporary increase includes a review of initial baseline data, evaluation of service effectiveness, redetermination of service need, modification of service plan and appropriate referrals, update of initial forms, obtaining service authorization, and on going consumer education. Assessments for medical assistance home care services for mental retardation or related conditions and alternative care services for developmentally disabled home and community-based 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 July 1, 2001:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(h)~~ (l) "Service plan" means a written description of the services needed based on the assessment developed by the nurse who conducts the assessment together with the recipient or responsible party. The service plan shall include a description of the covered home care services, frequency and duration of services, and expected outcomes and goals. The recipient and the provider chosen by the recipient or responsible party must be given a copy of the completed service plan within 30 calendar days of the request for home care services by the recipient or responsible party.

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

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

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

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

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

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

Sec. 29. Minnesota Statutes 2000, section 256B.0627, subdivision 2, is amended to read:

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

- (1) nursing services under section 256B.0625, subdivision 6a;
- (2) private duty nursing services under section 256B.0625, subdivision 7;
- (3) home health ~~aide~~ services under section 256B.0625, subdivision 6a;
- (4) personal care assistant services under section 256B.0625, subdivision 19a;
- (5) supervision of personal care assistant services provided by a qualified professional under section 256B.0625, subdivision 19a;
- (6) ~~consulting~~ qualified professional of personal care assistant services under the fiscal ~~agent~~ intermediary option as specified in subdivision 10;
- (7) face-to-face assessments by county public health nurses for services under section 256B.0625, subdivision 19a; and
- (8) service updates and review of temporary increases for personal care assistant services by the county public health nurse for services under section 256B.0625, subdivision 19a.

Sec. 30. Minnesota Statutes 2000, section 256B.0627, subdivision 4, is amended to read:

Subd. 4. [PERSONAL CARE ASSISTANT SERVICES.] (a) The personal care assistant services that are eligible for payment are ~~the following: services and supports furnished to an individual, as needed, to assist in accomplishing activities of daily living; instrumental activities of daily living; health-related functions through hands-on assistance, supervision, and cuing; and redirection and intervention for behavior including observation and monitoring.~~

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

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

- (1) bowel and bladder care;
- (2) skin care to maintain the health of the skin;
- (3) repetitive maintenance range of motion, muscle strengthening exercises, and other tasks specific to maintaining a recipient's optimal level of function;
- (4) respiratory assistance;
- (5) transfers and ambulation;
- (6) bathing, grooming, and hairwashing necessary for personal hygiene;
- (7) turning and positioning;
- (8) assistance with furnishing medication that is self-administered;

- (9) application and maintenance of prosthetics and orthotics;
- (10) cleaning medical equipment;
- (11) dressing or undressing;
- (12) assistance with eating and meal preparation and necessary grocery shopping;
- (13) accompanying a recipient to obtain medical diagnosis or treatment;
- (14) assisting, monitoring, or prompting the recipient to complete the services in clauses (1) to (13);
- (15) redirection, monitoring, and observation that are medically necessary and an integral part of completing the personal care assistant services described in clauses (1) to (14);
- (16) redirection and intervention for behavior, including observation and monitoring;
- (17) interventions for seizure disorders, including monitoring and observation if the recipient has had a seizure that requires intervention within the past three months;
- (18) tracheostomy suctioning using a clean procedure if the procedure is properly delegated by a registered nurse. Before this procedure can be delegated to a personal care assistant, a registered nurse must determine that the tracheostomy suctioning can be accomplished utilizing a clean rather than a sterile procedure and must ensure that the personal care assistant has been taught the proper procedure; and
- (19) incidental household services that are an integral part of a personal care service described in clauses (1) to (18).

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

- ~~(b)~~ (d) The personal care assistant services that are not eligible for payment are the following:
- (1) services not ordered by the physician;
  - (2) assessments by personal care assistant provider organizations or by independently enrolled registered nurses;
  - (3) services that are not in the service plan;
  - (4) services provided by the recipient's spouse, legal guardian for an adult or child recipient, or parent of a recipient under age 18;
  - (5) services provided by a foster care provider of a recipient who cannot direct the recipient's own care, unless monitored by a county or state case manager under section 256B.0625, subdivision 19a;
  - (6) services provided by the residential or program license holder in a residence for more than four persons;
  - (7) services that are the responsibility of a residential or program license holder under the terms of a service agreement and administrative rules;
  - (8) sterile procedures;

- (9) injections of fluids into veins, muscles, or skin;
- (10) services provided by parents of adult recipients, adult children, or siblings of the recipient, unless these relatives meet one of the following hardship criteria and the commissioner waives this requirement:
  - (i) the relative resigns from a part-time or full-time job to provide personal care for the recipient;
  - (ii) the relative goes from a full-time to a part-time job with less compensation to provide personal care for the recipient;
  - (iii) the relative takes a leave of absence without pay to provide personal care for the recipient;
  - (iv) the relative incurs substantial expenses by providing personal care for the recipient; or
  - (v) because of labor conditions, special language needs, or intermittent hours of care needed, the relative is needed in order to provide an adequate number of qualified personal care assistants to meet the medical needs of the recipient;
- (11) homemaker services that are not an integral part of a personal care assistant services;
- (12) home maintenance, or chore services;
- (13) services not specified under paragraph (a); and
- (14) services not authorized by the commissioner or the commissioner's designee.

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

Sec. 31. Minnesota Statutes 2000, section 256B.0627, subdivision 5, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

(1) The amount and type of service authorized based upon the assessment and service plan will follow the recipient if the recipient chooses to change providers.

(2) If the recipient's medical need changes, the recipient's provider may assess the need for a change in service authorization and request the change from the county public health nurse. Within 30 days of the request, the public health nurse will determine whether to request the change in services based upon the provider assessment, or conduct a home visit to assess the need and determine whether the change is appropriate.

(3) To continue to receive personal care assistant services after the first year, the recipient or the responsible party, in conjunction with the public health nurse, may complete a service update on forms developed by the commissioner according to criteria and procedures in subdivision 1.

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

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

(2) [PERSONAL CARE ASSISTANT SERVICES.] (i) All personal care assistant services and supervision by a qualified professional, if requested by the recipient, must be prior authorized by the commissioner or the commissioner's designee except for the assessments established in paragraph (a). The amount of personal care assistant services authorized must be based on the recipient's home care rating. A child may not be found to be



dependent in an activity of daily living if because of the child's age an adult would either perform the activity for the child or assist the child with the activity and the amount of assistance needed is similar to the assistance appropriate for a typical child of the same age. Based on medical necessity, the commissioner may authorize:

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

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

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

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

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

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

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

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

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

(A) daily tube feedings;

(B) daily parenteral therapy;

(C) wound or decubiti care;

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

(E) catheterization;

(F) ostomy care;

(G) quadriplegia; or

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

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

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

(B) physical injury to other people; or

(C) destruction of property.

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

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

(A) unusual or repetitive habits;

(B) withdrawn behavior; or

(C) offensive behavior.

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

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

(i) the recipient requires more individual and continuous care than can be provided during a nurse visit; or

(ii) the cares are outside of the scope of services that can be provided by a home health aide or personal care assistant.

The commissioner may authorize:

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

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

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

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

Beginning July 1, 2001, private duty nursing services shall be authorized for complex and regular care according to subdivision 1.

(4) [VENTILATOR-DEPENDENT RECIPIENTS.] If the recipient is ventilator-dependent, the monthly medical assistance authorization for home care services shall not exceed what the commissioner would pay for care at the highest cost hospital designated as a long-term hospital under the Medicare program. For purposes of this clause, home care services means all services provided in the home that would be included in the payment for care at the long-term hospital. "Ventilator-dependent" means an individual who receives mechanical ventilation for life support at least six hours per day and is expected to be or has been dependent for at least 30 consecutive days.

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

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

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

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

The commissioner may not authorize:

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

(2) personal care assistant services when the foster care license holder is also the personal care provider or personal care assistant unless the recipient can direct the recipient's own care, or case management is provided as required in section 256B.0625, subdivision 19a;

(3) personal care assistant services when the responsible party is an employee of, or under contract with, or has any direct or indirect financial relationship with the personal care provider or personal care assistant, unless case management is provided as required in section 256B.0625, subdivision 19a; or

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

Sec. 32. Minnesota Statutes 2000, section 256B.0627, subdivision 7, is amended to read:

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

(1) skilled nurse visits for the sole purpose of supervision of the home health aide;

(2) a skilled nursing visit:

(i) only for the purpose of monitoring medication compliance with an established medication program for a recipient; or

(ii) to administer or assist with medication administration, including injections, prefiling syringes for injections, or oral medication set-up of an adult recipient, when as determined and documented by the registered nurse, the need can be met by an available pharmacy or the recipient is physically and mentally able to self-administer or prefill a medication;

(3) home care services to a recipient who is eligible for covered services ~~including hospice, if elected by the recipient,~~ under the Medicare program or any other insurance held by the recipient;

(4) services to other members of the recipient's household;

(5) a visit made by a skilled nurse solely to train other home health agency workers;

(6) any home care service included in the daily rate of the community-based residential facility where the recipient is residing;

(7) nursing and rehabilitation therapy services that are reasonably accessible to a recipient outside the recipient's place of residence, excluding the assessment, counseling and education, and personal assistant care;

(8) any home health agency service, excluding personal care assistant services and private duty nursing services, which are performed in a place other than the recipient's residence; and

(9) Medicare evaluation or administrative nursing visits on dual-eligible recipients that do not qualify for Medicare visit billing.

Sec. 33. Minnesota Statutes 2000, section 256B.0627, subdivision 8, is amended to read:

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

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

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

- (1) the home or foster care home of one of the individual recipients; or
- (2) a child care program in which all recipients served by one personal care assistant are participating, which is licensed under chapter 245A or operated by a local school district or private school; or
- (3) outside the home or foster care home of one of the recipients when normal life activities take the recipients outside the home.

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

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

- (1) whether shared personal care assistant services is an appropriate option based on the individual needs and preferences of the recipient; and
- (2) the amount of shared services allocated as part of the overall authorization of personal care assistant services.

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

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

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

- (3) the setting in which the shared services will be provided;
  - (4) the ongoing monitoring and evaluation of the effectiveness and appropriateness of the service and process used to make changes in service or setting; and
  - (5) a contingency plan which accounts for absence of the recipient in a shared services setting due to illness or other circumstances and staffing contingencies.
- (f) The provider must offer the recipient or the responsible party the option of shared or one-on-one personal care assistant services. The recipient or the responsible party can withdraw from participating in a shared services arrangement at any time.
- (g) In addition to documentation requirements under Minnesota Rules, part 9505.2175, a personal care provider must meet documentation requirements for shared personal care assistant services and must document the following in the health service record for each individual recipient sharing services:
- (1) permission by the recipient or the recipient's responsible party, if any, for the maximum number of shared services hours per week chosen by the recipient;
  - (2) permission by the recipient or the recipient's responsible party, if any, for personal care assistant services provided outside the recipient's residence;
  - (3) permission by the recipient or the recipient's responsible party, if any, for others to receive shared services in the recipient's residence;
  - (4) revocation by the recipient or the recipient's responsible party, if any, of the shared service authorization, or the shared service to be provided to others in the recipient's residence, or the shared service to be provided outside the recipient's residence;
  - (5) supervision of the shared personal care assistant services by the qualified professional, if a qualified professional is requested by one of the recipients or responsible parties, including the date, time of day, number of hours spent supervising the provision of shared services, whether the supervision was face-to-face or another method of supervision, changes in the recipient's condition, shared services scheduling issues and recommendations;
  - (6) documentation by the qualified professional, if a qualified professional is requested by one of the recipients or responsible parties, of telephone calls or other discussions with the personal care assistant regarding services being provided to the recipient who has requested the supervision; and
  - (7) daily documentation of the shared services provided by each identified personal care assistant including:
    - (i) the names of each recipient receiving shared services together;
    - (ii) the setting for the shared services, including the starting and ending times that the recipient received shared services; and
    - (iii) notes by the personal care assistant regarding changes in the recipient's condition, problems that may arise from the sharing of services, scheduling issues, care issues, and other notes as required by the qualified professional, if a qualified professional is requested by one of the recipients or responsible parties.
- (h) Unless otherwise provided in this subdivision, all other statutory and regulatory provisions relating to personal care assistant services apply to shared services.

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

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

Sec. 34. Minnesota Statutes 2000, section 256B.0627, subdivision 10, is amended to read:

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

- ~~(1) use a fiscal agent instead of a personal care provider organization;~~
- ~~(2) supervise the personal care assistant; and~~
- ~~(3) use a consulting professional.~~

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

(b) The recipient or responsible party shall:

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

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

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

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

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

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

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

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

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

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

- (1) bill the medical assistance program for personal care assistant and ~~consulting~~ qualified professional services;
- (2) request and secure background checks on personal care assistants and ~~consulting~~ qualified professionals according to section 245A.04;
- (3) pay the personal care assistant and ~~consulting~~ qualified professional based on actual hours of services provided;
- (4) withhold and pay all applicable federal and state taxes;
- (5) verify and ~~document~~ keep records of hours worked by the personal care assistant and ~~consulting~~ qualified professional;
- (6) make the arrangements and pay unemployment insurance, taxes, workers' compensation, liability insurance, and other benefits, if any;
- (7) enroll in the medical assistance program as a fiscal ~~agent~~ intermediary; and
- (8) enter into a written agreement as specified in paragraph (f) before services are provided.

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

- (1) may not be related to the recipient, ~~consulting~~ qualified professional, or the personal care assistant;
- (2) must ensure arm's length transactions with the recipient and personal care assistant; and
- (3) shall be considered a joint employer of the personal care assistant and ~~consulting~~ qualified professional to the extent specified in this section.

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

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

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

- (1) the duties of the recipient, qualified professional, personal care assistant, and fiscal agent based on paragraphs (a) to (e);
- (2) the salary and benefits for the personal care assistant and ~~those providing professional consultation the~~ qualified professional;



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 35. Minnesota Statutes 2000, section 256B.0627, subdivision 11, is amended to read:

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

(b) Recipients of private duty nursing services may share nursing staff and the commissioner shall provide a rate methodology for shared private duty nursing. For two persons sharing nursing care, the rate paid to a provider shall not exceed 1.5 times the ~~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. 36. Minnesota Statutes 2000, section 256B.0627, is amended by adding a subdivision to read:

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

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

historical expenditures made on behalf of the enrollee for personal care, home health aide, or private duty nursing services during the 12 month period directly prior to enrollment in the project. The grant award will equal 90 percent of the average monthly expenditure.

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

(d) The state of Minnesota, county agencies, tribal governments, or administrative entities under contract with the state that participate in the implementation and administration of the consumer-directed home care demonstration project, shall not be liable for damages, injuries, or liabilities sustained through the purchase of support by the individual, the individual's family, or the authorized representative under this section with funds received through the consumer-directed home care demonstration project. Liabilities include but are not limited to: workers' compensation liability, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA).

Sec. 37. Minnesota Statutes 2000, section 256B.0627, is amended by adding a subdivision to read:

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

Sec. 38. Minnesota Statutes 2000, section 256B.0627, is amended by adding a subdivision to read:

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

(b) [OCCUPATIONAL THERAPY.] Medical assistance covers occupational therapy and related services, including specialized maintenance therapy. Services provided by an occupational therapy assistant shall be reimbursed at the same rate as services performed by an occupational therapist when the services of the occupational therapy assistant are provided under the direction of the occupational therapist who is on the premises. Services

provided by an occupational therapy assistant under the direction of an occupational therapist who is not on the premises shall be reimbursed at 65 percent of the occupational therapist rate. Direction of the occupational therapy assistant must be provided by the occupational therapist as described in Minnesota Rules, part 9505.0390, subpart 1, item B. The occupational therapist and occupational therapist assistant may not both bill for services provided to a recipient on the same day.

Sec. 39. Minnesota Statutes 2000, section 256B.0627, is amended by adding a subdivision to read:

Subd. 16. [HARDSHIP CRITERIA; PRIVATE DUTY NURSING.] (a) Payment is allowed for extraordinary services that require specialized nursing skills and are provided by parents of minor children, spouses, and legal guardians who are providing private duty nursing care under the following conditions:

(1) the provision of these services is not legally required of the parents, spouses, or legal guardians;

(2) the services are necessary to prevent hospitalization of the recipient; and

(3) the recipient is eligible for state plan home care or a home and community-based waiver and one of the following hardship criteria are met:

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

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

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

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

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

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

Sec. 40. Minnesota Statutes 2000, section 256B.0627, is amended by adding a subdivision to read:

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

(1) performance-based provider agreements;

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

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

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

Sec. 41. Minnesota Statutes 2000, section 256B.0911, is amended by adding a subdivision to read:

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

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

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

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

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

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

(g) At the face-to-face assessment, the long-term care consultation team member or the case manager must present information about home and community-based options so the individual can make informed choices. If the individual chooses home and community-based services, the long-term care consultation team member or case manager must complete a written relocation plan within 20 working days of the visit. The plan shall describe the services needed to move out of the facility and a time line for the move which is designed to ensure a smooth transition to the individual's home and community.

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

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

Sec. 42. Minnesota Statutes 2000, section 256B.0916, subdivision 1, is amended to read:

Subdivision 1. [REDUCTION OF WAITING LIST.] (a) The legislature recognizes that as of January 1, 1999, 3,300 persons with mental retardation or related conditions have been screened and determined eligible for the home and community-based waiver services program for persons with mental retardation or related conditions. Many wait for several years before receiving service.

(b) The waiting list for this program shall be reduced or eliminated by June 30, 2003. In order to reduce the number of eligible persons waiting for identified services provided through the home and community-based waiver for persons with mental retardation or related conditions, during the period from July 1, 1999, to June 30, 2003, funding shall be increased to add 100 additional eligible persons each year beyond the February 1999 medical assistance forecast.

(c) The commissioner shall allocate resources in such a manner as to use all resources budgeted during a biennium for the home and community-based waiver for persons with mental retardation or related conditions according to the priorities listed in subdivision 2, paragraph (b), and then to serve other persons on the waiting list. Resources allocated for a fiscal year to serve persons affected by public and private sector ICF/MR closures, but not expected to be expended for that purpose, must be reallocated within that fiscal year to serve other persons on the waiting list, and the number of waiver diversion slots shall be adjusted accordingly.

(d) For fiscal year 2001, at least one-half of the increase in funding over the previous year provided in the February 1999 medical assistance forecast for the home and community-based waiver for persons with mental retardation and related conditions, including changes made by the 1999 legislature, must be used to serve persons who are not affected by public and private sector ICF/MR closures.

(e) The commissioner of finance shall not reduce the expenditure forecast for a biennium for which appropriations have been made, if at the time of the forecast there is a waiting list for waiver services for persons with mental retardation or related conditions who need services within the next 30 months. Funds that would have resulted from a projected reduction in expenditures must be used by the commissioner of human services to serve persons with developmental disabilities through the home and community-based waiver for persons with mental retardation or related conditions.

Sec. 43. Minnesota Statutes 2000, section 256B.0916, is amended by adding a subdivision to read:

Subd. 6a. [STATEWIDE AVAILABILITY OF CONSUMER-DIRECTED COMMUNITY SUPPORT SERVICES.] (a) The commissioner shall submit to the federal Health Care Financing Administration by August 1, 2001, an amendment to the home and community-based waiver for persons with mental retardation or related conditions to make consumer-directed community support services available in every county of the state by January 1, 2002.

(b) If a county declines to meet the requirements for provision of consumer-directed community supports, the commissioner shall contract with another county, a group of counties, or a private agency to plan for and administer consumer-directed community supports in that county.

(c) The state of Minnesota, county agencies, tribal governments, or administrative entities under contract to participate in the implementation and administration of the home and community-based waiver for persons with mental retardation or a related condition, shall not be liable for damages, injuries, or liabilities sustained through the purchase of support by the individual, the individual's family, or the authorized representative with funds received through the consumer-directed community support service under this section. Liabilities include but are not limited to: workers' compensation liability, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA).

Sec. 44. Minnesota Statutes 2000, section 256B.0916, subdivision 7, is amended to read:

Subd. 7. [ANNUAL REPORT BY COMMISSIONER.] Beginning ~~October 1, 1999, and each October 1~~ November 1, 2001, and each November 1 thereafter, the commissioner shall issue an annual report on county and state use of available resources for the home and community-based waiver for persons with mental retardation or related conditions. For each county or county partnership, the report shall include:

(1) the amount of funds allocated but not used;

- (2) the county specific allowed reserve amount approved and used;
- (3) the number, ages, and living situations of individuals screened and waiting for services;
- (4) the urgency of need for services to begin within one, two, or more than two years for each individual;
- (5) the services needed;
- (6) the number of additional persons served by approval of increased capacity within existing allocations;
- (7) results of action by the commissioner to streamline administrative requirements and improve county resource management; and
- (8) additional action that would decrease the number of those eligible and waiting for waived services.

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

Sec. 45. Minnesota Statutes 2000, section 256B.0916, subdivision 9, is amended to read:

Subd. 9. [LEGAL REPRESENTATIVE PARTICIPATION EXCEPTION.] The commissioner, in cooperation with representatives of counties, service providers, service recipients, family members, legal representatives and advocates, shall develop criteria to allow legal representatives to be reimbursed for providing specific support services to meet the person's needs when a plan which assures health and safety has been agreed upon and carried out by the legal representative, the person, and the county. Legal representatives providing support under ~~consumer-directed community support services pursuant to section 256B.092, subdivision 4, the home and community-based waiver for persons with mental retardation or related conditions~~ or the consumer support grant program pursuant to section 256B.092, subdivision 7 ~~256.476~~, shall not be considered to have a direct or indirect service provider interest under section 256B.092, subdivision 7, if a health and safety plan which meets the criteria established has been agreed upon and implemented. By ~~October 1, 1999~~ August 1, 2001, the commissioner shall submit, for federal approval, amendments to allow legal representatives to provide support and receive reimbursement under the ~~consumer-directed community support services section of the home and community-based waiver plan.~~

Sec. 46. Minnesota Statutes 2000, section 256B.092, subdivision 2a, is amended to read:

Subd. 2a. [MEDICAL ASSISTANCE FOR CASE MANAGEMENT ACTIVITIES UNDER THE STATE PLAN MEDICAID OPTION.] (a) Upon receipt of federal approval, the commissioner shall make payments to approved vendors counties, private individuals, and agencies enrolled as providers of case management services participating in the medical assistance program to reimburse costs for providing case management service activities to medical assistance eligible persons with mental retardation or a related condition, in accordance with the state Medicaid plan, the home and community-based waiver for persons with mental retardation and related conditions plan, and federal requirements and limitations.

(b) The commissioner shall ensure that each eligible person is given a choice of county and private agency case management service providers. Case management service providers are prohibited from providing any other service to the person receiving case management services.

Sec. 47. Minnesota Statutes 2000, section 256B.092, subdivision 5, is amended to read:

Subd. 5. [FEDERAL WAIVERS.] (a) The commissioner shall apply for any federal waivers necessary to secure, to the extent allowed by law, federal financial participation under United States Code, title 42, sections 1396 et seq., as amended, for the provision of services to persons who, in the absence of the services, would need the level of care provided in a regional treatment center or a community intermediate care facility for persons with mental retardation or related conditions. The commissioner may seek amendments to the waivers or apply for additional waivers under



United States Code, title 42, sections 1396 et seq., as amended, to contain costs. The commissioner shall ensure that payment for the cost of providing home and community-based alternative services under the federal waiver plan shall not exceed the cost of intermediate care services including day training and habilitation services that would have been provided without the waived services.

(b) The commissioner, in administering home and community-based waivers for persons with mental retardation and related conditions, shall ensure that day services for eligible persons are not provided by the person's residential service provider, unless the person or the person's legal representative is offered a choice of providers and agrees in writing to provision of day services by the residential service provider. The individual service plan for individuals who choose to have their residential service provider provide their day services must describe how health, safety, and protection needs will be met by frequent and regular contact with persons other than the residential service provider.

Sec. 48. Minnesota Statutes 2000, section 256B.093, subdivision 3, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

Sec. 49. Minnesota Statutes 2000, section 256B.095, is amended to read:

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

Effective July 1, 1998, an alternative quality assurance licensing system ~~pilot~~ project for programs for persons with developmental disabilities is established in Dodge, Fillmore, Freeborn, Goodhue, Houston, Mower, Olmsted, Rice, Steele, Wabasha, and Winona counties for the purpose of improving the quality of services provided to persons with developmental disabilities. A county, at its option, may choose to have all programs for persons with developmental disabilities located within the county licensed under chapter 245A using standards determined under the alternative quality assurance licensing system ~~pilot~~ project or may continue regulation of these programs under the licensing system operated by the commissioner. The ~~pilot~~ project expires on June 30, ~~2001~~ 2005.

Sec. 50. Minnesota Statutes 2000, section 256B.0951, subdivision 1, is amended to read:

Subdivision 1. [MEMBERSHIP.] The region 10 quality assurance commission is established. The commission consists of at least 14 but not more than 21 members as follows: at least three but not more than five members representing advocacy organizations; at least three but not more than five members representing consumers, families, and their legal representatives; at least three but not more than five members representing service providers; at least three but not more than five members representing counties; and the commissioner of human services or the commissioner's designee. Initial membership of the commission shall be recruited and approved by the region 10 stakeholders group. Prior to approving the commission's membership, the stakeholders group shall provide to the commissioner a list of the membership in the stakeholders group, as of February 1, 1997, a brief summary of meetings held by the group since July 1, 1996, and copies of any materials prepared by the group for public distribution. The first commission shall establish membership guidelines for the transition and recruitment of membership for the commission's ongoing existence. Members of the commission who do not receive a salary or wages from an employer for time spent on commission duties may receive a per diem payment when performing commission duties and functions. All members may be reimbursed for expenses related to commission activities. Notwithstanding the provisions of section 15.059, subdivision 5, the commission expires on June 30, ~~2001~~ 2005.

Sec. 51. Minnesota Statutes 2000, section 256B.0951, subdivision 3, is amended to read:

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

(b) By January 15, 1998, the commission shall approve, in cooperation with the commissioner of human services, a training program for members of the quality assurance teams established under section 256B.0952, subdivision 4.

(c) The commission and the commissioner shall establish an ongoing review process for the alternative quality assurance licensing system. The review shall take into account the comprehensive nature of the alternative system, which is designed to evaluate the broad spectrum of licensed and unlicensed entities that provide services to clients, as compared to the current licensing system.

(d) The commission shall contract with an independent entity to conduct a financial review of the alternative quality assurance ~~pilot~~ project. The review shall take into account the comprehensive nature of the alternative system, which is designed to evaluate the broad spectrum of licensed and unlicensed entities that provide services to clients, as compared to the current licensing system. The review shall include an evaluation of possible budgetary savings within the department of human services as a result of implementation of the alternative quality assurance ~~pilot~~ project. If a federal waiver is approved under subdivision 7, the financial review shall also evaluate possible savings within the department of health. This review must be completed by December 15, 2000.

(e) The commission shall submit a report to the legislature by January 15, 2001, on the results of the review process for the alternative quality assurance ~~pilot~~ project, a summary of the results of the independent financial review, and a recommendation on whether the ~~pilot~~ project should be extended beyond June 30, 2001.

(f) The commissioner, in consultation with the commission, shall examine the feasibility of expanding the project to other populations or geographic areas and identify barriers to expansion. The commissioner shall report findings and recommendations to the legislature by December 15, 2004.

Sec. 52. Minnesota Statutes 2000, section 256B.0951, subdivision 4, is amended to read:

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

Sec. 53. Minnesota Statutes 2000, section 256B.0951, subdivision 5, is amended to read:

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

Sec. 54. Minnesota Statutes 2000, section 256B.0951, subdivision 7, is amended to read:

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

Sec. 55. Minnesota Statutes 2000, section 256B.0951, is amended by adding a subdivision to read:

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

Sec. 56. Minnesota Statutes 2000, section 256B.0951, is amended by adding a subdivision to read:

Subd. 9. [EVALUATION.] The commission, in consultation with the commissioner of human services, shall conduct an evaluation of the alternative quality assurance system, and present a report to the commissioner by June 30, 2004.

Sec. 57. Minnesota Statutes 2000, section 256B.0952, subdivision 1, is amended to read:

Subdivision 1. [NOTIFICATION.] ~~By January 15, 1998, each affected county shall notify the commission and the commissioners of human services and health as to whether it chooses to implement on July 1, 1998, the alternative licensing system for the pilot project. A county that does not implement the alternative licensing system~~

on July 1, 1998, may give notice to the commission and the commissioners by January 15, 1999, or January 15, 2000; that it will implement the alternative licensing system on the following July 1. A county that implements the alternative licensing system commits to participate until June 30, 2001. For each year of the project, region 10 counties shall give notice to the commission and commissioners of human services and health by March 15 of intent to join the quality assurance alternative licensing system, effective July 1 of that year. A county choosing to participate in the alternative licensing system commits to participate until June 30, 2005. Counties participating in the quality assurance alternative licensing system as of January 1, 2001, shall notify the commission and the commissioners of human services and health by March 15, 2001, of intent to continue participation. Counties that elect to continue participation must participate in the alternative licensing system until June 30, 2005.

Sec. 58. Minnesota Statutes 2000, section 256B.0952, subdivision 4, is amended to read:

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

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

Sec. 59. Minnesota Statutes 2000, section 256B.49, is amended by adding a subdivision to read:

Subd. 11. [AUTHORITY.] (a) The commissioner is authorized to apply for home and community-based service waivers, as authorized under section 1915(c) of the Social Security Act to serve persons under the age of 65 who are determined to require the level of care provided in a nursing home and persons who require the level of care provided in a hospital. The commissioner shall apply for the home and community-based waivers in order to: (i) promote the support of persons with disabilities in the most integrated settings; (ii) expand the availability of services for persons who are eligible for medical assistance; (iii) promote cost-effective options to institutional care; and (iv) obtain federal financial participation.

(b) The provision of 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.

(d) The commissioner shall seek approval, as authorized under section 1915(c) of the Social Security Act, to allow medical assistance eligibility under this section for children under age 21 without deeming of parental income or assets.

(e) The commissioner shall seek approval, as authorized under section 1915(c) of the Social Act, to allow medical assistance eligibility under this section for individuals under age 65 without deeming the spouse's income or assets.

Sec. 60. Minnesota Statutes 2000, section 256B.49, is amended by adding a subdivision to read:

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

Sec. 61. Minnesota Statutes 2000, section 256B.49, is amended by adding a subdivision to read:

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

- (1) assessing the needs of the individual within 20 working days of a recipient's request;
- (2) developing the written individual service plan within ten working days after the assessment is completed;
- (3) informing the recipient or the recipient's legal guardian or conservator of service options;
- (4) assisting the recipient in the identification of potential service providers;
- (5) assisting the recipient to access services;
- (6) coordinating, evaluating, and monitoring of the services identified in the service plan;
- (7) completing the annual reviews of the service plan; and
- (8) informing the recipient or legal representative of the right to have assessments completed and service plans developed within specified time periods, and to appeal county action or inaction under section 256.045, subdivision 3.

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

Sec. 62. Minnesota Statutes 2000, section 256B.49, is amended by adding a subdivision to read:

Subd. 14. [ASSESSMENT AND REASSESSMENT.] (a) Assessments of each recipient's strengths, informal support systems, and need for services shall be completed within 20 working days of the recipient's request. Reassessment of each recipient's strengths, support systems, and need for services shall be conducted at least every 12 months and at other times when there has been a significant change in the recipient's functioning.

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

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

Sec. 63. Minnesota Statutes 2000, section 256B.49, is amended by adding a subdivision to read:

Subd. 15. [INDIVIDUALIZED SERVICE PLAN.] Each recipient of home and community-based waived services shall be provided a copy of the written service plan which:

- (1) is developed and signed by the recipient within ten working days of the completion of the assessment;

- (2) meets the assessed needs of the recipient;
- (3) reasonably ensures the health and safety of the recipient;
- (4) promotes independence;
- (5) allows for services to be provided in the most integrated settings; and
- (6) provides for an informed choice, as defined in section 256B.77, subdivision 2, paragraph (p), of service and support providers.

Sec. 64. Minnesota Statutes 2000, section 256B.49, is amended by adding a subdivision to read:

Subd. 16. [SERVICES AND SUPPORTS.] (a) Services and supports included in the home and community-based waivers for persons with disabilities shall meet the requirements set out in United States Code, title 42, section 1396n. The services and supports, which are offered as alternatives to institutional care, shall promote consumer choice, community inclusion, self-sufficiency, and self-determination.

(b) Beginning January 1, 2003, the commissioner shall simplify and improve access to home and community-based 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.

(c) Consumer directed community support services shall be offered as an option to all persons eligible for services under section 256B.49, subdivision 11, by January 1, 2002.

(d) Services and supports shall be arranged and provided consistent with individualized written plans of care for eligible waiver recipients.

(e) The state of Minnesota and county agencies that administer home and community-based waived services for persons with disabilities, shall not be liable for damages, injuries, or liabilities sustained through the purchase of supports by the individual, the individual's family, or the authorized representative with funds received through the consumer-directed community support service under this section. Liabilities include but are not limited to: workers' compensation liability, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA).

Sec. 65. Minnesota Statutes 2000, section 256B.49, is amended by adding a subdivision to read:

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

(b) The commissioner shall implement on January 1, 2002, one or more aggregate, need-based methods for allocating to local agencies the home and community-based 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:

- (1) an incentive-based payment process for achieving outcomes;
- (2) the need for a state-level risk pool;
- (3) the need for retention of management responsibility at the state agency level; and
- (4) a phase-in strategy as appropriate.

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

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

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

(d) Beginning July 1, 2001, medically necessary private duty nursing services will be authorized under this section as complex and regular care according to section 256B.0627.

Sec. 66. Minnesota Statutes 2000, section 256B.49, is amended by adding a subdivision to read:

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

Sec. 67. Minnesota Statutes 2000, section 256B.49, is amended by adding a subdivision to read:

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

Sec. 68. Minnesota Statutes 2000, section 256B.49, is amended by adding a subdivision to read:

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

Sec. 69. Minnesota Statutes 2000, section 256B.69, subdivision 23, is amended to read:

Subd. 23. [ALTERNATIVE INTEGRATED LONG-TERM CARE SERVICES; ELDERLY AND DISABLED PERSONS.] (a) The commissioner may implement demonstration projects to create alternative integrated delivery systems for acute and long-term care services to elderly persons and persons with disabilities as defined in section 256B.77, subdivision 7a, that provide increased coordination, improve access to quality services, and mitigate future cost increases. The commissioner may seek federal authority to combine Medicare and Medicaid capitation payments for the purpose of such demonstrations. Medicare funds and services shall be administered according to the terms and conditions of the federal waiver and demonstration provisions. For the purpose of administering medical assistance funds, demonstrations under this subdivision are subject to subdivisions 1 to 22. The provisions of Minnesota Rules, parts 9500.1450 to 9500.1464, apply to these demonstrations, with the exceptions of parts 9500.1452, subpart 2, item B; and 9500.1457, subpart 1, items B and C, which do not apply to persons enrolling in demonstrations under this section. An initial open enrollment period may be provided. Persons who disenroll from demonstrations under this subdivision remain subject to Minnesota Rules, parts 9500.1450 to 9500.1464. When a person is enrolled in a health plan under these demonstrations and the health plan's participation is subsequently terminated for any reason, the person shall be provided an opportunity to select a new health plan and shall have the right to change health plans within the first 60 days of enrollment in the second health

plan. Persons required to participate in health plans under this section who fail to make a choice of health plan shall not be randomly assigned to health plans under these demonstrations. Notwithstanding section 256L.12, subdivision 5, and Minnesota Rules, part 9505.5220, subpart 1, item A, if adopted, for the purpose of demonstrations under this subdivision, the commissioner may contract with managed care organizations, including counties, to serve only elderly persons eligible for medical assistance, elderly and disabled persons, or disabled persons only. For persons with primary diagnoses of mental retardation or a related condition, serious and persistent mental illness, or serious emotional disturbance, the commissioner must ensure that the county authority has approved the demonstration and contracting design. Enrollment in these projects for persons with disabilities shall be voluntary ~~until July 1, 2001~~. The commissioner shall not implement any demonstration project under this subdivision for persons with primary diagnoses of mental retardation or a related condition, serious and persistent mental illness, or serious emotional disturbance, without approval of the county board of the county in which the demonstration is being implemented.

Before implementation of a demonstration project for disabled persons, the commissioner must provide information to appropriate committees of the house of representatives and senate and must involve representatives of affected disability groups in the design of the demonstration projects.

(b) A nursing facility reimbursed under the alternative reimbursement methodology in section 256B.434 may, in collaboration with a hospital, clinic, or other health care entity provide services under paragraph (a). The commissioner shall amend the state plan and seek any federal waivers necessary to implement this paragraph.

Sec. 70. Minnesota Statutes 2000, section 256D.35, is amended by adding a subdivision to read:

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

Sec. 71. Minnesota Statutes 2000, section 256D.35, is amended by adding a subdivision to read:

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

Sec. 72. Minnesota Statutes 2000, section 256D.44, subdivision 5, is amended to read:

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

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

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

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



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

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

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

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

Sec. 73. Minnesota Statutes 2000, section 256I.05, subdivision 1e, is amended to read:

Subd. 1e. [SUPPLEMENTARY RATE FOR CERTAIN FACILITIES.] Notwithstanding the provisions of subdivisions 1a and 1c, beginning July 1, ~~1999~~ 2001, a county agency shall negotiate a supplementary rate in addition to the rate specified in subdivision 1, equal to ~~25~~ 125 percent of the amount specified in subdivision 1a, including any legislatively authorized inflationary adjustments, for a group residential housing provider that:

(1) is located in Hennepin county and has had a group residential housing contract with the county since June 1996;

(2) operates in three separate locations a ~~56-bed~~ 71-bed facility, ~~and two 40-bed facility,~~ and a 30-bed facility facilities; and

(3) serves a chemically dependent clientele, providing 24 hours per day supervision and limiting a resident's maximum length of stay to 13 months out of a consecutive 24-month period.

Sec. 74. [256I.07] [RESPITE CARE PILOT PROJECT FOR FAMILY ADULT FOSTER CARE PROVIDERS.]

Subdivision 1. [PROGRAM ESTABLISHED.] The state recognizes the importance of developing and maintaining quality family foster care resources. In order to accomplish that goal, the commissioner shall establish a two-year respite care pilot project for family adult foster care providers in three counties. This pilot project is intended to provide support to caregivers of adult foster care residents. The commissioner shall establish a pilot project to accomplish the provisions in subdivisions 2 to 4.

Subd. 2. [ELIGIBILITY.] A family adult foster care home provider as defined under section 144D.01, subdivision 7, who has been licensed for six months is eligible for 30 days of respite care per calendar year. In cases of emergency, a county social services agency may waive the six-month licensing requirement. In order to be eligible to receive respite payment from group residential housing and alternative care, a provider must take time off away from their foster care residents.

Subd. 3. [PAYMENT STRUCTURE.] (a) The payment for respite care for an adult foster care resident eligible for only group residential housing shall be based on the current monthly group residential housing base room and board rate and the current maximum monthly group residential housing difficulty of care rate.

(b) The payment for respite care for an adult foster care resident eligible for alternative care funds shall be based on the resident's alternative care foster care rate.

(c) The payment for respite care for an adult foster care resident eligible for Medicaid home and community-based services waiver funds shall be based on the group residential housing base room and board rate.

(d) The total amount available to pay for respite care for a family adult foster care provider shall be based on the number of residents currently served in the foster care home and the source of funding used to pay for each resident's foster care. Respite care must be paid for on a per diem basis and for a full day.

Subd. 4. [PRIVATE PAY RESIDENTS.] Payment for respite care for private pay foster care residents must be arranged between the provider and the resident or the resident's family.

Sec. 75. Laws 1999, chapter 152, section 1, is amended to read:

Section 1. [TASK FORCE.]

A day training and habilitation task force is established. Task force membership shall consist of representatives of the commissioner of human services, counties, service consumers, and vendors of day training and habilitation as defined in Minnesota Statutes, section 252.41, subdivision 9, including at least one representative from each association representing day training and habilitation vendors. Appointments to the task force shall be made by the commissioner of human services and technical assistance shall be provided by the department of human services.

Sec. 76. Laws 1999, chapter 152, section 4, is amended to read:

Sec. 4. [REPORT.]

The task force shall present a report recommending a new payment rate structure to the legislature by January 15, 2000, and shall make recommendations to the commissioner of human services regarding the implementation of the pilot project for the individualized payment rate structure, so the pilot project can be implemented by July 1, 2002, as required in section 3. The task force expires on ~~March 15, 2000~~ December 30, 2003.

Sec. 77. [DAY TRAINING AND HABILITATION PAYMENT STRUCTURE PILOT PROJECT.]

Subdivision 1. [INDIVIDUALIZED PAYMENT RATE STRUCTURE.] Notwithstanding Minnesota Statutes, sections 252.451, subdivision 5; and 252.46; and Minnesota Rules, part 9525.1290, subpart 1, items A and B, the commissioner of human services shall initiate a pilot project and phase-in for the individualized payment rate structure described in this section and section 74. The pilot project shall include actual transfers of funds, not simulated transfers. The pilot project may include all or some of the vendors in up to eight counties, with no more than two counties from the seven-county Minneapolis-St. Paul metropolitan area. Following initiation of the pilot project, the commissioner shall phase in implementation of the individualized payment rate structure to the remaining counties and vendors according to the implementation plan developed by the task force. The pilot and phase-in shall not extend over more than 18 months and shall be completed by December 31, 2003.

Subd. 2. [SUNSET.] The pilot project shall sunset upon implementation of a new statewide rate structure according to the implementation plan developed by the task force described in subdivision 3, in its report to the legislature on December 1, 2001. The rates of vendors participating in the pilot project must be modified to be consistent with the new statewide rate structure, as implemented.

Subd. 3. [TASK FORCE RESPONSIBILITIES.] The day training and habilitation task force established under Laws 1999, chapter 152, section 4, shall evaluate the pilot project authorized under subdivision 1, and by December 1, 2001, shall report to the legislature with an implementation plan, which shall address how and when the pilot project individualized payment rate structure will be implemented statewide, shall ensure that vendors that wish to maintain their current per diem rate may do so within the new payment system, and shall identify criteria that would halt statewide implementation if vendors or clients were adversely affected by the new payment rate structure, and with recommendations for any amendments that should be made before statewide implementation. These recommendations shall be made in a report to the chairs of the house health and human services policy and finance committees and the senate health and family security committee and finance division.

Subd. 4. [RATE SETTING.] (a) The rate structure under this section is intended to allow a county to authorize an individual rate for each client in the vendor's program based on the needs and expected outcomes of the individual client. Rates shall be based on an authorized package of services for each individual over a typical time frame. Rates may be established across multiple sites run by a single vendor.

(b) With county concurrence, a vendor shall establish up to four levels of service, A through D, based on the intensity of services provided to an individual client of day training and habilitation services. Service level A shall be the highest intensity of services, marked primarily, but not exclusively, by a one-to-one client-to-staff ratio. Service level D shall be the lowest intensity of services. The county shall document the vendor's description of the type and amount of services associated with each service level.

(c) For each vendor, a county board shall establish a dollar value for one hour of service at each of the service levels defined in paragraph (b). In establishing these values for existing vendors transitioning from the payment rate structure under Minnesota Statutes, section 252.46, subdivision 1, the county board shall follow the formula and guidelines developed by the day training and habilitation task force under paragraph (e).

(d) A vendor may elect to maintain a single transportation rate or may elect to establish up to five types of transportation services: public transportation, public special transportation, nonambulatory transportation, out-of-service area transportation, and ambulatory transportation. For vendors that elect to establish multiple transportation services, the county board shall establish a dollar value for a round trip on each type of transportation service offered through the vendor. With vendor concurrence, the county may also establish a uniform one-way trip value for some or all of the transportation service types.

(e) The county board shall ensure that the vendor translates the vendor's existing program and transportation rates to the rates and values in the pilot project by using the conversion calculations for services and transportation approved by the day training and habilitation task force established under Laws 1999, chapter 152, and included in the task force's recommendations to the legislature. The conversion calculation may be amended by the task force with the approval of the commissioner and any amendments shall become effective upon notification to the pilot project counties from the commissioner. The calculation shall take the total reimbursement dollars available to the vendor and divide by the units of service expected at each service level and of each transportation type. In determining the total reimbursement dollars available to a vendor, the vendor shall multiply the vendor's current per diem rate for both services and transportation, including any new rate increases, by the vendor's actual utilization for the year prior to implementation of the pilot project. Vendors shall be allowed to allocate available reimbursement dollars between service and transportation before the vendor's service level and transportation values are calculated. After translating its existing service and transportation rates to the service level and transportation values under the pilot, the vendor shall project its expected reimbursement income using the expected service and transportation packages for its existing clients, based on current service authorizations. If the projected reimbursement income is less than the vendor would have received under the payment structure of Minnesota Statutes, section 252.46, the vendor and the county, with the approval of the commissioner, shall adjust the vendor's service level and transportation values to eliminate the shortfall. The commissioner shall report all adjustments to the day training and habilitation task force for consideration of possible modifications to the pilot project individualized payment rate structure.

Subd. 5. [INDIVIDUAL RATE AUTHORIZATION.] (a) As part of its annual authorization of services for each client under Minnesota Statutes, section 252.44, paragraph (a), clause (1), and Minnesota Rules, part 9525.0016, subpart 12, the county shall authorize and document a service package and a transportation package as follows:

(1) the service package shall include the amount and type of services at each applicable service level to be provided to the client over a package period. An individual client may receive services at multiple service levels over the course of the package period. The service package rate shall be the sum of the amount of services at each level over the package period, multiplied by the dollar value for each service level;

(2) the transportation package shall include the amount and type of transportation services to be provided to the client over the package period. The transportation package rate shall be the sum of the amount of transportation services, multiplied by the dollar value associated with the type of transportation service authorized for the client;

(3) the package period shall be established by the county, and may be one week, two weeks, or one month; and

(4) the individual rate authorization may be reviewed and modified by the county at any time and must be reviewed and reauthorized by the county at least annually.

(b) For vendors with rates established under this section, a service day under Minnesota Statutes, sections 245B.06 and 252.44, includes any day in which a client receives any reimbursable service from a vendor or attends employment arranged by the vendor.

Subd. 6. [BILLING FOR SERVICES.] The vendor shall bill for, and shall be reimbursed for, the service package rate and transportation package rate for the package period as authorized by the county for each client in the vendor's program. The length of the package period shall not affect the timing or frequency of vendors' submissions of claims for payment under the Medicaid Management Information System II (MMIS) or its successors.

Subd. 7. [NOTIFICATION OF CHANGE IN CLIENT NEEDS.] The vendor shall notify an individual client's case manager if the vendor has knowledge of a material change in the client's needs that may indicate a need for a change in service authorization. Factors that would require such notice include, but are not limited to, significant changes in medical status, residential placement, attendance patterns, behavioral needs, or skill functioning. The vendor shall notify the case manager as soon as possible but no later than 30 calendar days after becoming aware of the change in needs. The service authorization for the client shall not change until the county authorizes a new service and transportation package for the client in accordance with the provisions in Minnesota Statutes, section 256B.092.

#### Sec. 78. [COUNTY BOARD RESPONSIBILITIES.]

For each vendor with rates established under section 73, the county board shall document the vendor's description of the type and amount of services associated with each service level, the vendor's service level values, the vendor's transportation values, and the package period that will be used to determine the rate for each individual client. The county shall establish a package period of one week, two weeks, or one month.

#### Sec. 79. [STUDY OF DAY TRAINING AND HABILITATION VENDOR RATES.]

The commissioner shall identify the vendors with the lowest rates or underfunded programs in the state and make recommendations to reconcile the discrepancies prior to the implementation of the individualized payment rate structure described in sections 73 and 74.

#### Sec. 80. [FEDERAL APPROVAL.]

The commissioner shall seek any amendments to the state Medicaid plan and any waivers necessary to permit implementation of section 74 within the timelines specified.

## Sec. 81. [SEMI-INDEPENDENT LIVING SERVICES (SILS) STUDY.]

The commissioner of human services, in consultation with county representatives and other interested persons, shall develop recommendations revising the funding methodology for SILS as defined in Minnesota Statutes, section 252.275, subdivisions 3, 4, 4a, 4b, and 4c, and report by January 15, 2002, to the chair of the house of representatives health and human services finance committee and the chairs of the senate health, human services, and corrections budget division.

## Sec. 82. [WAIVER REQUEST REGARDING SPOUSAL INCOME.]

By September 1, 2001, the commissioner of human services shall seek federal approval to allow recipients of home and community-based waivers authorized under Minnesota Statutes, section 256B.49, to choose either a waiver of deeming of spousal income or the spousal impoverishment protections authorized under United States Code, title 42, section 1396r-5, with the addition of the group residential housing rate set according to Minnesota Statutes, section 256I.03, subdivision 5, to the personal needs allowance authorized by Minnesota Statutes, section 256B.0575.

## Sec. 83. [PROGRAM OPTIONS FOR CERTAIN PERSONS WITH DEVELOPMENTAL DISABILITIES.]

(a) The commissioner of human services shall ensure that services continue to be available to persons with developmental disabilities who were covered by social services supplemental grants prior to July 1, 2001. Services shall be provided in priority order as follows:

(1) to the extent possible, the commissioner shall establish for these persons targeted slots under the home and community-based waived services program for persons with mental retardation or related conditions;

(2) persons accommodated under clause (1) shall, if eligible, receive room and board services through group residential housing under Minnesota Statutes, chapter 256I; and

(3) any remaining persons shall continue to receive services through community social services supplemental grants to the affected counties.

(b) This section applies only to individuals receiving services under social services supplemental grants as of June 30, 2001.

## Sec. 84. [FEDERAL APPROVAL.]

The commissioner of human services, by September 1, 2001, shall request any federal approval and plan amendments necessary to implement the choice of case manager provision in section 256B.092, subdivision 2a, paragraph (b).

## Sec. 85. [FEDERAL WAIVER REQUESTS.]

The commissioner of human services shall submit to the federal Health Care Financing Administration by September 1, 2001, a request for a home and community-based services waiver for day services, including: community inclusion, supported employment, and day training and habilitation services defined in Minnesota Statutes, section 252.41, subdivision 3, clause (1), for persons eligible for the waiver under Minnesota Statutes, section 256B.092.

## Sec. 86. [REPEALER.]

(a) Minnesota Statutes 2000, sections 256B.0951, subdivision 6; and 256E.06, subdivision 2b, are repealed.

(b) Minnesota Statutes 2000, sections 145.9245; 256.476, subdivision 7; 256B.0912; 256B.0915, subdivisions 3a, 3b, and 3c; and 256B.49, subdivisions 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10, are repealed.

(c) Laws 1995, chapter 178, article 2, section 48, subdivision 6, is repealed.

(d) Minnesota Rules, parts 9505.2455; 9505.2458; 9505.2460; 9505.2465; 9505.2470; 9505.2473; 9505.2475; 9505.2480; 9505.2485; 9505.2486; 9505.2490; 9505.2495; 9505.2496; 9505.2500; 9505.3010; 9505.3015; 9505.3020; 9505.3025; 9505.3030; 9505.3035; 9505.3040; 9505.3065; 9505.3085; 9505.3135; 9505.3500; 9505.3510; 9505.3520; 9505.3530; 9505.3535; 9505.3540; 9505.3545; 9505.3550; 9505.3560; 9505.3570; 9505.3575; 9505.3580; 9505.3585; 9505.3600; 9505.3610; 9505.3620; 9505.3622; 9505.3624; 9505.3626; 9505.3630; 9505.3635; 9505.3640; 9505.3645; 9505.3650; 9505.3660; and 9505.3670, are repealed.

#### ARTICLE 4

### CONSUMER INFORMATION AND ASSISTANCE AND COMMUNITY-BASED CARE

Section 1. [144A.35] [EXPANSION OF BED DISTRIBUTION STUDY AND CREATION OF CRITICAL ACCESS SITES.]

Subdivision 1. [OLDER ADULT SERVICES DISTRIBUTION STUDY.] The commissioner of health, in coordination with the commissioner of human services, shall monitor and analyze the distribution of older adult services, including, but not limited to, nursing home beds, senior housing, housing with services units, and home and community-based services in the different geographic areas of the state. The study shall include an analysis of the impact of amendments to the nursing home moratorium law which would allow for transfers of nursing home beds within the state. The commissioner of health shall submit to the legislature, beginning January 15, 2002, and each January 15 thereafter, an assessment of the distribution of long-term health care services by geographic area, with particular attention to service deficits or problems, the designation of critical access service sites, and corrective action plans.

Subd. 2. [CRITICAL ACCESS SERVICE SITE.] "Critical access service site" shall include nursing homes, senior housing, housing with services, and home and community-based services that are certified by the state as necessary providers of health care services to a specific geographic area. For purposes of this requirement, a "necessary provider of health care services" is a provider that is:

- (1) located more than 20 miles, defined as official mileage as reported by the Minnesota department of transportation, from the next nearest long-term health care provider;
- (2) the sole long-term health care provider in the county; or
- (3) a long-term health care provider located in a medically underserved area or health professional shortage area.

Subd. 3. [IDENTIFICATION OF CRITICAL ACCESS SERVICE SITES.] Based on the results of the analysis completed in subdivision 1, the commissioners of health and human services shall identify and designate long-term health care providers as critical access service sites.

Subd. 4. [CRITICAL ACCESS SERVICE SITES.] The commissioner of health, in consultation with the commissioner of human services, shall:

- (1) develop and implement specific waivers to regulations governing health care personnel scope of duties, physical plant requirements, and location of community-based services, to address critical access service site older adult service needs;
- (2) identify payment barriers to the continued operation of older adult services in critical access service sites, and provide recommendations on changes to reimbursement rates to facilitate the continued operation of these services.

Sec. 2. Minnesota Statutes 2000, section 256.973, is amended by adding a subdivision to read:

Subd. 6. [GRANTS FOR HOME-SHARING PROGRAMS.] Grants awarded for home-sharing programs under this section shall be awarded through a request for proposals process every two years according to criteria developed by the commissioner. In awarding grants, the commissioner shall not give priority to an applicant solely because the applicant has previously received a grant under this section. Nothing under this subdivision shall prohibit the commissioner from evaluating the performance of a home-sharing program receiving a grant under this section and allocating funds based on the evaluation.

Sec. 3. Minnesota Statutes 2000, section 256.975, is amended by adding a subdivision to read:

Subd. 7. [CONSUMER INFORMATION AND ASSISTANCE; SENIOR LINKAGE.] (a) The Minnesota board on aging shall operate a statewide information and assistance service to aid older Minnesotans and their families in making informed choices about long-term care options and health care benefits. Language services to persons with limited English language skills may be made available. The service, known as Senior LinkAge Line, must be available during business hours through a statewide toll-free number and must also be available through the Internet.

(b) The service must assist older adults, caregivers, and providers in accessing information about choices in long-term care services that are purchased through private providers or available through public options. The service must:

(1) develop a comprehensive database that includes detailed listings in both consumer- and provider-oriented formats;

(2) make the database accessible on the Internet and through other telecommunication and media-related tools;

(3) link callers to interactive long-term care screening tools and make these tools available through the Internet by integrating the tools with the database;

(4) develop community education materials with a focus on planning for long-term care and evaluating independent living, housing, and service options;

(5) conduct an outreach campaign to assist older adults and their caregivers in finding information on the Internet and through other means of communication;

(6) implement a messaging system for overflow callers and respond to these callers by the next business day;

(7) link callers with county human services and other providers to receive more in-depth assistance and consultation related to long-term care options; and

(8) link callers with quality profiles for nursing facilities and other providers developed by the commissioner of health.

(c) The Minnesota board on aging shall conduct an evaluation of the effectiveness of the statewide information and assistance, and submit this evaluation to the legislature by December 1, 2002. The evaluation must include an analysis of funding adequacy, gaps in service delivery, continuity in information between the service and identified linkages, and potential use of private funding to enhance the service.

Sec. 4. [256.9754] [COMMUNITY SERVICES DEVELOPMENT GRANTS PROGRAM.]

Subdivision 1. [DEFINITIONS.] For purposes of this section, the following terms have the meanings given.

(a) "Community" means a town, township, city, or targeted neighborhood within a city, or a consortium of towns, townships, cities, or targeted neighborhoods within cities.

(b) "Older adult services" means any services available under the elderly waiver program or alternative care grant programs; nursing facility services; transportation services; respite services; and other community-based services identified as necessary either to maintain lifestyle choices for older Minnesotans, or to promote independence.

(c) "Older adult" refers to individuals 65 years of age and older.

Subd. 2. [CREATION.] The community services development grants program is created under the administration of the commissioner of human services.

Subd. 3. [PROVISION OF GRANTS.] The commissioner shall make grants available to communities, providers of older adult services identified in subdivision 1, or to a consortium of providers of older adult services, to establish older adult services. Grants may be provided for capital and other costs including, but not limited to, start-up and training costs, equipment, and supplies related to older adult services or other residential or service alternatives to nursing facility care. Grants may also be made to renovate current buildings, provide transportation services, fund programs that would allow older adults or disabled individuals to stay in their own homes by sharing a home, fund programs that coordinate and manage formal and informal services to older adults in their homes to enable them to live as independently as possible in their own homes as an alternative to nursing home care, or expand state-funded programs in the area.

Subd. 4. [ELIGIBILITY.] Grants may be awarded only to communities and providers or to a consortium of providers that have a local match of 50 percent of the costs for the project in the form of donations, local tax dollars, in-kind donations, fundraising, or other local matches.

Subd. 5. [GRANT PREFERENCE.] The commissioner of human services may award grants to the extent grant funds are available and to the extent applications are approved by the commissioner. Denial of approval of an application in one year does not preclude submission of an application in a subsequent year. The maximum grant amount is limited to \$750,000.

Sec. 5. Minnesota Statutes 2000, section 256B.0911, subdivision 1, is amended to read:

Subdivision 1. [PURPOSE AND GOAL.] (a) The purpose of the preadmission screening program long-term care consultation services is to assist persons with long-term or chronic care needs in making long-term care decisions and selecting options that meet their needs and reflect their preferences. The availability of, and access to, information and other types of assistance is also intended to prevent or delay certified nursing facility placements by assessing applicants and residents and offering cost-effective alternatives appropriate for the person's needs and to provide transition assistance after admission. Further, the goal of the program these services is to contain costs associated with unnecessary certified nursing facility admissions. The commissioners of human services and health shall seek to maximize use of available federal and state funds and establish the broadest program possible within the funding available.

(b) These services must be coordinated with services provided under sections 256.975, subdivision 7, and 256.9772, and with services provided by other public and private agencies in the community to offer a variety of cost-effective alternatives to persons with disabilities and elderly persons. The county agency providing long-term care consultation services shall encourage the use of volunteers from families, religious organizations, social clubs, and similar civic and service organizations to provide community-based services.

Sec. 6. Minnesota Statutes 2000, section 256B.0911, is amended by adding a subdivision to read:

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

(a) "Long-term care consultation services" means:

(1) providing information and education to the general public regarding availability of the services authorized under this section;



- (2) an intake process that provides access to the services described in this section;
  - (3) assessment of the health, psychological, and social needs of referred individuals;
  - (4) assistance in identifying services needed to maintain an individual in the least restrictive environment;
  - (5) providing recommendations on cost-effective community services that are available to the individual;
  - (6) development of an individual's community support plan;
  - (7) providing information regarding eligibility for Minnesota health care programs;
  - (8) preadmission screening to determine the need for a nursing facility level of care;
  - (9) preliminary determination of Minnesota health care programs eligibility for individuals who need a nursing facility level of care, with appropriate referrals for final determination;
  - (10) providing recommendations for nursing facility placement when there are no cost-effective community services available; and
  - (11) assistance to transition people back to community settings after facility admission.
- (b) "Minnesota health care programs" means the medical assistance program under chapter 256B, the alternative care program under section 256B.0913, and the prescription drug program under section 256.955.

Sec. 7. Minnesota Statutes 2000, section 256B.0911, subdivision 3, is amended to read:

Subd. 3. ~~[PERSONS RESPONSIBLE FOR CONDUCTING THE PREADMISSION SCREENING LONG-TERM CARE CONSULTATION TEAM.]~~ (a) ~~A local screening long-term care consultation team shall be established by the county board of commissioners. Each local screening consultation team shall consist of screeners who are a at least one social worker and a at least one public health nurse from their respective county agencies. The board may designate public health or social services as the lead agency for long-term care consultation services. If a county does not have a public health nurse available, it may request approval from the commissioner to assign a county registered nurse with at least one year experience in home care to participate on the team. The screening team members must confer regarding the most appropriate care for each individual screened. Two or more counties may collaborate to establish a joint local screening consultation team or teams.~~

(b) ~~In assessing a person's needs, screeners shall have a physician available for consultation and shall consider the assessment of the individual's attending physician, if any. The individual's physician shall be included if the physician chooses to participate. Other personnel may be included on the team as deemed appropriate by the county agencies. The team is responsible for providing long-term care consultation services to all persons located in the county who request the services, regardless of eligibility for Minnesota health care programs.~~

Sec. 8. Minnesota Statutes 2000, section 256B.0911, is amended by adding a subdivision to read:

Subd. 3a. ~~[ASSESSMENT AND SUPPORT PLANNING.]~~ (a) Persons requesting assessment, services planning, or other assistance intended to support community-based living must be visited by a long-term care consultation team within ten working days after the date on which an assessment was requested or recommended. Assessments must be conducted according to paragraphs (b) to (g).

(b) The county may utilize a team of either the social worker or public health nurse, or both, to conduct the assessment in a face-to-face interview. The consultation team members must confer regarding the most appropriate care for each individual screened or assessed.

(c) The long-term care consultation team must assess the health and social needs of the person, using an assessment form provided by the commissioner of human services.

(d) The team must conduct the assessment in a face-to-face interview with the person being assessed and the person's legal representative, if applicable.

(e) The team must provide the person, or the person's legal representative, with written recommendations for facility- or community-based services. The team must document that the most cost-effective alternatives available were offered to the individual. For purposes of this requirement, "cost-effective alternatives" means community services and living arrangements that cost the same as or less than nursing facility care.

(f) If the person chooses to use community-based services, the team must provide the person or the person's legal representative with a written community support plan, regardless of whether the individual is eligible for Minnesota health care programs. The person may request assistance in developing a community support plan without participating in a complete assessment.

(g) The team must give the person receiving assessment or support planning, or the person's legal representative, materials supplied by the commissioner of human services containing the following information:

- (1) the purpose of preadmission screening and assessment;
- (2) information about Minnesota health care programs;
- (3) the person's freedom to accept or reject the recommendations of the team;
- (4) the person's right to confidentiality under the Minnesota Government Data Practices Act, chapter 13; and
- (5) the person's right to appeal the decision regarding the need for nursing facility level of care or the county's final decisions regarding public programs eligibility according to section 256.045, subdivision 3.

Sec. 9. Minnesota Statutes 2000, section 256B.0911, is amended by adding a subdivision to read:

Subd. 3b. [TRANSITION ASSISTANCE.] (a) A long-term care consultation team shall provide assistance to persons residing in a nursing facility, hospital, regional treatment center, or intermediate care facility for persons with mental retardation who request or are referred for such assistance. Transition assistance must include assessment, community support plan development, referrals to Minnesota health care programs, and referrals to programs that provide assistance with housing.

(b) The county shall develop transition processes with institutional social workers and discharge planners to ensure that:

- (1) persons admitted to facilities receive information about transition assistance that is available;
- (2) the assessment is completed for persons within ten working days of the date of request or recommendation for assessment; and
- (3) there is a plan for transition and follow-up for the individual's return to the community. The plan must require notification of other local agencies when a person who may require assistance is screened by one county for admission to a facility located in another county.

(c) If a person who is eligible for a Minnesota health care program is admitted to a nursing facility, the nursing facility must include a consultation team member or the case manager in the discharge planning process.

Sec. 10. Minnesota Statutes 2000, section 256B.0911, is amended by adding a subdivision to read:

Subd. 4a. [PREADMISSION SCREENING ACTIVITIES RELATED TO NURSING FACILITY ADMISSIONS.]

(a) All applicants to Medicaid certified nursing facilities, including certified boarding care facilities, must be screened prior to admission regardless of income, assets, or funding sources for nursing facility care, except as described in subdivision 4b. The purpose of the screening is to determine the need for nursing facility level of care as described in paragraph (d) and to complete activities required under federal law related to mental illness and mental retardation as outlined in paragraph (b).

(b) A person who has a diagnosis or possible diagnosis of mental illness, mental retardation, or a related condition must receive a preadmission screening before admission regardless of the exemptions outlined in subdivision 4b, paragraph (b), to identify the need for further evaluation and specialized services, unless the admission prior to screening is authorized by the local mental health authority or the local developmental disabilities case manager, or unless authorized by the county agency according to Public Law Number 100-508.

The following criteria apply to the preadmission screening:

(1) the county must use forms and criteria developed by the commissioner of human services to identify persons who require referral for further evaluation and determination of the need for specialized services; and

(2) the evaluation and determination of the need for specialized services must be done by:

(i) a qualified independent mental health professional, for persons with a primary or secondary diagnosis of a serious mental illness; or

(ii) a qualified mental retardation professional, for persons with a primary or secondary diagnosis of mental retardation or related conditions. For purposes of this requirement, a qualified mental retardation professional must meet the standards for a qualified mental retardation professional under Code of Federal Regulations, title 42, section 483.430.

(c) The local county mental health authority or the state mental retardation authority under Public Laws Numbers 100-203 and 101-508 may prohibit admission to a nursing facility if the individual does not meet the nursing facility level of care criteria or needs specialized services as defined in Public Laws Numbers 100-203 and 101-508. For purposes of this section, "specialized services" for a person with mental retardation or a related condition means active treatment as that term is defined under Code of Federal Regulations, title 42, section 483.440, paragraph (a), clause (1).

(d) The determination of the need for nursing facility level of care must be made according to criteria developed by the commissioner of human services. In assessing a person's needs, consultation team members shall have a physician available for consultation and shall consider the assessment of the individual's attending physician, if any. The individual's physician must be included if the physician chooses to participate. Other personnel may be included on the team as deemed appropriate by the county.

Sec. 11. Minnesota Statutes 2000, section 256B.0911, is amended by adding a subdivision to read:

Subd. 4b. [EXEMPTIONS AND EMERGENCY ADMISSIONS.] (a) Exemptions from the federal screening requirements outlined in subdivision 4a, paragraphs (b) and (c), are limited to:

(1) a person who, having entered an acute care facility from a certified nursing facility, is returning to a certified nursing facility; and

(2) a person transferring from one certified nursing facility in Minnesota to another certified nursing facility in Minnesota.

(b) Persons who are exempt from preadmission screening for purposes of level of care determination include:

(1) persons described in paragraph (a);

(2) an individual who has a contractual right to have nursing facility care paid for indefinitely by the veterans' administration;

(3) an individual enrolled in a demonstration project under section 256B.69, subdivision 8, at the time of application to a nursing facility;

(4) an individual currently being served under the alternative care program or under a home and community-based services waiver authorized under section 1915(c) of the federal Social Security Act; and

(5) individuals admitted to a certified nursing facility for a short-term stay, which is expected to be 14 days or less in duration based upon a physician's certification, and who have been assessed and approved for nursing facility admission within the previous six months. This exemption applies only if the consultation team member determines at the time of the initial assessment of the six-month period that it is appropriate to use the nursing facility for short-term stays and that there is an adequate plan of care for return to the home or community-based setting. If a stay exceeds 14 days, the individual must be referred no later than the first county working day following the 14th resident day for a screening, which must be completed within five working days of the referral. The payment limitations in subdivision 7 apply to an individual found at screening to not meet the level of care criteria for admission to a certified nursing facility.

(c) Persons admitted to a Medicaid-certified nursing facility from the community on an emergency basis as described in paragraph (d) or from an acute care facility on a nonworking day must be screened the first working day after admission.

(d) Emergency admission to a nursing facility prior to screening is permitted when all of the following conditions are met:

(1) a person is admitted from the community to a certified nursing or certified boarding care facility during county nonworking hours;

(2) a physician has determined that delaying admission until preadmission screening is completed would adversely affect the person's health and safety;

(3) there is a recent precipitating event that precludes the client from living safely in the community, such as sustaining an injury, sudden onset of acute illness, or a caregiver's inability to continue to provide care;

(4) the attending physician has authorized the emergency placement and has documented the reason that the emergency placement is recommended; and

(5) the county is contacted on the first working day following the emergency admission.

Transfer of a patient from an acute care hospital to a nursing facility is not considered an emergency except for a person who has received hospital services in the following situations: hospital admission for observation, care in an emergency room without hospital admission, or following hospital 24-hour bed care.

Sec. 12. Minnesota Statutes 2000, section 256B.0911, is amended by adding a subdivision to read:

Subd. 4c. [SCREENING REQUIREMENTS.] (a) A person may be screened for nursing facility admission by telephone or in a face-to-face screening interview. Consultation team members shall identify each individual's needs using the following categories:

(1) the person needs no face-to-face screening interview to determine the need for nursing facility level of care based on information obtained from other health care professionals;

(2) the person needs an immediate face-to-face screening interview to determine the need for nursing facility level of care and complete activities required under subdivision 4a; or

(3) the person may be exempt from screening requirements as outlined in subdivision 4b, but will need transitional assistance after admission or in-person follow-along after a return home.

(b) Persons admitted on a nonemergency basis to a Medicaid-certified nursing facility must be screened prior to admission.

(c) The long-term care consultation team shall recommend a case mix classification for persons admitted to a certified nursing facility when sufficient information is received to make that classification. The nursing facility is authorized to conduct all case mix assessments for persons who have been screened prior to admission for whom the county did not recommend a case mix classification. The nursing facility is authorized to conduct all case mix assessments for persons admitted to the facility prior to a preadmission screening. The county retains the responsibility of distributing appropriate case mix forms to the nursing facility.

(d) The county screening or intake activity must include processes to identify persons who may require transition assistance as described in subdivision 3b.

Sec. 13. Minnesota Statutes 2000, section 256B.0911, subdivision 5, is amended to read:

Subd. 5. [~~SIMPLIFICATION OF FORMS ADMINISTRATIVE ACTIVITY.~~] The commissioner shall minimize the number of forms required in the ~~preadmission screening process~~ provision of long-term care consultation services and shall limit the screening document to items necessary for care community support plan approval, reimbursement, program planning, evaluation, and policy development.

Sec. 14. Minnesota Statutes 2000, section 256B.0911, subdivision 6, is amended to read:

Subd. 6. [~~PAYMENT FOR PREADMISSION SCREENING LONG-TERM CARE CONSULTATION SERVICES.~~] (a) The total ~~screening~~ payment for each county must be paid monthly by certified nursing facilities in the county. The monthly amount to be paid by each nursing facility for each fiscal year must be determined by dividing the county's annual allocation for ~~screenings~~ long-term care consultation services by 12 to determine the monthly payment and allocating the monthly payment to each nursing facility based on the number of licensed beds in the nursing facility. Payments to counties in which there is no certified nursing facility must be made by increasing the payment rate of the two facilities located nearest to the county seat.

(b) The commissioner shall include the total annual payment ~~for screening~~ determined under paragraph (a) for each nursing facility according to section 256B.431, subdivision 2b, paragraph (g), 256B.434, or 256B.435.

(c) Payments for ~~screening activities~~ long-term care consultation services are available to the county or counties to cover staff salaries and expenses to provide the ~~screening function~~ services described in subdivision 1a. The ~~lead agency~~ county shall employ, or contract with other agencies to employ, within the limits of available funding, sufficient personnel to ~~conduct the preadmission screening activity~~ provide long-term care consultation services while meeting the state's long-term care outcomes and objectives as defined in section 256B.0917, subdivision 1. The ~~local agency~~ county shall be accountable for meeting local objectives as approved by the commissioner in the CSSA biennial plan.

(d) Notwithstanding section 256B.0641, overpayments attributable to payment of the screening costs under the medical assistance program may not be recovered from a facility.

(e) The commissioner of human services shall amend the Minnesota medical assistance plan to include reimbursement for the local screening consultation teams.

~~(f) The county may bill, as case management services, assessments, support planning, and follow-along provided to persons determined to be eligible for case management under Minnesota health care programs. No individual or family member shall be charged for an initial assessment or initial support plan development provided under subdivision 3a or 3b.~~

Sec. 15. Minnesota Statutes 2000, section 256B.0911, subdivision 7, is amended to read:

Subd. 7. [REIMBURSEMENT FOR CERTIFIED NURSING FACILITIES.] (a) Medical assistance reimbursement for nursing facilities shall be authorized for a medical assistance recipient only if a preadmission screening has been conducted prior to admission or the ~~local county agency~~ has authorized an exemption. Medical assistance reimbursement for nursing facilities shall not be provided for any recipient who the local screener has determined does not meet the level of care criteria for nursing facility placement or, if indicated, has not had a level II PASARR OBRA evaluation as required under the federal Omnibus Reconciliation Act of 1987 completed unless an admission for a recipient with mental illness is approved by the local mental health authority or an admission for a recipient with mental retardation or related condition is approved by the state mental retardation authority.

~~(b) The nursing facility must not bill a person who is not a medical assistance recipient for resident days that preceded the date of completion of screening activities as required under subdivisions 4a, 4b, and 4c. The nursing facility must include unreimbursed resident days in the nursing facility resident day totals reported to the commissioner.~~

~~(c) The commissioner shall make a request to the health care financing administration for a waiver allowing screening team approval of Medicaid payments for certified nursing facility care. An individual has a choice and makes the final decision between nursing facility placement and community placement after the screening team's recommendation, except as provided in paragraphs (b) and (c) subdivision 4a, paragraph (c).~~

~~(e) The local county mental health authority or the state mental retardation authority under Public Law Numbers 100-203 and 101-508 may prohibit admission to a nursing facility, if the individual does not meet the nursing facility level of care criteria or needs specialized services as defined in Public Law Numbers 100-203 and 101-508. For purposes of this section, "specialized services" for a person with mental retardation or a related condition means "active treatment" as that term is defined in Code of Federal Regulations, title 42, section 483.440(a)(1).~~

~~(e) Appeals from the screening team's recommendation or the county agency's final decision shall be made according to section 256.045, subdivision 3.~~

Sec. 16. Minnesota Statutes 2000, section 256B.0913, subdivision 1, is amended to read:

Subdivision 1. [PURPOSE AND GOALS.] The purpose of the alternative care program is to provide funding for ~~or access to~~ home and community-based services for ~~frail~~ elderly persons, in order to limit nursing facility placements. The program is designed to support ~~frail~~ elderly persons in their desire to remain in the community as independently and as long as possible and to support informal caregivers in their efforts to provide care for ~~frail~~ elderly people. Further, the goals of the program are:

(1) to contain medical assistance expenditures by providing funding care in the community ~~at a cost the same or less than nursing facility costs~~; and

(2) to maintain the moratorium on new construction of nursing home beds.

Sec. 17. Minnesota Statutes 2000, section 256B.0913, subdivision 2, is amended to read:

Subd. 2. [ELIGIBILITY FOR SERVICES.] Alternative care services are available to ~~all frail older~~ Minnesotans. This includes:

(1) ~~persons who are receiving medical assistance and served under the medical assistance program or the Medicaid waiver program;~~

(2) ~~persons age 65 or older who are not eligible for medical assistance without a spenddown or waiver obligation but who would be eligible for medical assistance within 180 days of admission to a nursing facility and served under subject to subdivisions 4 to 13; and~~

(3) ~~persons who are paying for their services out-of-pocket.~~

Sec. 18. Minnesota Statutes 2000, section 256B.0913, subdivision 4, is amended to read:

Subd. 4. [ELIGIBILITY FOR FUNDING FOR SERVICES FOR NONMEDICAL ASSISTANCE RECIPIENTS.]

(a) Funding for services under the alternative care program is available to persons who meet the following criteria:

(1) ~~the person has been screened by the county screening team or, if previously screened and served under the alternative care program, assessed by the local county social worker or public health nurse determined by a community assessment under section 256B.0911, to be a person who would require the level of care provided in a nursing facility, but for the provision of services under the alternative care program;~~

(2) the person is age 65 or older;

(3) the person would be ~~financially~~ eligible for medical assistance within 180 days of admission to a nursing facility;

(4) the person ~~meets the asset transfer requirements of~~ is not ineligible for the medical assistance program due to an asset transfer penalty;

(5) ~~the screening team would recommend nursing facility admission or continued stay for the person if alternative care services were not available;~~

(6) ~~the person needs services that are not available at that time in the county funded through other county, state, or federal funding sources; and~~

(7) (6) the monthly cost of the alternative care services funded by the program for this person does not exceed 75 percent of the statewide average monthly medical assistance payment for nursing facility care at the individual's case mix classification weighted average monthly nursing facility rate of the case mix resident class to which the individual alternative care client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, less the recipient's maintenance needs allowance as described in section 256B.0915, subdivision 1d, paragraph (a), until the first day of the state fiscal year in which the resident assessment system, under section 256B.437, for nursing home rate determination is implemented. Effective on the first day of the state fiscal year in which a resident assessment system, under section 256B.437, for nursing home rate determination is implemented and the first day of each subsequent state fiscal year, the monthly cost of alternative care services for this person shall not exceed the alternative care monthly cap for the case mix resident class to which the alternative care client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, which was in effect on the last day of the previous state fiscal year, and adjusted by the greater of any legislatively adopted home and community-based services cost-of-living percentage increase or any legislatively adopted statewide percent rate increase for nursing facilities. This monthly limit does not prohibit the alternative care client from payment for additional services, but in no case may the cost of additional services purchased under this section exceed the difference between the client's monthly service limit defined under section 256B.0915, subdivision 3, and the alternative care program monthly service limit defined in

~~this paragraph.~~ If medical supplies and equipment or ~~adaptations~~ environmental modifications are or will be purchased for an alternative care services recipient, the costs may be prorated on a monthly basis ~~throughout the year in which they are purchased for up to 12 consecutive months beginning with the month of purchase.~~ If the monthly cost of a recipient's other alternative care services exceeds the monthly limit established in this paragraph, the annual cost of the alternative care services shall be determined. In this event, the annual cost of alternative care services shall not exceed 12 times the monthly limit ~~calculated~~ described in this paragraph.

~~(b) Individuals who meet the criteria in paragraph (a) and who have been approved for alternative care funding are called 180-day eligible clients.~~

~~(c) The statewide average payment for nursing facility care is the statewide average monthly nursing facility rate in effect on July 1 of the fiscal year in which the cost is incurred, less the statewide average monthly income of nursing facility residents who are age 65 or older and who are medical assistance recipients in the month of March of the previous fiscal year. This monthly limit does not prohibit the 180-day eligible client from paying for additional services needed or desired.~~

~~(d) In determining the total costs of alternative care services for one month, the costs of all services funded by the alternative care program, including supplies and equipment, must be included.~~

~~(e) Alternative care funding under this subdivision is not available for a person who is a medical assistance recipient or who would be eligible for medical assistance without a spenddown, unless authorized by the commissioner or waiver obligation. A person whose initial application for medical assistance is being processed may be served under the alternative care program for a period up to 60 days. If the individual is found to be eligible for medical assistance, the county must bill medical assistance must be billed for services payable under the federally approved elderly waiver plan and delivered from the date the individual was found eligible for services reimbursable under the federally approved elderly waiver program plan. Notwithstanding this provision, upon federal approval, alternative care funds may not be used to pay for any service the cost of which is payable by medical assistance or which is used by a recipient to meet a medical assistance income spenddown or waiver obligation.~~

~~(f) (c) Alternative care funding is not available for a person who resides in a licensed nursing home or, certified boarding care home, hospital, or intermediate care facility, except for case management services which are being provided in support of the discharge planning process to a nursing home resident or certified boarding care home resident who is ineligible for case management funded by medical assistance.~~

Sec. 19. Minnesota Statutes 2000, section 256B.0913, subdivision 5, is amended to read:

Subd. 5. [SERVICES COVERED UNDER ALTERNATIVE CARE.] (a) Alternative care funding may be used for payment of costs of:

- (1) adult foster care;
- (2) adult day care;
- (3) home health aide;
- (4) homemaker services;
- (5) personal care;
- (6) case management;
- (7) respite care;
- (8) assisted living;



- (9) residential care services;
- (10) care-related supplies and equipment;
- (11) meals delivered to the home;
- (12) transportation;
- (13) skilled nursing;
- (14) chore services;
- (15) companion services;
- (16) nutrition services;
- (17) training for direct informal caregivers;
- (18) telemedicine devices to monitor recipients in their own homes as an alternative to hospital care, nursing home care, or home visits; ~~and~~
- (19) other services ~~including which includes discretionary funds and~~ direct cash payments to clients, ~~approved by the county agency following approval by the commissioner,~~ subject to the provisions of paragraph ~~(m)~~ (j). Total annual payments for "other services" for all clients within a county may not exceed either ten percent of that county's annual alternative care program base allocation or \$5,000, whichever is greater. In no case shall this amount exceed the county's total annual alternative care program base allocation; and

(20) environmental modifications.

(b) The county agency must ensure that the funds are not ~~only to supplement and not to~~ supplant services available through other public assistance or services programs.

(c) Unless specified in statute, the service definitions and standards for alternative care services shall be the same as the service definitions and standards defined specified in the federally approved elderly waiver plan. Except for the county agencies' approval of direct cash payments to clients as described in paragraph (j) or for a provider of supplies and equipment when the monthly cost of the supplies and equipment is less than \$250, persons or agencies must be employed by or under a contract with the county agency or the public health nursing agency of the local board of health in order to receive funding under the alternative care program. Supplies and equipment may be purchased from a non-Medicaid certified vendor if the cost for the item is less than that of a Medicaid vendor.

(d) The adult foster care rate shall be considered a difficulty of care payment and shall not include room and board. The adult foster care ~~daily~~ rate shall be negotiated between the county agency and the foster care provider. ~~The rate established under this section shall not exceed 75 percent of the state average monthly nursing home payment for the case mix classification to which the individual receiving foster care is assigned, and it must allow for other alternative care services to be authorized by the case manager.~~ The alternative care payment for the foster care service in combination with the payment for other alternative care services, including case management, must not exceed the limit specified in subdivision 4, paragraph (a), clause (6).

(e) ~~Personal care services may be provided by a personal care provider organization.~~ must meet the service standards defined in the federally approved elderly waiver plan, except that a county agency may contract with a client's relative of the client who meets the relative hardship waiver requirement as defined in section 256B.0627, subdivision 4, paragraph (b), clause (10), to provide personal care services, but must ensure nursing if the county

agency ensures supervision of this service by a registered nurse or mental health practitioner. Covered personal care services defined in section 256B.0627, subdivision 4, must meet applicable standards in Minnesota Rules, part 9505.0335.

~~(f) A county may use alternative care funds to purchase medical supplies and equipment without prior approval from the commissioner when: (1) there is no other funding source; (2) the supplies and equipment are specified in the individual's care plan as medically necessary to enable the individual to remain in the community according to the criteria in Minnesota Rules, part 9505.0210, item A; and (3) the supplies and equipment represent an effective and appropriate use of alternative care funds. A county may use alternative care funds to purchase supplies and equipment from a non-Medicaid-certified vendor if the cost for the items is less than that of a Medicaid vendor. A county is not required to contract with a provider of supplies and equipment if the monthly cost of the supplies and equipment is less than \$250.~~

~~(g) For purposes of this section, residential care services are services which are provided to individuals living in residential care homes. Residential care homes are currently licensed as board and lodging establishments and are registered with the department of health as providing special services under section 157.17 and are not subject to registration under chapter 144D. Residential care services are defined as "supportive services" and "health-related services." "Supportive services" means the provision of up to 24-hour supervision and oversight. Supportive services includes: (1) transportation, when provided by the residential care ~~center~~ home only; (2) socialization, when socialization is part of the plan of care, has specific goals and outcomes established, and is not diversional or recreational in nature; (3) assisting clients in setting up meetings and appointments; (4) assisting clients in setting up medical and social services; (5) providing assistance with personal laundry, such as carrying the client's laundry to the laundry room. Assistance with personal laundry does not include any laundry, such as bed linen, that is included in the room and board rate. "Health-related services" are limited to minimal assistance with dressing, grooming, and bathing and providing reminders to residents to take medications that are self-administered or providing storage for medications, if requested. Individuals receiving residential care services cannot receive homemaking services funded under this section.~~

~~(h) (g) For the purposes of this section, "assisted living" refers to supportive services provided by a single vendor to clients who reside in the same apartment building of three or more units which are not subject to registration under chapter 144D and are licensed by the department of health as a class A home care provider or a class E home care provider. Assisted living services are defined as up to 24-hour supervision, and oversight, supportive services as defined in clause (1), individualized home care aide tasks as defined in clause (2), and individualized home management tasks as defined in clause (3) provided to residents of a residential center living in their units or apartments with a full kitchen and bathroom. A full kitchen includes a stove, oven, refrigerator, food preparation counter space, and a kitchen utensil storage compartment. Assisted living services must be provided by the management of the residential center or by providers under contract with the management or with the county.~~

(1) Supportive services include:

(i) socialization, when socialization is part of the plan of care, has specific goals and outcomes established, and is not diversional or recreational in nature;

(ii) assisting clients in setting up meetings and appointments; and

(iii) providing transportation, when provided by the residential center only.

~~Individuals receiving assisted living services will not receive both assisted living services and homemaking services. Individualized means services are chosen and designed specifically for each resident's needs, rather than provided or offered to all residents regardless of their illnesses, disabilities, or physical conditions.~~

(2) Home care aide tasks means:

(i) preparing modified diets, such as diabetic or low sodium diets;

- (ii) reminding residents to take regularly scheduled medications or to perform exercises;
- (iii) household chores in the presence of technically sophisticated medical equipment or episodes of acute illness or infectious disease;
- (iv) household chores when the resident's care requires the prevention of exposure to infectious disease or containment of infectious disease; and
- (v) assisting with dressing, oral hygiene, hair care, grooming, and bathing, if the resident is ambulatory, and if the resident has no serious acute illness or infectious disease. Oral hygiene means care of teeth, gums, and oral prosthetic devices.

(3) Home management tasks means:

- (i) housekeeping;
- (ii) laundry;
- (iii) preparation of regular snacks and meals; and
- (iv) shopping.

Individuals receiving assisted living services shall not receive both assisted living services and homemaking services. Individualized means services are chosen and designed specifically for each resident's needs, rather than provided or offered to all residents regardless of their illnesses, disabilities, or physical conditions. Assisted living services as defined in this section shall not be authorized in boarding and lodging establishments licensed according to sections 157.011 and 157.15 to 157.22.

(h) For establishments registered under chapter 144D, assisted living services under this section means either the services described and licensed in paragraph (g) and delivered by a class E home care provider licensed by the department of health or the services described under section 144A.4605 and delivered by an assisted living home care provider or a class A home care provider licensed by the commissioner of health.

(j) For the purposes of this section, reimbursement (i) Payment for assisted living services and residential care services shall be a monthly rate negotiated and authorized by the county agency based on an individualized service plan for each resident and may not cover direct rent or food costs. The rate

(1) The individualized monthly negotiated payment for assisted living services as described in paragraph (g) or (h), and residential care services as described in paragraph (f), shall not exceed the nonfederal share in effect on July 1 of the state fiscal year for which the rate limit is being calculated of the greater of either the statewide or any of the geographic groups' weighted average monthly medical-assistance nursing facility payment rate of the case mix resident class to which the 180-day alternative care eligible client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, unless the less the maintenance needs allowance as described in subdivision 1d, paragraph (a), until the first day of the state fiscal year in which a resident assessment system, under section 256B.437, of nursing home rate determination is implemented. Effective on the first day of the state fiscal year in which a resident assessment system, under section 256B.437, of nursing home rate determination is implemented and the first day of each subsequent state fiscal year, the individualized monthly negotiated payment for the services described in this clause shall not exceed the limit described in this clause which was in effect on the last day of the previous state fiscal year and which has been adjusted by the greater of any legislatively adopted home and community-based services cost-of-living percentage increase or any legislatively adopted statewide percent rate increase for nursing facilities.

~~(2) The individualized monthly negotiated payment for assisted living services are provided by a home care described under section 144A.4605 and delivered by a provider licensed by the department of health as a class A home care provider or an assisted living home care provider and are provided in a building that is registered as a housing with services establishment under chapter 144D and that provides 24-hour supervision in combination with the payment for other alternative care services, including case management, must not exceed the limit specified in subdivision 4, paragraph (a), clause (6).~~

~~(k) For purposes of this section, companion services are defined as nonmedical care, supervision and oversight, provided to a functionally impaired adult. Companions may assist the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on medical care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the recipient. This service must be approved by the case manager as part of the care plan. Companion services must be provided by individuals or organizations who are under contract with the local agency to provide the service. Any person related to the waiver recipient by blood, marriage or adoption cannot be reimbursed under this service. Persons providing companion services will be monitored by the case manager.~~

~~(l) For purposes of this section, training for direct informal caregivers is defined as a classroom or home course of instruction which may include: transfer and lifting skills, nutrition, personal and physical cares, home safety in a home environment, stress reduction and management, behavioral management, long-term care decision making, care coordination and family dynamics. The training is provided to an informal unpaid caregiver of a 180-day eligible client which enables the caregiver to deliver care in a home setting with high levels of quality. The training must be approved by the case manager as part of the individual care plan. Individuals, agencies, and educational facilities which provide caregiver training and education will be monitored by the case manager.~~

~~(m) (j) A county agency may make payment from their alternative care program allocation for "other services" provided to an alternative care program recipient if those services prevent, shorten, or delay institutionalization. These services may which include use of "discretionary funds" for services that are not otherwise defined in this section and direct cash payments to the recipient client for the purpose of purchasing the recipient's services. The following provisions apply to payments under this paragraph:~~

~~(1) a cash payment to a client under this provision cannot exceed 80 percent of the monthly payment limit for that client as specified in subdivision 4, paragraph (a), clause (7) (6);~~

~~(2) a county may not approve any cash payment for a client who meets either of the following:~~

~~(i) has been assessed as having a dependency in orientation, unless the client has an authorized representative under section 256.476, subdivision 2, paragraph (g), or for a client who. An "authorized representative" means an individual who is at least 18 years of age and is designated by the person or the person's legal representative to act on the person's behalf. This individual may be a family member, guardian, representative payee, or other individual designated by the person or the person's legal representative, if any, to assist in purchasing and arranging for supports; or~~

~~(ii) is concurrently receiving adult foster care, residential care, or assisted living services;~~

~~(3) any service approved under this section must be a service which meets the purpose and goals of the program as listed in subdivision 1;~~

~~(4) cash payments must also meet the criteria of and are governed by the procedures and liability protection established in section 256.476, subdivision 4, paragraphs (b) through (h), and recipients of cash grants must meet the requirements in section 256.476, subdivision 10; and cash payments to a person or a person's family will be provided through a monthly payment and be in the form of cash, voucher, or direct county payment to vendor. Fees~~

or premiums assessed to the person for eligibility for health and human services are not reimbursable through this service option. Services and goods purchased through cash payments must be identified in the person's individualized care plan and must meet all of the following criteria:

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

(ii) they must be directly attributable to the person's functional limitations;

(iii) they must have the potential to be effective at meeting the goals of the program;

(iv) they must be consistent with the needs identified in the individualized service plan. The service plan shall specify the needs of the person and family, the form and amount of payment, the items and services to be reimbursed, and the arrangements for management of the individual grant; and

(v) the person, the person's family, or the legal representative shall be provided sufficient information to ensure an informed choice of alternatives. The local agency shall document this information in the person's care plan, including the type and level of expenditures to be reimbursed;

(4) the county, lead agency under contract, or tribal government under contract to administer the alternative care program shall not be liable for damages, injuries, or liabilities sustained through the purchase of direct supports or goods by the person, the person's family, or the authorized representative with funds received through the cash payments under this section. Liabilities include, but are not limited to, workers' compensation, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA);

(5) persons receiving grants under this section shall have the following responsibilities:

(i) spend the grant money in a manner consistent with their individualized service plan with the local agency;

(ii) notify the local agency of any necessary changes in the grant-expenditures;

(iii) arrange and pay for supports; and

(iv) inform the local agency of areas where they have experienced difficulty securing or maintaining supports; and

~~(5)~~ (6) the county shall report client outcomes, services, and costs under this paragraph in a manner prescribed by the commissioner.

(k) Upon implementation of direct cash payments to clients under this section, any person determined eligible for the alternative care program who chooses a cash payment approved by the county agency shall receive the cash payment under this section and not under section 256.476 unless the person was receiving a consumer support grant under section 256.476 before implementation of direct cash payments under this section.

Sec. 20. Minnesota Statutes 2000, section 256B.0913, subdivision 6, is amended to read:

Subd. 6. [ALTERNATIVE CARE PROGRAM ADMINISTRATION.] The alternative care program is administered by the county agency. This agency is the lead agency responsible for the local administration of the alternative care program as described in this section. However, it may contract with the public health nursing service to be the lead agency. The commissioner may contract with federally recognized Indian tribes with a reservation in Minnesota to serve as the lead agency responsible for the local administration of the alternative care program as described in the contract.

Sec. 21. Minnesota Statutes 2000, section 256B.0913, subdivision 7, is amended to read:

Subd. 7. [CASE MANAGEMENT.] Providers of case management services for persons receiving services funded by the alternative care program must meet the qualification requirements and standards specified in section 256B.0915, subdivision 1b. ~~The case manager must ensure the health and safety of the individual client and not approve alternative care funding for a client in any setting in which the case manager cannot reasonably ensure the client's health and safety. The case manager is responsible for the cost-effectiveness of the alternative care individual care plan and must not approve any care plan in which the cost of services funded by alternative care and client contributions exceeds the limit specified in section 256B.0915, subdivision 3, paragraph (b).~~ The county may allow a case manager employed by the county to delegate certain aspects of the case management activity to another individual employed by the county provided there is oversight of the individual by the case manager. The case manager may not delegate those aspects which require professional judgment including assessments, reassessments, and care plan development.

Sec. 22. Minnesota Statutes 2000, section 256B.0913, subdivision 8, is amended to read:

Subd. 8. [REQUIREMENTS FOR INDIVIDUAL CARE PLAN.] (a) The case manager shall implement the plan of care for each ~~180-day eligible~~ alternative care client and ensure that a client's service needs and eligibility are reassessed at least every 12 months. The plan shall include any services prescribed by the individual's attending physician as necessary to allow the individual to remain in a community setting. In developing the individual's care plan, the case manager should include the use of volunteers from families and neighbors, religious organizations, social clubs, and civic and service organizations to support the formal home care services. The county shall be held harmless for damages or injuries sustained through the use of volunteers under this subdivision including workers' compensation liability. ~~The lead agency shall provide documentation to the commissioner verifying that the individual's alternative care is not available at that time through any other public assistance or service program.~~ The lead agency shall provide documentation in each individual's plan of care and, if requested, to the commissioner that the most cost-effective alternatives available have been offered to the individual and that the individual was free to choose among available qualified providers, both public and private. The case manager must give the individual a ten-day written notice of any decrease in or termination of alternative care services.

(b) If the county administering alternative care services is different than the county of financial responsibility, the care plan may be implemented without the approval of the county of financial responsibility.

Sec. 23. Minnesota Statutes 2000, section 256B.0913, subdivision 9, is amended to read:

Subd. 9. [CONTRACTING PROVISIONS FOR PROVIDERS.] ~~The lead agency shall document to the commissioner that the agency made reasonable efforts to inform potential providers of the anticipated need for services under the alternative care program or waiver programs under sections 256B.0915 and 256B.49, including a minimum of 14 days' written advance notice of the opportunity to be selected as a service provider and an annual public meeting with providers to explain and review the criteria for selection. The lead agency shall also document to the commissioner that the agency allowed potential providers an opportunity to be selected to contract with the county agency. Funds reimbursed to counties under this subdivision Alternative care funds paid to service providers are subject to audit by the commissioner for fiscal and utilization control.~~

The lead agency must select providers for contracts or agreements using the following criteria and other criteria established by the county:

- (1) the need for the particular services offered by the provider;
- (2) the population to be served, including the number of clients, the length of time services will be provided, and the medical condition of clients;
- (3) the geographic area to be served;

- (4) quality assurance methods, including appropriate licensure, certification, or standards, and supervision of employees when needed;
- (5) rates for each service and unit of service exclusive of county administrative costs;
- (6) evaluation of services previously delivered by the provider; and
- (7) contract or agreement conditions, including billing requirements, cancellation, and indemnification.

The county must evaluate its own agency services under the criteria established for other providers. ~~The county shall provide a written statement of the reasons for not selecting providers.~~

Sec. 24. Minnesota Statutes 2000, section 256B.0913, subdivision 10, is amended to read:

Subd. 10. [ALLOCATION FORMULA.] (a) The alternative care appropriation for fiscal years 1992 and beyond shall cover only ~~180-day alternative care~~ eligible clients. ~~Prior to July 1 of each year, the commissioner shall allocate to county agencies the state funds available for alternative care for persons eligible under subdivision 2.~~

(b) ~~Prior to July 1 of each year, the commissioner shall allocate to county agencies the state funds available for alternative care for persons eligible under subdivision 2. The allocation for fiscal year 1992 shall be calculated using a base that is adjusted to exclude the medical assistance share of alternative care expenditures. The adjusted base is calculated by multiplying each county's allocation for fiscal year 1991 by the percentage of county alternative care expenditures for 180-day eligible clients. The percentage is determined based on expenditures for services rendered in fiscal year 1989 or calendar year 1989, whichever is greater. The adjusted base for each county is the county's current fiscal year base allocation plus any targeted funds approved during the current fiscal year. Calculations for paragraphs (c) and (d) are to be made as follows: for each county, the determination of alternative care program expenditures shall be based on payments for services rendered from April 1 through March 31 in the base year, to the extent that claims have been submitted and paid by June 1 of that year.~~

(c) ~~If the county alternative care program expenditures for 180-day eligible clients as defined in paragraph (b) are 95 percent or more of its the county's adjusted base allocation, the allocation for the next fiscal year is 100 percent of the adjusted base, plus inflation to the extent that inflation is included in the state budget.~~

(d) ~~If the county alternative care program expenditures for 180-day eligible clients as defined in paragraph (b) are less than 95 percent of its the county's adjusted base allocation, the allocation for the next fiscal year is the adjusted base allocation less the amount of unspent funds below the 95 percent level.~~

(e) ~~For fiscal year 1992 only, a county may receive an increased allocation if annualized service costs for the month of May 1991 for 180-day eligible clients are greater than the allocation otherwise determined. A county may apply for this increase by reporting projected expenditures for May to the commissioner by June 1, 1991. The amount of the allocation may exceed the amount calculated in paragraph (b). The projected expenditures for May must be based on actual 180-day eligible client caseload and the individual cost of clients' care plans. If a county does not report its expenditures for May, the amount in paragraph (c) or (d) shall be used.~~

(f) ~~Calculations for paragraphs (c) and (d) are to be made as follows: for each county, the determination of expenditures shall be based on payments for services rendered from April 1 through March 31 in the base year, to the extent that claims have been submitted by June 1 of that year. Calculations for paragraphs (c) and (d) must also include the funds transferred to the consumer support grant program for clients who have transferred to that program from April 1 through March 31 in the base year.~~

(g) ~~For the biennium ending June 30, 2001, the allocation of state funds to county agencies shall be calculated as described in paragraphs (c) and (d): If the annual legislative appropriation for the alternative care program is inadequate to fund the combined county allocations for fiscal year 2000 or 2001 a biennium, the commissioner shall distribute to each county the entire annual appropriation as that county's percentage of the computed base as calculated in paragraph (f) paragraphs (c) and (d).~~

Sec. 25. Minnesota Statutes 2000, section 256B.0913, subdivision 11, is amended to read:

Subd. 11. [TARGETED FUNDING.] (a) The purpose of targeted funding is to make additional money available to counties with the greatest need. Targeted funds are not intended to be distributed equitably among all counties, but rather, allocated to those with long-term care strategies that meet state goals.

(b) The funds available for targeted funding shall be the total appropriation for each fiscal year minus county allocations determined under subdivision 10 as adjusted for any inflation increases provided in appropriations for the biennium.

(c) The commissioner shall allocate targeted funds to counties that demonstrate to the satisfaction of the commissioner that they have developed feasible plans to increase alternative care spending. In making targeted funding allocations, the commissioner shall use the following priorities:

(1) counties that received a lower allocation in fiscal year 1991 than in fiscal year 1990. Counties remain in this priority until they have been restored to their fiscal year 1990 level plus inflation;

(2) counties that sustain a base allocation reduction for failure to spend 95 percent of the allocation if they demonstrate that the base reduction should be restored;

(3) counties that propose projects to divert community residents from nursing home placement or convert nursing home residents to community living; and

(4) counties that can otherwise justify program growth by demonstrating the existence of waiting lists, demographically justified needs, or other unmet needs.

(d) Counties that would receive targeted funds according to paragraph (c) must demonstrate to the commissioner's satisfaction that the funds would be appropriately spent by showing how the funds would be used to further the state's alternative care goals as described in subdivision 1, and that the county has the administrative and service delivery capability to use them.

(e) The commissioner shall request applications ~~by June 1 each year, for county agencies to apply~~ for targeted funds by November 1 of each year. The counties selected for targeted funds shall be notified of the amount of their additional funding ~~by August 1 of each year~~. Targeted funds allocated to a county agency in one year shall be treated as part of the county's base allocation for that year in determining allocations for subsequent years. No reallocations between counties shall be made.

~~(f) The allocation for each year after fiscal year 1992 shall be determined using the previous fiscal year's allocation, including any targeted funds, as the base and then applying the criteria under subdivision 10, paragraphs (c), (d), and (f), to the current year's expenditures.~~

Sec. 26. Minnesota Statutes 2000, section 256B.0913, subdivision 12, is amended to read:

Subd. 12. [CLIENT PREMIUMS.] (a) A premium is required for all ~~180-day~~ alternative care eligible clients to help pay for the cost of participating in the program. The amount of the premium for the alternative care client shall be determined as follows:

(1) when the alternative care client's income less recurring and predictable medical expenses is greater than the ~~medical assistance income standard~~ recipient's maintenance needs allowance as defined in section 256B.0915, subdivision 1d, paragraph (a), but less than 150 percent of the federal poverty guideline effective on July 1 of the state fiscal year in which the premium is being computed, and total assets are less than \$10,000, the fee is zero;



(2) when the alternative care client's income less recurring and predictable medical expenses is greater than 150 percent of the federal poverty guideline effective on July 1 of the state fiscal year in which the premium is being computed, and total assets are less than \$10,000, the fee is 25 percent of the cost of alternative care services or the difference between 150 percent of the federal poverty guideline effective on July 1 of the state fiscal year in which the premium is being computed and the client's income less recurring and predictable medical expenses, whichever is less; and

(3) when the alternative care client's total assets are greater than \$10,000, the fee is 25 percent of the cost of alternative care services.

For married persons, total assets are defined as the total marital assets less the estimated community spouse asset allowance, under section 256B.059, if applicable. For married persons, total income is defined as the client's income less the monthly spousal allotment, under section 256B.058.

All alternative care services except case management shall be included in the estimated costs for the purpose of determining 25 percent of the costs.

The monthly premium shall be calculated based on the cost of the first full month of alternative care services and shall continue unaltered until the next reassessment is completed or at the end of 12 months, whichever comes first. Premiums are due and payable each month alternative care services are received unless the actual cost of the services is less than the premium.

(b) The fee shall be waived by the commissioner when:

- (1) a person who is residing in a nursing facility is receiving case management only;
- (2) a person is applying for medical assistance;
- (3) a married couple is requesting an asset assessment under the spousal impoverishment provisions;
- (4) ~~a person is a medical assistance recipient, but has been approved for alternative care-funded assisted living services;~~
- (5) a person is found eligible for alternative care, but is not yet receiving alternative care services; or
- (6) (5) a person's fee under paragraph (a) is less than \$25.

(c) The county agency must record in the state's receivable system the client's assessed premium amount or the reason the premium has been waived. The commissioner will bill and collect the premium from the client ~~and forward the amounts collected to the commissioner in the manner and at the times prescribed by the commissioner.~~ Money collected must be deposited in the general fund and is appropriated to the commissioner for the alternative care program. The client must supply the county with the client's social security number at the time of application. ~~If a client fails or refuses to pay the premium due,~~ The county shall supply the commissioner with the client's social security number and other information the commissioner requires to collect the premium from the client. The commissioner shall collect unpaid premiums using the Revenue Recapture Act in chapter 270A and other methods available to the commissioner. The commissioner may require counties to inform clients of the collection procedures that may be used by the state if a premium is not paid.

(d) The commissioner shall begin to adopt emergency or permanent rules governing client premiums within 30 days after July 1, 1991, including criteria for determining when services to a client must be terminated due to failure to pay a premium.

Sec. 27. Minnesota Statutes 2000, section 256B.0913, subdivision 13, is amended to read:

Subd. 13. [COUNTY BIENNIAL PLAN.] The county biennial plan for ~~the preadmission screening program long-term care consultation under section 256B.0911, the alternative care program under this section, and~~ waivers for the elderly under section 256B.0915, ~~and waivers for the disabled under section 256B.49;~~ shall be incorporated into the biennial Community Social Services Act plan and shall meet the regulations and timelines of that plan. ~~This county biennial plan shall include:~~

- ~~(1) information on the administration of the preadmission screening program;~~
- ~~(2) information on the administration of the home and community-based services waivers for the elderly under section 256B.0915, and for the disabled under section 256B.49; and~~
- ~~(3) information on the administration of the alternative care program.~~

Sec. 28. Minnesota Statutes 2000, section 256B.0913, subdivision 14, is amended to read:

Subd. 14. [REIMBURSEMENT PAYMENT AND RATE ADJUSTMENTS.] (a) ~~Reimbursement Payment~~ for expenditures for the provided alternative care services as approved by the client's case manager shall be through the invoice processing procedures of the department's Medicaid Management Information System (MMIS). To receive reimbursement payment, the county or vendor must submit invoices within 12 months following the date of service. The county agency and its vendors under contract shall not be reimbursed for services which exceed the county allocation.

~~(b) If a county collects less than 50 percent of the client premiums due under subdivision 12, the commissioner may withhold up to three percent of the county's final alternative care program allocation determined under subdivisions 10 and 11.~~

~~(c)~~ (e) The county shall negotiate individual rates with vendors and may ~~be reimbursed~~ authorize service payment for actual costs up to ~~the greater of the county's current approved rate or 60 percent of the maximum rate in fiscal year 1994 and 65 percent of the maximum rate in fiscal year 1995 for each alternative care service.~~ Notwithstanding any other rule or statutory provision to the contrary, the commissioner shall not be authorized to increase rates by an annual inflation factor, unless so authorized by the legislature.

~~(d) (c) On July 1, 1993, the commissioner shall increase the maximum rate for home delivered meals to \$4.50 per meal. To improve access to community services and eliminate payment disparities between the alternative care program and the elderly waiver program, the commissioner shall establish statewide maximum service rate limits and eliminate county-specific service rate limits.~~

(1) Effective July 1, 2001, for service rate limits, except those in subdivision 5, paragraphs (d) and (j), the rate limit for each service shall be the greater of the alternative care statewide maximum rate or the elderly waiver statewide maximum rate.

(2) Counties may negotiate individual service rates with vendors for actual costs up to the statewide maximum service rate limit.

Sec. 29. Minnesota Statutes 2000, section 256B.0915, subdivision 1d, is amended to read:

Subd. 1d. [POSTELIGIBILITY TREATMENT OF INCOME AND RESOURCES FOR ELDERLY WAIVER.] ~~(a)~~ Notwithstanding the provisions of section 256B.056, the commissioner shall make the following amendment to the medical assistance elderly waiver program effective July 1, 1999, or upon federal approval, whichever is later.

A recipient's maintenance needs will be an amount equal to the Minnesota supplemental aid equivalent rate as defined in section 256I.03, subdivision 5, plus the medical assistance personal needs allowance as defined in section 256B.35, subdivision 1, paragraph (a), when applying posteligibility treatment of income rules to the gross income of elderly waiver recipients, except for individuals whose income is in excess of the special income standard according to Code of Federal Regulations, title 42, section 435.236. Recipient maintenance needs shall be adjusted under this provision each July 1.

~~(b) The commissioner of human services shall secure approval of additional elderly waiver slots sufficient to serve persons who will qualify under the revised income standard described in paragraph (a) before implementing section 256B.0913, subdivision 16.~~

~~(c) In implementing this subdivision, the commissioner shall consider allowing persons who would otherwise be eligible for the alternative care program but would qualify for the elderly waiver with a spenddown to remain on the alternative care program.~~

Sec. 30. Minnesota Statutes 2000, section 256B.0915, subdivision 3, is amended to read:

Subd. 3. [LIMITS OF CASES, RATES, ~~REIMBURSEMENT PAYMENTS~~, AND FORECASTING.] (a) The number of medical assistance waiver recipients that a county may serve must be allocated according to the number of medical assistance waiver cases open on July 1 of each fiscal year. Additional recipients may be served with the approval of the commissioner.

~~(b) The monthly limit for the cost of 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.~~

~~(j)~~ (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.

~~(l)~~ (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.~~

~~(1) The commissioner shall establish a maximum rate unit for baths provided by an adult day care provider that are not included in the provider's contractual daily or hourly rate. This maximum rate must equal the home health aide extended rate and shall be paid for baths provided to clients served under the elderly and disabled waivers.~~

Sec. 31. Minnesota Statutes 2000, section 256B.0915, subdivision 5, is amended to read:

Subd. 5. [REASSESSMENTS FOR WAIVER CLIENTS.] A reassessment of a client served under the elderly ~~or disabled~~ waiver must be conducted at least every 12 months and at other times when the case manager determines that there has been significant change in the client's functioning. This may include instances where the client is discharged from the hospital.

Sec. 32. Minnesota Statutes 2000, section 256B.0917, subdivision 7, is amended to read:

Subd. 7. [CONTRACT.] (a) The commissioner of human services shall execute a contract with Living at Home/Block Nurse Program, Inc. (LAH/BN, Inc.). The contract shall require LAH/BN, Inc. to:

(1) develop criteria for and award grants to establish community-based organizations that will implement living-at-home/block nurse programs throughout the state;

(2) award grants to enable ~~current~~ living-at-home/block nurse programs to continue to implement the combined living-at-home/block nurse program model;

(3) serve as a state technical assistance center to assist and coordinate the living-at-home/block nurse programs established; and

(4) manage contracts with individual living-at-home/block nurse programs.

(b) The contract shall be effective July 1, 1997, and section 16B.17 shall not apply.

Sec. 33. [256B.0918] [DEVELOPMENT AND PURPOSE OF MEDICAL ASSISTANCE PILOT PROJECT ON SENIOR SERVICES.]

Subdivision 1. [DEVELOPMENT AND PURPOSE.] The commissioner of human services shall develop a medical assistance pilot project on senior services to determine how converting the delivery of housing, supportive services, and health care for seniors into a flexible voucher program will impact public expenditures for older adult service care and provide an alternative way to purchase services based on consumer choice.

Subd. 2. [FEDERAL WAIVER AUTHORITY.] The commissioner shall apply for any necessary federal waivers or approvals to implement this pilot project. The commissioner shall submit the waiver request no later than April 15, 2002.

Subd. 3. [REPORT.] The commissioner shall report to the legislature by January 15, 2003, on approval of waivers requested. Upon federal approval, the commissioner shall seek legislative authorization to implement the pilot project. Once the pilot project is implemented, participating communities and the commissioner of human services shall collaborate to prepare and issue an annual report each December 1 to the appropriate committee chairs in the senate and house on: (1) the use of state resources, including other funds leveraged for this initiative; (2) the status of individuals being served in the pilot project; and (3) the cost-effectiveness of the pilot project. The commissioner shall provide data that may be needed to evaluate the pilot project to communities that request the data.

Subd. 4. [SUNSET.] This section sunsets June 30, 2008.

Sec. 34. [SERVICE ACCESS STUDY.]

By February 15, 2002, the commissioner of human services shall submit to the legislature recommendations for creating coordinated service access at the county agency level for both publicly subsidized and nonsubsidized long-term care services and housing options. The report must:

(1) include a plan to coordinate public funding streams to allow low-income, privately paying consumers to purchase services through a sliding fee scale; and

(2) evaluate the feasibility of statewide implementation, based upon an evaluation of public cost, consumer preferences and satisfaction, and other relevant factors.

Sec. 35. [RESPITE CARE.]

The Minnesota board on aging shall report to the legislature by February 1, 2002, on the provision of in-home and out-of-home respite care services on a sliding scale basis under the federal Older Americans Act.

Sec. 36. [REPEALER.]

Minnesota Statutes 2000, sections 256B.0911, subdivisions 2, 2a, 4, 8, and 9; and 256B.0913, subdivisions 3, 15a, 15b, 15c, and 16; Minnesota Rules, parts 9505.2390; 9505.2395; 9505.2396; 9505.2400; 9505.2405; 9505.2410; 9505.2413; 9505.2415; 9505.2420; 9505.2425; 9505.2426; 9505.2430; 9505.2435; 9505.2440; 9505.2445; 9505.2450; 9505.2455; 9505.2458; 9505.2460; 9505.2465; 9505.2470; 9505.2473; 9505.2475; 9505.2480; 9505.2485; 9505.2486; 9505.2490; 9505.2495; 9505.2496; and 9505.2500, are repealed.

## ARTICLE 5

### LONG-TERM CARE REFORM AND REIMBURSEMENT

Section 1. [144.0724] [RESIDENT REIMBURSEMENT CLASSIFICATION.]

Subdivision 1. [RESIDENT REIMBURSEMENT CLASSIFICATIONS.] The commissioner of health shall establish resident reimbursement classifications based upon the assessments of residents of nursing homes and boarding care homes conducted under this section and according to section 256B.437. The reimbursement classifications established under this section shall be implemented after June 30, 2002, but no later than January 1, 2003.

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

(a) [ASSESSMENT REFERENCE DATE.] "Assessment reference date" means the last day of the minimum data set observation period. The date sets the designated endpoint of the common observation period, and all minimum data set items refer back in time from that point.

(b) [CASE MIX INDEX.] "Case mix index" means the weighting factors assigned to the RUG-III classifications.

(c) [INDEX MAXIMIZATION.] "Index maximization" means classifying a resident who could be assigned to more than one category, to the category with the highest case mix index.

(d) [MINIMUM DATA SET.] "Minimum data set" means the assessment instrument specified by the Health Care Financing Administration and designated by the Minnesota department of health.

(e) [REPRESENTATIVE.] "Representative" means a person who is the resident's guardian or conservator, the person authorized to pay the nursing home expenses of the resident, a representative of the nursing home ombudsman's office whose assistance has been requested, or any other individual designated by the resident.

(f) [RESOURCE UTILIZATION GROUPS OR RUG.] "Resource utilization groups" or "RUG" means the system for grouping a nursing facility's residents according to their clinical and functional status identified in data supplied by the facility's minimum data set.

Subd. 3. [RESIDENT REIMBURSEMENT CLASSIFICATIONS.] (a) Resident reimbursement classifications shall be based on the minimum data set, version 2.0 assessment instrument, or its successor version mandated by the Health Care Financing Administration that nursing facilities are required to complete for all residents. The commissioner of health shall establish resident classes according to the 34 group, resource utilization groups, version III or RUG-III model. Resident classes must be established based on the individual items on the minimum data set and must be completed according to the facility manual for case mix classification issued by the Minnesota department of health. The facility manual for case mix classification shall be drafted by the Minnesota department of health and presented to the chairs of health and human services legislative committees by December 31, 2001.

(b) Each resident must be classified based on the information from the minimum data set according to general domains in clauses (1) to (7):

(1) extensive services where a resident requires intravenous feeding or medications, suctioning, tracheostomy care, or is on a ventilator or respirator;

(2) rehabilitation where a resident requires physical, occupational, or speech therapy;

(3) special care where a resident has cerebral palsy; quadriplegia; multiple sclerosis; pressure ulcers; fever with vomiting, weight loss, or dehydration; tube feeding and aphasia; or is receiving radiation therapy;

(4) clinically complex status where a resident has burns, coma, septicemia, pneumonia, internal bleeding, chemotherapy, wounds, kidney failure, urinary tract infections, oxygen, or transfusions;

(5) impaired cognition where a resident has poor cognitive performance;

(6) behavior problems where a resident exhibits wandering, has hallucinations, or is physically or verbally abusive toward others, unless the resident's other condition would place the resident in other categories; and

(7) reduced physical functioning where a resident has no special clinical conditions.

(c) The commissioner of health shall establish resident classification according to a 34 group model based on the information on the minimum data set and within the general domains listed in paragraph (b), clauses (1) to (7). Detailed descriptions of each resource utilization group shall be defined in the facility manual for case mix classification issued by the Minnesota department of health. The 34 groups are described as follows:

(1) SE3: requires four or five extensive services;

(2) SE2: requires two or three extensive services;

(3) SE1: requires one extensive service;

(4) RAD: requires rehabilitation services and is dependent in activity of daily living (ADL) at a count of 17 or 18;

(5) RAC: requires rehabilitation services and ADL count is 14 to 16;

(6) RAB: requires rehabilitation services and ADL count is ten to 13;



- (7) RAA: requires rehabilitation services and ADL count is four to nine;
- (8) SSC: requires special care and ADL count is 17 or 18;
- (9) SSB: requires special care and ADL count is 15 or 16;
- (10) SSA: requires special care and ADL count is seven to 14;
- (11) CC2: clinically complex with depression and ADL count is 17 or 18;
- (12) CC1: clinically complex with no depression and ADL count is 17 or 18;
- (13) CB2: clinically complex with depression and ADL count is 12 to 16;
- (14) CB1: clinically complex with no depression and ADL count is 12 to 16;
- (15) CA2: clinically complex with depression and ADL count is four to 11;
- (16) CA1: clinically complex with no depression and ADL count is four to 11;
- (17) IB2: impaired cognition with nursing rehabilitation and ADL count is six to ten;
- (18) IB1: impaired cognition with no nursing rehabilitation and ADL count is six to ten;
- (19) IA2: impaired cognition with nursing rehabilitation and ADL count is four or five;
- (20) IA1: impaired cognition with no nursing rehabilitation and ADL count is four or five;
- (21) BB2: behavior problems with nursing rehabilitation and ADL count is six to ten;
- (22) BB1: behavior problems with no nursing rehabilitation and ADL count is six to ten;
- (23) BA2: behavior problems with nursing rehabilitation and ADL count is four to five;
- (24) BA1: behavior problems with no nursing rehabilitation and ADL count is four to five;
- (25) PE2: reduced physical functioning with nursing rehabilitation and ADL count is 16 to 18;
- (26) PE1: reduced physical functioning with no nursing rehabilitation and ADL count is 16 to 18;
- (27) PD2: reduced physical functioning with nursing rehabilitation and ADL count is 11 to 15;
- (28) PD1: reduced physical functioning with no nursing rehabilitation and ADL count is 11 to 15;
- (29) PC2: reduced physical functioning with nursing rehabilitation and ADL count is nine or ten;
- (30) PC1: reduced physical functioning with no nursing rehabilitation and ADL count is nine or ten;
- (31) PB2: reduced physical functioning with nursing rehabilitation and ADL count is six to eight;
- (32) PB1: reduced physical functioning with no nursing rehabilitation and ADL count is six to eight;

(33) PA2: reduced physical functioning with nursing rehabilitation and ADL count is four or five; and

(34) PA1: reduced physical functioning with no nursing rehabilitation and ADL count is four or five.

Subd. 4. [RESIDENT ASSESSMENT SCHEDULE.] (a) A facility must conduct and electronically submit to the commissioner of health case mix assessments that conform with the assessment schedule defined by the Code of Federal Regulations, title 42, section 483.20, and published by the United States Department of Health and Human Services, Health Care Financing Administration, in the Long Term Care Assessment Instrument User's Manual, version 2.0, October 1995, and subsequent clarifications made in the Long-Term Care Assessment Instrument Questions and Answers, version 2.0, August 1996. The commissioner of health may substitute successor manuals or question and answer documents published by the United States Department of Health and Human Services, Health Care Financing Administration, to replace or supplement the current version of the manual or document.

(b) The assessments used to determine a case mix classification for reimbursement include the following:

(1) a new admission assessment must be completed by day 14 following admission;

(2) an annual assessment must be completed within 366 days of the last comprehensive assessment;

(3) a significant change assessment must be completed within 14 days of the identification of a significant change; and

(4) the second quarterly assessment following either a new admission assessment, an annual assessment, or a significant change assessment. Each quarterly assessment must be completed within 92 days of the previous assessment.

Subd. 5. [SHORT STAYS.] (a) A facility must submit to the commissioner of health an initial admission assessment for all residents who stay in the facility less than 14 days.

(b) Notwithstanding the admission assessment requirements of paragraph (a), a facility may elect to accept a default rate with a case mix index of 1.0 for all facility residents who stay less than 14 days in lieu of submitting an initial assessment. Facilities may make this election to be effective on the day of implementation of the revised case mix system.

(c) After implementation of the revised case mix system, nursing facilities must elect one of the options described in paragraphs (a) and (b) on the annual report to the commissioner of human services filed for each report year ending September 30. The election shall be effective on the following July 1.

(d) For residents who are admitted or readmitted and leave the facility on a frequent basis and for whom readmission is expected, the resident may be discharged on an extended leave status. This status does not require reassessment each time the resident returns to the facility unless a significant change in the resident's status has occurred since the last assessment. The case mix classification for these residents is determined by the facility election made in paragraphs (a) and (b).

Subd. 6. [PENALTIES FOR LATE OR NONSUBMISSION.] A facility that fails to complete or submit an assessment for a RUG-III classification within seven days of the time requirements in subdivisions 4 and 5 is subject to a reduced rate for that resident. The reduced rate shall be the lowest rate for that facility. The reduced rate is effective on the day of admission for new admission assessments or on the day that the assessment was due for all other assessments and continues in effect until the first day of the month following the date of submission of the resident's assessment.

Subd. 7. [NOTICE OF RESIDENT REIMBURSEMENT CLASSIFICATION.] (a) A facility must elect between the options in clauses (1) and (2) to provide notice to a resident of the resident's case mix classification.

(1) The commissioner of health shall provide to a nursing facility a notice for each resident of the reimbursement classification established under subdivision 1. The notice must inform the resident of the classification that was assigned, the opportunity to review the documentation supporting the classification, the opportunity to obtain clarification from the commissioner, and the opportunity to request a reconsideration of the classification. The commissioner must send notice of resident classification by first class mail. A nursing facility is responsible for the distribution of the notice to each resident, to the person responsible for the payment of the resident's nursing home expenses, or to another person designated by the resident. This notice must be distributed within three working days after the facility's receipt of the notice from the commissioner of health.

(2) A facility may choose to provide a classification notice, as prescribed by the commissioner of health, to a resident upon receipt of the confirmation of the case mix classification calculated by a facility or a corrected case mix classification as indicated on the final validation report from the commissioner. A nursing facility is responsible for the distribution of the notice to each resident, to the person responsible for the payment of the resident's nursing home expenses, or to another person designated by the resident. This notice must be distributed within three working days after the facility's receipt of the validation report from the commissioner. If a facility elects this option, the commissioner of health shall provide the facility with a list of residents and their case mix classifications as determined by the commissioner. A nursing facility may make this election to be effective on the day of implementation of the revised case mix system.

(3) After implementation of the revised case mix system, a nursing facility shall elect a notice of resident reimbursement classification procedure as described in clause (1) or (2) on the annual report to the commissioner of human services filed for each report year ending September 30. The election will be effective the following July 1.

(b) If a facility submits a correction to an assessment conducted under subdivision 3 that results in a change in case mix classification, the facility shall give written notice to the resident or the resident's representative about the item that was corrected and the reason for the correction. The notice of corrected assessment may be provided at the same time that the resident or resident's representative is provided the resident's corrected notice of classification.

Subd. 8. [REQUEST FOR RECONSIDERATION OF RESIDENT CLASSIFICATIONS.] (a) The resident, or resident's representative, or the nursing facility or boarding care home may request that the commissioner of health reconsider the assigned reimbursement classification. The request for reconsideration must be submitted in writing to the commissioner within 30 days of the day the resident or the resident's representative receives the resident classification notice. The request for reconsideration must include the name of the resident, the name and address of the facility in which the resident resides, the reasons for the reconsideration, the requested classification changes, and documentation supporting the requested classification. The documentation accompanying the reconsideration request is limited to documentation which establishes that the needs of the resident at the time of the assessment justify a classification which is different than the classification established by the commissioner of health.

(b) Upon request, the nursing facility must give the resident or the resident's representative a copy of the assessment form and the other documentation that was given to the commissioner of health to support the assessment findings. The nursing facility shall also provide access to and a copy of other information from the resident's record that has been requested by or on behalf of the resident to support a resident's reconsideration request. A copy of any requested material must be provided within three working days of receipt of a written request for the information. If a facility fails to provide the material within this time, it is subject to the issuance of a correction order and penalty assessment under sections 144.653 and 144A.10. Notwithstanding those sections, any correction order issued under this subdivision must require that the nursing facility immediately comply with the request for information and that as of the date of the issuance of the correction order, the facility shall forfeit to the state a \$100 fine for the first day of noncompliance, and an increase in the \$100 fine by \$50 increments for each day the noncompliance continues.

(c) In addition to the information required under paragraphs (a) and (b), a reconsideration request from a nursing facility must contain the following information: (i) the date the reimbursement classification notices were received by the facility; (ii) the date the classification notices were distributed to the resident or the resident's representative; and (iii) a copy of a notice sent to the resident or to the resident's representative. This notice must inform the resident or the resident's representative that a reconsideration of the resident's classification is being requested, the

reason for the request, that the resident's rate will change if the request is approved by the commissioner, the extent of the change, that copies of the facility's request and supporting documentation are available for review, and that the resident also has the right to request a reconsideration. If the facility fails to provide the required information with the reconsideration request, the request must be denied, and the facility may not make further reconsideration requests on that specific reimbursement classification.

(d) Reconsideration by the commissioner must be made by individuals not involved in reviewing the assessment, audit, or reconsideration that established the disputed classification. The reconsideration must be based upon the initial assessment and upon the information provided to the commissioner under paragraphs (a) and (b). If necessary for evaluating the reconsideration request, the commissioner may conduct on-site reviews. Within 15 working days of receiving the request for reconsideration, the commissioner shall affirm or modify the original resident classification. The original classification must be modified if the commissioner determines that the assessment resulting in the classification did not accurately reflect the needs or assessment characteristics of the resident at the time of the assessment. The resident and the nursing facility or boarding care home shall be notified within five working days after the decision is made. A decision by the commissioner under this subdivision is the final administrative decision of the agency for the party requesting reconsideration.

(e) The resident classification established by the commissioner shall be the classification that applies to the resident while the request for reconsideration is pending.

(f) The commissioner may request additional documentation regarding a reconsideration necessary to make an accurate reconsideration determination.

Subd. 9. [AUDIT AUTHORITY.] (a) The commissioner shall audit the accuracy of resident assessments performed under section 256B.437 through desk audits, on-site review of residents and their records, and interviews with staff and families. The commissioner shall reclassify a resident if the commissioner determines that the resident was incorrectly classified.

(b) The commissioner is authorized to conduct on-site audits on an unannounced basis.

(c) A facility must grant the commissioner access to examine the medical records relating to the resident assessments selected for audit under this subdivision. The commissioner may also observe and speak to facility staff and residents.

(d) The commissioner shall consider documentation under the time frames for coding items on the minimum data set as set out in the Resident Assessment Instrument Manual published by the Health Care Financing Administration.

(e) The commissioner shall develop an audit selection procedure that includes the following factors:

(1) The commissioner may target facilities that demonstrate an atypical pattern of scoring minimum data set items, nonsubmission of assessments, late submission of assessments, or a previous history of audit changes of greater than 35 percent. The commissioner shall select at least 20 percent of the most current assessments submitted to the state for audit. Audits of assessments selected in the targeted facilities must focus on the factors leading to the audit. If the number of targeted assessments selected does not meet the threshold of 20 percent of the facility residents, then a stratified sample of the remainder of assessments shall be drawn to meet the quota. If the total change exceeds 35 percent, the commissioner may conduct an expanded audit up to 100 percent of the remaining current assessments.

(2) Facilities that are not a part of the targeted group shall be placed in a general pool from which facilities will be selected on a random basis for audit. Every facility shall be audited annually. If a facility has two successive audits in which the percentage of change is five percent or less and the facility has not been the subject of a targeted audit in the past 36 months, the facility may be audited biannually. A stratified sample of 15 percent of the most

current assessments shall be selected for audit. If more than 20 percent of the RUGS-III classifications after the audit are changed, the audit shall be expanded to a second 15 percent sample. If the total change between the first and second samples exceed 35 percent, the commissioner may expand the audit to all of the remaining assessments.

(3) If a facility qualifies for an expanded audit, the commissioner may audit the facility again within six months. If a facility has two expanded audits within a 24-month period, that facility will be audited at least every six months for the next 18 months.

(4) The commissioner may conduct special audits if the commissioner determines that circumstances exist that could alter or affect the validity of case mix classifications of residents. These circumstances include, but are not limited to, the following:

- (i) frequent changes in the administration or management of the facility;
- (ii) an unusually high percentage of residents in a specific case mix classification;
- (iii) a high frequency in the number of reconsideration requests received from a facility;
- (iv) frequent adjustments of case mix classifications as the result of reconsiderations or audits;
- (v) a criminal indictment alleging provider fraud; or
- (vi) other similar factors that relate to a facility's ability to conduct accurate assessments.

(f) Within 15 working days of completing the audit process, the commissioner shall mail the written results of the audit to the facility, along with a written notice for each resident affected to be forwarded by the facility. The notice must contain the resident's classification and a statement informing the resident, the resident's authorized representative, and the facility of their right to review the commissioner's documents supporting the classification and to request a reconsideration of the classification. This notice must also include the address and telephone number of the area nursing home ombudsman.

Subd. 10. [TRANSITION.] After implementation of this section, reconsiderations requested for classifications made under section 144.0722, subdivision 1, shall be determined under section 144.0722, subdivision 3.

Sec. 2. Minnesota Statutes 2000, section 144A.071, subdivision 1, is amended to read:

Subdivision 1. [FINDINGS.] The legislature declares that a moratorium on the licensure and medical assistance certification of new nursing home beds and construction projects that exceed ~~\$750,000~~ \$1,000,000 is necessary to control nursing home expenditure growth and enable the state to meet the needs of its elderly by providing high quality services in the most appropriate manner along a continuum of care.

Sec. 3. Minnesota Statutes 2000, section 144A.071, subdivision 1a, is amended to read:

Subd. 1a. [DEFINITIONS.] For purposes of sections 144A.071 to 144A.073, the following terms have the meanings given them:

- (a) "attached fixtures" has the meaning given in Minnesota Rules, part 9549.0020, subpart 6.
- (b) "buildings" has the meaning given in Minnesota Rules, part 9549.0020, subpart 7.
- (c) "capital assets" has the meaning given in section 256B.421, subdivision 16.

(d) "commenced construction" means that all of the following conditions were met: the final working drawings and specifications were approved by the commissioner of health; the construction contracts were let; a timely construction schedule was developed, stipulating dates for beginning, achieving various stages, and completing construction; and all zoning and building permits were applied for.

(e) "completion date" means the date on which a certificate of occupancy is issued for a construction project, or if a certificate of occupancy is not required, the date on which the construction project is available for facility use.

(f) "construction" means any erection, building, alteration, reconstruction, modernization, or improvement necessary to comply with the nursing home licensure rules.

(g) "construction project" means:

(1) a capital asset addition to, or replacement of a nursing home or certified boarding care home that results in new space or the remodeling of or renovations to existing facility space;

(2) the remodeling or renovation of existing facility space the use of which is modified as a result of the project described in clause (1). This existing space and the project described in clause (1) must be used for the functions as designated on the construction plans on completion of the project described in clause (1) for a period of not less than 24 months; or

(3) capital asset additions or replacements that are completed within 12 months before or after the completion date of the project described in clause (1).

(h) "new licensed" or "new certified beds" means:

(1) newly constructed beds in a facility or the construction of a new facility that would increase the total number of licensed nursing home beds or certified boarding care or nursing home beds in the state; or

(2) newly licensed nursing home beds or newly certified boarding care or nursing home beds that result from remodeling of the facility that involves relocation of beds but does not result in an increase in the total number of beds, except when the project involves the upgrade of boarding care beds to nursing home beds, as defined in section 144A.073, subdivision 1. "Remodeling" includes any of the type of conversion, renovation, replacement, or upgrading projects as defined in section 144A.073, subdivision 1.

(i) "project construction costs" means the cost of the facility capital asset additions, replacements, renovations, or remodeling projects, construction site preparation costs, and related soft costs. Project construction costs ~~also~~ include the cost of any remodeling or renovation of existing facility space which is modified as a result of the construction project. Project construction costs also includes the cost of new technology implemented as part of the construction project.

(j) "technology" means information systems or devices that make documentation, charting, and staff time more efficient or encourage and allow for care through alternative settings including, but not limited to, touch screens, monitors, hand-helds, swipe cards, motion detectors, pagers, telemedicine, medication dispensers, and equipment to monitor vital signs and self-injections, and to observe skin and other conditions.

Sec. 4. Minnesota Statutes 2000, section 144A.071, subdivision 2, is amended to read:

Subd. 2. [MORATORIUM.] The commissioner of health, in coordination with the commissioner of human services, shall deny each request for new licensed or certified nursing home or certified boarding care beds except as provided in subdivision 3 or 4a, or section 144A.073. "Certified bed" means a nursing home bed or a boarding care bed certified by the commissioner of health for the purposes of the medical assistance program, under United States Code, title 42, sections 1396 et seq.

The commissioner of human services, in coordination with the commissioner of health, shall deny any request to issue a license under section 252.28 and chapter 245A to a nursing home or boarding care home, if that license would result in an increase in the medical assistance reimbursement amount.

In addition, the commissioner of health must not approve any construction project whose cost exceeds ~~\$750,000~~ \$1,000,000 unless:

(a) any construction costs exceeding ~~\$750,000~~ \$1,000,000 are not added to the facility's appraised value and are not included in the facility's payment rate for reimbursement under the medical assistance program; or

(b) the project:

(1) has been approved through the process described in section 144A.073;

(2) meets an exception in subdivision 3 or 4a;

(3) is necessary to correct violations of state or federal law issued by the commissioner of health;

(4) is necessary to repair or replace a portion of the facility that was damaged by fire, lightning, groundshifts, or other such hazards, including environmental hazards, provided that the provisions of subdivision 4a, clause (a), are met;

(5) as of May 1, 1992, the facility has submitted to the commissioner of health written documentation evidencing that the facility meets the "commenced construction" definition as specified in subdivision 1a, clause (d), or that substantial steps have been taken prior to April 1, 1992, relating to the construction project. "Substantial steps" require that the facility has made arrangements with outside parties relating to the construction project and include the hiring of an architect or construction firm, submission of preliminary plans to the department of health or documentation from a financial institution that financing arrangements for the construction project have been made; or

(6) is being proposed by a licensed nursing facility that is not certified to participate in the medical assistance program and will not result in new licensed or certified beds.

Prior to the final plan approval of any construction project, the commissioner of health shall be provided with an itemized cost estimate for the project construction costs. If a construction project is anticipated to be completed in phases, the total estimated cost of all phases of the project shall be submitted to the commissioner and shall be considered as one construction project. Once the construction project is completed and prior to the final clearance by the commissioner, the total project construction costs for the construction project shall be submitted to the commissioner. If the final project construction cost exceeds the dollar threshold in this subdivision, the commissioner of human services shall not recognize any of the project construction costs or the related financing costs in excess of this threshold in establishing the facility's property-related payment rate.

The dollar thresholds for construction projects are as follows: for construction projects other than those authorized in clauses (1) to (6), the dollar threshold is ~~\$750,000~~ \$1,000,000. For projects authorized after July 1, 1993, under clause (1), the dollar threshold is the cost estimate submitted with a proposal for an exception under section 144A.073, plus inflation as calculated according to section 256B.431, subdivision 3f, paragraph (a). For projects authorized under clauses (2) to (4), the dollar threshold is the itemized estimate project construction costs submitted to the commissioner of health at the time of final plan approval, plus inflation as calculated according to section 256B.431, subdivision 3f, paragraph (a).

The commissioner of health shall adopt rules to implement this section or to amend the emergency rules for granting exceptions to the moratorium on nursing homes under section 144A.073.

Sec. 5. Minnesota Statutes 2000, section 144A.071, subdivision 4a, is amended to read:

Subd. 4a. [EXCEPTIONS FOR REPLACEMENT BEDS.] It is in the best interest of the state to ensure that nursing homes and boarding care homes continue to meet the physical plant licensing and certification requirements by permitting certain construction projects. Facilities should be maintained in condition to satisfy the physical and emotional needs of residents while allowing the state to maintain control over nursing home expenditure growth.

The commissioner of health in coordination with the commissioner of human services, may approve the renovation, replacement, upgrading, or relocation of a nursing home or boarding care home, under the following conditions:

(a) to license or certify beds in a new facility constructed to replace a facility or to make repairs in an existing facility that was destroyed or damaged after June 30, 1987, by fire, lightning, or other hazard provided:

(i) destruction was not caused by the intentional act of or at the direction of a controlling person of the facility;

(ii) at the time the facility was destroyed or damaged the controlling persons of the facility maintained insurance coverage for the type of hazard that occurred in an amount that a reasonable person would conclude was adequate;

(iii) the net proceeds from an insurance settlement for the damages caused by the hazard are applied to the cost of the new facility or repairs;

(iv) the new facility is constructed on the same site as the destroyed facility or on another site subject to the restrictions in section 144A.073, subdivision 5;

(v) the number of licensed and certified beds in the new facility does not exceed the number of licensed and certified beds in the destroyed facility; and

(vi) the commissioner determines that the replacement beds are needed to prevent an inadequate supply of beds.

Project construction costs incurred for repairs authorized under this clause shall not be considered in the dollar threshold amount defined in subdivision 2;

(b) to license or certify beds that are moved from one location to another within a nursing home facility, provided the total costs of remodeling performed in conjunction with the relocation of beds does not exceed ~~\$750,000~~ \$1,000,000;

(c) to license or certify beds in a project recommended for approval under section 144A.073;

(d) to license or certify beds that are moved from an existing state nursing home to a different state facility, provided there is no net increase in the number of state nursing home beds;

(e) to certify and license as nursing home beds boarding care beds in a certified boarding care facility if the beds meet the standards for nursing home licensure, or in a facility that was granted an exception to the moratorium under section 144A.073, and if the cost of any remodeling of the facility does not exceed ~~\$750,000~~ \$1,000,000. If boarding care beds are licensed as nursing home beds, the number of boarding care beds in the facility must not increase beyond the number remaining at the time of the upgrade in licensure. The provisions contained in section 144A.073 regarding the upgrading of the facilities do not apply to facilities that satisfy these requirements;

(f) to license and certify up to 40 beds transferred from an existing facility owned and operated by the Amherst H. Wilder Foundation in the city of St. Paul to a new unit at the same location as the existing facility that will serve persons with Alzheimer's disease and other related disorders. The transfer of beds may occur gradually or in stages, provided the total number of beds transferred does not exceed 40. At the time of licensure and certification of a bed or beds in the new unit, the commissioner of health shall delicense and decertify the same number of beds in the



existing facility. As a condition of receiving a license or certification under this clause, the facility must make a written commitment to the commissioner of human services that it will not seek to receive an increase in its property-related payment rate as a result of the transfers allowed under this paragraph;

(g) to license and certify nursing home beds to replace currently licensed and certified boarding care beds which may be located either in a remodeled or renovated boarding care or nursing home facility or in a remodeled, renovated, newly constructed, or replacement nursing home facility within the identifiable complex of health care facilities in which the currently licensed boarding care beds are presently located, provided that the number of boarding care beds in the facility or complex are decreased by the number to be licensed as nursing home beds and further provided that, if the total costs of new construction, replacement, remodeling, or renovation exceed ten percent of the appraised value of the facility or \$200,000, whichever is less, the facility makes a written commitment to the commissioner of human services that it will not seek to receive an increase in its property-related payment rate by reason of the new construction, replacement, remodeling, or renovation. The provisions contained in section 144A.073 regarding the upgrading of facilities do not apply to facilities that satisfy these requirements;

(h) to license as a nursing home and certify as a nursing facility a facility that is licensed as a boarding care facility but not certified under the medical assistance program, but only if the commissioner of human services certifies to the commissioner of health that licensing the facility as a nursing home and certifying the facility as a nursing facility will result in a net annual savings to the state general fund of \$200,000 or more;

(i) to certify, after September 30, 1992, and prior to July 1, 1993, existing nursing home beds in a facility that was licensed and in operation prior to January 1, 1992;

(j) to license and certify new nursing home beds to replace beds in a facility acquired by the Minneapolis community development agency as part of redevelopment activities in a city of the first class, provided the new facility is located within three miles of the site of the old facility. Operating and property costs for the new facility must be determined and allowed under section 256B.431 or 256B.434;

(k) to license and certify up to 20 new nursing home beds in a community-operated hospital and attached convalescent and nursing care facility with 40 beds on April 21, 1991, that suspended operation of the hospital in April 1986. The commissioner of human services shall provide the facility with the same per diem property-related payment rate for each additional licensed and certified bed as it will receive for its existing 40 beds;

(l) to license or certify beds in renovation, replacement, or upgrading projects as defined in section 144A.073, subdivision 1, so long as the cumulative total costs of the facility's remodeling projects do not exceed ~~\$750,000~~ \$1,000,000;

(m) to license and certify beds that are moved from one location to another for the purposes of converting up to five four-bed wards to single or double occupancy rooms in a nursing home that, as of January 1, 1993, was county-owned and had a licensed capacity of 115 beds;

(n) to allow a facility that on April 16, 1993, was a 106-bed licensed and certified nursing facility located in Minneapolis to layaway all of its licensed and certified nursing home beds. These beds may be relicensed and recertified in a newly-constructed teaching nursing home facility affiliated with a teaching hospital upon approval by the legislature. The proposal must be developed in consultation with the interagency committee on long-term care planning. The beds on layaway status shall have the same status as voluntarily delicensed and decertified beds, except that beds on layaway status remain subject to the surcharge in section 256.9657. This layaway provision expires July 1, 1998;

(o) to allow a project which will be completed in conjunction with an approved moratorium exception project for a nursing home in southern Cass county and which is directly related to that portion of the facility that must be repaired, renovated, or replaced, to correct an emergency plumbing problem for which a state correction order has been issued and which must be corrected by August 31, 1993;

(p) to allow a facility that on April 16, 1993, was a 368-bed licensed and certified nursing facility located in Minneapolis to layaway, upon 30 days prior written notice to the commissioner, up to 30 of the facility's licensed and certified beds by converting three-bed wards to single or double occupancy. Beds on layaway status shall have the same status as voluntarily delicensed and decertified beds except that beds on layaway status remain subject to the surcharge in section 256.9657, remain subject to the license application and renewal fees under section 144A.07 and shall be subject to a \$100 per bed reactivation fee. In addition, at any time within three years of the effective date of the layaway, the beds on layaway status may be:

(1) relicensed and recertified upon relocation and reactivation of some or all of the beds to an existing licensed and certified facility or facilities located in Pine River, Brainerd, or International Falls; provided that the total project construction costs related to the relocation of beds from layaway status for any facility receiving relocated beds may not exceed the dollar threshold provided in subdivision 2 unless the construction project has been approved through the moratorium exception process under section 144A.073;

(2) relicensed and recertified, upon reactivation of some or all of the beds within the facility which placed the beds in layaway status, if the commissioner has determined a need for the reactivation of the beds on layaway status.

The property-related payment rate of a facility placing beds on layaway status must be adjusted by the incremental change in its rental per diem after recalculating the rental per diem as provided in section 256B.431, subdivision 3a, paragraph (c). The property-related payment rate for a facility relicensing and recertifying beds from layaway status must be adjusted by the incremental change in its rental per diem after recalculating its rental per diem using the number of beds after the relicensing to establish the facility's capacity day divisor, which shall be effective the first day of the month following the month in which the relicensing and recertification became effective. Any beds remaining on layaway status more than three years after the date the layaway status became effective must be removed from layaway status and immediately delicensed and decertified;

(q) to license and certify beds in a renovation and remodeling project to convert 12 four-bed wards into 24 two-bed rooms, expand space, and add improvements in a nursing home that, as of January 1, 1994, met the following conditions: the nursing home was located in Ramsey county; had a licensed capacity of 154 beds; and had been ranked among the top 15 applicants by the 1993 moratorium exceptions advisory review panel. The total project construction cost estimate for this project must not exceed the cost estimate submitted in connection with the 1993 moratorium exception process;

(r) to license and certify up to 117 beds that are relocated from a licensed and certified 138-bed nursing facility located in St. Paul to a hospital with 130 licensed hospital beds located in South St. Paul, provided that the nursing facility and hospital are owned by the same or a related organization and that prior to the date the relocation is completed the hospital ceases operation of its inpatient hospital services at that hospital. After relocation, the nursing facility's status under section 256B.431, subdivision 2j, shall be the same as it was prior to relocation. The nursing facility's property-related payment rate resulting from the project authorized in this paragraph shall become effective no earlier than April 1, 1996. For purposes of calculating the incremental change in the facility's rental per diem resulting from this project, the allowable appraised value of the nursing facility portion of the existing health care facility physical plant prior to the renovation and relocation may not exceed \$2,490,000;

(s) to license and certify two beds in a facility to replace beds that were voluntarily delicensed and decertified on June 28, 1991;

(t) to allow 16 licensed and certified beds located on July 1, 1994, in a 142-bed nursing home and 21-bed boarding care home facility in Minneapolis, notwithstanding the licensure and certification after July 1, 1995, of the Minneapolis facility as a 147-bed nursing home facility after completion of a construction project approved in 1993 under section 144A.073, to be laid away upon 30 days' prior written notice to the commissioner. Beds on layaway status shall have the same status as voluntarily delicensed or decertified beds except that they shall remain subject to the surcharge in section 256.9657. The 16 beds on layaway status may be relicensed as nursing home beds and recertified at any time within five years of the effective date of the layaway upon relocation of some or all of the beds to a licensed and certified facility located in Watertown, provided that the total project construction costs related to

the relocation of beds from layaway status for the Watertown facility may not exceed the dollar threshold provided in subdivision 2 unless the construction project has been approved through the moratorium exception process under section 144A.073.

The property-related payment rate of the facility placing beds on layaway status must be adjusted by the incremental change in its rental per diem after recalculating the rental per diem as provided in section 256B.431, subdivision 3a, paragraph (c). The property-related payment rate for the facility relicensing and recertifying beds from layaway status must be adjusted by the incremental change in its rental per diem after recalculating its rental per diem using the number of beds after the relicensing to establish the facility's capacity day divisor, which shall be effective the first day of the month following the month in which the relicensing and recertification became effective. Any beds remaining on layaway status more than five years after the date the layaway status became effective must be removed from layaway status and immediately delicensed and decertified;

(u) to license and certify beds that are moved within an existing area of a facility or to a newly constructed addition which is built for the purpose of eliminating three- and four-bed rooms and adding space for dining, lounge areas, bathing rooms, and ancillary service areas in a nursing home that, as of January 1, 1995, was located in Fridley and had a licensed capacity of 129 beds;

(v) to relocate 36 beds in Crow Wing county and four beds from Hennepin county to a 160-bed facility in Crow Wing county, provided all the affected beds are under common ownership;

(w) to license and certify a total replacement project of up to 49 beds located in Norman county that are relocated from a nursing home destroyed by flood and whose residents were relocated to other nursing homes. The operating cost payment rates for the new nursing facility shall be determined based on the interim and settle-up payment provisions of Minnesota Rules, part 9549.0057, and the reimbursement provisions of section 256B.431, except that subdivision 26, paragraphs (a) and (b), shall not apply until the second rate year after the settle-up cost report is filed. Property-related reimbursement rates shall be determined under section 256B.431, taking into account any federal or state flood-related loans or grants provided to the facility;

(x) to license and certify a total replacement project of up to 129 beds located in Polk county that are relocated from a nursing home destroyed by flood and whose residents were relocated to other nursing homes. The operating cost payment rates for the new nursing facility shall be determined based on the interim and settle-up payment provisions of Minnesota Rules, part 9549.0057, and the reimbursement provisions of section 256B.431, except that subdivision 26, paragraphs (a) and (b), shall not apply until the second rate year after the settle-up cost report is filed. Property-related reimbursement rates shall be determined under section 256B.431, taking into account any federal or state flood-related loans or grants provided to the facility;

(y) to license and certify beds in a renovation and remodeling project to convert 13 three-bed wards into 13 two-bed rooms and 13 single-bed rooms, expand space, and add improvements in a nursing home that, as of January 1, 1994, met the following conditions: the nursing home was located in Ramsey county, was not owned by a hospital corporation, had a licensed capacity of 64 beds, and had been ranked among the top 15 applicants by the 1993 moratorium exceptions advisory review panel. The total project construction cost estimate for this project must not exceed the cost estimate submitted in connection with the 1993 moratorium exception process;

(z) to license and certify up to 150 nursing home beds to replace an existing 285 bed nursing facility located in St. Paul. The replacement project shall include both the renovation of existing buildings and the construction of new facilities at the existing site. The reduction in the licensed capacity of the existing facility shall occur during the construction project as beds are taken out of service due to the construction process. Prior to the start of the construction process, the facility shall provide written information to the commissioner of health describing the process for bed reduction, plans for the relocation of residents, and the estimated construction schedule. The relocation of residents shall be in accordance with the provisions of law and rule;

(aa) to allow the commissioner of human services to license an additional 36 beds to provide residential services for the physically handicapped under Minnesota Rules, parts 9570.2000 to 9570.3400, in a 198-bed nursing home located in Red Wing, provided that the total number of licensed and certified beds at the facility does not increase;

(bb) to license and certify a new facility in St. Louis county with 44 beds constructed to replace an existing facility in St. Louis county with 31 beds, which has resident rooms on two separate floors and an antiquated elevator that creates safety concerns for residents and prevents nonambulatory residents from residing on the second floor. The project shall include the elimination of three- and four-bed rooms;

(cc) to license and certify four beds in a 16-bed certified boarding care home in Minneapolis to replace beds that were voluntarily delicensed and decertified on or before March 31, 1992. The licensure and certification is conditional upon the facility periodically assessing and adjusting its resident mix and other factors which may contribute to a potential institution for mental disease declaration. The commissioner of human services shall retain the authority to audit the facility at any time and shall require the facility to comply with any requirements necessary to prevent an institution for mental disease declaration, including delicensure and decertification of beds, if necessary; or

(dd) to license and certify 72 beds in an existing facility in Mille Lacs county with 80 beds as part of a renovation project. The renovation must include construction of an addition to accommodate ten residents with beginning and midstage dementia in a self-contained living unit; creation of three resident households where dining, activities, and support spaces are located near resident living quarters; designation of four beds for rehabilitation in a self-contained area; designation of 30 private rooms; and other improvements;

(ee) to license and certify beds in a facility that has undergone replacement or remodeling as part of a planned closure under section 256B.437;

(ff) to license and certify a total replacement project of up to 124 beds located in Wilkin county that are in need of relocation from a nursing home substantially destroyed by flood. The operating cost payment rates for the new nursing facility shall be determined based on the interim and settle-up payment provisions of Minnesota Rules, part 9549.0057, and the reimbursement provisions of section 256B.431, except that section 256B.431, subdivision 26, paragraphs (a) and (b), shall not apply until the second rate year after the settle-up cost report is filed. Property-related reimbursement rates shall be determined under section 256B.431, taking into account any federal or state flood-related loans or grants provided to the facility;

(gg) to allow the commissioner of human services to license an additional nine beds to provide residential services for the physically handicapped under Minnesota Rules, parts 9570.2000 to 9570.3400, in a 215-bed nursing home located in Duluth, provided that the total number of licensed and certified beds at the facility does not increase;

(hh) to license and certify up to 120 new nursing facility beds to replace beds in a facility in Anoka county, which was licensed for 98 beds as of July 1, 2000, provided the new facility is located within four miles of the existing facility and is in Anoka county. Operating and property rates shall be determined and allowed under section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, or section 256B.434 or 256B.435. The provisions of section 256B.431, subdivision 26, paragraphs (a) and (b), do not apply until the second rate year following settle-up; or

(ii) to transfer up to 98 beds of a 129-licensed bed facility located in Anoka county that, as of March 25, 2001, is in the active process of closing, to a 122-licensed bed nonprofit nursing facility located in the city of Columbia Heights or its affiliate. The transfer is effective when the receiving facility notifies the commissioner in writing of the number of beds accepted. The commissioner shall place all transferred beds on layaway status held in the name of the receiving facility. The layaway adjustment provisions of section 256B.431, subdivision 30, do not apply to this layaway. The receiving facility may only remove the beds from layaway for recertification and relicensure at the receiving facility's current site, or at a newly constructed facility located in Anoka county. The receiving facility must receive statutory authorization before removing these beds from layaway.

Sec. 6. Minnesota Statutes 2000, section 144A.073, subdivision 2, is amended to read:

Subd. 2. [REQUEST FOR PROPOSALS.] At the authorization by the legislature of additional medical assistance expenditures for exceptions to the moratorium on nursing homes, the interagency committee shall publish in the State Register a request for proposals for nursing home projects to be licensed or certified under section 144A.071, subdivision 4a, clause (c). The public notice of this funding and the request for proposals must specify how the approval criteria will be prioritized by the advisory review panel, the interagency long-term care planning committee, and the commissioner. The notice must describe the information that must accompany a request and state that proposals must be submitted to the interagency committee within 90 days of the date of publication. The notice must include the amount of the legislative appropriation available for the additional costs to the medical assistance program of projects approved under this section. If no money is appropriated for a year, the interagency committee shall publish a notice to that effect, and no proposals shall be requested. If money is appropriated, the interagency committee shall initiate the application and review process described in this section at least twice each biennium and up to four times each biennium, according to dates established by rule. Authorized funds shall be allocated proportionally to the number of processes. Funds not encumbered by an earlier process within a biennium shall carry forward to subsequent iterations of the process. Authorization for expenditures does not carry forward into the following biennium. To be considered for approval, a proposal must include the following information:

- (1) whether the request is for renovation, replacement, upgrading, conversion, or relocation;
- (2) a description of the problem the project is designed to address;
- (3) a description of the proposed project;
- (4) an analysis of projected costs of the nursing facility proposal, which are not required to exceed the cost threshold referred to in section 144A.071, subdivision 1, to be considered under this section, including initial construction and remodeling costs; site preparation costs; technology costs; financing costs, including the current estimated long-term financing costs of the proposal, which consists of estimates of the amount and sources of money, reserves if required under the proposed funding mechanism, annual payments schedule, interest rates, length of term, closing costs and fees, insurance costs, and any completed marketing study or underwriting review; and estimated operating costs during the first two years after completion of the project;
- (5) for proposals involving replacement of all or part of a facility, the proposed location of the replacement facility and an estimate of the cost of addressing the problem through renovation;
- (6) for proposals involving renovation, an estimate of the cost of addressing the problem through replacement;
- (7) the proposed timetable for commencing construction and completing the project;
- (8) a statement of any licensure or certification issues, such as certification survey deficiencies;
- (9) the proposed relocation plan for current residents if beds are to be closed so that the department of human services can estimate the total costs of a proposal; and
- (10) other information required by permanent rule of the commissioner of health in accordance with subdivisions 4 and 8.

Sec. 7. Minnesota Statutes 2000, section 144A.073, subdivision 4, is amended to read:

Subd. 4. [CRITERIA FOR REVIEW.] The following criteria shall be used in a consistent manner to compare, evaluate, and rank all proposals submitted. Except for the criteria specified in clause (3), the application of criteria listed under this subdivision shall not reflect any distinction based on the geographic location of the proposed project:

(1) the extent to which the proposal furthers state long-term care goals, ~~including the goals stated in section 144A.31, and~~ including the goal of enhancing the availability and use of alternative care services and the goal of reducing the number of long-term care resident rooms with more than two beds;

(2) the proposal's long-term effects on state costs including the cost estimate of the project according to section 144A.071, subdivision 5a;

(3) the extent to which the proposal promotes equitable access to long-term care services in nursing homes through redistribution of the nursing home bed supply, as measured by the number of beds relative to the population 85 or older, projected to the year 2000 by the state demographer, and according to items (i) to (iv):

(i) reduce beds in counties where the supply is high, relative to the statewide mean, and increase beds in counties where the supply is low, relative to the statewide mean;

(ii) adjust the bed supply so as to create the greatest benefits in improving the distribution of beds;

(iii) adjust the existing bed supply in counties so that the bed supply in a county moves toward the statewide mean; and

(iv) adjust the existing bed supply so that the distribution of beds as projected for the year 2020 would be consistent with projected need, based on the methodology outlined in the interagency long-term care committee's ~~1993~~ nursing home bed distribution study;

(4) the extent to which the project improves conditions that affect the health or safety of residents, such as narrow corridors, narrow door frames, unenclosed fire exits, and wood frame construction, and similar provisions contained in fire and life safety codes and licensure and certification rules;

(5) the extent to which the project improves conditions that affect the comfort or quality of life of residents in a facility or the ability of the facility to provide efficient care, such as a relatively high number of residents in a room; inadequate lighting or ventilation; poor access to bathing or toilet facilities; a lack of available ancillary space for dining rooms, day rooms, or rooms used for other activities; problems relating to heating, cooling, or energy efficiency; inefficient location of nursing stations; narrow corridors; or other provisions contained in the licensure and certification rules;

(6) the extent to which the applicant demonstrates the delivery of quality care, as defined in state and federal statutes and rules, to residents as evidenced by the two most recent state agency certification surveys and the applicants' response to those surveys;

(7) the extent to which the project removes the need for waivers or variances previously granted by either the licensing agency, certifying agency, fire marshal, or local government entity; ~~and~~

(8) the extent to which the project increases the number of private or single bed rooms; and

(9) other factors that may be developed in permanent rule by the commissioner of health that evaluate and assess how the proposed project will further promote or protect the health, safety, comfort, treatment, or well-being of the facility's residents.

Sec. 8. [144A.185] [DEFINITIONS.]

Subdivision 1. [APPLICABILITY.] For purposes of sections 144A.185 to 144A.1887, the terms defined in this section have the meanings given them.

Subd. 2. [CLOSURE.] "Closure" means the cessation of operations of a nursing home and the delicensure or decertification of all beds within the facility.

Subd. 3. [CURTAILMENT, REDUCTION, OR CHANGE IN OPERATIONS.] "Curtailment, reduction, or change in operations" means any change in operations or services that would result in or encourage the relocation of residents.

Subd. 4. [FACILITY.] "Facility" means a licensed nursing home or a certified boarding care home licensed according to sections 144.50 to 144.56.

Subd. 5. [LICENSEE.] "Licensee" means the owner of the facility or the owner's designee or the commissioner of health for a facility in receivership.

Subd. 6. [LOCAL AGENCY.] "Local agency" means a county or a multicounty social service agency authorized under section 393.01 as the agency responsible for providing social services for the county in which the facility is located.

Subd. 7. [PLAN.] "Plan" means a process developed under section 144A.186 for the closure or curtailment, reduction, or change in operations of a facility and for the subsequent relocation of residents.

Subd. 8. [RELOCATION.] "Relocation" means the discharge of a resident and movement of the resident to another facility or living arrangement as a result of a closure or curtailment, reduction, or change in operations of a facility.

Sec. 9. [144A.1855] [INITIAL NOTICE.]

Subdivision 1. [NOTIFICATION; PARTIES.] A licensee shall notify the following parties in writing when there is an intent to close or curtail, reduce, or change operations which would result in or encourage the relocation of residents:

- (1) the commissioner of health;
- (2) the commissioner of human services;
- (3) the local agency;
- (4) the office of the ombudsman for older Minnesotans; and
- (5) the office of the ombudsman for mental health and mental retardation.

Subd. 2. [NOTICE REQUIREMENTS.] The written notice shall include the names, telephone numbers, fax numbers, and e-mail addresses of the persons in the facility who are responsible for coordinating the facility's efforts in the planning process and the number of residents potentially affected by the closure or curtailment, reduction, or change in operations.

Sec. 10. [144A.186] [PLANNING PROCESS.]

Subdivision 1. [LOCAL AGENCY REQUIREMENTS.] (a) A local agency, within five working days of receiving an initial notice from a licensee according to section 144A.1855, shall provide all parties identified in section 144A.1855, subdivision 1, with the names, telephone numbers, fax numbers, and e-mail addresses of those persons who are responsible for coordinating local agency efforts in the planning process.

(b) Within ten working days of receipt of the notice under paragraph (a), the local agency and licensee shall meet to develop the relocation plan under subdivision 2. The local agency shall inform the departments of health and human services, the office of the ombudsman for older Minnesotans, and the office of the ombudsman for mental health and mental retardation of the date, time, and location of the meeting so that their representatives may attend. The relocation plan must be completed within 45 days, but may be completed earlier according to a schedule agreed to by all parties.

Subd. 2. [RELOCATION PLAN.] (a) The plan shall:

- (1) identify the expected date of closure or curtailment, reduction, or change in operations;
  - (2) outline the process for public notification of the closure or curtailment, reduction, or change in operations;
  - (3) outline the process to ensure 60-day advance written notice to residents, family members, and designated representatives of residents;
  - (4) present an aggregate description of the resident population remaining to be relocated and the population's needs;
  - (5) outline the individual resident assessment process to be used;
  - (6) identify an inventory of available relocation options, including home and community-based services;
  - (7) identify a timeline for submission of the list required under section 144A.1865, subdivision 3; and
  - (8) identify a schedule for each element of the plan.
- (b) All parties to the plan shall refrain from any public notification of the intent to close or curtail, reduce, or change operations until a relocation plan has been established.

Sec. 11. [144A.1865] [REQUIREMENTS OF LICENSEE.]

Subdivision 1. [RELOCATION.] The licensee shall provide for the safe, orderly, and appropriate relocation of residents. The licensee and facility staff shall cooperate with representatives from the local agency, the departments of health and human services, the office of the ombudsman for older Minnesotans, and the office of the ombudsman for mental health and mental retardation in planning for and implementing the relocation of residents.

Subd. 2. [INTERDISCIPLINARY TEAM.] The licensee shall establish an interdisciplinary team responsible for coordinating and implementing the plan under section 144A.186, subdivision 2. The interdisciplinary team shall include representatives from the local agency, the office of the ombudsman for older Minnesotans, facility staff who provide direct care services to the residents, and the facility administration.

Subd. 3. [RESIDENT LISTS.] The licensee shall provide a list to the local agency that includes the following information on each resident to be relocated:

- (1) name;
- (2) date of birth;
- (3) social security number;
- (4) medical assistance ID number;
- (5) all diagnoses; and
- (6) name of and contact information for the resident's family or other designated representative.

Subd. 4. [CONSULTATION WITH LOCAL AGENCY.] The licensee shall consult with the local agency on the availability and development of resources and in the resident relocation process.

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



## Sec. 12. [144A.187] [RESIDENT AND PHYSICIAN NOTICE.]

Subdivision 1. [RESIDENT NOTICE REQUIRED.] (a) At least 60 days before the proposed date of closure or curtailment, reduction, or change in operations as agreed to in the plan under section 144A.186, the licensee shall send a written notice of closure or curtailment, reduction, or change in operations to each resident being relocated, the resident's family member or designated representative, and the resident's attending physician.

(b) The notice must include:

(1) the date of the proposed closure or curtailment, reduction, or change in operations;

(2) the name, address, telephone number, fax number, and e-mail address of the individuals in the facility responsible for providing assistance and information;

(3) a notice of upcoming meetings for residents, families and designated representatives, and resident and family councils to discuss the relocation of residents;

(4) the name, address, and telephone number of the local agency contact person;

(5) the name, address, and telephone number of the office of the ombudsman for older Minnesotans and the office of the ombudsman for mental health and mental retardation; and

(6) a notice of resident rights during discharge and relocation.

(c) The notice to residents must comply with all applicable state and federal requirements for notice of transfer or discharge of nursing home residents.

Subd. 2. [MEDICAL INFORMATION REQUEST.] The licensee shall request the attending physician to furnish the licensee with, or arrange for the release of, any medical information needed to update a resident's medical records and to prepare transfer forms and discharge summaries.

## Sec. 13. [144A.1875] [RELOCATION OF RESIDENTS.]

Subdivision 1. [PREPARATION; PLACEMENT INFORMATION.] A licensee shall provide sufficient preparation to residents to ensure safe, orderly, and appropriate discharge and relocation. The facility is responsible for assisting residents in finding placement within the resident's desired geographic location using the Senior LinkAge database of the department of human services. By January 1, 2002, Senior LinkAge line shall make available via a Web site the name, address, and telephone and fax numbers of each facility with available beds, the certification level of the available beds, the types of services available, and the number of beds that are available as updated daily by the licensee. The Web site shall include the information required by section 256.975, subdivision 7, paragraph (b), clause (1), and home and community-based services and other options for individuals with special needs. The licensee must provide residents, their families or designated representatives, the office of the ombudsman for older Minnesotans, the office of the ombudsman for mental health and mental retardation, and the local agency with the toll-free number and Web site address for the Senior LinkAge line.

Subd. 2. [RESIDENT AND FAMILY MEETINGS.] After preparing the plan according to section 144A.186, the licensee shall conduct meetings with residents, families and designated representatives, and resident and family councils to notify them of the process for resident relocation. Representatives from the local agency, the office of the ombudsman for older Minnesotans, the office of the ombudsman for mental health and mental retardation, the departments of health and human services shall receive advance notice of these meetings.

Subd. 3. [PERSONAL PROPERTY.] (a) The licensee shall update the inventory of residents' personal possessions and provide a copy of the final inventory to each resident and the resident's family or designated representative prior to the relocation of the resident. The licensee is responsible for the timely transfer of a resident's possessions for all relocations within the state and within a 50-mile radius of the facility for relocations outside the state.

(b) The licensee shall complete a final accounting of personal funds held in trust by the licensee and provide a copy of the accounting to each resident and the resident's family or designated representative. The licensee is responsible for the timely transfer of all personal funds held in trust by the licensee.

Subd. 4. [SITE VISITS.] The licensee is responsible for assisting residents desiring to make site visits to facilities or other placements to which the resident may be relocated, unless it is medically inadvisable, as documented by the attending physician in the resident's care record. The licensee shall provide, or make arrangements for, transportation for site visits to facilities or other placements within a 50-mile radius.

Subd. 5. [FINAL NOTICE OF RELOCATION.] (a) Before relocating a resident, the licensee shall provide a final written notice to the resident, the resident's family or designated representative, and the resident's attending physician.

(b) The final written notice shall:

(1) be provided seven days before the relocation of a resident, unless the resident agrees to waive the resident's right to advance notice; and

(2) identify the date of the anticipated relocation and the location to which the resident is being relocated.

Subd. 6. [ADMINISTRATIVE DUTIES.] (a) All administrative duties of the licensee under subdivisions 1, 2, 4, and 5 must be completed before relocation of a resident.

(b) The licensee is responsible for providing the receiving facility or other health, housing, or care entity with a complete and accurate resident record, including information on family members, designated representatives, guardians, social service caseworkers, and other contact information. The record must also include all information necessary to provide appropriate medical care and social services, including, but not limited to, information on preadmission screening, Level I and Level II screening, minimum data set and all other assessments, resident diagnosis, behavior, and medication.

(c) For residents with special care needs, the licensee shall consult with the receiving facility or other placement entity and provide staff training or other preparation as needed to assist in providing for the special needs.

(d) The licensee shall assist residents with the transfer or reconnection of telephone service. The licensee shall bear all costs associated with reestablishing telephone service.

Subd. 7. [TRANSPORTATION; CONTINUITY OF CARE.] The licensee shall make arrangements or provide for the transportation of residents to the new facility or placement within the state or within a 50-mile radius for relocations outside the state. The licensee shall provide a staff person to accompany the resident during transportation, upon request of the resident, the resident's family, or designated representative. The discharge and relocation of residents must comply with all applicable state and federal requirements and must be conducted in a safe, orderly, and appropriate manner. The licensee must ensure that there is no disruption in providing meals, medications, or treatments of a resident during the relocation process.

Sec. 14. [144A.1885] [RELOCATION REPORTS.]

(a) Beginning the week following development of the initial relocation plan under section 144A.186, the licensee shall submit weekly status reports to the commissioners of health and human services, or their designees, and to the local agency.

(b) The first status report must identify the relocation plan developed under section 144A.186, the interdisciplinary team members, and the number of residents to be relocated.

(c) Subsequent status reports must note any modifications to the relocation plan, any change of interdisciplinary team members or number of residents relocated, the placement destination to which residents have been relocated, and the number of residents remaining to be relocated. Subsequent status reports must also identify issues or problems encountered during the relocation process and the resolution of these issues.

Sec. 15. [144A.1886] [REQUIREMENTS OF LOCAL AGENCY.]

Subdivision 1. [MEETING; REPRESENTATION.] (a) The local agency with the licensee shall convene a meeting to develop a plan according to section 144A.186, subdivision 1, paragraph (b).

(b) The local agency shall designate a representative to the interdisciplinary team established by the licensee responsible for coordinating the relocation efforts.

Subd. 2. [RESOURCE.] (a) The local agency shall serve as a resource in the relocation process.

(b) Concurrent with the notice sent to residents from the licensee according to section 144A.187, subdivision 1, the local agency shall provide written notice to residents, family members, and designated representatives describing:

(1) the local agency's role in the relocation process and in the follow-up to relocation;

(2) a local agency contact name, address, and telephone number; and

(3) the name, address, and telephone number of the office of the ombudsman for older Minnesotans and the office of the ombudsman for mental health and mental retardation.

(c) The local agency is responsible for the safe and orderly relocation of residents in cases where an emergent need arises or when the licensee has abrogated the licensee's responsibilities under the relocation plan.

Subd. 3. [COORDINATION; OVERSIGHT.] (a) The local agency shall meet with appropriate facility staff to coordinate any assistance. Coordination shall include participating in group meetings with residents, family members, and designated representatives to explain the transfer or relocation process.

(b) The local agency shall monitor compliance with all components of the relocation plan. When the licensee is not in compliance, the local agency shall notify the commissioners of health and human services.

(c) Except as requested by the resident, family member, or designated representative and within the parameters of the Vulnerable Adults Act, the local agency may halt a relocation that it deems inappropriate or dangerous to the health or safety of a resident.

Subd. 4. [FOLLOW-UP REVIEW.] (a) A member of the local agency staff shall visit residents relocated within 100 miles of the county within 30 days after a relocation. Local agency staff shall interview the resident and family member or designated representative or shall observe the resident on-site, or both, and review and discuss pertinent medical or social records with appropriate facility staff to assess the adjustment of the resident to the new placement, recommend services or methods to meet any special needs of the resident, and identify residents at risk.

(b) The local agency may conduct subsequent follow-up visits in cases where the adjustment of the resident to the new placement is in question.

(c) Within 60 days of the completion of the follow-up visits, the local agency shall submit a written summary of the follow-up work to the commissioners of health and human services, in a manner approved by the commissioners.

(d) The local agency shall submit a report of any issues that may require further review or monitoring to the commissioner of health.

Sec. 16. [144A.1887] [FUNDING.]

(a) Within 60 days of a nursing home ceasing operations, the commissioner of human services shall reimburse nursing homes that are reimbursed under sections 256B.431, 256B.434, and 256B.435 for operating costs incurred by the nursing home during the closure process. The amount to be reimbursed to the nursing home shall be determined by applying paragraphs (b) to (f).

(b) The facility shall provide the commissioner of human services with the nursing home's operating costs for the time period of 30 days prior to the notice specified under section 144A.16, to 30 days after the nursing home's closure.

(c) The nursing home shall provide the commissioner of human services with the number of medical assistance, Medicare, private pay, and other resident days for the period referenced in paragraph (b) by the 11 case mix categories.

(d) The commissioner of human services shall calculate a nursing home closure rate by dividing the facility operating costs in paragraph (b) by the total resident days in paragraph (c).

(e) The total closure costs attributable to medical assistance shall be determined by multiplying the nursing home closure rate in paragraph (d) by the medical assistance days provided by the nursing facility in paragraph (c).

(f) The amount to be reimbursed to the nursing home is equal to the total closure costs in paragraph (e) minus the sum of the nursing facility's 11 operating rates times their respective number of medical assistance days by case mix as referenced in paragraph (c).

Sec. 17. [144A.36] [TRANSITION PLANNING GRANTS.]

Subdivision 1. [DEFINITIONS.] "Eligible nursing home" means any nursing home licensed under sections 144A.01 to 144A.16 and certified by the appropriate authority under United States Code, title 42, sections 1396-1396p, to participate as a vendor in the medical assistance program established under chapter 256B.

Subd. 2. [GRANTS AUTHORIZED.] (a) The commissioner shall establish a program of transition planning grants to assist eligible nursing homes in implementing the provisions in paragraphs (b) and (c).

(b) Transition planning grants may be used by nursing homes to develop strategic plans which identify the appropriate institutional and noninstitutional settings necessary to meet the older adult service needs of the community.

(c) At a minimum, a strategic plan must consist of:

(1) a needs assessment to determine what older adult services are needed and desired by the community;

(2) an assessment of the appropriate settings in which to provide needed older adult services;

(3) an assessment identifying currently available services and their settings in the community; and

(4) a transition plan to achieve the needed outcome identified by the assessment.

Subd. 3. [ALLOCATION OF GRANTS.] (a) Eligible nursing homes must apply to the commissioner no later than September 1 of each fiscal year for grants awarded in that fiscal year. A grant shall be awarded upon signing of a grant contract.

(b) The commissioner must make a final decision on the funding of each application within 60 days of the deadline for receiving applications.

Subd. 4. [EVALUATION.] The commissioner shall evaluate the overall effectiveness of the grant program. The commissioner may collect, from the nursing homes receiving grants, the information necessary to evaluate the grant program. Information related to the financial condition of individual nursing homes shall be classified as nonpublic data.

Sec. 18. [144A.37] [ALTERNATIVE NURSING HOME SURVEY PROCESS.]

Subdivision 1. [ALTERNATIVE NURSING HOME SURVEY SCHEDULES.] (a) The commissioner of health shall implement alternative procedures for the nursing home survey process as authorized under this section.

(b) These alternative survey process procedures seek to: (1) use department resources more effectively and efficiently to target problem areas; (2) use other existing or new mechanisms to provide objective assessments of quality and to measure quality improvement; (3) provide for frequent collaborative interaction of facility staff and surveyors rather than a punitive approach; and (4) reward a nursing home that has performed very well by extending intervals between full surveys.

(c) The commissioner shall pursue changes in federal law necessary to accomplish this process and shall apply for any necessary federal waivers or approval. If a federal waiver is approved, the commissioner shall promptly submit, to the house and senate committees with jurisdiction over health and human services policy and finance, fiscal estimates for implementing the alternative survey process waiver. The commissioner shall also pursue any necessary federal law changes during the 107th Congress.

(d) The alternative nursing home survey schedule and related educational activities shall not be implemented until funding is appropriated by the legislature.

Subd. 2. [SURVEY INTERVALS.] The commissioner of health must extend the time period between standard surveys up to 30 months based on the criteria established in subdivision 4. In using the alternative survey schedule, the requirement for the statewide average to not exceed 12 months does not apply.

Subd. 3. [COMPLIANCE HISTORY.] The commissioner shall develop a process for identifying the survey cycles for skilled nursing facilities based upon the compliance history of the facility. This process can use a range of months for survey intervals. At a minimum, the process must be based on information from the last two survey cycles and shall take into consideration any deficiencies issued as the result of a survey or a complaint investigation during the interval. A skilled nursing facility with a finding of substandard quality of care or a finding of immediate jeopardy is not entitled to a survey interval greater than 12 months. The commissioner shall alter the survey cycle for a specific skilled nursing facility based on findings identified through the completion of a survey, a monitoring visit, or a complaint investigation. The commissioner must also take into consideration information other than the facility's compliance history.

Subd. 4. [CRITERIA FOR SURVEY INTERVAL CLASSIFICATION.] (a) The commissioner shall provide public notice of the classification process and shall identify the selected survey cycles for each skilled nursing facility. The classification system must be based on an analysis of the findings made during the past two standard survey intervals, but it only takes one survey or complaint finding to modify the interval.

(b) The commissioner shall also take into consideration information obtained from residents and family members in each skilled nursing facility and from other sources such as employees and ombudsmen in determining the appropriate survey intervals for facilities.

Subd. 5. [REQUIRED MONITORING.] (a) The commissioner shall conduct at least one monitoring visit on an annual basis for every skilled nursing facility which has been selected for a survey cycle greater than 12 months. The commissioner shall develop protocols for the monitoring visits which shall be less extensive than the requirements for a standard survey. The commissioner shall use the criteria in paragraph (b) to determine whether additional monitoring visits to a facility will be required.

(b) The criteria shall include, but not be limited to, the following:

- (1) changes in ownership, administration of the facility, or direction of the facility's nursing service;
- (2) changes in the facility's quality indicators which might evidence a decline in the facility's quality of care;
- (3) reductions in staffing or an increase in the utilization of temporary nursing personnel; and
- (4) complaint information or other information that identifies potential concerns for the quality of the care and services provided in the skilled nursing facility.

Subd. 6. [SURVEY REQUIREMENTS FOR FACILITIES NOT APPROVED FOR EXTENDED SURVEY INTERVALS.] The commissioner shall establish a process for surveying and monitoring of facilities which require a survey interval of less than 15 months. This information shall identify the steps that the commissioner must take to monitor the facility in addition to the standard survey.

Subd. 7. [IMPACT ON SURVEY AGENCY'S BUDGET.] The implementation of an alternative survey process for the state must not result in any reduction of funding that would have been provided to the state survey agency for survey and enforcement activity based upon the completion of full standard surveys for each skilled nursing facility in the state.

Subd. 8. [EDUCATIONAL ACTIVITIES.] The commissioner shall expand the state survey agency's ability to conduct training and educational efforts for skilled nursing facilities, residents and family members, residents and family councils, long-term care ombudsman programs, and the general public.

Subd. 9. [EVALUATION.] The commissioner shall develop a process for the evaluation of the effectiveness of an alternative survey process conducted under this section.

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

Sec. 19. [144A.38] [INNOVATIONS IN QUALITY DEMONSTRATION GRANTS.]

Subdivision 1. [PROGRAM ESTABLISHED.] The commissioner of health and the commissioner of human services shall establish a long-term care grant program that demonstrates best practices and innovation for long-term care service delivery and housing. The grants must fund demonstrations that create new means and models for serving the elderly or demonstrate creativity in service provision through the scope of their program or service.

Subd. 2. [ELIGIBILITY.] Grants may only be made to those who provide direct service or housing to the elderly within the state. Grants may only be made for projects that show innovations and measurable improvement in resident care, quality of life, use of technology, or customer satisfaction.

Subd. 3. [AWARDING OF GRANTS.] (a) Applications for grants must be made to the commissioners on forms prescribed by the commissioners.

(b) The commissioners shall review applications and award grants based on the following criteria:

- (1) improvement in direct care to residents;

- (2) increase in efficiency through the use of technology;
- (3) increase in quality of care through the use of technology;
- (4) increase in the access and delivery of service;
- (5) enhancement of nursing staff training;
- (6) the effectiveness of the project as a demonstration; and
- (7) the immediate transferability of the project to scale.

(c) In reviewing applications and awarding grants, the commissioners shall consult with long-term care providers, consumers of long-term care, long-term care researchers, and staff of other state agencies.

(d) Grants for eligible projects may not exceed \$100,000.

Sec. 20. [144A.39] [LONG-TERM CARE QUALITY PROFILES.]

Subdivision 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 new data. To the extent possible, the system must incorporate or be coordinated with information on quality maintained by area agencies on aging, long-term care trade associations, and other entities. The system must be designed to provide information on quality:

(1) to consumers and their families to facilitate informed choices of service providers;

(2) to providers to enable them to measure the results of their quality improvement efforts and compare quality achievements with other service providers; and

(3) to public and private purchasers of long-term care services to enable them to purchase high-quality care.

(b) The system must be developed in consultation with the long-term care task force, area agencies on aging, and representatives of consumers, providers, and labor unions. Within the limits of available appropriations, the commissioners may employ consultants to assist with this project.

Subd. 2. [QUALITY MEASUREMENT TOOLS.] The commissioners shall identify and apply existing quality measurement tools to:

(1) emphasize quality of care and its relationship to quality of life; and

(2) address the needs of various users of long-term care services, including, but not limited to, short-stay residents, persons with behavioral problems, persons with dementia, and persons who are members of minority groups.

The tools must be identified and applied, to the extent possible, without requiring providers to supply information beyond current state and federal requirements.

Subd. 3. [CONSUMER SURVEYS.] Following identification of the quality measurement tool, the commissioners shall conduct surveys of long-term care service consumers to develop quality profiles of providers. To the extent possible, surveys must be conducted face-to-face by state employees or contractors. At the discretion of the commissioners, surveys may be conducted by telephone or by provider staff. Surveys must be conducted periodically to update quality profiles of individual service providers.

Subd. 4. [DISSEMINATION OF QUALITY PROFILES.] By July 1, 2002, the commissioners shall implement a system to disseminate the quality profiles developed from consumer surveys using the quality measurement tool. Profiles must be disseminated to the Senior LinkAge line and to consumers, providers, and purchasers of long-term care services through all feasible printed and electronic outlets. The commissioners shall conduct a public awareness campaign to inform potential users regarding profile contents and potential uses.

Sec. 21. Minnesota Statutes 2000, section 256B.431, subdivision 17, is amended to read:

Subd. 17. [SPECIAL PROVISIONS FOR MORATORIUM EXCEPTIONS.] (a) Notwithstanding Minnesota Rules, part 9549.0060, subpart 3, for rate periods beginning on October 1, 1992, and for rate years beginning after June 30, 1993, a nursing facility that (1) has completed a construction project approved under section 144A.071, subdivision 4a, clause (m); (2) has completed a construction project approved under section 144A.071, subdivision 4a, and effective after June 30, 1995; or (3) has completed a renovation, replacement, or upgrading project approved under the moratorium exception process in section 144A.073 shall be reimbursed for costs directly identified to that project as provided in subdivision 16 and this subdivision.

(b) Notwithstanding Minnesota Rules, part 9549.0060, subparts 5, item A, subitems (1) and (3), and 7, item D, allowable interest expense on debt shall include:

(1) interest expense on debt related to the cost of purchasing or replacing depreciable equipment, excluding vehicles, not to exceed six percent of the total historical cost of the project; and

(2) interest expense on debt related to financing or refinancing costs, including costs related to points, loan origination fees, financing charges, legal fees, and title searches; and issuance costs including bond discounts, bond counsel, underwriter's counsel, corporate counsel, printing, and financial forecasts. Allowable debt related to items in this clause shall not exceed seven percent of the total historical cost of the project. To the extent these costs are financed, the straight-line amortization of the costs in this clause is not an allowable cost; and

(3) interest on debt incurred for the establishment of a debt reserve fund, net of the interest earned on the debt reserve fund.

(c) Debt incurred for costs under paragraph (b) is not subject to Minnesota Rules, part 9549.0060, subpart 5, item A, subitem (5) or (6).

(d) The incremental increase in a nursing facility's rental rate, determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section, resulting from the acquisition of allowable capital assets, and allowable debt and interest expense under this subdivision shall be added to its property-related payment rate and shall be effective on the first day of the month following the month in which the moratorium project was completed.

(e) Notwithstanding subdivision 3f, paragraph (a), for rate periods beginning on October 1, 1992, and for rate years beginning after June 30, 1993, the replacement-costs-new per bed limit to be used in Minnesota Rules, part 9549.0060, subpart 4, item B, for a nursing facility that has completed a renovation, replacement, or upgrading project that has been approved under the moratorium exception process in section 144A.073, or that has completed an addition to or replacement of buildings, attached fixtures, or land improvements for which the total historical cost exceeds the lesser of \$150,000 or ten percent of the most recent appraised value, must be \$47,500 per licensed bed in multiple-bed rooms and \$71,250 per licensed bed in a single-bed room. These amounts must be adjusted annually as specified in subdivision 3f, paragraph (a), beginning January 1, 1993.

(f) For purposes of this paragraph, a total replacement means the complete replacement of the nursing facility's physical plant through the construction of a new physical plant, the transfer of the nursing facility's license from one physical plant location to another, or a new building addition to relocate beds from three- and four-bed wards. For total replacement projects completed on or after July 1, 1992, the commissioner shall compute the incremental change in the nursing facility's rental per diem, for rate years beginning on or after July 1, 1995, by replacing its appraised value, including the historical capital asset costs, and the capital debt and interest costs with the new



nursing facility's allowable capital asset costs and the related allowable capital debt and interest costs. If the new nursing facility has decreased its licensed capacity, the aggregate investment per bed limit in subdivision 3a, paragraph (c), shall apply. If the new nursing facility has retained a portion of the original physical plant for nursing facility usage, then a portion of the appraised value prior to the replacement must be retained and included in the calculation of the incremental change in the nursing facility's rental per diem. For purposes of this part, the original nursing facility means the nursing facility prior to the total replacement project. The portion of the appraised value to be retained shall be calculated according to clauses (1) to (3):

(1) The numerator of the allocation ratio shall be the square footage of the area in the original physical plant which is being retained for nursing facility usage.

(2) The denominator of the allocation ratio shall be the total square footage of the original nursing facility physical plant.

(3) Each component of the nursing facility's allowable appraised value prior to the total replacement project shall be multiplied by the allocation ratio developed by dividing clause (1) by clause (2).

In the case of either type of total replacement as authorized under section 144A.071 or 144A.073, the provisions of this subdivision shall also apply. For purposes of the moratorium exception authorized under section 144A.071, subdivision 4a, paragraph (s), if the total replacement involves the renovation and use of an existing health care facility physical plant, the new allowable capital asset costs and related debt and interest costs shall include first the allowable capital asset costs and related debt and interest costs of the renovation, to which shall be added the allowable capital asset costs of the existing physical plant prior to the renovation, and if reported by the facility, the related allowable capital debt and interest costs.

(g) Notwithstanding Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2), for a total replacement, as defined in paragraph (f), authorized under section 144A.071 or 144A.073 after July 1, 1999, or any building project that is a relocation, renovation, upgrading, or conversion ~~authorized under section 144A.073; completed on~~ or after July 1, 2001, the replacement-costs-new per bed limit shall be \$74,280 per licensed bed in multiple-bed rooms, \$92,850 per licensed bed in semiprivate rooms with a fixed partition separating the resident beds, and \$111,420 per licensed bed in single rooms. Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2), does not apply. These amounts must be adjusted annually as specified in subdivision 3f, paragraph (a), beginning January 1, 2000.

(h) For a total replacement, as defined in paragraph (f), authorized under section 144A.073 for a 96-bed nursing home in Carlton county, the replacement-costs-new per bed limit shall be \$74,280 per licensed bed in multiple-bed rooms, \$92,850 per licensed bed in semiprivate rooms with a fixed partition separating the resident's beds, and \$111,420 per licensed bed in a single room. Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2), does not apply. The resulting maximum allowable replacement-costs-new multiplied by 1.25 shall constitute the project's dollar threshold for purposes of application of the limit set forth in section 144A.071, subdivision 2. The commissioner of health may waive the requirements of section 144A.073, subdivision 3b, paragraph (b), clause (2), on the condition that the other requirements of that paragraph are met.

(i) For a renovation authorized under section 144A.073 for a 65-bed nursing home in St. Louis county, the incremental increase in rental rate for purposes of paragraph (d) shall be \$8.16, and the total replacement cost, allowable appraised value, allowable debt, and allowable interest shall be increased according to the incremental increase.

(j) For a total replacement, as defined in paragraph (f), authorized under section 144A.073 involving a new building addition that relocates beds from three-bed wards for an 80-bed nursing home in Redwood county, the replacement-costs-new per bed limit shall be \$74,280 per licensed bed for multiple-bed rooms; \$92,850 per licensed bed for semiprivate rooms with a fixed partition separating the beds; and \$111,420 per licensed bed for single rooms. These amounts shall be adjusted annually, beginning January 1, 2001. Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2), does not apply. The resulting maximum allowable replacement-costs-new multiplied by 1.25

shall constitute the project's dollar threshold for purposes of application of the limit set forth in section 144A.071, subdivision 2. The commissioner of health may waive the requirements of section 144A.073, subdivision 3b, paragraph (b), clause (2), on the condition that the other requirements of that paragraph are met.

Sec. 22. Minnesota Statutes 2000, section 256B.431, is amended by adding a subdivision to read:

Subd. 31. [PAYMENT DURING FIRST 90 DAYS.] (a) For rate years beginning on or after July 1, 2001, the total payment rate for a facility reimbursed under this section, section 256B.434, or any other section for the first 90 days after admission shall be:

(1) for the first 30 paid days, the rate shall be 120 percent of the facility's medical assistance rate for each case mix class; and

(2) for the next 60 days after the first 30 paid days, the rate shall be 110 percent of the facility's medical assistance rate for each case mix class.

(b) Beginning with the 91st paid day after admission, the payment rate shall be the rate otherwise determined under this section, section 256B.434, or any other section.

(c) This subdivision applies to admissions occurring on or after July 1, 2001.

Sec. 23. Minnesota Statutes 2000, section 256B.431, is amended by adding a subdivision to read:

Subd. 32. [NURSING FACILITY RATE INCREASES BEGINNING JULY 1, 2001, AND JULY 1, 2002.] For the rate years beginning July 1, 2001, and July 1, 2002, the commissioner shall make available to each nursing facility reimbursed under this section or section 256B.434 an adjustment equal to 3.0 percent of the total operating payment rate. The operating payment rates in effect on June 30, 2001, and June 30, 2002, respectively, shall include the adjustment in subdivision 2i, paragraph (c).

Sec. 24. Minnesota Statutes 2000, section 256B.431, is amended by adding a subdivision to read:

Subd. 33. [ADDITIONAL INCREASES FOR LOW RATE METROPOLITAN AREA FACILITIES.] After the calculation of the increase for the rate year beginning July 1, 2001, in subdivision 31, the commissioner must provide for special increases to facilities determined to be the lowest rate facilities in state development region 11, as defined in section 462.385. Within this region, the commissioner shall identify the median nursing facility rate by case mix category for all nursing facilities under section 256B.431 or 256B.434. Nursing home rates that are below the median for case mix class A must be adjusted to the set of case mix rates for the facility at the median for case mix class A.

Sec. 25. Minnesota Statutes 2000, section 256B.431, is amended by adding a subdivision to read:

Subd. 34. [RATE FLOOR FOR FACILITIES LOCATED OUTSIDE THE METROPOLITAN AREA.] (a) For the rate year beginning July 1, 2001, the commissioner shall adjust operating costs per diem for nursing facilities located outside of state development region 11, as defined in section 462.385, reimbursed under this section and sections 256B.434 and 256B.435, as provided in this subdivision.

(b) For each nursing facility, the commissioner shall compare the operating costs per diem listed in this paragraph to the operating costs per diem the facility would otherwise receive for the July 1, 2001, rate year after provision of any other rate increases required by this chapter.

<u>Case mix classification</u>	<u>Operating costs per diem</u>
<u>A</u>	<u>\$ 67.02</u>
<u>B</u>	<u>\$ 73.00</u>

<u>C</u>	<u>\$ 79.77</u>
<u>D</u>	<u>\$ 85.94</u>
<u>E</u>	<u>\$ 92.32</u>
<u>F</u>	<u>\$ 92.72</u>
<u>G</u>	<u>\$ 98.13</u>
<u>H</u>	<u>\$108.40</u>
<u>I</u>	<u>\$112.03</u>
<u>J</u>	<u>\$117.67</u>
<u>K</u>	<u>\$129.55</u>

(c) If a facility's total reimbursement for operating costs, using the case mix classification operating costs per diem listed in paragraph (b), is greater than the total reimbursement for operating costs the facility would otherwise receive, the commissioner shall calculate operating costs per diem for that facility for the rate year beginning July 1, 2001, using the case mix classification operating costs per diem listed in paragraph (b).

(d) If a facility's total reimbursement for operating costs, using the case mix classification costs per diem listed in paragraph (b), is less than the total reimbursement for operating costs the facility would otherwise receive, the commissioner shall reimburse that facility for the rate year beginning July 1, 2001, as provided in this section, section 256B.434, or 256B.435, whichever is applicable, and shall not calculate operating costs per diem for that facility using the case mix classification operating costs per diem listed in paragraph (b).

Sec. 26. Minnesota Statutes 2000, section 256B.431, is amended by adding a subdivision to read:

Subd. 35. [EXCLUSION OF RAW FOOD COST ADJUSTMENT.] For rate years beginning on or after July 1, 2001, in calculating a nursing facility's operating cost per diem for the purposes of constructing an array of nursing facility payment rates to be used to determine future rate increases under this section, section 256B.434, or any other section, the commissioner shall exclude adjustments for raw food costs under subdivision 2b, paragraph (h), that are related to providing special diets based on religious beliefs.

Sec. 27. Minnesota Statutes 2000, section 256B.434, subdivision 4, is amended to read:

Subd. 4. [ALTERNATE RATES FOR NURSING FACILITIES.] (a) For nursing facilities which have their payment rates determined under this section rather than section 256B.431, the commissioner shall establish a rate under this subdivision. The nursing facility must enter into a written contract with the commissioner.

(b) A nursing facility's case mix payment rate for the first rate year of a facility's contract under this section is the payment rate the facility would have received under section 256B.431.

(c) A nursing facility's case mix payment rates for the second and subsequent years of a facility's contract under this section are the previous rate year's contract payment rates plus an inflation adjustment and an adjustment to include the cost of any increase in health department licensing fees for the facility taking effect on or after July 1, 2001. The index for the inflation adjustment must be based on the change in the Consumer Price Index-All Items (United States City average) (CPI-U) forecasted by Data Resources, Inc., as forecasted in the fourth quarter of the calendar year preceding the rate year. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined. For the rate years beginning on July 1, 1999, and July 1, 2000, July 1, 2001, and July 1, 2002, this paragraph shall apply only to the property-related payment rate, except that adjustments to include the cost of any increase in health department licensing fees taking effect on or after July 1, 2001, shall be provided. In determining the amount of the property-related payment rate adjustment under this paragraph, the commissioner shall determine the proportion of the facility's rates that are property-related based on the facility's most recent cost report.

(d) The commissioner shall develop additional incentive-based payments of up to five percent above the standard contract rate for achieving outcomes specified in each contract. The specified facility-specific outcomes must be measurable and approved by the commissioner. The commissioner may establish, for each contract, various levels

of achievement within an outcome. After the outcomes have been specified the commissioner shall assign various levels of payment associated with achieving the outcome. Any incentive-based payment cancels if there is a termination of the contract. In establishing the specified outcomes and related criteria the commissioner shall consider the following state policy objectives:

- (1) improved cost effectiveness and quality of life as measured by improved clinical outcomes;
- (2) successful diversion or discharge to community alternatives;
- (3) decreased acute care costs;
- (4) improved consumer satisfaction;
- (5) the achievement of quality; or
- (6) any additional outcomes proposed by a nursing facility that the commissioner finds desirable.

Sec. 28. Minnesota Statutes 2000, section 256B.434, is amended by adding a subdivision to read:

Subd. 4c. [FACILITY RATE INCREASES EFFECTIVE JANUARY 1, 2002.] For the rate period beginning January 1, 2002, and for the rate year beginning July 1, 2002, a nursing facility in Morrison county licensed for 83 beds shall receive an increase of \$2.54 in each case mix payment rate to offset property tax payments due as a result of the facility's conversion from nonprofit to for-profit status. The increases under this subdivision shall be added following the determination under this chapter of the payment rate for the rate year beginning July 1, 2001, and shall be included in the facility's total payment rates for the purposes of determining future rates under this section or any other section.

Sec. 29. Minnesota Statutes 2000, section 256B.434, is amended by adding a subdivision to read:

Subd. 4d. [FACILITY RATE INCREASES EFFECTIVE JULY 1, 2001.] For the rate year beginning July 1, 2001, a nursing facility in Hennepin county licensed for 302 beds shall receive an increase of 29 cents in each case mix payment rate to correct an error in the cost-reporting system that occurred prior to the date that the facility entered the alternative payment demonstration project. The increases under this subdivision shall be added following the determination under this chapter of the payment rate for the rate year beginning July 1, 2001, and shall be included in the facility's total payment rates for the purposes of determining future rates under this section or any other section.

Sec. 30. Minnesota Statutes 2000, section 256B.434, is amended by adding a subdivision to read:

Subd. 4e. [RATE INCREASE EFFECTIVE JULY 1, 2001.] A nursing facility in Anoka county licensed for 98 beds as of July 1, 2000, shall receive an increase of \$10 in each case mix rate for the rate year beginning July 1, 2001. This increase shall be included in the facility's total payment rate for purposes of determining future rates under this section or any other section through June 30, 2004.

Sec. 31. Minnesota Statutes 2000, section 256B.434, subdivision 10, is amended to read:

Subd. 10. [EXEMPTIONS.] (a) To the extent permitted by federal law, (1) a facility that has entered into a contract under this section is not required to file a cost report, as defined in Minnesota Rules, part 9549.0020, subpart 13, for any year after the base year that is the basis for the calculation of the contract payment rate for the first rate year of the alternative payment demonstration project contract; and (2) a facility under contract is not subject to audits of historical costs or revenues, or paybacks or retroactive adjustments based on these costs or revenues, except audits, paybacks, or adjustments relating to the cost report that is the basis for calculation of the first rate year under the contract.

(b) A facility that is under contract with the commissioner under this section is not subject to the moratorium on licensure or certification of new nursing home beds in section 144A.071, unless the project results in a net increase in bed capacity or involves relocation of beds from one site to another. Contract payment rates must not be adjusted to reflect any additional costs that a nursing facility incurs as a result of a construction project undertaken under this paragraph. In addition, as a condition of entering into a contract under this section, a nursing facility must agree that any future medical assistance payments for nursing facility services will not reflect any additional costs attributable to the sale of a nursing facility under this section and to construction undertaken under this paragraph that otherwise would not be authorized under the moratorium in section 144A.073. Nothing in this section prevents a nursing facility participating in the alternative payment demonstration project under this section from seeking approval of an exception to the moratorium through the process established in section 144A.073, and if approved the facility's rates shall be adjusted to reflect the cost of the project. Nothing in this section prevents a nursing facility participating in the alternative payment demonstration project from seeking legislative approval of an exception to the moratorium under section 144A.071, and, if enacted, the facility's rates shall be adjusted to reflect the cost of the project.

(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) (c) Notwithstanding paragraph (a), if by April 1, 1996, the health care financing administration has not approved a required waiver, or the health care financing administration otherwise requires cost reports to be filed prior to the waiver's approval, the commissioner shall require a cost report for the rate year.

(e) (d) A facility that is under contract with the commissioner under this section shall be allowed to change therapy arrangements from an unrelated vendor to a related vendor during the term of the contract. The commissioner may develop reasonable requirements designed to prevent an increase in therapy utilization for residents enrolled in the medical assistance program.

Sec. 32. [256B.437] [IMPLEMENTATION OF A CASE MIX SYSTEM FOR NURSING FACILITIES BASED ON THE MINIMUM DATA SET.]

Subdivision 1. [SCOPE.] This section establishes the method and criteria used to determine resident reimbursement classifications based upon the assessments of residents of nursing homes and boarding care homes whose payment rates are established under section 256B.431, 256B.434, or 256B.435. Resident reimbursement classifications shall be established according to the 34 group, resource utilization groups, version III or RUG-III model as described in section 144.0724. Reimbursement classifications established under this section shall be implemented after June 30, 2002, but no later than January 1, 2003.

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

(a) [ASSESSMENT REFERENCE DATE.] "Assessment reference date" has the meaning given in section 144.0724, subdivision 2, paragraph (a).

(b) [CASE MIX INDEX.] "Case mix index" has the meaning given in section 144.0724, subdivision 2, paragraph (b).

(c) [INDEX MAXIMIZATION.] "Index maximization" has the meaning given in section 144.0724, subdivision 2, paragraph (c).

(d) [MINIMUM DATA SET.] "Minimum data set" has the meaning given in section 144.0724, subdivision 2, paragraph (d).

(e) [REPRESENTATIVE.] "Representative" has the meaning given in section 144.0724, subdivision 2, paragraph (e).

(f) [RESOURCE UTILIZATION GROUPS OR RUG.] "Resource utilization groups" or "RUG" has the meaning given in section 144.0724, subdivision 2, paragraph (f).

Subd. 3. [CASE MIX INDICES.] (a) The commissioner of human services shall assign a case mix index to each resident class based on the Health Care Financing Administration's staff time measurement study and adjusted for Minnesota-specific wage indices. The case mix indices assigned to each resident class shall be published in the Minnesota State Register at least 120 days prior to the implementation of the 34 group, RUG-III resident classification system.

(b) An index maximization approach shall be used to classify residents.

(c) After implementation of the revised case mix system, the commissioner of human services may annually rebase case mix indices and base rates using more current data on average wage rates and staff time measurement studies. This rebasing shall be calculated under subdivision 7, paragraph (b). The commissioner shall publish in the Minnesota State Register adjusted case mix indices at least 45 days prior to the effective date of the adjusted case mix indices.

Subd. 4. [RESIDENT ASSESSMENT SCHEDULE.] (a) Nursing facilities shall conduct and submit case mix assessments according to the schedule established by the commissioner of health under section 144.0724, subdivisions 4 and 5.

(b) The resident reimbursement classifications established under section 144.0724, subdivision 3, shall be effective the day of admission for new admission assessments. The effective date for significant change assessments shall be the assessment reference date. The effective date for annual and second quarterly assessments shall be the first day of the month following assessment reference date.

Subd. 5. [NOTICE OF RESIDENT REIMBURSEMENT CLASSIFICATION.] Nursing facilities shall provide notice to a resident of the resident's case mix classification according to procedures established by the commissioner of health under section 144.0724, subdivision 7.

Subd. 6. [RECONSIDERATION OF RESIDENT CLASSIFICATION.] Any request for reconsideration of a resident classification must be made under section 144.0724, subdivision 8.

Subd. 7. [RATE DETERMINATION UPON TRANSITION TO RUG-III PAYMENT RATES.] (a) The commissioner of human services shall determine payment rates at the time of transition to the RUG based payment model in a facility-specific, budget-neutral manner. The case mix indices as defined in subdivision 3 shall be used to allocate the case mix adjusted component of total payment across all case mix groups. To transition from the current calculation methodology to the RUG based methodology, the commissioner of health shall report to the commissioner of human services the resident days classified according to the categories defined in subdivision 3 for the 12-month reporting period ending September 30, 2001, for each nursing facility. The commissioner of human services shall use this data to compute the standardized days for the reporting period under the RUG system.

(b) The commissioner of human services shall determine the case mix adjusted component of the rate as follows:

(1) determine the case mix portion of the 11 case mix rates in effect on June 30, 2002, or the 34 case mix rates in effect on or after June 30, 2003;

(2) multiply each amount in clause (1) by the number of resident days assigned to each group for the reporting period ending September 30, 2001, or the most recent year for which data is available;

(3) compute the sum of the amounts in clause (2);

(4) determine the total RUG standardized days for the reporting period ending September 30, 2001, or the most recent year for which data is available using new indices calculated under subdivision 3, paragraph (c);

(5) divide the amount in clause (3) by the amount in clause (4) which shall be the average case mix adjusted component of the rate under the RUG method; and

(6) multiply this average rate by the case mix weight in subdivision 3 for each RUG group.

(c) The noncase mix component will be allocated to each RUG group as a constant amount to determine the transition payment rate. Any other rate adjustments that are effective on or after July 1, 2002, shall be applied to the transition rates determined under this section.

Sec. 33. [256B.4371] [NURSING FACILITY VOLUNTARY CLOSURES AND PLANNING AND DEVELOPMENT OF COMMUNITY-BASED ALTERNATIVES.]

Subdivision 1. [DEFINITIONS.] (a) The definitions in this subdivision apply to subdivisions 2 to 9.

(b) "Closure" means the cessation of operations of a nursing facility and delicensure and decertification of all beds within the facility.

(c) "Commencement of closure" means the date on which residents and designated representatives are notified of a planned closure according to sections 144A.185 to 144A.1887 as part of an approved closure plan.

(d) "Completion of closure" means the date on which the final resident of the nursing facility or nursing facilities designated for closure in an approved closure plan is discharged from the facility or facilities.

(e) "Closure plan" means a plan to close a nursing facility and reallocate the resulting savings to provide planned closure rate adjustments at other facilities.

(f) "Partial closure" means the delicensure and decertification of a portion of the beds within the facility.

(g) "Planned closure rate adjustment" means an increase in a nursing facility's operating rates resulting from a partial planned closure of a facility or a planned closure of another facility.

Subd. 2. [PLANNING AND DEVELOPMENT OF COMMUNITY BASED SERVICES.]

(a) The commissioner of human services shall establish a process to adjust the capacity and distribution of long-term care services to equalize the supply and demand for different types of services. This process must include community planning, expansion or establishment of needed services, and analysis of voluntary nursing facility closures.

(b) The purpose of this process is to support the planning and development of community-based services. This process must support early intervention, advocacy, and consumer protection while providing resources and incentives for expanded county planning and for nursing facilities to transition to meet community needs.

(c) The process shall support and facilitate expansion of community-based services under the county-administered alternative care program under section 256B.0913 and waivers for elderly under section 256B.0915, including the development of supportive services such as housing and transportation. The process shall utilize community assessments and planning developed for the community health services plan and plan update and for the community social services act plan.

(d) The addendum to the biennial plan shall be submitted annually, beginning in 2001, and shall include recommendations for development of community-based services. Both planning and implementation shall be implemented within the amount of funding made available to the county board for these purposes.

(e) The commissioner of health and the commissioner of human services, as appropriate, shall provide available data necessary for the county, including but not limited to data on nursing facility bed distribution, housing with services options, the closure of nursing facilities that occur outside of the planned closure process, and approval of planned closures in the county and contiguous counties.

(f) The plan, within the funding allocated, shall:

(1) identify the need for services based on demographic data, service availability, caseload information, and provider information;

(2) involve providers, consumers, cities, townships, businesses, and area agencies on aging in the planning process;

(3) address the availability of alternative care and elderly waiver services for eligible recipients;

(4) address the development of other supportive services, such as transit, housing, and workforce and economic development; and

(5) estimate the cost and timelines for development.

(g) The biennial plan addendum shall be coordinated with the county mental health plan for inclusion in the community health services plan and included as an addendum to the community social services plan.

(h) The county board having financial responsibility for persons present in another county shall cooperate with that county for planning and development of services.

(i) The county board shall cooperate in planning and development of community based services with other counties, as necessary, and coordinate planning for long-term care services that involve more than one county, within the funding allocated for these purposes.

(j) The commissioners of health and human services, in cooperation with county boards, shall report to the legislature by February 1 of each year, beginning February 1, 2002, regarding the development of community based services, transition or closure of nursing facilities, and consumer outcomes achieved, as documented by each county and reported to the commissioner by December 31 of each year.

(k) The process established by the commissioner of human services shall ensure:

(1) that counties consider multicounty service areas in developing services that may impact delivery efficiencies; and

(2) review and comment by the area agencies on aging, regional development commissions, where they exist, and other planning agencies of the biennial plan addendum.

Subd. 3. [REQUEST FOR APPLICATIONS FOR PLANNED CLOSURE OF NURSING FACILITIES.] (a) By July 15, 2001, the commissioner of human services shall implement and announce a program for closure or partial closure of nursing facilities. Names and identifying information provided in response to the announcement shall remain private unless approved, according to the timelines established in the plan. The announcement must specify:

(1) the criteria that will be used by the interagency long-term care planning committee established under section 144A.31 and the commissioner to approve or reject applications;

(2) a requirement for the submission of a letter of intent before the submission of an application;

(3) the information that must accompany an application;



(4) a schedule for letters of intent, applications, and consideration of applications for a minimum of four review processes to be conducted before June 30, 2003; and

(5) that applications may combine planned closure rate adjustments with moratorium exception funding, in which case a single application may serve both purposes.

Between October 1, 2001, and June 30, 2003, the commissioner shall approve planned closures of at least 5,140 nursing facility beds, with no more than 2,070 approved for closure prior to July 1, 2002, less the number of licensed beds in facilities that close during the same time period without approved closure plans or have notified the commissioner of health of their intent to close without an approved closure plan.

(b) A facility or facilities reimbursed under section 256B.431, 256B.434, or 256B.435 with a closure plan approved by the commissioner under subdivision 6 may assign a planned closure rate adjustment to another facility that is not closing or facilities that are not closing, or in the case of a partial closure, to the facility undertaking the partial closure. A facility may also elect to have a planned closure rate adjustment shared equally by the five nursing facilities with the lowest total operating payment rates in the state development region, designated under section 462.385, in which the facility receiving the planned closure rate adjustment is located. The planned closure rate adjustment must be calculated under subdivision 7. A planned closure rate adjustment under this section is effective on the first day of the month following completion of closure of all facilities designated for closure in the application and becomes part of the nursing facility's total operating payment rate.

Applicants may use the planned closure rate adjustment to allow for a property payment for a new nursing facility or an addition to an existing nursing facility. Applications approved under this paragraph are exempt from other requirements for moratorium exceptions under section 144A.073, subdivisions 2 and 3.

Facilities without a closure plan, or whose closure plan is not approved by the commissioner, are not eligible for a planned closure rate adjustment under subdivision 7. However, the commissioner shall calculate the amount the facility would have received under subdivision 7 and shall use this amount to provide equal rate adjustments to the five nursing facilities with the lowest total operating payment rates in the state development region, designated under section 462.385, in which the facility is located.

(c) To be considered for approval, an application must include:

(1) a description of the proposed closure plan, which must include identification of the facility or facilities to receive a planned closure rate adjustment and the amount and timing of a planned closure rate adjustment proposed for each facility;

(2) the proposed timetable for any proposed closure, including the proposed dates for announcement to residents, commencement of closure, and completion of closure;

(3) the proposed relocation plan for current residents of any facility designated for closure. The proposed relocation plan must be designed to comply with all applicable state and federal statutes and regulations, including, but not limited to, section 144A.16 and Minnesota Rules, parts 4655.6810 to 4655.6830, 4658.1600 to 4658.1690, and 9546.0010 to 9546.0060;

(4) a description of the relationship between the nursing facility that is proposed for closure and the nursing facility or facilities proposed to receive the planned closure rate adjustment. If these facilities are not under common ownership, copies of any contracts, purchase agreements, or other documents establishing a relationship or proposed relationship must be provided;

(5) documentation, in a format approved by the commissioner, that all the nursing facilities receiving a planned closure rate adjustment under the plan have accepted joint and several liability for recovery of overpayments under section 256B.0641, subdivision 2, for the facilities designated for closure under the plan; and

(6) an explanation of how the application coordinates with planning efforts under subdivision 2.

(d) The application must address the criteria listed in subdivision 4.

Subd. 4. [CRITERIA FOR REVIEW OF APPLICATION.] In reviewing and approving closure proposals, the commissioner shall consider, but not be limited to, the following criteria:

(1) improved quality of care and quality of life for consumers;

(2) closure of a nursing facility that has a poor physical plant;

(3) the existence of excess nursing facility beds, measured in terms of beds per thousand persons aged 85 or older. The excess must be measured in reference to:

(i) the county in which the facility is located;

(ii) the county and all contiguous counties;

(iii) the region in which the facility is located; or

(iv) the facility's service area.

The facility shall indicate in its proposal the area it believes is appropriate for this measurement. A facility in a county that is in the lowest quartile of counties with reference to beds per thousand persons aged 85 or older is not in an area of excess capacity;

(4) low-occupancy rates, provided that the unoccupied beds are not the result of a personnel shortage. In analyzing occupancy rates, the commissioner shall examine waiting lists in the applicant facility and at facilities in the surrounding area, as determined under clause (3);

(5) evidence of a community planning process to determine what services are needed and ensure that needed services are established;

(6) innovative use of reinvestment funds;

(7) innovative use planned for the closed facility's physical plant;

(8) evidence that the proposal serves the interests of the state; and

(9) evidence of other factors that affect the viability of the facility, including excessive nursing pool costs.

Subd. 5. [REVIEW AND APPROVAL OF PROPOSALS.] (a) The interagency long-term care planning committee may recommend that the commissioner of human services grant approval, within the limits established in subdivision 3, paragraph (a), to applications that satisfy the requirements of this section. The interagency committee may appoint an advisory review panel composed of representatives of counties, SAIL projects, consumers, and providers to review proposals and provide comments and recommendations to the committee. The commissioners of human services and health shall provide staff and technical assistance to the committee for the review and analysis of proposals. The commissioners of human services and health shall jointly approve or disapprove an application within 30 days after receiving the committee's recommendations.

(b) Approval of a planned closure expires 18 months after approval by the commissioner of human services, unless commencement of closure has begun.

(c) The commissioner of human services may change any provision of the application to which all parties agree.

Subd. 6. [PLANNED CLOSURE RATE ADJUSTMENT.] The commissioner of human services shall calculate the amount of the planned closure rate adjustment available under subdivision 3, paragraph (b), according to clauses (1) to (4):

(1) the amount available is the net reduction of nursing facility beds multiplied by \$2,080;

(2) the total number of beds in the nursing facility receiving the planned closure rate adjustment must be identified;

(3) capacity days are determined by multiplying the number determined under clause (2) by 365; and

(4) the planned closure rate adjustment is the amount available in clause (1), divided by capacity days determined under clause (3).

Subd. 7. [OTHER RATE ADJUSTMENTS.] Facilities receiving planned closure rate adjustments remain eligible for any applicable rate adjustments provided under section 256B.431, 256B.434, or any other section.

Subd. 8. [COUNTY COSTS.] The commissioner of human services shall allocate up to \$500 per nursing facility bed that is closing, within the limits of the appropriation specified for this purpose, to be used for relocation costs incurred by counties for planned closures under this section or resident relocation under sections 144A.185 to 144A.1887. To be eligible for this allocation, a county in which a nursing facility closes must provide to the commissioner a detailed statement in a form provided by the commissioner of additional costs, not to exceed \$500 per bed closed, that are directly incurred related to the county's required role in the relocation process.

Sec. 34. Minnesota Statutes 2000, section 256B.501, is amended by adding a subdivision to read:

Subd. 14. [ICF/MR RATE INCREASES BEGINNING JULY 1, 2001, AND JULY 1, 2002.] (a) For the rate periods beginning July 1, 2001, and July 1, 2002, the commissioner shall make available to each facility reimbursed under this section, section 256B.5011, and Laws 1993, First Special Session chapter 1, article 4, section 11, an adjustment to the total operating payment rate of 3.0 percent.

(b) For each facility, the commissioner shall determine the payment rate adjustment using the percentage specified in paragraph (a) multiplied by the total operating payment rate in effect on the last day of the prior rate year, and dividing the resulting amount by the facility's actual resident days. The total operating payment rate shall include the adjustment provided in subdivision 12.

(c) Any facility whose payment rates are governed by closure agreements, receivership agreements, or Minnesota Rules, part 9553.0075, is not eligible for an adjustment otherwise granted under this subdivision.

Sec. 35. Minnesota Statutes 2000, section 256B.76, is amended to read:

256B.76 [PHYSICIAN AND DENTAL REIMBURSEMENT.]

(a) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for physician services as follows:

(1) payment for level one Health Care Finance Administration's common procedural coding system (HCPCS) codes titled "office and other outpatient services," "preventive medicine new and established patient," "delivery, antepartum, and postpartum care," "critical care," ~~Caesarean~~ cesarean delivery and pharmacologic management provided to psychiatric patients, and HCPCS level three codes for enhanced services for prenatal high risk, shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992. If the rate on any procedure code within these categories is different than the rate that would have been paid under the methodology in section 256B.74, subdivision 2, then the larger rate shall be paid;

(2) payments for all other services shall be paid at the lower of (i) submitted charges, or (ii) 15.4 percent above the rate in effect on June 30, 1992;

(3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases except that payment rates for home health agency services shall be the rates in effect on September 30, 1992;

(4) effective for services rendered on or after January 1, 2000, payment rates for physician and professional services shall be increased by three percent over the rates in effect on December 31, 1999, except for home health agency and family planning agency services; and

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

(b) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for dental services as follows:

(1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992;

(2) dental rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases;

(3) effective for services rendered on or after January 1, 2000, payment rates for dental services shall be increased by three percent over the rates in effect on December 31, 1999;

(4) the commissioner shall award grants to community clinics or other nonprofit community organizations, political subdivisions, professional associations, or other organizations that demonstrate the ability to provide dental services effectively to public program recipients. Grants may be used to fund the costs related to coordinating access for recipients, developing and implementing patient care criteria, upgrading or establishing new facilities, acquiring furnishings or equipment, recruiting new providers, or other development costs that will improve access to dental care in a region. In awarding grants, the commissioner shall give priority to applicants that plan to serve areas of the state in which the number of dental providers is not currently sufficient to meet the needs of recipients of public programs or uninsured individuals. The commissioner shall consider the following in awarding the grants: (i) potential to successfully increase access to an underserved population; (ii) the ability to raise matching funds; (iii) the long-term viability of the project to improve access beyond the period of initial funding; (iv) the efficiency in the use of the funding; and (v) the experience of the proposers in providing services to the target population.

The commissioner shall monitor the grants and may terminate a grant if the grantee does not increase dental access for public program recipients. The commissioner shall consider grants for the following:

(i) implementation of new programs or continued expansion of current access programs that have demonstrated success in providing dental services in underserved areas;

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

(iii) a program that organizes a network of volunteer dentists, establishes a system to refer eligible individuals to volunteer dentists, and through that network provides donated dental care services to public program recipients or uninsured individuals.

(5) beginning October 1, 1999, the payment for tooth sealants and fluoride treatments shall be the lower of (i) submitted charge, or (ii) 80 percent of median 1997 charges; and

(6) the increases listed in clauses (3) and (5) shall be implemented January 1, 2000, for managed care.

(c) An entity that operates both a Medicare certified comprehensive outpatient rehabilitation facility and a facility which was certified prior to January 1, 1993, that is licensed under Minnesota Rules, parts 9570.2000 to 9570.3600, and for whom at least 33 percent of the clients receiving rehabilitation services and mental health services in the most recent calendar year are medical assistance recipients, shall be reimbursed by the commissioner for rehabilitation services and mental health services at rates that are 38 percent greater than the maximum reimbursement rate allowed under paragraph (a), clause (2), when those services are (1) provided within the comprehensive outpatient rehabilitation facility and (2) provided to residents of nursing facilities owned by the entity.

Sec. 36. Laws 1995, chapter 207, article 3, section 21, as amended by Laws 1999, chapter 245, article 3, section 43, is amended to read:

Sec. 21. [FACILITY CERTIFICATION.]

(a) Notwithstanding Minnesota Statutes, section 252.291, subdivisions 1 and 2, the commissioner of health shall inspect to certify a large community-based facility currently licensed under Minnesota Rules, parts 9525.0215 to 9525.0355, for more than 16 beds and located in Northfield. The facility may be certified for up to 44 beds. The commissioner of health must inspect to certify the facility as soon as possible after the effective date of this section. The commissioner of human services shall work with the facility and affected counties to relocate any current residents of the facility who do not meet the admission criteria for an ICF/MR. Until January 1, 1999, in order to fund the ICF/MR services and relocations of current residents authorized, the commissioner of human services may transfer on a quarterly basis to the medical assistance account from each affected county's community social service allocation, an amount equal to the state share of medical assistance reimbursement for the residential and day habilitation services funded by medical assistance and provided to clients for whom the county is financially responsible.

(b) After January 1, 1999, the commissioner of human services shall fund the services under the state medical assistance program and may transfer on a quarterly basis to the medical assistance account from each affected county's community social service allocation, an amount equal to one-half of the state share of medical assistance reimbursement for the residential and day habilitation services funded by medical assistance and provided to clients for whom the county is financially responsible.

(c) Effective July 1, 2001, the commissioner of human services shall fund the entire state share of medical assistance reimbursement for the residential and day habilitation services funded by medical assistance and provided to clients for whom counties are financially responsible from the medical assistance account, and shall not make any transfer from the community social service allocations of affected counties.

(d) For nonresidents of Minnesota seeking admission to the facility, Rice county shall be notified in order to assure that appropriate funding is guaranteed from their state or country of residence.

Sec. 37. Laws 1999, chapter 245, article 3, section 45, as amended by Laws 2000, chapter 312, section 3, is amended to read:

Sec. 45. [STATE LICENSURE CONFLICTS WITH FEDERAL REGULATIONS.]

(a) Notwithstanding the provisions of Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval.

(b) This section expires July 1, ~~2001~~ 2003.

## Sec. 38. [DEVELOPMENT OF NEW NURSING FACILITY REIMBURSEMENT SYSTEM.]

(a) The commissioner of human services shall develop and report to the legislature by January 15, 2003, a system to replace the current nursing facility reimbursement system established under Minnesota Statutes, sections 256B.431, 256B.434, and 256B.435.

(b) The system must be developed in consultation with the long-term care task force and with representatives of consumers, providers, and labor unions. Within the limits of available appropriations, the commissioner may employ consultants to assist with this project.

(c) The new reimbursement system must:

(1) provide incentives to enhance quality of life and quality of care;

(2) recognize cost differences in the care of different types of populations, including subacute care and dementia care;

(3) establish rates that are sufficient without being excessive;

(4) be affordable for the state and for private-pay residents;

(5) be sensitive to changing conditions in the long-term care environment;

(6) avoid creating access problems related to insufficient funding;

(7) allow providers maximum flexibility in their business operations;

(8) recognize the need for capital investment to improve physical plants; and

(9) provide incentives for the development and use of private rooms.

(d) Notwithstanding Minnesota Statutes, section 256B.435, the commissioner must not implement a performance-based contracting system for nursing facilities prior to July 1, 2003. The commissioner shall continue to reimburse nursing facilities under Minnesota Statutes, section 256B.431 or 256B.434, until otherwise directed by law.

(e) The commissioner of human services, in consultation with the commissioner of health, shall conduct or contract for a time study to determine staff time being spent on various case mix categories; recommend adjustments to the case mix weights based on the time study data; and determine whether current staffing standards are adequate for providing quality care based on professional best practice and consumer experience. If the commissioner determines the current standards are inadequate, the commissioner shall determine an appropriate staffing standard for the various case mix categories and the financial implications of phasing into this standard over the next four years.

## Sec. 39. [REPORT ON STANDARDS FOR SUBACUTE CARE FACILITY LICENSURE.]

By January 15, 2003, the commissioner of health shall submit a report to the legislature on implementation of a licensure program for subacute care. This report must include:

(1) definitions of subacute care and applicability of the proposed licensure program to various types of licensed facilities;

(2) an analysis of whether specific standards for subacute levels of care need to be developed and the potential for increased costs for existing providers of subacute care;

(3) recommendations on the applicability of the nursing home moratorium law to the licensure of subacute care facilities or programs;

(4) identification of federal regulations guiding the provision of subacute care and whether further state standards are needed; and

(5) identification of current and potential reimbursement for subacute care under Medicare, Medicaid, or managed care programs.

Sec. 40. [REGULATORY FLEXIBILITY.]

(a) By July 1, 2001, the commissioners of health and human services shall:

(1) develop a summary of federal nursing facility and community long-term care regulations that hamper state flexibility and place burdens on the goal of achieving high-quality care and optimum outcomes for consumers of services; and

(2) share this summary with the legislature, other states, national groups that advocate for state interests with Congress, and the Minnesota congressional delegation.

(b) The commissioners shall conduct ongoing follow-up with the entities to which this summary is provided and with the health care financing administration to achieve maximum regulatory flexibility, including the possibility of pilot projects to demonstrate regulatory flexibility on less than a statewide basis.

Sec. 41. [REPORT.]

By January 15, 2003, the commissioner of health and the commissioner of human services shall report to the senate health and family security committee and the house health and human services policy committee on the number of closures that have taken place under Minnesota Statutes, section 256B.437, and any other nursing facility closures that may have taken place, alternatives to nursing facility care that have been developed, any problems with access to long-term care services that have resulted, and any recommendations for continuation of the regional long-term care planning process and the closure process after June 30, 2003.

Sec. 42. [NURSING ASSISTANT; HOME HEALTH AIDE CURRICULUM.]

By January 1, 2003, the commissioner of health, in consultation with long-term care consumers, advocates, unions, and trade associations, shall present to the chairs of the legislative committees dealing with health care policy recommendations for updating the nursing assistant and home health aide curriculum (1998 edition) to help students learn front-line survival skills that support job motivation and satisfaction. These skills include, but are not limited to, working with challenging behaviors, communication skills, stress management including the impact of personal life stress in the work setting, building relationships with families, cultural competencies, and working with death and dying.

Sec. 43. [EVALUATION OF REPORTING REQUIREMENTS.]

The commissioners of human services and health, in consultation with interested parties, shall evaluate long-term care provider reporting requirements, balancing the need for public accountability with the need to reduce unnecessary paperwork, and shall eliminate unnecessary reporting requirements, seeking any necessary changes in federal and state law. The commissioners shall present a progress report by February 1, 2002, to the chairs of the house and senate committees with jurisdiction over health and human services policy and finance.

## Sec. 44. [NURSING FACILITY MULTIPLE SCLEROSIS PILOT PROJECT.]

(a) For the period from July 1, 2001, to June 30, 2003, the commissioner of human services shall establish and implement a pilot project to contract with nursing facilities eligible to receive medical assistance payments that, at the time of enrollment in the pilot project, serve ten or more persons with a diagnosis of multiple sclerosis. The commissioner shall negotiate a payment rate with eligible facilities to provide services to persons with multiple sclerosis that must not exceed 150 percent of the person's case mix classification payment rate for that facility. The commissioner may contract with up to six nursing facilities.

(b) Facilities may enroll in the pilot project between July 1, 2001, and December 31, 2001.

(c) The commissioner shall evaluate the additional payments made under the pilot project to determine if the adjustment enables participating facilities to adequately meet the needs for individual care and specialized programming, including programs to meet psychosocial, physiological, and case management needs, without incurring financial losses. The commissioner of human services, in consultation with the commissioner of health, shall report to the legislature by January 15, 2003, on the results of the project and with a recommendation on whether the project should be made permanent.

(d) The negotiated adjustment shall not affect the payment rate charged to private paying residents under the provisions of Minnesota Statutes, section 256B.48, subdivision 1.

## Sec. 45. [MINIMUM STAFFING STANDARDS REPORT.]

By January 15, 2002, the commissioner of health and the commissioner of human services shall report to the legislature on whether they should translate the minimum nurse staffing requirement in Minnesota Statutes, section 144A.04, subdivision 7, paragraph (a), upon the transition to the RUG-III classification system, or whether they should establish different time-based standards, and how to accomplish either.

## Sec. 46. [REPEALER.]

Minnesota Statutes 2000, sections 144.0721, subdivision 1, and 256B.434, subdivision 5, are repealed.

## ARTICLE 6

## WORK FORCE

Section 1. Minnesota Statutes 2000, section 144.1464, is amended to read:

## 144.1464 [SUMMER HEALTH CARE INTERNS.]

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 2. [144.1499] [PROMOTION OF HEALTH CARE AND LONG-TERM CARE CAREERS.]

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

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

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

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

Sec. 3. Minnesota Statutes 2000, section 144A.62, subdivision 1, is amended to read:

Subdivision 1. [ASSISTANCE WITH EATING AND DRINKING.] (a) Upon federal approval, a nursing home may employ resident attendants to assist with the activities authorized under subdivision 2. The resident attendant ~~will not~~ shall be counted in the minimum staffing requirements under section 144A.04, subdivision 7.

(b) The commissioner shall submit by ~~May July 15, 2000~~ 2001, a new request for a federal waiver necessary to implement this section.

Sec. 4. Minnesota Statutes 2000, section 144A.62, subdivision 2, is amended to read:

Subd. 2. [DEFINITION.] (a) "Resident attendant" means an individual who assists residents ~~in a nursing home with the one or more of the following activities of eating and drinking;~~

(1) eating and drinking; and

(2) transporting.

(b) A resident attendant does not include an individual who:

(1) is a licensed health professional or a registered dietitian;

(2) volunteers without monetary compensation; or

(3) is a registered nursing assistant.

Sec. 5. Minnesota Statutes 2000, section 144A.62, subdivision 3, is amended to read:

Subd. 3. [REQUIREMENTS.] (a) A nursing home may not use on a full-time or other paid basis any individual as a resident attendant in the nursing home unless the individual:

(1) has completed a training and competency evaluation program encompassing the ~~tasks~~ activities in subdivision 2 that the individual provides;

(2) is competent to provide ~~feeding and hydration services~~ those activities; and

(3) is under the supervision of the director of nursing.

(b) A nursing home may not use a current employee as a resident attendant unless the employee satisfies the requirements of paragraph (a) and volunteers to be used in that capacity.

Sec. 6. Minnesota Statutes 2000, section 144A.62, subdivision 4, is amended to read:

Subd. 4. [EVALUATION.] The training and competency evaluation program may be facility based. It must include, at a minimum, the training and competency standards for ~~eating and drinking assistance~~ the specific activities the attendant will be conducting contained in the nursing assistant training curriculum.

Sec. 7. Minnesota Statutes 2000, section 148.212, is amended to read:

148.212 [TEMPORARY PERMIT.]

Upon receipt of the applicable licensure or reregistration fee and permit fee, and in accordance with rules of the board, the board may issue a nonrenewable temporary permit to practice professional or practical nursing to an applicant for licensure or reregistration who is not the subject of a pending investigation or disciplinary action, nor disqualified for any other reason, under the following circumstances:

(a) The applicant for licensure by examination under section 148.211, subdivision 1, has graduated from an approved nursing program within the 60 days preceding board receipt of an affidavit of graduation or transcript and has been authorized by the board to write the licensure examination for the first time in the United States. The permit holder must practice professional or practical nursing under the direct supervision of a registered nurse. The permit is valid from the date of issue until the date the board takes action on the application or for 60 days whichever occurs first.

(b) The applicant for licensure by endorsement under section 148.211, subdivision 2, is currently licensed to practice professional or practical nursing in another state, territory, or Canadian province. The permit is valid from submission of a proper request until the date of board action on the application.

(c) The applicant for licensure by endorsement under section 148.211, subdivision 2, or for reregistration under section 148.231, subdivision 5, is currently registered in a formal, structured refresher course or its equivalent for nurses that includes clinical practice.

(d) The applicant for licensure by examination under section 148.211, subdivision 1, as a registered nurse has been issued a commission on graduates of foreign nurse schools certificate, has completed all requirements for licensure except the licensing examination, and has been authorized by the board to write the licensure examination for the first time in the United States. The permit holder must practice professional nursing under the direct supervision of a registered nurse. The permit is valid from the date of issue until the date the board takes action on the application or for 60 days, whichever occurs first.

## ARTICLE 7

### REGULATION OF SUPPLEMENTAL NURSING SERVICES AGENCIES

Section 1. [144A.70] [REGISTRATION OF SUPPLEMENTAL NURSING SERVICES AGENCIES; DEFINITIONS.]

Subdivision 1. [SCOPE.] As used in sections 144A.70 to 144A.74, the terms defined in this section have the meanings given them.

Subd. 2. [COMMISSIONER.] "Commissioner" means the commissioner of health.

Subd. 3. [CONTROLLING PERSON.] "Controlling person" means a business entity, officer, program administrator, or director whose responsibilities include the direction of the management or policies of a supplemental nursing services agency. Controlling person also means an individual who, directly or indirectly, beneficially owns an interest in a corporation, partnership, or other business association that is a controlling person.

Subd. 4. [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. 2. [144A.71] [SUPPLEMENTAL NURSING SERVICES AGENCY REGISTRATION.]

Subdivision 1. [DUTY TO REGISTER.] A person who operates a supplemental nursing services agency shall register the agency with the commissioner. Each separate location of the business of a supplemental nursing services agency shall register the agency with the commissioner. Each separate location of the business of a supplemental nursing services agency shall have a separate registration.

Subd. 2. [APPLICATION INFORMATION AND FEE.] The commissioner shall establish forms and procedures for processing each supplemental nursing services agency registration application. An application for a supplemental nursing services agency registration must include at least the following:

- (1) the names and addresses of the owner or owners of the supplemental nursing services agency;
- (2) if the owner is a corporation, copies of its articles of incorporation and current bylaws, together with the names and addresses of its officers and directors;
- (3) any other relevant information that the commissioner determines is necessary to properly evaluate an application for registration; and
- (4) the annual registration fee for a supplemental nursing services agency, which is \$891.

Subd. 3. [REGISTRATION NOT TRANSFERABLE.] A registration issued by the commissioner according to this section is effective for a period of one year from the date of its issuance unless the registration is revoked or suspended under section 144A.72, subdivision 2, or unless the supplemental nursing services agency is sold or ownership or management is transferred. When a supplemental nursing services agency is sold or ownership or management is transferred, the registration of the agency must be voided and the new owner or operator may apply for a new registration.

Sec. 3. [144A.72] [REGISTRATION REQUIREMENTS.]

The commissioner shall require that, as a condition of registration:

- (1) the supplemental nursing services agency shall document that each temporary employee provided to health care facilities currently meets the minimum licensing, training, and continuing education standards for the position in which the employee will be working;
- (2) the supplemental nursing services agency shall comply with all pertinent requirements relating to the health and other qualifications of personnel employed in health care facilities;

(3) the supplemental nursing services agency must not restrict in any manner the employment opportunities of its employees;

(4) the supplemental nursing services agency, when supplying temporary employees to a health care facility, and when requested by the facility to do so, shall agree that at least 30 percent of the total personnel hours supplied are during night, holiday, or weekend shifts;

(5) the supplemental nursing services agency shall carry medical malpractice insurance to insure against the loss, damage, or expense incident to a claim arising out of the death or injury of any person as the result of negligence or malpractice in the provision of health care services by the supplemental nursing services agency or by any employee of the agency; and

(6) the supplemental nursing services agency must not, in any contract with any employee or health care facility, require the payment of liquidated damages, employment fees, or other compensation should the employee be hired as a permanent employee of a health care facility.

Sec. 4. [144A.73] [COMPLAINT SYSTEM.]

The commissioner shall establish a system for reporting complaints against a supplemental nursing services agency or its employees. Complaints may be made by any member of the public. Written complaints must be forwarded to the employer of each person against whom a complaint is made. The employer shall promptly report to the commissioner any corrective action taken.

Sec. 5. [144A.74] [MAXIMUM CHARGES.]

A supplemental nursing services agency must not bill or receive payments from a nursing home licensed under this chapter at a rate higher than 150 percent of the weighted average wage rate for the applicable employee classification for the geographic group to which the nursing home is assigned under chapter 256B. The weighted average wage rates must be determined by the commissioner of human services and reported to the commissioner of health on an annual basis. Facilities shall provide information necessary to determine weighted average wage rates to the commissioner of human services in a format requested by the commissioner. The maximum rate must include all charges for administrative fees, contract fees, or other special charges in addition to the hourly rates for the temporary nursing pool personnel supplied to a nursing home.

Sec. 6. Minnesota Statutes 2000, section 245A.04, subdivision 3, is amended to read:

Subd. 3. [BACKGROUND STUDY OF THE APPLICANT; DEFINITIONS.] (a) Before the commissioner issues a license, the commissioner shall conduct a study of the individuals specified in paragraph ~~(c)~~ (d), clauses (1) to (5), according to rules of the commissioner.

Beginning January 1, 1997, the commissioner shall also conduct a study of employees providing direct contact services for nonlicensed personal care provider organizations described in paragraph ~~(c)~~ (d), clause (5).

The commissioner shall recover the cost of these background studies through a fee of no more than \$12 per study charged to the personal care provider organization. The fees collected under this paragraph are appropriated to the commissioner for the purpose of conducting background studies.

Beginning August 1, 1997, the commissioner shall conduct all background studies required under this chapter for adult foster care providers who are licensed by the commissioner of human services and registered under chapter 144D. The commissioner shall conduct these background studies in accordance with this chapter. The commissioner shall initiate a pilot project to conduct up to 5,000 background studies under this chapter in programs with joint licensure as home and community-based services and adult foster care for people with developmental disabilities when the license holder does not reside in the foster care residence.

(b) Beginning July 1, 1998, the commissioner shall conduct a background study on individuals specified in paragraph ~~(c)~~ (d), clauses (1) to (5), who perform direct contact services in a nursing home or a home care agency licensed under chapter 144A or a boarding care home licensed under sections 144.50 to 144.58, when the subject of the study resides outside Minnesota; the study must be at least as comprehensive as that of a Minnesota resident and include a search of information from the criminal justice data communications network in the state where the subject of the study resides.

(c) Beginning August 1, 2001, the commissioner shall conduct all background studies required under this chapter and initiated by supplemental nursing services agencies registered under chapter 144A. Studies for the agencies must be initiated annually by each agency. The commissioner shall conduct the background studies according to this chapter. The commissioner shall recover the cost of the background studies through a fee of no more than \$8 per study, charged to the supplemental nursing services agency. The fees collected under this paragraph are appropriated to the commissioner for the purpose of conducting background studies.

(d) The applicant, license holder, ~~the registrant~~, bureau of criminal apprehension, ~~the~~ commissioner of health, and county agencies, after written notice to the individual who is the subject of the study, shall help with the study by giving the commissioner criminal conviction data and reports about the maltreatment of adults substantiated under section 626.557 and the maltreatment of minors in licensed programs substantiated under section 626.556. The individuals to be studied shall include:

- (1) the applicant;
- (2) persons over the age of 13 living in the household where the licensed program will be provided;
- (3) current employees or contractors of the applicant who will have direct contact with persons served by the facility, agency, or program;
- (4) volunteers or student volunteers who have direct contact with persons served by the program to provide program services, if the contact is not directly supervised by the individuals listed in clause (1) or (3); and
- (5) any person who, as an individual or as a member of an organization, exclusively offers, provides, or arranges for personal care assistant services under the medical assistance program as authorized under sections 256B.04, subdivision 16, and 256B.0625, subdivision 19a.

The juvenile courts shall also help with the study by giving the commissioner existing juvenile court records on individuals described in clause (2) relating to delinquency proceedings held within either the five years immediately preceding the application or the five years immediately preceding the individual's 18th birthday, whichever time period is longer. The commissioner shall destroy juvenile records obtained pursuant to this subdivision when the subject of the records reaches age 23.

For purposes of this section and Minnesota Rules, part 9543.3070, a finding that a delinquency petition is proven in juvenile court shall be considered a conviction in state district court.

For purposes of this subdivision, "direct contact" means providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by a program. For purposes of this subdivision, "directly supervised" means an individual listed in clause (1), (3), or (5) is within sight or hearing of a volunteer to the extent that the individual listed in clause (1), (3), or (5) is capable at all times of intervening to protect the health and safety of the persons served by the program who have direct contact with the volunteer.

A study of an individual in clauses (1) to (5) shall be conducted at least upon application for initial license or registration and reapplication for a license or registration. The commissioner is not required to conduct a study of an individual at the time of reapplication for a license or if the individual has been continuously affiliated with a foster care provider licensed by the commissioner of human services and registered under chapter 144D, other than a family day care or foster care license, if: (i) a study of the individual was conducted either at the time of initial

licensure or when the individual became affiliated with the license holder; (ii) the individual has been continuously affiliated with the license holder since the last study was conducted; and (iii) the procedure described in paragraph ~~(d)~~ (e) has been implemented and was in effect continuously since the last study was conducted. For the purposes of this section, a physician licensed under chapter 147 is considered to be continuously affiliated upon the license holder's receipt from the commissioner of health or human services of the physician's background study results. For individuals who are required to have background studies under clauses (1) to (5) and who have been continuously affiliated with a foster care provider that is licensed in more than one county, criminal conviction data may be shared among those counties in which the foster care programs are licensed. A county agency's receipt of criminal conviction data from another county agency shall meet the criminal data background study requirements of this section.

The commissioner may also conduct studies on individuals specified in clauses (3) and (4) when the studies are initiated by:

- (i) personnel pool agencies;
- (ii) temporary personnel agencies;
- (iii) educational programs that train persons by providing direct contact services in licensed programs; and
- (iv) professional services agencies that are not licensed and which contract with licensed programs to provide direct contact services or individuals who provide direct contact services.

Studies on individuals in items (i) to (iv) must be initiated annually by these agencies, programs, and individuals. Except for personal care provider organizations and supplemental nursing services agencies, no applicant, license holder, or individual who is the subject of the study shall pay any fees required to conduct the study.

(1) At the option of the licensed facility, rather than initiating another background study on an individual required to be studied who has indicated to the licensed facility that a background study by the commissioner was previously completed, the facility may make a request to the commissioner for documentation of the individual's background study status, provided that:

- (i) the facility makes this request using a form provided by the commissioner;
- (ii) in making the request the facility informs the commissioner that either:
  - (A) the individual has been continuously affiliated with a licensed facility since the individual's previous background study was completed, or since October 1, 1995, whichever is shorter; or
  - (B) the individual is affiliated only with a personnel pool agency, a temporary personnel agency, an educational program that trains persons by providing direct contact services in licensed programs, or a professional services agency that is not licensed and which contracts with licensed programs to provide direct contact services or individuals who provide direct contact services; and
- (iii) the facility provides notices to the individual as required in paragraphs (a) to ~~(d)~~ (e), and that the facility is requesting written notification of the individual's background study status from the commissioner.

(2) The commissioner shall respond to each request under paragraph (1) with a written or electronic notice to the facility and the study subject. If the commissioner determines that a background study is necessary, the study shall be completed without further request from a licensed agency or notifications to the study subject.

(3) When a background study is being initiated by a licensed facility or a foster care provider that is also registered under chapter 144D, a study subject affiliated with multiple licensed facilities may attach to the background study form a cover letter indicating the additional facilities' names, addresses, and background study identification

numbers. When the commissioner receives such notices, each facility identified by the background study subject shall be notified of the study results. The background study notice sent to the subsequent agencies shall satisfy those facilities' responsibilities for initiating a background study on that individual.

~~(d)~~ (e) If an individual who is affiliated with a program or facility regulated by the department of human services or department of health or who is affiliated with a nonlicensed personal care provider organization, is convicted of a crime constituting a disqualification under subdivision 3d, the probation officer or corrections agent shall notify the commissioner of the conviction. The commissioner, in consultation with the commissioner of corrections, shall develop forms and information necessary to implement this paragraph and shall provide the forms and information to the commissioner of corrections for distribution to local probation officers and corrections agents. The commissioner shall inform individuals subject to a background study that criminal convictions for disqualifying crimes will be reported to the commissioner by the corrections system. A probation officer, corrections agent, or corrections agency is not civilly or criminally liable for disclosing or failing to disclose the information required by this paragraph. Upon receipt of disqualifying information, the commissioner shall provide the notifications required in subdivision 3a, as appropriate to agencies on record as having initiated a background study or making a request for documentation of the background study status of the individual. This paragraph does not apply to family day care and child foster care programs.

~~(e)~~ (f) The individual who is the subject of the study must provide the applicant or license holder with sufficient information to ensure an accurate study including the individual's first, middle, and last name; home address, city, county, and state of residence for the past five years; zip code; sex; date of birth; and driver's license number. The applicant or license holder shall provide this information about an individual in paragraph ~~(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 ~~(e)~~ (d), clause (1), (2), (3), (4), or (5), made in good faith reliance on a notice of disqualification provided by the commissioner shall not subject the applicant or license holder to civil liability.

~~(k)~~ (l) The commissioner may establish records to fulfill the requirements of this section.

~~(l)~~ (m) The commissioner may not disqualify an individual subject to a study under this section because that person has, or has had, a mental illness as defined in section 245.462, subdivision 20.

~~(m)~~ (n) An individual subject to disqualification under this subdivision has the applicable rights in subdivision 3a, 3b, or 3c.

~~(n)~~ (o) For the purposes of background studies completed by tribal organizations performing licensing activities otherwise required of the commissioner under this chapter, after obtaining consent from the background study subject, tribal licensing agencies shall have access to criminal history data in the same manner as county licensing agencies and private licensing agencies under this chapter.

#### Sec. 7. [REPORT ON SUPPLEMENTAL NURSING SERVICES AGENCY USE.]

Beginning July 1, 2001, through June 30, 2003, the commissioner of human services shall require nursing facilities and other providers of long-term care services to report semiannually on the use of supplemental nursing services, in the form and manner specified by the commissioner. The information reported must include, but is not limited to:

(1) number of hours worked by supplemental nursing services personnel, by job classification, for each month;

(2) payments to supplemental nursing services agencies, on a per hour worked basis, by job classification, for each month; and

(3) percentage of total monthly work hours provided by supplemental nursing services agency personnel, by job classification, for each shift and for weekdays and weekends.

### ARTICLE 8

#### LONG-TERM CARE INSURANCE

Section 1. Minnesota Statutes 2000, section 62A.48, subdivision 4, is amended to read:

Subd. 4. [LOSS RATIO.] The anticipated loss ratio for long-term care policies must not be less than 65 percent for policies issued on a group basis or 60 percent for policies issued on an individual or mass-market basis. This subdivision does not apply to policies issued on or after January 1, 2002, that comply with sections 62S.021 and 62S.081.

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

Sec. 2. Minnesota Statutes 2000, section 62A.48, is amended by adding a subdivision to read:

Subd. 10. [REGULATION OF PREMIUMS AND PREMIUM INCREASES.] Policies issued under sections 62A.46 to 62A.56 on or after January 1, 2002, must comply with sections 62S.021, 62S.081, 62S.265, and 62S.266 to the same extent as policies issued under chapter 62S.

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

Sec. 3. Minnesota Statutes 2000, section 62A.48, is amended by adding a subdivision to read:

Subd. 11. [NONFORFEITURE BENEFITS.] Policies issued under sections 62A.46 to 62A.56 on or after January 1, 2002, must comply with section 62S.02, subdivision 2, to the same extent as policies issued under chapter 62S.

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

Sec. 4. Minnesota Statutes 2000, section 62S.01, is amended by adding a subdivision to read:

Subd. 13a. [EXCEPTIONAL INCREASE.] (a) "Exceptional increase" means only those premium rate increases filed by an insurer as exceptional for which the commissioner determines that the need for the premium rate increase is justified due to changes in laws or rules applicable to long-term care coverage in this state, or due to increased and unexpected utilization that affects the majority of insurers of similar products.

(b) Except as provided in section 62S.265, exceptional increases are subject to the same requirements as other premium rate schedule increases. The commissioner may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase. The commissioner, in determining that the necessary basis for an exceptional increase exists, shall also determine any potential offsets to higher claims costs.

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

Sec. 5. Minnesota Statutes 2000, section 62S.01, is amended by adding a subdivision to read:

Subd. 17a. [INCIDENTAL.] "Incidental," as used in section 62S.265, subdivision 10, means that the value of the long-term care benefits provided is less than ten percent of the total value of the benefits provided over the life of the policy. These values must be measured as of the date of issue.

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

Sec. 6. Minnesota Statutes 2000, section 62S.01, is amended by adding a subdivision to read:

Subd. 23a. [QUALIFIED ACTUARY.] "Qualified actuary" means a member in good standing of the American Academy of Actuaries.

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

Sec. 7. Minnesota Statutes 2000, section 62S.01, is amended by adding a subdivision to read:

Subd. 25a. [SIMILAR POLICY FORMS.] "Similar policy forms" means all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition in section 62S.01, subdivision 15, clause (1), are not considered similar to certificates or policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: institutional long-term care benefits only, noninstitutional long-term care benefits only, or comprehensive long-term care benefits.

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

Sec. 8. [62S.021] [LONG-TERM CARE INSURANCE; INITIAL FILING.]

Subdivision 1. [APPLICABILITY.] This section applies to any long-term care policy issued in this state on or after January 1, 2002, under this chapter or sections 62A.46 to 62A.56.

Subd. 2. [REQUIRED SUBMISSION TO COMMISSIONER.] An insurer shall provide the following information to the commissioner 30 days prior to making a long-term care insurance form available for sale:

(1) a copy of the disclosure documents required in section 62S.081; and

(2) an actuarial certification consisting of at least the following:

(i) a statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;

(ii) a statement that the policy design and coverage provided have been reviewed and taken into consideration;

(iii) a statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration; and

(iv) a complete description of the basis for contract reserves that are anticipated to be held under the form, to include:

(A) sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;

(B) a statement that the assumptions used for reserves contain reasonable margins for adverse experience;

(C) a statement that the net valuation premium for renewal years does not increase, except for attained-age rating where permitted;

(D) a statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses, or if such a statement cannot be made, a complete description of the situations in which this does not occur. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship. If the gross premiums for certain age groups appear to be inconsistent with this requirement, the commissioner may request a demonstration under item (i) based on a standard age distribution; and

(E) either a statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits, or a comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.

Subd. 3. [ACTUARIAL DEMONSTRATION.] The commissioner may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration must include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both. If the commissioner asks for additional information under this subdivision, the 30-day time limit in subdivision 2 does not include the time during which the insurer is preparing the requested information.

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

Sec. 9. [62S.081] [REQUIRED DISCLOSURE OF RATING PRACTICES TO CONSUMERS.]

Subdivision 1. [APPLICATION.] This section applies as follows:

(a) Except as provided in paragraph (b), this section applies to any long-term care policy or certificate issued in this state on or after January 1, 2002.

(b) For certificates issued on or after the effective date of this section under a policy of group long-term care insurance as defined in section 62S.01, subdivision 15, that was in force on the effective date of this section, this section applies on the policy anniversary following June 30, 2002.

Subd. 2. [REQUIRED DISCLOSURES.] Other than policies for which no applicable premium rate or rate schedule increases can be made, insurers shall provide all of the information listed in this subdivision to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that time; in this case, an insurer shall provide all of the information listed in this subdivision to the applicant no later than at the time of delivery of the policy or certificate:

(1) a statement that the policy may be subject to rate increases in the future;

(2) an explanation of potential future premium rate revisions and the policyholder's or certificate holder's option in the event of a premium rate revision;

(3) the premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase;

(4) a general explanation of applying premium rate or rate schedule adjustments that must include:

(i) a description of when premium rate or rate schedule adjustments will be effective, for example the next anniversary date or the next billing date; and

(ii) the right to a revised premium rate or rate schedule as provided in clause (3) if the premium rate or rate schedule is changed; and

(5)(i) information regarding each premium rate increase on this policy form or similar policy forms over the past ten years for this state or any other state that, at a minimum, identifies:

(A) the policy forms for which premium rates have been increased;

(B) the calendar years when the form was available for purchase; and

(C) the amount or percent of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics;

(ii) the insurer may, in a fair manner, provide additional explanatory information related to the rate increases;

(iii) an insurer has the right to exclude from the disclosure premium rate increases that apply only to blocks of business acquired from other nonaffiliated insurers or the long-term care policies acquired from other nonaffiliated insurers when those increases occurred prior to the acquisition;

(iv) if an acquiring insurer files for a rate increase on a long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers on or before the later of the effective date of this section, or the end of a 24-month period following the acquisition of the block of policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling company must include the disclosure of that rate increase according to item (i); and

(v) if the acquiring insurer in item (iv) files for a subsequent rate increase, even within the 24-month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers referenced in item (iv), the acquiring insurer shall make all disclosures required by this subdivision, including disclosure of the earlier rate increase referenced in item (iv).

Subd. 3. [ACKNOWLEDGMENT.] An applicant shall sign an acknowledgment at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required under subdivision 2. If, due to the method of application, the applicant cannot sign an acknowledgment at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

Subd. 4. [FORMS.] An insurer shall use the forms in Appendices B and F of the Long-term Care Insurance Model Regulation adopted by the National Association of Insurance Commissioners to comply with the requirements of subdivisions 1 and 2.

Subd. 5. [NOTICE OF INCREASE.] An insurer shall provide notice of an upcoming premium rate schedule increase, after the increase has been approved by the commissioner, to all policyholders or certificate holders, if applicable, at least 45 days prior to the implementation of the premium rate schedule increase by the insurer. The notice must include the information required by subdivision 2 when the rate increase is implemented.

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

Sec. 10. Minnesota Statutes 2000, section 62S.26, is amended to read:

62S.26 [LOSS RATIO.]

(a) The minimum loss ratio must be at least 60 percent, calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, the commissioner shall give consideration to all relevant factors, including:

- (1) statistical credibility of incurred claims experience and earned premiums;
- (2) the period for which rates are computed to provide coverage;
- (3) experienced and projected trends;
- (4) concentration of experience within early policy duration;
- (5) expected claim fluctuation;
- (6) experience refunds, adjustments, or dividends;
- (7) renewability features;
- (8) all appropriate expense factors;

(9) interest;

(10) experimental nature of the coverage;

(11) policy reserves;

(12) mix of business by risk classification; and

(13) product features such as long elimination periods, high deductibles, and high maximum limits.

(b) This section does not apply to policies or certificates that are subject to sections 62S.021, 62S.081, and 62S.265, and that comply with those sections.

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

Sec. 11. [62S.265] [PREMIUM RATE SCHEDULE INCREASES.]

Subdivision 1. [APPLICABILITY.] (a) Except as provided in paragraph (b), this section applies to any long-term care policy or certificate issued in this state on or after January 1, 2002, under this chapter or sections 62A.46 to 62A.56.

(b) For certificates issued on or after the effective date of this section under a group long-term care insurance policy as defined in section 62S.01, subdivision 15, issued under this chapter, that was in force on the effective date of this section, this section applies on the policy anniversary following June 30, 2002.

Subd. 2. [NOTICE.] An insurer shall file a requested premium rate schedule increase, including an exceptional increase, to the commissioner for prior approval at least 60 days prior to the notice to the policyholders and shall include:

(1) all information required by section 62S.081;

(2) certification by a qualified actuary that:

(i) if the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated; and

(ii) the premium rate filing complies with this section;

(3) an actuarial memorandum justifying the rate schedule change request that includes:

(i) lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale;

(A) annual values for the five years preceding and the three years following the valuation date must be provided separately;

(B) the projections must include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;

(C) the projections must demonstrate compliance with subdivision 3; and

(D) for exceptional increases, the projected experience must be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase and, if the commissioner determines that offsets to higher claim costs may exist, the insurer shall use appropriate net projected experience;

(ii) disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;

(iii) disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied upon by the actuary;

(iv) a statement that policy design, underwriting, and claims adjudication practices have been taken into consideration; and

(v) if it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer shall file composite rates reflecting projections of new certificates;

(4) a statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commissioner; and

(5) sufficient information for review and approval of the premium rate schedule increase by the commissioner.

Subd. 3. [REQUIREMENTS PERTAINING TO RATE INCREASES.] All premium rate schedule increases must be determined according to the following requirements:

(1) exceptional increases must provide that 70 percent of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

(2) premium rate schedule increases must be calculated so that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

(i) the accumulated value of the initial earned premium times 58 percent;

(ii) 85 percent of the accumulated value of prior premium rate schedule increases on an earned basis;

(iii) the present value of future projected initial earned premiums times 58 percent; and

(iv) 85 percent of the present value of future projected premiums not in item (iii) on an earned basis;

(3) if a policy form has both exceptional and other increases, the values in clause (2), items (ii) and (iv), must also include 70 percent for exceptional rate increase amounts; and

(4) all present and accumulated values used to determine rate increases must use the maximum valuation interest rate for contract reserves permitted for valuation of whole life insurance policies issued in this state on the same date. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

Subd. 4. [PROJECTIONS.] For each rate increase that is implemented, the insurer shall file for approval by the commissioner updated projections, as described in subdivision 2, clause (3), item (i), annually for the next three years and include a comparison of actual results to projected values. The commissioner may extend the period to greater than three years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in subdivision 11, the projections required by this subdivision must be provided to the policyholder in lieu of filing with the commissioner.

Subd. 5. [LIFETIME PROJECTIONS.] If any premium rate in the revised premium rate schedule is greater than 200 percent of the comparable rate in the initial premium schedule, lifetime projections, as described in subdivision 2, clause (3), item (i), must be filed for approval by the commissioner every five years following the end of the required period in subdivision 4. For group insurance policies that meet the conditions in subdivision 11, the projections required by this subdivision must be provided to the policyholder in lieu of filing with the commissioner.

Subd. 6. [EFFECT OF ACTUAL EXPERIENCE.] (a) If the commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in subdivision 3, the commissioner may require the insurer to implement any of the following:

- (1) premium rate schedule adjustments; or
- (2) other measures to reduce the difference between the projected and actual experience.

(b) In determining whether the actual experience adequately matches the projected experience, consideration must be given to subdivision 2, clause (3), item (v), if applicable.

Subd. 7. [CONTINGENT BENEFIT UPON LAPSE.] If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:

(1) a plan, subject to commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or a demonstration that appropriate administration and claims processing have been implemented or are in effect; otherwise, the commissioner may impose the condition in subdivision 8, paragraph (b); and

(2) the original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to subdivision 3 had the greater of the original anticipated lifetime loss ratio or 58 percent been used in the calculations described in subdivision 3, clause (2), items (i) and (iii).

Subd. 8. [PROJECTED LAPSE RATES.] (a) For a rate increase filing that meets the following criteria, the commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the 12 months following each increase to determine if significant adverse lapsation has occurred or is anticipated:

- (1) the rate increase is not the first rate increase requested for the specific policy form or forms;
- (2) the rate increase is not an exceptional increase; and
- (3) the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

(b) If significant adverse lapsation has occurred, is anticipated in the filing, or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the commissioner may determine that a rate spiral exists. Following the determination that a rate spiral exists, the commissioner may require the insurer to offer, without underwriting, to all in-force insureds subject to the rate increase, the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates. The offer must:

- (1) be subject to the approval of the commissioner;
- (2) be based upon actuarially sound principles, but not be based upon attained age; and
- (3) provide that maximum benefits under any new policy accepted by an insured will be reduced by comparable benefits already paid under the existing policy.



(c) The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase must be limited to the lesser of the maximum rate increase determined based on the combined experience and the maximum rate increase determined based only upon the experience of the insureds originally issued the form plus ten percent.

Subd. 9. [PERSISTENT PRACTICE OF INADEQUATE INITIAL RATES.] If the commissioner determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the commissioner may, in addition to the provisions of subdivision 8, take either of the following actions:

(1) prohibit the insurer from filing and marketing comparable coverage for a period of up to five years; or

(2) prohibit the insurer from offering all other similar coverages and limit the insurer's marketing of new applications for the products that are subject to recent premium rate schedule increases.

Subd. 10. [INCIDENTAL LONG-TERM CARE BENEFITS.] Subdivisions 1 to 9 do not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in section 62S.01, subdivision 17a, if the policy complies with all of the following provisions:

(1) the interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

(2) the portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following:

(i) for life insurance, section 61A.25;

(ii) for individual deferred annuities, section 61A.245; and

(iii) for variable annuities, section 61A.21;

(3) the policy meets the disclosure requirements of sections 62S.10 and 62S.11 if the policy is governed by chapter 62S and of section 62A.50 if the policy is governed by sections 62A.46 to 62A.56;

(4) the portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements as applicable in the following:

(i) policy illustrations to the extent required by state law applicable to life insurance;

(ii) disclosure requirements in state law applicable to annuities; and

(iii) disclosure requirements applicable to variable annuities; and

(5) an actuarial memorandum is filed with the commissioner that includes:

(i) a description of the basis on which the long-term care rates were determined;

(ii) a description of the basis for the reserves;

(iii) a summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(iv) a description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

(v) a description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(vi) the estimated average annual premium per policy and the average issue age;

(vii) a statement as to whether underwriting is performed at the time of application. The statement must indicate whether underwriting is used and, if used, the statement must include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement must indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(viii) a description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values, and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

Subd. 11. [LARGE GROUP POLICIES.] Subdivisions 6 and 9 do not apply to group long-term care insurance policies as defined in section 62S.01, subdivision 15, where:

(1) the policies insure 250 or more persons, and the policyholder has 5,000 or more eligible employees of a single employer; or

(2) the policyholder, and not the certificate holders, pays a material portion of the premium, which is not less than 20 percent of the total premium for the group in the calendar year prior to the year in which a rate increase is filed.

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

Sec. 12. [62S.266] [NONFORFEITURE BENEFIT REQUIREMENT.]

Subdivision 1. [APPLICABILITY.] This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

Subd. 2. [REQUIREMENT.] An insurer must offer each prospective policyholder a nonforfeiture benefit in compliance with the following requirements:

(1) a policy or certificate offered with nonforfeiture benefits must have coverage elements, eligibility, benefit triggers, and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer must be the benefit described in subdivision 5; and

(2) the offer must be in writing if the nonforfeiture benefit is not otherwise described in the outline of coverage or other materials given to the prospective policyholder.

Subd. 3. [EFFECT OF REJECTION OF OFFER.] If the offer required to be made under subdivision 2 is rejected, the insurer shall provide the contingent benefit upon lapse described in this section.

Subd. 4. [CONTINGENT BENEFIT UPON LAPSE.] (a) After rejection of the offer required under subdivision 2, for individual and group policies without nonforfeiture benefits issued after the effective date of this section, the insurer shall provide a contingent benefit upon lapse.

(b) If a group policyholder elects to make the nonforfeiture benefit an option to the certificate holder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

(c) The contingent benefit on lapse must be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium based on the insured's issue age provided in this paragraph, and the policy or certificate lapses within 120 days of the due date of the premium increase. Unless otherwise required, policyholders shall be notified at least 30 days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase

<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) is deemed to be the election of the offer to convert in clause (2).

Subd. 5. [NONFORFEITURE BENEFITS; REQUIREMENTS.] (a) Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse, must be as described in this subdivision.

(b) For purposes of this subdivision, "attained age rating" is defined as a schedule of premiums starting from the issue date which increases with age at least one percent per year prior to age 50, and at least three percent per year beyond age 50.

(c) For purposes of this subdivision, the nonforfeiture benefit must be of a shortened benefit period providing paid-up, long-term care insurance coverage after lapse. The same benefits, amounts, and frequency in effect at the time of lapse, but not increased thereafter, will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits must be determined as specified in paragraph (d).

(d) The standard nonforfeiture credit is equal to 100 percent of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, so long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit must not be less than 30 times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of this subdivision.

(e) The nonforfeiture benefit must begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse must be effective during the first three years as well as thereafter.

(f) Notwithstanding paragraph (e), for a policy or certificate with attained age rating, the nonforfeiture benefit must begin on the earlier of:

(1) the end of the tenth year following the policy or certificate issue date; or

(2) the end of the second year following the date the policy or certificate is no longer subject to attained age rating.

(g) Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

Subd. 6. [BENEFIT LIMIT.] All benefits paid by the insurer while the policy or certificate is in premium-paying status and in the paid-up status will not exceed the maximum benefits which would be payable if the policy or certificate had remained in premium-paying status.

Subd. 7. [MINIMUM BENEFITS; INDIVIDUAL AND GROUP POLICIES.] There must be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.

Subd. 8. [APPLICATION; EFFECTIVE DATES.] This section becomes effective January 1, 2002, and applies as follows:

(a) Except as provided in paragraph (b), this section applies to any long-term care policy issued in this state on or after the effective date of this section.

(b) For certificates issued on or after the effective date of this section, under a group long-term care insurance policy that was in force on the effective date of this section, the provisions of this section do not apply.

Subd. 9. [EFFECT ON LOSS RATIO.] Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse are subject to the loss ratio requirements of section 62A.48, subdivision 4, or 62S.26, treating the policy as a whole, except for policies or certificates that are subject to sections 62S.021, 62S.081, and 62S.265 and that comply with those sections.

Subd. 10. [PURCHASED BLOCKS OF BUSINESS.] To determine whether contingent nonforfeiture upon lapse provisions are triggered under subdivision 4, paragraph (c), a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

Subd. 11. [LEVEL PREMIUM CONTRACTS.] A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts must be offered that meets the following requirements:

(1) the nonforfeiture provision must be appropriately captioned;

(2) the nonforfeiture provision must provide a benefit available in the event of a default in the payment of any premiums and must state that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying contracts approved by the commissioner for the same contract form; and

(3) the nonforfeiture provision must provide at least one of the following:

(i) reduced paid-up insurance;

(ii) extended term insurance;

(iii) shortened benefit period; or

(iv) other similar offerings approved by the commissioner.

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

Sec. 13. Minnesota Statutes 2000, section 256.975, is amended by adding a subdivision to read:

Subd. 8. [PROMOTION OF LONG-TERM CARE INSURANCE.] The Minnesota board on aging, either directly or through contract, shall promote the provision of employer-sponsored, long-term care insurance. The board shall encourage private and public sector employers to make long-term care insurance available to employees, provide interested employers with information on the long-term care insurance product offered to state employees, and provide technical assistance to employers in designing long-term care insurance products and contacting companies offering long-term care insurance products.

Sec. 14. [256B.0571] [LONG-TERM CARE PARTNERSHIP.]

Subdivision 1. [DEFINITIONS.] For purposes of this section, the following terms have the meanings given them.

(a) "Home care service" means care described in section 144A.43.

(b) "Long-term care insurance" means a policy described in section 62S.01.

(c) "Medical assistance" means the program of medical assistance established under section 256B.01.

(d) "Nursing home" means nursing home as described in section 144A.01.

(e) "Partnership policy" means a long-term care insurance policy that meets the requirements under chapter 62S.

(f) "Partnership program" means the Minnesota partnership for long-term care program established under this section.

Subd. 2. [PARTNERSHIP PROGRAM.] (a) Subject to federal waiver approval, the commissioner of human services, along with the commissioner of commerce, shall establish the Minnesota partnership for long-term care program to provide for the financing of long-term care through a combination of private insurance and medical assistance.

(b) An individual who meets the requirements in paragraph (c) is eligible to participate in the partnership program.

(c) The individual must:

(1) be a Minnesota resident;

(2) purchase a partnership policy that is delivered, issued for delivery, or renewed on or after the effective date of this section, and maintains the partnership policy in effect throughout the period of participation in the partnership program; and

(3) exhaust the minimum benefits under the partnership policy as described in this section. Benefits received under a long-term care insurance policy before the effective date of this section do not count toward the exhaustion of benefits required in this subdivision.

Subd. 3. [MEDICAL ASSISTANCE ELIGIBILITY.] (a) Upon application of an individual who meets the requirements described in subdivision 2, the commissioner of human services shall determine the individual's eligibility for medical assistance according to paragraphs (b) and (c).

(b) After disregarding financial assets exempted under medical assistance eligibility requirements, the department shall disregard an additional amount of financial assets equal to the dollar amount of coverage under the partnership policy.

(c) The department shall consider the individual's income according to medical assistance eligibility requirements.

Subd. 4. [FEDERAL APPROVAL.] (a) The commissioner of human services shall seek appropriate amendments to the medical assistance state plan and shall apply for any necessary waiver of medical assistance requirements by the federal Health Care Financing Administration to implement the partnership program. The state shall not implement the partnership program unless the provisions in paragraphs (b) and (c) apply.

(b) The commissioner shall seek any necessary federal waiver of medical assistance requirements.

(c) Individuals who receive medical assistance under this section are exempt from estate recovery requirements under section 1917, title XIX of the federal Social Security Act, United States Code, title 42, section 1396p.

Subd. 5. [APPROVED POLICIES.] (a) A partnership policy must meet all of the requirements in paragraphs (b) to (h).

(b) Minimum coverage shall be for a period of not less than three years and for a dollar amount equal to 36 months of nursing home care at the minimum daily benefit rate determined and adjusted under paragraph (c). The policy shall provide for home health care benefits to be substituted for nursing home care benefits on the basis of two home health care days for one nursing home care day.

(c) Minimum daily benefits shall be \$130 for nursing home care or \$65 for home care. These minimum daily benefit amounts shall be adjusted by the department on October 1 of each year, based on the health care index used under medical assistance for nursing home rate setting. Adjusted minimum daily benefit amounts shall be rounded to the nearest whole dollar.

(d) The insured shall be entitled to designate a third party to receive notice if the policy is about to lapse for nonpayment of premium, and an additional 30-day grace period for payment of premium shall be granted following notification to that person.

(e) The policy must cover all of the following services:

(1) nursing home stay;

(2) home care service;

(3) care management; and

(4) up to 14 days of nursing care in a hospital while the individual is waiting for long-term care placement.

(f) Payment for service under paragraph (e), clause (4), must not exceed the daily benefit amount for nursing home care.

(g) A partnership policy must offer both options in paragraph (h) for an adjusted premium.

(h) The options are:

(1) an elimination period of not more than 100 days; and

(2) nonforfeiture benefits for applicants between the ages of 18 and 75.

## ARTICLE 9

### MENTAL HEALTH AND CIVIL COMMITMENT

#### Section 1. [145.56] [SUICIDE PREVENTION.]

Subdivision 1. [PUBLIC HEALTH GOAL; SUICIDE PREVENTION PLAN.] The commissioner of health shall make suicide prevention an important public health goal of the state and shall conduct suicide prevention activities to accomplish that goal using an evidence-based, public health approach focused on prevention. The commissioner shall refine, coordinate, and implement the state's suicide prevention plan, in collaboration with assigned staff from the department of human services; the department of public safety; the department of children, families, and learning; and appropriate agencies, organizations, and institutions in the community.

Subd. 2. [COMMUNITY-BASED PROGRAMS.] (a) The commissioner shall establish a grant program consistent with the policy goals of this section to fund:

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

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

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

(b) Education to populations at risk for suicide and to community helpers and gatekeepers must include information on the symptoms of depression and other psychiatric illnesses, the warning signs of suicide, skills for preventing suicides, and making or seeking effective referrals to intervention and community resources.

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

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

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

Subd. 5. [PERIODIC EVALUATIONS; BIENNIAL REPORTS.] The commissioner shall conduct periodic evaluations of the impact of and outcomes from implementation of the state's suicide prevention plan and each of the activities specified in this section. By July 1, 2002, and July 1 of each even-numbered year thereafter, the commissioner shall report the results of these evaluations to the chairs of the policy and finance committees in the house and senate with jurisdiction over health and human services issues.

Sec. 2. Minnesota Statutes 2000, section 245.462, subdivision 8, is amended to read:

Subd. 8. [DAY TREATMENT SERVICES.] "Day treatment," "day treatment services," or "day treatment program" means a structured program of treatment and care provided to an adult in or by: (1) a hospital accredited by the joint commission on accreditation of health organizations and licensed under sections 144.50 to 144.55; (2) a community mental health center under section 245.62; or (3) an entity that is under contract with the county board to operate a program that meets the requirements of section 245.4712, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475. Day treatment consists of group psychotherapy and other intensive therapeutic services that are provided at least one day a week by a multidisciplinary staff under the clinical supervision of a mental health professional. Day treatment may include education and consultation provided to families and other individuals as part of the treatment process. The services are aimed at stabilizing the adult's mental health status, providing mental health services, and developing and improving the adult's independent living and socialization skills. The goal of day treatment is to reduce or relieve mental illness and to enable the adult to live in the community. Day treatment services are not a part of inpatient or residential treatment services. Day treatment services are distinguished from day care by their structured therapeutic program of psychotherapy services. The commissioner may limit medical assistance reimbursement for day treatment to 15 hours per week per person instead of the three hours per day per person specified in Minnesota Rules, part 9505.0323, subpart 15.

Sec. 3. Minnesota Statutes 2000, section 245.462, subdivision 18, is amended to read:

Subd. 18. [MENTAL HEALTH PROFESSIONAL.] "Mental health professional" means a person providing clinical services in the treatment of mental illness who is qualified in at least one of the following ways:

(1) in psychiatric nursing: a registered nurse who is licensed under sections 148.171 to 148.285, and who is certified as a clinical specialist in adult psychiatric and mental health nursing by a national nurse certification organization or who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;



(2) in clinical social work: a person licensed as an independent clinical social worker under section 148B.21, subdivision 6, or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;

(3) in psychology: ~~a psychologist~~ an individual licensed by the board of psychology under sections 148.88 to 148.98 who has stated to the board of psychology competencies in the diagnosis and treatment of mental illness;

(4) in psychiatry: a physician licensed under chapter 147 and certified by the American board of psychiatry and neurology or eligible for board certification in psychiatry;

(5) in marriage and family therapy: the mental health professional must be a marriage and family therapist licensed under sections 148B.29 to 148B.39 with at least two years of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness; or

(6) in allied fields: a person with a master's degree from an accredited college or university in one of the behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness.

Sec. 4. Minnesota Statutes 2000, section 245.462, is amended by adding a subdivision to read:

Subd. 25a. [SIGNIFICANT IMPAIRMENT IN FUNCTIONING.] "Significant impairment in functioning" means a condition, including significant suicidal ideation or thoughts of harming self or others, which harmfully affects, recurrently or consistently, a person's activities of daily living in employment, housing, family, and social relationships, or education.

Sec. 5. Minnesota Statutes 2000, section 245.4871, subdivision 10, is amended to read:

Subd. 10. [DAY TREATMENT SERVICES.] "Day treatment," "day treatment services," or "day treatment program" means a structured program of treatment and care provided to a child in:

(1) an outpatient hospital accredited by the joint commission on accreditation of health organizations and licensed under sections 144.50 to 144.55;

(2) a community mental health center under section 245.62;

(3) an entity that is under contract with the county board to operate a program that meets the requirements of section 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475; or

(4) an entity that operates a program that meets the requirements of section 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475, that is under contract with an entity that is under contract with a county board.

Day treatment consists of group psychotherapy and other intensive therapeutic services that are provided for a minimum three-hour time block by a multidisciplinary staff under the clinical supervision of a mental health professional. Day treatment may include education and consultation provided to families and other individuals as an extension of the treatment process. The services are aimed at stabilizing the child's mental health status, and developing and improving the child's daily independent living and socialization skills. Day treatment services are distinguished from day care by their structured therapeutic program of psychotherapy services. Day treatment services are not a part of inpatient hospital or residential treatment services. Day treatment services for a child are an integrated set of education, therapy, and family interventions.

A day treatment service must be available to a child at least five days a week throughout the year and must be coordinated with, integrated with, or part of an education program offered by the child's school.

Sec. 6. Minnesota Statutes 2000, section 245.4871, subdivision 27, is amended to read:

Subd. 27. [MENTAL HEALTH PROFESSIONAL.] "Mental health professional" means a person providing clinical services in the diagnosis and treatment of children's emotional disorders. A mental health professional must have training and experience in working with children consistent with the age group to which the mental health professional is assigned. A mental health professional must be qualified in at least one of the following ways:

(1) in psychiatric nursing, the mental health professional must be a registered nurse who is licensed under sections 148.171 to 148.285 and who is certified as a clinical specialist in child and adolescent psychiatric or mental health nursing by a national nurse certification organization or who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;

(2) in clinical social work, the mental health professional must be a person licensed as an independent clinical social worker under section 148B.21, subdivision 6, or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental disorders;

(3) in psychology, the mental health professional must be ~~a psychologist~~ an individual licensed by the board of psychology under sections 148.88 to 148.98 who has stated to the board of psychology competencies in the diagnosis and treatment of mental disorders;

(4) in psychiatry, the mental health professional must be a physician licensed under chapter 147 and certified by the American board of psychiatry and neurology or eligible for board certification in psychiatry;

(5) in marriage and family therapy, the mental health professional must be a marriage and family therapist licensed under sections 148B.29 to 148B.39 with at least two years of post-master's supervised experience in the delivery of clinical services in the treatment of mental disorders or emotional disturbances; or

(6) in allied fields, the mental health professional must be a person with a master's degree from an accredited college or university in one of the behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of emotional disturbances.

Sec. 7. Minnesota Statutes 2000, section 245.4876, subdivision 1, is amended to read:

Subdivision 1. [CRITERIA.] Children's mental health services required by sections 245.487 to 245.4888 must be:

(1) based, when feasible, on research findings;

(2) based on individual clinical, cultural, and ethnic needs, and other special needs of the children being served;

(3) delivered in a manner that improves family functioning when clinically appropriate;

(4) provided in the most appropriate, least restrictive setting that meets the requirements in subdivision 1a, and that is available to the county board to meet the child's treatment needs;

(5) accessible to all age groups of children;

(6) appropriate to the developmental age of the child being served;

(7) delivered in a manner that provides accountability to the child for the quality of service delivered and continuity of services to the child during the years the child needs services from the local system of care;

(8) provided by qualified individuals as required in sections 245.487 to 245.4888;

- (9) coordinated with children's mental health services offered by other providers;
- (10) provided under conditions that protect the rights and dignity of the individuals being served; and
- (11) provided in a manner and setting most likely to facilitate progress toward treatment goals.

Sec. 8. Minnesota Statutes 2000, section 245.4876, is amended by adding a subdivision to read:

Subd. 1a. [APPROPRIATE SETTING TO RECEIVE SERVICES.] A child must be provided with mental health services in the least restrictive setting that is appropriate to the needs and current condition of the individual child. For a child to receive mental health services in a residential treatment or acute care hospital inpatient setting, the family may not be required to demonstrate that services were first provided in a less restrictive setting and that the child failed to make progress toward or meet treatment goals in the less restrictive setting.

Sec. 9. Minnesota Statutes 2000, section 245.4885, subdivision 1, is amended to read:

Subdivision 1. [SCREENING REQUIRED.] The county board shall, prior to admission, except in the case of emergency admission, screen all children referred for treatment of severe emotional disturbance to a residential treatment facility or informally admitted to a regional treatment center if public funds are used to pay for the services. The county board shall also screen all children admitted to an acute care hospital for treatment of severe emotional disturbance if public funds other than reimbursement under chapters 256B and 256D are used to pay for the services. If a child is admitted to a residential treatment facility or acute care hospital for emergency treatment or held for emergency care by a regional treatment center under section 253B.05, subdivision 1, screening must occur within three working days of admission. Screening shall determine whether the proposed treatment:

- (1) is necessary;
- (2) is appropriate to the child's individual treatment needs;
- (3) cannot be effectively provided in the child's home; and
- (4) provides a length of stay as short as possible consistent with the individual child's need.

When a screening is conducted, the county board may not determine that referral or admission to a residential treatment facility or acute care hospital is not appropriate solely because services were not first provided to the child in a less restrictive setting and the child failed to make progress toward or meet treatment goals in the less restrictive setting. Screening shall include both a diagnostic assessment and a functional assessment which evaluates family, school, and community living situations. If a diagnostic assessment or functional assessment has been completed by a mental health professional within 180 days, a new diagnostic or functional assessment need not be completed unless in the opinion of the current treating mental health professional the child's mental health status has changed markedly since the assessment was completed. The child's parent shall be notified if an assessment will not be completed and of the reasons. A copy of the notice shall be placed in the child's file. Recommendations developed as part of the screening process shall include specific community services needed by the child and, if appropriate, the child's family, and shall indicate whether or not these services are available and accessible to the child and family.

During the screening process, the child, child's family, or child's legal representative, as appropriate, must be informed of the child's eligibility for case management services and family community support services and that an individual family community support plan is being developed by the case manager, if assigned.

Screening shall be in compliance with section 256F.07 or 260C.212, whichever applies. Wherever possible, the parent shall be consulted in the screening process, unless clinically inappropriate.

The screening process, and placement decision, and recommendations for mental health services must be documented in the child's record.

An alternate review process may be approved by the commissioner if the county board demonstrates that an alternate review process has been established by the county board and the times of review, persons responsible for the review, and review criteria are comparable to the standards in clauses (1) to (4).

Sec. 10. Minnesota Statutes 2000, section 245.4886, subdivision 1, is amended to read:

Subdivision 1. [STATEWIDE PROGRAM; ESTABLISHMENT.] The commissioner shall establish a statewide program to assist counties in providing services to children with severe emotional disturbance as defined in section 245.4871, subdivision 15, and their families; and to young adults meeting the criteria for transition services in section 245.4875, subdivision 8, and their families. Services must be designed to help each child to function and remain with the child's family in the community. Transition services to eligible young adults must be designed to foster independent living in the community. The commissioner shall make grants to counties to establish, operate, or contract with private providers to provide the following services in the following order of priority when these cannot be reimbursed under section 256B.0625:

- (1) family community support services including crisis placement and crisis respite care as specified in section 245.4871, subdivision 17;
- (2) case management services as specified in section 245.4871, subdivision 3;
- (3) day treatment services as specified in section 245.4871, subdivision 10;
- (4) professional home-based family treatment as specified in section 245.4871, subdivision 31; and
- (5) therapeutic support of foster care as specified in section 245.4871, subdivision 34.

Funding appropriated beginning July 1, 1991, must be used by county boards to provide family community support services and case management services. Additional services shall be provided in the order of priority as identified in this subdivision.

Sec. 11. Minnesota Statutes 2000, section 245.99, subdivision 4, is amended to read:

Subd. 4. [ADMINISTRATION OF CRISIS HOUSING ASSISTANCE.] The commissioner may contract with organizations or government units experienced in housing assistance to operate the program under this section. This program is not an entitlement. The commissioner may take any of the following steps whenever the commissioner projects that funds will be inadequate to meet demand in a given fiscal year:

- (1) transfer funds from mental health grants in the same appropriation; and
- (2) impose statewide restrictions as to the type and amount of assistance available to each recipient under this program including reducing the income eligibility level, limiting reimbursement to a percentage of each recipient's costs, limiting housing assistance to 60 days per recipient, or closing the program for the remainder of the fiscal year.

Sec. 12. Minnesota Statutes 2000, section 256.969, subdivision 3a, is amended to read:

Subd. 3a. [PAYMENTS.] Acute care hospital billings under the medical assistance program must not be submitted until the recipient is discharged. However, the commissioner shall establish monthly interim payments for inpatient hospitals that have individual patient lengths of stay over 30 days regardless of diagnostic category. Except as provided in section 256.9693, medical assistance reimbursement for treatment of mental illness shall be reimbursed based on diagnostic classifications. The commissioner may selectively contract with hospitals for services within the diagnostic categories relating to mental illness and chemical dependency under competitive

bidding when reasonable geographic access by recipients can be assured. No physician shall be denied the privilege of treating a recipient required to use a hospital under contract with the commissioner, as long as the physician meets credentialing standards of the individual hospital. Individual hospital payments established under this section and sections 256.9685, 256.9686, and 256.9695, in addition to third party and recipient liability, for discharges occurring during the rate year shall not exceed, in aggregate, the charges for the medical assistance covered inpatient services paid for the same period of time to the hospital. This payment limitation shall be calculated separately for medical assistance and general assistance medical care services. The limitation on general assistance medical care shall be effective for admissions occurring on or after July 1, 1991. Services that have rates established under subdivision 11 or 12, must be limited separately from other services. After consulting with the affected hospitals, the commissioner may consider related hospitals one entity and may merge the payment rates while maintaining separate provider numbers. The operating and property base rates per admission or per day shall be derived from the best Medicare and claims data available when rates are established. The commissioner shall determine the best Medicare and claims data, taking into consideration variables of recency of the data, audit disposition, settlement status, and the ability to set rates in a timely manner. The commissioner shall notify hospitals of payment rates by December 1 of the year preceding the rate year. The rate setting data must reflect the admissions data used to establish relative values. Base year changes from 1981 to the base year established for the rate year beginning January 1, 1991, and for subsequent rate years, shall not be limited to the limits ending June 30, 1987, on the maximum rate of increase under subdivision 1. The commissioner may adjust base year cost, relative value, and case mix index data to exclude the costs of services that have been discontinued by the October 1 of the year preceding the rate year or that are paid separately from inpatient services. Inpatient stays that encompass portions of two or more rate years shall have payments established based on payment rates in effect at the time of admission unless the date of admission preceded the rate year in effect by six months or more. In this case, operating payment rates for services rendered during the rate year in effect and established based on the date of admission shall be adjusted to the rate year in effect by the hospital cost index.

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

Sec. 13. [256.9693] [CONTINUING CARE PROGRAM FOR PERSONS WITH MENTAL ILLNESS.]

The commissioner shall establish a continuing care benefit program for persons with mental illness, in which persons with mental illness may obtain acute care hospital inpatient treatment for mental illness for up to 45 days beyond that allowed by section 256.969. Persons with mental illness who are eligible for medical assistance may obtain inpatient treatment under this program in hospital beds for which the commissioner contracts under this section. The commissioner may selectively contract with hospitals to provide this benefit through competitive bidding when reasonable geographic access by recipients can be assured. Payments under this section shall not affect payments under section 256.969. The commissioner may contract externally with a utilization review organization to authorize persons with mental illness to access the continuing care benefit program. The commissioner, as part of the contracts with hospitals, shall establish admission criteria to allow persons with mental illness to access the continuing care benefit program. If a court orders acute care hospital inpatient treatment for mental illness for a person, the person may obtain the treatment under the continuing care benefit program. The commissioner shall not require, as part of the admission criteria, any commitment or petition under chapter 253B as a condition of accessing the program. This benefit is not available for people who are also eligible for Medicare and who have not exhausted their annual or lifetime inpatient psychiatric benefit under Medicare. If a recipient is enrolled in a prepaid plan, this program is included in the plan's coverage.

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

Sec. 14. [256B.0623] [ADULT REHABILITATIVE MENTAL HEALTH SERVICES.]

Subdivision 1. [SCOPE.] Medical assistance covers adult rehabilitative mental health services as defined in subdivision 2, subject to federal approval, if provided to recipients as defined in subdivision 3 and provided by a qualified provider entity meeting the standards in this section and by a qualified individual provider working within the provider's scope of practice and identified in the recipient's individual treatment plan as defined in section 245.462, subdivision 14, and if determined to be medically necessary according to section 62Q.53.

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

(a) "Adult rehabilitative mental health services" means mental health services which are rehabilitative and enable the recipient to develop and enhance psychiatric stability, social competencies, personal and emotional adjustment, and independent living and community skills, when these abilities are impaired by the symptoms of mental illness. Adult rehabilitative mental health services are also appropriate when provided to enable a recipient to retain stability and functioning, if the recipient would be at risk of significant functional decompensation or more restrictive service settings without these services.

(1) Adult rehabilitative mental health services instruct, assist, and support the recipient in areas such as: interpersonal communication skills, community resource utilization and integration skills, crisis assistance, relapse prevention skills, health care directives, budgeting and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills, transportation skills, medication education and monitoring, mental illness symptom management skills, household management skills, employment-related skills, and transition to community living services.

(2) These services shall be provided to the recipient on a one-to-one basis in the recipient's home or another community setting or in groups.

(b) "Medication education services" means services provided individually or in groups which focus on educating the recipient about mental illness and symptoms; the role and effects of medications in treating symptoms of mental illness; and the side effects of medications. Medication education is coordinated with medication management services, and does not duplicate it. Medication education services are provided by physicians, pharmacists, or registered nurses.

(c) "Transition to community living services" means services which maintain continuity of contact between the rehabilitation services provider and the recipient and which facilitate discharge from a hospital, residential treatment program under Minnesota Rules, chapter 9505, board and lodging facility, or nursing home. Transition to community living services are not intended to provide other areas of adult rehabilitative mental health services.

Subd. 3. [ELIGIBILITY.] An eligible recipient is an individual who:

(1) is age 18 or older;

(2) is diagnosed with a medical condition, such as mental illness or traumatic brain injury, for which adult rehabilitative mental health services are needed;

(3) has substantial disability and functional impairment in three or more of the areas listed in section 245.462, subdivision 11a, so that self-sufficiency is markedly reduced; and

(4) has had a recent diagnostic assessment by a qualified professional that documents adult rehabilitative mental health services are medically necessary to address identified disability and functional impairments and individual recipient goals.

Subd. 4. [PROVIDER ENTITY STANDARDS.] (a) The provider entity must be:

(1) a county operated entity certified by the state; or

(2) a noncounty entity certified by the entity's host county.

(b) The certification process is a determination as to whether the entity meets the standards in this subdivision. The certification must specify which adult rehabilitative mental health services the entity is qualified to provide.

(c) If an entity seeks to provide services outside its host county, it must obtain additional certification from each county in which it will provide services. The additional certification must be based on the adequacy of the entity's knowledge of that county's local health and human service system, and the ability of the entity to coordinate its services with the other services available in that county.

(d) Recertification must occur at least every two years.

(e) The commissioner may intervene at any time and decertify providers with cause. The decertification is subject to appeal to the state. A county board may recommend that the state decertify a provider for cause.

(f) The adult rehabilitative mental health services provider entity must meet the following standards:

(1) have capacity to recruit, hire, manage, and train mental health professionals, mental health practitioners, and mental health rehabilitation workers;

(2) have adequate administrative ability to ensure availability of services;

(3) ensure adequate preservice and inservice training for staff;

(4) ensure that mental health professionals, mental health practitioners, and mental health rehabilitation workers are skilled in the delivery of the specific adult rehabilitative mental health services provided to the individual eligible recipient;

(5) ensure that staff is capable of implementing culturally specific services that are culturally competent and appropriate as determined by the recipient's culture, beliefs, values, and language as identified in the individual treatment plan;

(6) ensure enough flexibility in service delivery to respond to the changing and intermittent care needs of a recipient as identified by the recipient and the individual treatment plan;

(7) ensure that the mental health professional or mental health practitioner, who is under the clinical supervision of a mental health professional, involved in a recipient's services participates in the development of the individual treatment plan;

(8) assist the recipient in arranging needed crisis assessment, intervention, and stabilization services;

(9) ensure that services are coordinated with other recipient mental health services providers and the county mental health authority and the federally recognized American Indian authority and necessary others after obtaining the consent of the recipient. Services must also be coordinated with the recipient's case manager or care coordinator, if the recipient is receiving case management or care coordination services;

(10) develop and maintain recipient files, individual treatment plans, and contact charting;

(11) develop and maintain staff training and personnel files;

(12) submit information as required by the state;

(13) establish and maintain a quality assurance plan to evaluate the outcome of services provided;

(14) keep all necessary records required by law;

(15) deliver services as required by section 245.461;

(16) comply with all applicable laws;

(17) be an enrolled Medicaid provider;

(18) maintain a quality assurance plan to determine specific service outcomes and the recipient's satisfaction with services; and

(19) develop and maintain written policies and procedures regarding service provision and administration of the provider entity.

(g) The commissioner shall develop statewide procedures for provider certification, including timelines for counties to certify qualified providers.

Subd. 5. [QUALIFICATIONS OF PROVIDER STAFF.] Adult rehabilitative mental health services must be provided by qualified individual provider staff of a certified provider entity. Individual provider staff must be qualified under one of the following criteria:

(1) a mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (5);

(2) a mental health practitioner as defined in section 245.462, subdivision 17. The mental health practitioner must work under the clinical supervision of a mental health professional; or

(3) a mental health rehabilitation worker. A mental health rehabilitation worker means a staff person working under the direction of a mental health practitioner or mental health professional, and under the clinical supervision of a mental health professional in the implementation of rehabilitative mental health services as identified in the recipient's individual treatment plan; and who:

(i) is at least 21 years of age;

(ii) has a high school diploma or equivalent;

(iii) has successfully completed 30 hours of training during the past two years in all of the following areas: recipient rights, recipient-centered individual treatment planning, behavioral terminology, mental illness, co-occurring mental illness and substance abuse, psychotropic medications and side effects, functional assessment, local community resources, adult vulnerability, recipient confidentiality; and

(iv) meets the qualifications in (A) or (B):

(A) has an associate of arts degree in one of the behavioral sciences or human services, or is a registered nurse without a bachelor's degree, or who within the previous ten years has:

(1) three years of personal life experience with serious and persistent mental illness;

(2) three years of life experience as a primary caregiver to an adult with a serious mental illness or traumatic brain injury; or

(3) 4,000 hours of supervised paid work experience in the delivery of mental health services to adults with a serious mental illness or traumatic brain injury; or

(B)(1) be fluent in the non-English language or competent in the culture of the ethnic group to which at least 50 percent of the mental health rehabilitation worker's clients belong;

(2) receives during the first 2,000 hours of work, monthly documented individual clinical supervision by a mental health professional;



(3) has 18 hours of documented field supervision by a mental health professional or practitioner during the first 160 hours of contact work with recipients, and at least six hours of field supervision quarterly during the following year;

(4) has review and cosignature of charting of recipient contacts during field supervision by a mental health professional or practitioner; and

(5) has 40 hours of additional continuing education on mental health topics during the first year of employment.

Subd. 6. [REQUIRED TRAINING AND SUPERVISION.] (a) Mental health rehabilitation workers must receive ongoing continuing education training of at least 30 hours every two years in areas of mental illness and mental health services and other areas specific to the population being served. Mental health rehabilitation workers must also be subject to the ongoing direction and clinical supervision standards in paragraphs (c) and (d).

(b) Mental health practitioners must receive ongoing continuing education training as required by their professional license; or if the practitioner is not licensed, the practitioner must receive ongoing continuing education training of at least 30 hours every two years in areas of mental illness and mental health services. Mental health practitioners must meet the ongoing clinical supervision standards in paragraph (c).

(c) A mental health professional providing clinical supervision of staff delivering adult rehabilitative mental health services must provide the following guidance:

(1) review the information in the recipient's file;

(2) review and approve initial and updates of individual treatment plans;

(3) meet with mental health rehabilitation workers and practitioners, individually or in small groups, at least monthly to discuss treatment topics of interest to the workers and practitioners;

(4) meet with mental health rehabilitation workers and practitioners, individually or in small groups, at least monthly to discuss treatment plans of recipients, and approve by signature and document in the recipient's file any resulting plan updates;

(5) meet at least twice a month with the directing mental health practitioner, if there is one, to review needs of the adult rehabilitative mental health services program, review staff on-site observations and evaluate mental health rehabilitation workers, plan staff training, review program evaluation and development, and consult with the directing practitioner;

(6) be available for urgent consultation as the individual recipient needs or the situation necessitates; and

(7) provide clinical supervision by full- or part-time mental health professionals employed by or under contract with the provider entity.

(d) An adult rehabilitative mental health services provider entity must have a treatment director who is a mental health practitioner or mental health professional. The treatment director must ensure the following:

(1) while delivering direct services to recipients, a newly hired mental health rehabilitation worker must be directly observed delivering services to recipients by the mental health practitioner or mental health professional for at least six hours per 40 hours worked during the first 160 hours that the mental health rehabilitation worker works;

(2) the mental health rehabilitation worker must receive ongoing on-site direct service observation by a mental health professional or mental health practitioner for at least six hours for every six months of employment;

(3) progress notes are reviewed from on-site service observation prepared by the mental health rehabilitation worker and mental health practitioner for accuracy and consistency with actual recipient contact and the individual treatment plan and goals;

(4) immediate availability by phone or in person for consultation by a mental health professional or a mental health practitioner to the mental health rehabilitation services worker during service provision;

(5) oversee the identification of changes in individual recipient treatment strategies, revise the plan and communicate treatment instructions and methodologies as appropriate to ensure that treatment is implemented correctly;

(6) model service practices which: respect the recipient, include the recipient in planning and implementation of the individual treatment plan, recognize the recipient's strengths, collaborate and coordinate with other involved parties and providers;

(7) ensure that mental health practitioners and mental health rehabilitation workers are able to effectively communicate with the recipients, significant others, and providers; and

(8) oversee the record of the results of on-site observation and charting evaluation and corrective actions taken to modify the work of the mental health practitioners and mental health rehabilitation workers.

(e) A mental health practitioner who is providing treatment direction for a provider entity must receive supervision at least monthly from a mental health professional to:

(1) identify and plan for general needs of the recipient population served;

(2) identify and plan to address provider entity program needs and effectiveness;

(3) identify and plan provider entity staff training and personnel needs and issues; and

(4) plan, implement, and evaluate provider entity quality improvement programs.

Subd. 7. [PERSONNEL FILE.] The adult rehabilitative mental health services provider entity must maintain a personnel file on each staff. Each file must contain:

(1) an annual performance review;

(2) a summary of on-site service observations and charting review;

(3) a criminal background check of all direct service staff;

(4) evidence of academic degree and qualifications;

(5) a copy of professional license;

(6) any job performance recognition and disciplinary actions;

(7) any individual staff written input into own personnel file;

(8) all clinical supervision provided; and

(9) documentation of compliance with continuing education requirements.

Subd. 8. [DIAGNOSTIC ASSESSMENT.] Providers of adult rehabilitative mental health services must complete a diagnostic assessment as defined in section 245.462, subdivision 9, within five days after the recipient's second visit or within 30 days after intake, whichever occurs first. In cases where a diagnostic assessment is available that reflects the recipient's current status, and has been completed within 180 days preceding admission, an update must be completed. An update shall include a written summary by a mental health professional of the recipient's current mental health status and service needs. If the recipient's mental health status has changed significantly since the adult's most recent diagnostic assessment, a new diagnostic assessment is required.

Subd. 9. [FUNCTIONAL ASSESSMENT.] Providers of adult rehabilitative mental health services must complete a written functional assessment as defined in section 245.462, subdivision 11a, for each recipient. The functional assessment must be completed within 30 days of intake, and reviewed and updated at least every six months after it is developed, unless there is a significant change in the functioning of the recipient. If there is a significant change in functioning, the assessment must be updated. A single functional assessment can meet case management and adult rehabilitative mental health services requirements, if agreed to by the recipient. Unless the recipient refuses, the recipient must have significant participation in the development of the functional assessment.

Subd. 10. [INDIVIDUAL TREATMENT PLAN.] All providers of adult rehabilitative mental health services must develop and implement an individual treatment plan for each recipient. The provisions in clauses (1) and (2) apply:

(1) Individual treatment plan means a plan of intervention, treatment, and services for an individual recipient written by a mental health professional or by a mental health practitioner under the clinical supervision of a mental health professional. The individual treatment plan must be based on diagnostic and functional assessments. To the extent possible, the development and implementation of a treatment plan must be a collaborative process involving the recipient, and with the permission of the recipient, the recipient's family and others in the recipient's support system. Providers of adult rehabilitative mental health services must develop the individual treatment plan within 30 calendar days of intake. The treatment plan must be updated at least every six months thereafter, or more often when there is significant change in the recipient's situation or functioning, or in services or service methods to be used, or at the request of the recipient or the recipient's legal guardian.

(2) The individual treatment plan must include:

(i) a list of problems identified in the assessment;

(ii) the recipient's strengths and resources;

(iii) concrete, measurable goals to be achieved, including time frames for achievement;

(iv) specific objectives directed toward the achievement of each one of the goals;

(v) documentation of participants in the treatment planning. The recipient, if possible, must be a participant. The recipient or the recipient's legal guardian must sign the treatment plan, or documentation must be provided why this was not possible. A copy of the plan must be given to the recipient or legal guardian. Referral to formal services must be arranged, including specific providers where applicable;

(vi) cultural considerations, resources, and needs of the recipient must be included;

(vii) planned frequency and type of services must be initiated; and

(viii) clear progress notes on outcome of goals.

(3) The individual community support plan defined in section 245.462, subdivision 12, may serve as the individual treatment plan if there is involvement of a mental health case manager, and with the approval of the recipient. The individual community support plan must include the criteria in clause (2).

Subd. 11. [RECIPIENT FILE.] Providers of adult rehabilitative mental health services must maintain a file for each recipient that contains the following information:

(1) diagnostic assessment or verification of its location, that is current and that was reviewed by a mental health professional who is employed by or under contract with the provider entity;

(2) functional assessments;

(3) individual treatment plans signed by the recipient and the mental health professional, or if the recipient refused to sign the plan, the date and reason stated by the recipient as to why the recipient would not sign the plan;

(4) recipient history;

(5) signed release forms;

(6) recipient health information and current medications;

(7) emergency contacts for the recipient;

(8) case records which document the date of service, the place of service delivery, signature of the person providing the service, nature, extent and units of service, and place of service delivery;

(9) contacts, direct or by telephone, with recipient's family or others, other providers, or other resources for service coordination;

(10) summary of recipient case reviews by staff; and

(11) written information by the recipient that the recipient requests be included in the file.

Subd. 12. [ADDITIONAL REQUIREMENTS.] (a) Providers of adult rehabilitative mental health services must comply with the requirements relating to referrals for case management in section 245.467, subdivision 4.

(b) Adult rehabilitative mental health services are provided for most recipients in the recipient's home and community. Services may also be provided at the home of a relative or significant other, job site, psychosocial clubhouse, drop-in center, social setting, classroom, or other places in the community. Except for "transition to community services," the place of service does not include a regional treatment center, nursing home, residential treatment facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0670 (Rule 36), or an acute care hospital.

(c) Adult rehabilitative mental health services may be provided in group settings if appropriate to each participating recipient's needs and treatment plan. A group is defined as two to ten clients, at least one of whom is a recipient, who is concurrently receiving a service which is identified in this section. The service and group must be specified in the recipient's treatment plan. No more than two qualified staff may bill Medicaid for services provided to the same group of recipients. If two adult rehabilitative mental health workers bill for recipients in the same group session, they must each bill for different recipients.

Subd. 13. [EXCLUDED SERVICES.] The following services are excluded from reimbursement as adult rehabilitative mental health services:

(1) recipient transportation services;

(2) a service provided and billed by a provider who is not enrolled to provide adult rehabilitative mental health service;

(3) adult rehabilitative mental health services performed by volunteers;

(4) provider performance of household tasks, chores, or related activities, such as laundering clothes, moving the recipient's household, housekeeping, and grocery shopping for the recipient;

(5) direct billing of time spent "on call" when not delivering services to recipients;

(6) activities which are primarily social or recreational in nature, rather than rehabilitative, for the individual recipient, as determined by the individual's needs and treatment plan;

(7) job-specific skills services, such as on-the-job training;

(8) provider service time included in case management reimbursement;

(9) outreach services to potential recipients;

(10) a mental health service that is not medically necessary; and

(11) any services provided by a hospital, board and lodging, or residential facility to an individual who is a patient in or resident of that facility.

Subd. 14. [BILLING WHEN SERVICES ARE PROVIDED BY QUALIFIED STATE STAFF.] When rehabilitative services are provided by qualified state staff who are assigned to pilot projects under section 245.4661, the county or other local entity to which the qualified state staff are assigned may consider these staff part of the local provider entity for which certification is sought under this section, and may bill the medical assistance program for qualifying services provided by the qualified state staff. Notwithstanding section 256.025, subdivision 2, payments for services provided by state staff who are assigned to adult mental health initiatives shall only be made from federal funds.

Sec. 15. [256B.0624] [ADULT MENTAL HEALTH CRISIS RESPONSE SERVICES.]

Subdivision 1. [SCOPE.] Medical assistance covers adult mental health crisis response services as defined in subdivision 2, paragraphs (c) to (e), subject to federal approval, if provided to a recipient as defined in subdivision 3 and provided by a qualified provider entity as defined in this section and by a qualified individual provider working within the provider's scope of practice and as defined in this subdivision and identified in the recipient's individual crisis treatment plan as defined in subdivision 10 and if determined to be medically necessary.

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

(a) "Mental health crisis" is an adult behavioral, emotional, or psychiatric situation which, but for the provision of crisis response services, would likely result in significantly reduced levels of functioning in primary activities of daily living, or in an emergency situation, or in the placement of the recipient in a more restrictive setting, including, but not limited to, inpatient hospitalization.

(b) "Mental health emergency" is an adult behavioral, emotional, or psychiatric situation which causes an immediate need for mental health services and is consistent with section 62Q.55.

A mental health crisis or emergency is determined for medical assistance service reimbursement by a physician, a mental health professional, or crisis mental health practitioner with input from the recipient whenever possible.

(c) "Mental health crisis assessment" means an immediate face-to-face assessment by a physician, a mental health professional, or mental health practitioner under the clinical supervision of a mental health professional, following a screening that suggests that the adult may be experiencing a mental health crisis or mental health emergency situation.

(d) "Mental health mobile crisis intervention services" means face-to-face, short-term intensive mental health services initiated during a mental health crisis or mental health emergency to help the recipient cope with immediate stressors, identify and utilize available resources and strengths, and begin to return to the recipient's baseline level of functioning.

(1) This service is provided on-site by a mobile crisis intervention team outside of an inpatient hospital setting. Mental health mobile crisis intervention services must be available 24 hours a day, seven days a week.

(2) The initial screening must consider other available services to determine which service intervention would best address the recipient's needs and circumstances.

(3) The mobile crisis intervention team must be available to meet promptly face-to-face with a person in mental health crisis or emergency in a community setting.

(4) The intervention must consist of a mental health crisis assessment and a crisis treatment plan.

(5) The treatment plan must include recommendations for any needed crisis stabilization services for the recipient.

(e) "Mental health crisis stabilization services" means individualized mental health services provided to a recipient following crisis intervention services which are designed to restore the recipient to the recipient's prior functional level. Mental health crisis stabilization services may be provided in the recipient's home, the home of a family member or friend of the recipient, another community setting, or a short-term supervised, licensed residential program. Mental health crisis stabilization does not include partial hospitalization or day treatment.

Subd. 3. [ELIGIBILITY.] An eligible recipient is an individual who:

(1) is age 18 or older;

(2) is screened as possibly experiencing a mental health crisis or emergency where a mental health crisis assessment is needed; and

(3) is assessed as experiencing a mental health crisis or emergency, and mental health crisis intervention or crisis intervention and stabilization services are determined to be medically necessary.

Subd. 4. [PROVIDER ENTITY STANDARDS.] (a) A provider entity is an entity that meets the standards listed in paragraph (b) and:

(1) is a county board operated entity; or

(2) is a provider entity that is under contract with the county board in the county where the potential crisis or emergency is occurring. To provide services under this section, the provider entity must directly provide the services; or if services are subcontracted, the provider entity must maintain responsibility for services and billing.

(b) The adult mental health crisis response services provider entity must meet the following standards:

(1) has the capacity to recruit, hire, and manage and train mental health professionals, practitioners, and rehabilitation workers;

(2) has adequate administrative ability to ensure availability of services;

(3) is able to ensure adequate preservice and in-service training;

(4) is able to ensure that staff providing these services are skilled in the delivery of mental health crisis response services to recipients;

(5) is able to ensure that staff are capable of implementing culturally specific treatment identified in the individual treatment plan that is meaningful and appropriate as determined by the recipient's culture, beliefs, values, and language;

(6) is able to ensure enough flexibility to respond to the changing intervention and care needs of a recipient as identified by the recipient during the service partnership between the recipient and providers;

(7) is able to ensure that mental health professionals and mental health practitioners have the communication tools and procedures to communicate and consult promptly about crisis assessment and interventions as services occur;

(8) is able to coordinate these services with county emergency services and mental health crisis services;

(9) is able to ensure that mental health crisis assessment and mobile crisis intervention services are available 24 hours a day, seven days a week;

(10) is able to ensure that services are coordinated with other mental health service providers, county mental health authorities, or federally recognized American Indian authorities and others as necessary, with the consent of the adult. Services must also be coordinated with the recipient's case manager if the adult is receiving case management services;

(11) is able to ensure that crisis intervention services are provided in a manner consistent with sections 245.461 to 245.486;

(12) is able to submit information as required by the state;

(13) maintains staff training and personnel files;

(14) is able to establish and maintain a quality assurance and evaluation plan to evaluate the outcomes of services and recipient satisfaction;

(15) is able to keep records as required by applicable laws;

(16) is able to comply with all applicable laws and statutes;

(17) is an enrolled medical assistance provider; and

(18) develops and maintains written policies and procedures regarding service provision and administration of the provider entity including safety of staff and recipients in high risk situations.

Subd. 5. [MOBILE CRISIS INTERVENTION STAFF QUALIFICATIONS.] For provision of adult mental health mobile crisis intervention services, a mobile crisis intervention team is comprised of at least two mental health professionals as defined in section 245.462, subdivision 18, clauses (1) to (5), or a combination of at least one mental health professional and one mental health practitioner as defined in section 245.462, subdivision 17, with the required mental health crisis training and under the clinical supervision of a mental health professional on the team. The team must have at least two people with at least one member providing on-site crisis intervention services when needed. Team members must be experienced in mental health assessment, crisis intervention techniques, and clinical decision-making under emergency conditions and have knowledge of local services and resources. The team must recommend and coordinate the team's services with appropriate local resources such as the county social services agency, mental health services, and local law enforcement when necessary.

Subd. 6. [INITIAL SCREENING, CRISIS ASSESSMENT, AND MOBILE INTERVENTION TREATMENT PLANNING.] (a) Prior to initiating mobile crisis intervention services, a screening of the potential crisis situation must be conducted. The screening may use the resources of crisis assistance and emergency services as defined in sections 245.462, subdivision 6, and 245.469, subdivisions 1 and 2. The screening must gather information, determine whether a crisis situation exists, identify parties involved, and determine an appropriate response.

(b) If a crisis exists, a crisis assessment must be completed. A crisis assessment evaluates any immediate needs for which emergency services are needed and, as time permits, the recipient's current life situation, sources of stress, mental health problems and symptoms, strengths, cultural considerations, support network, vulnerabilities, and current functioning.

(c) If the crisis assessment determines mobile crisis intervention services are needed, the intervention services must be provided promptly. As opportunity presents during the intervention, at least two members of the mobile crisis intervention team must confer directly or by telephone about the assessment, treatment plan, and actions taken and needed. At least one of the team members must be on-site providing crisis intervention services. If providing on-site crisis intervention services, a mental health practitioner must seek clinical supervision as required in subdivision 8.

(d) The mobile crisis intervention team must develop an initial, brief crisis treatment plan as soon as appropriate but no later than 24 hours after the initial face-to-face intervention. The plan must address the needs and problems noted in the crisis assessment and include measurable short-term goals, cultural considerations, and frequency and type of services to be provided to achieve the goals and reduce or eliminate the crisis. The treatment plan must be updated as needed to reflect current goals and services.

(e) The team must document which short-term goals have been met, and when no further crisis intervention services are required.

(f) If the recipient's crisis is stabilized, but the recipient needs a referral to other services, the team must provide referrals to these services. If the recipient has a case manager, planning for other services must be coordinated with the case manager.

Subd. 7. [CRISIS STABILIZATION SERVICES.] (a) Crisis stabilization services must be provided by qualified staff of a crisis stabilization services provider entity and must meet the following standards:

(1) a crisis stabilization treatment plan must be developed which meets the criteria in subdivision 11;

(2) staff must be qualified as defined in subdivision 8; and

(3) services must be delivered according to the treatment plan and include face-to-face contact with the recipient by qualified staff for further assessment, help with referrals, updating of the crisis stabilization treatment plan, supportive counseling, skills training, and collaboration with other service providers in the community.

(b) If crisis stabilization services are provided in a supervised, licensed residential setting, the recipient must be contacted face-to-face daily by a qualified mental health practitioner or mental health professional. The program must have 24-hour-a-day residential staffing which may include staff who do not meet the qualifications in subdivision 8. The residential staff must have 24-hour-a-day immediate direct or telephone access to a qualified mental health professional or practitioner.

(c) If crisis stabilization services are provided in a supervised, licensed residential setting that serves no more than four adult residents, and no more than two are recipients of crisis stabilization services, the residential staff must include, for at least eight hours per day, at least one individual who meets the qualifications in subdivision 8.

(d) If crisis stabilization services are provided in a supervised, licensed residential setting that serves more than four adult residents, and one or more are recipients of crisis stabilization services, the residential staff must include, for 24 hours a day, at least one individual who meets the qualifications in subdivision 8. During the first 48 hours that a recipient is in the residential program, the residential program must have at least two staff working 24 hours a day. Staffing levels may be adjusted thereafter according to the needs of the recipient as specified in the crisis stabilization treatment plan.



Subd. 8. [ADULT CRISIS STABILIZATION STAFF QUALIFICATIONS.] (a) Adult mental health crisis stabilization services must be provided by qualified individual staff of a qualified provider entity. Individual provider staff must have the following qualifications:

(1) be a mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (5);

(2) be a mental health practitioner as defined in section 245.462, subdivision 17. The mental health practitioner must work under the clinical supervision of a mental health professional; or

(3) be a mental health rehabilitation worker who meets the criteria in section 256B.0623, subdivision 5, clause (3); works under the direction of a mental health practitioner as defined in section 245.462, subdivision 17, or under direction of a mental health professional; and works under the clinical supervision of a mental health professional.

(b) Mental health practitioners and mental health rehabilitation workers must have completed at least 30 hours of training in crisis intervention and stabilization during the past two years.

Subd. 9. [SUPERVISION.] Mental health practitioners may provide crisis assessment and mobile crisis intervention services if the following clinical supervision requirements are met:

(1) the mental health provider entity must accept full responsibility for the services provided;

(2) the mental health professional of the provider entity, who is an employee or under contract with the provider entity, must be available by phone or in person for clinical supervision;

(3) the mental health professional is consulted, in person or by phone, during the first three hours when a mental health practitioner provides on-site service;

(4) the mental health professional must:

(i) review and approve of the tentative crisis assessment and crisis treatment plan;

(ii) document the consultation; and

(iii) sign the crisis assessment and treatment plan within the next business day;

(5) if the mobile crisis intervention services continue into a second calendar day, a mental health professional must contact the recipient face-to-face on the second day to provide services and update the crisis treatment plan; and

(6) the on-site observation must be documented in the recipient's record and signed by the mental health professional.

Subd. 10. [RECIPIENT FILE.] Providers of mobile crisis intervention or crisis stabilization services must maintain a file for each recipient containing the following information:

(1) individual crisis treatment plans signed by the recipient, mental health professional, and mental health practitioner who developed the crisis treatment plan, or if the recipient refused to sign the plan, the date and reason stated by the recipient as to why the recipient would not sign the plan;

(2) signed release forms;

(3) recipient health information and current medications;

(4) emergency contacts for the recipient;

(5) case records which document the date of service, place of service delivery, signature of the person providing the service, and the nature, extent, and units of service. Direct or telephone contact with the recipient's family or others should be documented;

(6) required clinical supervision by mental health professionals;

(7) summary of the recipient's case reviews by staff; and

(8) any written information by the recipient that the recipient wants in the file.

Documentation in the file must comply with all requirements of the commissioner.

Subd. 11. [TREATMENT PLAN.] The individual crisis stabilization treatment plan must include, at a minimum:

(1) a list of problems identified in the assessment;

(2) a list of the recipient's strengths and resources;

(3) concrete, measurable short-term goals and tasks to be achieved, including time frames for achievement;

(4) specific objectives directed toward the achievement of each one of the goals;

(5) documentation of the participants involved in the service planning. The recipient, if possible, must be a participant. The recipient or the recipient's legal guardian must sign the service plan or documentation must be provided why this was not possible. A copy of the plan must be given to the recipient and the recipient's legal guardian. The plan should include services arranged, including specific providers where applicable;

(6) planned frequency and type of services initiated;

(7) a crisis response action plan if a crisis should occur;

(8) clear progress notes on outcome of goals;

(9) a written plan must be completed within 24 hours of beginning services with the recipient; and

(10) a treatment plan must be developed by a mental health professional or mental health practitioner under the clinical supervision of a mental health professional. The mental health professional must approve and sign all treatment plans.

Subd. 12. [EXCLUDED SERVICES.] The following services are excluded from reimbursement under this section:

(1) room and board services;

(2) services delivered to a recipient while admitted to an inpatient hospital;

(3) recipient transportation costs may be covered under other medical assistance provisions, but transportation services are not an adult mental health crisis response service;

(4) services provided and billed by a provider who is not enrolled under medical assistance to provide adult mental health crisis response services;

(5) services performed by volunteers;

(6) direct billing of time spent "on call" when not delivering services to a recipient;

(7) provider service time included in case management reimbursement. When a provider is eligible to provide more than one type of medical assistance service, the recipient must have a choice of provider for each service, unless otherwise provided for by law;

(8) outreach services to potential recipients; and

(9) a mental health service that is not medically necessary.

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

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

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

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

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

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

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

(e) Payment for mental health case management provided by Indian health services or by agencies operated by Indian tribes may be made according to this section or other relevant federally approved rate setting methodology.

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

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

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

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

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

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

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

- (1) the costs of developing and implementing this section; and
- (2) programming the information systems.

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

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

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

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

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

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

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

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

(1) a continuation of the minimum allocation in paragraph ~~(t)~~ (h); or

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

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

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

Subd. 43. [APPEAL PROCESS.] If a county contract or certification is required to enroll as an authorized provider of mental health services under medical assistance, and if a county refuses to grant the necessary contract or certification, the provider may appeal the county decision to the commissioner. A recipient may initiate an appeal on behalf of a provider who has been denied certification. The commissioner shall determine whether the provider meets applicable standards under state laws and rules based on an independent review of the facts, including comments from the county review. If the commissioner finds that the provider meets the applicable standards, the commissioner shall enroll the provider as an authorized provider. The commissioner shall develop procedures for providers and recipients to appeal a county decision to refuse to enroll a provider. After the commissioner makes a decision regarding an appeal, the county, provider, or recipient may request that the commissioner reconsider the commissioner's initial decision. The commissioner's reconsideration decision is final and not subject to further appeal.

Sec. 18. Minnesota Statutes 2000, section 256B.0625, is amended by adding a subdivision to read:

Subd. 44. [MENTAL HEALTH PROVIDER TRAVEL TIME.] Medical assistance covers provider travel time if a recipient's individual treatment plan requires the provision of mental health services outside of the provider's normal place of business. This does not include any travel time which is included in other billable services, and is only covered when the mental health service being provided to a recipient is covered under medical assistance.

Sec. 19. [256B.761] [REIMBURSEMENT FOR MENTAL HEALTH SERVICES.]

Payment for medication management provided to psychiatric patients, outpatient mental health services, day treatment services, home-based mental health services, and family community support services shall be paid at:

(1) for services rendered on or after July 1, 2001, and before July 1, 2002, the lower of (i) submitted charges, or (ii) the 73rd percentile of the 50th percentile of 1999 charges; and

(2) for services rendered on or after July 1, 2002, the lower of (i) submitted charges, or (ii) the 75th percentile of the 50th percentile of 1999 charges.

## Sec. 20. [299A.76] [SUICIDE STATISTICS.]

(a) The commissioner of public safety shall not:

(1) include any statistics on committing suicide or attempting suicide in any compilation of crime statistics published by the commissioner; or

(2) label as a crime statistic, any data on committing suicide or attempting suicide.

(b) This section does not apply to the crimes of aiding suicide under section 609.215, subdivision 1, or aiding attempted suicide under section 609.215, subdivision 2, or to statistics directly related to the commission of a crime.

## Sec. 21. [NOTICE REGARDING ESTABLISHMENT OF CONTINUING CARE BENEFIT PROGRAM.]

When the continuing care benefit program for persons with mental illness under Minnesota Statutes, section 256.9693 is established, the commissioner of human services shall notify counties, health plan companies with prepaid medical assistance contracts, health care providers, and enrollees of the benefit program through bulletins, workshops, and other meetings.

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

## Sec. 22. [STUDY; LENGTH OF STAY FOR MEDICARE-ELIGIBLE PERSONS.]

The commissioner of human services shall study and make recommendations on how Medicare-eligible persons with mental illness may obtain acute care hospital inpatient treatment for mental illness for a length of stay beyond that allowed by the diagnostic classifications for mental illness according to Minnesota Statutes, section 256.969, subdivision 3a. The study and recommendations shall be reported to the legislature by January 15, 2002.

## Sec. 23. [DEVELOPMENT OF PAYMENT SYSTEM FOR ADULT RESIDENTIAL SERVICES GRANTS.]

The commissioner of human services shall review funding methods for adult residential services grants under Minnesota Rules, parts 9535.2000 to 9535.3000, and shall develop a payment system that takes into account client difficulty of care as manifested by client physical, mental, or behavioral conditions. The payment system must provide reimbursement for education, consultation, and support services provided to families and other individuals as an extension of the treatment process. The commissioner shall present recommendations and draft legislation for an adult residential services payment system to the legislature by January 15, 2002. The recommendations must address whether additional funding for adult residential services grants is necessary for the provision of high quality services under a payment reimbursement system.

## ARTICLE 10

## ASSISTANCE PROGRAMS

Section 1. Minnesota Statutes 2000, section 256.01, subdivision 18, is amended to read:

Subd. 18. [IMMIGRATION STATUS VERIFICATIONS.] (a) Notwithstanding any waiver of this requirement by the secretary of the United States Department of Health and Human Services, effective July 1, 2001, the commissioner shall utilize the Systematic Alien Verification for Entitlements (SAVE) program to conduct immigration status verifications:

(1) as required under United States Code, title 8, section 1642;

(2) for all applicants for food assistance benefits, whether under the federal food stamp program, the MFIP or work first program, or the Minnesota food assistance program;

(3) for all applicants for general assistance medical care, except assistance for an emergency medical condition, for immunization with respect to an immunizable disease, or for testing and treatment of symptoms of a communicable disease; and

(4) for all applicants for general assistance, Minnesota supplemental aid, MinnesotaCare, or group residential housing, when the benefits provided by these programs would fall under the definition of "federal public benefit" under United States Code, title 8, section 1642, if federal funds were used to pay for all or part of the benefits.

~~The commissioner shall report to the Immigration and Naturalization Service all undocumented persons who have been identified through application verification procedures or by the self-admission of an applicant for assistance. Reports made under this subdivision must comply with the requirements of section 411A of the Social Security Act, as amended, and United States Code, title 8, section 1644.~~

(b) The commissioner shall comply with the reporting requirements under United States Code, title 42, section 611a, and any federal regulation or guidance adopted under that law.

Sec. 2. Minnesota Statutes 2000, section 256D.053, subdivision 1, is amended to read:

Subdivision 1. [PROGRAM ESTABLISHED.] The Minnesota food assistance program is established to provide food assistance to legal noncitizens residing in this state who are ineligible to participate in the federal Food Stamp Program solely due to the provisions of section 402 or 403 of Public Law Number 104-193, as authorized by Title VII of the 1997 Emergency Supplemental Appropriations Act, Public Law Number 105-18, and as amended by Public Law Number 105-185.

Beginning July 1, ~~2002~~ 2003, the Minnesota food assistance program is limited to those noncitizens described in this subdivision who are 50 years of age or older.

Sec. 3. [256J.021] [SEPARATE STATE PROGRAM FOR USE OF STATE MONEY.]

Beginning October 1, 2001, and each year thereafter, the commissioner of human services must treat financial assistance expenditures made to or on behalf of any minor child under section 256J.02, subdivision 2, clause (1), who is a resident of this state under section 256J.12, and who is part of a two-parent eligible household as expenditures under a separately funded state program and report those expenditures to the federal Department of Health and Human Services as separate state program expenditures under Code of Federal Regulations, title 45, section 263.5.

Sec. 4. Minnesota Statutes 2000, section 256J.09, subdivision 1, is amended to read:

Subdivision 1. [WHERE TO APPLY.] To apply for assistance a person must ~~apply for assistance at~~ submit a signed application to the county agency in the county where that person lives.

Sec. 5. Minnesota Statutes 2000, section 256J.09, subdivision 2, is amended to read:

Subd. 2. [COUNTY AGENCY RESPONSIBILITY TO PROVIDE INFORMATION.] When a person inquires about assistance, a county agency must ~~inform a person who inquires about assistance about:~~

(1) explain the eligibility requirements for assistance of, and how to apply for, diversionary assistance, including diversionary assistance and as provided in section 256J.47; emergency assistance; as provided in section 256J.48; MFIP as provided in section 256J.10; or any other assistance for which the person may be eligible; and

A county agency must (2) offer the person brochures developed or approved by the commissioner that describe how to apply for assistance.

Sec. 6. Minnesota Statutes 2000, section 256J.09, subdivision 3, is amended to read:

Subd. 3. [SUBMITTING THE APPLICATION FORM.] (a) A county agency must offer, in person or by mail, the application forms prescribed by the commissioner as soon as a person makes a written or oral inquiry. At that time, the county agency must:

(1) inform the person that assistance begins with the date the signed application is received by the county agency or the date all eligibility criteria are met, whichever is later. ~~The county agency must;~~

(2) inform the applicant person that any delay in submitting the application will reduce the amount of assistance paid for the month of application. ~~A county agency must;~~

(3) inform a person that the person may submit the application before an interview ~~appointment. To apply for assistance, a person must submit a signed application to the county agency.;~~

(4) explain the information that will be verified during the application process by the county agency as provided in section 256J.32;

(5) inform a person about the county agency's average application processing time and explain how the application will be processed under subdivision 5;

(6) explain how to contact the county agency if a person's application information changes and how to withdraw the application;

(7) inform a person that the next step in the application process is an interview and what a person must do if the application is approved including, but not limited to, attending orientation under section 256J.45 and complying with employment and training services requirements in sections 256J.52 to 256J.55;

(8) explain the child care and transportation services that are available under paragraph (c) to enable caregivers to attend the interview, screening, and orientation; and

(9) identify any language barriers and arrange for translation assistance during appointments, including, but not limited to, screening under subdivision 3a, orientation under section 256J.45, and the initial assessment under section 256J.52.

(b) Upon receipt of a signed application, the county agency must stamp the date of receipt on the face of the application. The county agency must process the application within the time period required under subdivision 5. An applicant may withdraw the application at any time by giving written or oral notice to the county agency. The county agency must issue a written notice confirming the withdrawal. The notice must inform the applicant of the county agency's understanding that the applicant has withdrawn the application and no longer wants to pursue it. When, within ten days of the date of the agency's notice, an applicant informs a county agency, in writing, that the applicant does not wish to withdraw the application, the county agency must reinstate the application and finish processing the application.

(c) Upon a participant's request, the county agency must arrange for transportation and child care or reimburse the participant for transportation and child care expenses necessary to enable participants to attend the screening under subdivision 3a and orientation under section 256J.45.

Sec. 7. Minnesota Statutes 2000, section 256J.09, is amended by adding a subdivision to read:

Subd. 3a. [SCREENING.] The county agency, or at county option, the county's employment and training service provider as defined in section 256J.49, must screen each applicant to determine immediate needs and to determine if the applicant may be eligible for:



(1) another program that is not partially funded through the federal temporary assistance to needy families block grant under Title I of Public Law Number 104-193, including the expedited issuance of food stamps under section 256J.28, subdivision 1. If the applicant may be eligible for another program, a county caseworker must provide the appropriate referral to the program;

(2) the diversionary assistance program under section 256J.47; or

(3) the emergency assistance program under section 256J.48.

Sec. 8. Minnesota Statutes 2000, section 256J.09, is amended by adding a subdivision to read:

Subd. 3b. [INTERVIEW TO DETERMINE REFERRALS AND SERVICES.] If the applicant is not diverted from applying for MFIP, and if the applicant meets the MFIP eligibility requirements, then a county agency must:

(1) identify an applicant who is under the age of 20 and explain to the applicant the assessment procedures and employment plan requirements for minor parents under section 256J.54;

(2) explain to the applicant the eligibility criteria for an exemption under the family violence provisions in section 256J.52, subdivision 6, and explain what an applicant should do to develop an alternative employment plan;

(3) determine if an applicant qualifies for an exemption under section 256J.56 from employment and training services requirements, explain how a person should report to the county agency any status changes, and explain that an applicant who is exempt may volunteer to participate in employment and training services;

(4) for applicants who are not exempt from the requirement to attend orientation, arrange for an orientation under section 256J.45 and an initial assessment under section 256J.52;

(5) inform an applicant who is not exempt from the requirement to attend orientation that failure to attend the orientation is considered an occurrence of noncompliance with program requirements and will result in an imposition of a sanction under section 256J.46; and

(6) explain how to contact the county agency if an applicant has questions about compliance with program requirements.

Sec. 9. Minnesota Statutes 2000, section 256J.15, is amended by adding a subdivision to read:

Subd. 3. [ELIGIBILITY AFTER DISQUALIFICATION DUE TO NONCOMPLIANCE.] (a) An applicant who is a member of an assistance unit that was disqualified from receiving MFIP under section 256J.46, subdivision 1, paragraph (d), clause (3), and who applies for MFIP assistance within six months of the date of the disqualification is considered to be a new applicant for purposes of the property limitations under section 256J.20 and, at county option, the payment of assistance provisions under section 256J.24, subdivision 8. The county agency must also use the initial income test under section 256J.21, subdivision 3, in determining the applicant's eligibility for assistance.

(b) Notwithstanding section 256J.24, subdivisions 5 to 7 and 9, for an applicant who is eligible for MFIP under this subdivision, the residual amount of the grant, after making any applicable vendor payments for shelter and utility costs, if any, must be reduced by ten percent of the applicable MFIP standard of need for an assistance unit of the same size for each of the first six months on MFIP before the residual amount of the grant is paid to the assistance unit.

(c) A participant who is disqualified from MFIP a second or subsequent time and who is eligible for MFIP under this subdivision is considered to have a third occurrence of noncompliance and must be sanctioned under section 256J.46, subdivision 1, paragraph (d), clause (2), for the first six months on MFIP under this subdivision.

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

Subd. 10. [MFIP EXIT LEVEL.] ~~(a) In state fiscal years 2000 and 2001,~~ The commissioner shall adjust the MFIP earned income disregard to ensure that most participants do not lose eligibility for MFIP until their income reaches at least 120 percent of the federal poverty guidelines in effect in October of each fiscal year. The adjustment to the disregard shall be based on a household size of three, and the resulting earned income disregard percentage must be applied to all household sizes. The adjustment under this subdivision must be implemented at the same time as the October food stamp cost-of-living adjustment is reflected in the food portion of MFIP transitional standard as required under subdivision 5a.

~~(b) In state fiscal year 2002 and thereafter, the earned income disregard percentage must be the same as the percentage implemented in October 2000.~~

Sec. 11. Minnesota Statutes 2000, section 256J.26, subdivision 1, is amended to read:

Subdivision 1. [PERSON CONVICTED OF DRUG OFFENSES.] (a) Applicants or participants who have been convicted of a drug offense committed after July 1, 1997, may, if otherwise eligible, receive MFIP benefits subject to the following conditions:

(1) Benefits for the entire assistance unit must be paid in vendor form for shelter and utilities during any time the applicant is part of the assistance unit.

(2) The convicted applicant or participant shall be subject to random drug testing as a condition of continued eligibility and following any positive test for an illegal controlled substance is subject to the following sanctions:

(i) for failing a drug test the first time, ~~the participant's grant shall be reduced by ten percent of the MFIP standard of need, prior to making vendor payments for shelter and utility costs; or~~

~~(ii) for failing a drug test two or more times, the residual amount of the participant's grant after making vendor payments for shelter and utility costs, if any, must be reduced by an amount equal to 30 percent of the MFIP standard of need for an assistance unit of the same size. When a sanction under this subdivision is in effect, the job counselor must attempt to meet with the person face-to-face. During the face-to-face meeting, the job counselor must explain the consequences of a subsequent drug test failure and inform the participant of the right to appeal the sanction under section 256J.40. If a face-to-face meeting is not possible, the county agency must send the participant a notice of adverse action as provided in section 256J.31, subdivisions 4 and 5, and must include the information required in the face-to-face meeting; or~~

~~(ii) for failing a drug test two times, the participant is permanently disqualified from receiving MFIP assistance, both the cash and food portions. The assistance unit's MFIP grant must be reduced by the amount which would have otherwise been made available to the disqualified participant. Disqualification under this item does not make a participant ineligible for food stamps. Before a disqualification under this provision is imposed, the job counselor must attempt to meet with the participant face-to-face. During the face-to-face meeting, the job counselor must identify other resources that may be available to the participant to meet the needs of the family and inform the participant of the right to appeal the disqualification under section 256J.40. If a face-to-face meeting is not possible, the county agency must send the participant a notice of adverse action as provided in section 256J.31, subdivisions 4 and 5, and must include the information required in the face-to-face meeting.~~

(3) A participant who fails ~~an initial~~ a drug test the first time and is under a sanction due to other MFIP program requirements is considered to have more than one occurrence of noncompliance and is subject to the applicable level of sanction in clause (2)(ii) as specified under section 256J.46, subdivision 1, paragraph (d).

(b) Applicants requesting only food stamps or participants receiving only food stamps, who have been convicted of a drug offense that occurred after July 1, 1997, may, if otherwise eligible, receive food stamps if the convicted applicant or participant is subject to random drug testing as a condition of continued eligibility. Following a positive test for an illegal controlled substance, the applicant is subject to the following sanctions:

(1) for failing a drug test the first time, ~~food stamps shall be reduced by ten percent of the applicable food stamp allotment; and~~

~~(2) for failing a drug test two or more times, food stamps shall be reduced by an amount equal to 30 percent of the applicable food stamp allotment. When a sanction under this clause is in effect, a job counselor must attempt to meet with the person face-to-face. During the face-to-face meeting, a job counselor must explain the consequences of a subsequent drug test failure and inform the participant of the right to appeal the sanction under section 256J.40. If a face-to-face meeting is not possible, a county agency must send the participant a notice of adverse action as provided in section 256J.31, subdivisions 4 and 5, and must include the information required in the face-to-face meeting; and~~

~~(2) for failing a drug test two times, the participant is permanently disqualified from receiving food stamps. Before a disqualification under this provision is imposed, a job counselor must attempt to meet with the participant face-to-face. During the face-to-face meeting, the job counselor must identify other resources that may be available to the participant to meet the needs of the family and inform the participant of the right to appeal the disqualification under section 256J.40. If a face-to-face meeting is not possible, a county agency must send the participant a notice of adverse action as provided in section 256J.31, subdivisions 4 and 5, and must include the information required in the face-to-face meeting.~~

(c) For the purposes of this subdivision, "drug offense" means an offense that occurred after July 1, 1997, of sections 152.021 to 152.025, 152.0261, or 152.096. Drug offense also means a conviction in another jurisdiction of the possession, use, or distribution of a controlled substance, or conspiracy to commit any of these offenses, if the offense occurred after July 1, 1997, and the conviction is a felony offense in that jurisdiction, or in the case of New Jersey, a high misdemeanor.

Sec. 12. Minnesota Statutes 2000, section 256J.31, subdivision 4, is amended to read:

Subd. 4. [PARTICIPANT'S RIGHT TO NOTICE.] A county agency must give a participant written notice of all adverse actions affecting the participant including payment reductions, suspensions, terminations, and use of protective, vendor, or two-party payments. The notice of adverse action must be on a form prescribed or approved by the commissioner, must be understandable at a seventh grade reading level, and must be mailed to the last known mailing address provided by the participant. A notice written in English must include the department of human services language block and must be sent to every applicable participant. The county agency must state on the notice of adverse action the action it intends to take, the reasons for the action, the participant's right to appeal the action, the conditions under which assistance can be continued pending an appeal decision, and the related consequences of the action.

Sec. 13. Minnesota Statutes 2000, section 256J.32, subdivision 7a, is amended to read:

Subd. 7a. [REQUIREMENT TO REPORT TO IMMIGRATION AND NATURALIZATION SERVICES.] ~~Notwithstanding subdivision 7, effective July 1, 2001, the commissioner shall report to the Immigration and Naturalization Services all undocumented persons who have been identified through application verification procedures or by the self-admission of an applicant for assistance. Reports made under this subdivision must comply with the requirements of section 411A of the Social Security Act, as amended, and United States Code, title 8, section 1644. The commissioner shall comply with the reporting requirements under United States Code, title 42, section 611a, and any federal regulation or guidance adopted under that law.~~

Sec. 14. Minnesota Statutes 2000, section 256J.42, is amended by adding a subdivision to read:

Subd. 6. [CASE REVIEW.] (a) Within 180 days before the end of the participant's 60th month on MFIP, the county agency or job counselor must review the participant's case to determine if the employment plan is still appropriate, or if the participant is exempt under section 256J.56 from the employment and training services component, and attempt to meet with the participant face-to-face.

(b) During the face-to-face meeting, a county agency or the job counselor must:

(1) inform the participant how many months of counted assistance the participant has accrued and when the participant is expected to reach the 60th month;

(2) explain the hardship extension criteria under section 256J.425 and what the participant should do if the participant thinks a hardship extension applies;

(3) identify other resources that may be available to the participant to meet the needs of the family; and

(4) inform the participant of the right to appeal the case closure under section 256J.40.

(c) If a face-to-face meeting is not possible, the county agency must send the participant a notice of adverse action as provided in section 256J.31, subdivisions 4 and 5.

(d) Before a participant's case is closed under this section, the county must ensure that:

(1) the case has been reviewed by the job counselor's supervisor or the review team designated in the county's approved local service unit plan to determine if the criteria for a hardship extension, if requested, were applied appropriately; and

(2) the county agency or the job counselor attempted to meet with the participant face-to-face.

Sec. 15. [256J.425] [HARDSHIP EXTENSIONS.]

Subdivision 1. [ELIGIBILITY.] An assistance unit subject to the time limit under section 256J.42, subdivision 1, in which any participant has received 60 counted months of assistance is not eligible to receive months of assistance beyond the first 60 months under a hardship extension, if the participant is not in compliance. If there is more than one participant in the household, each participant must be in compliance to be eligible for a hardship extension. For purposes of determining eligibility for a hardship extension, a participant is in compliance in any month that the participant has not been sanctioned under section 256J.46, subdivision 1, or under 256J.26, subdivision 1.

Subd. 2. [ILL OR INCAPACITATED PARTICIPANTS; DEPENDENT HOUSEHOLD MEMBER.] (a) An assistance unit subject to the time limit in section 256J.42, subdivision 1, in which any participant has received 60 counted months of assistance, is eligible to receive months of assistance under a hardship extension if the participant belongs to any of the following groups:

(1) participants who are suffering from a professionally certified illness, injury, or incapacity which is expected to continue for more than 30 days and which prevents the person from obtaining or retaining employment and who are following the treatment recommendations of the health care provider certifying the illness, injury, or incapacity;

(2) participants whose presence in the home is required because of the professionally certified illness or incapacity of another member in the assistance unit, a relative in the household, or a foster child in the household and the illness or incapacity is expected to continue for more than 30 days; or

(3) caregivers with a child or an adult in the household who meets the disability or medical criteria for home care services under section 256B.0627, subdivision 1, paragraph (c), or a home and community-based waiver services program under chapter 256B, or meets the criteria for severe emotional disturbance under section 245.4871, subdivision 6, or for serious and persistent mental illness under section 245.462, subdivision 20, paragraph (c). Caregivers in this category are presumed to be prevented from obtaining or retaining employment.

(b) An assistance unit receiving assistance under a hardship extension under this subdivision may continue to receive assistance under MFIP as long as the participant meets the criteria in paragraph (a), clause (1), (2), or (3). A county agency or job counselor must, on a quarterly basis, review the case file of an assistance unit receiving assistance under this subdivision to determine if the participant still meets the criteria in paragraph (a), clause (1), (2), or (3).

Subd. 3. [CERTAIN HARD-TO-EMPLOY PARTICIPANTS.] (a) An assistance unit subject to the time limit in section 256J.42, subdivision 1, in which any participant has received 60 counted months of assistance, is eligible to receive months of assistance under a hardship extension if the participant belongs to any of the following groups:

(1) a person who is diagnosed by a licensed physician, psychological practitioner, or other qualified professional, as mentally retarded or mentally ill, and that condition prevents the person from obtaining or retaining employment;

(2) a person who has been assessed by a vocational specialist, job counselor, or the county agency to be unemployable for purposes of this subdivision; a person is considered employable if positions of employment in the local labor market exist, regardless of the current availability of openings for those positions, that the person is capable of performing. The person's eligibility under this category must be reassessed at least annually; or

(3) a person who is determined by the county agency, according to Minnesota Rules, part 9500.1251, subpart 2, item 1, to be learning disabled, provided that if a rehabilitation plan for the person is developed or approved by the county agency, the person is following the plan. A rehabilitation plan does not replace the requirement to develop and comply with an employment plan under section 256J.52.

(b) An assistance unit receiving assistance under a hardship extension under this subdivision may continue to receive assistance under MFIP as long as the participant meets the criteria in paragraph (a), clause (1), (2), or (3), and all participants in the assistance unit remain in compliance with, or are exempt from, the employment and training services requirements in sections 256J.52 to 256J.55.

Subd. 4. [VICTIMS OF FAMILY VIOLENCE.] A participant who received TANF assistance that counted towards the federal 60-month time limit while the participant complied with a safety plan or, after October 1, 2001, an alternative employment plan under the MFIP employment and training component is eligible for assistance under a hardship extension for a period of time equal to the number of months that were counted toward the federal 60-month time limit while the participant complied with a safety plan or, after October 1, 2001, an alternative employment plan under the MFIP employment and training component.

Subd. 5. [ACCRUAL OF CERTAIN EXEMPT MONTHS.] (a) A participant who received TANF assistance that counted towards the federal 60-month time limit while the participant was or would have been exempt under section 256J.56, paragraph (a), clause (7), from employment and training services requirements and who is no longer eligible for assistance under a hardship extension under subdivision 2, paragraph (a), clause (3), is eligible for assistance under a hardship extension for a period of time equal to the number of months that were counted toward the federal 60-month time limit while the participant was or would have been exempt under section 256J.56, paragraph (a), clause (7), from the employment and training services requirements.

(b) A participant who received TANF assistance that counted towards the federal 60-month time limit while the participant met the state time limit exemption criteria under section 256J.42, subdivision 5, is eligible for assistance under a hardship extension for a period of time equal to the number of months that were counted toward the federal 60-month time limit while the participant met the state time limit exemption criteria under section 256J.42, subdivision 5.

Sec. 16. Minnesota Statutes 2000, section 256J.45, subdivision 1, is amended to read:

Subdivision 1. [COUNTY AGENCY TO PROVIDE ORIENTATION.] A county agency must provide a face-to-face orientation to each MFIP caregiver who is not exempt under section 256J.56, paragraph (a), clause (6) or (8), with a face-to-face orientation unless the caregiver is:

(1) a single parent, or one parent in a two-parent family, employed at least 35 hours per week; or

(2) a second parent in a two-parent family who is employed for 20 or more hours per week provided the first parent is employed at least 35 hours per week.

The county agency must inform caregivers who are not exempt under ~~section 256J.56, paragraph (a), clause (6) or (8); clause (1) or (2)~~ that failure to attend the orientation is considered an occurrence of noncompliance with program requirements, and will result in the imposition of a sanction under section 256J.46. If the client complies with the orientation requirement prior to the first day of the month in which the grant reduction is proposed to occur, the orientation sanction shall be lifted.

Sec. 17. Minnesota Statutes 2000, section 256J.46, subdivision 1, is amended to read:

Subdivision 1. ~~[SANCTIONS FOR PARTICIPANTS NOT COMPLYING WITH PROGRAM REQUIREMENTS.]~~ (a) A participant who fails without good cause to comply with the requirements of this chapter, and who is not subject to a sanction under subdivision 2, shall be subject to a sanction as provided in this subdivision. Prior to the imposition of a sanction, a county agency shall provide a notice of intent to sanction under section 256J.57, subdivision 2, and, when applicable, a notice of adverse action as provided in section 256J.31.

(b) A participant who fails to comply with an alternative employment plan must have the plan reviewed by a person trained in domestic violence and a job counselor to determine if components of the alternative employment plan are still appropriate. If the activities are no longer appropriate, the plan must be revised with a person trained in domestic violence and approved by a job counselor. A participant who fails to comply with a plan that is determined not to need revision will lose their exemption and be required to comply with regular employment services activities.

(c) A sanction under this subdivision becomes effective the month following the month in which a required notice is given. A sanction must not be imposed when a participant comes into compliance with the requirements for orientation under section 256J.45 or third-party liability for medical services under section 256J.30, subdivision 10, prior to the effective date of the sanction. A sanction must not be imposed when a participant comes into compliance with the requirements for employment and training services under sections 256J.49 to ~~256J.72~~ 256J.55 ten days prior to the effective date of the sanction. For purposes of this subdivision, each month that a participant fails to comply with a requirement of this chapter shall be considered a separate occurrence of noncompliance. A participant who has had one or more sanctions imposed must remain in compliance with the provisions of this chapter for six months in order for a subsequent occurrence of noncompliance to be considered a first occurrence.

~~(b)~~ (d) Sanctions for noncompliance shall be imposed as follows:

(1) For the first occurrence of noncompliance by a participant in ~~a single-parent household or by one participant in a two-parent household~~ an assistance unit, the assistance unit's grant shall be reduced by ten percent of the MFIP standard of need for an assistance unit of the same size with the residual grant paid to the participant. The reduction in the grant amount must be in effect for a minimum of one month and shall be removed in the month following the month that the participant returns to compliance.

(2) For a second ~~or subsequent~~ and third occurrence of noncompliance by a participant in an assistance unit, or when ~~both each of the~~ participants in a two-parent household ~~are out of compliance~~ assistance unit have a first occurrence of noncompliance at the same time, the assistance unit's shelter costs shall be vendor paid up to the amount of the cash portion of the MFIP grant for which the ~~participant's~~ assistance unit is eligible. At county option, the assistance unit's utilities may also be vendor paid up to the amount of the cash portion of the MFIP grant remaining after vendor payment of the assistance unit's shelter costs. The residual amount of the grant after vendor payment, if any, must be reduced by an amount equal to 30 percent of the MFIP standard of need for an assistance unit of the same size before the residual grant is paid to the assistance unit. The reduction in the grant amount must be in effect for a minimum of one month and shall be removed in the month following the month that ~~a~~ the participant in a one-parent ~~household~~ assistance unit returns to compliance. In a two-parent ~~household~~ assistance unit, the grant reduction must be in effect for a minimum of one month and shall be removed in the month following the month both participants return to compliance. The vendor payment of shelter costs and, if applicable, utilities

shall be removed six months after the month in which the participant or participants return to compliance. If an assistance unit is sanctioned under this clause, the participant's case file must be reviewed as required under paragraph (e).

(3) For a fourth occurrence of noncompliance, the assistance unit is disqualified from receiving MFIP assistance, both the cash and food portions. This disqualification must be in effect for a minimum of one full month. Disqualification under this clause does not make a participant ineligible for food stamps. Before an assistance unit is disqualified under this clause, the county must ensure that:

(i) the case has been reviewed by the job counselor's supervisor or the review team designated in the county's approved local service unit plan to determine if the review required under paragraph (e) has occurred; and

(ii) the job counselor attempted to meet with the participant face-to-face.

(c) No later than during the second month that (e) When a sanction under paragraph (b) (d), clause (2), is in effect due to noncompliance with employment services, the participant's case file must be reviewed to determine if the county agency or job counselor must review the participant's case to determine if the employment plan is still appropriate and attempt to meet with the participant face-to-face. If a face-to-face meeting is not possible, the county agency must send the participant a notice of adverse action as provided in section 256J.31, subdivisions 4 and 5.

(1) During the face-to-face meeting, the job counselor must:

(i) determine whether the continued noncompliance can be explained and mitigated by providing a needed preemployment activity, as defined in section 256J.49, subdivision 13, clause (16), or services under a local intervention grant for self-sufficiency under section 256J.625;

(ii) determine whether the participant qualifies for a good cause exception under section 256J.57; or

(iii) determine whether the participant qualifies for an exemption under section 256J.56;

(iv) determine whether the participant qualifies for an exemption for victims of family violence under section 256J.52, subdivision 6;

(v) inform the participant of the participant's sanction status and explain the consequences of continuing noncompliance;

(vi) identify other resources that may be available to the participant to meet the needs of the family if the participant is sanctioned and disqualified from MFIP under paragraph (d), clause (3); and

(vii) inform the participant of the right to appeal under section 256J.40.

(2) If the lack of an identified activity can explain the noncompliance, the county must work with the participant to provide the identified activity, and the county must restore the participant's grant amount to the full amount for which the assistance unit is eligible. The grant must be restored retroactively to the first day of the month in which the participant was found to lack preemployment activities or to qualify for an exemption or under section 256J.56, a good cause exception under section 256J.57, or an exemption for victims of family violence under section 256J.52, subdivision 6.

(3) If the participant is found to qualify for a good cause exception or an exemption, the county must restore the participant's grant to the full amount for which the assistance unit is eligible.

[EFFECTIVE DATE.] The family violence provisions in paragraph (e) are effective October 1, 2001, if the alternative employment plan and family violence provisions in section 256J.52, subdivision 6, are enacted during the 2001 session.

Sec. 18. Minnesota Statutes 2000, section 256J.46, subdivision 2a, is amended to read:

Subd. 2a. [DUAL SANCTIONS.] (a) Notwithstanding the provisions of subdivisions 1 and 2, for a participant subject to a sanction for refusal to comply with child support requirements under subdivision 2 and subject to a concurrent sanction for refusal to cooperate with other program requirements under subdivision 1, sanctions shall be imposed in the manner prescribed in this subdivision.

A participant who has had one or more sanctions imposed under this subdivision must remain in compliance with the provisions of this chapter for six months in order for a subsequent occurrence of noncompliance to be considered a first occurrence. Any vendor payment of shelter costs or utilities under this subdivision must remain in effect for six months after the month in which the participant is no longer subject to sanction under subdivision 1.

(b) If the participant was subject to sanction ~~for~~

~~(i) noncompliance under subdivision 1 before being subject to sanction for noncooperation under subdivision 2;~~  
or

~~(ii) noncooperation under subdivision 2 before being subject to sanction for noncompliance under subdivision 1;~~ under subdivision 1 or 2 before being subject to sanction under the other of those subdivisions, the participant shall be sanctioned as provided in subdivision 1, paragraph ~~(b)~~ (d), ~~clause clauses~~ (2) and (3), and the requirement that the county conduct a review as specified in subdivision 1, paragraph ~~(c)~~ (e), remains in effect.

(c) A participant who first becomes subject to sanction under both subdivisions 1 and 2 in the same month is subject to sanction as follows:

(i) in the first month of noncompliance and noncooperation, the participant's grant must be reduced by 25 percent of the applicable MFIP standard of need, with any residual amount paid to the participant;

(ii) in the second and subsequent months of noncompliance and noncooperation, the participant shall be sanctioned as provided in subdivision 1, paragraph ~~(b)~~ (d), ~~clause clauses~~ (2) and (3).

The requirement that the county conduct a review as specified in subdivision 1, paragraph ~~(c)~~ (e), remains in effect.

(d) A participant remains subject to sanction under subdivision 2 if the participant:

(i) returns to compliance and is no longer subject to sanction under subdivision 1; or

(ii) has the sanction under subdivision 1, paragraph ~~(b)~~ (d), removed upon completion of the review under subdivision 1, paragraph ~~(c)~~ (e).

A participant remains subject to sanction under subdivision 1, paragraph ~~(b)~~ (d), if the participant cooperates and is no longer subject to sanction under subdivision 2.

Sec. 19. Minnesota Statutes 2000, section 256J.46, is amended by adding a subdivision to read:

Subd. 3. [SANCTION STATUS AFTER DISQUALIFICATION.] An applicant who is a member of an assistance unit that was disqualified from receiving MFIP under subdivision 1, paragraph (d), clause (3), who applies for MFIP assistance within six months of the date of the disqualification, and who is determined to be eligible for MFIP assistance, is considered to have a first occurrence of noncompliance. An applicant who is a member of an assistance unit that was disqualified from MFIP under subdivision 1, paragraph (d), clause (3), a second or subsequent time, who applies for assistance within six months of the date of disqualification, and who is determined to be eligible for MFIP assistance, is considered to have a third occurrence of noncompliance. The applicant must remain in compliance with the provisions of this chapter for six months in order for a subsequent occurrence of noncompliance to be considered a first occurrence.



Sec. 20. Minnesota Statutes 2000, section 256J.50, subdivision 1, is amended to read:

Subdivision 1. [EMPLOYMENT AND TRAINING SERVICES COMPONENT OF MFIP.] (a) By January 1, 1998, each county must develop and implement an employment and training services component of MFIP which is designed to put participants on the most direct path to unsubsidized employment. Participation in these services is mandatory for all MFIP caregivers, unless the caregiver is exempt under section 256J.56.

(b) A county must provide employment and training services under sections 256J.515 to 256J.74 within 30 days after the caregiver's participation becomes mandatory under subdivision 5 or within 30 days of receipt of a request for services from a caregiver who under section 256J.42 is no longer eligible to receive MFIP but whose income is below 120 percent of the federal poverty guidelines for a family of the same size. The request must be made within 12 months of the date the caregivers' MFIP case was closed.

Sec. 21. Minnesota Statutes 2000, section 256J.50, subdivision 7, is amended to read:

Subd. 7. [LOCAL SERVICE UNIT PLAN.] (a) Each local or county service unit shall prepare and submit a plan as specified in section 268.88.

(b) The plan must include a description of how projects funded under the local intervention grants for self-sufficiency in section 256J.625, subdivisions 2 and 3, operate in the local service unit, including:

(1) the target populations of hard-to-employ participants ~~and~~ working participants in need of job retention and wage advancement services, and caregivers who, within the last 12 months, have been determined under section 256J.42 to no longer be eligible to receive MFIP and whose income is below 120 percent of the federal poverty guidelines for a family of the same size, with a description of how individual participant needs will be met;

(2) services that will be provided which may include paid work experience, enhanced mental health services, outreach to sanctioned families and to caregivers who, within the last 12 months, have been determined under section 256J.42 to no longer be eligible to receive MFIP but whose income is below 120 percent of the federal poverty guidelines for a family of the same size, child care for social services, child care transition year set-aside, homeless and housing advocacy, and transportation;

(3) projected expenditures by activity;

(4) anticipated program outcomes including the anticipated impact the intervention efforts will have on performance measures under section 256J.751 and on reducing the number of MFIP participants expected to reach their 60-month time limit; and

(5) a description of services that are provided or will be provided to MFIP participants affected by chemical dependency, mental health issues, learning disabilities, or family violence.

Each plan must demonstrate how the county or tribe is working within its organization and with other organizations in the community to serve hard-to-employ populations, including how organizations in the community were engaged in planning for use of these funds, services other entities will provide under the plan, and whether multicounty or regional strategies are being implemented as part of this plan.

(c) Activities and expenditures in the plan must enhance or supplement MFIP activities without supplanting existing activities and expenditures. However, this paragraph does not require a county to maintain either:

(1) its current provision of child care assistance to MFIP families through the expenditure of county resources under chapter 256E for social services child care assistance if funds are appropriated by another law for an MFIP social services child care pool;

(2) its current provision of transition-year child care assistance through the expenditure of county resources if funds are appropriated by another law for this purpose; or

(3) its current provision of intensive ESL programs through the expenditure of county resources if funds are appropriated by another law for intensive ESL grants.

(d) The plan required under this subdivision must be approved before the local or county service unit is eligible to receive funds under section 256J.625, subdivisions 2 and 3.

Sec. 22. Minnesota Statutes 2000, section 256J.56, is amended to read:

256J.56 [EMPLOYMENT AND TRAINING SERVICES COMPONENT; EXEMPTIONS.]

(a) An MFIP ~~caregiver~~ participant is exempt from the requirements of sections 256J.52 to 256J.55 if the ~~caregiver~~ participant belongs to any of the following groups:

(1) ~~individuals~~ participants who are age 60 or older;

(2) ~~individuals~~ participants who are suffering from a professionally certified permanent or temporary illness, injury, or incapacity which is expected to continue for more than 30 days and which prevents the person from obtaining or retaining employment. Persons in this category with a temporary illness, injury, or incapacity must be reevaluated at least quarterly;

(3) ~~caregivers~~ participants whose presence in the home is required because of the professionally certified illness or incapacity of another member in the assistance unit, a relative in the household, or a foster child in the household and the illness or incapacity is expected to continue for more than 30 days;

(4) women who are pregnant, if the pregnancy has resulted in a professionally certified incapacity that prevents the woman from obtaining or retaining employment;

(5) caregivers of a child under the age of one year who personally provide full-time care for the child. This exemption may be used for only 12 months in a lifetime. In two-parent households, only one parent or other relative may qualify for this exemption;

~~(6) individuals who are single parents, or one parent in a two-parent family, employed at least 35 hours per week;~~

~~(7) individuals~~ (6) participants experiencing a personal or family crisis that makes them incapable of participating in the program, as determined by the county agency. If the participant does not agree with the county agency's determination, the participant may seek professional certification, as defined in section 256J.08, that the participant is incapable of participating in the program.

Persons in this exemption category must be reevaluated every 60 days; or

~~(8) second parents in two-parent families employed for 20 or more hours per week, provided the first parent is employed at least 35 hours per week; or~~

~~(9)~~ (7) caregivers with a child or an adult in the household who meets the disability or medical criteria for home care services under section 256B.0627, subdivision 1, paragraph (c), or a home and community-based waiver services program under chapter 256B, or meets the criteria for severe emotional disturbance under section 245.4871, subdivision 6, or for serious and persistent mental illness under section 245.462, subdivision 20, paragraph (c). Caregivers in this exemption category are presumed to be prevented from obtaining or retaining employment.

A caregiver who is exempt under clause (5) must enroll in and attend an early childhood and family education class, a parenting class, or some similar activity, if available, during the period of time the caregiver is exempt under this section. Notwithstanding section 256J.46, failure to attend the required activity shall not result in the imposition of a sanction.

(b) The county agency must provide employment and training services to MFIP ~~caregivers~~ participants who are exempt under this section, but who volunteer to participate. Exempt volunteers may request approval for any work activity under section 256J.49, subdivision 13. The hourly participation requirements for nonexempt ~~caregivers~~ participants under section 256J.50, subdivision 5, do not apply to exempt ~~caregivers~~ participants who volunteer to participate.

Sec. 23. Minnesota Statutes 2000, section 256J.57, subdivision 2, is amended to read:

Subd. 2. [NOTICE OF INTENT TO SANCTION.] (a) When a participant fails without good cause to comply with the requirements of sections 256J.52 to 256J.55, the job counselor or the county agency must provide a notice of intent to sanction to the participant specifying the program requirements that were not complied with, informing the participant that the county agency will impose the sanctions specified in section 256J.46, and informing the participant of the opportunity to request a conciliation conference as specified in paragraph (b). The notice must also state that the participant's continuing noncompliance with the specified requirements will result in additional sanctions under section 256J.46, without the need for additional notices or conciliation conferences under this subdivision. The notice, written in English, must include the department of human services language block, and must be sent to every applicable participant. If the participant does not request a conciliation conference within ten calendar days of the mailing of the notice of intent to sanction, the job counselor must notify the county agency that the assistance payment should be reduced. The county must then send a notice of adverse action to the participant informing the participant of the sanction that will be imposed, the reasons for the sanction, the effective date of the sanction, and the participant's right to have a fair hearing under section 256J.40.

(b) The participant may request a conciliation conference by sending a written request, by making a telephone request, or by making an in-person request. The request must be received within ten calendar days of the date the county agency mailed the ten-day notice of intent to sanction. If a timely request for a conciliation is received, the county agency's service provider must conduct the conference within five days of the request. The job counselor's supervisor, or a designee of the supervisor, must review the outcome of the conciliation conference. If the conciliation conference resolves the noncompliance, the job counselor must promptly inform the county agency and request withdrawal of the sanction notice.

(c) Upon receiving a sanction notice, the participant may request a fair hearing under section 256J.40, without exercising the option of a conciliation conference. In such cases, the county agency shall not require the participant to engage in a conciliation conference prior to the fair hearing.

(d) If the participant requests a fair hearing or a conciliation conference, sanctions will not be imposed until there is a determination of noncompliance. Sanctions must be imposed as provided in section 256J.46.

Sec. 24. Minnesota Statutes 2000, section 256J.62, subdivision 9, is amended to read:

Subd. 9. [CONTINUATION OF CERTAIN SERVICES.] At the request of the ~~caregiver~~ participant, the county may continue to provide case management, counseling, or other support services to a participant ~~following the participant's achievement of:~~

(a) who has achieved the employment goal; or

(b) who under section 256J.42 is no longer eligible to receive MFIP.

These services may be provided for up to 12 months following termination of the participant's eligibility for MFIP.

A county may expend funds for a specific employment and training service for the duration of that service to a participant if the funds are obligated or expended prior to the participant losing MFIP eligibility.

Sec. 25. Minnesota Statutes 2000, section 256J.625, subdivision 1, is amended to read:

Subdivision 1. [ESTABLISHMENT; GUARANTEED MINIMUM ALLOCATION.] (a) The commissioner shall make grants under this subdivision to assist county and tribal TANF programs to more effectively serve hard-to-employ MFIP participants and participants who, within the last 12 months, have been determined under section 256J.42 to no longer be eligible to receive MFIP but whose income is below 120 percent of the federal poverty guidelines for a family of the same size. Funds appropriated for local intervention grants for self-sufficiency must be allocated first in amounts equal to the guaranteed minimum in paragraph (b), and second according to the provisions of subdivision 2. Any remaining funds must be allocated according to the formula in subdivision 3. Counties or tribes must have an approved local service unit plan under section 256J.50, subdivision 7, paragraph (b), in order to receive and expend funds under subdivisions 2 and 3.

(b) Each county or tribal program shall receive a guaranteed minimum annual allocation of \$25,000.

Sec. 26. Minnesota Statutes 2000, section 256J.625, subdivision 2, is amended to read:

Subd. 2. [SET-ASIDE FUNDS.] (a) Of the funds appropriated for grants under this section, after the allocation in subdivision 1, paragraph (b), is made, 20 percent of the remaining funds each year shall be retained by the commissioner and awarded to counties or tribes whose approved plans demonstrate additional need based on their identification of hard-to-employ families and, working participants in need of job retention and wage advancement services, and participants who, within the last 12 months, have been determined under section 256J.42 to no longer be eligible to receive MFIP but whose income is below 120 percent of the federal poverty guidelines for a family of same size, strong anticipated outcomes for families and an effective plan for monitoring performance, or, use of a multicounty, multi-entity or regional approach to serve hard-to-employ families and, working participants in need of job retention and wage advancement services, and participants who, within the last 12 months, have been determined under section 256J.42 to no longer be eligible to receive MFIP but whose income is below 120 percent of the federal poverty guidelines for a family of the same size, who are identified as a target population to be served in the plan submitted under section 256J.50, subdivision 7, paragraph (b). In distributing funds under this paragraph, the commissioner must achieve a geographic balance. The commissioner may award funds under this paragraph to other public, private, or nonprofit entities to deliver services in a county or region where the entity or entities submit a plan that demonstrates a strong capability to fulfill the terms of the plan and where the plan shows an innovative or multi-entity approach.

(b) For fiscal year 2001 only, of the funds available under this subdivision the commissioner must allocate funding in the amounts specified in article 1, section 2, subdivision 7, for an intensive intervention transitional employment training project and for nontraditional career assistance and training programs. These allocations must occur before any set-aside funds are allocated under paragraph (a).

Sec. 27. Minnesota Statutes 2000, section 256J.625, subdivision 4, is amended to read:

Subd. 4. [USE OF FUNDS.] (a) A county or tribal program may use funds allocated under this subdivision to provide services to MFIP participants who are hard-to-employ and their families. Services provided must be intended to reduce the number of MFIP participants who are expected to reach the 60-month time limit under section 256J.42. Counties, tribes, and other entities receiving funds under subdivision 2 or 3 must submit semiannual progress reports to the commissioner which detail program outcomes.

(b) Funds allocated under this section may not be used to provide benefits that are defined as "assistance" in Code of Federal Regulations, title 45, section 260.31, to an assistance unit that is only receiving the food portion of MFIP benefits or under section 256J.42 is no longer eligible to receive MFIP.

(c) A county may use funds allocated under this section for that part of the match for federal access to jobs transportation funds that is TANF-eligible. A county may also use funds allocated under this section to enhance transportation choices for eligible recipients up to 150 percent of the federal poverty guidelines.

Sec. 28. Minnesota Statutes 2000, section 256J.751, is amended to read:

256J.751 [COUNTY PERFORMANCE MANAGEMENT.]

~~(a)~~ Subdivision 1. [QUARTERLY COUNTY CASELOAD REPORT.] The commissioner shall report quarterly to ~~all counties~~ each county on the county's performance on the following measures:

~~(1) percent of MFIP caseload working in paid employment;~~

~~(2) percent number of MFIP caseload cases receiving only the food portion of assistance;~~

(2) number of child-only cases;

(3) number of minor caregivers;

(4) number of cases that are exempt from the 60-month time limit by the exemption category under section 256J.42;

(5) number of participants who are exempt from employment and training services requirements by the exemption category under section 256J.56;

(6) number of assistance units receiving assistance under a hardship extension under section 256J.425;

(7) number of participants and number of months spent in each level of sanction under section 256J.46, subdivision 1;

~~(8)~~ (8) number of MFIP cases that have left assistance;

~~(9)~~ (9) federal participation requirements as specified in title 1 of Public Law Number 104-193; and

~~(10)~~ (10) median placement wage rate; and

~~(11)~~ (11) of each county's total MFIP caseload less the number of cases in clauses (1) to (6):

(i) number of one-parent cases;

(ii) number of two-parent cases;

(iii) percent of one-parent cases that are working more than 20 hours per week;

(iv) percent of two-parent cases that are working more than 20 hours per week; and

(v) percent of cases that have received more than 36 months of assistance.

Subd. 2. [QUARTERLY COMPARISON REPORT.] The commissioner shall report quarterly to all counties on each county's performance on the following measures:

(1) percent of MFIP caseload working in paid employment;

(2) percent of MFIP caseload receiving only the food portion of assistance;

(3) number of MFIP cases that have left assistance;

(4) federal participation requirements as specified in Title 1 of Public Law Number 104-193;

(5) median placement wage rate; and

(6) caseload by months of TANF assistance.

Subd. 3. [ANNUAL REPORT.] The commissioner must report to all counties and to the legislature on each county's annual performance on the measures required under subdivision 1 by racial and ethnic group and, to the extent consistent with state and federal law, must include each county's performance on:

(1) the number of out-of-wedlock births and births to teen mothers; and

(2) number of cases by racial and ethnic group.

The report must be completed by January 1, 2002, and January 1 of each year thereafter and must comply with sections 3.195 and 3.197.

Subd. 4. [DEVELOPMENT OF PERFORMANCE MEASURES.] By January 1, 2002, the commissioner shall, in consultation with counties, develop measures for county performance in addition to those in ~~paragraph (a)~~ subdivision 1 and 2. In developing these measures, the commissioner must consider:

(1) a measure for MFIP cases that leave assistance due to employment;

(2) job retention after participants leave MFIP; and

(3) participant's earnings at a follow-up point after the participant has left MFIP; and

(4) the appropriateness of services provided to minority groups.

~~(c)~~ Subd. 5. [FAILURE TO MEET FEDERAL PERFORMANCE STANDARDS.] (a) If sanctions occur for failure to meet the performance standards specified in title 1 of Public Law Number 104-193 of the Personal Responsibility and Work Opportunity Act of 1996, the state shall pay 88 percent of the sanction. The remaining 12 percent of the sanction will be paid by the counties. The county portion of the sanction will be distributed across all counties in proportion to each county's percentage of the MFIP average monthly caseload during the period for which the sanction was applied.

~~(d)~~ (b) If a county fails to meet the performance standards specified in title 1 of Public Law Number 104-193 of the Personal Responsibility and Work Opportunity Act of 1996 for any year, the commissioner shall work with counties to organize a joint state-county technical assistance team to work with the county. The commissioner shall coordinate any technical assistance with other departments and agencies including the departments of economic security and children, families, and learning as necessary to achieve the purpose of this paragraph.

Sec. 29. Minnesota Statutes 2000, section 256K.25, subdivision 1, is amended to read:

Subdivision 1. [ESTABLISHMENT AND PURPOSE.] (a) The commissioner shall establish a supportive housing and managed care pilot project in two counties, one within the seven-county metropolitan area and one outside of that area, to determine whether the integrated delivery of employment services, supportive services, housing, and health care into a single, flexible program will:

(1) reduce public expenditures on homeless families with minor children, homeless noncustodial parents, and other homeless individuals;

(2) increase the employment rates of these persons; and

(3) provide a new alternative to providing services to this hard-to-serve population.

(b) The commissioner shall create a program for counties for the purpose of providing integrated intensive and individualized case management services, employment services, health care services, rent subsidies or other short- or medium-term housing assistance, and other supportive services to eligible families and individuals. Minimum project and application requirements shall be developed by the commissioner in cooperation with counties and their nonprofit partners with the goal to provide the maximum flexibility in program design.

(c) Services available under this project must be coordinated with available health care services for an eligible project participant.

Sec. 30. Minnesota Statutes 2000, section 256K.25, subdivision 3, is amended to read:

Subd. 3. [COUNTY ELIGIBILITY.] (a) A county may request funding under this pilot project if the county:

(1) agrees to develop, in cooperation with nonprofit partners, a supportive housing and managed care pilot project that integrates the delivery of employment services, supportive services, housing and health care for eligible families and individuals, or agrees to contract with an existing integrated program;

(2) for eligible participants who are also MFIP recipients, agrees to develop, in cooperation with nonprofit partners, procedures to ensure that the services provided under the pilot project are closely coordinated with the services provided under MFIP; ~~and~~

(3) develops a method for evaluating the quality of the integrated services provided and the amount of any resulting cost savings to the county and state; and

(4) addresses in the pilot design the prevalence in the homeless population served those individuals with mental illness, a history of substance abuse, or HIV.

(b) Preference may be given to counties that cooperate with other counties participating in the pilot project for purposes of evaluation and counties that provide additional funding.

Sec. 31. Minnesota Statutes 2000, section 256K.25, subdivision 4, is amended to read:

Subd. 4. [PARTICIPANT ELIGIBILITY.] (a) In order to ~~be eligible~~ meet initial eligibility criteria for the pilot project, the county must determine that a participant is homeless or is at risk of homelessness; ~~has a mental illness, a history of substance abuse, or HIV~~; and is a family that meets the criteria in paragraph (b) or is an individual who meets the criteria in paragraph (c).

(b) An eligible family must include a minor child or a pregnant woman, and:

(1) be receiving or be eligible for MFIP assistance under chapter 256J; or

(2) include an adult caregiver who is employed or is receiving employment and training services, and have household income below the MFIP exit level in section 256J.24, subdivision 10.

(c) An eligible individual must:

(1) meet the eligibility requirements of the group residential housing program under section 256I.04, subdivision 1; or

(2) be a noncustodial parent who is employed or is receiving employment and training services, and have household income below the MFIP exit level in section 256J.24, subdivision 10.

(d) Counties participating in the pilot project may develop and initiate disenrollment criteria, subject to approval by the commissioner of human services.

Sec. 32. Minnesota Statutes 2000, section 256K.25, subdivision 5, is amended to read:

Subd. 5. [FUNDING.] A county may request funding from the commissioner for a specified number of TANF-eligible project participants. The commissioner shall review the request for compliance with subdivisions 1 to 4 and may approve or disapprove the request. If other funds are available, the commissioner may allocate funding for project participants who meet the eligibility requirements of subdivision 4, paragraph (c). The commissioner may also redirect funds to the pilot project.

Sec. 33. Minnesota Statutes 2000, section 256K.25, subdivision 6, is amended to read:

Subd. 6. [REPORT.] Participating counties and the commissioner shall collaborate to prepare and issue an annual report, beginning December 1, 2001, to the chairs of the appropriate legislative committees on the pilot project's use of public resources, including other funds leveraged for this initiative; and an assessment of the feasibility of financing the pilot through other health and human services programs, the employment and housing status of the families and individuals served in the project, and the cost-effectiveness of the project. The annual report must also evaluate the pilot project with respect to the following project goals: that participants will lead more productive, healthier, more stable and better quality lives; that the teams created under the project to deliver services for each project participant will be accountable for ensuring that services are more appropriate, cost-effective and well-coordinated; and that the system-wide costs of serving this population, and the inappropriate use of emergency, crisis-oriented or institutional services, will be materially reduced. The commissioner shall provide data that may be needed to evaluate the project to participating counties that request the data.

Sec. 34. Minnesota Statutes 2000, section 268.0122, subdivision 2, is amended to read:

Subd. 2. [SPECIFIC POWERS.] The commissioner of economic security shall:

(1) administer and supervise all forms of unemployment benefits provided for under federal and state laws that are vested in the commissioner, including make investigations and audits, secure and transmit information, and make available services and facilities as the commissioner considers necessary or appropriate to facilitate the administration of any other states, or the federal Economic Security Law, and accept and use information, services, and facilities made available by other states or the federal government;

(2) administer and supervise all employment and training services assigned to the department under federal or state law;

(3) review and comment on local service unit plans and community investment program plans and approve or disapprove the plans;

(4) establish and maintain administrative units necessary to perform administrative functions common to all divisions of the department;

(5) supervise the county boards of commissioners, local service units, and any other units of government designated in federal or state law as responsible for employment and training programs;

(6) establish administrative standards and payment conditions for providers of employment and training services;

(7) act as the agent of, and cooperate with, the federal government in matters of mutual concern, including the administration of any federal funds granted to the state to aid in the performance of functions of the commissioner;



(8) obtain reports from local service units and service providers for the purpose of evaluating the performance of employment and training services; ~~and~~

(9) review and comment on plans for Indian tribe employment and training services and approve or disapprove the plans; and

(10) require all general employment and training programs that receive state funds to make available information about opportunities for women in nontraditional careers in the trades and technical occupations.

Sec. 35. Laws 1997, chapter 203, article 9, section 21, as amended by Laws 1998, chapter 407, article 6, section 111, and Laws 2000, chapter 488, article 10, section 28, is amended to read:

Sec. 21. [INELIGIBILITY FOR STATE FUNDED PROGRAMS.]

(a) Effective on the date specified, the following persons will be ineligible for general assistance and general assistance medical care under Minnesota Statutes, chapter 256D, group residential housing under Minnesota Statutes, chapter 256I, and MFIP assistance under Minnesota Statutes, chapter 256J, funded with state money:

(1) Beginning July 1, 2002, persons who are terminated from or denied Supplemental Security Income due to the 1996 changes in the federal law making persons whose alcohol or drug addiction is a material factor contributing to the person's disability ineligible for Supplemental Security Income, and are eligible for general assistance under Minnesota Statutes, section 256D.05, subdivision 1, paragraph (a), clause (15), general assistance medical care under Minnesota Statutes, chapter 256D, or group residential housing under Minnesota Statutes, chapter 256I;

(2) Beginning July 1, 2002, legal noncitizens who are ineligible for Supplemental Security Income due to the 1996 changes in federal law making certain noncitizens ineligible for these programs due to their noncitizen status; and

(3) Beginning July 1, ~~2001~~ 2002, legal noncitizens who are eligible for MFIP assistance, either the cash assistance portion or the food assistance portion, funded entirely with state money.

(b) State money that remains unspent due to changes in federal law enacted after May 12, 1997, that reduce state spending for legal noncitizens or for persons whose alcohol or drug addiction is a material factor contributing to the person's disability, or enacted after February 1, 1998, that reduce state spending for food benefits for legal noncitizens shall not cancel and shall be deposited in the TANF reserve account.

Sec. 36. [REPORT ON ASSESSMENT OF COUNTY PERFORMANCE.]

By January 15, 2003, the commissioner, in consultation with counties, must report to the chairs of the house and senate committees having jurisdiction over human services, on a proposal for assessing county performance using a methodology that controls for demographic, economic, and other variables that may impact county achievement of MFIP performance outcomes. The proposal must recommend how state and federal funds may be allocated to counties to encourage and reward high performance.

Sec. 37. [REPEALER.]

Minnesota Statutes 2000, sections 256J.42, subdivision 4; 256J.44; and 256J.46, subdivision 1a, are repealed.

ARTICLE 11

DHS LICENSING

Section 1. Minnesota Statutes 2000, section 13.46, subdivision 4, is amended to read:

Subd. 4. [LICENSING DATA.] (a) As used in this subdivision:

(1) "licensing data" means all data collected, maintained, used, or disseminated by the welfare system pertaining to persons licensed or registered or who apply for licensure or registration or who formerly were licensed or registered under the authority of the commissioner of human services;

(2) "client" means a person who is receiving services from a licensee or from an applicant for licensure; and

(3) "personal and personal financial data" means social security numbers, identity of and letters of reference, insurance information, reports from the bureau of criminal apprehension, health examination reports, and social/home studies.

(b)(1) Except as provided in paragraph (c), the following data on current and former licensees are public: name, address, telephone number of licensees, licensed capacity, type of client preferred, variances granted, type of dwelling, name and relationship of other family members, previous license history, class of license, and the existence and status of complaints. When disciplinary action has been taken against a licensee or the complaint is resolved, the following data are public: the substance of the complaint, the findings of the investigation of the complaint, the record of informal resolution of a licensing violation, orders of hearing, findings of fact, conclusions of law, and specifications of the final disciplinary action contained in the record of disciplinary action.

(2) The following data on persons subject to disqualification under section 245A.04 in connection with a license to provide family day care for children, child care center services, foster care for children in the provider's home, or foster care or day care services for adults in the provider's home, are public: the nature of any disqualification set aside under section 245A.04, subdivision 3b, and the reasons for setting aside the disqualification; and the reasons for granting any variance under section 245A.04, subdivision 9.

(3) When maltreatment is substantiated under section 626.556 or 626.557 and the victim and the substantiated perpetrator are affiliated with a program licensed under chapter 245A, the commissioner of human services, local social services agency, or county welfare agency may inform the license holder where the maltreatment occurred of the identity of the substantiated perpetrator and the victim.

(c) The following are private data on individuals under section 13.02, subdivision 12, or nonpublic data under section 13.02, subdivision 9: personal and personal financial data on family day care program and family foster care program applicants and licensees and their family members who provide services under the license.

(d) The following are private data on individuals: the identity of persons who have made reports concerning licensees or applicants that appear in inactive investigative data, and the records of clients or employees of the licensee or applicant for licensure whose records are received by the licensing agency for purposes of review or in anticipation of a contested matter. The names of reporters under sections 626.556 and 626.557 may be disclosed only as provided in section 626.556, subdivision 11, or 626.557, subdivision 12b.

(e) Data classified as private, confidential, nonpublic, or protected nonpublic under this subdivision become public data if submitted to a court or administrative law judge as part of a disciplinary proceeding in which there is a public hearing concerning the disciplinary action.

(f) Data generated in the course of licensing investigations that relate to an alleged violation of law are investigative data under subdivision 3.

(g) Data that are not public data collected, maintained, used, or disseminated under this subdivision that relate to or are derived from a report as defined in section 626.556, subdivision 2, are subject to the destruction provisions of section 626.556, subdivision 11.

(h) Upon request, not public data collected, maintained, used, or disseminated under this subdivision that relate to or are derived from a report of substantiated maltreatment as defined in section 626.556 or 626.557 may be exchanged with the department of health for purposes of completing background studies pursuant to section 144.057.

(i) Data on individuals collected according to licensing activities under chapter 245A, and data on individuals collected by the commissioner of human services according to maltreatment investigations under sections 626.556 and 626.557, may be shared with the department of human rights, the department of health, the department of corrections, the ombudsman for mental health and retardation, and the individual's professional regulatory board when there is reason to believe that laws or standards under the jurisdiction of those agencies may have been violated.

(j) In addition to the notice of determinations required under section 626.556, subdivision 10f, if the commissioner or the local social services agency has determined that an individual is a substantiated perpetrator of maltreatment of a child based on sexual abuse, as defined in section 626.556, subdivision 2, and the commissioner or local social services agency knows that the individual is a person responsible for a child's care in another facility, the commissioner or local social services agency shall notify the head of that facility of this determination. The notification must include an explanation of the individual's available appeal rights and the status of any appeal. If a notice is given under this paragraph, the government entity making the notification shall provide a copy of the notice to the individual who is the subject of the notice.

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

Sec. 2. Minnesota Statutes 2000, section 144.057, is amended to read:

144.057 [BACKGROUND STUDIES ON LICENSEES AND SUPPLEMENTAL NURSING SERVICES AGENCY PERSONNEL.]

Subdivision 1. [BACKGROUND STUDIES REQUIRED.] The commissioner of health shall contract with the commissioner of human services to conduct background studies of:

(1) individuals providing services which have direct contact, as defined under section 245A.04, subdivision 3, with patients and residents in hospitals, boarding care homes, outpatient surgical centers licensed under sections 144.50 to 144.58; nursing homes and home care agencies licensed under chapter 144A; residential care homes licensed under chapter 144B, and board and lodging establishments that are registered to provide supportive or health supervision services under section 157.17; ~~and~~

(2) beginning July 1, 1999, all other employees in nursing homes licensed under chapter 144A, and boarding care homes licensed under sections 144.50 to 144.58. A disqualification of an individual in this section shall disqualify the individual from positions allowing direct contact or access to patients or residents receiving services;

(3) individuals employed by a supplemental nursing services agency, as defined under section 144A.70, who are providing services in health care facilities; and

(4) controlling persons of a supplemental nursing services agency, as defined under section 144A.70.

If a facility or program is licensed by the department of human services and subject to the background study provisions of chapter 245A and is also licensed by the department of health, the department of human services is solely responsible for the background studies of individuals in the jointly licensed programs.

Subd. 2. [RESPONSIBILITIES OF DEPARTMENT OF HUMAN SERVICES.] The department of human services shall conduct the background studies required by subdivision 1 in compliance with the provisions of chapter 245A and Minnesota Rules, parts 9543.3000 to 9543.3090. For the purpose of this section, the term "residential program" shall include all facilities described in subdivision 1. The department of human services shall provide necessary forms and instructions, shall conduct the necessary background studies of individuals, and shall provide notification of the results of the studies to the facilities, supplemental nursing services agencies, individuals, and the commissioner of health. Individuals shall be disqualified under the provisions of chapter 245A and Minnesota Rules, parts 9543.3000 to 9543.3090. If an individual is disqualified, the department of human services shall notify the facility, the supplemental nursing services agency, and the individual and shall inform the individual of the right to request a reconsideration of the disqualification by submitting the request to the department of health.

Subd. 3. [RECONSIDERATIONS.] The commissioner of health shall review and decide reconsideration requests, including the granting of variances, in accordance with the procedures and criteria contained in chapter 245A and Minnesota Rules, parts 9543.3000 to 9543.3090. The commissioner's decision shall be provided to the individual and to the department of human services. The commissioner's decision to grant or deny a reconsideration of disqualification is the final administrative agency action, except for the provisions under section 245A.04, subdivisions 3b, paragraphs (e) and (f); and 3c, paragraph (a).

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

Subd. 4. [RESPONSIBILITIES OF FACILITIES AND AGENCIES.] Facilities and agencies described in subdivision 1 shall be responsible for cooperating with the departments in implementing the provisions of this section. The responsibilities imposed on applicants and licensees under chapter 245A and Minnesota Rules, parts 9543.3000 to 9543.3090, shall apply to these facilities and supplemental nursing services agencies. The provision of section 245A.04, subdivision 3, paragraph (e), shall apply to applicants, licensees, registrants, or an individual's refusal to cooperate with the completion of the background studies. Supplemental nursing services agencies subject to the registration requirements in section 144A.71 must maintain records verifying compliance with the background study requirements under this section.

Sec. 3. Minnesota Statutes 2000, section 214.104, is amended to read:

214.104 [HEALTH-RELATED LICENSING BOARDS; DETERMINATIONS REGARDING ~~DISQUALIFICATIONS FOR MALTREATMENT.~~]

(a) A health-related licensing board shall make determinations as to whether licensees regulated persons who are under the board's jurisdiction should be ~~disqualified under section 245A.04, subdivision 3d, from positions allowing direct contact with persons receiving services the subject of disciplinary or corrective action~~ because of substantiated maltreatment under section 626.556 or 626.557. ~~A determination under this section may be done as part of an investigation under section 214.103.~~ The board shall make a determination within 90 days of upon receipt, and after the review, of an investigation memorandum or other notice of substantiated maltreatment under section 626.556 or 626.557, or of a notice from the commissioner of human services that a background study of a licensee regulated person shows substantiated maltreatment. ~~The board shall also make a determination under this section upon consideration of the licensure of an individual who was subject to disqualification before licensure because of substantiated maltreatment.~~

~~(b) In making a determination under this section, the board shall consider the nature and extent of any injury or harm resulting from the conduct that would constitute grounds for disqualification, the seriousness of the misconduct, the extent that disqualification is necessary to protect persons receiving services or the public, and other factors specified in section 245A.04, subdivision 3b, paragraph (b).~~

~~(c) The board shall determine the duration and extent of the disqualification or may establish conditions under which the licensee may hold a position allowing direct contact with persons receiving services or in a licensed facility.~~

(b) Upon completion of its review of a report of substantiated maltreatment, the board shall notify the commissioner of human services ~~and the lead agency that conducted an investigation under section 626.556 or 626.557, as applicable,~~ of its determination. The board shall notify the commissioner of human services if, following a review of the report of substantiated maltreatment, the board determines that it does not have jurisdiction in the matter and the commissioner shall make the appropriate disqualification decision regarding the regulated person as otherwise provided in chapter 245A. The board shall also notify the commissioner of health or the commissioner of human services immediately upon receipt of knowledge of a facility or program allowing a regulated person to provide direct contact services at the facility or program while not complying with requirements placed on the regulated person.

(c) In addition to any other remedy provided by law, the board may, through its designated board member, temporarily suspend the license of a licensee; deny a credential to an applicant; or require the regulated person to be continuously supervised, if the board finds there is probable cause to believe the regulated person referred to the board according to paragraph (a) poses an immediate risk of harm to vulnerable persons. The board shall consider all relevant information available, which may include but is not limited to:

- (1) the extent the action is needed to protect persons receiving services or the public;
- (2) the recency of the maltreatment;
- (3) the number of incidents of maltreatment;
- (4) the intrusiveness or violence of the maltreatment; and
- (5) the vulnerability of the victim of maltreatment.

The action shall take effect upon written notice to the regulated person, served by certified mail, specifying the statute violated. The board shall notify the commissioner of health or the commissioner of human services of the suspension or denial of a credential. The action shall remain in effect until the board issues a temporary stay or a final order in the matter after a hearing or upon agreement between the board and the regulated person. At the time the board issues the notice, the regulated person shall inform the board of all settings in which the regulated person is employed or practices and the board shall inform all known employment and practice settings of the board action and schedule a disciplinary hearing to be held under chapter 14. The board shall provide the regulated person with at least 30 days' notice of the hearing, unless the parties agree to a hearing date that provides less than 30 days notice, and shall schedule the hearing to begin no later than 90 days after issuance of the notice of hearing.

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

Sec. 4. Minnesota Statutes 2000, section 245A.03, subdivision 2b, is amended to read:

Subd. 2b. [EXCEPTION.] The provision in subdivision 2, clause (2), does not apply to:

(1) a child care provider who as an applicant for licensure or as a license holder has received a license denial under section 245A.05, a ~~fine~~ conditional license under section 245A.06, or a sanction under section 245A.07 from the commissioner that has not been reversed on appeal; or

(2) a child care provider, or a child care provider who has a household member who, as a result of a licensing process, has a disqualification under this chapter that has not been set aside by the commissioner.

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

Sec. 5. Minnesota Statutes 2000, section 245A.04, subdivision 3a, is amended to read:

Subd. 3a. [NOTIFICATION TO SUBJECT AND LICENSE HOLDER OF STUDY RESULTS; DETERMINATION OF RISK OF HARM.] (a) The commissioner shall notify the applicant ~~or~~ license holder, or registrant and the individual who is the subject of the study, in writing or by electronic transmission, of the results of the study. When the study is completed, a notice that the study was undertaken and completed shall be maintained in the personnel files of the program. For studies on individuals pertaining to a license to provide family day care or group family day care, foster care for children in the provider's own home, or foster care or day care services for adults in the provider's own home, the commissioner is not required to provide a separate notice of the background study results to the individual who is the subject of the study unless the study results in a disqualification of the individual.

The commissioner shall notify the individual studied if the information in the study indicates the individual is disqualified from direct contact with persons served by the program. The commissioner shall disclose the information causing disqualification and instructions on how to request a reconsideration of the disqualification to the individual studied. An applicant or license holder who is not the subject of the study shall be informed that the commissioner has found information that disqualifies the subject from direct contact with persons served by the program. However, only the individual studied must be informed of the information contained in the subject's background study unless the only basis for the disqualification is failure to cooperate, substantiated maltreatment under section 626.556 or 626.557, the Data Practices Act provides for release of the information, or the individual studied authorizes the release of the information. When a disqualification is based on the subject's failure to cooperate with the background study or substantiated maltreatment under section 626.556 or 626.557, the agency that initiated the study shall be informed by the commissioner of the reason for the disqualification.

(b) Except as provided in subdivision 3d, paragraph (b), if the commissioner determines that the individual studied has a disqualifying characteristic, the commissioner shall review the information immediately available and make a determination as to the subject's immediate risk of harm to persons served by the program where the individual studied will have direct contact. The commissioner shall consider all relevant information available, including the following factors in determining the immediate risk of harm: the recency of the disqualifying characteristic; the recency of discharge from probation for the crimes; the number of disqualifying characteristics; the intrusiveness or violence of the disqualifying characteristic; the vulnerability of the victim involved in the disqualifying characteristic; and the similarity of the victim to the persons served by the program where the individual studied will have direct contact. The commissioner may determine that the evaluation of the information immediately available gives the commissioner reason to believe one of the following:

(1) The individual poses an imminent risk of harm to persons served by the program where the individual studied will have direct contact. If the commissioner determines that an individual studied poses an imminent risk of harm to persons served by the program where the individual studied will have direct contact, the individual and the license holder must be sent a notice of disqualification. The commissioner shall order the license holder to immediately remove the individual studied from direct contact. The notice to the individual studied must include an explanation of the basis of this determination.

(2) The individual poses a risk of harm requiring continuous supervision while providing direct contact services during the period in which the subject may request a reconsideration. If the commissioner determines that an individual studied poses a risk of harm that requires continuous supervision, the individual and the license holder must be sent a notice of disqualification. The commissioner shall order the license holder to immediately remove the individual studied from direct contact services or assure that the individual studied is within sight or hearing of another staff person when providing direct contact services during the period in which the individual may request a reconsideration of the disqualification. If the individual studied does not submit a timely request for reconsideration, or the individual submits a timely request for reconsideration, but the disqualification is not set aside for that license holder, the license holder will be notified of the disqualification and ordered to immediately remove the individual from any position allowing direct contact with persons receiving services from the license holder.

(3) The individual does not pose an imminent risk of harm or a risk of harm requiring continuous supervision while providing direct contact services during the period in which the subject may request a reconsideration. If the commissioner determines that an individual studied does not pose a risk of harm that requires continuous supervision, only the individual must be sent a notice of disqualification. The license holder must be sent a notice that more time is needed to complete the individual's background study. If the individual studied submits a timely request for reconsideration, and if the disqualification is set aside for that license holder, the license holder will receive the same notification received by license holders in cases where the individual studied has no disqualifying characteristic. If the individual studied does not submit a timely request for reconsideration, or the individual submits a timely request for reconsideration, but the disqualification is not set aside for that license holder, the license holder will be notified of the disqualification and ordered to immediately remove the individual from any position allowing direct contact with persons receiving services from the license holder.

(c) County licensing agencies performing duties under this subdivision may develop an alternative system for determining the subject's immediate risk of harm to persons served by the program, providing the notices under paragraph (b), and documenting the action taken by the county licensing agency. Each county licensing agency's implementation of the alternative system is subject to approval by the commissioner. Notwithstanding this alternative system, county licensing agencies shall complete the requirements of paragraph (a).

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

Sec. 6. Minnesota Statutes 2000, section 245A.04, subdivision 3b, is amended to read:

Subd. 3b. [RECONSIDERATION OF DISQUALIFICATION.] (a) The individual who is the subject of the disqualification may request a reconsideration of the disqualification.

The individual must submit the request for reconsideration to the commissioner in writing. A request for reconsideration for an individual who has been sent a notice of disqualification under subdivision 3a, paragraph (b), clause (1) or (2), must be submitted within 30 calendar days of the disqualified individual's receipt of the notice of disqualification. A request for reconsideration for an individual who has been sent a notice of disqualification under subdivision 3a, paragraph (b), clause (3), must be submitted within 15 calendar days of the disqualified individual's receipt of the notice of disqualification. An individual who was determined to have maltreated a child under section 626.556 or a vulnerable adult under section 626.557, and who was disqualified under this section on the basis of serious or recurring maltreatment, may request reconsideration of both the maltreatment and the disqualification determinations. The request for reconsideration of the maltreatment determination and the disqualification must be submitted within 30 calendar days of the individual's receipt of the notice of disqualification. Removal of a disqualified individual from direct contact shall be ordered if the individual does not request reconsideration within the prescribed time, and for an individual who submits a timely request for reconsideration, if the disqualification is not set aside. The individual must present information showing that:

(1) the information the commissioner relied upon is incorrect or inaccurate. If the basis of a reconsideration request is that a maltreatment determination or disposition under section 626.556 or 626.557 is incorrect, and the commissioner has issued a final order in an appeal of that determination or disposition under section 256.045 or 245A.08, subdivision 5, the commissioner's order is conclusive on the issue of maltreatment. If the individual did not request reconsideration of the maltreatment determination, the maltreatment determination is deemed conclusive; or

(2) the subject of the study does not pose a risk of harm to any person served by the applicant ~~or~~<sub>2</sub> license holder<sub>2</sub> or registrant.

(b) The commissioner shall rescind the disqualification if the commissioner finds that the information relied on to disqualify the subject is incorrect. The commissioner may set aside the disqualification under this section if the commissioner finds that the ~~information the commissioner relied upon is incorrect or the~~ individual does not pose a risk of harm to any person served by the applicant ~~or~~<sub>2</sub> license holder<sub>2</sub> 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~~<sub>2</sub> applicant<sub>2</sub> or registrant over the interests of the license holder ~~or~~<sub>2</sub> applicant<sub>2</sub> or registrant.

(c) Unless the information the commissioner relied on in disqualifying an individual is incorrect, the commissioner may not set aside the disqualification of an individual in connection with a license to provide family day care for children, foster care for children in the provider's own home, or foster care or day care services for adults in the provider's own home if:

(1) less than ten years have passed since the discharge of the sentence imposed for the offense; and the individual has been convicted of a violation of any offense listed in sections 609.20 (manslaughter in the first degree), 609.205 (manslaughter in the second degree), criminal vehicular homicide under 609.21 (criminal vehicular homicide and injury), 609.215 (aiding suicide or aiding attempted suicide), felony violations under 609.221 to 609.2231 (assault in the first, second, third, or fourth degree), 609.713 (terroristic threats), 609.235 (use of drugs to injure or to facilitate crime), 609.24 (simple robbery), 609.245 (aggravated robbery), 609.25 (kidnapping), 609.255 (false imprisonment), 609.561 or 609.562 (arson in the first or second degree), 609.71 (riot), burglary in the first or second degree under 609.582 (burglary), 609.66 (dangerous weapon), 609.665 (spring guns), 609.67 (machine guns and short-barreled shotguns), 609.749 (harassment; stalking), 152.021 or 152.022 (controlled substance crime in the first or second degree), 152.023, subdivision 1, clause (3) or (4), or subdivision 2, clause (4) (controlled substance crime in the third degree), 152.024, subdivision 1, clause (2), (3), or (4) (controlled substance crime in the fourth degree), 609.224, subdivision 2, paragraph (c) (fifth-degree assault by a caregiver against a vulnerable adult), 609.228 (great bodily harm caused by distribution of drugs), 609.23 (mistreatment of persons confined), 609.231 (mistreatment of residents or patients), 609.2325 (criminal abuse of a vulnerable adult), 609.233 (criminal neglect of a vulnerable adult), 609.2335 (financial exploitation of a vulnerable adult), 609.234 (failure to report), 609.265 (abduction), 609.2664 to 609.2665 (manslaughter of an unborn child in the first or second degree), 609.267 to 609.2672 (assault of an unborn child in the first, second, or third degree), 609.268 (injury or death of an unborn child in the commission of a crime), 617.293 (disseminating or displaying harmful material to minors), a gross misdemeanor offense under 609.324, subdivision 1 (other prohibited acts), a gross misdemeanor offense under 609.378 (neglect or endangerment of a child), a gross misdemeanor offense under 609.377 (malicious punishment of a child), 609.72, subdivision 3 (disorderly conduct against a vulnerable adult); or an attempt or conspiracy to commit any of these offenses, as each of these offenses is defined in Minnesota Statutes; or an offense in any other state, the elements of which are substantially similar to the elements of any of the foregoing offenses;

(2) regardless of how much time has passed since the discharge of the sentence imposed for the offense, the individual was convicted of a violation of any offense listed in sections 609.185 to 609.195 (murder in the first, second, or third degree), 609.2661 to 609.2663 (murder of an unborn child in the first, second, or third degree), a felony offense under 609.377 (malicious punishment of a child), a felony offense under 609.324, subdivision 1 (other prohibited acts), a felony offense under 609.378 (neglect or endangerment of a child), 609.322 (solicitation, inducement, and promotion of prostitution), 609.342 to 609.345 (criminal sexual conduct in the first, second, third, or fourth degree), 609.352 (solicitation of children to engage in sexual conduct), 617.246 (use of minors in a sexual performance), 617.247 (possession of pictorial representations of a minor), 609.365 (incest), a felony offense under sections 609.2242 and 609.2243 (domestic assault), a felony offense of spousal abuse, a felony offense of child abuse or neglect, a felony offense of a crime against children, or an attempt or conspiracy to commit any of these offenses as defined in Minnesota Statutes, or an offense in any other state, the elements of which are substantially similar to any of the foregoing offenses;

(3) within the seven years preceding the study, the individual committed an act that constitutes maltreatment of a child under section 626.556, subdivision 10e, and that resulted in substantial bodily harm as defined in section 609.02, subdivision 7a, or substantial mental or emotional harm as supported by competent psychological or psychiatric evidence; or

(4) within the seven years preceding the study, the individual was determined under section 626.557 to be the perpetrator of a substantiated incident of maltreatment of a vulnerable adult that resulted in substantial bodily harm as defined in section 609.02, subdivision 7a, or substantial mental or emotional harm as supported by competent psychological or psychiatric evidence.

In the case of any ground for disqualification under clauses (1) to (4), if the act was committed by an individual other than the applicant or, license holder, or registrant residing in the applicant's or, license holder's, or registrant's home, the applicant or, license holder, or registrant may seek reconsideration when the individual who committed the act no longer resides in the home.



The disqualification periods provided under clauses (1), (3), and (4) are the minimum applicable disqualification periods. The commissioner may determine that an individual should continue to be disqualified from licensure or registration because the license holder ~~or~~, applicant, or registrant poses a risk of harm to a person served by that individual after the minimum disqualification period has passed.

(d) The commissioner shall respond in writing or by electronic transmission to all reconsideration requests for which the basis for the request is that the information relied upon by the commissioner to disqualify is incorrect or inaccurate within 30 working days of receipt of a request and all relevant information. If the basis for the request is that the individual does not pose a risk of harm, the commissioner shall respond to the request within 15 working days after receiving the request for reconsideration and all relevant information. If the request is based on both the correctness or accuracy of the information relied on to disqualify the individual and the risk of harm, the commissioner shall respond to the request within 45 working days after receiving the request for reconsideration and all relevant information. If the disqualification is set aside, the commissioner shall notify the applicant or license holder in writing or by electronic transmission of the decision.

(e) Except as provided in subdivision 3c, ~~the commissioner's decision to disqualify an individual, including the decision to grant or deny a rescission or set aside a disqualification under this section, is the final administrative action and shall not be subject to further review in a contested case under chapter 14 involving a negative licensing appeal taken in response to the disqualification or involving an accuracy and completeness appeal under section 13.04; if a disqualification is not set aside or is not rescinded, an individual who was disqualified on the basis of a preponderance of evidence that the individual committed an act or acts that meet the definition of any of the crimes lists in subdivision 3d, paragraph (a), clauses (1) to (4); or for failure to make required reports under section 626.556, subdivision 3, or 626.557, subdivision 3, pursuant to subdivision 3d, paragraph (a), clause (4), may request a fair hearing under section 256.045. Except as provided under subdivision 3c, the commissioner's final order for an individual under this paragraph is conclusive on the issue of disqualification, including for purposes of subsequent studies conducted under section 245A.04, subdivision 3, and is the only administrative appeal of the final agency determination, specifically, including a challenge to the accuracy and completeness of data under section 13.04.~~

(f) Except as provided under subdivision 3c, if an individual was disqualified on the basis of a determination of maltreatment under section 626.556 or 626.557, which was serious or recurring, and the individual has requested reconsideration of the maltreatment determination under section 626.556, subdivision 10i, or 626.557, subdivision 9d, and also requested reconsideration of the disqualification under this subdivision, reconsideration of the maltreatment determination and reconsideration of the disqualification shall be consolidated into a single reconsideration. For maltreatment and disqualification determinations made by county agencies, the consolidated reconsideration shall be conducted by the county agency. Except as provided under subdivision 3c, if an individual who was disqualified on the basis of serious or recurring maltreatment requests a fair hearing on the maltreatment determination under section 626.556, subdivision 10i, or 626.557, subdivision 9d, the scope of the fair hearing under section 256.045 shall include the maltreatment determination and the disqualification. Except as provided under subdivision 3c, the commissioner's final order for an individual under this paragraph is conclusive on the issue of maltreatment and disqualification, including for purposes of subsequent studies conducted under subdivision 3, and is the only administrative appeal of the final agency determination, specifically, including a challenge to the accuracy and completeness of data under section 13.04.

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

Sec. 7. Minnesota Statutes 2000, section 245A.04, subdivision 3c, is amended to read:

Subd. 3c. [CONTESTED CASE.] (a) Notwithstanding subdivision 3b, paragraphs (e) and (f), if a disqualification is not set aside, a person who is an employee of an employer, as defined in section 179A.03, subdivision 15, may request a contested case hearing under chapter 14. If the disqualification which was not set aside or was not rescinded was based on a maltreatment determination, the scope of the contested case hearing shall include the maltreatment determination and the disqualification. In such cases, a fair hearing shall not be conducted under section 256.045. Rules adopted under this chapter may not preclude an employee in a contested case hearing for disqualification from submitting evidence concerning information gathered under subdivision 3, paragraph (e).

(b) If a disqualification for which reconsideration was requested and which was not set aside or was not rescinded under subdivision 3b is the basis for a denial of a license under section 245A.05 or a licensing sanction under section 245A.07, the license holder has the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8510 to 1400.8612 and successor rules. The appeal must be submitted in accordance with section 245A.05 or 245A.07, subdivision 3. As provided for under section 245A.08, subdivision 2a, the scope of the consolidated contested case hearing shall include the disqualification and the licensing sanction or denial of a license. If the disqualification was based on a determination of substantiated serious or recurring maltreatment under section 626.556 or 626.557, the appeal must be submitted in accordance with sections 245A.07, subdivision 3, and 626.556, subdivision 10i, or 626.557, subdivision 9d. As provided for under section 245A.08, subdivision 2a, the scope of the contested case hearing shall include the maltreatment determination, the disqualification, and the licensing sanction or denial of a license. In such cases, a fair hearing shall not be conducted under section 256.045.

(c) If a maltreatment determination or disqualification, which was not set aside or was not rescinded under subdivision 3b, is the basis for a denial of a license under section 245A.05 or a licensing sanction under section 245A.07, and the disqualified subject is an individual other than the license holder and upon whom a background study must be conducted under subdivision 3, the hearing of all parties may be consolidated into a single contested case hearing upon consent of all parties and the administrative law judge.

(d) The commissioner's final order under section 245A.08, subdivision 5, is conclusive on the issue of maltreatment and disqualification, including for purposes of subsequent background studies. The contested case hearing under this subdivision is the only administrative appeal of the final agency determination, specifically, including a challenge to the accuracy and completeness of data under section 13.04.

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

Sec. 8. Minnesota Statutes 2000, section 245A.04, subdivision 3d, is amended to read:

Subd. 3d. **[DISQUALIFICATION.]** (a) Except as provided in paragraph (b), when a background study completed under subdivision 3 shows any of the following: a conviction of one or more crimes listed in clauses (1) to (4); the individual has admitted to or a preponderance of the evidence indicates the individual has committed an act or acts that meet the definition of any of the crimes listed in clauses (1) to (4); or an investigation results in an administrative determination listed under clause (4), the individual shall be disqualified from any position allowing direct contact with persons receiving services from the license holder, registrant and for individuals studied under section 245A.04, subdivision 3, paragraph (c), clauses (2), (6), and (7), in H. F. 1381, if enacted, the individual shall also be disqualified from access to persons receiving services from the license holder:

(1) regardless of how much time has passed since the discharge of the sentence imposed for the offense, and unless otherwise specified, regardless of the level of the conviction, the individual was convicted of any of the following offenses: sections 609.185 (murder in the first degree); 609.19 (murder in the second degree); 609.195 (murder in the third degree); 609.2661 (murder of an unborn child in the first degree); 609.2662 (murder of an unborn child in the second degree); 609.2663 (murder of an unborn child in the third degree); 609.322 (solicitation, inducement, and promotion of prostitution); 609.342 (criminal sexual conduct in the first degree); 609.343 (criminal sexual conduct in the second degree); 609.344 (criminal sexual conduct in the third degree); 609.345 (criminal sexual conduct in the fourth degree); 609.352 (solicitation of children to engage in sexual conduct); 609.365 (incest); felony offense under 609.377 (malicious punishment of a child); a felony offense under 609.378 (neglect or endangerment of a child); a felony offense under 609.324, subdivision 1 (other prohibited acts); 617.246 (use of minors in sexual performance prohibited); 617.247 (possession of pictorial representations of minors); a felony offense under sections 609.2242 and 609.2243 (domestic assault), a felony offense of spousal abuse, a felony offense of child abuse or neglect, a felony offense of a crime against children; or attempt or conspiracy to commit any of these offenses as defined in Minnesota Statutes, or an offense in any other state or country, where the elements are substantially similar to any of the offenses listed in this clause;

(2) if less than 15 years have passed since the discharge of the sentence imposed for the offense; and the individual has received a felony conviction for a violation of any of these offenses: sections 609.20 (manslaughter in the first degree); 609.205 (manslaughter in the second degree); 609.21 (criminal vehicular homicide and injury); 609.215 (suicide); 609.221 to 609.2231 (assault in the first, second, third, or fourth degree); repeat offenses under 609.224 (assault in the fifth degree); repeat offenses under 609.3451 (criminal sexual conduct in the fifth degree); 609.713 (terroristic threats); 609.235 (use of drugs to injure or facilitate crime); 609.24 (simple robbery); 609.245 (aggravated robbery); 609.25 (kidnapping); 609.255 (false imprisonment); 609.561 (arson in the first degree); 609.562 (arson in the second degree); 609.563 (arson in the third degree); repeat offenses under 617.23 (indecent exposure; penalties); repeat offenses under 617.241 (obscene materials and performances; distribution and exhibition prohibited; penalty); 609.71 (riot); 609.66 (dangerous weapons); 609.67 (machine guns and short-barreled shotguns); 609.749 (harassment; stalking; penalties); 609.228 (great bodily harm caused by distribution of drugs); 609.2325 (criminal abuse of a vulnerable adult); 609.2664 (manslaughter of an unborn child in the first degree); 609.2665 (manslaughter of an unborn child in the second degree); 609.267 (assault of an unborn child in the first degree); 609.2671 (assault of an unborn child in the second degree); 609.268 (injury or death of an unborn child in the commission of a crime); 609.52 (theft); 609.2335 (financial exploitation of a vulnerable adult); 609.521 (possession of shoplifting gear); 609.582 (burglary); 609.625 (aggravated forgery); 609.63 (forgery); 609.631 (check forgery; offering a forged check); 609.635 (obtaining signature by false pretense); 609.27 (coercion); 609.275 (attempt to coerce); 609.687 (adulteration); 260C.301 (grounds for termination of parental rights); and chapter 152 (drugs; controlled substance). An attempt or conspiracy to commit any of these offenses, as each of these offenses is defined in Minnesota Statutes; or an offense in any other state or country, the elements of which are substantially similar to the elements of the offenses in this clause. If the individual studied is convicted of one of the felonies listed in this clause, but the sentence is a gross misdemeanor or misdemeanor disposition, the lookback period for the conviction is the period applicable to the disposition, that is the period for gross misdemeanors or misdemeanors;

(3) if less than ten years have passed since the discharge of the sentence imposed for the offense; and the individual has received a gross misdemeanor conviction for a violation of any of the following offenses: sections 609.224 (assault in the fifth degree); 609.2242 and 609.2243 (domestic assault); violation of an order for protection under 518B.01, subdivision 14; 609.3451 (criminal sexual conduct in the fifth degree); repeat offenses under 609.746 (interference with privacy); repeat offenses under 617.23 (indecent exposure); 617.241 (obscene materials and performances); 617.243 (indecent literature, distribution); 617.293 (harmful materials; dissemination and display to minors prohibited); 609.71 (riot); 609.66 (dangerous weapons); 609.749 (harassment; stalking; penalties); 609.224, subdivision 2, paragraph (c) (assault in the fifth degree by a caregiver against a vulnerable adult); 609.23 (mistreatment of persons confined); 609.231 (mistreatment of residents or patients); 609.2325 (criminal abuse of a vulnerable adult); 609.233 (criminal neglect of a vulnerable adult); 609.2335 (financial exploitation of a vulnerable adult); 609.234 (failure to report maltreatment of a vulnerable adult); 609.72, subdivision 3 (disorderly conduct against a vulnerable adult); 609.265 (abduction); 609.378 (neglect or endangerment of a child); 609.377 (malicious punishment of a child); 609.324, subdivision 1a (other prohibited acts; minor engaged in prostitution); 609.33 (disorderly house); 609.52 (theft); 609.582 (burglary); 609.631 (check forgery; offering a forged check); 609.275 (attempt to coerce); or an attempt or conspiracy to commit any of these offenses, as each of these offenses is defined in Minnesota Statutes; or an offense in any other state or country, the elements of which are substantially similar to the elements of any of the offenses listed in this clause. If the defendant is convicted of one of the gross misdemeanors listed in this clause, but the sentence is a misdemeanor disposition, the lookback period for the conviction is the period applicable to misdemeanors; or

(4) if less than seven years have passed since the discharge of the sentence imposed for the offense; and the individual has received a misdemeanor conviction for a violation of any of the following offenses: sections 609.224 (assault in the fifth degree); 609.2242 (domestic assault); violation of an order for protection under 518B.01 (Domestic Abuse Act); violation of an order for protection under 609.3232 (protective order authorized; procedures; penalties); 609.746 (interference with privacy); 609.79 (obscene or harassing phone calls); 609.795 (letter, telegram, or package; opening; harassment); 617.23 (indecent exposure; penalties); 609.2672 (assault of an unborn child in the third degree); 617.293 (harmful materials; dissemination and display to minors prohibited); 609.66 (dangerous weapons); 609.665 (spring guns); 609.2335 (financial exploitation of a vulnerable adult); 609.234 (failure to report maltreatment of a vulnerable adult); 609.52 (theft); 609.27 (coercion); or an attempt or conspiracy to commit any of these offenses, as each of these offenses is defined in Minnesota Statutes; or an offense in any other state or

country, the elements of which are substantially similar to the elements of any of the offenses listed in this clause; failure to make required reports under section 626.556, subdivision 3, or 626.557, subdivision 3, for incidents in which: (i) the final disposition under section 626.556 or 626.557 was substantiated maltreatment, and (ii) the maltreatment was recurring or serious; or substantiated serious or recurring maltreatment of a minor under section 626.556 or of a vulnerable adult under section 626.557 for which there is a preponderance of evidence that the maltreatment occurred, and that the subject was responsible for the maltreatment.

For the purposes of this section, "serious maltreatment" means sexual abuse; maltreatment resulting in death; or maltreatment resulting in serious injury which reasonably requires the care of a physician whether or not the care of a physician was sought; or abuse resulting in serious injury. For purposes of this section, "abuse resulting in serious injury" means: bruises, bites, skin laceration or tissue damage; fractures; dislocations; evidence of internal injuries; head injuries with loss of consciousness; extensive second-degree or third-degree burns and other burns for which complications are present; extensive second-degree or third-degree frostbite, and others for which complications are present; irreversible mobility or avulsion of teeth; injuries to the eyeball; ingestion of foreign substances and objects that are harmful; near drowning; and heat exhaustion or sunstroke. For purposes of this section, "care of a physician" is treatment received or ordered by a physician, but does not include diagnostic testing, assessment, or observation. For the purposes of this section, "recurring maltreatment" means more than one incident of maltreatment for which there is a preponderance of evidence that the maltreatment occurred, and that the subject was responsible for the maltreatment. For purposes of this section, "access" means physical access to an individual receiving services or the individual's personal property without continuous, direct supervision as defined in section 245A.04, subdivision 3.

(b) ~~If Except for background studies related to child foster care, adult foster care, or family child care licensure, when the subject of a background study is licensed regulated by a health-related licensing board as defined in chapter 214, and the regulated person has been determined to have been responsible for substantiated maltreatment under section 626.556 or 626.557, instead of the commissioner making a decision regarding disqualification, the board shall make the a determination regarding a disqualification under this subdivision based on a finding of substantiated maltreatment under section 626.556 or 626.557. The commissioner shall notify the health-related licensing board if a background study shows that a licensee would be disqualified because of substantiated maltreatment and the board shall make a determination under section 214.104. whether to impose disciplinary or corrective action under chapter 214.~~

(1) The commissioner shall notify the health-related licensing board:

(i) upon completion of a background study that produces a record showing that the individual was determined to have been responsible for substantiated maltreatment;

(ii) upon the commissioner's completion of an investigation that determined the individual was responsible for substantiated maltreatment; or

(iii) upon receipt from another agency of a finding of substantiated maltreatment for which the individual was responsible.

(2) The commissioner's notice shall indicate whether the individual would have been disqualified by the commissioner for the substantiated maltreatment if the individual were not regulated by the board. The commissioner shall concurrently send a copy of this notice to the individual.

(3) Notwithstanding the exclusion from this subdivision for individuals who provide child foster care, adult foster care, or family child care, when the commissioner or a local agency has reason to believe that the direct contact services provided by the individual may fall within the jurisdiction of a health-related licensing board, a referral shall be made to the board as provided in this section.

(4) If, upon review of the information provided by the commissioner, a health-related licensing board informs the commissioner that the board does not have jurisdiction to take disciplinary or corrective action, the commissioner shall make the appropriate disqualification decision regarding the individual as otherwise provided in this chapter.

(5) The commissioner has the authority to monitor the facility's compliance with any requirements that the health-related licensing board places on regulated persons practicing in a facility either during the period pending a final decision on a disciplinary or corrective action or as a result of a disciplinary or corrective action. The commissioner has the authority to order the immediate removal of a regulated person from direct contact or access when a board issues an order of temporary suspension based on a determination that the regulated person poses an immediate risk of harm to persons receiving services in a licensed facility.

(6) A facility that allows a regulated person to provide direct contact services while not complying with the requirements imposed by the health-related licensing board is subject to action by the commissioner as specified under sections 245A.06 and 245A.07.

(7) The commissioner shall notify a health-related licensing board immediately upon receipt of knowledge of noncompliance with requirements placed on a facility or upon a person regulated by the board.

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

Sec. 9. Minnesota Statutes 2000, section 245A.05, is amended to read:

245A.05 [DENIAL OF APPLICATION.]

The commissioner may deny a license if an applicant fails to comply with applicable laws or rules, or knowingly withholds relevant information from or gives false or misleading information to the commissioner in connection with an application for a license or during an investigation. An applicant whose application has been denied by the commissioner must be given notice of the denial. Notice must be given by certified mail. The notice must state the reasons the application was denied and must inform the applicant of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8510 to 1400.8612 and successor rules. The applicant may appeal the denial by notifying the commissioner in writing by certified mail within 20 calendar days after receiving notice that the application was denied. Section 245A.08 applies to hearings held to appeal the commissioner's denial of an application.

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

Sec. 10. Minnesota Statutes 2000, section 245A.06, is amended to read:

245A.06 [CORRECTION ORDER AND ~~FINES~~ CONDITIONAL LICENSE.]

Subdivision 1. [CONTENTS OF CORRECTION ORDERS ~~OR FINES~~ AND CONDITIONAL LICENSES.] (a) If the commissioner finds that the applicant or license holder has failed to comply with an applicable law or rule and this failure does not imminently endanger the health, safety, or rights of the persons served by the program, the commissioner may issue a correction order and an order of conditional license to or impose a fine on the applicant or license holder. When issuing a conditional license, the commissioner shall consider the nature, chronicity, or severity of the violation of law or rule and the effect of the violation on the health, safety, or rights of persons served by the program. The correction order or ~~fine~~ conditional license must state:

- (1) the conditions that constitute a violation of the law or rule;
- (2) the specific law or rule violated;
- (3) the time allowed to correct each violation; and

(4) if a ~~fine is imposed, the amount of the fine~~ license is made conditional, the length and terms of the conditional license.

(b) Nothing in this section prohibits the commissioner from proposing a sanction as specified in section 245A.07, prior to issuing a correction order or ~~fine~~ conditional license.

Subd. 2. [RECONSIDERATION OF CORRECTION ORDERS.] If the applicant or license holder believes that the contents of the commissioner's correction order are in error, the applicant or license holder may ask the department of human services to reconsider the parts of the correction order that are alleged to be in error. The request for reconsideration must be in writing and received by the commissioner within 20 calendar days after receipt of the correction order by the applicant or license holder, and:

- (1) specify the parts of the correction order that are alleged to be in error;
- (2) explain why they are in error; and
- (3) include documentation to support the allegation of error.

A request for reconsideration does not stay any provisions or requirements of the correction order. The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14.

Subd. 3. [FAILURE TO COMPLY.] If the commissioner finds that the applicant or license holder has not corrected the violations specified in the correction order or conditional license, the commissioner may impose a fine and order other licensing sanctions pursuant to section 245A.07. ~~If a fine was imposed and the violation was not corrected, the commissioner may impose an additional fine. This section does not prohibit the commissioner from seeking a court order, denying an application, or suspending, revoking, or making conditional the license in addition to imposing a fine.~~

Subd. 4. [NOTICE OF ~~FINE~~ CONDITIONAL LICENSE; RECONSIDERATION OF ~~FINE~~ CONDITIONAL LICENSE.] ~~A license holder who is ordered to pay a fine~~ If a license is made conditional, the license holder must be notified of the order by certified mail. The notice must be mailed to the address shown on the application or the last known address of the license holder. The notice must state the reasons the ~~fine~~ conditional license was ordered and must inform the license holder of the ~~responsibility for payment of fines in subdivision 7 and~~ the right to request reconsideration of the ~~fine~~ conditional license by the commissioner. The license holder may request reconsideration of the order ~~to forfeit a fine of conditional license~~ by notifying the commissioner by certified mail within 20 calendar days after receiving the order. The request must be in writing and must be received by the commissioner within ten calendar days after the license holder received the order. The license holder may submit with the request for reconsideration written argument or evidence in support of the request for reconsideration. A timely request for reconsideration shall stay ~~forfeiture of the fine~~ imposition of the terms of the conditional license until the commissioner issues a decision on the request for reconsideration. ~~The request for reconsideration must be in writing and:~~

- (1) ~~specify the parts of the violation that are alleged to be in error;~~
- (2) ~~explain why they are in error;~~
- (3) ~~include documentation to support the allegation of error; and~~
- (4) ~~any other information relevant to the fine or the amount of the fine.~~

The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14.

~~Subd. 5. [FORFEITURE OF FINES.] The license holder shall pay the fines assessed on or before the payment date specified in the commissioner's order. If the license holder fails to fully comply with the order, the commissioner shall issue a second fine or suspend the license until the license holder complies. If the license holder receives state funds, the state, county, or municipal agencies or departments responsible for administering the funds shall withhold payments and recover any payments made while the license is suspended for failure to pay a fine.~~

~~Subd. 5a. [ACCRUAL OF FINES.] A license holder shall promptly notify the commissioner of human services, in writing, when a violation specified in an order to forfeit is corrected. If upon reinspection the commissioner determines that a violation has not been corrected as indicated by the order to forfeit, the commissioner may issue a second fine. The commissioner shall notify the license holder by certified mail that a second fine has been assessed. The license holder may request reconsideration of the second fine under the provisions of subdivision 4.~~

~~Subd. 6. [AMOUNT OF FINES.] Fines shall be assessed as follows:~~

~~(1) the license holder shall forfeit \$1,000 for each occurrence of violation of law or rule prohibiting the maltreatment of children or the maltreatment of vulnerable adults, including but not limited to corporal punishment, illegal or unauthorized use of physical, mechanical, or chemical restraints, and illegal or unauthorized use of aversive or deprivation procedures;~~

~~(2) the license holder shall forfeit \$200 for each occurrence of a violation of law or rule governing matters of health, safety, or supervision, including but not limited to the provision of adequate staff to child or adult ratios; and~~

~~(3) the license holder shall forfeit \$100 for each occurrence of a violation of law or rule other than those included in clauses (1) and (2).~~

~~For the purposes of this section, "occurrence" means each violation identified in the commissioner's forfeiture order.~~

~~Subd. 7. [RESPONSIBILITY FOR PAYMENT OF FINES.] When a fine has been assessed, the license holder may not avoid payment by closing, selling, or otherwise transferring the licensed program to a third party. In such an event, the license holder will be personally liable for payment. In the case of a corporation, each controlling individual is personally and jointly liable for payment.~~

~~Fines for child care centers must be assessed according to this section.~~

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

Sec. 11. Minnesota Statutes 2000, section 245A.07, is amended to read:

245A.07 [SANCTIONS.]

Subdivision 1. [SANCTIONS AVAILABLE.] In addition to ~~ordering forfeiture of fines~~ making a license conditional under section 245A.06, the commissioner may propose to suspend; ~~or revoke; or make conditional~~ the license, impose a fine, or secure an injunction against the continuing operation of the program of a license holder who does not comply with applicable law or rule. When applying sanctions authorized under this section, the commissioner shall consider the nature, chronicity, or severity of the violation of law or rule and the effect of the violation on the health, safety, or rights of persons served by the program.

Subd. 2. ~~[IMMEDIATE SUSPENSION IN CASES OF IMMINENT DANGER TO HEALTH, SAFETY, OR RIGHTS TEMPORARY IMMEDIATE SUSPENSION.]~~ (a) If the license holder's ~~actions or failure to comply with applicable law or rule has placed~~ poses an imminent risk of harm to the health, safety, or rights of persons served by the program ~~in imminent danger~~, the commissioner shall act immediately to temporarily suspend the license. No state funds shall be made available or be expended by any agency or department of state, county, or municipal government for use by a license holder regulated under this chapter while a license is under immediate suspension.

A notice stating the reasons for the immediate suspension and informing the license holder of the right to ~~a contested case~~ an expedited hearing under chapter 14 and Minnesota Rules, parts 1400.8510 to 1400.8612 and successor rules, must be delivered by personal service to the address shown on the application or the last known address of the license holder. The license holder may appeal an order immediately suspending a license. The appeal of an order immediately suspending a license must be made in writing by certified mail and must be received by the commissioner within five calendar days after the license holder receives notice that the license has been immediately suspended. A license holder and any controlling individual shall discontinue operation of the program upon receipt of the commissioner's order to immediately suspend the license.

(b) The commissioner is liable to the license holder for actual damages for days of lost service in an amount not more than \$50,000 when:

(1) the commissioner immediately suspends a license under paragraph (a); and

(2) the administrative law judge recommends, after a review of the facts in an expedited hearing under chapter 14 and Minnesota Rules, parts 1400.8510 to 1400.8612 and successor rules, that reasonable cause did not exist at the time the commissioner issued the immediate suspension.

(c) If the commissioner immediately suspends a license under paragraph (a) and the administrative law judge recommends that reasonable cause exists for the immediate suspension, the commissioner is not liable to the license holder.

Subd. 2a. [IMMEDIATE SUSPENSION EXPEDITED HEARING.] (a) Within five working days of receipt of the license holder's timely appeal, the commissioner shall request assignment of an administrative law judge. The request must include a proposed date, time, and place of a hearing. A hearing must be conducted by an administrative law judge within 30 calendar days of the request for assignment, unless an extension is requested by either party and granted by the administrative law judge for good cause. The commissioner shall issue a notice of hearing by certified mail at least ten working days before the hearing. The scope of the hearing shall be limited solely to the issue of whether the temporary immediate suspension should remain in effect pending the commissioner's final order under section 245A.08, regarding a licensing sanction issued under subdivision 3 following the immediate suspension. The burden of proof in expedited hearings under this subdivision shall be limited to the commissioner's demonstration that reasonable cause exists to believe that the license holder's actions or failure to comply with applicable law or rule poses an imminent risk of harm to the health, safety, or rights of persons served by the program.

(b) The administrative law judge shall issue findings of fact, conclusions, and a recommendation within ten working days from the date of hearing. The commissioner's final order shall be issued within ten working days from receipt of the recommendation of the administrative law judge. Within 90 calendar days after a final order affirming an immediate suspension, the commissioner shall make a determination regarding whether a final licensing sanction shall be issued under subdivision 3. The license holder shall continue to be prohibited from operation of the program during this 90-day period.

Subd. 3. [LICENSE SUSPENSION, REVOCATION, ~~DENIAL~~ OR ~~CONDITIONAL LICENSE FINE~~.] The commissioner may suspend; or revoke; ~~make conditional; or deny~~ a license, or impose a fine if an applicant or a license holder fails to comply fully with applicable laws or rules, or knowingly withholds relevant information from or gives false or misleading information to the commissioner in connection with an application for a license or during an investigation. A license holder who has had a license suspended, revoked, or ~~made conditional~~ has been ordered to pay a fine must be given notice of the action by certified mail. The notice must be mailed to the address shown on the application or the last known address of the license holder. The notice must state the reasons the license was suspended, revoked, or ~~made conditional~~ a fine was ordered.



(a) If the license was suspended or revoked, the notice must inform the license holder of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8510 to 1400.8612 and successor rules. The license holder may appeal an order suspending or revoking a license. The appeal of an order suspending or revoking a license must be made in writing by certified mail and must be received by the commissioner within ten calendar days after the license holder receives notice that the license has been suspended or revoked.

~~(b) If the license was made conditional, the notice must inform the license holder of the right to request a reconsideration by the commissioner. The request for reconsideration must be made in writing by certified mail and must be received by the commissioner within ten calendar days after the license holder receives notice that the license has been made conditional. The license holder may submit with the request for reconsideration written argument or evidence in support of the request for reconsideration. The commissioner's disposition of a request for reconsideration is final and is not subject to appeal under chapter 14. (1) If the license holder was ordered to pay a fine, the notice must inform the license holder of the responsibility for payment of fines and the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8510 to 1400.8612 and successor rules. The appeal of an order to pay a fine must be made in writing by certified mail and must be received by the commissioner within ten calendar days after the license holder receives notice that the fine has been ordered.~~

(2) The license holder shall pay the fines assessed on or before the payment date specified. If the license holder fails to fully comply with the order, the commissioner may issue a second fine or suspend the license until the license holder complies. If the license holder receives state funds, the state, county, or municipal agencies or departments responsible for administering the funds shall withhold payments and recover any payments made while the license is suspended for failure to pay a fine. A timely appeal shall stay payment of the fine until the commissioner issues a final order.

(3) A license holder shall promptly notify the commissioner of human services, in writing, when a violation specified in the order to forfeit a fine is corrected. If upon reinspection the commissioner determines that a violation has not been corrected as indicated by the order to forfeit a fine, the commissioner may issue a second fine. The commissioner shall notify the license holder by certified mail that a second fine has been assessed. The license holder may appeal the second fine as provided under this subdivision.

(4) Fines shall be assessed as follows: the license holder shall forfeit \$1,000 for each determination of maltreatment of a child under section 626.556 or the maltreatment of a vulnerable adult under section 626.557; the license holder shall forfeit \$200 for each occurrence of a violation of law or rule governing matters of health, safety, or supervision, including but not limited to the provision of adequate staff to child or adult ratios, and failure to submit a background study; and the license holder shall forfeit \$100 for each occurrence of a violation of law or rule other than those subject to a \$1,000 or \$200 fine above. For purposes of this section, "occurrence" means each violation identified in the commissioner's fine order.

(5) When a fine has been assessed, the license holder may not avoid payment by closing, selling, or otherwise transferring the licensed program to a third party. In such an event, the license holder will be personally liable for payment. In the case of a corporation, each controlling individual is personally and jointly liable for payment.

Subd. 4. [ADOPTION AGENCY VIOLATIONS.] If a license holder licensed to place children for adoption fails to provide services as described in the disclosure form required by section 259.37, subdivision 2, the sanctions under this section may be imposed.

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

Sec. 12. Minnesota Statutes 2000, section 245A.08, is amended to read:

245A.08 [HEARINGS.]

Subdivision 1. [RECEIPT OF APPEAL; CONDUCT OF HEARING.] Upon receiving a timely appeal or petition pursuant to section 245A.04, subdivision 3c, 245A.05, or 245A.07, subdivision 3, the commissioner shall issue a notice of and order for hearing to the appellant under chapter 14 and Minnesota Rules, parts 1400.8510 to 1400.8612 and successor rules.

Subd. 2. [CONDUCT OF HEARINGS.] At any hearing provided for by section 245A.04, subdivision 3c, 245A.05, or 245A.07, subdivision 3, the appellant may be represented by counsel and has the right to call, examine, and cross-examine witnesses. The administrative law judge may require the presence of witnesses and evidence by subpoena on behalf of any party.

Subd. 2a. [CONSOLIDATED CONTESTED CASE HEARINGS FOR SANCTIONS BASED ON MALTREATMENT DETERMINATIONS AND DISQUALIFICATIONS.] (a) When a denial of a license under section 245A.05 or a licensing sanction under section 245A.07, subdivision 3, is based on a disqualification for which reconsideration was requested and which was not set aside or was not rescinded under section 245A.04, subdivision 3b, the scope of the contested case hearing shall include the disqualification and the licensing sanction or denial of a license. When the licensing sanction or denial of a license is based on a determination of maltreatment under section 626.556 or 626.557, or a disqualification for serious or recurring maltreatment which was not set aside or was not rescinded, the scope of the contested case hearing shall include the maltreatment determination, disqualification, and the licensing sanction or denial of a license. In such cases, a fair hearing under section 256.045 shall not be conducted as provided for in sections 626.556, subdivision 10i, and 626.557, subdivision 9d.

(b) In consolidated contested case hearings regarding sanctions issued in family child care, child foster care, and adult foster care, the county attorney shall defend the commissioner's orders in accordance with section 245A.16, subdivision 4.

(c) The commissioner's final order under subdivision 5 is the final agency action on the issue of maltreatment and disqualification, including for purposes of subsequent background studies under section 245A.04, subdivision 3, and is the only administrative appeal of the final agency determination, specifically, including a challenge to the accuracy and completeness of data under section 13.04.

(d) When consolidated hearings under this subdivision involve a licensing sanction based on a previous maltreatment determination for which the commissioner has issued a final order in an appeal of that determination under section 256.045, or the individual failed to exercise the right to appeal the previous maltreatment determination under section 626.556, subdivision 10i, or 626.557, subdivision 9d, the commissioner's order is conclusive on the issue of maltreatment. In such cases, the scope of the administrative law judge's review shall be limited to the disqualification and the licensing sanction or denial of a license. In the case of a denial of a license or a licensing sanction issued to a facility based on a maltreatment determination regarding an individual who is not the license holder or a household member, the scope of the administrative law judge's review includes the maltreatment determination.

(e) If a maltreatment determination or disqualification, which was not set aside or was not rescinded under section 245A.04, subdivision 3b, is the basis for a denial of a license under section 245A.05 or a licensing sanction under section 245A.07, and the disqualified subject is an individual other than the license holder and upon whom a background study must be conducted under section 245A.04, subdivision 3, the hearings of all parties may be consolidated into a single contested case hearing upon consent of all parties and the administrative law judge.

Subd. 3. [BURDEN OF PROOF.] (a) At a hearing regarding ~~suspension, immediate suspension, or revocation~~ of a license for family day care or foster care a licensing sanction under section 245A.07, including consolidated hearings under subdivision 2a, the commissioner may demonstrate reasonable cause for action taken by submitting statements, reports, or affidavits to substantiate the allegations that the license holder failed to comply fully with applicable law or rule. If the commissioner demonstrates that reasonable cause existed, the burden of proof ~~in~~ hearings involving suspension, immediate suspension, or revocation of a family day care or foster care license shifts to the license holder to demonstrate by a preponderance of the evidence that the license holder was in full compliance with those laws or rules that the commissioner alleges the license holder violated, at the time that the commissioner alleges the violations of law or rules occurred.

(b) At a hearing on denial of an application, the applicant bears the burden of proof to demonstrate by a preponderance of the evidence that the appellant has complied fully with ~~sections 245A.01 to 245A.15~~ this chapter and other applicable law or rule and that the application should be approved and a license granted.

~~(c) At all other hearings under this section, the commissioner bears the burden of proof to demonstrate, by a preponderance of the evidence, that the violations of law or rule alleged by the commissioner occurred.~~

Subd. 4. [RECOMMENDATION OF ADMINISTRATIVE LAW JUDGE.] The administrative law judge shall recommend whether or not the commissioner's order should be affirmed. The recommendations must be consistent with this chapter and the rules of the commissioner. The recommendations must be in writing and accompanied by findings of fact and conclusions and must be mailed to the parties by certified mail to their last known addresses as shown on the license or application.

Subd. 5. [NOTICE OF THE COMMISSIONER'S FINAL ORDER.] After considering the findings of fact, conclusions, and recommendations of the administrative law judge, the commissioner shall issue a final order. The commissioner shall consider, but shall not be bound by, the recommendations of the administrative law judge. The appellant must be notified of the commissioner's final order as required by chapter 14 and Minnesota Rules, parts 1400.8510 to 1400.8612 and successor rules. The notice must also contain information about the appellant's rights under chapter 14 and Minnesota Rules, parts 1400.8510 to 1400.8612 and successor rules. The institution of proceedings for judicial review of the commissioner's final order shall not stay the enforcement of the final order except as provided in section 14.65. A license holder and each controlling individual of a license holder whose license has been revoked because of noncompliance with applicable law or rule must not be granted a license for five years following the revocation. An applicant whose application was denied must not be granted a license for two years following a denial, unless the applicant's subsequent application contains new information which constitutes a substantial change in the conditions that caused the previous denial.

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

Sec. 13. Minnesota Statutes 2000, section 245A.16, subdivision 1, is amended to read:

Subdivision 1. [DELEGATION OF AUTHORITY TO AGENCIES.] (a) County agencies and private agencies that have been designated or licensed by the commissioner to perform licensing functions and activities under section 245A.04, to recommend denial of applicants under section 245A.05, to issue correction orders, to issue variances, and recommend ~~finer~~ a conditional license under section 245A.06, or to recommend suspending; or revoking; ~~and making licenses probationary~~ a license or issuing a fine under section 245A.07, shall comply with rules and directives of the commissioner governing those functions and with this section.

(b) For family day care programs, the commissioner may authorize licensing reviews every two years after a licensee has had at least one annual review.

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

Sec. 14. Minnesota Statutes 2000, section 245B.08, subdivision 3, is amended to read:

Subd. 3. [SANCTIONS AVAILABLE.] Nothing in this subdivision shall be construed to limit the commissioner's authority to suspend; or revoke a license, or ~~make conditional~~ issue a fine at any time ~~a license~~ under section 245A.07; make correction orders and ~~require fines~~ make a license conditional for failure to comply with applicable laws or rules under section 245A.06; or deny an application for license under section 245A.05.

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

Sec. 15. Minnesota Statutes 2000, section 256.045, subdivision 3, is amended to read:

Subd. 3. [STATE AGENCY HEARINGS.] (a) State agency hearings are available for the following: (1) any person applying for, receiving or having received public assistance, medical care, or a program of social services granted by the state agency or a county agency or the federal Food Stamp Act whose application for assistance is denied, not acted upon with reasonable promptness, or whose assistance is suspended, reduced, terminated, or claimed to have been incorrectly paid; (2) any patient or relative aggrieved by an order of the commissioner under

section 252.27; (3) a party aggrieved by a ruling of a prepaid health plan; (4) except as provided under chapter 245A, any individual or facility determined by a lead agency to have maltreated a vulnerable adult under section 626.557 after they have exercised their right to administrative reconsideration under section 626.557; (5) any person whose claim for foster care payment according to a placement of the child resulting from a child protection assessment under section 626.556 is denied or not acted upon with reasonable promptness, regardless of funding source; (6) any person to whom a right of appeal according to this section is given by other provision of law; (7) an applicant aggrieved by an adverse decision to an application for a hardship waiver under section 256B.15; ~~or~~ (8) except as provided under chapter 245A, an individual or facility determined to have maltreated a minor under section 626.556, after the individual or facility has exercised the right to administrative reconsideration under section 626.556; ~~or~~ (9) except as provided under chapter 245A, an individual disqualified under section 245A.04, subdivision 3d, on the basis of serious or recurring maltreatment; a preponderance of the evidence that the individual has committed an act or acts that meet the definition of any of the crimes listed in section 245A.04, subdivision 3d, paragraph (a), clauses (1) to (4); or for failing to make reports required under section 626.556, subdivision 3, or 626.557, subdivision 3. Hearings regarding a maltreatment determination under clause (4) or (8) and a disqualification under this clause in which the basis for a disqualification is serious or recurring maltreatment, which has not been set aside or rescinded under section 245A.04, subdivision 3b, shall be consolidated into a single fair hearing. In such cases, the scope of review by the human services referee shall include both the maltreatment determination and the disqualification. The failure to exercise the right to an administrative reconsideration shall not be a bar to a hearing under this section if federal law provides an individual the right to a hearing to dispute a finding of maltreatment. Individuals and organizations specified in this section may contest the specified action, decision, or final disposition before the state agency by submitting a written request for a hearing to the state agency within 30 days after receiving written notice of the action, decision, or final disposition, or within 90 days of such written notice if the applicant, recipient, patient, or relative shows good cause why the request was not submitted within the 30-day time limit.

The hearing for an individual or facility under clause (4) ~~or~~ (8) or (9) is the only administrative appeal to the final agency determination specifically, including a challenge to the accuracy and completeness of data under section 13.04. Hearings requested under clause (4) apply only to incidents of maltreatment that occur on or after October 1, 1995. Hearings requested by nursing assistants in nursing homes alleged to have maltreated a resident prior to October 1, 1995, shall be held as a contested case proceeding under the provisions of chapter 14. Hearings requested under clause (8) apply only to incidents of maltreatment that occur on or after July 1, 1997. A hearing for an individual or facility under clause (8) is only available when there is no juvenile court or adult criminal action pending. If such action is filed in either court while an administrative review is pending, the administrative review must be suspended until the judicial actions are completed. If the juvenile court action or criminal charge is dismissed or the criminal action overturned, the matter may be considered in an administrative hearing.

For purposes of this section, bargaining unit grievance procedures are not an administrative appeal.

The scope of hearings involving claims to foster care payments under clause (5) shall be limited to the issue of whether the county is legally responsible for a child's placement under court order or voluntary placement agreement and, if so, the correct amount of foster care payment to be made on the child's behalf and shall not include review of the propriety of the county's child protection determination or child placement decision.

(b) A vendor of medical care as defined in section 256B.02, subdivision 7, or a vendor under contract with a county agency to provide social services under section 256E.08, subdivision 4, is not a party and may not request a hearing under this section, except if assisting a recipient as provided in subdivision 4.

(c) An applicant or recipient is not entitled to receive social services beyond the services included in the amended community social services plan developed under section 256E.081, subdivision 3, if the county agency has met the requirements in section 256E.081.

(d) The commissioner may summarily affirm the county or state agency's proposed action without a hearing when the sole issue is an automatic change due to a change in state or federal law.

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

Sec. 16. Minnesota Statutes 2000, section 256.045, subdivision 3b, is amended to read:

Subd. 3b. [STANDARD OF EVIDENCE FOR MALTREATMENT AND DISQUALIFICATION HEARINGS.] The state human services referee shall determine that maltreatment has occurred if a preponderance of evidence exists to support the final disposition under sections 626.556 and 626.557. For purposes of hearings regarding disqualification, the state human services referee shall affirm the proposed disqualification in an appeal under subdivision 3, paragraph (a), clause (9), if a preponderance of the evidence shows the individual has:

(1) committed maltreatment under section 626.556 or 626.557, which is serious or recurring;

(2) committed an act or acts meeting the definition of any of the crimes listed in section 245A.04, subdivision 3d, paragraph (a), clauses (1) to (4); or

(3) failed to make required reports under section 626.556 or 626.557 for incidents in which:

(i) the final disposition under section 626.556 or 626.557 was substantiated maltreatment; and

(ii) the maltreatment was recurring or serious; or substantiated serious or recurring maltreatment of a minor under section 626.556 or of a vulnerable adult under section 626.557 for which there is a preponderance of evidence that the maltreatment occurred, and that the subject was responsible for the maltreatment. If the disqualification is affirmed, the state human services referee shall determine whether the individual poses a risk of harm in accordance with the requirements of section 245A.04, subdivision 3b.

The state human services referee shall recommend an order to the commissioner of health or human services, as applicable, who shall issue a final order. The commissioner shall affirm, reverse, or modify the final disposition. Any order of the commissioner issued in accordance with this subdivision is conclusive upon the parties unless appeal is taken in the manner provided in subdivision 7. Except as provided under section 245A.04, subdivisions 3b, paragraphs (e) and (f); and 3c, in any licensing appeal under chapter 245A and sections 144.50 to 144.58 and 144A.02 to 144A.46, the commissioner's determination as to maltreatment is conclusive.

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

Sec. 17. Minnesota Statutes 2000, section 256.045, subdivision 4, is amended to read:

Subd. 4. [CONDUCT OF HEARINGS.] (a) All hearings held pursuant to subdivision 3, 3a, 3b, or 4a shall be conducted according to the provisions of the federal Social Security Act and the regulations implemented in accordance with that act to enable this state to qualify for federal grants-in-aid, and according to the rules and written policies of the commissioner of human services. County agencies shall install equipment necessary to conduct telephone hearings. A state human services referee may schedule a telephone conference hearing when the distance or time required to travel to the county agency offices will cause a delay in the issuance of an order, or to promote efficiency, or at the mutual request of the parties. Hearings may be conducted by telephone conferences unless the applicant, recipient, former recipient, person, or facility contesting maltreatment objects. The hearing shall not be held earlier than five days after filing of the required notice with the county or state agency. The state human services referee shall notify all interested persons of the time, date, and location of the hearing at least five days before the date of the hearing. Interested persons may be represented by legal counsel or other representative of their choice, including a provider of therapy services, at the hearing and may appear personally, testify and offer evidence, and examine and cross-examine witnesses. The applicant, recipient, former recipient, person, or facility contesting maltreatment shall have the opportunity to examine the contents of the case file and all documents and records to be used by the county or state agency at the hearing at a reasonable time before the date of the hearing and during the hearing. In hearings under subdivision 3, paragraph (a), clauses (4) ~~and~~ (8), and (9), either party may subpoena the private data relating to the investigation prepared by the agency under section 626.556 or 626.557 that is not otherwise accessible under section 13.04, provided the identity of the reporter may not be disclosed.

(b) The private data obtained by subpoena in a hearing under subdivision 3, paragraph (a), clause (4) ~~or~~ (8), or (9), must be subject to a protective order which prohibits its disclosure for any other purpose outside the hearing provided for in this section without prior order of the district court. Disclosure without court order is punishable by a sentence of not more than 90 days imprisonment or a fine of not more than \$700, or both. These restrictions on the use of private data do not prohibit access to the data under section 13.03, subdivision 6. Except for appeals under subdivision 3, paragraph (a), clauses (4), (5), ~~and~~ (8), and (9), upon request, the county agency shall provide reimbursement for transportation, child care, photocopying, medical assessment, witness fee, and other necessary and reasonable costs incurred by the applicant, recipient, or former recipient in connection with the appeal. All evidence, except that privileged by law, commonly accepted by reasonable people in the conduct of their affairs as having probative value with respect to the issues shall be submitted at the hearing and such hearing shall not be "a contested case" within the meaning of section 14.02, subdivision 3. The agency must present its evidence prior to or at the hearing, and may not submit evidence after the hearing except by agreement of the parties at the hearing, provided the petitioner has the opportunity to respond.

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

Sec. 18. Minnesota Statutes 2000, section 626.556, subdivision 3, is amended to read:

Subd. 3. **[PERSONS MANDATED TO REPORT.]** (a) A person who knows or has reason to believe a child is being neglected or physically or sexually abused, as defined in subdivision 2, or has been neglected or physically or sexually abused within the preceding three years, shall immediately report the information to the local welfare agency, agency responsible for assessing or investigating the report, police department, or the county sheriff if the person is:

(1) a professional or professional's delegate who is engaged in the practice of the healing arts, social services, hospital administration, psychological or psychiatric treatment, child care, education, or law enforcement; or

(2) employed as a member of the clergy and received the information while engaged in ministerial duties, provided that a member of the clergy is not required by this subdivision to report information that is otherwise privileged under section 595.02, subdivision 1, paragraph (c).

The police department or the county sheriff, upon receiving a report, shall immediately notify the local welfare agency or agency responsible for assessing or investigating the report, orally and in writing. The local welfare agency, or agency responsible for assessing or investigating the report, upon receiving a report, shall immediately notify the local police department or the county sheriff orally and in writing. The county sheriff and the head of every local welfare agency, agency responsible for assessing or investigating reports, and police department shall each designate a person within their agency, department, or office who is responsible for ensuring that the notification duties of this paragraph and paragraph (b) are carried out. Nothing in this subdivision shall be construed to require more than one report from any institution, facility, school, or agency.

(b) Any person may voluntarily report to the local welfare agency, agency responsible for assessing or investigating the report, police department, or the county sheriff if the person knows, has reason to believe, or suspects a child is being or has been neglected or subjected to physical or sexual abuse. The police department or the county sheriff, upon receiving a report, shall immediately notify the local welfare agency or agency responsible for assessing or investigating the report, orally and in writing. The local welfare agency or agency responsible for assessing or investigating the report, upon receiving a report, shall immediately notify the local police department or the county sheriff orally and in writing.

(c) A person mandated to report physical or sexual child abuse or neglect occurring within a licensed facility shall report the information to the agency specified under subdivisions 3b and 3c as responsible for licensing the assessing or investigating a facility licensed under sections 144.50 to 144.58; a facility licensed under section 241.021; 245A.01 to 245A.16; or 245B; or a facility licensed under chapter 245A; a school as defined in sections section 120A.05, subdivisions 9, 11, and 13; ~~and~~ or section 124D.10; or a nonlicensed personal care provider organization

as defined in ~~sections~~ section 256B.04, subdivision 16; ~~and, or~~ section 256B.0625, subdivision 19. ~~A health or corrections~~ An agency receiving a report may request the local welfare agency to provide assistance pursuant to subdivisions 10, 10a, and 10b.

(d) Any person mandated to report shall receive a summary of the disposition of any report made by that reporter, including whether the case has been opened for child protection or other services, or if a referral has been made to a community organization, unless release would be detrimental to the best interests of the child. Any person who is not mandated to report shall, upon request to the local welfare agency, receive a concise summary of the disposition of any report made by that reporter, unless release would be detrimental to the best interests of the child.

(e) For purposes of this subdivision, "immediately" means as soon as possible but in no event longer than 24 hours.

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

Sec. 19. Minnesota Statutes 2000, section 626.556, subdivision 3c, is amended to read:

Subd. 3c. [AGENCY RESPONSIBLE FOR ASSESSING OR INVESTIGATING REPORTS OF MALTREATMENT.] The following agencies are the administrative agencies responsible for assessing or investigating reports of alleged child maltreatment in facilities made under this section:

(1) the county local welfare agency is the agency responsible for assessing or investigating allegations of maltreatment in child foster care, family child care, and legally unlicensed child care ~~and;~~

(2) the department of human services is the agency responsible for assessing or investigating allegations of maltreatment in juvenile correctional facilities licensed under section 241.021 located in the local welfare agency's county;

~~(2) (3)~~ (3) the department of human services is the agency responsible for assessing or investigating allegations of maltreatment in facilities licensed under chapters 245A and 245B, except for child foster care and family child care; and

~~(3) (4)~~ (4) the department of health is the agency responsible for assessing or investigating allegations of child maltreatment in facilities licensed under sections 144.50 to 144.58, and in unlicensed home health care.

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

Sec. 20. Minnesota Statutes 2000, section 626.556, subdivision 10b, is amended to read:

Subd. 10b. [DUTIES OF COMMISSIONER; NEGLECT OR ABUSE IN FACILITY.] (a) This section applies to the commissioners of human services, health, and children, families, and learning. The commissioner of the agency responsible for assessing or investigating the report shall immediately investigate if the report alleges that:

(1) a child who is in the care of a facility as defined in subdivision 2 is neglected, physically abused, or sexually abused by an individual in that facility, or has been so neglected or abused by an individual in that facility within the three years preceding the report; or

(2) a child was neglected, physically abused, or sexually abused by an individual in a facility defined in subdivision 2, while in the care of that facility within the three years preceding the report.

The commissioner of the agency responsible for assessing or investigating the report shall arrange for the transmittal to the commissioner of reports received by local agencies and may delegate to a local welfare agency the duty to investigate reports. In conducting an investigation under this section, the commissioner has the powers and duties specified for local welfare agencies under this section. The commissioner of the agency responsible for assessing or investigating the report or local welfare agency may interview any children who are or have been in the care of a facility under investigation and their parents, guardians, or legal custodians.

(b) Prior to any interview, the commissioner of the agency responsible for assessing or investigating the report or local welfare agency shall notify the parent, guardian, or legal custodian of a child who will be interviewed in the manner provided for in subdivision 10d, paragraph (a). If reasonable efforts to reach the parent, guardian, or legal custodian of a child in an out-of-home placement have failed, the child may be interviewed if there is reason to believe the interview is necessary to protect the child or other children in the facility. The commissioner of the agency responsible for assessing or investigating the report or local agency must provide the information required in this subdivision to the parent, guardian, or legal custodian of a child interviewed without parental notification as soon as possible after the interview. When the investigation is completed, any parent, guardian, or legal custodian notified under this subdivision shall receive the written memorandum provided for in subdivision 10d, paragraph (c).

(c) In conducting investigations under this subdivision the ~~commissioner or local welfare agency~~ responsible for assessing or investigating the report shall obtain be given access to information consistent with subdivision 10, paragraphs (g), (h), (i), and (j), and shall be granted the same access to the facility as the facility's licensing agency under the corresponding facility licensing statute. A facility that denies the investigating agency access to this information shall be subject to a negative licensing action by the appropriate licensing agency. When the agency responsible for assessing or investigating a report under this section and the licensing agency for the facility involved are not the same agency, the investigating agency and the licensing agency may share not public data as necessary to complete the investigation or to determine appropriate licensing action.

(d) Except for foster care and family child care, the commissioner has the primary responsibility for the investigations and notifications required under subdivisions 10d and 10f for reports that allege maltreatment related to the care provided by or in facilities licensed by the commissioner. The commissioner may request assistance from the local social services agency.

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

Sec. 21. Minnesota Statutes 2000, section 626.556, subdivision 10i, is amended to read:

Subd. 10i. [ADMINISTRATIVE RECONSIDERATION OF FINAL DETERMINATION OF MALTREATMENT AND DISQUALIFICATION BASED ON SERIOUS OR RECURRING MALTREATMENT.] (a) Except as provided under paragraph (e), an individual or facility that the commissioner or a local social service agency determines has maltreated a child, or the child's designee, regardless of the determination, who contests the investigating agency's final determination regarding maltreatment, may request the investigating agency to reconsider its final determination regarding maltreatment. The request for reconsideration must be submitted in writing to the investigating agency within 15 calendar days after receipt of notice of the final determination regarding maltreatment. An individual who was determined to have maltreated a child under this section and who was disqualified on the basis of serious or recurring maltreatment under section 245A.04, subdivision 3d, may request reconsideration of the maltreatment determination and the disqualification. The request for reconsideration of the maltreatment determination and the disqualification must be submitted within 30 calendar days of the individual's receipt of the notice of disqualification under section 245A.04, subdivision 3a.

(b) Except as provided under paragraphs (e) and (f), if the investigating agency denies the request or fails to act upon the request within 15 calendar days after receiving the request for reconsideration, the person or facility entitled to a fair hearing under section 256.045 may submit to the commissioner of human services a written request for a hearing under that section.

(c) If, as a result of the reconsideration, the investigating agency changes the final determination of maltreatment, that agency shall notify the parties specified in subdivisions 10b, 10d, and 10f.

(d) Except as provided under paragraph (f), if an individual or facility contests the investigating agency's final determination regarding maltreatment by requesting a fair hearing under section 256.045, the commissioner of human services shall assure that the hearing is conducted and a decision is reached within 90 days of receipt of the request for a hearing. The time for action on the decision may be extended for as many days as the hearing is postponed or the record is held open for the benefit of either party.



(e) If an individual was disqualified under section 245A.04, subdivision 3d, on the basis of a determination of maltreatment, which was serious or recurring, and the individual has requested reconsideration of the maltreatment determination under paragraph (a) and requested reconsideration of the disqualification under section 245A.04, subdivision 3b, reconsideration of the maltreatment determination and reconsideration of the disqualification shall be consolidated into a single reconsideration. If an individual disqualified on the basis of a determination of maltreatment, which was serious or recurring requests a fair hearing under paragraph (b), the scope of the fair hearing shall include the maltreatment determination and the disqualification.

(f) If a maltreatment determination or a disqualification based on serious or recurring maltreatment is the basis for a denial of a license under section 245A.05 or a licensing sanction under section 245A.07, the license holder has the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8510 to 1400.8612 and successor rules. As provided for under section 245A.08, subdivision 2a, the scope of the contested case hearing shall include the maltreatment determination, disqualification, and licensing sanction or denial of a license. In such cases, a fair hearing regarding the maltreatment determination shall not be conducted under paragraph (b). If the disqualified subject is an individual other than the license holder and upon whom a background study must be conducted under section 245A.04, subdivision 3, the hearings of all parties may be consolidated into a single contested case hearing upon consent of all parties and the administrative law judge.

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

Sec. 22. Minnesota Statutes 2000, section 626.557, subdivision 3, is amended to read:

Subd. 3. [TIMING OF REPORT.] (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:

(1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or

(2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4).

(b) A person not required to report under the provisions of this section may voluntarily report as described above.

(c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.

(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.

(e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c.

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

Sec. 23. Minnesota Statutes 2000, section 626.557, subdivision 9d, is amended to read:

Subd. 9d. [ADMINISTRATIVE RECONSIDERATION OF FINAL DISPOSITION OF MALTREATMENT AND DISQUALIFICATION BASED ON SERIOUS OR RECURRING MALTREATMENT; REVIEW PANEL.] (a) Except as provided under paragraph (e), any individual or facility which a lead agency determines has maltreated

a vulnerable adult, or the vulnerable adult or an interested person acting on behalf of the vulnerable adult, regardless of the lead agency's determination, who contests the lead agency's final disposition of an allegation of maltreatment, may request the lead agency to reconsider its final disposition. The request for reconsideration must be submitted in writing to the lead agency within 15 calendar days after receipt of notice of final disposition or, if the request is made by an interested person who is not entitled to notice, within 15 days after receipt of the notice by the vulnerable adult or the vulnerable adult's legal guardian. An individual who was determined to have maltreated a vulnerable adult under this section and who was disqualified on the basis of serious or recurring maltreatment under section 245A.04, subdivision 3d, may request reconsideration of the maltreatment determination and the disqualification. The request for reconsideration of the maltreatment determination and the disqualification must be submitted within 30 calendar days of the individual's receipt of the notice of disqualification under section 245A.04, subdivision 3a.

(b) Except as provided under paragraphs (e) and (f), if the lead agency denies the request or fails to act upon the request within 15 calendar days after receiving the request for reconsideration, the person or facility entitled to a fair hearing under section 256.045, may submit to the commissioner of human services a written request for a hearing under that statute. The vulnerable adult, or an interested person acting on behalf of the vulnerable adult, may request a review by the vulnerable adult maltreatment review panel under section 256.021 if the lead agency denies the request or fails to act upon the request, or if the vulnerable adult or interested person contests a reconsidered disposition. The lead agency shall notify persons who request reconsideration of their rights under this paragraph. The request must be submitted in writing to the review panel and a copy sent to the lead agency within 30 calendar days of receipt of notice of a denial of a request for reconsideration or of a reconsidered disposition. The request must specifically identify the aspects of the agency determination with which the person is dissatisfied.

(c) If, as a result of a reconsideration or review, the lead agency changes the final disposition, it shall notify the parties specified in subdivision 9c, paragraph (d).

(d) For purposes of this subdivision, "interested person acting on behalf of the vulnerable adult" means a person designated in writing by the vulnerable adult to act on behalf of the vulnerable adult, or a legal guardian or conservator or other legal representative, a proxy or health care agent appointed under chapter 145B or 145C, or an individual who is related to the vulnerable adult, as defined in section 245A.02, subdivision 13.

(e) If an individual was disqualified under section 245A.04, subdivision 3d, on the basis of a determination of maltreatment, which was serious or recurring, and the individual has requested reconsideration of the maltreatment determination under paragraph (a) and reconsideration of the disqualification under section 245A.04, subdivision 3b, reconsideration of the maltreatment determination and requested reconsideration of the disqualification shall be consolidated into a single reconsideration. If an individual who was disqualified on the basis of serious or recurring maltreatment requests a fair hearing under paragraph (b), the scope of the fair hearing shall include the maltreatment determination and the disqualification.

(f) If a maltreatment determination or a disqualification based on serious or recurring maltreatment is the basis for a denial of a license under section 245A.05 or a licensing sanction under section 245A.07, the license holder has the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8510 to 1400.8612 and successor rules. As provided for under section 245A.08, the scope of the contested case hearing shall include the maltreatment determination, disqualification, and licensing sanction or denial of a license. In such cases, a fair hearing shall not be conducted under paragraph (b). If the disqualified subject is an individual other than the license holder and upon whom a background study must be conducted under section 245A.04, subdivision 3, the hearings of all parties may be consolidated into a single contested case hearing upon consent of all parties and the administrative law judge.

(g) Until August 1, 2002, an individual or facility that was determined by the commissioner of human services or the commissioner of health to be responsible for neglect under section 626.5572, subdivision 17, after October 1, 1995, and before August 1, 2001, that believes that the finding of neglect does not meet an amended definition of neglect may request a reconsideration of the determination of neglect. The commissioner of human services or the commissioner of health shall mail a notice to the last known address of individuals who are eligible

to seek this reconsideration. The request for reconsideration must state how the established findings no longer meet the elements of the definition of neglect. The commissioner shall review the request for reconsideration and make a determination within 15 calendar days. The commissioner's decision on this reconsideration is the final agency action.

(1) For purposes of compliance with the data destruction schedule under subdivision 12b, paragraph (d), when a finding of substantiated maltreatment has been changed as a result of a reconsideration under this paragraph, the date of the original finding of a substantiated maltreatment must be used to calculate the destruction date.

(2) For purposes of any background studies under section 245A.04, when a determination of substantiated maltreatment has been changed as a result of a reconsideration under this paragraph, any prior disqualification of the individual under section 245A.04 that was based on this determination of maltreatment shall be rescinded, and for future background studies under section 245A.04 the commissioner must not use the previous determination of substantiated maltreatment as a basis for disqualification or as a basis for referring the individual's maltreatment history to a health-related licensing board under section 245A.04, subdivision 3d, paragraph (b).

[EFFECTIVE DATE.] Paragraph (g) of this section is effective the day following final enactment. Paragraphs (a), (b), (e), and (f) are effective January 1, 2002.

Sec. 24. Minnesota Statutes 2000, section 626.5572, subdivision 17, is amended to read:

Subd. 17. [NEGLECT.] "Neglect" means:

(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

(c) For purposes of this section, a vulnerable adult is not neglected for the sole reason that:

(1) the vulnerable adult or a person with authority to make health care decisions for the vulnerable adult under sections 144.651, 144A.44, chapter 145B, 145C, or 252A, or section 253B.03, or 525.539 to 525.6199, refuses consent or withdraws consent, consistent with that authority and within the boundary of reasonable medical practice, to any therapeutic conduct, including any care, service, or procedure to diagnose, maintain, or treat the physical or mental condition of the vulnerable adult, or, where permitted under law, to provide nutrition and hydration parenterally or through intubation; this paragraph does not enlarge or diminish rights otherwise held under law by:

(i) a vulnerable adult or a person acting on behalf of a vulnerable adult, including an involved family member, to consent to or refuse consent for therapeutic conduct; or

(ii) a caregiver to offer or provide or refuse to offer or provide therapeutic conduct; or

(2) the vulnerable adult, a person with authority to make health care decisions for the vulnerable adult, or a caregiver in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the vulnerable adult in lieu of medical care, provided that this is consistent with the prior practice or belief of the vulnerable adult or with the expressed intentions of the vulnerable adult;

(3) the vulnerable adult, who is not impaired in judgment or capacity by mental or emotional dysfunction or undue influence, engages in sexual contact with:

(i) a person including a facility staff person when a consensual sexual personal relationship existed prior to the caregiving relationship; or

(ii) a personal care attendant, regardless of whether the consensual sexual personal relationship existed prior to the caregiving relationship; or

(4) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult which ~~(i) does not result in injury or harm which reasonably requires medical or mental health care; or, if it reasonably requires care,~~

(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm which reasonably requires the care of a physician; and:

(i) the necessary care is sought and provided in a timely fashion as dictated by the condition of the vulnerable adult; and (ii) the injury or harm that required care does not result in substantial acute, or chronic injury or illness, or permanent disability above and beyond the vulnerable adult's preexisting condition;

~~(ii) is~~ (iii) the error is not part of a pattern of errors by the individual;

(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally by the employee or person providing services in the facility in order to evaluate and identify corrective action;

(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and

~~(iii) is~~ (vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency; and

~~(iv) is not part of a pattern of errors by the individual.~~

(d) Nothing in this definition requires a caregiver, if regulated, to provide services in excess of those required by the caregiver's license, certification, registration, or other regulation.

(e) If the findings of an investigation by a lead agency result in a determination of substantiated maltreatment for the sole reason that the actions required of a facility under paragraph (c), clause (5), item (iv), (v), or (vi), were not taken, then the facility is subject to a correction order. This must not alter the lead agency's determination of mitigating factors under section 626.557, subdivision 9c, paragraph (c).

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

Sec. 25. [FEDERAL LAW CHANGE REQUEST OR WAIVER.]

The commissioner of health or human services, whichever is appropriate, shall pursue changes to federal law necessary to allow greater discretion on disciplinary activities of unlicensed health care workers and apply for necessary federal waivers or approval that would allow for a set-aside process related to disqualifications for nurse aides in nursing homes by July 1, 2002.

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

## Sec. 26. [WAIVER FROM FEDERAL RULES AND REGULATIONS.]

By January 2002, the commissioner of health shall work with providers to examine federal rules and regulations prohibiting neglect, abuse, and financial exploitation of residents in licensed nursing facilities and shall apply for federal waivers to:

(1) allow the use of Minnesota Statutes, section 626.5572, to control the identification and prevention of maltreatment of residents in licensed nursing facilities, rather than the definitions under federal rules and regulations; and

(2) allow the use of Minnesota Statutes, sections 214.104, 245A.04, and 626.557 to control the disqualification or discipline of any persons providing services to residents in licensed nursing facilities, rather than the nurse aide registry or other exclusionary provisions of federal rules and regulations.

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

## ARTICLE 12

## MISCELLANEOUS

Section 1. Minnesota Statutes 2000, section 144.1222, is amended by adding a subdivision to read:

Subd. 2a. [POOLS AT FAMILY DAY CARE OR GROUP FAMILY DAY CARE HOMES.] Notwithstanding Minnesota Rules, part 4717.0250, subpart 8, a pool that is located at a family day care or group family day care home licensed under Minnesota Rules, chapter 9502, shall not be considered a public pool, and is exempt from the requirements for public pools in Minnesota Rules, parts 4717.0150 to 4717.3975. If the provider chooses to allow children cared for at the family day care or group family day care home to use the pool located at the home, the provider must satisfy the requirements in section 245A.14, subdivision 10.

Sec. 2. Minnesota Statutes 2000, section 148B.21, subdivision 6a, is amended to read:

Subd. 6a. [BACKGROUND CHECKS.] The board shall request a criminal history background check from the superintendent of the bureau of criminal apprehension on all applicants for initial licensure. An application for a license under this section must be accompanied by an executed criminal history consent form and the fee for conducting the criminal history background check. The board shall deposit all fees paid by applicants for criminal history background checks under this subdivision into the miscellaneous special revenue fund and shall reimburse the bureau of criminal apprehension for the cost of the background checks upon their completion.

Sec. 3. Minnesota Statutes 2000, section 148B.22, subdivision 3, is amended to read:

Subd. 3. [BACKGROUND CHECKS.] The board shall request a criminal history background check from the superintendent of the bureau of criminal apprehension on all licensees under its jurisdiction who did not complete a criminal history background check as part of an application for initial licensure. This background check is a one-time requirement. An application for a license under this section must be accompanied by an executed criminal history consent form and the fee for conducting the criminal history background check. The board shall deposit all fees paid by licensees for criminal history background checks under this subdivision into the miscellaneous special revenue fund and shall reimburse the bureau of criminal apprehension for the cost of the background checks upon their completion.

Sec. 4. Minnesota Statutes 2000, section 245A.14, is amended by adding a subdivision to read:

Subd. 10. [SWIMMING POOLS; FAMILY DAY CARE AND GROUP FAMILY DAY CARE PROVIDERS.] (a) This subdivision governs pools located at family day care or group family day care homes licensed under Minnesota Rules, chapter 9502. This subdivision does not apply to portable wading pools or whirlpools located at

family day care or group family day care homes licensed under Minnesota Rules, chapter 9502. For a provider to be eligible to allow a child cared for at the family day care or group family day care home to use the pool located at the home, the provider must not have had a licensing sanction under section 245A.07 or a correction order or fine under section 245A.06 relating to the supervision or health and safety of children substantiated by the county agency during the prior 24 months, and must satisfy the following requirements:

(1) obtain written consent from a child's parent or legal guardian allowing the child to use the pool, and renew the parent's or legal guardian's written consent at least annually. The written consent must include a statement that the parent or legal guardian has received and read materials provided by the department of health to the department of human services for distribution to all family day care or group family day care homes related to the risk of disease transmission as well as other health risks associated with swimming pools. The written consent must also include a statement that the department of health and county agency will not monitor or inspect the provider's swimming pool to ensure compliance with the requirements in this subdivision;

(2) enter into a written contract with a child's parent or legal guardian, and renew the written contract annually. The terms of the written contract must specify that the provider agrees to perform all of the requirements in this subdivision;

(3) attend and successfully complete a pool operator training course once every five years. Acceptable training courses are:

(i) the National Swimming Pool Foundation Certified Pool Operator course;

(ii) the National Spa and Pool Institute Tech I and Tech II courses (both required); or

(iii) the National Recreation and Park Association Aquatic Facility Operator course;

(4) require a caregiver trained in first aid and adult and child cardiopulmonary resuscitation to supervise and be present at the pool with any children in the pool;

(5) toilet all potty-trained children before they enter the pool;

(6) require all children who are not potty-trained to wear swim diapers while in the pool;

(7) if fecal material enters the pool water, add three times the normal shock treatment to the pool water to raise the chlorine level to at least 20 parts per million, and close the pool to swimming for the 24 hours following the entrance of fecal material into the water or until the water pH and disinfectant concentration levels have returned to the standards specified in clause (9), whichever is later;

(8) prevent any child from entering the pool who has an open wound or any child who has or is suspected of having a communicable disease;

(9) maintain the pool water at a pH of not less than 7.2 and not more than 8.0, maintain the disinfectant concentration between two and five parts per million for chlorine or between 2.3 and 4.5 parts per million for bromine, and maintain a daily record of the pool's operation with pH and disinfectant concentration readings on days when children cared for at the family day care or group family day care home are present;

(10) have a disinfectant feeder or feeders;

(11) have a recirculation system that will clarify and disinfect the pool volume of water in ten hours or less;

(12) maintain the pool's water clarity so that an object on the pool floor at the pool's deepest point is easily visible;

(13) have two or more suction lines in the pool;

(14) have in place and enforce written safety rules and pool policies;

(15) prohibit diving;

(16) prohibit pushing or rough play in the pool area;

(17) have in place at all times a safety rope that divides the shallow and deep portions of the pool;

(18) satisfy any existing local ordinances regarding pool installation, decks, and fencing;

(19) maintain a water temperature of not more than 104 degrees Fahrenheit and not less than 70 degrees Fahrenheit; and

(20) for lifesaving equipment, have a United States Coast Guard-approved life ring attached to a rope, an exit ladder, and a shepherd's hook available at all times to the caregiver supervising the pool.

(b) A violation of this subdivision is grounds for a sanction under section 245A.07, or a correction order or fine under section 245A.06. If a provider under this subdivision receives a licensing sanction or a correction order or fine relating to the supervision or health and safety of children, the provider is prohibited from allowing a child cared for at the family day care or group family day care home to continue to use the pool located at the home.

Sec. 5. Minnesota Statutes 2000, section 246.57, is amended by adding a subdivision to read:

Subd. 7. [SHARED SERVICES ACCOUNT.] Notwithstanding subdivision 1, beginning July 1, 2001, \$6,000,000 each biennium is transferred from the shared services account into which receipts for shared services under subdivision 1 are deposited to the general fund. This subdivision expires June 30, 2005.

Sec. 6. Minnesota Statutes 2000, section 252A.02, is amended by adding a subdivision to read:

Subd. 3a. [GUARDIANSHIP SERVICE PROVIDERS.] "Guardianship service providers" are individuals or agencies that meet the ethical conduct and best practice standards of the National Guardianship Association, meet the criminal background check requirements of section 245A.04, and do not provide any other services to the individuals for whom guardianship services are provided.

Sec. 7. Minnesota Statutes 2000, section 252A.02, subdivision 12, is amended to read:

Subd. 12. [COMPREHENSIVE EVALUATION.] "Comprehensive evaluation" shall consist of:

(1) a medical report on the health status and physical condition of the proposed ward, prepared under the direction of a licensed physician;

(2) a report on the proposed ward's intellectual capacity and functional abilities, specifying the tests and other data used in reaching its conclusions, prepared by a psychologist who is qualified in the diagnosis of mental retardation; and

(3) a report from the case manager that includes:

(i) the most current assessment of individual service needs as described in rules of the commissioner;

(ii) the most current individual service plan ~~as described in rules of the commissioner~~ under section 256B.092, subdivision 1b; and

(iii) a description of contacts with and responses of near relatives of the proposed ward notifying them that a nomination for public guardianship has been made and advising them that they may seek private guardianship.

Each report shall contain recommendations as to the amount of assistance and supervision required by the proposed ward to function as independently as possible in society. To be considered part of the comprehensive evaluation, reports must be completed no more than one year before filing the petition under section 252A.05.

Sec. 8. Minnesota Statutes 2000, section 252A.02, subdivision 13, is amended to read:

Subd. 13. [CASE MANAGER.] "Case manager" means the person designated ~~by the county board under rules of the commissioner to provide case management services~~ under section 256B.092.

Sec. 9. Minnesota Statutes 2000, section 252A.111, subdivision 6, is amended to read:

Subd. 6. [SPECIAL DUTIES.] In exercising powers and duties under this chapter, the commissioner shall:

(1) maintain close contact with the ward, visiting at least twice a year;

(2) ~~prohibit filming a ward in any way that would reveal the identity of the ward unless the commissioner determines the filming to be in the best interests of the ward. The commissioner may give written consent for filming of the ward after permitting and encouraging input by the nearest relative~~ protect and exercise the legal rights of the ward;

(3) take actions and make decisions on behalf of the ward that encourage and allow the maximum level of independent functioning in a manner least restrictive of the ward's personal freedom consistent with the need for supervision and protection; and

(4) permit and encourage maximum self-reliance on the part of the ward and permit and encourage input by the nearest relative of the ward in planning and decision making on behalf of the ward.

Sec. 10. Minnesota Statutes 2000, section 252A.16, subdivision 1, is amended to read:

Subdivision 1. [REVIEW REQUIRED.] The commissioner shall ~~provide~~ require an annual review of the physical, mental, and social adjustment and progress of every ward and conservatee. A copy of this review shall be kept on file at the department of human services and may be inspected by the ward or conservatee, the ward's or conservatee's parents, spouse, or relatives and other persons who receive the permission of the commissioner. The review shall contain information required under ~~rules of the commissioner~~ Minnesota Rules, part 9525.3065, subpart 1.

Sec. 11. Minnesota Statutes 2000, section 252A.19, subdivision 2, is amended to read:

Subd. 2. [PETITION.] The commissioner, ward, or any interested person may petition the appointing court or the court to which venue has been transferred for an order to remove the guardianship or to limit or expand the powers of the conservatorship or to appoint a guardian or conservator under sections 525.539 to 525.705 or to restore the ward or conservatee to full legal capacity or to review de novo any decision made by the public guardian or public conservator for or on behalf of a ward or conservatee or for any other order as the court may deem just and equitable. Section 525.61, subdivision 3, does not apply to a petition to remove a public guardian.

Sec. 12. Minnesota Statutes 2000, section 252A.20, subdivision 1, is amended to read:

Subdivision 1. [WITNESS AND ATTORNEY FEES.] In each proceeding under sections 252A.01 to 252A.21, the court shall allow and order paid to each witness subpoenaed the fees and mileage prescribed by law; to each physician, psychologist, or social worker who assists in the preparation of the comprehensive evaluation and who is not in the employ of the local agency; ~~or the state department of human services, or area mental health-mental retardation board;~~ a reasonable sum for services and for travel; and to the ward's counsel, when appointed by the court, a reasonable sum for travel and for each day or portion of a day actually employed in court or actually consumed in preparing for the hearing. Upon order the county auditor shall issue a warrant on the county treasurer for payment of the amount allowed.



Sec. 13. Minnesota Statutes 2000, section 256.482, subdivision 8, is amended to read:

Subd. 8. [SUNSET.] Notwithstanding section 15.059, subdivision 5, the council on disability shall not sunset until June 30, ~~2004~~ 2005.

Sec. 14. [PUBLIC GUARDIANSHIP ALTERNATIVES.]

The commissioner of human services shall provide county agencies with funds up to the amount appropriated for public guardianship alternatives based on proposals by the counties to establish private alternatives.

Sec. 15. [AUTOMATIC DEFIBRILLATOR STUDY.]

The emergency medical services regulatory board, in consultation with the department of public safety, shall study and report to the legislature by December 15, 2002, regarding the availability of automatic defibrillators outside the seven-county metropolitan area. The report shall include recommendations to make these devices accessible within a reasonable distance throughout the nonmetropolitan area, including recommendations for funding their acquisition and distribution.

Sec. 16. [REPEALER.]

Minnesota Statutes 2000, section 252A.111, subdivision 3, is repealed.

## ARTICLE 13

### APPROPRIATIONS

Section 1. [HEALTH AND HUMAN SERVICES APPROPRIATIONS.]

The sums shown in the columns marked "APPROPRIATIONS" are appropriated from the general fund, or any other named fund, to the agencies and for the purposes specified in the following sections of this article, to be available for the fiscal years indicated for each purpose. The figures "2002" and "2003" where used in this article, mean that the appropriation or appropriations listed under them are available for the fiscal year ending June 30, 2002, or June 30, 2003, respectively. Where a dollar amount appears in parentheses, it means a reduction of an appropriation.

#### SUMMARY BY FUND

APPROPRIATIONS	2002	2003	BIENNIAL TOTAL
General	\$3,083,417,000	\$3,390,915,000	\$6,474,332,000
State Government Special Revenue	35,451,000	37,127,000	72,578,000
Health Care Access	214,712,000	269,923,000	484,635,000
Federal TANF	318,103,000	277,420,000	595,523,000
Lottery Cash Flow	1,300,000	1,300,000	2,600,000
TOTAL	\$3,652,983,000	\$3,976,685,000	\$7,629,668,000

APPROPRIATIONS  
Available for the Year  
Ending June 30  
2002                      2003

Sec. 2. COMMISSIONER OF HUMAN SERVICES

Subdivision 1. Total Appropriation                      \$3,467,982,000                      \$3,792,993,000

Summary by Fund

General	2,960,188,000	3,270,671,000
State Government Special Revenue	507,000	507,000
Health Care Access	207,884,000	263,095,000
Federal TANF	298,103,000	257,420,000
Lottery Cash Flow	1,300,000	1,300,000

[APPROPRIATION FOR COURT-ORDERED MENTAL HEALTH TREATMENT.] Of the general fund appropriation, \$2,289,000 in fiscal year 2002 and \$2,289,000 in fiscal year 2003 are for the cost of implementing H. F. 560, if enacted. This appropriation is available only if H. F. 560 is enacted.

[APPROPRIATIONS FOR CIVIL COMMITMENT.] (a) Of the general fund appropriation, \$3,386,000 in fiscal year 2003 is for the cost of implementing H. F. 281, if enacted. This appropriation is available only if H. F. 281 is enacted.

(b) Of the general fund appropriation, \$155,000 in fiscal year 2003 is appropriated to the commissioner to be transferred to the Minnesota supreme court for costs associated with petitions filed for judicial commitment. This appropriation is available only if H. F. 281 is enacted.

[APPROPRIATIONS FOR CHILD SUPPORT.] (1) Of the general fund appropriation, \$32,000 in fiscal year 2002 and \$32,000 in fiscal year 2003 are for the cost of implementing H. F. 1807, if enacted. This appropriation is available only if H. F. 1807 is enacted.

(2) Of the general fund appropriation, \$435,000 in fiscal year 2002 is for the cost of implementing H. F. 1446, if enacted. This appropriation is available only if H. F. 1446 is enacted.

[APPROPRIATION FOR PATIENT PROTECTIONS.] (a) Of the general fund appropriation, \$248,000 in fiscal year 2002 and \$591,000 in fiscal year 2003 are for the cost of implementing the patient protection provisions in H. F. 560, if enacted. This appropriation is available only if H. F. 560 is enacted.

APPROPRIATIONS  
Available for the Year  
Ending June 30  
2002 2003

(b) Of the health care access fund appropriation, \$106,000 in fiscal year 2002 and \$255,000 in fiscal year 2003 are for the cost of implementing H. F. 560, if enacted. This appropriation is available only if H. F. 560 is enacted.

[RECEIPTS FOR SYSTEMS PROJECTS.] Appropriations and federal receipts for information system projects for MAXIS, PRISM, MMIS, and SSIS must be deposited in the state system account authorized in Minnesota Statutes, section 256.014. Money appropriated for computer projects approved by the Minnesota office of technology, funded by the legislature, and approved by the commissioner of finance may be transferred from one project to another and from development to operations as the commissioner of human services considers necessary. Any unexpended balance in the appropriation for these projects does not cancel but is available for ongoing development and operations.

[GIFTS.] Notwithstanding Minnesota Statutes, chapter 7, the commissioner may accept on behalf of the state additional funding from sources other than state funds for the purpose of financing the cost of assistance program grants or nongrant administration. All additional funding is appropriated to the commissioner for use as designated by the grantor of funding.

[SYSTEMS CONTINUITY.] In the event of disruption of technical systems or computer operations, the commissioner may use available grant appropriations to ensure continuity of payments for maintaining the health, safety, and well-being of clients served by programs administered by the department of human services. Grant funds must be used in a manner consistent with the original intent of the appropriation.

[SPECIAL REVENUE FUND INFORMATION.] On December 1, 2001, and December 1, 2002, the commissioner shall provide the chairs of the house health and human services finance committee and the senate health, human services, and corrections budget division with detailed fund balance information for each special revenue fund account.

[FEDERAL ADMINISTRATIVE REIMBURSEMENT.] Federal administrative reimbursement resulting from MinnesotaCare outreach grants and the Minnesota senior health options project are appropriated to the commissioner for these activities. Any balance from this appropriation remaining at the end of the biennium shall be transferred to the general fund.



APPROPRIATIONS  
Available for the Year  
Ending June 30  
2002 2003

[TANF MAINTENANCE OF EFFORT.] (a) In order to meet the basic maintenance of effort (MOE) requirements of the TANF block grant specified under Code of Federal Regulations, title 45, section 263.1, the commissioner may only report nonfederal money expended for allowable activities listed in the following clauses as TANF MOE expenditures:

(1) MFIP cash and food assistance benefits under Minnesota Statutes, chapter 256J;

(2) the child care assistance programs under Minnesota Statutes, sections 119B.03 and 119B.05, and county child care administrative costs under Minnesota Statutes, section 119B.15;

(3) state and county MFIP administrative costs under Minnesota Statutes, chapters 256J and 256K;

(4) state, county, and tribal MFIP employment services under Minnesota Statutes, chapters 256J and 256K; and

(5) expenditures made on behalf of noncitizen MFIP recipients who qualify for the medical assistance without federal financial participation program under Minnesota Statutes, section 256B.06, subdivision 4, paragraphs (d), (e), and (j).

(b) The commissioner shall ensure that sufficient qualified nonfederal expenditures are made each year to meet the state's TANF MOE requirements. For the activities listed in paragraph (a), clauses (2) to (5), the commissioner may only report expenditures that are excluded from the definition of assistance under Code of Federal Regulations, title 45, section 260.31.

(c) If nonfederal expenditures for the programs and purposes listed in paragraph (a) are insufficient to meet the state's TANF MOE requirements, the commissioner shall recommend additional allowable sources of nonfederal expenditures to the legislature, if the legislature is or will be in session to take action to specify additional sources of nonfederal expenditures for TANF MOE before a federal penalty is imposed. The commissioner shall otherwise provide notice to the legislative commission on planning and fiscal policy under paragraph (e).

(d) If the commissioner uses authority granted under Laws 1999, chapter 245, article 1, section 10, or similar authority granted by a subsequent legislature, to meet the state's TANF MOE requirements in a reporting period, the commissioner shall inform the chairs of the appropriate legislative committees about all transfers made under that authority for this purpose.

APPROPRIATIONS  
 Available for the Year  
 Ending June 30  
 2002                                 2003

(e) If the commissioner determines that nonfederal expenditures under paragraph (a) are insufficient to meet TANF MOE expenditure requirements, and if the legislature is not or will not be in session to take timely action to avoid a federal penalty, the commissioner may report nonfederal expenditures from other allowable sources as TANF MOE expenditures after the requirements of this paragraph are met. The commissioner may report nonfederal expenditures in addition to those specified under paragraph (a) as nonfederal TANF MOE expenditures, but only ten days after the commissioner of finance has first submitted the commissioner's recommendations for additional allowable sources of nonfederal TANF MOE expenditures to the members of the legislative commission on planning and fiscal policy for their review.

(f) The commissioner of finance shall not incorporate any changes in federal TANF expenditures or nonfederal expenditures for TANF MOE that may result from reporting additional allowable sources of nonfederal TANF MOE expenditures under the interim procedures in paragraph (e) into the February or November forecasts required under Minnesota Statutes, section 16A.103, unless the commissioner of finance has approved the additional sources of expenditures under paragraph (e).

(g) The provisions of Minnesota Statutes, section 256.011, subdivision 3, which require that federal grants or aids secured or obtained under that subdivision be used to reduce any direct appropriations provided by law, do not apply if the grants or aids are federal TANF funds.

(h) Notwithstanding section 14 of this article, paragraphs (a) to (h) expire June 30, 2005.

Subd. 2. Agency Management

General	34,500,000	32,971,000
State Government		
Special Revenue	392,000	392,000
Health Care		
Access	3,591,000	3,602,000
Federal TANF	546,000	454,000

APPROPRIATIONS  
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Ending June 30  
2002                      2003

The amounts that may be spent from the appropriation for each purpose are as follows:

(a) Financial Operations

General	6,708,000	6,708,000
Health Care Access	803,000	803,000
Federal TANF	546,000	454,000

(b) Legal and Regulation Operations

General	8,682,000	8,305,000
State Government Special Revenue	392,000	392,000
Health Care Access	233,000	244,000

[CORE LICENSING ACTIVITIES.] Of the general fund appropriation, \$1,138,000 in fiscal year 2002 and \$923,000 in fiscal year 2003 is to support 14 new licensor positions. Of this amount, \$72,000 in fiscal year 2002 and \$107,000 in fiscal year 2003 is to cover maintenance and operational costs for a new computer system, which will provide public access to licensing information. In order to receive continued appropriations for these purposes, by January 1, 2003, the commissioner shall:

- (1) reduce the average length of time to complete investigations of licensing complaints within 75 days;
- (2) complete all licensing reviews within the one-year and two-year intervals set forth in statutes; and
- (3) complete negative licensing action decisions within 45 days of county recommendations.

[EXPEDITED MALTREATMENT INVESTIGATIONS.] Of the general fund appropriation, \$359,000 in fiscal year 2002 and \$277,000 in fiscal year 2003 are for one senior investigator position, three investigator positions, and one-half of a clerical position to achieve the goals for expedited maltreatment investigations. In order to receive continued appropriations for this purpose, by January 1, 2003, the commissioner shall reduce the average length of time to complete maltreatment investigations to 60 days.

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2002                      2003

[PUBLIC GUARDIANSHIP INCENTIVES.] Of the general fund appropriation, \$250,000 in fiscal year 2002 and \$250,000 in fiscal year 2003 is to be used for the purposes of providing fiscal incentives to encourage counties to establish private alternatives.

(c) Management Operations

General	19,110,000	17,958,000
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Health Care Access	2,555,000	2,555,000
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Subd. 3. Administrative Reimbursement/ Pass Through

Federal TANF	60,565	51,992
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Subd. 4. Children's Services Grants

General	59,320,000	59,833,000
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Federal TANF	6,290,000	6,290,000
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[ADOPTION ASSISTANCE INCENTIVE GRANTS.] Federal funds available during fiscal year 2002 and fiscal year 2003, for adoption incentive grants are appropriated to the commissioner for these purposes.

[TANF TRANSFER TO SOCIAL SERVICES.] \$4,650,000 is appropriated to the commissioner in fiscal year 2002 and in fiscal year 2003 for purposes of increasing services for families with children whose incomes are at or below 200 percent of the federal poverty guidelines. The commissioner shall authorize a sufficient transfer of funds from the state's federal TANF block grant to the state's federal social services block grant to meet this appropriation.

[SOCIAL SERVICES BLOCK GRANT FUNDS FOR CONCURRENT PERMANENCY PLANNING.] Notwithstanding Minnesota Statutes, section 256E.07, \$4,650,000 in fiscal year 2002 and \$4,650,000 in fiscal year 2003 in social services block grant funds allocated to the commissioner under title XX of the Social Security Act are available for distribution to counties under the formula in Minnesota Statutes, section 260C.213, for the purposes of concurrent permanency planning.

Subd. 5. Children's Services Management

General	5,487,000	5,487,000
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APPROPRIATIONS  
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Ending June 30  
2002                      2003

## Subd. 6. Basic Health Care Grants

## Summary by Fund

General	1,114,020,000	1,317,641,000
Health Care Access	189,392,000	244,592,000

The amounts that may be spent from this appropriation for each purpose are as follows:

## (a) MinnesotaCare Grants

Health Care Access	188,642,000	243,842,000
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[MINNESOTACARE FEDERAL RECEIPTS.] Receipts received as a result of federal participation pertaining to administrative costs of the Minnesota health care reform waiver shall be deposited as nondedicated revenue in the health care access fund. Receipts received as a result of federal participation pertaining to grants shall be deposited in the federal fund and shall offset health care access funds for payments to providers.

[MINNESOTACARE FUNDING.] The commissioner may expend money appropriated from the health care access fund for MinnesotaCare in either fiscal year of the biennium.

## (b) MA Basic Health Care Grants - Families and Children

General	433,298,000	517,563,000
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## (c) MA Basic Health Care Grants - Elderly and Disabled

General	511,946,000	604,451,000
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[MEDICALLY NEEDY STANDARD AND FEDERAL AUTHORIZATION.] If federal authorization to use the medical assistance income standard in Minnesota Statutes, section 256B.056, subdivision 4, as the medically needy standard is not obtained, the commissioner shall use all resulting savings to provide services under the home and community-based waiver for persons with mental retardation and related conditions.

## (d) General Assistance Medical Care

General	155,744,000	176,748,000
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APPROPRIATIONS  
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2002                      2003

## (e) Health Care Grants - Other Assistance

General	13,032,000	18,879,000
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Health Care Access	750,000	750,000
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[PURCHASING ALLIANCE STOP-LOSS FUNDING.] Of the general fund appropriation, \$150,000 in fiscal year 2002 and \$500,000 in fiscal year 2003 are appropriated to the commissioner for the cost of establishing the Purchasing Alliance Stop-loss fund under Minnesota Statutes, section 256.956.

## Subd. 7. Basic Health Care Management

General	20,730,000	20,715,000
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Health Care Access	13,583,000	13,583,000
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The amounts that may be spent from this appropriation for each purpose are as follows:

## (a) Health Care Policy Administration

General	2,822,000	2,862,000
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Health Care Access	562,000	562,000
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## (b) Health Care Operations

General	17,908,000	17,853,000
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Health Care Access	13,021,000	13,021,000
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[PREPAID MEDICAL PROGRAMS.] The nonfederal share of the prepaid medical assistance program fund, which has been appropriated to fund county managed care advocacy and enrollment operating costs, shall be disbursed as grants using either a reimbursement or block grant mechanism.

## Subd. 8. State-Operated Services

General	205,868,000	199,287,000
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The amounts that may be spent from this appropriation for each purpose are as follows:

APPROPRIATIONS  
Available for the Year  
Ending June 30  
2002                      2003

[MITIGATION RELATED TO STATE-OPERATED SERVICES RESTRUCTURING.] Money appropriated to finance mitigation expenses related to restructuring state-operated services programs and administrative services may be transferred between fiscal years within the biennium.

[STATE-OPERATED SERVICES CHEMICAL DEPENDENCY PROGRAMS.] When the operations of the state-operated services chemical dependency fund created in Minnesota Statutes, section 246.18, subdivision 2, are impeded by projected cash deficiencies resulting from delays in the receipt of grants, dedicated income, or other similar receivables, and when the deficiencies would be corrected within the budget period involved, the commissioner of finance may transfer general fund cash reserves into this account as necessary to meet cash demands. The cash flow transfers must be returned to the general fund in the fiscal year that the transfer was made. Any interest earned on general fund cash flow transfers accrues to the general fund and not the state-operated services chemical dependency fund.

[STATE-OPERATED SERVICES RESTRUCTURING.] For purposes of restructuring state-operated services, any state-operated services employee whose position is to be eliminated shall be afforded the options provided in applicable collective bargaining agreements. All salary and mitigation allocations from fiscal year 2002 shall be carried forward into fiscal year 2003. Provided there is no conflict with any collective bargaining agreement, any state-operated services position reduction must only be accomplished through mitigation, attrition, transfer, and other measures as provided in state or applicable collective bargaining agreements and in Minnesota Statutes, section 252.50, subdivision 11, and not through layoff.

[REPAIRS AND BETTERMENTS.] The commissioner may transfer unencumbered appropriation balances between fiscal years within the biennium for the state residential facilities repairs and betterments account and special equipment.

Subd. 9. Continuing Care Grants

General	1,366,856,000	1,483,268,000
Lottery Cash		
Flow	1,158,000	1,158,000

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 Ending June 30  
 2002                      2003

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) Community Social Services Block Grants

48,718,000	49,695,000
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[CSSA TRADITIONAL APPROPRIATION.] Notwithstanding Minnesota Statutes, section 256E.06, subdivisions 1 and 2, the appropriations available under that section in fiscal years 2002 and 2003 must be distributed to each county proportionately to the aid received by the county in calendar year 2000.

(b) Aging Adult Service Grants

10,300,000	10,532,000
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[COUNTY PLANNING AND SERVICE DEVELOPMENT.] Of this appropriation, \$1,200,000 in fiscal year 2002 and \$1,600,000 in fiscal year 2003 are for distribution to county boards for planning and development of community services for the elderly as required under Minnesota Statutes, section 256B.437, subdivision 2. For Phase I funding to develop the initial biennial plan addendum, the commissioner shall distribute a minimum of \$10,000 to each county on July 1, 2001. In a county with more than 10,000 persons over 65 years, the funding allocation shall be \$15,000; with more than 30,000 persons over 65 years - \$20,000; with more than 50,000 persons over 65 years - \$25,000; and with more than 100,000 persons over 65 years - \$30,000. Upon submission of the completed biennial plan addendum, the commissioner shall distribute Phase II funding to each county for development of community-based services no later than January 1, 2002. For counties with less than 4,500 persons under 65 years, the Phase II allocation shall be \$10,000. For counties with more than 4,500 persons over 65 years, the Phase II allocation shall be \$2.23 per person over 65 years. Any remaining funds shall be available as targeted funds distributed to counties with designated critical access sites. Phase I funding may be carried over by the county into 2002 and 2003 for the development of services.

(c) Deaf and Hard-of-Hearing Services Grants

1,923,000	1,825,000
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[SERVICES TO DEAF PERSONS WITH MENTAL ILLNESS.] Of this appropriation, \$100,000 in fiscal year 2002 and \$100,000 in fiscal year 2003 is for a grant to a nonprofit agency that



APPROPRIATIONS  
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adult and family community support grants under Minnesota Rules, parts 9535.1700 to 9535.1760; semi-independent living services under Minnesota Statutes, section 252.275, including SILS funding under county social services grants formerly funded under Minnesota Statutes, chapter 256I; community support services for deaf and hard-of-hearing adults with mental illness who use or wish to use sign language as their primary means of communication; and living skills training programs for persons with intractable epilepsy who need assistance in the transition to independent living; and group residential housing supplementary service rate under Minnesota Statutes, section 256I.05, subdivision 1a.

(g) Medical Assistance Long-Term Care Facilities

590,638,000                         599,866,000

[MORATORIUM EXCEPTIONS.] During each year of the biennium beginning July 1, 2001, the commissioner of health may approve moratorium exception projects under Minnesota Statutes, section 144A.073, for which the full annualized state share of medical assistance costs does not exceed \$2,000,000.

[NURSING FACILITY OPERATED BY THE RED LAKE BAND OF CHIPPEWA INDIANS.] (1) The medical assistance payment rates for the 47-bed nursing facility operated by the Red Lake Band of Chippewa Indians must be calculated according to allowable reimbursement costs under the medical assistance program, as specified in Minnesota Statutes, section 246.50, and are subject to the facility-specific Medicare upper limits.

(2) In addition, the commissioner shall make available rate adjustments for the biennium beginning July 1, 2001, on the same basis as the adjustments provided to nursing facilities under Minnesota Statutes, section 256B.431. The commissioner must use the facility's final 2000 and 2001 Medicare cost reports to calculate the adjustments. This rate increase shall become part of the facility's base rate for future rate years.

[ICF/MR DISALLOWANCES.] Of this appropriation, \$65,000 in each fiscal year is to reimburse a four-bed ICF/MR in Ramsey county for disallowance resulting from field audit findings. The commissioner shall exempt these facilities from the provisions of Minnesota Statutes, section 256B.501, subdivision 5b, paragraph (d), clause (6), for the rate years beginning October 1, 1996, and October 1, 1997.

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[COMMUNITY SERVICES DEVELOPMENT GRANTS PROGRAM.] Of this appropriation, \$18,000,000 for the biennium ending June 30, 2003, is to the commissioner for grants under Minnesota Statutes, section 256.9754. Unexpended appropriations in fiscal year 2002 do not cancel but are available to the commissioner for these purposes in fiscal year 2003. This is a one-time appropriation and shall not become part of the base-level funding for the 2004-2005 biennium.

[LONG-TERM CARE CONSULTATION SERVICES.] Long-term care consultation services payments to all counties shall continue at the payment amount in effect for preadmission screening in fiscal year 2001.

(h) Alternative Care Grants

General	75,764,000	89,646,000
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[ALTERNATIVE CARE TRANSFER.] Any money allocated to the alternative care program that is not spent for the purposes indicated does not cancel but shall be transferred to the medical assistance account.

[ALTERNATIVE CARE APPROPRIATION.] The commissioner may expend the money appropriated for the alternative care program for that purpose in either year of the biennium.

(i) Group Residential Housing

General	78,712,000	86,807,000
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(j) Chemical Dependency Entitlement Grants

General	39,459,000	41,045,000
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(k) Chemical Dependency Nonentitlement Grants

General	5,941,000	5,918,000
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[CONSOLIDATED CHEMICAL DEPENDENCY TREATMENT FUND ONE-TIME TRANSFER.] \$9,367,000 of funds available in the consolidated chemical dependency treatment fund general reserve account is transferred in fiscal year 2002 to the general fund.

Subd. 10. Continuing Care Management

General	24,546,000	23,928,000
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State Government		
Special Revenue	115,000	115,000
Lottery Cash Flow	142,000	142,000

[COUNTY INVOLVEMENT COSTS.] Of this appropriation, up to \$481,000 in fiscal year 2002 and up to \$642,000 in fiscal year 2003 are for the commissioner to allocate to counties for resident relocation costs resulting from planned closures under Minnesota Statutes, section 256B.437, and resident relocations under Minnesota Statutes, section 144A.161. Unexpended funds for fiscal year 2002 do not cancel but are available to the commissioner for this purpose in fiscal year 2003.

[REGION 10 QUALITY ASSURANCE COMMISSION.] (1) Of the appropriation from the general fund for the biennium ending June 30, 2003, \$548,000 is to the commissioner of human services to be allocated to the region 10 quality assurance commission for operating costs of the alternative quality assurance licensing project and for grants to counties participating in that project.

(2) \$50,000 is appropriated from the general fund to the commissioner of human services for the biennium ending June 30, 2003, for the region 10 quality assurance commission to conduct the evaluation required under Minnesota Statutes, section 256B.0951, subdivision 9.

(3) \$150,000 is appropriated from the general fund to the commissioner of human services for the biennium ending June 30, 2003, for the commissioner to conduct the project evaluation required for the federal 1115 waiver of ICF/MR regulations.

Subd. 11. Economic Support Grants

General	91,086,000	90,136,000
Federal TANF	228,209,000	197,741,000

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) Assistance to Families Grants

General	25,237,000	21,821,000
Federal TANF	164,745,000	133,553,000





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## (c) Economic Support Grants - Other Assistance

General	4,682,000	6,931,000
Federal TANF	1,001,000	2,525,000

[TANF TRANSFER TO CHILD CARE AND DEVELOPMENT BLOCK GRANT.] \$1,526,000 for fiscal year 2003 is appropriated to the commissioner of children, families, and learning for the purposes of Minnesota Statutes, section 119B.05. The commissioner of human services shall authorize a sufficient transfer of funds from the state's federal TANF block grant to the state's child care and development fund block grant to meet this appropriation.

[WORKING FAMILY TAX CREDITS.] (1) On a regular basis, the commissioner of revenue, with the assistance of the commissioner of human services, shall calculate the value of the refundable portion of the Minnesota working family credits provided under Minnesota Statutes, section 290.0671, that qualifies for federal reimbursement from the temporary assistance for needy families block grant. The commissioner of revenue shall provide the commissioner of human services with such expenditure records and information as are necessary to support draws of federal funds.

(2) Federal TANF funds, as specified in this paragraph, are appropriated to the commissioner of human services based on calculations under paragraph (a) of working family tax credit expenditures that qualify for reimbursement from the TANF block grant for income tax refunds payable in federal fiscal years beginning October 1, 2001. The draws of federal TANF funds shall be made on a regular basis based on calculations of credit expenditures by the commissioner of revenue. Up to the following amounts of federal TANF draws are appropriated to the commissioner of human services to deposit in the general fund: in fiscal year 2002, \$25,000,000; and in fiscal year 2003, \$16,000,000.

## (d) Child Support Enforcement

General	4,239,000	4,239,000
Federal TANF	260,000	260,000

[CHILD SUPPORT PAYMENT CENTER.] Payments to the commissioner from other governmental units, private enterprises, and individuals for services performed by the child support

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payment center must be deposited in the state systems account authorized under Minnesota Statutes, section 256.014. These payments are appropriated to the commissioner for the operation of the child support payment center or system, according to Minnesota Statutes, section 256.014.

(e) General Assistance

General	17,156,000	15,700,000
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[GENERAL ASSISTANCE STANDARD.] The commissioner shall set the monthly standard of assistance for general assistance units consisting of an adult recipient who is childless and unmarried or living apart from his or her parents or a legal guardian at \$203. The commissioner may reduce this amount in accordance with Laws 1997, chapter 85, article 3, section 54.

(f) Minnesota Supplemental Aid

General	29,678,000	31,351,000
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(g) Refugee Services

General	250,000	250,000
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Subd. 12. Economic Support Management

General	37,775,000	37,405,000
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Health Care Access	1,318,000	1,318,000
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Federal TANF	2,493,000	943,000
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The amounts that may be spent from this appropriation for each purpose are as follows:

(a) Economic Support Policy Administration

General	6,528,000	6,191,000
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Federal TANF	2,493,000	943,000
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[FOOD STAMP ADMINISTRATIVE REIMBURSEMENT.] The commissioner shall reduce quarterly food stamp administrative reimbursement to counties in fiscal years 2002 and 2003 by the amount that the United States Department of Health and Human Services determines to be the county random moment study share



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Sec. 3. COMMISSIONER OF HEALTH

Subdivision 1. Total Appropriation	138,591,000	138,716,000
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Summary by Fund

General	87,619,000	86,160,000
State Government Special Revenue	24,144,000	25,728,000
Health Care Access	6,828,000	6,828,000
Federal TANF	20,000,000	20,000,000

Subd. 2. Family and Community Health	72,535,000	72,847,000
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Summary by Fund

General	47,943,000	47,256,000
State Government Special Revenue	936,000	1,935,000
Health Care Access	3,656,000	3,656,000
Federal TANF	20,000,000	20,000,000

[ELIMINATING HEALTH DISPARITIES.] Of the general fund appropriation, \$6,000,000 each year is for reducing health disparities. Of the amounts available:

(1) \$1,500,000 each year is for competitive grants under Minnesota Statutes, section 145.928, subdivision 7, to eligible applicants to reduce health disparities in infant mortality rates and adult and child immunization rates.

(2) \$2,000,000 each year is for competitive grants under Minnesota Statutes, section 145.928, subdivision 8, to eligible applicants to reduce health disparities in breast and cervical cancer screening rates, HIV/AIDS and sexually transmitted infection rates, cardiovascular disease rates, diabetes rates, and rates of accidental injuries and violence.

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(3) \$500,000 each year is for grants under Minnesota Statutes, section 145.928, subdivision 9, to community health boards as defined in Minnesota Statutes, section 145A.02, to improve access to health screening and follow-up services for refugee populations.

(4) \$2,000,000 each year is for grants to community health boards as defined in Minnesota Statutes, section 145A.02, according to the formula in Minnesota Statutes, section 145.882, subdivision 4a, to provide services targeted at reducing maternal and child health disparities.

[TEEN PREGNANCY PREVENTION.] \$20,000,000 from the TANF fund for the 2002-2003 biennium is appropriated to the commissioner of health for a teen pregnancy prevention program. Of the amounts available:

(1) \$3,500,000 in fiscal year 2002 and \$5,000,000 in fiscal year 2003 are for teen pregnancy prevention disparity grants under Minnesota Statutes, section 145.9257, subdivision 6.

(2) \$3,000,000 in fiscal year 2002 and \$3,000,000 in fiscal year 2003 are for high-risk community teen pregnancy prevention grants under Minnesota Statutes, section 145.9257, subdivision 7.

(3) \$2,000,000 in fiscal year 2002 and \$2,000,000 in fiscal year 2003 are for transfer to the commissioner of children, families, and learning to increase the number of adolescent parenting grants.

(4) \$1,500,000 in fiscal year 2002 is for one-time grants to public school districts to implement an abstinence until marriage curriculum and to train staff to implement the curriculum. The curriculum shall educate adolescents that abstinence from sexual activity outside of marriage is the expected standard and that sexual activity outside the context of marriage is likely to have harmful emotional, physical, and social effects; and shall provide an explanation of the value of the institution of marriage and a discussion of the historical purpose and significance of marriage. The commissioner of health, in consultation with the commissioner of children, families, and learning, shall make school districts aware of the availability of funds for this purpose. This appropriation shall not become part of the base-level funding for this activity.

[POISON INFORMATION SYSTEM.] Of the general fund appropriation, \$1,360,000 each fiscal year is for poison control system grants under Minnesota Statutes, section 145.93. This is a one-time appropriation that shall not become part of base-level funding in 2004-2005.

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[SUICIDE PREVENTION.] Of the general fund appropriation, \$1,100,000 each fiscal year is for suicide prevention activities under Minnesota Statutes, section 145.56. Of the amounts available:

(1) \$275,000 each fiscal year is for refining, coordinating, and implementing the suicide prevention plan according to Minnesota Statutes, section 145.56, subdivisions 1, 3, 4, and 5.

(2) \$825,000 each fiscal year is to fund community-based programs under Minnesota Statutes, section 145.56, subdivision 2.

[TANF HOME VISITING PROGRAM.] Of the federal TANF appropriation, \$10,000,000 in fiscal year 2002 and \$10,000,000 in fiscal year 2003 are for family home visiting programs under Minnesota Statutes, section 145A.17. These amounts include \$7,000,000 in fiscal year 2002 and \$7,000,000 in fiscal year 2003 of appropriations to the commissioner of human services for transfer to the commissioner of health authorized in Laws 2000, chapter 488, article 13, section 15, subdivision 6, clause (3), as amended by Laws 2000, chapter 499, sections 22 and 39.

[TANF HOME VISITING CARRYFORWARD.] Any unexpended balance of the TANF funds appropriated for family home visiting in the first year of the biennium does not cancel but is available for the second year.

[TEEN PREGNANCY PREVENTION CARRYFORWARD.] Any unexpended balance of the TANF funds appropriated for teen pregnancy prevention in the first fiscal year of the biennium does not cancel but is available for the second year.

[WIC TRANSFERS.] The general fund appropriation for the women, infants, and children (WIC) food supplement program is available for either year of the biennium. Transfers of these funds between fiscal years must be either to maximize federal funds or to minimize fluctuations in the number of program participants.

[MINNESOTA CHILDREN WITH SPECIAL HEALTH NEEDS CARRYFORWARD.] General fund appropriations for treatment services in the services for Minnesota children with special health needs program are available for either year of the biennium.

[ONE-TIME REDUCTION FOR FAMILY PLANNING SPECIAL PROJECT GRANTS.] For fiscal year 2003, base-level funding for the Family Planning Special Project Grants under Minnesota Statutes, section 145.925, shall be reduced by \$690,000.

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		2002	2003
Subd. 3. Access and Quality Improvement		31,284,000	30,268,000
Summary by Fund			
General	21,160,000	20,194,000	
State Government Special Revenue	6,952,000	6,902,000	
Health Care Access	3,172,000	3,172,000	
<p>[HEALTH CARE SAFETY NET.] (1) Of the general fund appropriation, \$5,000,000 each year is for a grant program to aid safety net community clinics.</p> <p>(2) \$5,000,000 each year is for a grant program to provide rural hospital capital improvement grants described in Minnesota Statutes, section 144.148.</p>			
Subd. 4. Health Protection		29,808,000	30,639,000
Summary by Fund			
General	13,699,000	13,895,000	
State Government Special Revenue	16,109,000	16,744,000	
<p>[EMERGING HEALTH THREATS.] (a) Of the general fund appropriation, \$2,200,000 in the first year and \$2,400,000 in the second year are to increase the state capacity to identify and respond to emerging health threats.</p> <p>(b) Of these amounts, \$1,900,000 in the first year and \$2,100,000 in the second year are to expand state laboratory capacity to identify infectious disease organisms, evaluate environmental contaminants, develop new analytical techniques, provide emergency response, and support local government by training health care system workers to deal with biological and chemical health threats.</p> <p>(c) \$300,000 each year is to train, consult, and otherwise assist local officials responding to clandestine drug laboratories and minimizing health risks to responders and the public.</p>			
Subd. 5. Management and Support Services		4,964,000	4,962,000



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Summary by Fund

General	4,817,000	4,815,000		
State Government Special Revenue	147,000	147,000		
Sec. 4. VETERANS NURSING HOMES BOARD			30,336,000	28,784,000

[VETERANS HOMES SPECIAL REVENUE ACCOUNT.] The general fund appropriations made to the board may be transferred to a veterans homes special revenue account in the special revenue fund in the same manner as other receipts are deposited according to Minnesota Statutes, section 198.34, and are appropriated to the board for the operation of board facilities and programs.

[SETTING COST OF CARE.] The cost of care for the domiciliary residents at the Minneapolis veterans home for fiscal year 2002 and fiscal year 2003 shall be calculated based on 100 percent occupancy at each facility.

[DEFICIENCY FUNDING.] Of the general fund appropriation in fiscal year 2002, \$2,000,000 is available with the approval of the commissioner of finance. Approval of the commissioner of finance is contingent upon review of the board's submittal of a report outlining the following:

- (1) a long-term revenue outlook for the homes;
- (2) a review and recommendation of alternative funding sources for the homes' operations; and
- (3) administrative and service options to bring cost growth in line with revenues.

Sec. 5. HEALTH-RELATED BOARDS

Subdivision 1. Total Appropriation			10,800,000	10,892,000
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[STATE GOVERNMENT SPECIAL REVENUE FUND.] The appropriations in this section are from the state government special revenue fund.

[NO SPENDING IN EXCESS OF REVENUES.] The commissioner of finance shall not permit the allotment, encumbrance, or expenditure of money appropriated in this section in excess of the anticipated biennial revenues or

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accumulated surplus revenues from fees collected by the boards. Neither this provision nor Minnesota Statutes, section 214.06, applies to transfers from the general contingent account.

Subd. 2. Board of Chiropractic Examiners	361,000	361,000
Subd. 3. Board of Dentistry	806,000	806,000
Subd. 4. Board of Dietetic and Nutrition Practice	95,000	95,000
Subd. 5. Board of Marriage and Family Therapy	111,000	111,000
Subd. 6. Board of Medical Practice	3,270,000	3,270,000
Subd. 7. Board of Nursing	2,704,000	2,772,000

[HEALTH PROFESSIONAL SERVICES ACTIVITY.] Of these appropriations, \$534,000 in fiscal year 2002 and \$566,000 in fiscal year 2003 are for the Health Professional Services Activity.

Subd. 8. Board of Nursing Home Administrators	194,000	186,000
Subd. 9. Board of Optometry	90,000	90,000
Subd. 10. Board of Pharmacy	1,301,000	1,316,000

[ADMINISTRATIVE SERVICES UNIT.] Of this appropriation, \$433,000 the first year and \$441,000 the second year are for the health boards administrative services unit. The administrative services unit may receive and expend reimbursements for services performed for other agencies.

Subd. 11. Board of Physical Therapy	185,000	185,000
Subd. 12. Board of Podiatry	52,000	42,000
Subd. 13. Board of Psychology	653,000	647,000
Subd. 14. Board of Social Work	825,000	832,000
Subd. 15. Board of Veterinary Medicine	153,000	179,000
Sec. 6. EMERGENCY MEDICAL SERVICES BOARD	3,033,000	3,037,000

Summary by Fund

General	3,033,000	3,037,000
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[COMPREHENSIVE ADVANCED LIFE SUPPORT (CALs).]  
\$500,000 in fiscal year 2002 and \$500,000 in fiscal year 2003 are  
for the comprehensive advanced life support educational program  
under Minnesota Statutes, section 144E.37.

Sec. 7. COUNCIL ON DISABILITY	692,000	714,000
Sec. 8. OMBUDSMAN FOR MENTAL HEALTH AND MENTAL RETARDATION	1,378,000	1,378,000
Sec. 9. OMBUDSMAN FOR FAMILIES	171,000	171,000
Sec. 10. TRANSFERS		

Subdivision 1. Grants

The commissioner of human services, with the approval of the commissioner of finance, and after notification of the chair of the senate health and family security budget division and the chair of the house health and human services finance committee, may transfer unencumbered appropriation balances for the biennium ending June 30, 2003, within fiscal years among the MFIP, general assistance, general assistance medical care, medical assistance, Minnesota supplemental aid, and group residential housing programs, and the entitlement portion of the chemical dependency consolidated treatment fund, and between fiscal years of the biennium.

Subd. 2. Administration

Positions, salary money, and nonsalary administrative money may be transferred within the departments of human services and health and within the programs operated by the veterans nursing homes board as the commissioners and the board consider necessary, with the advance approval of the commissioner of finance. The commissioner or the board shall inform the chairs of the house health and human services finance committee and the senate health and family security budget division quarterly about transfers made under this provision.

Sec. 11. INDIRECT COSTS NOT TO FUND PROGRAMS.

The commissioners of health and of human services shall not use indirect cost allocations to pay for the operational costs of any program for which they are responsible.



by adding subdivisions; 256B.0627, subdivisions 1, 2, 4, 5, 7, 8, 10, 11, by adding subdivisions; 256B.0635, subdivisions 1, 2; 256B.0911, subdivisions 1, 3, 5, 6, 7, by adding subdivisions; 256B.0913, subdivisions 1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14; 256B.0915, subdivisions 1d, 3, 5; 256B.0916, subdivisions 1, 7, 9, by adding a subdivision; 256B.0917, subdivision 7; 256B.092, subdivisions 2a, 5; 256B.093, subdivision 3; 256B.095; 256B.0951, subdivisions 1, 3, 4, 5, 7, by adding subdivisions; 256B.0952, subdivisions 1, 4; 256B.431, subdivision 17, by adding subdivisions; 256B.434, subdivisions 4, 10, by adding subdivisions; 256B.49, by adding subdivisions; 256B.501, by adding a subdivision; 256B.69, subdivisions 4, 5, 5b, 23, by adding a subdivision; 256B.75; 256B.76; 256D.03, subdivisions 3, 4; 256D.053, subdivision 1; 256D.35, by adding subdivisions; 256D.44, subdivision 5; 256I.05, subdivision 1e; 256J.09, subdivisions 1, 2, 3, by adding subdivisions; 256J.15, by adding a subdivision; 256J.24, subdivision 10; 256J.26, subdivision 1; 256J.31, subdivisions 4, 12; 256J.32, subdivision 7a; 256J.42, by adding a subdivision; 256J.45, subdivision 1; 256J.46, subdivisions 1, 2a, by adding a subdivision; 256J.50, subdivisions 1, 7; 256J.56; 256J.57, subdivision 2; 256J.62, subdivision 9; 256J.625, subdivisions 1, 2, 4; 256J.751; 256K.03, subdivision 1; 256K.07; 256K.25, subdivisions 1, 3, 4, 5, 6; 256L.06, subdivision 3; 256L.12, subdivision 9, by adding a subdivision; 256L.16; 268.0122, subdivision 2; 626.556, subdivisions 3, 3c, 10b, 10i; 626.557, subdivisions 3, 9d; 626.5572, subdivision 17; Laws 1995, chapter 178, article 2, section 36; Laws 1995, chapter 207, article 3, section 21, as amended; Laws 1997, chapter 203, article 9, section 21, as amended; Laws 1999, chapter 152, sections 1, 4; Laws 1999, chapter 245, article 3, section 45, as amended; Laws 1999, chapter 245, article 4, section 110; proposing coding for new law in Minnesota Statutes, chapters 62S; 144; 144A; 145; 145A; 246; 256; 256B; 256I; 256J; 299A; repealing Minnesota Statutes 2000, sections 144.0721, subdivision 1; 144.148, subdivision 8; 145.882, subdivisions 3, 4; 145.9245; 145.927; 252A.111, subdivision 3; 256.476, subdivision 7; 256B.037, subdivision 5; 256B.0635, subdivision 3; 256B.0911, subdivisions 2, 2a, 4, 8, 9; 256B.0912; 256B.0913, subdivisions 3, 15a, 15b, 15c, 16; 256B.0915, subdivisions 3a, 3b, 3c; 256B.0951, subdivision 6; 256B.434, subdivision 5; 256B.49, subdivisions 1, 2, 3, 4, 5, 6, 7, 8, 9, 10; 256E.06, subdivision 2b; 256J.42, subdivision 4; 256J.44; 256J.46, subdivision 1a; Laws 1995, chapter 178, article 2, section 48, subdivision 6; 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; 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; 9505.3670."

The motion prevailed and the amendment was adopted.

Dawkins was excused between the hours of 10:20 a.m. and 11:50 a.m.

Goodno moved to amend S. F. No. 2361, as amended, as follows:

Page 211, line 7, delete "section 256B.49."

Page 219, line 17, delete "3" and insert "77"

Page 219, line 27, delete "74" and insert "78"

Page 224, line 3, delete "73" and insert "77"

Page 224, line 16, delete "73 and 74" and insert "77 and 78"

Page 224, line 20, delete "74" and insert "77"

Page 224, line 26, delete "4a."

Page 235, line 31, delete "100-508" and insert "101-508"

Page 326, line 9, delete "make available" and insert "provide"

Page 326, line 19, delete "31" and insert "32"

Page 328, line 5, after "array" insert ", determining a median, or otherwise performing a statistical measure"

Page 328, line 26, after "and" insert ", for facilities reimbursed under this section or section 256B.431,"

Page 330, line 27, delete "This increase" and insert "The increases under this subdivision shall be added following the determination under this chapter of the payment rate for the rate year beginning July 1, 2001, and"

Pages 330 to 332, delete section 31 of article 5

Page 524, lines 9 to 10, delete "the day following final enactment" and insert "August 1, 2001"

Page 538, after line 14, insert:

"Sec. 16. [BOARD OF NURSING FEES.]

Fee modifications proposed by the governor for the board of nursing in the 2002-2003 health and human services biennial budget document are approved.

Sec. 17. [BOARD OF MARRIAGE AND FAMILY THERAPY FEES.]

Fee increases and new fees proposed by the governor for the board of marriage and family therapy in the 2002-2003 health and human services biennial budget document are approved."

Page 560, after line 32, insert:

"[LICENSE FEES.] Notwithstanding the provisions of Minnesota Statutes, sections 144.122, 144.53, and 144A.07, a health care facility licensed under the provisions of Minnesota Statutes, chapter 144 or 144A, may submit the required fee for licensure renewal in quarterly installments. Any health care facility requesting to pay the renewal fees in quarterly payments shall make the request at the time of license renewal. Facilities licensed under the provisions of Minnesota Statutes, chapter 144, shall submit quarterly payments by January 1, April 1, July 1, and October 1 of each year. Nursing homes licensed under Minnesota Statutes, chapter 144A, shall submit the first quarterly payment with the application for renewal, and the remaining payments shall be submitted at three-month intervals from the license expiration date. The commissioner of health can require full payment of any outstanding balance if a quarterly payment is late. Full payment of the annual renewal fee will be required in the

event that the facility is sold or ceases operation during the licensure year. Failure to pay the licensure fee is grounds for the nonrenewal of the license."

ReNUMBER the sections in sequence and correct internal references

Amend the title accordingly

The motion prevailed and the amendment was adopted.

Goodno moved to amend S. F. No. 2361, as amended, as follows:

Page 469, after line 20, insert:

"Sec. 34. Minnesota Statutes 2000, section 261.062, is amended to read:

261.062 [TAX FOR SUPPORT OF POOR.]

The county board ~~shall~~ may levy a tax annually sufficient to defray the estimated expenses of supporting and relieving the poor therein during the succeeding year, and to make up any deficiency in the fund raised for that purpose during the preceding year."

ReNUMBER the sections in sequence and correct internal references

Amend the title accordingly

The motion prevailed and the amendment was adopted.

Howes, Mares, Walz, Wenzel, Ozment, Fuller, Koskinen, Pugh, Leighton, Mullery, Ness, Smith, Osskopp and Solberg moved to amend S. F. No. 2361, as amended, as follows:

Page 564, after line 3, insert:

"Sec. 14. FINANCIAL ADJUSTMENTS AND DIRECT CARE STAFF OR SERVICES

The commissioners of health and of human services, in making agency financial adjustments related to funding levels for salary supplements and rent increases, shall not layoff employees providing direct health care or mental health services to patients, or reduce the level of funding for the provision of direct health care and mental health services."

Page 564, line 4, delete "14" and insert "15"

The motion prevailed and the amendment was adopted.

Howes moved to amend S. F. No. 2361, as amended, as follows:

Page 538, after line 14, insert:

"Sec. 16. [AH-GWAH-CHING CENTER.]

The commissioner of human services and the Cass county board of commissioners, in consultation with the commissioner of administration, shall evaluate the feasibility of allowing Cass county to buy or lease unused portions of Ah-Gwah-Ching center. The commissioner shall present the results of this evaluation and recommendations to the chairs of the house and senate committees with jurisdiction over health and human services policy and finance."

Page 538, line 15, delete "16" and insert "17"

The motion prevailed and the amendment was adopted.

Ozment moved to amend S. F. No. 2361, as amended, as follows:

Page 64, after line 30, insert:

"Sec. 56. [RECOMMENDATIONS; INCENTIVES FOR MAGNET HOSPITALS.]

The commissioner of health shall develop recommendations for incentives that may be implemented to increase the number of magnet hospitals in Minnesota. These recommendations must be reported by December 1, 2001 to the chairs of the house and senate committees with jurisdiction over health and human services policy and finance issues."

Renumber the sections in sequence and correct internal references

Amend the title accordingly

The motion prevailed and the amendment was adopted.

Nornes moved to amend S. F. No. 2361, as amended, as follows:

Page 22, after line 11, insert:

"Sec. 29. Minnesota Statutes 2000, section 144.551, subdivision 1, is amended to read:

Subdivision 1. [RESTRICTED CONSTRUCTION OR MODIFICATION.] (a) The following construction or modification may not be commenced:

(1) any erection, building, alteration, reconstruction, modernization, improvement, extension, lease, or other acquisition by or on behalf of a hospital that increases the bed capacity of a hospital, relocates hospital beds from one physical facility, complex, or site to another, or otherwise results in an increase or redistribution of hospital beds within the state; and

(2) the establishment of a new hospital.



(b) This section does not apply to:

(1) construction or relocation within a county by a hospital, clinic, or other health care facility that is a national referral center engaged in substantial programs of patient care, medical research, and medical education meeting state and national needs that receives more than 40 percent of its patients from outside the state of Minnesota;

(2) a project for construction or modification for which a health care facility held an approved certificate of need on May 1, 1984, regardless of the date of expiration of the certificate;

(3) a project for which a certificate of need was denied before July 1, 1990, if a timely appeal results in an order reversing the denial;

(4) a project exempted from certificate of need requirements by Laws 1981, chapter 200, section 2;

(5) a project involving consolidation of pediatric specialty hospital services within the Minneapolis-St. Paul metropolitan area that would not result in a net increase in the number of pediatric specialty hospital beds among the hospitals being consolidated;

(6) a project involving the temporary relocation of pediatric-orthopedic hospital beds to an existing licensed hospital that will allow for the reconstruction of a new philanthropic, pediatric-orthopedic hospital on an existing site and that will not result in a net increase in the number of hospital beds. Upon completion of the reconstruction, the licenses of both hospitals must be reinstated at the capacity that existed on each site before the relocation;

(7) the relocation or redistribution of hospital beds within a hospital building or identifiable complex of buildings provided the relocation or redistribution does not result in: (i) an increase in the overall bed capacity at that site; (ii) relocation of hospital beds from one physical site or complex to another; or (iii) redistribution of hospital beds within the state or a region of the state;

(8) relocation or redistribution of hospital beds within a hospital corporate system that involves the transfer of beds from a closed facility site or complex to an existing site or complex provided that: (i) no more than 50 percent of the capacity of the closed facility is transferred; (ii) the capacity of the site or complex to which the beds are transferred does not increase by more than 50 percent; (iii) the beds are not transferred outside of a federal health systems agency boundary in place on July 1, 1983; and (iv) the relocation or redistribution does not involve the construction of a new hospital building;

(9) a construction project involving up to 35 new beds in a psychiatric hospital in Rice county that primarily serves adolescents and that receives more than 70 percent of its patients from outside the state of Minnesota;

(10) a project to replace a hospital or hospitals with a combined licensed capacity of 130 beds or less if: (i) the new hospital site is located within five miles of the current site; and (ii) the total licensed capacity of the replacement hospital, either at the time of construction of the initial building or as the result of future expansion, will not exceed 70 licensed hospital beds, or the combined licensed capacity of the hospitals, whichever is less;

(11) the relocation of licensed hospital beds from an existing state facility operated by the commissioner of human services to a new or existing facility, building, or complex operated by the commissioner of human services; from one regional treatment center site to another; or from one building or site to a new or existing building or site on the same campus;

(12) the construction or relocation of hospital beds operated by a hospital having a statutory obligation to provide hospital and medical services for the indigent that does not result in a net increase in the number of hospital beds;  
or

(13) a construction project involving the addition of up to 31 new beds in an existing nonfederal hospital in Beltrami county; or

(14) a construction project involving the addition of up to eight new beds in an existing nonfederal hospital in Otter Tail county with 100 licensed acute care beds."

Renumber the sections in sequence and correct internal references

Amend the title accordingly

The motion prevailed and the amendment was adopted.

The Speaker resumed the Chair.

Vandever, Jacobson, Juhnke and Hackbarth moved to amend S. F. No. 2361, as amended, as follows:

Page 3, lines 34 and 36, reinstate the stricken language and delete the new language

Page 4, lines 28 and 30, reinstate the stricken language and delete the new language

Pages 5 to 8, delete section 5

Renumber the sections in sequence and correct internal references

Amend the title accordingly

A roll call was requested and properly seconded.

The question was taken on the Vandever et al amendment and the roll was called. There were 61 yeas and 67 nays as follows:

Those who voted in the affirmative were:

Anderson, I.	Finseth	Jennings	Mariani	Pelowski	Vandever
Bakk	Folliard	Johnson, R.	Marko	Peterson	Wasiluk
Bernardy	Gerlach	Johnson, S.	Marquart	Pugh	Wenzel
Biernat	Goodwin	Juhnke	McGuire	Rukavina	Westerberg
Carlson	Greiling	Kalis	Milbert	Schumacher	Westrom
Clark, K.	Hackbarth	Koskinen	Murphy	Sertich	Winter
Davnie	Hilstrom	Kubly	Olson	Skoe	
Dorman	Hilty	Leighton	Opatz	Slawik	
Dorn	Howes	Lenczewski	Osthoff	Solberg	
Entenza	Jacobson	Lieder	Otremba	Thompson	
Evans	Jaros	Luther	Paymar	Tingelstad	

Those who voted in the negative were:

Abeler	Buesgens	Dempsey	Gleason	Holsten	Knoblach
Abrams	Cassell	Dibble	Goodno	Huntley	Krinkie
Anderson, B.	Clark, J.	Eastlund	Gunther	Johnson, J.	Kuisle
Bishop	Daggett	Erhardt	Haas	Kahn	Leppik
Boudreau	Davids	Erickson	Hausman	Kelliher	Lindner
Bradley	Dehler	Fuller	Holberg	Kielkucki	Lipman

Mares	Nornes	Rhodes	Smith	Tuma	Spk. Sviggum
McElroy	Osskopp	Rifenberg	Stanek	Wagenius	
Molnau	Ozment	Ruth	Stang	Walz	
Mulder	Paulsen	Seagren	Swapinski	Wilkin	
Mullery	Pawlenty	Seifert	Swenson	Wolf	
Ness	Penas	Skoglund	Sykora	Workman	

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

Smith moved to amend S. F. No. 2361, as amended, as follows:

Page 564, after line 3, insert:

"Sec. 14. Minnesota Statutes 2000, section 13B.06, subdivision 4, is amended to read:

Subd. 4. [METHOD TO PROVIDE DATA.] To comply with the requirements of this section, a financial institution ~~may either:~~

~~(1) provide to the public authority a list containing only the names and other necessary personal identifying information of all account holders for the public authority to compare against its list of child support obligors for the purpose of identifying which obligors maintain an account at the financial institution; the names of the obligors who maintain an account at the institution shall then be transmitted to the financial institution which shall provide the public authority with account information on those obligors; or~~

~~(2) must obtain a list of child support obligors from the public authority and compare that data to the data maintained at the financial institution to identify which of the identified obligors maintains an account at the financial institution.~~

~~A financial institution shall elect either method in writing upon written request of the public authority, and the election remains in effect unless the public authority agrees in writing to a change.~~

~~The commissioner shall keep track of the number of financial institutions that elect to report under clauses (1) and (2) respectively and shall report this information to the legislature by December 1, 1999."~~

Renumber the sections in sequence and correct internal references

Amend the title accordingly

The motion prevailed and the amendment was adopted.

Seagren moved to amend S. F. No. 2361, as amended, as follows:

Page 57, after line 13, insert:

"(c) Data collected on individuals served by the home visiting programs must remain confidential and must not be disclosed by providers of home visiting services without a specific informed written consent that identifies disclosures to be made. Upon request, agencies providing home visiting services must provide recipients with

information on disclosures, including the names of entities and individuals receiving the information and the general purpose of the disclosure. Prospective and current recipients of home visiting services must be told and informed in writing that written consent for disclosure of data is not required for access to home visiting services."

The motion prevailed and the amendment was adopted.

Kubly, Juhnke, Winter and Peterson moved to amend S. F. No. 2361, as amended, as follows:

Page 549, after line 34, insert:

"[GRANTS FOR SENIOR NUTRITION.] Of the general fund appropriation, \$40,881 in fiscal year 2002 is appropriated to the commissioner for senior nutrition programs under Minnesota Statutes, section 256.9752 and shall be distributed as follows:

- (1) \$12,023 is for development region 6E;
- (2) \$18,692 is for development region 6W; and
- (3) \$10,166 is for development region 8."

The motion prevailed and the amendment was adopted.

Goodno moved to amend S. F. No. 2361, as amended, as follows:

Page 436, delete lines 25 to 36

Page 437, delete line 1

Re-number the sections in sequence

Amend the title accordingly

The motion prevailed and the amendment was adopted.

Kelliher; Johnson, R.; Otremba; Hilty; Juhnke; Wagenius; Kubly and Peterson moved to amend S. F. No. 2361, as amended, as follows:

Page 8, after line 15, insert:

"Sec. 6. [103I.237] [REAL PROPERTY SALE; TEST RESULTS PROVIDED TO BUYER.]

Subdivision 1. [PROVISION OF TEST RESULTS.] Before signing an agreement to sell or transfer real property, the seller must provide to the buyer, for each well connected to the potable water system of a building intended for human habitation or occupancy, the results of a well test for nitrate plus nitrite, total coliform bacteria, and arsenic performed by an environmental laboratory certified for those analytes under Minnesota Rules, part 4740.2040, subparts 2, item B, and 3, item B. The test must have been performed within one year preceding the date of delivery

of the test results to the buyer. The test results or accompanying documentation must indicate whether the results are within acceptable limits for nitrate plus nitrite, total coliform bacteria, and arsenic as established by the commissioner.

Subd. 2. [EXCLUSIONS.] This section does not apply to the transfer of real property where no consideration is given, or to the sale, exchange, or transfer of real property:

- (1) that consists solely of a sale or transfer of severed mineral interests; or
- (2) that consists of an individual condominium unit as described in chapters 515 and 515B.

Subd. 3. [EFFECT OF FAILURE TO COMPLY.] Failure to comply with a requirement of this section does not impair:

- (1) the validity of a deed or other instrument of conveyance as between the parties to the deed or instrument or as to any other person who otherwise would be bound by the deed or instrument; or
- (2) the record, as notice, of any deed or other instrument of conveyance accepted for filing or recording contrary to the provisions of this section.

Sec. 7. [103I.243] [MODEL NOTICE RECOMMENDING PERIODIC WELL TESTING.]

Subdivision 1. [CONTENT OF MODEL NOTICE.] The commissioner shall create a model notice recommending periodic well testing for all wells connected to the potable water system of a building intended for human habitation or occupancy. The notice must contain at least the following information:

- (1) the potential hazards of using water from wells for drinking and food preparation, why wells should be regularly tested for total coliform bacteria and nitrate plus nitrite, and why wells in certain areas of the state should be tested for arsenic;
- (2) recommendations that wells be tested at least annually for total coliform bacteria and nitrate plus nitrite;
- (3) recommendations that wells be tested once for arsenic in areas of the state in which, because of the geology of the area, arsenic may be present in well water;
- (4) instructions on taking water samples from wells and submitting samples to water testing laboratories for testing;
- (5) the estimated costs of having well water tested for total coliform bacteria, nitrate plus nitrite, and arsenic; and
- (6) what further steps to take if a test indicates the presence of total coliform bacteria, nitrate plus nitrite, or arsenic, including the importance of testing for pesticides as defined in section 18B.01, subdivision 18, if total coliform bacteria or nitrate plus nitrite is present in well water.

Subd. 2. [DISSEMINATION OF MODEL NOTICE; OTHER INFORMATION.] (a) The commissioner shall provide a copy of the model notice to each city, county, and town in the state that has private wells connected to the potable water system of a building intended for human habitation or occupancy. Each city, county, and town is encouraged to annually provide the model notice to all households in its jurisdiction that use such wells or to otherwise provide to the households all the information in the model notice. A local government may provide the notice to households by any means convenient, including distribution at public meetings, posting in public places, or enclosing the notice in mailings made for any other purpose.

- (b) The commissioner shall post the following information on the department's Web site:

- (1) a copy of the model notice created according to subdivision 1;
- (2) links to other Web sites that address children's health issues; and
- (3) a map of the state indicating areas in which, because of the geology of the area, arsenic may be present in well water."

Renumber the sections in sequence and correct internal references

Amend the title accordingly

A roll call was requested and properly seconded.

The question was taken on the Kelliher et al amendment and the roll was called. There were 56 yeas and 75 nays as follows:

Those who voted in the affirmative were:

Bernardy	Folliard	Jennings	Leighton	Osthoff	Swapinski
Biernat	Gleason	Johnson, R.	Lenczewski	Otremba	Thompson
Carlson	Goodwin	Johnson, S.	Luther	Paymar	Wagenius
Clark, K.	Gray	Juhnke	Mahoney	Peterson	Wasiluk
Davnie	Greiling	Kahn	Mariani	Pugh	Westerberg
Dibble	Hausman	Kalis	Marko	Schumacher	Winter
Dorn	Hilstrom	Kelliher	McGuire	Skoglund	
Eastlund	Hilty	Koskinen	Mullery	Slawik	
Entenza	Huntley	Kubly	Murphy	Smith	
Evans	Jaros	Larson	Opatz	Solberg	

Those who voted in the negative were:

Abeler	Dehler	Holberg	Mares	Penas	Tingelstad
Abrams	Dempsey	Holsten	Marquart	Rhodes	Tuma
Anderson, B.	Dorman	Howes	McElroy	Rifenberg	Vandever
Anderson, I.	Erhardt	Jacobson	Molnau	Rukavina	Walz
Bakk	Erickson	Johnson, J.	Mulder	Ruth	Wenzel
Bishop	Finseth	Kielkucki	Ness	Seagren	Westrom
Boudreau	Fuller	Knoblach	Nornes	Seifert	Wilkin
Bradley	Gerlach	Krinkie	Olson	Sertich	Wolf
Buesgens	Goodno	Kuisle	Osskopp	Skoe	Workman
Cassell	Gunther	Leppik	Ozment	Stanek	Spk. Sviggum
Clark, J.	Haas	Lieder	Paulsen	Stang	
Daggett	Hackbarth	Lindner	Pawlenty	Swenson	
Davids	Harder	Lipman	Pelowski	Sykora	

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

Jennings moved to amend S. F. No. 2361, as amended, as follows:

Page 64, after line 30, insert:

"Sec. 56. [STUDY; REIMBURSEMENT FOR CERTAIN ANTI-TOBACCO USE EDUCATION ACTIVITIES.]

The commissioner of health, in consultation with persons who have had laryngectomies to treat larynx cancer, who use artificial larynxes for communication, and who engage in anti-tobacco use education activities, shall study and develop recommendations establishing a program to reimburse these persons for mileage and other costs associated with traveling to schools in the state to educate students about the health risks of tobacco use. The recommendations must include proposals for reimbursement levels, a funding source, expenses for which persons may be reimbursed, and persons eligible for reimbursement. The recommendations must be reported to the chairs of the policy and finance committees in the House and Senate with jurisdiction over health and human services issues by January 15, 2002."

Re-number the sections in sequence and correct internal references

Amend the title accordingly

The motion prevailed and the amendment was adopted.

Johnson, R.; Carlson; Davnie; Gleason; Luther; Winter; Bernardy; Lieder; Skoe; Sertich; Koskinen; Evans; Thompson and Johnson, S., moved to amend S. F. No. 2361, as amended, as follows:

Page 74, after line 20, insert:

"(27) Have the authority to administer a drug rebate program for drugs purchased according to the fair drug pricing program established under section 256.954. The commissioner shall require a rebate agreement from all manufacturers of covered drugs as defined in section 256B.0625, subdivision 13. For each drug, the amount of the rebate shall be equal to the basic rebate as defined for purposes of the federal rebate program in United States Code, title 42, section 1396r-8. The rebate program shall utilize the terms and conditions used for the federal rebate program established according to section 1927 of title XIX of the federal Social Security Act.

Sec. 2. [256.954] [FAIR DRUG PRICING PROGRAM.]

Subdivision 1. [PURPOSE.] This section may be cited as the Fair Drug Pricing Act. It is the purpose of the legislature to promote the health and well-being of Minnesota citizens by providing affordable access to prescription drugs at prices that are fair, not excessive, and nondiscriminatory.

Subd. 2. [ESTABLISHMENT.] The commissioner of human services shall establish and administer the Fair Drug Pricing Act. The commissioner may contract with a pharmacy benefit manager to administer the program.

Subd. 3. [DEFINITIONS.] For the purpose of this section, the following terms have the meanings given them:

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

(b) "Manufacturer" means a manufacturer as defined in section 151.44, paragraph (c).

(c) "Covered prescription drug" means a prescription drug as defined in section 151.44, paragraph (d), that is covered under medical assistance as described in section 256B.0625, subdivision 13, and that is provided by a manufacturer that has a fully executed rebate agreement with the commissioner under this section and complies with that agreement.

(d) "Health carrier" means an insurance company licensed under chapter 60A to offer, sell, or issue an individual or group policy of accident and sickness insurance as defined in section 62A.01; a nonprofit health service plan corporation operating under chapter 62C; a health maintenance organization operating under chapter 62D; a joint self-insurance employee health plan operating under chapter 62H; a community integrated systems network licensed under chapter 62N; a fraternal benefit society operating under chapter 64B; and a self-funded health plan under the Employee Retirement Income Security Act of 1974, as amended.

(e) "Participating pharmacy" means a pharmacy as defined in section 151.01, subdivision 2, that agrees to participate in the fair drug pricing program.

(f) "Enrolled individual" means a person who is eligible for the program under subdivision 4 and has enrolled in the program according to subdivision 5.

Subd. 4. [ELIGIBILITY.] To be eligible for the program, an applicant must:

(1) be a permanent resident of Minnesota as defined in section 256L.09, subdivision 4;

(2) not be enrolled in medical assistance, general assistance medical care, MinnesotaCare, or the prescription drug program under section 256.955;

(3) not be enrolled in and have currently available prescription drug coverage under a health plan offered by a health carrier; and

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

Subd. 5. [APPLICATION.] (a) Applications and information on the program must be made available at county social services agencies, health care provider offices, and agencies and organizations serving senior citizens. Individuals shall submit applications and any information specified by the commissioner as being necessary to verify eligibility directly to the county social services agencies. County social services agencies shall determine an applicant's eligibility for the program within 30 days from the date the application is received. Eligibility begins the month after approval.

(b) The commissioner shall develop an application form that does not exceed one page in length and requires information necessary to determine eligibility for the program.

Subd. 6. [PARTICIPATING PHARMACY.] According to a valid prescription, a participating pharmacy must sell a covered prescription drug to an enrolled individual at the pharmacy's usual and customary retail price, minus an amount that is equal to the rebate amount described in subdivision 8, plus any administrative fee established by the commissioner. Each participating pharmacy shall provide the commissioner with all information necessary to administer the program, including, but not limited to, information on prescription drug sales to enrolled individuals and usual and customary retail prices.

Subd. 7. [NOTIFICATION.] The commissioner shall notify each drug manufacturer each calendar quarter or according to a schedule to be established by the commissioner of the amount of the rebate owed on the prescription drugs sold by participating pharmacies to enrolled individuals.

Subd. 8. [REBATE.] To the extent that a manufacturer's prescription drugs are prescribed to a citizen of this state, the manufacturer must provide a rebate equal to the rebate provided under the medical assistance program for any prescription drug distributed by the manufacturer that is purchased by an enrolled individual at a participating pharmacy. The manufacturer must provide full payment within 30 days of receipt of the state invoice for the rebate.



or according to a schedule to be established by the commissioner. The commissioner shall deposit all rebates received into the Minnesota prescription drug dedicated fund established under this section. The manufacturer must provide the commissioner with any information necessary to verify the rebate determined per drug.

Subd. 9. [DISTRIBUTION.] The commissioner shall distribute on a biweekly basis the amount collected under subdivision 8 to each participating pharmacy based on the prescription drugs sold by that pharmacy to enrolled individuals, minus the amount of the administrative fee established by the commissioner under subdivision 10.

Subd. 10. [ADMINISTRATIVE FEE.] The commissioner may establish a reasonable administrative fee that covers the commissioner's expenses for enrollment, processing claims, and distributing rebates under this program to be paid by enrolled individuals.

Subd. 11. [DEDICATED FUND.] (a) The Minnesota prescription drug dedicated fund is established as an account in the state treasury. The commissioner of finance shall credit to the dedicated fund all rebates paid under subdivision 8, and any appropriations or allocations designated for the fund. The commissioner of finance shall ensure that fund money is invested under section 11A.25. All money earned by the fund must be credited to the fund. The fund shall earn a proportionate share of the total state annual investment income.

(b) [USE OF FUND.] Money in the fund is appropriated to the commissioner of human services to reimburse participating pharmacies for prescription drug discounts provided to enrolled individuals under this section, to reimburse the commissioner of human services for costs related to enrollment, processing claims, distributing rebates, and for other reasonable administrative costs related to administration of the fair drug pricing program.

Subd. 12. [ENFORCEMENT.] (a) A violation of this section shall be deemed a violation of section 325F.69 and shall be enforceable according to section 8.31.

(b) The remedies provided by this section are cumulative and shall not be construed as restricting remedies otherwise available against the same conduct under the common law or other statutes of this state."

Page 547, after line 18, insert:

"[COST PROVISION.] For the biennium beginning July 1, 2001, any increased costs incurred by a state agency as a result of Article 2, section 2 (adding section 256.954) must be absorbed internally by the state agency within its appropriation budgeted for professional and technical services. For bienniums beginning on or after July 1, 2003, base funding for the department of human services for implementation of Article 2, section 2, shall be \$1,089,000 each fiscal year. Notwithstanding section 13, this rider does not expire."

Renumber the sections in sequence and correct internal references

Amend the title accordingly

A roll call was requested and properly seconded.

The question was taken on the Johnson, R., et al amendment and the roll was called. There were 65 yeas and 66 nays as follows:

Those who voted in the affirmative were:

Anderson, I.	Biernat	Davnie	Dorn	Evans	Goodwin
Bakk	Carlson	Dempsey	Eastlund	Folliard	Gray
Bernardy	Clark, K.	Dibble	Entenza	Gleason	Greiling

Hausman	Juhnke	Lenczewski	Milbert	Peterson	Solberg
Hilstrom	Kahn	Lieder	Mullery	Pugh	Swapinski
Hilty	Kalis	Luther	Murphy	Rukavina	Thompson
Huntley	Kelliher	Mahoney	Opatz	Schumacher	Wagenius
Jaros	Koskinen	Mariani	Osthoff	Sertich	Wasiluk
Jennings	Kubly	Marko	Otremba	Skoe	Wenzel
Johnson, R.	Larson	Marquart	Paymar	Skoglund	Winter
Johnson, S.	Leighton	McGuire	Pelowski	Slawik	

Those who voted in the negative were:

Abeler	Dehler	Harder	Lindner	Paulsen	Swenson
Abrams	Dorman	Holberg	Lipman	Pawlenty	Sykora
Anderson, B.	Erhardt	Holsten	Mares	Penas	Tingelstad
Bishop	Erickson	Howes	McElroy	Rhodes	Tuma
Boudreau	Finseth	Jacobson	Molnau	Rifenberg	Vandever
Bradley	Fuller	Johnson, J.	Mulder	Ruth	Walz
Buesgens	Gerlach	Kielkucki	Ness	Seagren	Westerberg
Cassell	Goodno	Knoblach	Nornes	Seifert	Westrom
Clark, J.	Gunther	Krinkie	Olson	Smith	Wilkin
Daggett	Haas	Kuisle	Osskopp	Stanek	Wolf
Davids	Hackbarth	Leppik	Ozment	Stang	Workman

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

Seagren moved to amend S. F. No. 2361, as amended, as follows:

Page 191, line 34, after the period, insert "Individually identifiable patient data obtained through real-time or store-and-forward technology must be maintained in a confidential manner. If the video is used for research, training, or other purposes unrelated to the care of the patient, the identity of the patient must be concealed."

The motion prevailed and the amendment was adopted.

Boudreau moved to amend S. F. No. 2361, as amended, as follows:

Pages 28 to 34, delete sections 32 to 37, and insert:

"Sec. 32. [145.4241] [DEFINITIONS.]

Subdivision 1. [APPLICABILITY.] As used in sections 145.4241 to 145.4246, the following terms have the meaning given them.

Subd. 2. [ABORTION.] "Abortion" includes an act, procedure, or use of any instrument, medicine, or drug which is supplied or prescribed for or administered to a woman known to be pregnant with the intention to terminate the pregnancy with an intention other than to increase the probability of live birth, to preserve the life or health of the child after live birth, or to remove a dead fetus.

Subd. 3. [ATTEMPT TO PERFORM AN ABORTION.] "Attempt to perform an abortion" means an act, or an omission of a statutorily required act, that, under the circumstances as the actor believes them to be, constitutes a substantial step in a course of conduct planned to culminate in the performance of an abortion in Minnesota in violation of sections 145.4241 to 145.4246.

Subd. 4. [MEDICAL EMERGENCY.] "Medical emergency" means any condition that, on the basis of the physician's good faith clinical judgment, complicates the medical condition of a pregnant female to the extent that:

- (1) an immediate abortion of her pregnancy is necessary to avert her death; or
- (2) a 24-hour delay in performing an abortion creates a serious risk of substantial injury or impairment of a major bodily function.

Subd. 5. [PHYSICIAN.] "Physician" means a person licensed under chapter 147.

Subd. 6. [PROBABLE GESTATIONAL AGE OF THE FETUS.] "Probable gestational age of the fetus" means what will, in the judgment of the physician, with reasonable probability, be the gestational age of the fetus at the time the abortion is planned to be performed.

Sec. 33. [145.4242] [INFORMED CONSENT.]

(a) No abortion shall be performed in this state except with the voluntary and informed consent of the female upon whom the abortion is to be performed. Except in the case of a medical emergency, consent to an abortion is voluntary and informed only if the female is told the following, by telephone or in person, by the physician who is to perform the abortion, the referring physician, a registered nurse, or a licensed practical nurse, at least 24 hours prior to the abortion:

(1) the particular medical risks associated with the particular abortion procedure to be employed including, when medically accurate, the risks of infection, hemorrhage, breast cancer, danger to subsequent pregnancies, and infertility;

(2) the probable gestational age of the fetus at the time the abortion is to be performed;

(3) the medical risks associated with carrying to term;

(4) that medical assistance benefits may be available for prenatal care, childbirth, and neonatal care;

(5) that the father is liable to assist in the support of her child except under certain circumstances, even in instances when the father has offered to pay for the abortion;

(6) the availability of a toll-free number and Web site that can provide information on support services during pregnancy and while the child is dependent and offer alternatives to abortion; and

(7) that she has the right to review the printed materials described in section 145.4243, and the printed materials are available on the state Web site.

(b) The physician or the physician's agent shall orally inform the female that the materials have been provided by the state of Minnesota and that they describe the unborn child and list agencies that offer alternatives to abortion.

(c) The physician or the physician's agent shall orally inform the female of the Web site address and toll-free number.

(d) If the female chooses to view the materials, they shall either be given to her at least 24 hours before the abortion or mailed to her at least 72 hours before the abortion by first class mail, or at the woman's request, by certified mail, restricted delivery to addressee, which means the postal employee may only deliver the mail to the addressee. The envelope used by the physician shall not identify the name of the physician or the physician's clinic or business.

(e) If a physical examination, tests, or the availability of other information to the physician subsequently indicates, in the medical judgment of the physician, a revision of the information previously supplied to the patient, that revised information may be communicated to the patient at any time prior to the performance of the abortion.

Sec. 34. [145.4243] [PRINTED INFORMATION.]

Subdivision 1. [MATERIALS.] (a) Within 90 days after the effective date of sections 145.4241 to 145.4246, the department of health shall cause to be published, in English and in each language that is the primary language of two percent or more of the state's population, the printed materials described in paragraphs (b) and (c) in such a way as to ensure that the information is easily comprehensible.

(b) The materials must be designed to inform the female of the probable anatomical and physiological characteristics of the fetus at two-week gestational increments from the time when a female can be known to be pregnant to full term, including any relevant information on the possibility of the fetus' survival and pictures or drawings representing the development of the fetus at two-week gestational increments, provided that any such pictures or drawings must contain the dimensions of the fetus and must be realistic and appropriate for the stage of pregnancy depicted. The materials must be objective, nonjudgmental, and designed to convey only accurate scientific information about the fetus at the various gestational ages.

(c) The materials must contain objective information describing the methods of abortion procedures commonly employed, the medical risks commonly associated with each procedure, the possible detrimental psychological effects of abortion, and the medical risks commonly associated with carrying a child to term.

Subd. 2. [TYPEFACE; AVAILABILITY.] The materials referred to in this section must be printed in a typeface large enough to be clearly legible. The materials required under this section must be available from the department of health upon request and in appropriate number to any person, facility, or hospital at no cost.

Sec. 35. [145.4244] [PROCEDURE IN CASE OF MEDICAL EMERGENCY.]

When a medical emergency compels the performance of an abortion, the physician shall inform the female, prior to the abortion if possible, of the medical indications supporting the physician's judgment that an abortion is necessary to avert her death or that a 24-hour delay in conformance with section 145.4242 creates a serious risk of substantial injury or impairment of a major bodily function.

Sec. 36. [145.4245] [TOLL-FREE TELEPHONE NUMBER AND WEB SITE.]

Subdivision 1. [RIGHT TO KNOW.] All pregnant women have the right to know information about resources available to assist them and their families. The commissioner of health shall establish and maintain a statewide toll-free telephone number available seven days a week to provide information and referrals to local community resources to assist women and families through pregnancy and childbirth and while the child is dependent.

Subd. 2. [INFORMATION.] The toll-free telephone number must provide information regarding community resources on the following topics:

- (1) information regarding avoiding unplanned pregnancies;
- (2) prenatal care, including the need for an initial risk screening and assessment;
- (3) adoption;
- (4) health education, including the importance of good nutrition during pregnancy and the risks associated with alcohol and tobacco use during pregnancy;
- (5) available social services, including medical assistance benefits for prenatal care, childbirth, and neonatal care;

(6) legal assistance in obtaining child support; and

(7) community support services and other resources to enhance family strengths and reduce the possibility of family violence.

Subd. 3. [WEB SITE.] The commissioner shall design and maintain a secure Web site to provide the information described under subdivision 2 and section 145.4243 with a minimum resolution of 72 PPI. The Web site shall provide the toll-free information and referral telephone number described under subdivision 2.

Sec. 37. [145.4246] [ENFORCEMENT PENALTIES.]

Subdivision 1. [STANDING.] A person with standing may maintain an action against the performance or attempted performance of abortions in violation of section 145.4242. Those with standing are:

(1) a woman upon whom an abortion in violation of section 145.4242 has been performed or attempted to be performed; and

(2) the parent of an unemancipated minor upon whom an abortion in violation of section 145.4242 has been, is about to be, or was attempted to be performed; and

(3) attorney general of the state of Minnesota.

Subd. 2. [INJUNCTIONS.] Parties bringing actions against the performance or attempted performance of abortions in violation of section 145.4242 may seek temporary restraining orders, preliminary injunctions, and injunctions related only to the physician or facility where the violation occurred in accordance with the Rules of Civil Procedure. Persons with standing must bring any actions within six months of the date of the performed or attempted performance of abortions in violation of section 145.4242.

Subd. 3. [CONTEMPT.] Any person knowingly violating the terms of an injunction against the performance or attempted performance of abortions in violation of section 145.4242 is subject to civil contempt, and shall be fined no more than \$1,000 for the first violation, no more than \$5,000 for the second violation, no more than \$10,000 for the third violation, and for each successive violation an amount sufficient to deter future violations. The fine shall be the exclusive penalty for a violation. Each performance or attempted performance of abortion in violation of section 145.4242 is a separate violation. No fine shall be assessed against the woman on whom an abortion is performed or attempted.

Subd. 4. [REALLOCATION OF THE FINE.] Any fines collected under this section must be sent to a special account at the Minnesota department of health to be used for materials cited in section 145.4243.

Sec. 38. [145.4247] [CUMULATIVE RIGHTS.]

The provisions of sections 145.4241 to 145.4246 are cumulative with existing law regarding an individual's right to consent to medical treatment and shall not impair any existing right any patient may have under the common law or statutes of this state."

Renumber the sections in sequence and correct internal references

Amend the title accordingly

A roll call was requested and properly seconded.

Folliard moved to amend the Boudreau amendment to S. F. No. 2361, as amended, as follows:

Delete pages 1 to 3

Page 4, delete lines 1 to 29

Page 5, line 22, delete "and section 145.4243"

Page 5, delete lines 26 to 36

Page 6, delete lines 1 to 31

A roll call was requested and properly seconded.

#### CALL OF THE HOUSE

On the motion of Seifert and on the demand of 10 members, a call of the House was ordered. The following members answered to their names:

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

Seifert moved that further proceedings of the roll call be suspended and that the Sergeant at Arms be instructed to bring in the absentees. The motion prevailed and it was so ordered.

The question recurred on the Folliard amendment to the Boudreau amendment and the roll was called.

Seifert moved that those not voting be excused from voting. The motion did not prevail.

There were 50 yeas and 83 nays as follows:

Those who voted in the affirmative were:

Abrams	Dibble	Greiling	Kahn	Marko	Slawik
Bakk	Dorn	Hausman	Kelliher	McGuire	Swapinski
Bernardy	Entenza	Hilstrom	Koskinen	Mullery	Thompson
Biernat	Erhardt	Hilty	Larson	Osthoff	Wagenius
Bishop	Evans	Huntley	Leighton	Paymar	Wasiluk
Carlson	Folliard	Jaros	Leppik	Rhodes	
Clark, K.	Gleason	Jennings	Luther	Rukavina	
Davnie	Goodwin	Johnson, R.	Mahoney	Sertich	
Dawkins	Gray	Johnson, S.	Mariani	Skoglund	

Those who voted in the negative were:

Abeler	Erickson	Juhnke	Milbert	Penas	Sykora
Anderson, B.	Finseth	Kalis	Molnau	Peterson	Tingelstad
Anderson, I.	Fuller	Kielkucki	Mulder	Pugh	Tuma
Boudreau	Gerlach	Knoblach	Murphy	Rifenberg	Vandever
Bradley	Goodno	Krinkie	Ness	Ruth	Walz
Buesgens	Gunther	Kubly	Nornes	Schumacher	Wenzel
Cassell	Haas	Kuisle	Olson	Seagren	Westerberg
Clark, J.	Hackbarth	Lenczewski	Opatz	Seifert	Westrom
Daggett	Harder	Lieder	Osskopp	Skoe	Wilkin
Davids	Holberg	Lindner	Otremba	Smith	Winter
Dehler	Holsten	Lipman	Ozment	Solberg	Wolf
Dempsey	Howes	Mares	Paulsen	Stanek	Workman
Dorman	Jacobson	Marquart	Pawlenty	Stang	Spk. Sviggum
Eastlund	Johnson, J.	McElroy	Pelowski	Swenson	

The motion did not prevail and the amendment to the amendment was not adopted.

Kahn; Folliard; Huntley; Clark, K., and Dibble moved to amend the Boudreau amendment to S. F. No. 2361, as amended, as follows:

Page 6, after line 31, insert:

"Sec. 39. [145.4247] [A MAN'S RIGHT-TO-KNOW INFORMED CONSENT.]

(a) No prescription for Viagra shall be prescribed in this state except with the voluntary and informed consent of the man for whom the prescription is prescribed. Except in the case of a medical emergency, consent to a prescription for Viagra is voluntary and informed only if:

(1) the man has the written permission of his wife or significant other;

(2) the man is told the following, by telephone or in person, by the physician who is to prescribe the Viagra or by a referring physician, at least 24 hours before the prescription is filled:

(i) the name of the physician who will prescribe the Viagra;

(ii) the particular medical risks associated with Viagra including, when medically accurate, the side effects and/or risks of STD (sexually transmitted disease) infection;

(iii) the importance of remaining faithful in a marriage relationship, including:

(A) educating men that monogamy within marriage is the expected standard;

(B) educating men that sexual activity outside the context of marriage is likely to have harmful emotional, physical, and social effects; and

(C) an explanation of the value of the institution of marriage and a discussion of the historical purpose and significance of marriage; and

(iv) that he has the right to review the printed materials described in this section. The physician or the physician's agent shall orally inform the man that the materials have been provided by the state of Minnesota and that they describe the medication and list agencies that offer alternatives to Viagra. If the man chooses to view the materials, they shall either be given to him at least 24 hours before the medication is prescribed or mailed to him at least 72 hours by certified mail, restricted delivery to addressee, which means the postal employee can only deliver the mail to the addressee;

(3) the man certifies in writing, prior to receiving the prescription, that the information described in this section has been furnished him, and that he has been informed of his opportunity to review the information referred to in item (iv); and

(4) prior to prescribing Viagra, the physician who is to prescribe the drug or the physician's agent receives a copy of the written certification prescribed by clause (3).

(b) The information required by paragraph (a), clause (2), items (i) to (iii), may be provided by telephone without conducting a physical examination or tests of the patient, in which case the information required to be provided may be based on facts supplied the physician by the man and whatever other relevant information is reasonably available to the physician. It may not be provided by a tape recording, but must be provided during a consultation in which the physician is able to ask questions of the man and the man is able to ask questions of the physician. If a physical examination, tests, or the availability of other information to the physician subsequently indicate, in the medical judgment of the physician, a revision of the information previously supplied to the patient, that revised information may be communicated to the patient at any time prior to prescribing Viagra. Nothing in this section may be construed to preclude provision of required information in a language understood by the patient through a translator.

(c) The information required by paragraph (a), clause (2), item (iv), may be provided by a tape recording if provision is made to record or otherwise register specifically whether the man does or does not choose to review the printed materials.

Sec. 40. [145.4248] [REMEDIES.]

Any person who receives a prescription for Viagra may maintain an action against the person who prescribed the drug in knowing or reckless violation of section 145.4247 for actual and punitive damages."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

A roll call was requested and properly seconded.



The question was taken on the amendment to the amendment and the roll was called.

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

There were 18 yeas and 112 nays as follows:

Those who voted in the affirmative were:

Clark, K.	Gleason	Hausman	Jaros	Luther	Rukavina
Dehler	Goodwin	Hilty	Kahn	Mariani	Skoe
Folliard	Gray	Huntley	Lieder	Pugh	Swapinski

Those who voted in the negative were:

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

The motion did not prevail and the amendment to the amendment was not adopted.

The Speaker called Abrams to the Chair.

The question recurred on the Boudreau amendment and the roll was called. There were 84 yeas and 49 nays as follows:

Those who voted in the affirmative were:

Abeler	Davids	Gerlach	Jacobson	Lenczewski	Mulder
Anderson, B.	Dehler	Goodno	Johnson, J.	Lieder	Murphy
Anderson, I.	Dempsey	Gunther	Juhnke	Lindner	Ness
Boudreau	Dorman	Haas	Kalis	Lipman	Nornes
Bradley	Dorn	Hackbarth	Kielkucki	Mares	Olson
Buesgens	Eastlund	Harder	Knoblach	Marquart	Opatz
Cassell	Erickson	Holberg	Krinkie	McElroy	Osskopp
Clark, J.	Finseth	Holsten	Kubly	Milbert	Otremba
Daggett	Fuller	Howes	Kuisle	Molnau	Ozment

Paulsen	Pugh	Seifert	Stang	Vandev eer	Wilkin
Pawlenty	Rifenberg	Skoe	Swenson	Walz	Winter
Pelowski	Ruth	Smith	Sykora	Wenzel	Wolf
Penas	Schumacher	Solberg	Tingelstad	Westerberg	Workman
Peterson	Seagren	Stanek	Tuma	Westrom	Spk. Sviggum

Those who voted in the negative were:

Abrams	Dibble	Hausman	Kelliher	McGuire	Swapinski
Bakk	Entenza	Hilstrom	Koskinen	Mullery	Thompson
Bernardy	Erhardt	Hilty	Larson	Osthoff	Wagenius
Biernat	Evans	Huntley	Leighton	Paymar	Wasiluk
Bishop	Folliard	Jaros	Leppik	Rhodes	
Carlson	Gleason	Jennings	Luther	Rukavina	
Clark, K.	Goodwin	Johnson, R.	Mahoney	Sertich	
Davnie	Gray	Johnson, S.	Mariani	Skoglund	
Dawkins	Greiling	Kahn	Marko	Slawik	

The motion prevailed and the amendment was adopted.

Workman and Rhodes moved to amend S. F. No. 2361, as amended, as follows:

Page 474, after line 33, insert:

"Sec. 2. Minnesota Statutes 2000, section 13.461, subdivision 17, is amended to read:

Subd. 17. [~~VULNERABLE ADULT MALTREATMENT REVIEW PANEL PANELS.~~] Data of the vulnerable adult maltreatment review panel or the child maltreatment review panel are classified under section 256.021 or section 16.

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

Page 510, after line 34, insert:

"Sec. 16. [256.022] [CHILD MALTREATMENT REVIEW PANEL.]

Subdivision 1. [CREATION.] The commissioner of human services shall establish a review panel for purposes of reviewing investigating agency determinations regarding maltreatment of a child in a facility in response to requests received under section 626.556, subdivision 10i, paragraph (b). The review panel consists of the commissioners of health; human services; children, families, and learning; and corrections; the ombudsman for crime victims; and the ombudsman for mental health and mental retardation; or their designees.

Subd. 2. [REVIEW PROCEDURE.] (a) The panel shall hold quarterly meetings for purposes of conducting reviews under this section. If an interested person acting on behalf of a child requests a review under this section, the panel shall review the request at its next quarterly meeting. If the next quarterly meeting is within ten days of the panel's receipt of the request for review, the review may be delayed until the next subsequent meeting. The panel shall review the request and the final determination regarding maltreatment made by the investigating agency and may review any other data on the investigation maintained by the agency that are pertinent and necessary to its review of the determination. If more than one person requests a review under this section with respect to the same

determination, the review panel shall combine the requests into one review. Upon receipt of a request for a review, the panel shall notify the alleged perpetrator of maltreatment that a review has been requested and provide an approximate timeline for conducting the review.

(b) Within 30 days of the review under this section, the panel shall notify the investigating agency and the interested person who requested the review as to whether the panel agrees with the determination or whether the investigating agency must reconsider the determination. If the panel determines that the agency must reconsider the determination, the panel must make specific investigative recommendations to the agency. Within 30 days the investigating agency shall conduct a review and report back to the panel with its reconsidered determination and the specific rationale for its determination.

Subd. 3. [REPORT.] By January 15 of each year, the panel shall submit a report to the committees of the legislature with jurisdiction over section 626.556 regarding the number of requests for review it receives under this section, the number of cases where the panel requires the investigating agency to reconsider its final determination, the number of cases where the final determination is changed, and any recommendations to improve the review or investigative process.

Subd. 4. [DATA.] Data of the review panel created as part of a review under this section are private data on individuals as defined in section 13.02.

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

Page 519, after line 8, insert:

"Sec. 22. Minnesota Statutes 2000, section 626.556, subdivision 10, is amended to read:

**Subd. 10. [DUTIES OF LOCAL WELFARE AGENCY AND LOCAL LAW ENFORCEMENT AGENCY UPON RECEIPT OF A REPORT.]** (a) If the report alleges neglect, physical abuse, or sexual abuse by a parent, guardian, or individual functioning within the family unit as a person responsible for the child's care, the local welfare agency shall immediately conduct an assessment including gathering information on the existence of substance abuse and offer protective social services for purposes of preventing further abuses, safeguarding and enhancing the welfare of the abused or neglected minor, and preserving family life whenever possible. If the report alleges a violation of a criminal statute involving sexual abuse, physical abuse, or neglect or endangerment, under section 609.378, the local law enforcement agency and local welfare agency shall coordinate the planning and execution of their respective investigation and assessment efforts to avoid a duplication of fact-finding efforts and multiple interviews. Each agency shall prepare a separate report of the results of its investigation. In cases of alleged child maltreatment resulting in death, the local agency may rely on the fact-finding efforts of a law enforcement investigation to make a determination of whether or not maltreatment occurred. When necessary the local welfare agency shall seek authority to remove the child from the custody of a parent, guardian, or adult with whom the child is living. In performing any of these duties, the local welfare agency shall maintain appropriate records.

If the assessment indicates there is a potential for abuse of alcohol or other drugs by the parent, guardian, or person responsible for the child's care, the local welfare agency shall conduct a chemical use assessment pursuant to Minnesota Rules, part 9530.6615. The local welfare agency shall report the determination of the chemical use assessment, and the recommendations and referrals for alcohol and other drug treatment services to the state authority on alcohol and drug abuse.

(b) When a local agency receives a report or otherwise has information indicating that a child who is a client, as defined in section 245.91, has been the subject of physical abuse, sexual abuse, or neglect at an agency, facility, or program as defined in section 245.91, it shall, in addition to its other duties under this section, immediately inform the ombudsman established under sections 245.91 to 245.97.

(c) Authority of the local welfare agency responsible for assessing the child abuse or neglect report and of the local law enforcement agency for investigating the alleged abuse or neglect includes, but is not limited to, authority to interview, without parental consent, the alleged victim and any other minors who currently reside with or who have resided with the alleged offender. The interview may take place at school or at any facility or other place where the alleged victim or other minors might be found or the child may be transported to, and the interview conducted at a place appropriate for the interview of a child designated by the local welfare agency or law enforcement agency. The interview may take place outside the presence of the alleged offender or parent, legal custodian, guardian, or school official. Except as provided in this paragraph, the parent, legal custodian, or guardian shall be notified by the responsible local welfare or law enforcement agency no later than the conclusion of the investigation or assessment that this interview has occurred. Notwithstanding rule 49.02 of the Minnesota rules of procedure for juvenile courts, the juvenile court may, after hearing on an ex parte motion by the local welfare agency, order that, where reasonable cause exists, the agency withhold notification of this interview from the parent, legal custodian, or guardian. If the interview took place or is to take place on school property, the order shall specify that school officials may not disclose to the parent, legal custodian, or guardian the contents of the notification of intent to interview the child on school property, as provided under this paragraph, and any other related information regarding the interview that may be a part of the child's school record. A copy of the order shall be sent by the local welfare or law enforcement agency to the appropriate school official.

(d) When the local welfare or local law enforcement agency determines that an interview should take place on school property, written notification of intent to interview the child on school property must be received by school officials prior to the interview. The notification shall include the name of the child to be interviewed, the purpose of the interview, and a reference to the statutory authority to conduct an interview on school property. For interviews conducted by the local welfare agency, the notification shall be signed by the chair of the local social services agency or the chair's designee. The notification shall be private data on individuals subject to the provisions of this paragraph. School officials may not disclose to the parent, legal custodian, or guardian the contents of the notification or any other related information regarding the interview until notified in writing by the local welfare or law enforcement agency that the investigation or assessment has been concluded. Until that time, the local welfare or law enforcement agency shall be solely responsible for any disclosures regarding the nature of the assessment or investigation.

Except where the alleged offender is believed to be a school official or employee, the time and place, and manner of the interview on school premises shall be within the discretion of school officials, but the local welfare or law enforcement agency shall have the exclusive authority to determine who may attend the interview. The conditions as to time, place, and manner of the interview set by the school officials shall be reasonable and the interview shall be conducted not more than 24 hours after the receipt of the notification unless another time is considered necessary by agreement between the school officials and the local welfare or law enforcement agency. Where the school fails to comply with the provisions of this paragraph, the juvenile court may order the school to comply. Every effort must be made to reduce the disruption of the educational program of the child, other students, or school staff when an interview is conducted on school premises.

(e) Where the alleged offender or a person responsible for the care of the alleged victim or other minor prevents access to the victim or other minor by the local welfare agency, the juvenile court may order the parents, legal custodian, or guardian to produce the alleged victim or other minor for questioning by the local welfare agency or the local law enforcement agency outside the presence of the alleged offender or any person responsible for the child's care at reasonable places and times as specified by court order.

(f) Before making an order under paragraph (e), the court shall issue an order to show cause, either upon its own motion or upon a verified petition, specifying the basis for the requested interviews and fixing the time and place of the hearing. The order to show cause shall be served personally and shall be heard in the same manner as provided in other cases in the juvenile court. The court shall consider the need for appointment of a guardian ad litem to protect the best interests of the child. If appointed, the guardian ad litem shall be present at the hearing on the order to show cause.

(g) The commissioner, the ombudsman for mental health and mental retardation, the local welfare agencies responsible for investigating reports, and the local law enforcement agencies have the right to enter facilities as defined in subdivision 2 and to inspect and copy the facility's records, including medical records, as part of the investigation. Notwithstanding the provisions of chapter 13, they also have the right to inform the facility under investigation that they are conducting an investigation, to disclose to the facility the names of the individuals under investigation for abusing or neglecting a child, and to provide the facility with a copy of the report and the investigative findings.

(h) The local welfare agency shall collect available and relevant information to ascertain whether maltreatment occurred and whether protective services are needed. Information collected includes, when relevant, information with regard to the person reporting the alleged maltreatment, including the nature of the reporter's relationship to the child and to the alleged offender, and the basis of the reporter's knowledge for the report; the child allegedly being maltreated; the alleged offender; the child's caretaker; and other collateral sources having relevant information related to the alleged maltreatment. The local welfare agency may make a determination of no maltreatment early in an assessment, and close the case and retain immunity, if the collected information shows no basis for a full assessment or investigation.

Information relevant to the assessment or investigation must be asked for, and may include:

(1) the child's sex and age, prior reports of maltreatment, information relating to developmental functioning, credibility of the child's statement, and whether the information provided under this clause is consistent with other information collected during the course of the assessment or investigation;

(2) the alleged offender's age, a record check for prior reports of maltreatment, and criminal charges and convictions. The local welfare agency must provide the alleged offender with an opportunity to make a statement. The alleged offender may submit supporting documentation relevant to the assessment or investigation;

(3) collateral source information regarding the alleged maltreatment and care of the child. Collateral information includes, when relevant: (i) a medical examination of the child; (ii) prior medical records relating to the alleged maltreatment or the care of the child maintained by any facility, clinic, or health care professional and an interview with the treating professionals; and (iii) interviews with the child's caretakers, including the child's parent, guardian, foster parent, child care provider, teachers, counselors, family members, relatives, and other persons who may have knowledge regarding the alleged maltreatment and the care of the child; and

(4) information on the existence of domestic abuse and violence in the home of the child, and substance abuse.

Nothing in this paragraph precludes the local welfare agency from collecting other relevant information necessary to conduct the assessment or investigation. Notwithstanding section 13.384 or 144.335, the local welfare agency has access to medical data and records for purposes of clause (3). Notwithstanding the data's classification in the possession of any other agency, data acquired by the local welfare agency during the course of the assessment or investigation are private data on individuals and must be maintained in accordance with subdivision 11.

(i) In the initial stages of an assessment or investigation, the local welfare agency shall conduct a face-to-face observation of the child reported to be maltreated and a face-to-face interview of the alleged offender. The interview with the alleged offender may be postponed if it would jeopardize an active law enforcement investigation.

(j) The local welfare agency shall use a question and answer interviewing format with questioning as nondirective as possible to elicit spontaneous responses. The following interviewing methods and procedures must be used whenever possible when collecting information:

(1) audio recordings of all interviews with witnesses and collateral sources; and

(2) in cases of alleged sexual abuse, audio-video recordings of each interview with the alleged victim and child witnesses.

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

Page 519, line 18, strike "or"

Page 519, line 19, after "abused" insert ", or is the victim of maltreatment in a facility"

Page 519, line 20, after "abused" insert ", or been the victim of maltreatment in a facility"

Page 519, line 22, strike "or"

Page 519, line 23, after "abused" insert ", or is the victim of maltreatment in a facility"

Page 521, after line 5, insert:

"Sec. 24. Minnesota Statutes 2000, section 626.556, subdivision 10d, is amended to read:

Subd. 10d. [NOTIFICATION OF NEGLECT OR ABUSE IN FACILITY.] (a) When a report is received that alleges neglect, physical abuse, ~~or~~ sexual abuse, or maltreatment of a child while in the care of a licensed or unlicensed day care facility, residential facility, agency, hospital, sanitarium, or other facility or institution required to be licensed according to sections 144.50 to 144.58; 241.021; or 245A.01 to 245A.16; or chapter 245B, or a school as defined in sections 120A.05, subdivisions 9, 11, and 13; and 124D.10; or a nonlicensed personal care provider organization as defined in section 256B.04, subdivision 16, and 256B.0625, subdivision 19a, the commissioner of the agency responsible for assessing or investigating the report or local welfare agency investigating the report shall provide the following information to the parent, guardian, or legal custodian of a child alleged to have been neglected, physically abused, ~~or~~ sexually abused, or the victim of maltreatment of a child in the facility: the name of the facility; the fact that a report alleging neglect, physical abuse, ~~or~~ sexual abuse, or maltreatment of a child in the facility has been received; the nature of the alleged neglect, physical abuse, ~~or~~ sexual abuse, or maltreatment of a child in the facility; that the agency is conducting an investigation; any protective or corrective measures being taken pending the outcome of the investigation; and that a written memorandum will be provided when the investigation is completed.

(b) The commissioner of the agency responsible for assessing or investigating the report or local welfare agency may also provide the information in paragraph (a) to the parent, guardian, or legal custodian of any other child in the facility if the investigative agency knows or has reason to believe the alleged neglect, physical abuse, ~~or~~ sexual abuse, or maltreatment of a child in the facility has occurred. In determining whether to exercise this authority, the commissioner of the agency responsible for assessing or investigating the report or local welfare agency shall consider the seriousness of the alleged neglect, physical abuse, ~~or~~ sexual abuse, or maltreatment of a child in the facility; the number of children allegedly neglected, physically abused, ~~or~~ sexually abused, or victims of maltreatment of a child in the facility; the number of alleged perpetrators; and the length of the investigation. The facility shall be notified whenever this discretion is exercised.

(c) When the commissioner of the agency responsible for assessing or investigating the report or local welfare agency has completed its investigation, every parent, guardian, or legal custodian notified of the investigation by the commissioner or local welfare agency shall be provided with the following information in a written memorandum: the name of the facility investigated; the nature of the alleged neglect, physical abuse, ~~or~~ sexual abuse, or maltreatment of a child in the facility; the investigator's name; a summary of the investigation findings; a statement whether maltreatment was found; and the protective or corrective measures that are being or will be taken. The memorandum shall be written in a manner that protects the identity of the reporter and the child and shall not contain the name, or to the extent possible, reveal the identity of the alleged perpetrator or of those interviewed during the investigation. If maltreatment is determined to exist, the commissioner or local welfare agency shall also provide the written memorandum to the parent, guardian, or legal custodian of each child in the facility ~~if maltreatment is determined to exist~~ who had contact with the individual responsible for the maltreatment. When the facility is the responsible party for maltreatment, the commissioner or local welfare agency shall also provide the written memorandum to the parent, guardian, or legal custodian of each child who received services in the population of the facility where the maltreatment occurred. This notification must be provided to the parent,

guardian, or legal custodian of each child receiving services from the time the maltreatment occurred until either the individual responsible for maltreatment is no longer in contact with a child or children in the facility or the conclusion of the investigation.

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

Sec. 25. Minnesota Statutes 2000, section 626.556, subdivision 10e, is amended to read:

Subd. 10e. [DETERMINATIONS.] Upon the conclusion of every assessment or investigation it conducts, the local welfare agency shall make two determinations: first, whether maltreatment has occurred; and second, whether child protective services are needed. When maltreatment is determined in an investigation involving a facility, the investigating agency shall also determine whether the facility or individual was responsible for the maltreatment using the mitigating factors in paragraph (d). Determinations under this subdivision must be made based on a preponderance of the evidence.

(a) For the purposes of this subdivision, "maltreatment" means any of the following acts or omissions ~~committed by a person responsible for the child's care:~~

- (1) physical abuse as defined in subdivision 2, paragraph (d);
- (2) neglect as defined in subdivision 2, paragraph (c);
- (3) sexual abuse as defined in subdivision 2, paragraph (a); ~~or~~
- (4) mental injury as defined in subdivision 2, paragraph (k); or
- (5) maltreatment of a child in a facility as defined in subdivision 2, paragraph (f).

(b) For the purposes of this subdivision, a determination that child protective services are needed means that the local welfare agency has documented conditions during the assessment or investigation sufficient to cause a child protection worker, as defined in section 626.559, subdivision 1, to conclude that a child is at significant risk of maltreatment if protective intervention is not provided and that the individuals responsible for the child's care have not taken or are not likely to take actions to protect the child from maltreatment or risk of maltreatment.

(c) This subdivision does not mean that maltreatment has occurred solely because the child's parent, guardian, or other person responsible for the child's care in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the child, in lieu of medical care. However, if lack of medical care may result in serious danger to the child's health, the local welfare agency may ensure that necessary medical services are provided to the child.

(d) When determining whether the facility or individual is the responsible party for determined maltreatment in a facility, the investigating agency shall consider at least the following mitigating factors:

(1) whether the actions of the facility or the individual caregivers were according to, and followed the terms of, an erroneous physician order, prescription, individual care plan, or directive; however, this is not a mitigating factor when the facility or caregiver was responsible for the issuance of the erroneous order, prescription, individual care plan, or directive or knew or should have known of the errors and took no reasonable measures to correct the defect before administering care;

(2) comparative responsibility between the facility, other caregivers, and requirements placed upon an employee, including the facility's compliance with related regulatory standards and the adequacy of facility policies and procedures, facility training, an individual's participation in the training, the caregiver's supervision, and facility staffing levels and the scope of the individual employee's authority and discretion; and

(3) whether the facility or individual followed professional standards in exercising professional judgment.

Individual counties may implement more detailed definitions or criteria that indicate which allegations to investigate, as long as a county's policies are consistent with the definitions in the statutes and rules and are approved by the county board. Each local welfare agency shall periodically inform mandated reporters under subdivision 3 who work in the county of the definitions of maltreatment in the statutes and rules and any additional definitions or criteria that have been approved by the county board.

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

Sec. 26. Minnesota Statutes 2000, section 626.556, subdivision 10f, is amended to read:

Subd. 10f. [NOTICE OF DETERMINATIONS.] Within ten working days of the conclusion of an assessment, the local welfare agency or agency responsible for assessing or investigating the report shall notify the parent or guardian of the child, the person determined to be maltreating the child, and if applicable, the director of the facility, of the determination and a summary of the specific reasons for the determination. The notice must also include a certification that the information collection procedures under subdivision 10, paragraphs (h), (i), and (j), were followed and a notice of the right of a data subject to obtain access to other private data on the subject collected, created, or maintained under this section. In addition, the notice shall include the length of time that the records will be kept under subdivision 11c. The investigating agency shall notify the parent or guardian of the child who is the subject of the report, and any person or facility determined to have maltreated a child, of their appeal or review rights under this section or section 16.

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

Page 521, line 10, after "MALTREATMENT" insert "; REVIEW PANEL"

Page 521, line 13, strike "the child's designee" and insert "an interested person acting on behalf of the child"

Page 521, line 19, before the period, insert "or, if the request is made by an interested person who is not entitled to notice, within 15 days after receipt of the notice by the parent or guardian of the child"

Page 521, line 19, before "An" insert "Effective January 1, 2002,"

Page 521, line 35, after the period, insert "For reports involving maltreatment of a child in a facility, an interested person acting on behalf of the child may request a review by the child maltreatment review panel under section 16 if the investigating agency denies the request or fails to act upon the request or if the interested person contests a reconsidered determination. The investigating agency shall notify persons who request reconsideration of their rights under this paragraph. The request must be submitted in writing to the review panel and a copy sent to the investigating agency within 30 calendar days of receipt of notice of a denial of a request for reconsideration or of a reconsidered determination. The request must specifically identify the aspects of the agency determination with which the person is dissatisfied."

Page 521, line 36, strike the first "the" and insert "a" and after "reconsideration" insert "or review"

Page 522, line 13, before "If" insert "Effective January 1, 2002,"

Page 522, line 26, before "If" insert "Effective January 1, 2002,"

Page 523, after line 6, insert:

"(g) For purposes of this subdivision, "interested person acting on behalf of the child" means a parent or legal guardian; stepparent; grandparent; guardian ad litem; adult stepbrother, stepsister, or sibling; or adult aunt or uncle; unless the person has been determined to be the perpetrator of the maltreatment."



Page 523, delete line 7 and insert:

"Sec. 28. Minnesota Statutes 2000, section 626.556, subdivision 11, is amended to read:

Subd. 11. [RECORDS.] (a) Except as provided in paragraph (b) or (c) and subdivisions 10b, 10d, 10g, and 11b, all records concerning individuals maintained by a local welfare agency or agency responsible for assessing or investigating the report under this section, including any written reports filed under subdivision 7, shall be private data on individuals, except insofar as copies of reports are required by subdivision 7 to be sent to the local police department or the county sheriff. Reports maintained by any police department or the county sheriff shall be private data on individuals except the reports shall be made available to the investigating, petitioning, or prosecuting authority, including county medical examiners or county coroners. Section 13.82, subdivisions 7, 5a, and 5b, apply to law enforcement data other than the reports. The local social services agency or agency responsible for assessing or investigating the report shall make available to the investigating, petitioning, or prosecuting authority, including county medical examiners or county coroners or their professional delegates, any records which contain information relating to a specific incident of neglect or abuse which is under investigation, petition, or prosecution and information relating to any prior incidents of neglect or abuse involving any of the same persons. The records shall be collected and maintained in accordance with the provisions of chapter 13. In conducting investigations and assessments pursuant to this section, the notice required by section 13.04, subdivision 2, need not be provided to a minor under the age of ten who is the alleged victim of abuse or neglect. An individual subject of a record shall have access to the record in accordance with those sections, except that the name of the reporter shall be confidential while the report is under assessment or investigation except as otherwise permitted by this subdivision. Any person conducting an investigation or assessment under this section who intentionally discloses the identity of a reporter prior to the completion of the investigation or assessment is guilty of a misdemeanor. After the assessment or investigation is completed, the name of the reporter shall be confidential. The subject of the report may compel disclosure of the name of the reporter only with the consent of the reporter or upon a written finding by the court that the report was false and that there is evidence that the report was made in bad faith. This subdivision does not alter disclosure responsibilities or obligations under the rules of criminal procedure.

(b) Upon request of the legislative auditor, data on individuals maintained under this section must be released to the legislative auditor in order for the auditor to fulfill the auditor's duties under section 3.971. The auditor shall maintain the data in accordance with chapter 13.

(c) The investigating agency shall exchange not public data with the child maltreatment review panel under section 16 if the data are pertinent and necessary for a review requested under section 16. Upon completion of the review, the not public data received by the review panel must be returned to the investigating agency.

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

Sec. 29. Minnesota Statutes 2000, section 626.556, subdivision 12, is amended to read:

Subd. 12. [DUTIES OF FACILITY OPERATORS.] Any operator, employee, or volunteer worker at any facility who intentionally neglects, physically abuses, or sexually abuses any child in the care of that facility may be charged with a violation of section 609.255, 609.377, or 609.378. Any operator of a facility who knowingly permits conditions to exist which result in neglect, physical abuse, ~~or sexual abuse,~~ or maltreatment of a child in a facility while in the care of that facility may be charged with a violation of section 609.378. The facility operator shall inform all mandated reporters employed by or otherwise associated with the facility of the duties required of mandated reporters and shall inform all mandatory reporters of the prohibition against retaliation for reports made in good faith under this section.

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

Page 530, after line 9, insert:

"Sec. 33. Minnesota Statutes 2000, section 626.559, subdivision 2, is amended to read:

Subd. 2. [JOINT TRAINING.] The commissioners of human services and public safety shall cooperate in the development of a joint program for training child abuse services professionals in the appropriate techniques for child abuse assessment and investigation. The program shall include but need not be limited to the following areas:

(1) the public policy goals of the state as set forth in section 260C.001 and the role of the assessment or investigation in meeting these goals;

(2) the special duties of child protection workers and law enforcement officers under section 626.556;

(3) the appropriate methods for directing and managing affiliated professionals who may be utilized in providing protective services and strengthening family ties;

(4) the appropriate methods for interviewing alleged victims of child abuse and other minors in the course of performing an assessment or an investigation;

(5) the dynamics of child abuse and neglect within family systems and the appropriate methods for interviewing parents in the course of the assessment or investigation, including training in recognizing cases in which one of the parents is a victim of domestic abuse and in need of special legal or medical services;

(6) the legal, evidentiary considerations that may be relevant to the conduct of an assessment or an investigation;

(7) the circumstances under which it is appropriate to remove the alleged abuser or the alleged victim from the home;

(8) the protective social services that are available to protect alleged victims from further abuse, to prevent child abuse and domestic abuse, and to preserve the family unit, and training in the preparation of case plans to coordinate services for the alleged child abuse victim with services for any parents who are victims of domestic abuse; ~~and~~

(9) the methods by which child protection workers and law enforcement workers cooperate in conducting assessments and investigations in order to avoid duplication of efforts; and

(10) appropriate methods for interviewing alleged victims of child abuse and conducting investigations in cases where the alleged victim is developmentally, physically, or mentally disabled.

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

Page 545, after line 10, insert:

"[CHILD MALTREATMENT REVIEW PANEL.] Of the general fund appropriation, \$46,000 in fiscal year 2002 and \$32,000 in fiscal year 2003 is to establish a review panel for purposes of reviewing investigating agency determinations regarding maltreatment of a child in a facility in response to requests received under Minnesota Statutes, section 626.556, subdivision 10i, paragraph (b)."

Renumber the sections in sequence and correct internal references

Adjust amounts accordingly

Amend the title accordingly

The question was taken on the Workman and Rhodes amendment and the roll was called.

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

There were 126 yeas and 4 nays as follows:

Those who voted in the affirmative were:

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

Those who voted in the negative were:

Anderson, B.	Boudreau	Holberg	Krinkie
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The motion prevailed and the amendment was adopted.

#### CALL OF THE HOUSE LIFTED

Seifert moved that the call of the House be suspended. The motion prevailed and it was so ordered.

Folliard moved to amend S. F. No. 2361, as amended, as follows:

Page 37, line 10, reinstate the stricken language and delete the new language

Page 37, lines 27 and 28, reinstate the stricken language and delete the new language

Page 37, line 35, delete the comma

Page 37, line 36, delete the new language

A roll call was requested and properly seconded.

The question was taken on the Folliard amendment and the roll was called. There were 57 yeas and 75 nays as follows:

Those who voted in the affirmative were:

Abrams	Dorn	Hilty	Leighton	Milbert	Skoglund
Bakk	Entenza	Huntley	Lenczewski	Mullery	Slawik
Bernardy	Erhardt	Jaros	Leppik	Opatz	Solberg
Biernat	Evans	Jennings	Lieder	Osthoff	Swapinski
Bishop	Folliard	Johnson, R.	Luther	Paymar	Thompson
Carlson	Gleason	Johnson, S.	Mahoney	Pugh	Wagenius
Clark, K.	Goodwin	Kahn	Mariani	Rhodes	Wasiluk
Davnie	Greiling	Kelliher	Marko	Rukavina	
Dawkins	Hausman	Koskinen	McElroy	Sertich	
Dibble	Hilstrom	Larson	McGuire	Skoe	

Those who voted in the negative were:

Abeler	Eastlund	Jacobson	Molnau	Peterson	Vandever
Anderson, B.	Erickson	Johnson, J.	Mulder	Rifenberg	Walz
Anderson, I.	Finseth	Juhnke	Murphy	Ruth	Wenzel
Boudreau	Fuller	Kalis	Ness	Schumacher	Westerberg
Bradley	Gerlach	Kielkucki	Nornes	Seagren	Westrom
Buesgens	Goodno	Knoblach	Olson	Seifert	Wilkin
Cassell	Gunther	Krinkie	Osskopp	Smith	Winter
Clark, J.	Haas	Kubly	Otremba	Stanek	Wolf
Daggett	Hackbarth	Kuise	Ozment	Stang	Workman
Davids	Harder	Lindner	Paulsen	Swenson	Spk. Sviggum
Dehler	Holberg	Lipman	Pawlenty	Sykora	
Dempsey	Holsten	Mares	Pelowski	Tingelstad	
Dorman	Howes	Marquart	Penas	Tuma	

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

Kelliher; Marko; Folliard; Johnson, R.; Larson; Dibble; Leppik; Slawik and Davnie moved to amend S. F. No. 2361, as amended, as follows:

Page 41, delete lines 27 to 30

A roll call was requested and properly seconded.

The question was taken on the Kelliher et al amendment and the roll was called. There were 56 yeas and 74 nays as follows:

Those who voted in the affirmative were:

Abrams	Carlson	Dorman	Folliard	Hilstrom	Jennings
Bakk	Clark, K.	Dorn	Goodwin	Hilty	Johnson, R.
Bernardy	Davnie	Entenza	Gray	Holsten	Johnson, S.
Biernat	Dawkins	Erhardt	Greiling	Huntley	Kahn
Bishop	Dibble	Evans	Hausman	Jaros	Kelliher

Koskinen	Luther	Mullery	Rhodes	Slawik	Wasiluk
Larson	Mahoney	Opatz	Rukavina	Solberg	
Leighton	Mariani	Osthoff	Sertich	Swapinski	
Leppik	Marko	Paymar	Skoe	Thompson	
Lieder	McGuire	Pugh	Skoglund	Wagenius	

Those who voted in the negative were:

Abeler	Erickson	Juhnke	Molnau	Rifenberg	Walz
Anderson, B.	Finseth	Kalis	Mulder	Ruth	Wenzel
Anderson, I.	Fuller	Kielkucki	Murphy	Schumacher	Westerberg
Boudreau	Gerlach	Knoblach	Ness	Seagren	Westrom
Bradley	Goodno	Krinkie	Nornes	Seifert	Wilkin
Buesgens	Gunther	Kubly	Olson	Smith	Winter
Cassell	Haas	Kuisle	Otremba	Stanek	Wolf
Clark, J.	Hackbarth	Lenczewski	Ozment	Stang	Workman
Daggett	Harder	Lindner	Paulsen	Swenson	Spk. Sviggum
Davids	Holberg	Lipman	Pawlenty	Sykora	
Dehler	Howes	Mares	Pelowski	Tingelstad	
Dempsey	Jacobson	Marquart	Penas	Tuma	
Eastlund	Johnson, J.	Milbert	Peterson	Vandever	

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

Boudreau; Abeler; Dehler; Anderson, B.; Erickson; Otremba; Hilty and Seagren moved to amend S. F. No. 2361, as amended, as follows:

Pages 13 to 14, delete sections 22 and 23

Renumber the sections in sequence and correct internal references

Amend the title accordingly

A roll call was requested and properly seconded.

The Speaker resumed the Chair.

The question was taken on the Boudreau et al amendment and the roll was called. There were 35 yeas and 97 nays as follows:

Those who voted in the affirmative were:

Abeler	Carlson	Entenza	Krinkie	Osskopp	Thompson
Anderson, B.	Clark, K.	Erickson	Kuisle	Otremba	Tingelstad
Anderson, I.	Daggett	Hilty	Lindner	Rifenberg	Tuma
Bakk	Davids	Holberg	Mariani	Seagren	Westrom
Boudreau	Dehler	Johnson, J.	Murphy	Smith	Wilkin
Buesgens	Dempsey	Kielkucki	Olson	Solberg	

Those who voted in the negative were:

Abrams	Fuller	Jaros	Luther	Pawlenty	Swapinski
Bernardy	Gerlach	Jennings	Mahoney	Paymar	Swenson
Biernat	Gleason	Johnson, R.	Mares	Pelowski	Vandever
Bishop	Goodno	Johnson, S.	Marko	Penas	Wagenius
Bradley	Goodwin	Juhnke	Marquart	Peterson	Walz
Cassell	Gray	Kahn	McElroy	Pugh	Wasiluk
Clark, J.	Greiling	Kalis	McGuire	Rhodes	Wenzel
Davnie	Gunther	Kelliher	Milbert	Rukavina	Westerberg
Dawkins	Haas	Knoblach	Molnau	Ruth	Winter
Dibble	Hackbarth	Koskinen	Mulder	Schumacher	Wolf
Dorman	Harder	Kubly	Mullery	Seifert	Workman
Dorn	Hausman	Larson	Ness	Sertich	Spk. Sviggum
Eastlund	Hilstrom	Leighton	Nornes	Skoe	
Erhardt	Holsten	Lenczewski	Opatz	Skoglund	
Evans	Howes	Leppik	Osthoff	Slawik	
Finseth	Huntley	Lieder	Ozment	Stanek	
Folliard	Jacobson	Lipman	Paulsen	Stang	

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

Otremba, Luther, Winter, Skoe, Kubly, Lieder and Peterson moved to amend S. F. No. 2361, as amended, as follows:

Page 127, after line 33, insert:

"Sec. 41. Minnesota Statutes 2000, section 256L.01, subdivision 4, is amended to read:

Subd. 4. [GROSS INDIVIDUAL OR GROSS FAMILY INCOME.] "Gross individual or gross family income" for farm and nonfarm self-employed means income calculated using as the baseline the adjusted gross income reported on the applicant's federal income tax form for the previous year ~~and adding back in reported depreciation, carryover loss, and net operating loss amounts that apply to the business in which the family is currently engaged.~~ Applicants shall report the most recent financial situation of the family if it has changed from the period of time covered by the federal income tax form. The report may be in the form of percentage increase or decrease."

Page 131, after line 26, insert:

"Sec. 47. [FEDERAL APPROVAL.]

The commissioner of human services shall seek any federal approval necessary to obtain federal financial participation for children and parents who become eligible for the MinnesotaCare program as a result of the change in the definition of income for the self-employed in section 41 [amending section 256L.01, subdivision 4.]"

Page 546, after line 27, insert:

"[MINNESOTACARE DEFINITION OF INCOME.] \$8,914,000 is appropriated from the health care access fund in fiscal year 2001 for costs related to the change in the definition of income for the MinnesotaCare program under Minnesota Statutes,

section 256L.01, subdivision 4. This appropriation is available until June 30, 2003. This rider is effective the day following final enactment."

Reorder the sections in sequence and correct internal references

Amend the title accordingly

A roll call was requested and properly seconded.

The question was taken on the Otremba et al amendment and the roll was called. There were 66 yeas and 66 nays as follows:

Those who voted in the affirmative were:

Anderson, I.	Evans	Jennings	Lenczewski	Olson	Skoe
Bakk	Folliard	Johnson, R.	Lieder	Opatz	Skoglund
Bernardy	Gleason	Johnson, S.	Luther	Osthoff	Slawik
Biernat	Goodwin	Juhnke	Mahoney	Otremba	Solberg
Carlson	Gray	Kahn	Mariani	Paymar	Swapinski
Clark, K.	Greiling	Kalis	Marko	Pelowski	Thompson
Davnie	Hausman	Kelliher	Marquart	Peterson	Wagenius
Dawkins	Hilstrom	Koskinen	McGuire	Pugh	Wasiluk
Dibble	Hilty	Kubly	Milbert	Rukavina	Wenzel
Dorn	Huntley	Larson	Mullery	Schumacher	Westrom
Entenza	Jaros	Leighton	Murphy	Sertich	Winter

Those who voted in the negative were:

Abeler	Dehler	Haas	Kuile	Ozment	Swenson
Abrams	Dempsey	Hackbarth	Leppik	Paulsen	Sykora
Anderson, B.	Dorman	Harder	Lindner	Pawlenty	Tingelstad
Bishop	Eastlund	Holberg	Lipman	Rhodes	Tuma
Boudreau	Erhardt	Holsten	Mares	Rifenberg	Vandever
Bradley	Erickson	Howes	McElroy	Ruth	Walz
Buesgens	Finseth	Jacobson	Molnau	Seagren	Westerberg
Cassell	Fuller	Johnson, J.	Mulder	Seifert	Wilkin
Clark, J.	Gerlach	Kielkucki	Ness	Smith	Wolf
Daggett	Goodno	Knoblach	Nornes	Stanek	Workman
Davids	Gunther	Krinkie	Osskopp	Stang	Spk. Sviggum

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

Abeler, Boudreau, Dehler, Otremba, Osskopp, Seagren, Entenza and Goodwin moved to amend S. F. No. 2361, as amended, as follows:

Page 13, delete lines 10 to 28 and insert:

"(b) The commissioner may adopt rules to modify existing immunization requirements under this section as to the timing of immunizations, number of doses, or frequency. The commissioner shall report to the legislature on

any rules adopted under this paragraph during the previous calendar year. Such reports are due by January 15 of the year following the calendar year in which the rule is adopted. In adopting rules under this paragraph, the commissioner shall not:

- (1) require immunization against any disease not specifically listed in this section;
- (2) require the administration of any vaccine which combines vaccines currently given separately; or
- (3) lower the age at which an immunization currently required under this section must be obtained."

Page 13, delete lines 31 to 36 and insert:

"Subd. 7. [MODIFICATIONS TO SCHEDULE.] The commissioner may adopt rules to modify existing immunization requirements under this section as to the timing of immunizations, number of doses, or frequency. The commissioner shall report to the legislature on any rules adopted under this subdivision during the previous calendar year. Such reports are due by January 15 of the year following the calendar year in which the rule is adopted. In adopting rules under this subdivision, the commissioner shall not:

- (1) require immunization against any disease not specifically listed in this section;
- (2) require the administration of any vaccine which combines vaccines currently given separately; or
- (3) lower the age at which an immunization currently required under this section must be obtained."

Page 14, delete lines 1 to 13

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

Kubly, Lieder and Skoe moved to amend S. F. No. 2361, as amended, as follows:

Page 21, after line 40, insert:

"Sec. 28. [144.1499] [HEALTH PROFESSIONAL LOAN FORGIVENESS PROGRAM.]

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

(a) "Clinical laboratory technician" means a person who is not a medical laboratory director, clinical laboratory technologist, or trainee; functions under the supervision of a medical laboratory director or clinical laboratory technologist; performs diagnostic and analytical laboratory tests in only those specialties and subspecialties in which the person is qualified by education, training, and experience; and has demonstrated ongoing competency by certification or other means. A clinical laboratory technician may also be called a medical technician.

(b) "Designated rural area" means:

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

(2) a municipal corporation, as defined by section 471.634, that is physically located, in whole or in part, in an area that meets the criteria in clause (1).



(c) "Health professional" means a physician assistant registered under chapter 147A; a registered nurse, licensed practical nurse, or nurse practitioner licensed under sections 148.171 to 148.285; a pharmacist licensed under sections 151.01 to 151.40; or a clinical laboratory technician.

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

(e) "Rural hospital" means a nonfederal, general acute care hospital that is located in a designated rural area; has 50 or fewer beds; and is not for profit.

(f) "Rural nursing home" means a nonfederal facility licensed under section 144A.02 that is located in a designated rural area and that has fewer than 75 beds.

Subd. 2. [CREATION OF ACCOUNT.] A rural hospital and nursing home health professional loan forgiveness account is established in the general fund. The commissioner of health shall use money from the account to establish a loan forgiveness program for health professionals who agree to practice in a rural hospital or rural nursing home. The account consists of money appropriated by the legislature and repayments and penalties collected under subdivision 5. Money from the account must be used for the loan forgiveness program.

Subd. 3. [ELIGIBILITY.] To be eligible to participate in the program, a person enrolled in a program of study designed to prepare the person to become a physician assistant, registered nurse, licensed practical nurse, nurse practitioner, pharmacist, or clinical laboratory technician must submit an application to the commissioner of health before completion of the education program. For fiscal year 2002, applicants may have graduated from an education program in calendar year 2001. A student who is selected to participate in the loan forgiveness program must sign a contract to agree to serve a minimum two-year service obligation in a rural hospital or rural nursing home. The service obligation shall begin no later than March 31 of the first year following completion of the education program.

Subd. 4. [LOAN FORGIVENESS.] (a) The commissioner of health may accept up to 50 applicants per year for participation in the loan forgiveness program. Applicants are responsible for securing their own loans. The commissioner shall select participants based on their suitability for rural practice, as indicated by rural experience or training. The commissioner shall give preference to applicants who are attending a Minnesota educational program and to those applicants closest to completing their training. For each year that a participant serves as a physician assistant, nurse, pharmacist, or clinical laboratory technician in a rural hospital or rural nursing home, up to a maximum of five years, the commissioner shall annually repay the participant an amount determined by the following schedule for each year of service, not to exceed \$15,000 or the balance of the qualified loans, whichever is less:

(1) for the first year of service, \$2,000;

(2) for the second year of service, \$2,500;

(3) for the third year of service, \$3,000;

(4) for the fourth year of service, \$3,500; and

(5) for the fifth year of service, \$4,000.

(b) Before loan repayment is made, the participant must complete and return to the commissioner an affidavit of practice form verifying that the participant is practicing as required under this section. The participant must verify that the full amount of loan repayment under this section was applied toward the qualified loan, in order to receive additional loan repayments. Participants who move their practice from one rural hospital or rural nursing home to another remain eligible for loan repayment.

Subd. 5. [PENALTY FOR NONFULFILLMENT.] If a participant does not fulfill the service commitment required under subdivision 3, the commissioner of health shall collect from the participant 50 percent of any payments made for qualified loans. The commissioner shall deposit the money collected in the rural hospital and nursing home health professional loan forgiveness account established in subdivision 2.

Subd. 6. [WAIVER OF OBLIGATION.] Payment or service obligations cancel in the event of a participant's death. The commissioner of health may waive or suspend payment or service obligations if a participant becomes permanently disabled or is temporarily disabled for more than two years. The commissioner may grant a waiver of all or part of the money owed as a result of a nonfulfillment penalty if emergency circumstances prevented fulfillment of the required service commitment."

Page 560, after line 32, insert:

"[LOAN FORGIVENESS PROGRAM.] \$581,000 is appropriated in fiscal year 2001 from the health care access fund for the health professional loan forgiveness program under Minnesota Statutes, section 144.1499. This appropriation is available until June 30, 2003. This provision is effective the day following final enactment."

Renumber the sections in sequence and correct internal references

Amend the title accordingly

A roll call was requested and properly seconded.

The question was taken on the Kubly et al amendment and the roll was called. There were 66 yeas and 67 nays as follows:

Those who voted in the affirmative were:

Anderson, I.	Evans	Jaros	Leighton	Murphy	Sertich
Bakk	Folliard	Jennings	Lenczewski	Opatz	Skoe
Bernardy	Gleason	Johnson, R.	Lieder	Osthoff	Skoglund
Biernat	Goodwin	Johnson, S.	Luther	Otremba	Slawik
Carlson	Gray	Juhnke	Mahoney	Paymar	Solberg
Clark, K.	Greiling	Kahn	Mariani	Pelowski	Swapinski
Davnie	Hausman	Kalis	Marko	Penas	Thompson
Dawkins	Hilstrom	Kelliher	Marquart	Peterson	Wagenius
Dibble	Hilty	Koskinen	McGuire	Pugh	Wasiluk
Dorn	Howes	Kubly	Milbert	Rukavina	Wenzel
Entenza	Huntley	Larson	Mullery	Schumacher	Winter

Those who voted in the negative were:

Abeler	Clark, J.	Erickson	Harder	Kuisle	Ness
Abrams	Daggett	Finseth	Holberg	Leppik	Nornes
Anderson, B.	Dauids	Fuller	Holsten	Lindner	Olson
Bishop	Dehler	Gerlach	Jacobson	Lipman	Osskopp
Boudreau	Dempsey	Goodno	Johnson, J.	Mares	Ozment
Bradley	Dorman	Gunther	Kielkucki	McElroy	Paulsen
Buesgens	Eastlund	Haas	Knoblach	Molnau	Pawlenty
Cassell	Erhardt	Hackbarth	Krinkie	Mulder	Rhodes

Rifenberg	Smith	Sykora	Walz	Wolf
Ruth	Stanek	Tingelstad	Westerberg	Workman
Seagren	Stang	Tuma	Westrom	Spk. Sviggum
Seifert	Swenson	Vandev eer	Wilkin	

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

Boudreau moved to amend S. F. No. 2361, as amended, as follows:

Page 13, line 20, after the period, insert "Section 14.389, subdivision 5 applies to rules adopted under this paragraph."

Page 14, line 5, after the period, insert "Section 14.389, subdivision 5 applies to rules adopted under this subdivision."

A roll call was requested and properly seconded.

The question was taken on the Boudreau amendment and the roll was called. There were 50 yeas and 82 nays as follows:

Those who voted in the affirmative were:

Abeler	Dehler	Harder	Kuisle	Rhodes	Tuma
Anderson, B.	Dempsey	Hilty	Mariani	Rifenberg	Vandev eer
Bernardy	Dibble	Holberg	Molnau	Ruth	Westerberg
Boudreau	Entenza	Jacobson	Murphy	Seagren	Wilkin
Buesgens	Erickson	Johnson, J.	Olson	Smith	Spk. Sviggum
Carlson	Evans	Kalis	Osskopp	Solberg	
Clark, K.	Folliard	Kelliher	Otremba	Sykora	
Daggett	Goodwin	Kielkucki	Ozment	Thompson	
Davids	Greiling	Krinkie	Pawlenty	Tingelstad	

Those who voted in the negative were:

Abrams	Finseth	Jennings	Lipman	Osthoff	Stanek
Anderson, I.	Fuller	Johnson, R.	Luther	Paulsen	Stang
Bakk	Gleason	Johnson, S.	Mahoney	Paymar	Swapinski
Biernat	Goodno	Juhnke	Mares	Pelowski	Swenson
Bishop	Gray	Kahn	Marko	Penas	Wagenius
Bradley	Gunther	Knoblach	Marquart	Peterson	Walz
Cassell	Haas	Koskinen	McElroy	Pugh	Wasiluk
Clark, J.	Hackbarth	Kubly	McGuire	Rukavina	Wenzel
Davnie	Hausman	Larson	Milbert	Schumacher	Westrom
Dawkins	Hilstrom	Leighton	Mulder	Seifert	Winter
Dorman	Holsten	Lenczewski	Mullery	Sertich	Wolf
Dorn	Howes	Leppik	Ness	Skoe	Workman
Eastlund	Huntley	Lieder	Nornes	Skoglund	
Erhardt	Jaros	Lindner	Opatz	Slawik	

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

## ANNOUNCEMENTS BY THE SPEAKER

The Speaker announced the appointment of the following members of the House to a Conference Committee on H. F. No. 82:

Seagren, Mares, Buesgens, Ness and Wenzel.

The Speaker announced the appointment of the following members of the House to a Conference Committee on S. F. No. 103:

Nornes, Stang and Marquart.

The Speaker announced the appointment of the following members of the House to a Conference Committee on S. F. No. 1394:

Tingelstad, Cassell and Entenza.

The Speaker announced the appointment of the following members of the House to a Conference Committee on S. F. No. 2340:

Molnau, Stanek, Workman, Holberg and Murphy.

**FISCAL CALENDAR, Continued**

Tingelstad moved to amend S. F. No. 2361, as amended, as follows:

Page 14, after line 13, insert:

"Sec. 24. [144.0751] [HEALTH STANDARDS.]

When establishing or revising safe drinking water or air quality standards, the commissioner shall take into account only peer-reviewed, scientifically acceptable information which includes a reasonable margin of safety in setting the standards to adequately protect the health of infants, children, and adults by taking into consideration each of the following specific risks:

- (1) reproductive development and function;
- (2) respiratory function;
- (3) immunologic suppression or hypersensitization;
- (4) development of the brain and nervous system;
- (5) endocrine (hormonal) function;
- (6) cancer;

(7) general infant and child development; and

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

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

Wagenius moved to amend the Tingelstad amendment to S. F. No. 2361, as amended, as follows:

Page 1, line 7, delete "which"

Page 1, line 8, delete everything before "in"

Page 1, line 9, after "of" insert "fetuses,"

Page 1, line 10, after "adults" insert "with a margin of safety that provides reasonable certainty of no harm"

A roll call was requested and properly seconded.

The question was taken on the amendment to the amendment and the roll was called. There were 55 yeas and 78 nays as follows:

Those who voted in the affirmative were:

Bernardy	Folliard	Jennings	Lenczewski	Osthoff	Swapinski
Biernat	Gleason	Johnson, R.	Lieder	Otremba	Thompson
Carlson	Goodwin	Johnson, S.	Luther	Paymar	Wagenius
Clark, K.	Gray	Juhnke	Mahoney	Peterson	Wasiluk
Davnie	Greiling	Kahn	Mariani	Pugh	Winter
Dawkins	Hausman	Kelliher	Marko	Rukavina	
Dibble	Hilstrom	Koskinen	McGuire	Schumacher	
Dorn	Hilty	Kubly	Milbert	Sertich	
Entenza	Huntley	Larson	Mullery	Skoglund	
Evans	Jaros	Leighton	Opatz	Slawik	

Those who voted in the negative were:

Abeler	Dehler	Harder	Lipman	Pawlenty	Swenson
Abrams	Dempsey	Holberg	Mares	Pelowski	Sykora
Anderson, B.	Dorman	Holsten	Marquart	Penas	Tingelstad
Anderson, I.	Eastlund	Howes	McElroy	Rhodes	Tuma
Bakk	Erhardt	Jacobson	Molnau	Rifenberg	Vandever
Bishop	Erickson	Johnson, J.	Mulder	Ruth	Walz
Boudreau	Finseth	Kalis	Murphy	Seagren	Wenzel
Bradley	Fuller	Kielkucki	Ness	Seifert	Westerberg
Buesgens	Gerlach	Knoblach	Nornes	Skoe	Westrom
Cassell	Goodno	Krinkie	Olson	Smith	Wilkin
Clark, J.	Gunther	Kuisle	Osskopp	Solberg	Wolf
Daggett	Haas	Leppik	Ozment	Stanek	Workman
Davids	Hackbarth	Lindner	Paulsen	Stang	Spk. Sviggum

The motion did not prevail and the amendment to the amendment was not adopted.

The question recurred on the Tinglestad amendment to S. F. No. 2631, as amended. The motion prevailed and the amendment was adopted.

Wilkin, Otremba, Cassell, Mulder, Wenzel, Kielkucki, Kubly, Marquart and Buesgens moved to amend S. F. No. 2361, as amended, as follows:

Page 554, after line 35, insert:

"[WELFARE-TO-WORK GRANTS.] Of the federal TANF appropriation, \$5,000,000 each year in fiscal year 2002 and fiscal year 2003 is for welfare-to-work programs administered by the commissioner of economic security that have utilized all of the federal welfare-to-work funding received. The commissioner of economic security shall establish guidelines for distributing the funds to local workforce service areas based on current expenditures and documented need and, by January 15, 2003, shall report to the chairs of the house health and human services finance committee and the senate health, human services and corrections budget division on the use of state and federal funds appropriated for welfare-to-work programs and the effectiveness of such programs."

Page 558, line 25, delete "\$20,000,000" and insert "\$10,000,000"

Page 558, line 30, delete "\$3,500,000" and insert "\$1,750,000"

Page 558, line 31, delete "\$5,000,000" and insert "\$2,500,000"

Page 558, line 35, delete "\$3,000,000" and insert "\$1,500,000"

Page 558, line 36, delete "\$3,000,000" and insert "\$1,500,000"

Page 558, line 41, delete "\$2,000,000" and insert "\$1,000,000"

Page 558, line 42, delete "\$2,000,000" and insert "\$1,000,000"

Page 558, line 47, delete "\$1,500,000" and insert "\$750,000"

Correct the totals and the summaries by fund accordingly

A roll call was requested and properly seconded.

The question was taken on the Wilkin et al amendment and the roll was called. There were 72 yeas and 58 nays as follows:

Those who voted in the affirmative were:

Anderson, B.	Bradley	Daggett	Eastlund	Gerlach	Holberg
Anderson, I.	Buesgens	Davids	Erickson	Haas	Holsten
Bakk	Cassell	Dehler	Finseth	Hackbarth	Howes
Boudreau	Clark, J.	Dempsey	Fuller	Harder	Jacobson

Jaros	Kuisle	Nornes	Penas	Stanek	Wenzel
Johnson, J.	Lindner	Olson	Peterson	Stang	Westerberg
Juhnke	Lipman	Osskopp	Rifenberg	Swenson	Westrom
Kalis	Marquart	Otremba	Rukavina	Sykora	Wilkin
Kielkucki	Molnau	Ozment	Ruth	Tingelstad	Winter
Knoblach	Mulder	Paulsen	Schumacher	Tuma	Wolf
Krinkie	Murphy	Pawlenty	Seifert	Vandever	Workman
Kubly	Ness	Pelowski	Smith	Walz	Spk. Sviggum

Those who voted in the negative were:

Abrams	Dorn	Gunther	Koskinen	McElroy	Skoe
Bernardy	Entenza	Hausman	Larson	McGuire	Skoglund
Biernat	Erhardt	Hilstrom	Leighton	Milbert	Slawik
Bishop	Evans	Hilty	Lenczewski	Opatz	Solberg
Carlson	Folliard	Huntley	Leppik	Osthoff	Swapinski
Clark, K.	Gleason	Jennings	Lieder	Paymar	Thompson
Davnie	Goodno	Johnson, R.	Luther	Pugh	Wagenius
Dawkins	Goodwin	Johnson, S.	Mahoney	Rhodes	Wasiluk
Dibble	Gray	Kahn	Mariani	Seagren	
Dorman	Greiling	Kelliher	Marko	Sertich	

The motion prevailed and the amendment was adopted.

Koskinen moved to amend S. F. No. 2361, as amended, as follows:

Page 326, delete section 23 and insert:

"Sec. 23. Minnesota Statutes 2000, section 256B.431, is amended by adding a subdivision to read:

Subd. 32. [NURSING FACILITY RATE INCREASES BEGINNING JULY 1, 2001, AND JULY 1, 2002.] (a) For the rate years beginning July 1, 2001, and July 1, 2002, the commissioner shall make available to each nursing facility reimbursed under this section or section 256B.434 an adjustment equal to 3.0 percent of the total operating payment rate. The operating payment rates in effect on June 30, 2001, and June 30, 2002, respectively, shall include the adjustment in subdivision 2i, paragraph (c).

(b) Seventy-five percent of the rate increase must be used to increase the per-hour rate of all employees except management fees, the administrator, and central office staff by an equal dollar amount and to pay associated payroll taxes.

Money received by a facility as a result of the additional rate increase provided under this paragraph shall be used only for wage increases implemented on or after July 1, 2001, or July 1, 2002, respectively, and shall not be used for wage increases implemented prior to those dates.

(c) Twenty-five percent of the adjustment may be used for other operating costs.

(d) A nursing facility may apply for the compensation-related payment rate adjustment calculated under paragraph (b). The application must be made to the commissioner and contain a plan by which the nursing facility will distribute the compensation-related portion of the payment rate adjustment to employees of the nursing facility. For nursing facilities in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative constitutes the plan. A negotiated agreement may constitute the plan only if the agreement is finalized after the date of enactment of all

increases for the rate year. The commissioner shall review the plan to ensure that the payment rate adjustment per diem is used as provided in paragraph (b). To be eligible, a facility must submit its plan for the compensation distribution by December 31 each year. If a facility's plan for compensation distribution is effective for its employees after July 1 of the year that the funds are available, the payment rate adjustment per diem shall be effective the same date as its plan.

(e) A copy of the approved distribution plan must be made available to all employees. This must be done by giving each employee a copy or by posting it in an area of the nursing facility to which all employees have access. If an employee does not receive the compensation adjustment described in their facility's approved plan and is unable to resolve the problem with the facility's management or through the employee's union representative, the employee may contact the commissioner at an address or phone number provided by the commissioner and included in the approved plan."

Pages 342 to 343, delete section 34, and insert:

"Sec. 34. Minnesota Statutes 2000, section 256B.501, is amended by adding a subdivision to read:

Subd. 14. [ICF/MR RATE INCREASES BEGINNING JULY 1, 2001, AND JULY 1, 2002.] (a) For the rate periods beginning July 1, 2001, and July 1, 2002, the commissioner shall make available to each facility reimbursed under this section, section 256B.5011, and Laws 1993, First Special Session chapter 1, article 4, section 11, an adjustment to the total operating payment rate of 3.0 percent.

(b) Seventy-five percent of the rate increase must be used to increase the per-hour rate of all employees except administrative and central office employees by an equal dollar amount and to pay associated payroll taxes provided that this increase shall be used only for wage increases implemented on or after the first day of the fiscal year in which the increase is available, and shall not be used for wage increases implemented prior to that date.

(c) Twenty-five percent of the adjustment may be used for other operating costs.

(d) For each facility, the commissioner shall determine the payment rate adjustment using the percentage specified in paragraph (a) multiplied by the total operating payment rate in effect on the last day of the prior rate year, and dividing the resulting amount by the facility's actual resident days. The total operating payment rate shall include the adjustment provided in subdivision 12.

(e) 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.

(f) A facility may apply for the compensation-related payment rate adjustment calculated under paragraph (b). The application must be made to the commissioner and contain a plan by which the facility will distribute the compensation-related portion of the payment rate adjustment to employees of the facility. For facilities in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative constitutes the plan. A negotiated agreement may constitute the plan only if the agreement is finalized after the date of enactment of all rate increases for the rate year. The commissioner shall review the plan to ensure that the payment rate adjustment per diem is used as provided in this subdivision. To be eligible, a facility must submit its plan for the compensation distribution by December 31, 2000, and March 31, 2002, respectively. If a facility's plan for compensation distribution is effective for its employees after the first day of the applicable rate year that the funds are available, the payment rate adjustment per diem shall be effective the same date as its plan.

(g) A copy of the approved distribution plan must be made available to all employees. This must be done by giving each employee a copy or by posting it in an area of the facility to which all employees have access. If an employee does not receive the compensation adjustment described in their facility's approved plan and is unable to resolve the problem with the facility's management or through the employee's union representative, the employee may contact the commissioner at an address or telephone number provided by the commissioner and included in the approved plan."



Page 550, after line 63, insert:

"(3) Providers that receive a rate increase under this section shall use 75 percent of the rate increase to increase the per-hour rate of all employees other than the administrator and central office staff by an equal dollar amount and to pay associated payroll taxes; and 25 percent for other operations costs. For public employees, the portion of this increase reserved to increase compensation for certain staff shall be available and pay rates shall be increased only to the extent that they comply with laws governing public employees collective bargaining. Money for wage increases received by a provider as a result of the additional rate increase described in this clause shall be used only for wage increases implemented on or after the first day of the state fiscal year in which the increase is available and shall not be used for wage increases implemented prior to that date.

(4) A copy of the provider's plan for complying with clause (3) must be made available to all employees. This must be done by giving each employee a copy or by posting it in an area of the provider's operation to which all employees have access. If an employee does not receive the compensation adjustment described in the plan and is unable to resolve the problem with the provider, the employee may contact the employee's union representative. If the employee is not covered by a collective bargaining agreement, the employee may contact the commissioner at a phone number provided by the commissioner and included in the provider's plan."

A roll call was requested and properly seconded.

Peterson moved to amend the Koskinen amendment to S. F. No. 2361, as amended, as follows:

Page 1, line 15, after "employees" insert ", and individuals providing services that are not nursing-related under contract at a nursing facility,"

Page 2, line 6, after "facility" insert ", and individuals providing services that are not nursing-related under contract at the nursing facility"

Page 2, line 7, after "employees" insert "or individuals"

Page 2, line 17, after "employees" insert "or individuals under contract"

Page 2, line 21, after "employees" insert ", and individuals providing services that are not nursing-related under contract"

Page 2, line 22, after "employee" insert "or individual"

Page 2, line 23, after "employees" insert "and individuals"

Page 2, line 23, after "employee" insert "or individual providing services under contract"

Page 2, line 26, after "employee's" insert "or individual's"

Page 2, line 27, after "employee" insert "or individual"

The motion did not prevail and the amendment to the amendment was not adopted.

The question recurred on the Koskinen amendment and the roll was called. There were 61 yeas and 70 nays as follows:

Those who voted in the affirmative were:

Anderson, I.	Evans	Jennings	Lenczewski	Paymar	Thompson
Bakk	Folliard	Johnson, R.	Luther	Pelowski	Wagenius
Bernardy	Gleason	Johnson, S.	Mahoney	Peterson	Walz
Biernat	Goodwin	Juhnke	Mariani	Pugh	Wasiluk
Carlson	Gray	Kahn	Marko	Rukavina	Westerberg
Clark, K.	Greiling	Kalis	McGuire	Schumacher	Winter
Davnie	Hausman	Kelliher	Milbert	Sertich	
Dawkins	Hilstrom	Koskinen	Mullery	Skoglund	
Dempsey	Hilty	Kubly	Murphy	Slawik	
Dorn	Huntley	Larson	Osthoff	Solberg	
Entenza	Jaros	Leighton	Otremba	Swapinski	

Those who voted in the negative were:

Abrams	Eastlund	Holsten	Mares	Pawlenty	Sykora
Anderson, B.	Erhardt	Howes	Marquart	Penas	Tingelstad
Bishop	Erickson	Jacobson	McElroy	Rhodes	Tuma
Boudreau	Finseth	Johnson, J.	Molnau	Rifenberg	Vandever
Bradley	Fuller	Kielkucki	Mulder	Ruth	Wenzel
Buesgens	Gerlach	Knoblach	Ness	Seagren	Westrom
Cassell	Goodno	Krinkie	Nornes	Seifert	Wilkin
Clark, J.	Gunther	Kuisele	Olson	Skoe	Wolf
Daggett	Haas	Leppik	Opatz	Smith	Workman
Davids	Hackbarth	Lieder	Osskopp	Stanek	Spk. Sviggum
Dehler	Harder	Lindner	Ozment	Stang	
Dorman	Holberg	Lipman	Paulsen	Swenson	

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

There being no objection, the order of business advanced to Motions and Resolutions to consider the following two motions:

### MOTIONS AND RESOLUTIONS

Wolf moved that S. F. No. 722 be recalled from the Committee on Rules and Legislative Administration and be re-referred to the Committee on Ways and Means. The motion prevailed.

Finseth moved that S. F. No. 1495, now on the General Register, be re-referred to the Committee on Ways and Means. The motion prevailed.

Pawlenty moved that the House recess subject to the call of the Chair. The motion prevailed.

RECESS

RECONVENED

The House reconvened and was called to order by Speaker pro tempore Abrams.

Mahoney was excused between the hours of 7:00 p.m. and 7:55 p.m.

### FISCAL CALENDAR, Continued

S. F. No. 2361, as amended, was again reported to the House.

Entenza, Smith, Tingelstad and Huntley moved to amend S. F. No. 2361, as amended, as follows:

Page 516, after line 19, insert:

"Sec. 18. Minnesota Statutes 2000, section 626.556, is amended by adding a subdivision to read:

Subd. 2a. [DEFINITION; THREATENED INJURY.] As used in this section, "threatened injury," as defined in subdivision 2, paragraph (1) includes, but is not limited to, exposing a child to a person responsible for the child's care, as defined in paragraph (b), clause (1), who has:

(1) subjected a child to, or failed to protect a child from, an overt act or condition that constitutes egregious harm, as defined in section 260C.007, subdivision 26, or a similar law of another jurisdiction;

(2) been found to be palpably unfit under section 260C.301, paragraph (b), clause (4), or a similar law of another jurisdiction;

(3) committed an act that has resulted in an involuntary termination of parental rights under section 260C.301, or a similar law of another jurisdiction; or

(4) committed an act that has resulted in the involuntary transfer of permanent legal and physical custody of a child to a relative under section 260C.201, subdivision 11, paragraph (e), clause (1), or a similar law of another jurisdiction."

Page 519, after line 8, insert:

"Sec. 20. Minnesota Statutes, section 626.556, is amended by adding a subdivision to read:

Subd. 3d. [COMMISSIONER OF HEALTH; DUTIES.] Notwithstanding the designation of certain data as confidential under section 144.225, subdivision 2 or private under section 144.225, subdivision 2a, the commissioner shall give the commissioner of human services access to birth record data and data contained in recognitions of parentage prepared according to section 257.75 necessary to enable the commissioner of human services to identify a child who is subject to threatened injury, as defined in subdivision 2, paragraph (1), by a person responsible for the child's care, as defined in subdivision 2, paragraph (b), clause (1). The commissioner shall be given access to all data included on official birth certificates."

Page 537, after line 35, insert:

Sec. 19. Minnesota Statutes 2000, section 260C.301, is amended by adding a subdivision to read:

Subd. 3a. [ADDITIONAL GROUND FOR REQUIRED TERMINATION OF PARENTAL RIGHTS.] In addition to the grounds listed in subdivision 3, paragraph (a), the county attorney shall file a termination of parental rights petition within 30 days of the responsible social services agency determining that the parent has lost parental rights to another child through an order involuntarily terminating the parent's rights, or another child of the parent is the subject of an order transferring permanent legal and physical custody of the child to a relative under section 260C.201, subdivision 11, paragraph (e), clause (1), or a similar law of another jurisdiction.

Sec. 20. Minnesota Statutes 2000, section 260C.301, is amended by adding a subdivision to read:

Subd. 1a. [ADDITIONAL FACTOR UPON WHICH PARENTAL RIGHTS MAY BE TERMINATED.] In addition to the presumptions upon which parental rights may be terminated that are listed in subdivision 1, paragraph (b), clause (4), it is presumed that a parent is palpably unfit to be a party to the parent and child relationship upon a showing that the parent's custodial rights to another child have been involuntarily transferred to a relative under section 260C.201, subdivision 11, paragraph (e), clause (1), or a similar law of another jurisdiction.

Sec. 21. [260.0121] [PRIOR INVOLUNTARY TERMINATION OF PARENTAL RIGHTS.]

In addition to the circumstances listed in section 260.012, paragraph (a), clause (1) under which reasonable efforts for rehabilitation and reunification are not required, reasonable efforts for rehabilitation and reunification are also not required upon a determination by the court that a termination of parental rights petition has been filed stating a prima facie case that the parent's custodial rights to another child have been involuntarily transferred to a relative under section 260C.201, subdivision 11, paragraph (e), clause (1), or a similar law of another jurisdiction."

Page 564, after line 12, insert:

"Sec. 15. [EXCHANGE OF RECORDS BETWEEN DEPARTMENT OF HEALTH AND DEPARTMENT OF HUMAN SERVICES.]

The commissioners of health and human services shall exchange birth record data and data contained in recognitions of parentage for the purpose of identifying a child who is subject to threatened injury by a person responsible for a child's care to the extent possible using existing resources and information systems."

Renumber the sections in sequence and correct internal references

Amend the title accordingly

The motion prevailed and the amendment was adopted.

Gray and Goodno moved to amend S. F. No. 2361, as amended, as follows:

Page 538, after line 14, insert:

"Sec. 16. [STUDY OF OUTCOMES FOR CHILDREN IN THE CHILD PROTECTION SYSTEM.]

(a) The commissioner of human services, in consultation with local social services agencies, councils of color, representatives of communities of color, and other interested parties, shall study why African American children in Minnesota are disproportionately represented in out-of-home placements. The commissioner also shall study each stage of the proceedings concerning children in need of protection or services, including the point at which children enter the child welfare system, each decision-making point in the child welfare system, and the outcomes for children in the child welfare system, to determine why outcomes for children differ by race. The commissioner shall use child welfare performance and outcome indicators and data and other available data as part of this study. The



Renumber the sections in sequence and correct the internal references

Amend the title accordingly

The motion prevailed and the amendment was adopted.

Slawik and Luther moved to amend S. F. No. 2361, as amended, as follows:

Pages 355 to 356, delete sections 3 to 6 of Article 6

A roll call was requested and properly seconded.

The question was taken on the Slawik and Luther amendment and the roll was called. There were 61 yeas and 70 nays as follows:

Those who voted in the affirmative were:

Anderson, I.	Folliard	Johnson, R.	Luther	Paymar	Swapinski
Bakk	Gleason	Johnson, S.	Mariani	Pelowski	Thompson
Bernardy	Goodwin	Juhnke	Marko	Peterson	Wagenius
Biernat	Gray	Kahn	Marquart	Pugh	Wasiluk
Carlson	Greiling	Kelliher	McGuire	Rukavina	Wenzel
Davnie	Hausman	Koskinen	Milbert	Schumacher	Winter
Dawkins	Hilstrom	Kubly	Mullery	Sertich	
Dibble	Hilty	Larson	Murphy	Skoe	
Dorn	Huntley	Leighton	Opatz	Skoglund	
Entenza	Jaros	Lenczewski	Osthoff	Slawik	
Evans	Jennings	Lieder	Otremba	Solberg	

Those who voted in the negative were:

Abeler	Dempsey	Harder	Lindner	Pawlenty	Tingelstad
Abrams	Dorman	Holberg	Lipman	Penas	Tuma
Anderson, B.	Eastlund	Holsten	Mares	Rhodes	Vandever
Bishop	Erhardt	Howes	McElroy	Rifenberg	Walz
Boudreau	Erickson	Jacobson	Molnau	Ruth	Westerberg
Bradley	Finseth	Johnson, J.	Mulder	Seagren	Westrom
Buesgens	Fuller	Kalis	Ness	Seifert	Wilkin
Cassell	Gerlach	Kielkucki	Nornes	Smith	Wolf
Clark, J.	Goodno	Knoblach	Olson	Stanek	Workman
Daggett	Gunther	Krinkie	Osskopp	Stang	Spk. Sviggum
Davids	Haas	Kuisle	Ozment	Swenson	
Dehler	Hackbarth	Leppik	Paulsen	Sykora	

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

Dorman was excused between the hours of 8:30 p.m. and 10:30 p.m.

Goodwin, Gleason, Bernardy, Jaros and Schumacher moved to amend S. F. No. 2361, as amended, as follows:

Page 547, after line 18, insert:

"[COST PROVISION.] For the biennium beginning July 1, 2001, any increased costs incurred by a state agency as a result of funding the Minnesota Senior Service Corps programs under section 2, subdivision 9, paragraph (b) must be absorbed internally by the state agency within its appropriation budgeted for professional and technical services."

Page 549, after line 34, insert:

"[MINNESOTA SENIOR SERVICE CORPS.] Of the general fund appropriation, \$3,200,000 for fiscal year 2002 and fiscal year 2003 is for the following purposes:

(a) \$1,000,000 each year in fiscal year 2002 and fiscal year 2003 is for the volunteer programs for retired senior citizens under Minnesota Statutes, section 256.9753, to expand the seniors in schools initiative, provide travel reimbursement to volunteers, and to continue community outreach and the expansion of the program.

(b) \$200,000 each year in fiscal year 2002 and fiscal year 2003 is for the foster grandparents program under Minnesota Statutes, section 256.976, to assist with necessary extensive training expenses and travel reimbursement for volunteers.

(c) \$400,000 each year in fiscal year 2002 and fiscal year 2003 is for the senior companion program under Minnesota Statutes, section 256.977, to expand the program, assist with travel reimbursement for volunteers, and continue the experience corps for independent living."

Correct the totals and the summaries by fund accordingly

A roll call was requested and properly seconded.

The Speaker resumed the Chair.

Seifert moved to amend the Goodwin et al amendment to S. F. No. 2361, as amended, as follows:

Page 1, delete lines 4 to 12, and insert:

"Reduce the general fund appropriation to the commissioner of health for family planning grants under Minnesota Statutes, section 145.925 by \$3,200,000 in fiscal years 2002 and 2003."

A roll call was requested and properly seconded.

The question was taken on the amendment to the amendment and the roll was called. There were 69 yeas and 62 nays as follows:

Those who voted in the affirmative were:

Anderson, B.	Eastlund	Howes	Mulder	Ruth	Walz
Anderson, I.	Erickson	Jacobson	Ness	Schumacher	Wenzel
Bakk	Finseth	Johnson, J.	Nornes	Seagren	Westerberg
Boudreau	Fuller	Kielkucki	Olson	Seifert	Westrom
Bradley	Gerlach	Knoblach	Osskopp	Smith	Wilkin
Buesgens	Goodno	Krinkie	Otremba	Stanek	Winter
Cassell	Gunther	Kuisle	Ozment	Stang	Wolf
Clark, J.	Haas	Lindner	Paulsen	Swenson	Workman
Daggett	Hackbarth	Lipman	Pawlenty	Sykora	Spk. Sviggum
Davids	Harder	Mares	Pelowski	Tingelstad	
Dehler	Holberg	Marquart	Penas	Tuma	
Dempsey	Holsten	Molnau	Rifenberg	Vandever	

Those who voted in the negative were:

Abeler	Entenza	Huntley	Leighton	Mullery	Skoglund
Abrams	Erhardt	Jaros	Lenczewski	Murphy	Slawik
Bernardy	Evans	Jennings	Leppik	Opatz	Solberg
Biernat	Folliard	Johnson, R.	Lieder	Osthoff	Swapinski
Bishop	Gleason	Johnson, S.	Luther	Paymar	Thompson
Carlson	Goodwin	Juhnke	Mahoney	Peterson	Wagenius
Clark, K.	Gray	Kahn	Mariani	Pugh	Wasiluk
Davnie	Greiling	Kelliher	Marko	Rhodes	
Dawkins	Hausman	Koskinen	McElroy	Rukavina	
Dibble	Hilstrom	Kubly	McGuire	Sertich	
Dorn	Hilty	Larson	Milbert	Skoe	

The motion prevailed and the amendment to the amendment was adopted.

Gray was excused for the remainder of today's session.

The question recurred on the Goodwin et al amendment, as amended, and the roll was called. There were 107 yeas and 22 nays as follows:

Those who voted in the affirmative were:

Abeler	Davids	Gerlach	Holberg	Koskinen	Mariani
Anderson, B.	Dehler	Gleason	Howes	Krinkie	Marquart
Anderson, I.	Dempsey	Goodno	Jacobson	Kubly	McGuire
Bakk	Dibble	Goodwin	Jaros	Kuisle	Milbert
Bernardy	Dorn	Greiling	Jennings	Larson	Molnau
Biernat	Eastlund	Gunther	Johnson, J.	Leighton	Mullery
Buesgens	Entenza	Haas	Johnson, R.	Lenczewski	Murphy
Carlson	Erickson	Hackbarth	Johnson, S.	Lieder	Nornes
Cassell	Evans	Harder	Juhnke	Lindner	Olson
Clark, J.	Finseth	Hausman	Kalis	Lipman	Opatz
Clark, K.	Folliard	Hilstrom	Kielkucki	Luther	Osskopp
Daggett	Fuller	Hilty	Knoblach	Mares	Otremba



Ozment	Pugh	Seifert	Stanek	Tuma	Westrom
Paulsen	Rifenberg	Sertich	Stang	Vandever	Wilkin
Pawlenty	Rukavina	Skoe	Swenson	Walz	Winter
Pelowski	Ruth	Slawik	Sykora	Wasiluk	Wolf
Penas	Schumacher	Smith	Thompson	Wenzel	Workman
Peterson	Seagren	Solberg	Tingelstad	Westerberg	

Those who voted in the negative were:

Abrams	Davnie	Huntley	Mahoney	Ness	Wagenius
Bishop	Dawkins	Kahn	Marko	Rhodes	Spk. Sviggum
Boudreau	Erhardt	Kelliher	McElroy	Skoglund	
Bradley	Holsten	Leppik	Mulder	Swapinski	

The motion prevailed and the amendment, as amended, was adopted.

Mariani and Gray moved to amend S. F. No. 2361, as amended, as follows:

Page 42, line 21, delete "this section" and insert "subdivisions 1 to 5 and 7 to 11"

Page 42, delete lines 25 to 28

Page 43, line 29, delete "(a)"

Page 43, delete lines 34 to 36

Page 44, delete lines 1 to 5

Page 44, delete lines 18 to 29 and insert:

"(1) reflects racially and ethnically appropriate approaches;

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

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

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

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

(6) includes an abstinence-based curriculum."

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

Anderson, I., moved to amend S. F. No. 2361, as amended, as follows:

Page 100, line 21, strike "20" and insert "35"

Page 547, after line 18, insert:

"[COST PROVISION.] For the biennium beginning July 1, 2001, any increased costs incurred by a state agency as a result of the amendment to Minnesota Statutes, section 256B.0625, subdivision 18a, paragraph (c), in Article 2, section 22, must be absorbed internally by the state agency within its appropriation budgeted for professional and technical services. For the fiscal year beginning July 1, 2003, base funding for the department of human services for implementation of this provision shall be \$877,000 and for the fiscal year beginning July 1, 2004 and subsequent fiscal years, base funding shall be \$921,000. Notwithstanding section 13, this rider does not expire."

A roll call was requested and properly seconded.

The question was taken on the Anderson, I., amendment and the roll was called. There were 61 yeas and 69 nays as follows:

Those who voted in the affirmative were:

Anderson, I.	Evans	Johnson, R.	Lieder	Otremba	Solberg
Bakk	Folliard	Johnson, S.	Luther	Paymar	Swapinski
Bernardy	Gleason	Juhnke	Mahoney	Pelowski	Wagenius
Biernat	Goodwin	Kahn	Marko	Peterson	Wasiluk
Carlson	Greiling	Kalis	Marquart	Pugh	Wenzel
Clark, K.	Hausman	Kelliher	McGuire	Rukavina	Winter
Davnie	Hilstrom	Koskinen	Milbert	Schumacher	
Dawkins	Hilty	Kubly	Mullery	Sertich	
Dibble	Huntley	Larson	Murphy	Skoe	
Dorn	Jaros	Leighton	Opatz	Skoglund	
Entenza	Jennings	Lenczewski	Osthoff	Slawik	

Those who voted in the negative were:

Abeler	Dempsey	Holberg	Mares	Rhodes	Tuma
Abrams	Eastlund	Holsten	McElroy	Rifenberg	Vandever
Anderson, B.	Erhardt	Howes	Molnau	Ruth	Walz
Bishop	Erickson	Jacobson	Mulder	Seagren	Westerberg
Boudreau	Finseth	Johnson, J.	Ness	Seifert	Westrom
Bradley	Fuller	Kielkucki	Nornes	Smith	Wilkin
Buesgens	Gerlach	Knoblach	Olson	Stanek	Wolf
Cassell	Goodno	Krinkie	Osskopp	Stang	Workman
Clark, J.	Gunther	Kuisle	Ozment	Swenson	Spk. Sviggum
Daggett	Haas	Leppik	Paulsen	Sykora	
Davids	Hackbarth	Lindner	Pawlenty	Thompson	
Dehler	Harder	Lipman	Penas	Tingelstad	

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

Pugh moved to amend S. F. No. 2361, as amended, as follows:

Page 64, after line 30, insert:

"Sec. 56. [STUDY; EFFECTS OF NURSE STAFFING SHORTAGES.]

The commissioner of health, in consultation with consumers, representatives of the Minnesota nurses association, and representatives of the Minnesota hospital and healthcare partnership, shall study and identify the effects of nurse staffing shortages in health care facilities on patient care and patient safety. The results of this study shall be reported by December 1, 2001 to the chairs of the house and senate committees with jurisdiction over health and human services policy issues."

Renumber the sections in sequence and correct internal references

Amend the title accordingly

The motion prevailed and the amendment was adopted.

Paymar, Huntley, Entenza, Evans and Greiling moved to amend S. F. No. 2361, as amended, as follows:

Page 64, after line 30, insert:

"Sec. 56. [TRANSFER OF TOBACCO SETTLEMENT FUNDS BETWEEN ENDOWMENTS; USES OF ENDOWMENT FUNDS; IRRECONCILABLE PROVISIONS.]

(a) No money shall be transferred from the tobacco use prevention and local public health endowment fund to the medical education endowment fund in fiscal year 2002 or 2003. No changes shall be made to how money from the tobacco use prevention and local public health endowment is expended under Minnesota Statutes, section 144.395, subdivision 3, and no changes shall be made to how money from the medical education endowment fund is expended under Minnesota Statutes, section 62J.694, subdivision 2.

(b) Paragraph (a) applies if a bill styled as S. F. No. 2343 is enacted during the 2001 regular session that does any of the following: (1) transfers money from the tobacco use prevention and local public health endowment fund to the medical education endowment fund; (2) changes the amounts of funds distributed or appropriated from the medical education endowment fund, the purposes for which they are distributed or appropriated, or both; or (3) changes the amounts of funds distributed from the tobacco use prevention and local public health endowment fund, the purposes for which they are distributed, or both. Notwithstanding Minnesota Statutes, section 645.26, subdivision 3, if such a bill is enacted that contains any of the listed provisions, those provisions are superseded by paragraph (a).

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

Renumber the sections in sequence and correct internal references

Amend the title accordingly

A roll call was requested and properly seconded.

The question was taken on the Paymar et al amendment and the roll was called. There were 62 yeas and 69 nays as follows:

Those who voted in the affirmative were:

Anderson, I.	Evans	Johnson, R.	Lieder	Otremba	Solberg
Bakk	Folliard	Johnson, S.	Luther	Paymar	Swapinski
Bernardy	Gleason	Juhnke	Mahoney	Pelowski	Thompson
Biernat	Goodwin	Kahn	Mariani	Peterson	Wagenius
Carlson	Greiling	Kalis	Marko	Pugh	Wasiluk
Clark, K.	Hausman	Kelliher	Marquart	Rukavina	Wenzel
Davnie	Hilstrom	Koskinen	McGuire	Schumacher	Winter
Dawkins	Hilty	Kubly	Milbert	Sertich	
Dibble	Huntley	Larson	Mullery	Skoe	
Dorn	Jaros	Leighton	Murphy	Skoglund	
Entenza	Jennings	Lenczewski	Opatz	Slawik	

Those who voted in the negative were:

Abeler	Dempsey	Holberg	Mares	Penas	Tuma
Abrams	Eastlund	Holsten	McElroy	Rhodes	Vandevveer
Anderson, B.	Erhardt	Howes	Molnau	Rifenberg	Walz
Bishop	Erickson	Jacobson	Mulder	Ruth	Westerberg
Boudreau	Finseth	Johnson, J.	Ness	Seagren	Westrom
Bradley	Fuller	Kielkucki	Nornes	Seifert	Wilkin
Buesgens	Gerlach	Knoblach	Olson	Smith	Wolf
Cassell	Goodno	Krinkie	Osskopp	Stanek	Workman
Clark, J.	Gunther	Kuisle	Osthoff	Stang	Spk. Sviggum
Daggett	Haas	Leppik	Ozment	Swenson	
Davids	Hackbarth	Lindner	Paulsen	Sykora	
Dehler	Harder	Lipman	Pawlenty	Tingelstad	

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

Otremba, Abeler and Rhodes moved to amend S. F. No. 2361, as amended, as follows:

Page 28, after line 32, insert:

"Sec. 32. Minnesota Statutes 2000, section 144A.4605, subdivision 4, is amended to read:

Subd. 4. [LICENSE REQUIRED.] (a) A housing with services establishment registered under chapter 144D that is required to obtain a home care license must obtain an assisted living home care license according to this section or a class A or class E license according to rule. A housing with services establishment that obtains a class E license under this subdivision remains subject to the payment limitations in sections 256B.0913, subdivision 5, paragraph (h), and 256B.0915, subdivision 3, paragraph (g).

(b) A board and lodging establishment registered for special services as of December 31, 1996, and also registered as a housing with services establishment under chapter 144D, must deliver home care services according to sections 144A.43 to 144A.48, and may apply for a waiver from requirements under Minnesota Rules, parts 4668.0002 to 4668.0240, to operate a licensed agency under the standards of section 157.17. Such waivers as may be granted by the department will expire upon promulgation of home care rules implementing section 144A.4605.

(c) An adult foster care provider licensed by the department of human services and registered under chapter 144D may continue to provide health-related services under its foster care license until the promulgation of home care rules implementing this section.

(d) An assisted living home care provider licensed under this section must comply with the disclosure provisions of section 325F.691 to the extent they are applicable.

Sec. 33. Minnesota Statutes 2000, section 144D.03, subdivision 2, is amended to read:

Subd. 2. [REGISTRATION INFORMATION.] The establishment shall provide the following information to the commissioner in order to be registered:

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

(2) the name and mailing address of the owner or owners of the establishment and, if the owner or owners are not natural persons, identification of the type of business entity of the owner or owners, and the names and addresses of the officers and members of the governing body, or comparable persons for partnerships, limited liability corporations, or other types of business organizations of the owner or owners;

(3) the name and mailing address of the managing agent, whether through management agreement or lease agreement, of the establishment, if different from the owner or owners, and the name of the on-site manager, if any;

(4) verification that the establishment has entered into an elderly housing with services contract, as required in section 144D.04, with each resident or resident's representative;

(5) verification that the establishment is complying with the requirements of section 325F.691, if applicable;

~~(5)~~ (6) the name and address of at least one natural person who shall be responsible for dealing with the commissioner on all matters provided for in sections 144D.01 to 144D.06, and on whom personal service of all notices and orders shall be made, and who shall be authorized to accept service on behalf of the owner or owners and the managing agent, if any; and

~~(6)~~ (7) the signature of the authorized representative of the owner or owners or, if the owner or owners are not natural persons, signatures of at least two authorized representatives of each owner, one of which shall be an officer of the owner.

Personal service on the person identified under clause ~~(5)~~ (6) by the owner or owners in the registration shall be considered service on the owner or owners, and it shall not be a defense to any action that personal service was not made on each individual or entity. The designation of one or more individuals under this subdivision shall not affect the legal responsibility of the owner or owners under sections 144D.01 to 144D.06.

Sec. 34. Minnesota Statutes 2000, section 144D.04, subdivision 2, is amended to read:

Subd. 2. [CONTENTS OF CONTRACT.] An elderly housing with services contract, which need not be entitled as such to comply with this section, shall include at least the following elements in itself or through supporting documents or attachments:

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

(2) the name and mailing address of the owner or owners of the establishment and, if the owner or owners is not a natural person, identification of the type of business entity of the owner or owners;

(3) the name and mailing address of the managing agent, through management agreement or lease agreement, of the establishment, if different from the owner or owners;

- (4) the name and address of at least one natural person who is authorized to accept service on behalf of the owner or owners and managing agent;
- (5) statement describing the registration and licensure status of the establishment and any provider providing health-related or supportive services under an arrangement with the establishment;
- (6) term of the contract;
- (7) description of the services to be provided to the resident in the base rate to be paid by resident;
- (8) description of any additional services available for an additional fee from the establishment directly or through arrangements with the establishment;
- (9) fee schedules outlining the cost of any additional services;
- (10) description of the process through which the contract may be modified, amended, or terminated;
- (11) description of the establishment's complaint resolution process available to residents including the toll-free complaint line for the office of ombudsman for older Minnesotans;
- (12) the resident's designated representative, if any;
- (13) the establishment's referral procedures if the contract is terminated;
- (14) criteria used by the establishment to determine who may continue to reside in the elderly housing with services establishment;
- (15) billing and payment procedures and requirements;
- (16) statement regarding the ability of residents to receive services from service providers with whom the establishment does not have an arrangement; and
- (17) statement regarding the availability of public funds for payment for residence or services in the establishment.

Sec. 35. Minnesota Statutes 2000, section 144D.04, subdivision 3, is amended to read:

Subd. 3. [CONTRACTS IN PERMANENT FILES.] Elderly housing with services contracts and related documents executed by each resident or resident's representative shall be maintained by the establishment in files from the date of execution until three years after the contract is terminated. The contracts and the written disclosures required under section 325F.691, if applicable, shall be made available for on-site inspection by the commissioner upon request at any time.

Sec. 36. Minnesota Statutes 2000, section 144D.06, is amended to read:

144D.06 [OTHER LAWS.]

A housing with services establishment shall obtain and maintain all other licenses, permits, registrations, or other governmental approvals required of it in addition to registration under this chapter. A housing with services establishment is subject to the provisions of section 325F.691 and chapter 504B."

Page 63, after line 22, insert:

"Sec. 55. [325F.691] [DISCLOSURE OF SPECIAL CARE STATUS REQUIRED.]

Subdivision 1. [PERSONS TO WHOM DISCLOSURE IS REQUIRED.] Housing with services establishments, as defined in sections 144D.01 to 144D.07, that secure, segregate, or provide a special program or special unit for residents with a diagnosis of probable Alzheimer's disease or a related disorder or that advertise, market, or otherwise promote the establishment as providing specialized care for Alzheimer's disease or a related disorder are considered a "special care unit." All special care units shall provide a written disclosure to the following:

(1) the commissioner of health, if requested;

(2) the office of ombudsman for older Minnesotans; and

(3) each person seeking placement within a residence, or the person's authorized representative, before an agreement to provide the care is entered into.

Subd. 2. [CONTENT.] Written disclosure shall include, but is not limited to, the following:

(1) a statement of the overall philosophy and how it reflects the special needs of residents with Alzheimer's disease or other dementias;

(2) the criteria for determining who may reside in the special care unit;

(3) the process used for assessment and establishment of the service plan or agreement, including how the plan is responsive to changes in the resident's condition;

(4) staffing credentials, job descriptions, and staff duties and availability, including any training specific to dementia;

(5) physical environment as well as design and security features that specifically address the needs of residents with Alzheimer's disease or other dementias;

(6) frequency and type of programs and activities for residents of the special care unit;

(7) involvement of families in resident care and availability of family support programs;

(8) fee schedules for additional services to the residents of the special care unit; and

(9) a statement that residents will be given a written notice 30 days prior to changes in the fee schedule.

Subd. 3. [DUTY TO UPDATE.] Substantial changes to disclosures must be reported to the parties listed in subdivision 1 at the time the change is made.

Subd. 4. [REMEDY.] The attorney general may seek the remedies set forth in section 8.31 for repeated and intentional violations of this section. However, no private right of action may be maintained as provided under section 8.31, subdivision 3a."

Renumber the sections in sequence and correct internal references

Amend the title accordingly

A roll call was requested and properly seconded.

The question was taken on the Otremba et al amendment and the roll was called. There were 129 yeas and 2 nays as follows:

Those who voted in the affirmative were:

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

Those who voted in the negative were:

Boudreau            Westrom

The motion prevailed and the amendment was adopted.

Otremba moved to amend S. F. No. 2361, as amended, as follows:

Page 561, line 12, delete "30,336,000" and insert "30,943,000" and delete "28,784,000" and insert "30,019,000"

Page 561, after line 12, insert:

"[VETERANS HOME RATE INCREASE.] Of the general fund appropriation, \$607,000 in fiscal year 2002 and \$1,235,000 in fiscal year 2003 is for a base adjustment for salary and benefits for employees of the veterans nursing homes board."

Reduce the general fund appropriation to the commissioner of human services for SSIS financing by \$607,000 in fiscal year 2002 and \$1,235,000 in fiscal year 2003

Correct the totals and summaries by fund accordingly

A roll call was requested and properly seconded.



The question was taken on the Otremba amendment and the roll was called. There were 131 yeas and 0 nays as follows:

Those who voted in the affirmative were:

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

The motion prevailed and the amendment was adopted.

Otremba moved to amend S. F. No. 2361, as amended, as follows:

Page 532, after line 5, insert:

"Sec. 4. [151.062] [REFUSAL OF PHARMACIST TO DISPENSE CERTAIN DRUGS.]

The board must not discipline a pharmacist for refusing to dispense, or refusing to assist a patient in obtaining, a prescription whose use the pharmacist opposes for moral or religious reasons."

Renumber the sections in sequence and correct internal references

Amend the title accordingly

A roll call was requested and properly seconded.

#### POINT OF ORDER

Folliard raised a point of order pursuant to rule 3.21 that the Otremba amendment was not in order. The Speaker ruled the point of order not well taken and the Otremba amendment in order.

Wasiluk moved to amend the Otremba amendment to S. F. No. 2361, as amended, as follows:

Page 1, line 6, delete "not"

The motion did not prevail and the amendment to the amendment was not adopted.

The question recurred on the Otremba amendment and the roll was called. There were 63 yeas and 65 nays as follows:

Those who voted in the affirmative were:

Abeler	Eastlund	Johnson, J.	Mulder	Rifenberg	Wenzel
Anderson, B.	Erickson	Juhnke	Ness	Ruth	Westerberg
Anderson, I.	Finseth	Kielkucki	Nornes	Schumacher	Westrom
Boudreau	Fuller	Krinkie	Olson	Seifert	Wilkin
Bradley	Gerlach	Kubly	Osskopp	Smith	Winter
Buesgens	Gunther	Kuisle	Otremba	Stang	Wolf
Cassell	Haas	Lindner	Ozment	Swenson	Workman
Clark, J.	Hackbarth	Lipman	Pawlenty	Tingelstad	Spk. Sviggum
Daggett	Holberg	Mares	Pelowski	Tuma	
Davids	Howes	Marquart	Penas	Vandevveer	
Dempsey	Jacobson	Molnau	Peterson	Walz	

Those who voted in the negative were:

Abrams	Dorn	Hilstrom	Koskinen	McGuire	Sertich
Bakk	Entenza	Hilty	Larson	Milbert	Skoe
Bernardy	Erhardt	Holsten	Leighton	Mullery	Skoglund
Biernat	Evans	Huntley	Lenczewski	Opatz	Slawik
Bishop	Folliard	Jaros	Leppik	Osthoff	Solberg
Carlson	Gleason	Jennings	Lieder	Paulsen	Swapinski
Clark, K.	Goodno	Johnson, R.	Luther	Paymar	Sykora
Davnie	Goodwin	Johnson, S.	Mahoney	Pugh	Thompson
Dawkins	Greiling	Kahn	Mariani	Rhodes	Wagenius
Dehler	Harder	Kelliher	Marko	Rukavina	Wasiluk
Dibble	Hausman	Knoblach	McElroy	Seagren	

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

S. F. No. 2361, as amended, was read for the third time.

#### POINT OF ORDER

Boudreau raised a point of order pursuant to section 124 of "Mason's Manual of Legislative Procedure," relating to Personalities Not Permitted in Debate. The Speaker ruled the point of order not well taken.

## POINT OF ORDER

Pawlenty raised a point of order pursuant to section 124 of "Mason's Manual of Legislative Procedure," relating to Personalities Not Permitted in Debate. The Speaker ruled the point of order well taken.

## CALL OF THE HOUSE

On the motion of Pawlenty and on the demand of 10 members, a call of the House was ordered. The following members answered to their names:

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

Pawlenty moved that further proceedings of the roll call be suspended and that the Sergeant at Arms be instructed to bring in the absentees. The motion prevailed and it was so ordered.

S. F. No. 2361, A bill for an act relating to the operation of state government; modifying provisions relating to health; health department; human services; human services department; long-term care; medical assistance; general assistance medical care; MinnesotaCare; prescription drug program; home and community-based waivers; services for persons with disabilities; group residential housing; state-operated services; chemical dependency; mental health; Minnesota family investment program; general assistance program; child support enforcement; adoption; children in need of protection or services; termination of parental rights; child protection; veterans nursing homes board; health-related licensing boards; emergency medical services regulatory board; Minnesota state council on disability; ombudsman for mental health and mental retardation; ombudsman for families; adding an informed consent provision for abortion procedures; requiring reports; appropriating money; amending Minnesota Statutes 2000, sections 13.46, subdivision 4; 13.461, subdivision 17; 13B.06, subdivisions 4, 7; 15A.083, subdivision 4; 16A.06, by adding a subdivision; 16A.87; 62A.095, subdivision 1; 62A.48, subdivision 4, by adding subdivisions; 62J.152, subdivision 8; 62J.451, subdivision 5; 62J.692, subdivision 7; 62J.694, subdivision 2; 62Q.19, subdivision 2; 62S.01, by adding subdivisions; 62S.26; 103I.101, subdivision 6; 103I.112; 103I.208, subdivisions 1, 2; 103I.235, subdivision 1; 103I.525, subdivisions 2, 6, 8, 9; 103I.531, subdivisions 2, 6, 8, 9; 103I.535, subdivisions 2, 6, 8, 9; 103I.541, subdivisions 2b, 4, 5; 103I.545; 116L.11, subdivision 4; 116L.12, subdivisions 4, 5; 116L.13, subdivision 1; 121A.15, by adding subdivisions; 144.057; 144.0721,

subdivision 1; 144.1202, subdivision 4; 144.122; 144.1464; 144.148, subdivision 2; 144.1494, subdivisions 1, 3, 4; 144.1496; 144.226, subdivision 4; 144.396, subdivision 7; 144.98, subdivision 3; 144A.071, subdivisions 1, 1a, 2, 4a; 144A.073, subdivision 2; 145.881, subdivision 2; 145.882, subdivision 7, by adding a subdivision; 145.885, subdivision 2; 145.925, subdivision 1; 148.212; 148.263, subdivision 2; 148.284; 150A.10, by adding a subdivision; 157.16, subdivision 3; 157.22; 214.001, by adding a subdivision; 214.002, subdivision 1; 214.01, by adding a subdivision; 214.104; 241.272, subdivision 6; 242.192; 245.462, subdivision 18, by adding subdivisions; 245.466, subdivision 2; 245.470, by adding a subdivision; 245.474, subdivision 2, by adding a subdivision; 245.4871, subdivision 27, by adding subdivisions; 245.4875, subdivision 2; 245.4876, subdivision 1, by adding a subdivision; 245.488, by adding a subdivision; 245.4885, subdivision 1; 245.4886, subdivision 1; 245.98, by adding a subdivision; 245.982; 245.99, subdivision 4; 245A.03, subdivision 2b; 245A.04, subdivisions 3, 3a, 3b, 3c, 3d; 245A.05; 245A.06; 245A.07; 245A.08; 245A.13, subdivisions 7, 8; 245A.16, subdivision 1; 245B.08, subdivision 3; 252.275, subdivision 4b; 253.28, by adding a subdivision; 253B.02, subdivision 10; 253B.03, subdivisions 5, 10, by adding a subdivision; 253B.04, subdivisions 1, 1a, by adding a subdivision; 253B.045, subdivision 6; 253B.05, subdivision 1; 253B.07, subdivision 1; 253B.09, subdivision 1; 253B.10, subdivision 4; 254B.03, subdivision 1; 254B.09, by adding a subdivision; 256.01, subdivision 2, by adding a subdivision; 256.045, subdivisions 3, 3b, 4; 256.476, subdivisions 1, 2, 3, 4, 5, 8, by adding a subdivision; 256.741, subdivisions 1, 5, 8; 256.955, subdivisions 2, 2a, 7, by adding a subdivision; 256.9657, subdivision 2; 256.969, subdivision 3a, by adding a subdivision; 256.975, by adding subdivisions; 256.979, subdivisions 5, 6; 256.98, subdivision 8; 256B.02, subdivision 7; 256B.04, by adding a subdivision; 256B.055, subdivision 3a; 256B.056, subdivisions 1a, 4, 4b; 256B.057, subdivisions 2, 9, by adding subdivisions; 256B.061; 256B.0625, subdivisions 7, 13, 13a, 17, 17a, 18a, 19a, 19c, 20, 30, 34, by adding subdivisions; 256B.0627, subdivisions 1, 2, 4, 5, 7, 8, 10, 11, by adding subdivisions; 256B.0635, subdivisions 1, 2; 256B.0644; 256B.0911, subdivisions 1, 3, 5, 6, 7, by adding subdivisions; 256B.0913, subdivisions 1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14; 256B.0915, subdivisions 1d, 3, 5; 256B.0917, by adding a subdivision; 256B.093, subdivision 3; 256B.431, subdivision 2e, by adding subdivisions; 256B.433, subdivision 3a; 256B.434, subdivision 4; 256B.49, by adding subdivisions; 256B.5012, subdivision 3, by adding subdivisions; 256B.69, subdivisions 4, 5c, 23, by adding a subdivision; 256B.75; 256B.76; 256D.053, subdivision 1; 256D.35, by adding subdivisions; 256D.425, subdivision 1; 256D.44, subdivision 5; 256I.05, subdivisions 1d, 1e, by adding a subdivision; 256J.08, subdivision 55a, by adding a subdivision; 256J.21, subdivision 2; 256J.24, subdivisions 2, 9, 10; 256J.31, subdivision 12; 256J.32, subdivision 4; 256J.37, subdivision 9; 256J.39, subdivision 2; 256J.42, subdivisions 1, 3, 4, 5; 256J.45, subdivisions 1, 2; 256J.46, subdivision 1; 256J.48, subdivision 1, by adding a subdivision; 256J.49, subdivisions 2, 13, by adding a subdivision; 256J.50, subdivisions 5, 10, by adding a subdivision; 256J.515; 256J.52, subdivisions 2, 3, 6; 256J.53, subdivisions 1, 2, 3; 256J.56; 256J.62, subdivisions 2a, 9; 256J.625; 256J.645; 256K.03, subdivisions 1, 5; 256K.07; 256L.01, subdivision 4; 256L.04, subdivision 2; 256L.05, subdivision 2; 256L.06, subdivision 3; 256L.07, subdivisions 1, 2, 3, by adding subdivisions; 256L.12, by adding a subdivision; 256L.15, subdivisions 1, 2; 256L.16; 257.0725; 260C.201, subdivision 1; 326.38; 393.07, by adding a subdivision; 518.551, subdivision 13; 518.5513, subdivision 5; 518.575, subdivision 1; 518.5851, by adding a subdivision; 518.5853, by adding a subdivision; 518.6111, subdivision 5; 518.6195; 518.64, subdivision 2; 518.641, subdivisions 1, 2, 3, by adding a subdivision; 548.091, subdivision 1a; 609.115, subdivision 9; 611.23; 626.556, subdivisions 2, 10, 10b, 10d, 10e, 10f, 10i, 11, 12, by adding a subdivision; 245.814, subdivision 1; 626.557, subdivisions 3, 9d, 12b; 626.5572, subdivision 17; 626.559, subdivision 2; Laws 1998, chapter 404, section 18, subdivision 4; Laws 1998, chapter 407, article 8, section 9; Laws 1999, chapter 152, section 4; Laws 1999, chapter 216, article 1, section 13, subdivision 4; Laws 1999, chapter 245, article 3, section 45, as amended; Laws 1999, chapter 245, article 4, section 110; Laws 1999, chapter 245, article 10, section 10, as amended; Laws 2000, chapter 364, section 2; proposing coding for new law in Minnesota Statutes, chapters 62Q; 62S; 116L; 144; 144A; 145; 214; 241; 244; 246; 256; 256B; 256J; 299A; repealing Minnesota Statutes 2000, sections 16A.76; 116L.12, subdivisions 2, 7; 144.148, subdivision 8; 144A.16; 145.882, subdivisions 3, 4; 145.9245; 145.927; 256.01, subdivision 18; 256.476, subdivision 7; 256.955, subdivision 2b; 256B.0635, subdivision 3; 256B.0911, subdivisions 2, 2a, 4, 8, 9; 256B.0912; 256B.0913, subdivisions 3, 15a, 15b, 15c, 16; 256B.0915, subdivisions 3a, 3b, 3c; 256B.434, subdivision 5; 256B.49, subdivisions 1, 2, 3, 4, 5, 6, 7, 8, 9, 10; 256D.066; 256E.06, subdivision 2b; 256J.08, subdivision 50a; 256J.12, subdivision 3; 256J.32, subdivision 7a; 256J.43; 256J.49, subdivision 11; 256J.53, subdivision 4; 256L.15, subdivision 3; 518.641, subdivisions 4, 5; Laws 1997, chapter 203, article 9, section 21; Laws 1998, chapter 404, section 18, subdivision 4; Laws 1998, chapter 407, article 6, section 111; Laws 2000, chapter 488, article 10, section 28; Laws 2000, chapter 488, article 10, section 30; Minnesota Rules, parts

4655.6810; 4655.6820; 4655.6830; 4658.1600; 4658.1605; 4658.1610; 4658.1690; 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; 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; 9505.3670; 9546.0010; 9546.0020; 9546.0030; 9546.0040; 9546.0050; 9546.0060.

The bill, as amended, was placed upon its final passage.

The question was taken on the passage of the bill and the roll was called. There were 89 yeas and 43 nays as follows:

Those who voted in the affirmative were:

Abeler	Erickson	Johnson, R.	Marquart	Penas	Thompson
Anderson, B.	Finseth	Juhnke	Milbert	Peterson	Tingelstad
Anderson, I.	Fuller	Kalis	Molnau	Pugh	Tuma
Bakk	Gerlach	Kielkucki	Mulder	Rifenberg	Vandever
Boudreau	Goodno	Knoblach	Murphy	Ruth	Walz
Bradley	Greiling	Krinkie	Ness	Schumacher	Wasiluk
Buesgens	Gunther	Kubly	Nornes	Seagren	Wenzel
Cassell	Haas	Kuisle	Olson	Seifert	Westerberg
Clark, J.	Hackbarth	Larson	Opatz	Skoe	Westrom
Daggett	Harder	Lenczewski	Osskopp	Smith	Wilkin
Davids	Holberg	Lieder	Otremba	Solberg	Winter
Dehler	Holsten	Lindner	Ozment	Stanek	Wolf
Dempsey	Howes	Lipman	Paulsen	Stang	Workman
Dorman	Jacobson	Luther	Pawlenty	Swenson	Spk. Sviggum
Eastlund	Johnson, J.	Mares	Pelowski	Sykora	

Those who voted in the negative were:

Abrams	Dibble	Hausman	Kelliher	McGuire	Slawik
Bernardy	Dorn	Hilstrom	Koskinen	Mullery	Swapinski
Biernat	Entenza	Hilty	Leighton	Osthoff	Wagenius
Bishop	Erhardt	Huntley	Leppik	Paymar	
Carlson	Evans	Jaros	Mahoney	Rhodes	
Clark, K.	Folliard	Jennings	Mariani	Rukavina	
Davnie	Gleason	Johnson, S.	Marko	Sertich	
Dawkins	Goodwin	Kahn	McElroy	Skoglund	

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

There being no objection, the order of business reverted to Reports of Standing Committees.

## REPORTS OF STANDING COMMITTEES

Pawlenty from the Committee on Rules and Legislative Administration to which was referred:

H. F. No. 2514, A bill for an act relating to agriculture; expanding emergency authority of the board of animal health to eradicate any dangerous, infectious, or communicable disease affecting domestic animals in the state; amending Minnesota Statutes 2000, section 35.09, subdivision 3; proposing coding for new law in Minnesota Statutes, chapter 35.

Reported the same back with the recommendation that the bill pass and be re-referred to the Committee on Civil Law.

Joint Rule 2.03 and Senate Concurrent Resolution No. 5 have been waived for subsequent committee action on this bill.

The report was adopted.

## MOTIONS AND RESOLUTIONS

Pawlenty moved that the name of Davids be added as an author on H. F. No. 402. The motion prevailed.

Finseth moved that the names of Johnson, R.; Westrom; Penas; Kubly; Cassell; Rifenberg; Ness; Skoe and Peterson be added as authors on H. F. No. 2514. The motion prevailed.

Paulsen moved that H. F. No. 1683 be recalled from the Committee on Jobs and Economic Development Finance and be re-referred to the Committee on Ways and Means. The motion prevailed.

## ANNOUNCEMENTS BY THE SPEAKER

The Speaker announced the appointment of the following members of the House to a Conference Committee on S. F. No. 2351:

Holsten, Finseth, Ozment, Harder and Osthoff.

The Speaker announced the appointment of the following members of the House to a Conference Committee on S. F. No. 2360:

Krinkie; Rhodes; Anderson, B.; Kielkucki and Erickson.

## ADJOURNMENT

Pawlenty moved that when the House adjourns today it adjourn until 11:00 a.m., Friday, May 11, 2001. The motion prevailed.

Pawlenty moved that the House adjourn. The motion prevailed, and the Speaker declared the House stands adjourned until 11:00 a.m., Friday, May 11, 2001.

EDWARD A. BURDICK, Chief Clerk, House of Representatives