

## STATE OF MINNESOTA

## EIGHTY-SECOND SESSION — 2001

## FIFTY-THIRD DAY

SAINT PAUL, MINNESOTA, MONDAY, MAY 14, 2001

The House of Representatives convened at 10:30 a.m. and was called to order by Steve Sviggum, Speaker of the House.

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

A quorum was present.

Clark, K., was excused until 1:05 p.m. Sertich was excused until 1:35 p.m.

The Chief Clerk proceeded to read the Journal of the preceding day. Ruth 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. 179 and H. F. No. 281, which had been referred to the Chief Clerk for comparison, were examined and found to be identical with certain exceptions.

**SUSPENSION OF RULES**

Greiling moved that the rules be so far suspended that S. F. No. 179 be substituted for H. F. No. 281 and that the House File be indefinitely postponed. The motion prevailed.

S. F. No. 1485 and H. F. No. 1311, which had been referred to the Chief Clerk for comparison, were examined and found to be identical with certain exceptions.

**SUSPENSION OF RULES**

McElroy moved that the rules be so far suspended that S. F. No. 1485 be substituted for H. F. No. 1311 and that the House File be indefinitely postponed. The motion prevailed.

S. F. No. 1944 and H. F. No. 1697, which had been referred to the Chief Clerk for comparison, were examined and found to be identical with certain exceptions.

**SUSPENSION OF RULES**

Smith moved that the rules be so far suspended that S. F. No. 1944 be substituted for H. F. No. 1697 and that the House File be indefinitely postponed. The motion prevailed.

**REPORTS OF STANDING COMMITTEES**

Abrams from the Committee on Taxes to which was referred:

H. F. No. 84, A bill for an act relating to taxation; making technical corrections and administrative changes to income and franchise, property, sales and use, petroleum, deed, cigarette and tobacco, liquor, MinnesotaCare, and other taxes; making administrative and technical changes to property tax refund and local government aid provisions; clarifying abandoned personal property sale procedures; providing that certain water service connection fees be paid to the commissioner of health; making technical changes to the Revenue Recapture Act; amending Minnesota Statutes 2000, sections 144.3831, subdivision 2; 270.06; 270A.03, subdivision 5; 273.072, subdivision 1; 273.1104, subdivision 2; 273.111, subdivision 4; 273.124, subdivision 13; 282.04, subdivision 2; 287.20, subdivision 9; 289A.12, subdivision 3; 289A.50, subdivision 2a; 290.067, subdivisions 2 and 2b; 290.0671, subdivisions 1 and 7; 290.0921, subdivision 3; 290.35, subdivision 2; 290A.04, subdivision 4; 295.50, subdivisions 3 and 15; 295.52, subdivision 4; 295.57, subdivision 1; 296A.16, subdivision 2; 296A.21, subdivisions 1 and 4; 297A.01, subdivision 3; 297A.25, subdivisions 3 and 11; 297F.16, subdivision 4; 297G.15, subdivision 4; 297G.16, subdivisions 5 and 7; and 477A.011, subdivision 36; proposing coding for new law in Minnesota Statutes, chapter 296A; repealing Minnesota Statutes 2000, sections 290.095, subdivision 7; 290.23; 290.25; 290.31, subdivisions 2, 2a, 3, 4, 5, and 19; 296A.16, subdivision 6; and 297B.032.

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. 187, A bill for an act relating to taxation; prohibiting modification and limiting expenditures of certain tax increment financing districts; proposing coding for new law in Minnesota Statutes, chapter 469.

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

The report was adopted.

Bishop from the Committee on Ways and Means 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 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.

Reported the same back with the following amendments:

Page 10, line 29, delete "\$45,000,000" and insert "\$44,000,000"

Page 10, line 32, after "for" insert "computer software, or for"

Page 10, line 33, delete the third comma and insert "or"

Page 10, line 34, before "busways" insert "construction or maintenance of"

Page 47, line 26, after the period, insert "Hearings under section 48 may be held at any time after the date of enactment."

With the recommendation that when so amended the bill pass.

The report was adopted.

Abrams from the Committee on Taxes to which was referred:

H. F. No. 2241, A bill for an act relating to a new sports stadium; creating a task force to study stadiums; mandating issues to be studied; imposing a deadline; inviting proposals; requiring a report.

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. 2506, A bill for an act relating to finance; updating and changing the Minnesota Bond Allocation Act; amending Minnesota Statutes 2000, sections 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; proposing coding for new law in Minnesota Statutes, chapter 474A; repealing Minnesota Statutes 2000, section 474A.061, subdivision 6.

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

The report was adopted.

## **SECOND READING OF HOUSE BILLS**

H. F. Nos. 84, 187, 2037, 2241 and 2506 were read for the second time.

## **SECOND READING OF SENATE BILLS**

S. F. Nos. 179, 1485 and 1944 were read for the second time.

## **INTRODUCTION AND FIRST READING OF HOUSE BILLS**

The following House Files were introduced:

Hackbarth; Rukavina; Davids; Bakk; McElroy; Leighton; Stang; Sertich; Gunther; Abeler; Haas; Opatz; Kielkucki; Marquart; Larson; Lindner; Walz; Fuller; Kalis; Ruth; Ozment; Murphy; Westerberg; Wenzel; Clark, J.; Howes; Solberg; Entenza; Sykora; Vandever and Hilstrom introduced:

H. F. No. 2525, A bill for an act relating to employment; requiring that employers allow unpaid leave for employees to perform volunteer firefighter duties; proposing coding for new law in Minnesota Statutes, chapter 181.

The bill was read for the first time and referred to the Committee on Commerce, Jobs and Economic Development.

Paulsen introduced:

H. F. No. 2526, A bill for an act relating to redistricting; adopting a congressional redistricting plan for use in 2002 and thereafter; amending Minnesota Statutes 2000, section 2.031, subdivision 2; repealing Minnesota Statutes 2000, sections 2.742; 2.752; 2.762; 2.772; 2.782; 2.792; 2.802; 2.812.

The bill was read for the first time and referred to the Committee on Redistricting.

Jaros introduced:

H. F. No. 2527, A bill for an act relating to higher education; directing the board of trustees of the Minnesota state colleges and universities and requesting the board of regents of the University of Minnesota to adopt a policy requiring a year of study abroad for certain students.

The bill was read for the first time and referred to the Committee on Higher Education Finance.

Hackbarth, Rhodes, Schumacher, Milbert, Stang and Erickson introduced:

H. F. No. 2528, A bill for an act relating to gambling; proposing an amendment to the Minnesota Constitution by adding a section to article XIII; allowing the legislature to authorize one or more privately operated casinos with the state's share of net proceeds as defined by law dedicated to highway purposes and educational infrastructure.

The bill was read for the first time and referred to the Committee on Governmental Operations and Veterans Affairs Policy.

Kahn, Greiling, Krinkie, Mares and Rhodes introduced:

H. F. No. 2529, A bill for an act relating to retirement; providing that certain aid is contingent on compliance with filing requirements; mandating a study of a merger of certain retirement plans; proposing coding for new law in Minnesota Statutes, chapter 356A.

The bill was read for the first time and referred to the Committee on Governmental Operations and Veterans Affairs Policy.

Kahn, Greiling, Krinkie, Mares and Rhodes introduced:

H. F. No. 2530, A bill for an act relating to retirement; various state retirement aid programs; conditioning state aid receipt on compliance with economic interest and investment business recipient disclosure requirements; amending Minnesota Statutes 2000, sections 10A.02, subdivision 8; 69.021, subdivisions 4, 7, 7a; 354A.12, subdivision 3a; 356A.06, subdivision 5; 422A.101, subdivision 3.

The bill was read for the first time and referred to the Committee on Governmental Operations and Veterans Affairs Policy.

Goodno, Nornes, Rhodes, Huntley and Abeler introduced:

H. F. No. 2531, A bill for an act relating to health; regulating hospice care providers; amending Minnesota Statutes 2000, sections 13.381, subdivision 10; 144A.43, subdivisions 1, 3, 4; 144A.45, subdivisions 1, 2; 144A.46, subdivisions 3a, 3b, 4; 144A.4605, subdivisions 2, 3, 4; 145C.01, subdivision 7; 157.17, subdivision 2; 609.7495, subdivision 1; proposing coding for new law in Minnesota Statutes, chapter 144A; repealing Minnesota Statutes 2000, section 144A.48.

The bill was read for the first time and referred to the Committee on Health and Human Services Policy.

Huntley, Cassell, Swapinski, Murphy, Jaros and Kalis introduced:

H. F. No. 2532, A bill for an act relating to appropriations; appropriating money for the state's share of the cost of the new Poe Lock at Sault Ste. Marie Narrows.

The bill was read for the first time and referred to the Committee on Jobs and Economic Development Finance.

### 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. 82, A bill for an act relating to education; providing for kindergarten through grade 12 education including general education revenue; education excellence; special programs; facilities and technology; nutrition, school accounting, and other programs; agency provisions; deficiencies; local achievement testing; and technical amendments; appropriating money; amending Minnesota Statutes 2000, sections 16B.616, subdivision 4; 120A.05, by adding a subdivision; 120B.02; 120B.031, subdivision 11; 120B.13, subdivision 1; 120B.30, subdivision 1; 120B.31, subdivision 3; 120B.35; 121A.11, by adding subdivisions; 121A.41, subdivision 10; 121A.45, subdivision 2, by adding a subdivision; 121A.582; 121A.61, subdivision 2; 122A.06, by adding a subdivision; 122A.09, subdivision 4; 122A.162; 122A.163; 122A.18, subdivisions 1, 2, 2a, 4, by adding subdivisions; 122A.20, subdivision 2; 122A.21; 122A.26, subdivision 3; 122A.31; 122A.61, subdivision 1; 123B.03, subdivision 3; 123B.143, subdivision 1; 123B.42, subdivision 3; 123B.44, subdivision 6; 123B.53, subdivisions 1, 2, 4, 5; 123B.54; 123B.57, subdivisions 3, 6, 8; 123B.71, subdivisions 1, 4, 8, 9; 123B.75, subdivision 5, by adding subdivisions; 123B.80, subdivision 1; 123B.92, by adding subdivisions; 124D.10, subdivisions 1, 3, 4, 6, 8, 10, 14, 15, 19, 23, 25, by adding subdivisions; 124D.11, subdivisions 4, 5, 9; 124D.128, subdivisions 1, 2, 3, 6; 124D.454, subdivision 11; 124D.65, subdivision 5; 124D.69, subdivision 1; 124D.74, subdivisions 1, 2, 3, 4, 6; 124D.75, subdivision 6; 124D.76; 124D.78, subdivision 1; 124D.81, subdivisions 1, 3, 5, 6, 7; 124D.86, subdivisions 3, 6; 125A.023, subdivision 4; 125A.08; 125A.09, subdivision 3; 125A.11, subdivision 3; 125A.17; 125A.27, subdivision 15; 125A.76, subdivisions 1, 2; 126C.05, subdivisions 1, 3, 5, 6, 15; 126C.10, subdivisions 1, 2, 3, 9, 20, 21, 22, 24, 25, 27, by adding a subdivision; 126C.12, subdivisions 2, 3, 4, 5, by adding a subdivision; 126C.13, subdivision 1; 126C.15, subdivisions 1, 2, 5; 126C.16, by adding a subdivision; 126C.17, subdivisions 1, 2, 5, 6, 9, 10, 11; 126C.23, subdivision 5; 126C.41, subdivision 3; 126C.43, subdivision 3; 126C.63, subdivision 8; 126C.69, subdivisions 2, 3, 9, 12, 15; 127A.05, subdivision 1; 127A.41, subdivisions 5, 8, 9; 127A.45, subdivision 12, by adding a subdivision; 127A.50, subdivision 2; 136D.281, subdivision 4; 136D.741, subdivision 4; 136D.88, subdivision 4; 179A.20, by adding a subdivision; 214.01, subdivision 3; 214.04, subdivisions 1, 3; 214.12, subdivision 1; 260A.01;

260C.163, subdivision 11; 475.53, subdivision 4; 475.61, subdivision 3; 626.556, subdivision 2; Laws 1992, chapter 499, article 7, section 31, as amended; Laws 2000, chapter 489, article 2, sections 34, 36, 37, subdivision 3, 39, subdivision 2; Laws 2000, chapter 489, article 3, sections 24, 25, subdivision 5; Laws 2000, chapter 489, article 5, section 21; Laws 2000, chapter 489, article 7, section 15, subdivision 3; proposing coding for new law in Minnesota Statutes, chapters 120B; 122A; 123B; 124D; 127A; repealing Minnesota Statutes 2000, sections 120B.031; 120B.31, subdivisions 1, 2, 4; 123B.05; 123B.71, subdivisions 3, 10; 124D.07; 124D.1155; 124D.128, subdivision 7; 124D.32; 124D.85; 126C.01, subdivision 10; 126C.10, subdivisions 3, 12, 23, 28; 126C.16, subdivision 2; 126C.17, subdivision 12; 126C.18; 126C.22; 126C.30; 126C.31; 126C.32; 126C.33; 126C.34; 126C.35; 126C.36; 126C.42, subdivisions 2, 3; 126C.47; 127A.44; 135A.081; 136D.281, subdivision 8; 136D.741, subdivision 8; 136D.88, subdivision 8; 136D.94; Laws 2000, chapter 254, section 30; Laws 2000, chapter 489, article 1, section 18; Minnesota Rules, parts 3501.0300; 3501.0310; 3501.0320; 3501.0330; 3501.0340; 3501.0350; 3501.0370; 3501.0380; 3501.0390; 3501.0400; 3501.0410; 3501.0420; 3501.0430; 3501.0440; 3501.0441; 3501.0442; 3501.0443; 3501.0444; 3501.0445; 3501.0446; 3501.0447; 3501.0448; 3501.0449; 3501.0450; 3501.0460; 3501.0461; 3501.0462; 3501.0463; 3501.0464; 3501.0465; 3501.0466; 3501.0467; 3501.0468; 3501.0469.

The Senate has appointed as such committee:

Senators Stumpf; Pappas; Robertson; Kelley, S. P., and Tomassoni.

Said House File is herewith returned to the House.

PATRICK E. FLAHAVEN, Secretary of the Senate

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. 1507, A bill for an act relating to municipal planning; zoning; clarifying the treatment of legal nonconforming uses; amending Minnesota Statutes 2000, section 462.357, by adding a subdivision.

PATRICK E. FLAHAVEN, Secretary of the Senate

Bishop moved that the House refuse to concur in the Senate amendments to H. F. No. 1507, that the Speaker appoint a Conference Committee of 3 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 House File, herewith returned, as amended by the Senate, in which amendments the concurrence of the House is respectfully requested:

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

PATRICK E. FLAHAVEN, Secretary of the Senate

Mulder moved that the House refuse to concur in the Senate amendments to H. F. No. 1153, that the Speaker appoint a Conference Committee of 3 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 House File, herewith returned, as amended by the Senate, in which amendments the concurrence of the House is respectfully requested:

H. F. No. 707, A bill for an act relating to crime prevention; classifying Carisoprodol as a controlled substance upon the effective date of a final rule adding Carisoprodol to the federal schedules of controlled substances; amending Laws 1997, chapter 239, article 4, section 15, as amended.

PATRICK E. FLAHAVEN, Secretary of the Senate

Skoglund moved that the House refuse to concur in the Senate amendments to H. F. No. 707, that the Speaker appoint a Conference Committee of 3 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 House File, herewith returned, as amended by the Senate, in which amendments the concurrence of the House is respectfully requested:

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

PATRICK E. FLAHAVEN, Secretary of the Senate

Abeler moved that the House refuse to concur in the Senate amendments to H. F. No. 1155, that the Speaker appoint a Conference Committee of 3 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 that the Senate refuses to concur in the House amendments to the following Senate File:

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

The Senate respectfully requests that a Conference Committee be appointed thereon. The Senate has appointed as such committee:



Senators Ranum, Foley and Limmer.

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

McGuire 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. 229. 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. 1487, A bill for an act relating to natural resources; modifying provisions rendered obsolete by the electronic licensing system; modifying the disposition of certain taxes and proceeds; clarifying certain licensing and training requirements; providing for removal of submerged vehicles; modifying watercraft license and title provisions; clarifying sale of live animals and animal portions; modifying rulemaking authority; modifying certain license revocation provisions; clarifying taxidermy and bow fishing provisions; modifying fish house requirements; repealing certain fleeing provisions; amending Minnesota Statutes 2000, sections 6.48; 84.788, subdivisions 3 and 4; 84.796; 84.798, subdivisions 3 and 5; 84.82, subdivision 2; 84.83, subdivisions 3 and 5; 84.862, subdivisions 1 and 2; 84.872, subdivision 1; 84.922, subdivisions 2 and 3; 86B.401, subdivisions 1, 3, and 4; 86B.705, subdivision 2; 86B.820, subdivision 13; 86B.825, subdivision 1; 86B.830, subdivision 1; 97A.065, subdivision 2; 97A.105, subdivisions 4 and 9; 97A.421, subdivision 1; 97A.425, subdivision 1; 97A.441, subdivision 1; 97A.512; 97B.055, subdivision 2; 97C.355, subdivision 1, and by adding a subdivision; and 297A.94; proposing coding for new law in Minnesota Statutes, chapter 86B; repealing Minnesota Statutes 2000, sections 84.792; and 84.801.

PATRICK E. FLAHAVEN, Secretary of the Senate

Haas moved that the House refuse to concur in the Senate amendments to H. F. No. 1487, that the Speaker appoint a Conference Committee of 3 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.

#### 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 bills to be placed on the Calendar for the Day, immediately following the remaining bills on the Calendar for the Day, for Monday, May 14, 2001:

S. F. No. 722; H. F. No. 94; S. F. Nos. 414 and 1430; H. F. No. 1019; S. F. Nos. 1397, 2142 and 1964; H. F. Nos. 2093 and 1270; and S. F. No. 494.

#### CALENDAR FOR THE DAY

S. F. No. 694 was reported to the House.

Howes moved to amend S. F. No. 694 as follows:

Delete everything after the enacting clause and insert:

"Section 1. [COUNCIL.]

Propane producers and propane retail marketers, as defined by United States Code, title 15, section 6402, may form a propane education and research council for the purpose of establishing, supporting, or conducting research, training, and education programs concerning the safe and efficient use of propane.

Sec. 2. [ORGANIZATION.]

Organization and membership of the council shall be in compliance with United States Code, title 15, sections 6403, subsections (a) and (b), and 6404, subsection (c), and must abide by the requirements of United States Code, title 15, section 6409. The council is established upon certification by the commissioner of public safety that the council has been organized in compliance with United States Code, title 15, sections 6403, subsections (a) and (b), and 6404, subsection (c).

Sec. 3. [ASSESSMENT.]

A propane education and research council, established and certified pursuant to section 2, may assess propane producers and retail marketers an amount not to exceed one mill per gallon of odorized propane in a manner established by the council in compliance with United States Code, title 15, section 6405, subsections (a) to (c). Propane producers and retail marketers shall be responsible for the amounts assessed.

Sec. 4. [ANNUAL REPORT.]

A propane education and research council collecting assessments pursuant to section 3 shall annually report to the commissioner of public safety, detailing collections and expenditures made pursuant to this act.

Sec. 5. [CONTINGENT REPEALER.]

Sections 1 to 4 are repealed effective August 1, 2004, if no propane energy and research council has been established by that date.

Sec. 6. [REPEALER.]

Sections 1 to 5 are repealed effective August 1, 2009."

The motion prevailed and the amendment was adopted.

S. F. No. 694, A bill for an act relating to public safety; providing for creation of a propane education and research council.

The bill was read for the third time, as amended, and placed upon its final passage.

The question was taken on the passage of the bill and the roll was called. There were 103 yeas and 28 nays as follows:

Those who voted in the affirmative were:

Abeler	Bakk	Bishop	Clark, J.	Davnie	Dempsey
Abrams	Bernardy	Carlson	Daggett	Dawkins	Dibble
Anderson, I.	Biernat	Cassell	Davids	Dehler	Dorn

Eastlund	Harder	Kubly	Mulder	Rhodes	Tingelstad
Entenza	Hausman	Larson	Mullery	Rukavina	Tuma
Erhardt	Hilstrom	Leighton	Murphy	Schumacher	Wagenius
Erickson	Hilty	Lenczewski	Ness	Seagren	Walker
Evans	Howes	Leppik	Opatz	Seifert	Walz
Folliard	Huntley	Lieder	Osskopp	Skoe	Wasiluk
Fuller	Jaros	Lipman	Osthoff	Skoglund	Wenzel
Gleason	Jennings	Luther	Otremba	Slawik	Westrom
Goodno	Johnson, R.	Mares	Ozment	Smith	Winter
Goodwin	Johnson, S.	Mariani	Pawlenty	Solberg	Wolf
Gray	Juhnke	Marquart	Paymar	Stanek	
Greiling	Kahn	McElroy	Pelowski	Stang	
Gunther	Kalis	McGuire	Penas	Swapinski	
Haas	Kelliher	Milbert	Peterson	Sykora	
Hackbarth	Koskinen	Molnau	Pugh	Thompson	

Those who voted in the negative were:

Anderson, B.	Finseth	Johnson, J.	Lindner	Rifenberg	Wilkin
Boudreau	Gerlach	Kielkucki	Marko	Ruth	Workman
Bradley	Holberg	Knoblach	Nornes	Swenson	Spk. Sviggum
Buesgens	Holsten	Krinkie	Olson	Vandever	
Dorman	Jacobson	Kuisle	Paulsen	Westerberg	

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

S. F. No. 1821, A bill for an act relating to utilities; modifying provisions regulating utility facilities in railroad rights-of-way; amending Minnesota Statutes 2000, section 237.04.

The bill was read for the third time and placed upon its final passage.

The question was taken on the passage of the bill and the roll was called. There were 131 yeas and 0 nays as follows:

Those who voted in the affirmative were:

Abeler	Dawkins	Goodwin	Johnson, J.	Lindner	Olson
Abrams	Dehler	Gray	Johnson, R.	Lipman	Opatz
Anderson, B.	Dempsey	Greiling	Johnson, S.	Luther	Osskopp
Anderson, I.	Dibble	Gunther	Juhnke	Mahoney	Osthoff
Bakk	Dorman	Haas	Kahn	Mares	Otremba
Bernardy	Dorn	Hackbarth	Kalis	Mariani	Ozment
Biernat	Eastlund	Harder	Kelliher	Marko	Paulsen
Bishop	Entenza	Hausman	Kielkucki	Marquart	Pawlenty
Boudreau	Erhardt	Hilstrom	Knoblach	McElroy	Paymar
Bradley	Erickson	Hilty	Koskinen	McGuire	Pelowski
Buesgens	Evans	Holberg	Kubly	Milbert	Penas
Carlson	Finseth	Holsten	Kuisle	Molnau	Peterson
Cassell	Folliard	Howes	Larson	Mulder	Pugh
Clark, J.	Fuller	Huntley	Leighton	Mullery	Rhodes
Daggett	Gerlach	Jacobson	Lenczewski	Murphy	Rifenburg
Davids	Gleason	Jaros	Leppik	Ness	Rukavina
Davnie	Goodno	Jennings	Lieder	Nornes	Ruth

Schumacher	Slawik	Swapinski	Tuma	Wasiluk	Winter
Seagren	Smith	Swenson	Vandever	Wenzel	Wolf
Seifert	Solberg	Sykora	Wagenius	Westerberg	Workman
Skoe	Stanek	Thompson	Walker	Westrom	Spk. Sviggum
Skoglund	Stang	Tingelstad	Walz	Wilkin	

The bill was passed and its title agreed to.

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

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 117 yeas and 11 nays as follows:

Those who voted in the affirmative were:

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

Those who voted in the negative were:

Gleason	Johnson, S.	Krinkie	Luther	Swapinski	Wasiluk
Hausman	Kahn	Lindner	Paymar	Wagenius	

The bill was passed and its title agreed to.

H. F. No. 1424 was reported to the House.

Krinkie moved that H. F. No. 1424 be returned to the General Register. The motion prevailed.

S. F. No. 2046 was reported to the House.

Rukavina, Marko, Pugh and Solberg moved to amend S. F. No. 2046 as follows:

Page 1, after line 17, insert:

"Section 1. Minnesota Statutes 2000, section 176.031, is amended to read:

176.031 [EMPLOYER'S LIABILITY EXCLUSIVE.]

(a) Except as otherwise provided in this section, the liability of an employer prescribed by this chapter is exclusive and in the place of any other liability to such employee, personal representative, surviving spouse, parent, any child, dependent, next of kin, or other person entitled to recover damages on account of such injury or death. If an employer other than the state or any municipal subdivision thereof fails to insure or self-insure liability for compensation to injured employees and their dependents, an injured employee, or legal representatives or, if death results from the injury, any dependent may elect to claim compensation under this chapter or to maintain an action in the courts for damages on account of such injury or death. In such action it is not necessary to plead or prove freedom from contributory negligence. The defendant may not plead as a defense that the injury was caused by the negligence of a fellow servant, that the employee assumed the risk of employment, or that the injury was due to the contributory negligence of the employee, unless it appears that such negligence was willful on the part of the employee. The burden of proof to establish such willful negligence is upon the defendant. For the purposes of this chapter the state and each municipal subdivision thereof is treated as a self-insurer when not carrying insurance at the time of the injury or death of an employee.

(b) In addition to the liability prescribed by this chapter, an injured employee or legal representative, or, if death results from the injury, any dependent, may maintain an action in the courts for damages on account of the injury or death if the employer knowingly violated a safety law, rule, standard, or ordinance, and the violation was a substantial contributing cause of the injury or death. It is negligence per se on the part of an employer if it is proved by a preponderance of the evidence that the employer knowingly violated a safety law, rule, standard, or ordinance, and the violation was a substantial contributing cause of the injury or death. Any recovery under this paragraph must be reduced by any benefits paid or payable under this chapter."

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 Rukavina 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.	Carlson	Dorn	Gleason	Hausman	Huntley
Bakk	Davnie	Entenza	Goodwin	Hilstrom	Jaros
Bernardy	Dawkins	Evans	Gray	Hilty	Jennings
Biernat	Dibble	Folliard	Greiling	Howes	Johnson, R.

Johnson, S.	Larson	Marko	Osthoff	Schumacher	Thompson
Juhnke	Leighton	Marquart	Otremba	Skoe	Tuma
Kahn	Lenczewski	McGuire	Paymar	Skoglund	Wagenius
Kalis	Lieder	Milbert	Pelowski	Slawik	Walker
Kelliher	Luther	Mullery	Peterson	Smith	Wasiluk
Koskinen	Mahoney	Murphy	Pugh	Solberg	Wenzel
Kubly	Mariani	Opatz	Rukavina	Swapinski	Winter

Those who voted in the negative were:

Abeler	Dehler	Haas	Leppik	Ozment	Swenson
Abrams	Dempsey	Hackbarth	Lindner	Paulsen	Sykora
Anderson, B.	Dorman	Harder	Lipman	Pawlenty	Tingelstad
Bishop	Eastlund	Holberg	Mares	Penas	Vanderveer
Boudreau	Erhardt	Holsten	McElroy	Rhodes	Walz
Bradley	Erickson	Jacobson	Molnau	Rifenberg	Westerberg
Buesgens	Finseth	Johnson, J.	Mulder	Ruth	Westrom
Cassell	Fuller	Kielkucki	Ness	Seagren	Wilkin
Clark, J.	Gerlach	Knoblach	Nornes	Seifert	Wolf
Daggett	Goodno	Krinkie	Olson	Stanek	Workman
Davids	Gunther	Kuisle	Osskopp	Stang	Spk. Sviggum

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

S. F. No. 2046, A bill for an act relating to workers' compensation; making technical changes; requiring interest earned on revenue collected by the special compensation fund to be deposited into the fund; extending a pilot program; providing for payment of various penalties to the commissioner of labor and industry; amending Minnesota Statutes 2000, sections 176.042, subdivision 2; 176.102, subdivisions 3a, 11, 14; 176.103, subdivision 3; 176.129, subdivisions 10, 13, by adding a subdivision; 176.1351, subdivision 5; 176.138; 176.1812, subdivision 6; 176.191, subdivision 1a; 176.192; 176.194, subdivision 4; 176.221, subdivisions 1, 3, 3a, 6; 176.231, subdivisions 2, 6, 10; 176.238, subdivision 10; repealing Minnesota Statutes 2000, section 176.445.

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	Clark, J.	Erickson	Hackbarth	Johnson, R.	Leighton
Abrams	Daggett	Evans	Harder	Johnson, S.	Lenczewski
Anderson, B.	Davids	Finseth	Hausman	Juhnke	Leppik
Anderson, I.	Davnie	Folliard	Hilstrom	Kahn	Lieder
Bakk	Dawkins	Fuller	Hilty	Kalis	Lindner
Bernardy	Dehler	Gerlach	Holberg	Kelliher	Lipman
Biernat	Dempsey	Gleason	Holsten	Kielkucki	Luther
Bishop	Dibble	Goodno	Howes	Knoblach	Mahoney
Boudreau	Dorman	Goodwin	Huntley	Koskinen	Mares
Bradley	Dorn	Gray	Jacobson	Krinkie	Mariani
Buesgens	Eastlund	Greiling	Jaros	Kubly	Marko
Carlson	Entenza	Gunther	Jennings	Kuisle	Marquart
Cassell	Erhardt	Haas	Johnson, J.	Larson	McElroy

McGuire	Osskopp	Peterson	Skoe	Sykora	Wenzel
Milbert	Osthoff	Pugh	Skoglund	Thompson	Westerberg
Molnau	Otremba	Rhodes	Slawik	Tingelstad	Westrom
Mulder	Ozment	Rifenberg	Smith	Tuma	Wilkin
Mullery	Paulsen	Rukavina	Solberg	Vandever	Winter
Murphy	Pawlenty	Ruth	Stanek	Wagenius	Wolf
Nornes	Paymar	Schumacher	Stang	Walker	Workman
Olson	Pelowski	Seagren	Swapinski	Walz	Spk. Sviggum
Opatz	Penas	Seifert	Swenson	Wasiluk	

The bill was passed and its title agreed to.

S. F. No. 1264, A bill for an act relating to insurance; no-fault auto; regulating income loss benefits to senior citizens; amending Minnesota Statutes 2000, section 65B.491.

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 132 yeas and 0 nays as follows:

Those who voted in the affirmative were:

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

The bill was passed and its title agreed to.

S. F. No. 1222, A bill for an act relating to veterans; authorizing the placement of a plaque on the capitol mall recognizing the service of Minnesota's civilians who contributed valiantly to the nation's war efforts during World War II.

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 130 yeas and 0 nays as follows:

Those who voted in the affirmative were:

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

The bill was passed and its title agreed to.

S. F. No. 1610 was reported to the House.

Entenza moved to amend S. F. No. 1610 as follows:

Delete everything after the enacting clause and insert the following language of H. F. No. 1615, the first engrossment:

"Section 1. Minnesota Statutes 2000, section 60A.11, subdivision 10, is amended to read:

Subd. 10. [DEFINITIONS.] The following terms have the meaning assigned in this subdivision for purposes of this section and section 60A.111:

(a) "Adequate evidence" means a written confirmation, advice, or other verification issued by a depository, issuer, or custodian bank which shows that the investment is held for the company;

(b) "Adequate security" means a letter of credit qualifying under subdivision 11, paragraph (f), cash, or the pledge of an investment authorized by any subdivision of this section;

(c) "Admitted assets," for purposes of computing percentage limitations on particular types of investments, means the assets as shown by the company's annual statement, required by section 60A.13, as of the December 31 immediately preceding the date the company acquires the investment;



(d) "Clearing corporation" means The Depository Trust Company or any other clearing agency registered with the securities and exchange commission pursuant to the Securities Exchange Act of 1934, section 17A, Euro-clear Clearance System Limited and CEDEL S.A., and, with the approval of the commissioner, any other clearing corporation as defined in section 336.8-102;

(e) "Control" has the meaning assigned to that term in, and must be determined in accordance with, section 60D.15, subdivision 4;

(f) "Custodian bank" means a bank or trust company or a branch of a bank or trust company that is acting as custodian and is supervised and examined by state or federal authority having supervision over the bank or trust company or with respect to a company's foreign investments only by the regulatory authority having supervision over banks or trust companies in the jurisdiction in which the bank, trust company, or branch is located, and any banking institutions qualifying as an "Eligible Foreign Custodian" under the Code of Federal Regulations, section 270.17f-5, adopted under section 17(f) of the Investment Company Act of 1940, and specifically including Euro-clear Clearance System Limited and CEDEL S.A., acting as custodians;

(g) "Evergreen clause" means a provision that automatically renews a letter of credit for a time certain if the issuer of the letter of credit fails to affirmatively signify its intention to nonrenew upon expiration;

(h) "Government obligations" means direct obligations for the payment of money, or obligations for the payment of money to the extent guaranteed as to the payment of principal and interest by any governmental issuer where the obligations are payable from ad valorem taxes or guaranteed by the full faith, credit, and taxing power of the issuer and are not secured solely by special assessments for local improvements;

(i) "Noninvestment grade obligations" means obligations which, at the time of acquisition, were rated below Baa/BBB or the equivalent by a securities rating agency or which, at the time of acquisition, were not in one of the two highest categories established by the securities valuation office of the National Association of Insurance Commissioners;

(j) "Issuer" means the corporation, business trust, governmental unit, partnership, association, individual, or other entity which issues or on behalf of which is issued any form of obligation;

(k) "Licensed real estate appraiser" means a person who develops and communicates real estate appraisals and who holds a current, valid license under chapter 82B or a substantially similar licensing requirement in another jurisdiction;

(l) "Member bank" means a national bank, state bank or trust company which is a member of the Federal Reserve System;

(m) "National securities exchange" means an exchange registered under section 6 of the Securities Exchange Act of 1934 or an exchange regulated under the laws of the Dominion of Canada;

(n) "NASDAQ" means the reporting system for securities meeting the definition of National Market System security as provided under Part I to Schedule D of the National Association of Securities Dealers Incorporated bylaws;

(o) "Obligations" include bonds, notes, debentures, transportation equipment certificates, repurchase agreements, bank certificates of deposit, time deposits, bankers' acceptances, and other obligations for the payment of money not in default as to payments of principal and interest on the date of investment, whether constituting general obligations of the issuer or payable only out of certain revenues or certain funds pledged or otherwise dedicated for payment. Leases are considered obligations if the lease is assigned for the benefit of the company and is nonterminable by the lessee or lessees thereunder upon foreclosure of any lien upon the leased property, and rental payments are sufficient to amortize the investment over the primary lease term;

(p) "Qualified assets" means the sum of (1) all investments qualified in accordance with this section other than investments in affiliates and subsidiaries, (2) investments in obligations of affiliates as defined in section 60D.15, subdivision 2, secured by real or personal property sufficient to qualify the investment under subdivision 19 or 23, (3) qualified investments in subsidiaries, as defined in section 60D.15, subdivision 9, on a consolidated basis with the insurance company without allowance for goodwill or other intangible value, and (4) cash on hand and on deposit, agent's balances or uncollected premiums not due more than 90 days, assets held pursuant to section 60A.12, subdivision 2, investment income due and accrued, funds due or on deposit or recoverable on loss payments under contracts of reinsurance entered into pursuant to section 60A.09, premium bills and notes receivable, federal income taxes recoverable, and equities and deposits in pools and associations;

(q) "Qualified net earnings" means that the net earnings of the issuer after elimination of extraordinary nonrecurring items of income and expense and before income taxes and fixed charges over the five immediately preceding completed fiscal years, or its period of existence if less than five years, has averaged not less than 1-1/4 times its average annual fixed charges applicable to the period;

(r) "Replicated investment position" means the statement value of the position reported under the heading "Replicated (Synthetic) Asset" on Schedule DB, Part F, of the annual statement of the insurer, or any successor provision;

(s) "Replication transaction" means a derivative transaction that is intended to replicate the performance of one or more assets that an insurer is authorized to acquire under this section. A derivative transaction that either is authorized by subdivision 18, clause (5), or by subdivision 24, or is entered into as a hedging transaction shall not be considered a replication transaction;

(t) "Required liabilities" means the sum of (1) total liabilities as required to be reported in the company's most recent annual report to the commissioner of commerce of this state, (2) for companies operating under the stock plan, the minimum paid-up capital and surplus required to be maintained pursuant to section 60A.07, subdivision 5a, (3) for companies operating under the mutual or reciprocal plan, the minimum amount of surplus required to be maintained pursuant to section 60A.07, subdivision 5b, and (4) the amount, if any, by which the company's loss and loss adjustment expense reserves exceed 350 percent of its surplus as it pertains to policyholders as of the same date. The commissioner may waive the requirement in clause (4) unless the company's written premiums exceed 300 percent of its surplus as it pertains to policyholders as of the same date. In addition to the required amounts pursuant to clauses (1) to (4), the commissioner may require that the amount of any apparent reserve deficiency that may be revealed by one to five year loss and loss adjustment expense development analysis for the five years reported in the company's most recent annual statement to the commissioner be added to required liabilities;

(s) (u) "Revenue obligations" means obligations for the payment of money by a governmental issuer where the obligations are payable from revenues, earnings, or special assessments on properties benefited by local improvements of the issuer which are specifically pledged therefor;

(t) (v) "Security" has the meaning given in section 5 of the Security Act of 1933 and specifically includes, but is not limited to, stocks, stock equivalents, warrants, rights, options, obligations, American Depository Receipts (ADR's), repurchase agreements, and reverse repurchase agreements; and

(t) (w) "Unrestricted surplus" means the amount by which qualified assets exceed 110 percent of required liabilities.

Sec. 2. Minnesota Statutes 2000, section 60A.11, is amended by adding a subdivision to read:

Subd. 25a. [REPLICATION TRANSACTIONS.] An insurer engaging in replication transactions shall include all replicated investment positions in calculating compliance with the limitations on investments applicable to the insurer. Replication transactions are permitted only under the authority of subdivision 25. An insurer may invest its unrestricted surplus in a replication transaction only to the extent that the replicated investment position does not cause the total positions represented by the unrestricted surplus to be greater than the total positions represented by the unrestricted surplus as would be permitted in the absence of the replicated investment position.

Sec. 3. Minnesota Statutes 2000, section 60A.129, subdivision 5, is amended to read:

Subd. 5. [CONSOLIDATED FILING.] (a) The commissioner may allow an insurer to file a consolidated loss reserve certification required by subdivision 2, in lieu of separate loss certifications and may allow an insurer to file consolidated or combined audited financial statements required by subdivision 3, paragraph (a), in lieu of separate annual audited financial statements, where it can be demonstrated that an insurer is part of a group of insurance companies that has a pooling or 100 percent reinsurance agreement which substantially affects the solvency and integrity of the reserves of the insurer and the insurer cedes all of its direct and assumed business to the pool. An affiliated insurance company not meeting these requirements may be included in the consolidated or combined audited financial statements, if the company's total admitted assets are less than five percent of the consolidated group's total admitted assets. If these circumstances exist, then the company may file a written application to file a consolidated loss reserve certification and/or consolidated or combined audited financial statements. This application shall be for a specified period.

(b) Upon written application by a domestic insurer, the commissioner may authorize the domestic insurer to include additional affiliated insurance companies in the consolidated or combined audited financial statements. Foreign insurers must obtain the prior written authorization of the commissioner of their state of domicile in order to submit an application for authority to file consolidated or combined audited financial statements. This application shall be for a specified period.

(c) A consolidated annual audit filing shall include a columnar consolidated or combining worksheet. Amounts shown on the audited consolidated or combined financial statement shall be shown on the worksheet. Amounts for each insurer shall be stated separately. Noninsurance operations may be shown on the worksheet on a combined or individual basis. Explanations of consolidating or eliminating entries shall be shown on the worksheet. A reconciliation of any differences between the amounts shown in the individual insurer columns of the worksheet and comparable amounts shown on the annual statement of the insurers shall be included on the worksheet.

Sec. 4. [60A.975] [DEFINITIONS.]

Subdivision 1. [APPLICATION.] For purposes of sections 60A.975 and 60A.976, the definitions in this section have the meanings given them.

Subd. 2. [ANNUITY ISSUER.] "Annuity issuer" means an insurer that issues an insurance contract used to fund periodic payments under a structured settlement agreement.

Subd. 3. [STRUCTURED SETTLEMENT.] "Structured settlement" means an arrangement for periodic payment of damages entered on behalf of a minor or incompetent person for personal injuries established by settlement or judgment.

Subd. 4. [STRUCTURED SETTLEMENT AGREEMENT.] "Structured settlement agreement" means the agreement, judgment, stipulation, or release embodying the terms of a structured settlement.

Sec. 5. [60A.976] [ANNUITY ISSUERS FINANCIAL REQUIREMENTS.]

An annuity purchased to finance a structured settlement agreement may be purchased only from an annuity issuer with a financial rating equivalent to A.M. Best Company A+ Class 8 or better; or a Standard & Poor's AA or better.

Sec. 6. Minnesota Statutes 2000, section 60B.44, subdivision 4, is amended to read:

Subd. 4. [LOSS CLAIMS; INCLUDING CLAIMS NOT COVERED BY A GUARANTY ASSOCIATION.] All claims under policies or contracts of coverage for losses incurred including third party claims, and all claims against the insurer for liability for bodily injury or for injury to or destruction of tangible property which are not under policies or contracts. All claims under life insurance and annuity policies, including funding agreements issued pursuant to section 61A.276, whether for death proceeds, annuity proceeds, or investment values, shall be treated

as loss claims. That portion of any loss for which indemnification is provided by other benefits or advantages recovered or recoverable by the claimant shall not be included in this class, other than benefits or advantages recovered or recoverable in discharge of familial obligations of support or by way of succession at death or as proceeds of life insurance, or as gratuities. No payment made by an employer to an employee shall be treated as a gratuity. Claims not covered by a guaranty association are loss claims.

Sec. 7. Minnesota Statutes 2000, section 60L.01, is amended by adding a subdivision to read:

Subd. 13a. [REPLICATED INVESTMENT POSITION.] "Replicated investment position" means the statement value of the position reported under the heading "Replicated (Synthetic) Asset" on Schedule DB, Part F, of the annual statement of the insurer, or any successor provision.

Sec. 8. Minnesota Statutes 2000, section 60L.01, subdivision 14, is amended to read:

Subd. 14. [REPLICATION TRANSACTION.] "Replication" "Replication transaction" means a derivative transaction involving one or more derivative instruments being used to modify the cash flow characteristics of one or more investments held by an insurer in a manner so that the aggregate cash flows of the derivative instruments and investments reproduce the cash flows of another investment having a higher risk-based capital charge than the risk-based capital charge of the original investments or investments that is intended to replicate the performance of one or more assets that an insurer is authorized to acquire under sections 60L.01 to 60L.15. A derivative transaction that is entered into as a hedging transaction is not considered a replication transaction.

Sec. 9. Minnesota Statutes 2000, section 60L.08, is amended by adding a subdivision to read:

Subd. 7. [REPLICATION TRANSACTIONS.] (a) An insurer engaging in replication transactions shall include all replicated investment positions in calculating compliance with the limitations on investments contained in this section. So long as the insurer so complies with the limitations on investments contained in this section, then the insurer may count a replication transaction and any related investment of the insurer for the purposes specified in section 60L.11, to the extent the insurer has appropriately assigned the transaction or other investment to an investment class authorized in section 60L.07. An insurer shall not otherwise count replicated investment positions for the purposes specified in section 60L.11.

(b) If an investment position of the insurer includes a replicated investment position and exceeds an applicable limitation contained in this section, then the insurer may allocate part or all of the replicated investment position as follows for the purposes of calculating compliance with the limitations on investments and other requirements contained in sections 60L.01 to 60L.15: to the extent an insurer owns assets in excess of its minimum asset requirement, the insurer may deem a replicated investment position to be among such excess assets, but only to the extent that the replicated investment position does not cause the total positions represented by such excess assets to be greater than the total positions represented by such excess assets as would be permitted in the absence of the replicated investment position.

Sec. 10. Minnesota Statutes 2000, section 60L.10, subdivision 1, is amended to read:

Subdivision 1. [PROHIBITIONS.] An insurer may not invest in investments that are prohibited for an insurer by law. The use of a derivative instrument for replication, or for any purposes other than hedging or income generation, or replication is prohibited.

Sec. 11. Minnesota Statutes 2000, section 61A.276, subdivision 2, is amended to read:

Subd. 2. [ISSUANCE.] The funding agreements may be issued to: (1) individuals; or (2) persons authorized by a state or foreign country to engage in an insurance business or subsidiaries or affiliates of these persons; or (3) entities other than individuals and other than persons authorized to engage in an insurance business, and subsidiaries and affiliates of these persons, for the following purposes: (i) to fund benefits under any employee benefit plan as defined in the Employee Retirement Income Security Act of 1974, as now or hereafter amended, maintained in the

United States or in a foreign country; (ii) to fund the activities of any organization exempt from taxation under section 501(c) of the Internal Revenue Code of 1986, as amended through December 31, 1992, or of any similar organization in any foreign country; (iii) to fund any program of any state, foreign country or political subdivision thereof, or any agency or instrumentality thereof; (iv) to fund any agreement providing for periodic payments in satisfaction of a claim; or (v) to fund a program of a financial an institution limited to banks, thrifts, credit unions, and investment companies registered under the Investment Company Act of 1940. No funding agreement shall be issued in an amount less than \$1,000,000 that has assets in excess of \$25,000,000. No funding agreement shall be issued in an amount less than \$1,000,000.

Sec. 12. Minnesota Statutes 2000, section 61A.28, subdivision 6, is amended to read:

Subd. 6. [STOCKS, OBLIGATIONS, AND OTHER INVESTMENTS.] (a) Common stocks, common stock equivalents, or securities convertible into common stock or common stock equivalents of a business entity organized under the laws of the United States or any state thereof, or the Dominion of Canada or any province thereof; ~~if the net earnings of the business entity after the elimination of extraordinary nonrecurring items of income and expense and before income taxes and fixed charges over the five immediately preceding completed fiscal years, or its period of existence if less than five years, has averaged not less than 1-1/4 times its average annual fixed charges applicable to the period.~~

(b) Preferred stock of, or common or preferred stock guaranteed as to dividends by a business entity organized under the laws of the United States or any state thereof, or the Dominion of Canada or any province thereof, under the following conditions: (1) No investment may be made under this paragraph in a stock upon which any dividend, current or cumulative, is in arrears; (2) the company may not invest in stocks under this paragraph and in common stocks under paragraph (a) if the investment causes the company's aggregate investments in the common or preferred stocks to exceed 25 percent of the company's total admitted assets, provided that no more than 20 percent of the company's admitted assets may be invested in common stocks under paragraph (a); and (3) the company may not invest in any preferred stock or common stock guaranteed as to dividends, which is rated in the four lowest categories established by the securities valuation office of the National Association of Insurance Commissioners, if the investment causes the company's aggregate investment in the lower rated preferred or common stock guaranteed as to dividends to exceed five percent of its total admitted assets.

(c) Warrants, options, and rights to purchase stock if the stock, at the time of the acquisition of the warrant, option, or right to purchase, would qualify as an investment under paragraph (a) or (b), whichever is applicable. A company shall not invest in a warrant, option, or right to purchase stock if, upon purchase and immediate exercise thereof, the acquisition of the stock violates any of the concentration limitations contained in paragraphs (a) and (b).

(d) In addition to amounts that may be invested under subdivision 8 and without regard to the percentage limitation applicable to stocks, warrants, options, and rights to purchase, the securities of any face amount certificate company, unit investment trust, or management type investment company, registered or in the process of registration under the Investment Company Act of 1940 as from time to time amended. In addition, the company may transfer assets into one or more of its separate accounts for the purpose of establishing, or supporting its contractual obligations under, the accounts in accordance with the provisions of sections 61A.13 to 61A.21. A company may not invest in a security authorized under this paragraph if the investment causes the company's aggregate investments in the securities to exceed ~~five~~ ten percent of its total admitted assets, except that for a health service plan corporation operating under chapter 62C, and for a health maintenance organization operating under chapter 62D, the company's aggregate investments may not exceed 20 percent of its total admitted assets. No more than five percent of the allowed investment by health service plan corporations or health maintenance organizations may be invested in funds that invest in assets not backed by the federal government. When investing in money market mutual funds, nonprofit health service plans regulated under chapter 62C, and health maintenance organizations regulated under chapter 62D, shall establish a trustee custodial account for the transfer of cash into the money market mutual fund.

(e) Investment grade obligations that are:

(1) bonds, obligations, notes, debentures, repurchase agreements, or other evidences of indebtedness of a business entity, organized under the laws of the United States or any state thereof, or the Dominion of Canada or any province thereof; and

(2) rated in one of the four highest rating categories by at least one nationally recognized statistical rating organization, or are rated in one of the two highest categories established by the securities valuation office of the National Association of Insurance Commissioners.

(f) Noninvestment grade obligations: A company may acquire noninvestment grade obligations as defined in subclause (i) (hereinafter noninvestment grade obligations) which meet the earnings test set forth in subclause (ii). A company may not acquire a noninvestment grade obligation if the acquisition will cause the company to exceed the limitations set forth in subclause (iii).

(i) A noninvestment grade obligation is an obligation of a business entity, organized under the laws of the United States or any state thereof, or the Dominion of Canada or any province thereof, that is not rated in one of the four highest rating categories by at least one nationally recognized statistical rating organization, or is not rated in one of the two highest categories established by the securities valuation office of the National Association of Insurance Commissioners.

(ii) Noninvestment grade obligations authorized by this subdivision may be acquired by a company if the business entity issuing or assuming the obligation, or the business entity securing or guaranteeing the obligation, has had net earnings after the elimination of extraordinary nonrecurring items of income and expense and before income taxes and fixed charges over the five immediately preceding completed fiscal years, or its period of existence of less than five years, has averaged not less than 1-1/4 times its average annual fixed charges applicable to the period; provided, however, that if a business entity issuing or assuming the obligation, or the business entity securing or guaranteeing the obligation, has undergone an acquisition, recapitalization, or reorganization within the immediately preceding 12 months, or will use the proceeds of the obligation for an acquisition, recapitalization, or reorganization, then such business entity shall also have, on a pro forma basis, for the next succeeding 12 months, net earnings averaging 1-1/4 times its average annual fixed charges applicable to such period after elimination of extraordinary nonrecurring items of income and expense and before taxes and fixed charges; no investment may be made under this section upon which any interest obligation is in default.

(iii) Limitation on aggregate interest in noninvestment grade obligations. A company may not invest in a noninvestment grade obligation if the investment will cause the company's aggregate investments in noninvestment grade obligations to exceed the applicable percentage of admitted assets set forth in the following table:

Effective Date	Percentage of Admitted Assets
January 1, 1992	20
January 1, 1993	17.5
January 1, 1994	15

Nothing in this paragraph limits the ability of a company to invest in noninvestment grade obligations as provided under subdivision 12.

(g) Obligations for the payment of money under the following conditions: (1) The obligation must be secured, either solely or in conjunction with other security, by an assignment of a lease or leases on property, real or personal; (2) the lease or leases must be nonterminable by the lessee or lessees upon foreclosure of any lien upon the leased property; (3) the rents payable under the lease or leases must be sufficient to amortize at least 90 percent of the obligation during the primary term of the lease; and (4) the lessee or lessees under the lease or leases, or a governmental entity or business entity, organized under the laws of the United States or any state thereof, or the Dominion of Canada, or any province thereof, that has assumed or guaranteed any lessee's performance thereunder, must be a governmental entity or business entity whose obligations would qualify as an investment under subdivision 2 or paragraph (e) or (f). A company may acquire leases assumed or guaranteed by a noninvestment grade lessee unless the value of the lease, when added to the other noninvestment grade obligations owned by the company, exceeds 15 percent of the company's admitted assets.

(h) A company may sell call options against stocks or other securities owned by the company and may purchase call options in a closing transaction against a call option previously written by the company. In addition to the authority granted by paragraph (c), to the extent and on the terms and conditions the commissioner determines to be consistent with the purposes of this chapter, a company may purchase or sell other exchange-traded call options, and may sell or purchase exchange-traded put options.

(i) A company may not invest in a security or other obligation authorized under this subdivision if the investment, valued at cost at the date of purchase, causes the company's aggregate investment in any one business entity to exceed two percent of the company's admitted assets.

(j) For nonprofit health service plan corporations regulated under chapter 62C, and for health maintenance organizations regulated under chapter 62D, a company may invest in commercial paper rated in one of the two highest rating categories by at least one nationally recognized statistical rating organization, or rated in one of the two highest categories established by the securities valuation office of the National Association of Insurance Commissioners, if the investment, valued at cost at the date of purchase, does not cause the company's aggregate investment in any one business entity to exceed six percent of the company's admitted assets.

Sec. 13. Minnesota Statutes 2000, section 61A.28, is amended by adding a subdivision to read:

Subd. 14. [REPLICATION TRANSACTIONS.] An insurer engaging in replication transactions shall include all replicated investment positions in calculating compliance with the limitations on investments applicable to the insurer. Replication transactions are permitted only under the authority of subdivision 12. For these purposes, "replication transaction" means a derivative transaction that is intended to replicate the performance of one or more assets that an insurer is authorized to acquire under applicable law. A derivative transaction that either is authorized by subdivision 6, 8, or 9a or section 61A.29, subdivision 2, paragraph (d), or is entered into as a hedging transaction shall not be considered a replication transaction. "Replicated investment position" means the statement value of the position reported under the heading "Replicated (Synthetic) Asset" on Schedule DB, Part F, of the annual statement of the insurer, or any successor provision.

Sec. 14. Minnesota Statutes 2000, section 61A.29, subdivision 2, is amended to read:

Subd. 2. [AUTHORIZED INVESTMENTS.] A company may invest in (i) foreign assets denominated in United States dollars; (ii) foreign assets denominated in foreign currency; and (iii) United States assets denominated in foreign currency. The investments may be made in any combination of the following:

(a) Obligations of sovereign governments and political subdivisions thereof and obligations issued or fully guaranteed by a supranational bank or organization, other than those described in section 61A.28, subdivision 2, paragraph (e), provided that the obligations are rated in one of the two highest rating categories by at least one nationally recognized statistical rating organization in the United States. For purposes of this section, "supranational bank" means a bank owned by a number of sovereign nations and engaging in international borrowing and lending.

(b) Obligations of a foreign business entity, provided that the obligation (i) is rated in one of the four highest rating categories by at least one nationally recognized statistical rating organization in the United States or by a similarly recognized statistical rating organization, as approved by the commissioner, in the country where the investment is made; or (ii) is rated in one of the two highest categories established by the securities valuation office of the National Association of Insurance Commissioners.

(c) Stock or stock equivalents issued by a foreign entity if the stock or stock equivalents are regularly traded on the Frankfurt, London, Paris, or Tokyo stock exchange or any similar securities exchange as may be approved from time to time by the commissioner and subject to oversight by the government of the country in which the exchange is located regular trading occurs.

(d) Financial transactions for the sole purpose of managing the foreign currency risk of investments made under this subdivision, provided that the financial transactions are entered into under a detailed plan maintained by the company. For purposes of this paragraph, "financial transactions" include, but are not limited to, the purchase or sale of currency swaps, forward agreements, and currency futures.

Sec. 15. [61A.321] [GUARANTY FUNDS.]

(a) A domestic mutual life insurance company may be formed with, or an existing domestic mutual life insurance company may establish, a guaranty fund divided into certificates of \$10 each, or multiples thereof, and this guaranty fund shall be invested in the same manner as is provided for the investment of capital stock of insurance companies.

(b) The certificate holders of the guaranty fund are entitled to an annual dividend of not more than ten percent on their respective certificates, if the net profits or unused premiums left after all losses, expenses, or liabilities then incurred, with reserves for reinsurance, are provided for, are sufficient to pay the annual dividend. If the dividends in any one year are less than ten percent, the difference may be made up in any subsequent year or years from the net profits. Approval of the commissioner must be obtained before accrual for or payment of the dividend, or any repayment of principal.

(c) The guaranty fund must be applied to the payment of losses and expenses when necessary, and, if the guaranty fund is impaired, the directors may make good the whole or any part of the impairment from future profits of the company, but no dividend shall be paid on guaranty fund certificates while the guaranty fund is impaired. The holder of the guaranty fund certificate is not liable for any more than the amount of the certificate which has not been paid in, and this amount must be plainly and legibly stated on the face of the certificate.

(d) Notwithstanding any other provision of law, each certificate holder of record is entitled to one vote in person or by proxy in any meeting of the members of the company for each \$10 investment in guaranty fund certificates.

(e) The guaranty fund may be reduced or retired by vote of the policyholders of the company and the assent of the commissioner, if the net assets of the company above its reinsurance reserve and all other claims and obligations and the amount of its guaranty fund certificates and interest on the certificates for two years last preceding and including the date of its last annual statement are not less than 50 percent of the premiums in force. Due notice of this proposed action on the part of the company shall be mailed to each policyholder of the company not less than 30 days before the meeting when the action may be taken.

(f) In domestic mutual life insurance companies with a guaranty fund, the certificate holders shall be entitled to choose and elect from among their own number or from among the policyholders at least one-half or more of the total number of directors.

(g) If any domestic mutual life insurance company with a guaranty fund ceases to do business, it shall not divide among its certificate holders any part of its assets or guaranty fund until all its debts and obligations have been paid or canceled.

(h) Foreign mutual life insurance companies having a guaranty fund shall not be required to make their certificate of guaranty fund conform to the provisions of this section, but when the certificates do not conform with this section, the amount of the guaranty fund shall be charged as a liability.

Sec. 16. Minnesota Statutes 2000, section 79.56, subdivision 3, is amended to read:

Subd. 3. [PENALTIES.] (a) Any insurer using a rate or a rating plan which has not been filed shall be subject to a fine of up to \$100 for each day the failure to file continues. The commissioner may, after a hearing on the record, find that the failure is willful. A willful failure to meet filing requirements shall be punishable by a fine of up to \$500 for each day during which a willful failure continues. These penalties shall be in addition to any other penalties provided by law.



(b) Notwithstanding this subdivision, an employer that generates ~~\$500,000~~ \$250,000 in annual written workers' compensation premium under the rates and rating plan of an insurer before the application of any large deductible rating plans, may be written by that insurer using rates or rating plans that are not subject to disapproval but which have been filed. ~~The \$500,000 threshold shall be increased on January 1, 1996, and on each January 1 thereafter by the percentage increase in the statewide average weekly wage, to the nearest \$1,000. The commissioner shall advise insurers licensed to write workers' compensation insurance in this state of the annual threshold adjustment.~~"

Delete the title and insert:

"A bill for an act relating to insurance; regulating liquidations and investments of insurers; regulating consolidated or combined financial statements and annuities purchased to finance structured settlement agreements; authorizing domestic mutual life companies to be formed with or establish guaranty funds; regulating certain workers compensation rates and rating plans; amending Minnesota Statutes 2000, sections 60A.11, subdivision 10, by adding a subdivision; 60A.129, subdivision 5; 60B.44, subdivision 4; 60L.01, subdivision 14, by adding a subdivision; 60L.08, by adding a subdivision; 60L.10, subdivision 1; 61A.276, subdivision 2; 61A.28, subdivision 6, by adding a subdivision; 61A.29, subdivision 2; 79.56, subdivision 3; proposing coding for new law in Minnesota Statutes, chapters 60A; 61A."

The motion prevailed and the amendment was adopted.

S. F. No. 1610, A bill for an act relating to insurance; regulating liquidations and investments of insurers; amending Minnesota Statutes 2000, sections 60A.11, subdivision 10, by adding a subdivision; 60B.44, subdivision 4; 60L.01, subdivision 14, by adding a subdivision; 60L.08, by adding a subdivision; 60L.10, subdivision 1; 61A.276, subdivision 2; 61A.28, subdivision 6, by adding a subdivision; 61A.29, subdivision 2.

The bill was read for the third time, as amended, and placed upon its final passage.

The question was taken on the passage of the bill and the roll was called. There were 132 yeas and 0 nays as follows:

Those who voted in the affirmative were:

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

Swenson	Tingelstad	Wagenius	Wasiluk	Westrom	Wolf
Sykora	Tuma	Walker	Wenzel	Wilkin	Workman
Thompson	Vandev eer	Walz	Westerberg	Winter	Spk. Sviggum

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

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

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 117 yeas and 14 nays as follows:

Those who voted in the affirmative were:

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

Those who voted in the negative were:

Buesgens	Holberg	Krinkie	Seifert	Westerberg
Eastlund	Johnson, J.	Paulsen	Smith	Wilkin
Erickson	Kielkucki	Pawlenty	Vandev eer	

The bill was passed and its title agreed to.

S. F. No. 970 was reported to the House.

Davids moved to amend S. F. No. 970 as follows:

Page 2, line 8, after "plus" insert "the lesser of" and before the period, insert "or eight cents"

The motion prevailed and the amendment was adopted.

Sykora moved to amend S. F. No. 970, as amended, as follows:

Page 1, after line 7, insert:

"Section 1. Minnesota Statutes 2000, section 8.31, subdivision 1, is amended to read:

Subdivision 1. [INVESTIGATE OFFENSES AGAINST THE PROVISIONS OF CERTAIN DESIGNATED SECTIONS; ASSIST IN ENFORCEMENT.] The attorney general ~~shall~~ must actively and thoroughly investigate violations of the law of this state respecting unfair, discriminatory, and other unlawful practices in business, commerce, or trade, and specifically, but not exclusively, the Nonprofit Corporation Act (sections 317A.001 to 317A.909), the Act Against Unfair Discrimination and Competition (sections 325D.01 to 325D.07), the Unlawful Trade Practices Act (sections 325D.09 to 325D.16), the Antitrust Act (sections 325D.49 to 325D.66), section 325F.67 and other laws against false or fraudulent advertising, the antidiscrimination acts contained in section 325D.67, the act against monopolization of food products (section 325D.68), the act against unlawful gasoline sales (section 325D.071), the act regulating telephone advertising services (section 325E.39), the Prevention of Consumer Fraud Act (sections 325F.68 to 325F.70), and chapter 53A regulating currency exchanges ~~and~~ assist in the enforcement of, and prosecute in the name of the state of Minnesota any action or suit to enforce those laws as in this section provided. The attorney general must conduct public service campaigns for the purpose of educating the public about those laws provided in this section and for the purpose of soliciting complaints from the public regarding possible violations of those laws."

Page 2, line 26, delete everything after "325D.04"

Page 2, line 27, delete everything before "In"

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

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

Bradley moved to amend S. F. No. 970, as amended, as follows:

Page 2, line 8, delete everything after "fees" and insert a period

A roll call was requested and properly seconded.

The question was taken on the Bradley amendment and the roll was called. There were 51 yeas and 79 nays as follows:

Those who voted in the affirmative were:

Abeler	Bernardy	Bradley	Clark, J.	Erhardt	Holberg
Abrams	Biernat	Buesgens	Dempsey	Gerlach	Howes
Anderson, B.	Boudreau	Carlson	Dorman	Goodno	Jacobson

Johnson, J.	Lindner	Mullery	Ruth	Stanek	Wolf
Kielkucki	Lipman	Nornes	Seagren	Sykora	Workman
Knoblach	McElroy	Paulsen	Seifert	Thompson	Spk. Sviggum
Krinkie	Milbert	Pawlenty	Skoglund	Tingelstad	
Kuisle	Molnau	Penas	Slawik	Westerberg	
Leppik	Mulder	Rhodes	Smith	Wilkin	

Those who voted in the negative were:

Anderson, I.	Evans	Huntley	Lieder	Otremba	Tuma
Bakk	Finseth	Jaros	Luther	Ozment	Vandever
Bishop	Folliard	Jennings	Mahoney	Paymar	Wagenius
Cassell	Fuller	Johnson, R.	Mares	Pelowski	Walker
Daggett	Gleason	Johnson, S.	Mariani	Peterson	Walz
Davids	Goodwin	Juhnke	Marko	Pugh	Wasiluk
Davnie	Greiling	Kahn	Marquart	Rifenberg	Wenzel
Dawkins	Gunther	Kalis	McGuire	Rukavina	Westrom
Dehler	Haas	Kelliher	Murphy	Schumacher	Winter
Dibble	Hackbarth	Koskinen	Ness	Skoe	
Dorn	Harder	Kubly	Olson	Solberg	
Eastlund	Hilstrom	Larson	Opatz	Stang	
Entenza	Hilty	Leighton	Osskopp	Swapinski	
Erickson	Holsten	Lenczewski	Osthoff	Swenson	

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

S. F. No. 970, as amended, was read for the third time.

Abeler was excused between the hours of 1:05 p.m. and 2:35 p.m.

#### 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:

Anderson, B.	Dibble	Hausman	Kelliher	Mariani	Otremba
Anderson, I.	Dorman	Hilstrom	Kielkucki	Marko	Ozment
Bakk	Dorn	Hilty	Knoblach	Marquart	Paulsen
Bishop	Eastlund	Holberg	Krinkie	McElroy	Pawlenty
Boudreau	Erhardt	Holsten	Kubly	McGuire	Paymar
Bradley	Erickson	Howes	Kuisle	Milbert	Pelowski
Buesgens	Finseth	Huntley	Larson	Molnau	Penas
Carlson	Fuller	Jacobson	Leighton	Mulder	Peterson
Cassell	Gerlach	Jaros	Lenczewski	Mullery	Pugh
Clark, J.	Goodno	Jennings	Leppik	Murphy	Rhodes
Clark, K.	Goodwin	Johnson, J.	Lieder	Ness	Rifenberg
Daggett	Gray	Johnson, R.	Lindner	Nornes	Rukavina
Davids	Gunther	Johnson, S.	Lipman	Olson	Ruth
Dawkins	Haas	Juhnke	Luther	Opatz	Schumacher
Dehler	Hackbarth	Kahn	Mahoney	Osskopp	Seagren
Dempsey	Harder	Kalis	Mares	Osthoff	Seifert

Skoe	Stang	Thompson	Walker	Westerberg	Wolf
Skoglund	Swapinski	Tingelstad	Walz	Westrom	Workman
Smith	Swenson	Tuma	Wasiluk	Wilkin	Spk. Sviggum
Solberg	Sykora	Vandever	Wenzel	Winter	

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. 970, A bill for an act relating to trade regulations; prohibiting gasoline sales below cost; providing enforcement authority; amending Minnesota Statutes 2000, section 325D.01, subdivision 5, and by adding subdivisions; proposing coding for new law in Minnesota Statutes, chapter 325D.

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 85 yeas and 46 nays as follows:

Those who voted in the affirmative were:

Anderson, I.	Eastlund	Hilty	Leighton	Otremba	Swenson
Bakk	Entenza	Holberg	Lenczewski	Ozment	Tingelstad
Biernat	Erickson	Holsten	Lieder	Paymar	Tuma
Bishop	Evans	Howes	Lipman	Pelowski	Vandever
Cassell	Finseth	Huntley	Mahoney	Penas	Walker
Clark, J.	Fuller	Jaros	Mares	Peterson	Wasiluk
Clark, K.	Gleason	Jennings	Mariani	Pugh	Wenzel
Daggett	Gray	Johnson, R.	Marko	Rifenberg	Westrom
Davids	Greiling	Johnson, S.	Marquart	Rukavina	Winter
Davnie	Gunther	Juhnke	McGuire	Schumacher	Workman
Dawkins	Haas	Kalis	Murphy	Skoe	
Dehler	Hackbarth	Kelliher	Ness	Slawik	
Dempsey	Harder	Koskinen	Olson	Solberg	
Dibble	Hausman	Kubly	Opatz	Stang	
Dorn	Hilstrom	Larson	Osskopp	Swapinski	

Those who voted in the negative were:

Abrams	Erhardt	Knoblach	Molnau	Ruth	Wagenius
Anderson, B.	Gerlach	Krinkie	Mulder	Seagren	Walz
Bernardy	Goodno	Kuisle	Mullery	Seifert	Westerberg
Boudreau	Goodwin	Leppik	Nornes	Skoglund	Wilkin
Bradley	Jacobson	Lindner	Osthoff	Smith	Wolf
Buesgens	Johnson, J.	Luther	Paulsen	Stanek	Spk. Sviggum
Carlson	Kahn	McElroy	Pawlenty	Sykora	
Dorman	Kielkucki	Milbert	Rhodes	Thompson	

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

## CALL OF THE HOUSE LIFTED

Pugh moved that the call of the House be suspended. The motion prevailed and it was so ordered.

S. F. No. 2031 was reported to the House.

Bakk and Rukavina moved to amend S. F. No. 2031 as follows:

Page 2, after line 14, insert:

"Sec. 2. Minnesota Statutes 2000, section 16A.124, subdivision 1, is amended to read:

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

(a) "Commissioner" means the commissioner of finance.

(b) "State agency" has the meaning assigned to it in section 16B.01 and, in addition, includes the University of Minnesota.

Sec. 3. Minnesota Statutes 2000, section 16C.02, subdivision 2, is amended to read:

Subd. 2. [AGENCY.] "Agency" means any state officer, employee, board, commission, authority, department, entity, or organization of the executive branch of state government.

Unless specifically provided elsewhere in this chapter, agency "agency" does not include the Minnesota state colleges and universities. Except as specifically provided elsewhere in this chapter, "agency" does include the University of Minnesota for the purposes of contracts the university proposes to enter into where funds appropriated by the legislature will be expended in connection with those contracts.

Sec. 4. Minnesota Statutes 2000, section 16C.25, is amended to read:

16C.25 [BUILDING AND CONSTRUCTION CONTRACTS.]

(a) Notwithstanding any contrary law, the provisions of Minnesota Statutes 1996, section 16B.07, 16B.08, 16B.09, and all other laws applicable to competitive bidding for building and construction contracts on June 30, 1998, apply to building and construction contracts entered into on or after July 1, 1998.

(b) Paragraph (a) applies to all projects undertaken by the University of Minnesota involving the demolition of, or construction of improvements to, real property.

Page 2, line 15, delete "2" and insert "5"

Amend the title as follows:

Page 1, line 3, after the semicolon, insert "extending competitive bidding and prompt payment requirements to the University of Minnesota; amending Minnesota Statutes 2000, sections 16A.124, subdivision 1; 16C.02, subdivision 2; 16C.25;"

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

S. F. No. 2031, A bill for an act relating to contracts; regulating public works contracts; proposing coding for new law in Minnesota Statutes, chapter 15.

The bill was read for the 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 133 yeas and 0 nays as follows:

Those who voted in the affirmative were:

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

The bill was passed and its title agreed to.

S. F. No. 1215 was reported to the House.

Holberg moved to amend S. F. No. 1215 as follows:

Delete everything after the enacting clause and insert the following language of H. F. No. 767, the first engrossment:

"Section 1. Minnesota Statutes 2000, section 363.01, is amended by adding a subdivision to read:

Subd. 7a. [CLOSED INTAKE FILE.] "Closed intake file" means a file containing human rights investigative data in which a charge of discrimination was not filed. The human rights investigative data contained in the closed intake file; the records made by the department of the department's contact with a potential charging party; and all other data that identify the potential charging party, witnesses, and potential respondents are confidential or protected nonpublic data.

Sec. 2. Minnesota Statutes 2000, section 363.01, subdivision 21, is amended to read:

Subd. 21. [HUMAN RIGHTS INVESTIGATIVE DATA.] "Human rights investigative data" means written documents issued or gathered, whether solicited or unsolicited, by the department for the purpose of determining whether to draft or file a charge of discrimination or for the purpose of investigating and prosecuting alleged or suspected discrimination.

Sec. 3. Minnesota Statutes 2000, section 363.01, subdivision 41, is amended to read:

Subd. 41. [SEXUAL HARASSMENT.] "Sexual harassment" includes unwelcome sexual advances, requests for sexual favors, sexually motivated physical contact or other verbal or physical conduct or communication of a sexual nature when:

(1) submission to that conduct or communication is made a term or condition, either explicitly or implicitly, of obtaining employment, public accommodations or public services, education, or housing;

(2) submission to or rejection of that conduct or communication by an individual is used as a factor in decisions affecting that individual's employment, public accommodations or public services, education, or housing; or

(3) that conduct or communication has the purpose or effect of substantially interfering with an individual's employment, public accommodations or public services, education, or housing, or creating an intimidating, hostile, or offensive employment, public accommodations, public services, educational, or housing environment; ~~and in the case of employment, the employer knows or should know of the existence of the harassment and fails to take timely and appropriate action.~~

Sec. 4. Minnesota Statutes 2000, section 363.03, subdivision 8a, is amended to read:

Subd. 8a. [BUSINESS DISCRIMINATION.] It is an unfair discriminatory practice for a person engaged in a trade or business or in the provision of a service:

(a) to refuse to do business with or provide a service to a woman based on her use of her current or former surname; or

(b) to impose, as a condition of doing business with or providing a service to a woman, that a woman use her current surname rather than a former surname; or

(c) ~~intentionally~~ to intentionally refuse to do business with, to refuse to contract with, or to discriminate in the basic terms, conditions, or performance of the contract because of a person's race, national origin, color, sex, sexual orientation, or disability, unless the alleged refusal or discrimination is because of a legitimate business purpose.

Nothing in this subdivision shall prohibit positive action plans.

Sec. 5. Minnesota Statutes 2000, section 363.06, subdivision 4, is amended to read:

Subd. 4. [INQUIRY INTO CHARGE.] (1) Consistent with clause (7), the commissioner shall promptly inquire into the truth of the allegations of the charge. The commissioner shall make an immediate inquiry when a charge alleges actual or threatened physical violence. The commissioner shall also make an immediate inquiry when it appears that a charge is frivolous or without merit and shall dismiss those charges.

The commissioner shall give priority to investigating and processing those charges, in the order below, which the commissioner determines have the following characteristics:

(a) there is evidence of irreparable harm if immediate action is not taken;



- (b) there is evidence that the respondent has intentionally engaged in a reprisal;
- (c) a significant number of recent charges have been filed against the respondent;
- (d) the respondent is a government entity;
- (e) there is potential for broadly promoting the policies of this chapter; or
- (f) the charge is supported by substantial and credible documentation, witnesses, or other evidence.

The commissioner shall inform charging parties of these priorities and shall tell each party if their charge is a priority case or not.

On other charges the commissioner shall make a determination within 12 months after the charge was filed as to whether or not there is probable cause to credit the allegation of unfair discriminatory practices, and

(2) If the commissioner determines after investigation that no probable cause exists to credit the allegations of the unfair discriminatory practice, the commissioner shall, within ten days of the determination, serve upon the charging party and respondent written notice of the determination. Within ten days after receipt of notice, the charging party may request in writing, on forms prepared by the department, that the commissioner reconsider the determination. The request shall contain a brief statement of the reasons for and new evidence in support of the request for reconsideration. At the time of submission of the request to the commissioner, the charging party shall deliver or mail to the respondent a copy of the request for reconsideration. The commissioner shall ~~either~~ reaffirm or ~~reverse~~ reverse, or vacate and remand for further consideration the determination of no probable cause within 20 days after receipt of the request for reconsideration, and shall within ten days notify in writing the charging party and respondent of the decision to ~~reaffirm or~~ reverse, or vacate and remand for further consideration.

A decision by the commissioner that no probable cause exists to credit the allegations of an unfair discriminatory practice shall not be appealed to the court of appeals pursuant to section 363.072 or sections 14.63 to 14.68.

(3) If the commissioner determines after investigation that probable cause exists to credit the allegations of unfair discriminatory practices, the commissioner shall serve on the respondent and the respondent's attorney if the respondent is represented by counsel, by first class mail, a notice setting forth a short plain written statement of the alleged facts which support the finding of probable cause and an enumeration of the provisions of law allegedly violated. If the commissioner determines that attempts to eliminate the alleged unfair practices through conciliation pursuant to subdivision 5 have been or would be unsuccessful or unproductive, the commissioner shall issue a complaint and serve on the respondent, by registered or certified mail, a written notice of hearing together with a copy of the complaint, requiring the respondent to answer the allegations of the complaint at a hearing before an administrative law judge at a time and place specified in the notice, not less than ten days after service of said complaint. A copy of the notice shall be furnished to the charging party and the attorney general.

(4) If, at any time after the filing of a charge, the commissioner has reason to believe that a respondent has engaged in any unfair discriminatory practice, the commissioner may file a petition in the district court in a county in which the subject of the complaint occurs, or in a county in which a respondent resides or transacts business, seeking appropriate temporary relief against the respondent, pending final determination of proceedings under this chapter, including an order or decree restraining the respondent from doing or procuring an act tending to render ineffectual an order the commissioner may enter with respect to the complaint. The court shall have power to grant temporary relief or a restraining order as it deems just and proper, but no relief or order extending beyond ten days shall be granted except by consent of the respondent or after hearing upon notice to the respondent and a finding by the court that there is reasonable cause to believe that the respondent has engaged in a discriminatory practice. Except as modified by this section, the Minnesota rules of civil procedure shall apply to an application, and the district court shall have authority to grant or deny the relief sought on conditions as it deems just and equitable. All hearings under this section shall be given precedence as nearly as practicable over all other pending civil actions.

(5) If a lessor, after engaging in a discriminatory practice defined in section 363.03, subdivision 2, clause (1)(a), leases or rents a dwelling unit to a person who has no knowledge of the practice or of the existence of a charge with respect to the practice, the lessor shall be liable for actual damages sustained by a person by reason of a final order as provided in this section requiring the person to be evicted from the dwelling unit.

(6) In any complaint issued under this section, the commissioner may seek relief for a class of individuals affected by an unfair discriminatory practice occurring on or after a date one year prior to the filing of the charge from which the complaint originates.

(7) The commissioner may adopt policies to determine which charges are processed and the order in which charges are processed based on their particular social or legal significance, administrative convenience, difficulty of resolution, or other standard consistent with the provisions of this chapter.

(8) The chief administrative law judge shall adopt policies to provide sanctions for intentional and frivolous delay caused by any charging party or respondent in an investigation, hearing, or any other aspect of proceedings before the department under this chapter.

Sec. 6. Minnesota Statutes 2000, section 363.061, subdivision 2, is amended to read:

Subd. 2. [ACCESS TO OPEN FILES.] (a) Except as otherwise provided in this subdivision, human rights investigative data contained in an open case file are confidential data on individuals or protected nonpublic data. If a verified charge of discrimination is filed, then the name and address of the charging party and respondent, factual basis of the allegations, and the statute under which the action is brought are private data on individuals or nonpublic data but are accessible to the charging party and the respondent.

~~(b) After making a finding of probable cause, the commissioner may make human rights investigative data contained in an open case file accessible to a person, government agency, or the public if access will aid the investigative and enforcement process. After a charge has been filed, the commissioner may disclose information to persons as the commissioner deems necessary (1) to facilitate investigation or disposition of the charge, or (2) to promote public health or safety. The commissioner may also disclose data about an open case file to another governmental entity to assist that entity or the department in processing a complaint or to eliminate duplication of efforts in the investigation of the same or similar facts as alleged in the charge. To the extent that data are disclosed to other governmental entities, the data disclosed shall have the same classification in the possession of the receiving entity as it had in the possession of the entity providing the data.~~

~~(c) After making a finding of probable cause, the commissioner may make human rights investigative data contained in an open case file accessible to a person, government agency, or the public if access will aid the investigative and enforcement process.~~

Sec. 7. Minnesota Statutes 2000, section 363.061, subdivision 3, is amended to read:

Subd. 3. [ACCESS TO CLOSED FILES.] (a) Except as otherwise provided in this subdivision, human rights investigative data contained in a closed case file are private data on individuals or nonpublic data. The name and address of the charging party and respondent, factual basis of the allegations, the statute under which the action is brought, the part of the summary of the investigation that does not contain identifying data on a person other than the complainant or respondent, and the commissioner's memorandum determining whether probable cause has been shown are public data. All data in a closed intake file, as defined in section 363.01, subdivision 7a, are either confidential data on individuals or protected nonpublic data.

(b) The commissioner may make human rights investigative data contained in a closed case file inaccessible to the charging party or the respondent in order to protect medical or other security interests of the parties or third persons."

Delete the title and insert:

"A bill for an act relating to human rights; changing provisions pertaining to business discrimination, and inquiry into a charge; permitting discretionary disclosure during investigation; amending Minnesota Statutes 2000, sections 363.01, subdivisions 21, 41, and by adding a subdivision; 363.03, subdivision 8a; 363.06, subdivision 4; and 363.061, subdivisions 2 and 3."

The motion prevailed and the amendment was adopted.

The Speaker called Abrams to the Chair.

Anderson, B.; Osskopp and Olson offered an amendment to S. F. No. 1215, as amended.

#### POINT OF ORDER

Pugh raised a point of order pursuant to rule 3.21 that the Anderson, B., et al amendment was not in order.

Pursuant to section 245 of "Mason's Manual of Legislative Procedure," Speaker pro tempore Abrams submitted the following question to the House: "Is it the judgment of the House that the Pugh point of order is well taken?"

It was the judgment of the House that the Pugh point of order was well taken and the Anderson, B., et al amendment was out of order.

S. F. No. 1215, A bill for an act relating to human rights; changing provisions pertaining to business discrimination and inquiry into a charge; permitting discretionary disclosure during investigation; amending Minnesota Statutes 2000, sections 363.01, subdivision 41; 363.03, subdivision 8a; 363.06, subdivision 4; 363.061, subdivision 2.

The bill was read for the third time, as amended, and placed upon its final passage.

The question was taken on the passage of the bill and the roll was called. There were 133 yeas and 0 nays as follows:

Those who voted in the affirmative were:

Abrams	Clark, J.	Entenza	Greiling	Jacobson	Koskinen
Anderson, B.	Clark, K.	Erhardt	Gunther	Jaros	Krinkie
Anderson, I.	Daggett	Erickson	Haas	Jennings	Kubly
Bakk	Davids	Evans	Hackbarth	Johnson, J.	Kuisle
Bernardy	Davnie	Finseth	Harder	Johnson, R.	Larson
Biernat	Dawkins	Folliard	Hausman	Johnson, S.	Leighton
Bishop	Dehler	Fuller	Hilstrom	Juhnke	Lenczewski
Boudreau	Dempsey	Gerlach	Hilty	Kahn	Leppik
Bradley	Dibble	Gleason	Holberg	Kalis	Lieder
Buesgens	Dorman	Goodno	Holsten	Kelliher	Lindner
Carlson	Dorn	Goodwin	Howes	Kielkucki	Lipman
Cassell	Eastlund	Gray	Huntley	Knoblach	Luther

Mahoney	Murphy	Paymar	Seifert	Sykora	Westrom
Mares	Ness	Pelowski	Sertich	Thompson	Wilkin
Mariani	Nornes	Penas	Skoe	Tingelstad	Winter
Marko	Olson	Peterson	Skoglund	Tuma	Wolf
Marquart	Opatz	Pugh	Slawik	Vandever	Workman
McElroy	Osskopp	Rhodes	Smith	Wagenius	Spk. Sviggum
McGuire	Osthoff	Rifenberg	Solberg	Walker	
Milbert	Otremba	Rukavina	Stanek	Walz	
Molnau	Ozment	Ruth	Stang	Wasiluk	
Mulder	Paulsen	Schumacher	Swapinski	Wenzel	
Mullery	Pawlenty	Seagren	Swenson	Westerberg	

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

S. F. No. 1407 was reported to the House.

Walker moved to amend S. F. No. 1407 as follows:

Delete everything after the enacting clause and insert the following language of H. F. No. 1928, the first engrossment:

"Section 1. Minnesota Statutes 2000, section 245B.02, is amended by adding a subdivision to read:

Subd. 23a. [SUPPORTED EMPLOYMENT.] "Supported employment" services include individualized counseling, individualized job development and placement that produce an appropriate job match for the individual and the employer, on-the-job training in work and related work skills required for job performance, ongoing supervision and monitoring of the person's performance, long-term support services to assure job retention, training in related skills essential to obtaining and retaining employment such as the effective use of community resources, use of break and lunch areas, transportation and mobility training, and transportation between the individual's place of residence and the work place when other forms of transportation are unavailable or inaccessible.

Sec. 2. Minnesota Statutes 2000, section 245B.03, subdivision 1, is amended to read:

Subdivision 1. [APPLICABILITY.] The standards in this chapter govern services to persons with mental retardation or related conditions receiving services from license holders providing residential-based habilitation; day training and habilitation services for adults; supported employment; semi-independent living services; residential programs that serve more than four consumers, including intermediate care facilities for persons with mental retardation; and respite care provided outside the consumer's home for more than four consumers at the same time at a single site.

Sec. 3. Minnesota Statutes 2000, section 252.28, subdivision 3a, is amended to read:

Subd. 3a. [LICENSING EXCEPTION.] (a) Notwithstanding the provisions of subdivision 3, the commissioner may license service sites, each accommodating up to six residents moving from a 48-bed intermediate care facility for persons with mental retardation or related conditions located in Dakota county that is closing under section 252.292.

(b) Notwithstanding the provisions of any other state law or administrative rule, the rate provisions of section 256I.05, subdivision 1, apply to the exception in this subdivision.

(c) If a service site is licensed for six persons according to this subdivision, the capacity of the license may remain at six persons.

Sec. 4. Minnesota Statutes 2000, section 252.28, subdivision 3b, is amended to read:

Subd. 3b. [OLMSTED COUNTY LICENSING EXEMPTION.] (a) Notwithstanding subdivision 3, the commissioner may license service sites each accommodating up to five residents moving from a 43-bed intermediate care facility for persons with mental retardation or related conditions located in Olmsted county that is closing under section 252.292.

(b) Notwithstanding the provisions of any other state law or administrative rule, the rate provisions of section 256I.05, subdivision 1, apply to the exception in this subdivision.

(c) If a service site is licensed for five persons according to this subdivision, the capacity of the license may remain at five persons.

Sec. 5. Minnesota Statutes 2000, section 256B.056, subdivision 1a, is amended to read:

Subd. 1a. [INCOME AND ASSETS GENERALLY.] Unless specifically required by state law or rule or federal law or regulation, the methodologies used in counting income and assets to determine eligibility for medical assistance for persons whose eligibility category is based on blindness, disability, or age of 65 or more years, the methodologies for the supplemental security income program shall be used. For 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. 6. Minnesota Statutes 2000, section 256B.056, subdivision 5a, is amended to read:

Subd. 5a. [INDIVIDUALS ON FIXED OR EXCLUDED INCOME.] Recipients of medical assistance who receive only fixed unearned or excluded income, ~~where such~~ when that income is excluded from consideration as income or unvarying in amount and timing of receipt throughout the year, shall report and verify their income annually.

Sec. 7. Minnesota Statutes 2000, section 256B.0595, subdivision 1, is amended to read:

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

(b) Effective for transfers made after August 10, 1993, a person, a person's spouse, or any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the person or person's spouse, may not give away, sell, or dispose of, for less than fair market value, any asset or interest therein, except assets other than the homestead that are excluded under the supplemental security income program, for the purpose of establishing or maintaining medical assistance eligibility. For purposes of determining eligibility for long-term care services, any transfer of such assets within 36 months before or any time after an institutionalized person applies for medical assistance, or 36 months before or any time after a medical assistance recipient becomes institutionalized, for less than fair market value may be considered. Any such transfer is presumed to have been made for the purpose of establishing or maintaining medical assistance eligibility and the person is

ineligible for long-term care services for the period of time determined under subdivision 2, unless the person furnishes convincing evidence to establish that the transaction was exclusively for another purpose, or unless the transfer is permitted under subdivision 3 or 4. Notwithstanding the provisions of this paragraph, in the case of payments from a trust or portions of a trust that are considered transfers of assets under federal law, any transfers made within 60 months before or any time after an institutionalized person applies for medical assistance and within 60 months before or any time after a medical assistance recipient becomes institutionalized, may be considered.

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

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

(e) This section applies to the portion of any asset or interest that a person, a person's spouse, or any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the person or the person's spouse, transfers to any annuity that exceeds the value of the benefit likely to be returned to the person or spouse while alive, based on estimated life expectancy using the life expectancy tables employed by the supplemental security income program to determine the value of an agreement for services for life. The commissioner may adopt rules reducing life expectancies based on the need for long-term care.

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

~~(g) Effective for transfers made on or after July 1, 1995, or upon federal approval, whichever is later, a person, a person's spouse, or any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the person or person's spouse, may not give away, sell, or dispose of, for less than fair market value, any asset or interest therein, for the purpose of establishing or maintaining medical assistance eligibility. For purposes of determining eligibility for long-term care services, any transfer of such assets within 60 months before, or any time after, an institutionalized person applies for medical assistance, or 60 months before, or any time after, a medical assistance recipient becomes institutionalized, for less than fair market value may be considered. Any such transfer is presumed to have been made for the purpose of establishing or maintaining medical assistance eligibility and the person is ineligible for long-term care services for the period of time determined under subdivision 2, unless the person furnishes convincing evidence to establish that the transaction was exclusively for another purpose, or unless the transfer is permitted under subdivision 3 or 4.~~

Sec. 8. Minnesota Statutes 2000, section 256B.0595, subdivision 2, is amended to read:

Subd. 2. [PERIOD OF INELIGIBILITY.] (a) For any uncompensated transfer occurring on or before August 10, 1993, the number of months of ineligibility for long-term care services shall be the lesser of 30 months, or the uncompensated transfer amount divided by the average medical assistance rate for nursing facility services in the state in effect on the date of application. The amount used to calculate the average medical assistance payment rate shall be adjusted each July 1 to reflect payment rates for the previous calendar year. The period of ineligibility begins with the month in which the assets were transferred. If the transfer was not reported to the local agency at the time

of application, and the applicant received long-term care services during what would have been the period of ineligibility if the transfer had been reported, a cause of action exists against the transferee for the cost of long-term care services provided during the period of ineligibility, or for the uncompensated amount of the transfer, whichever is less. The action may be brought by the state or the local agency responsible for providing medical assistance under chapter 256G. The uncompensated transfer amount is the fair market value of the asset at the time it was given away, sold, or disposed of, less the amount of compensation received.

(b) For uncompensated transfers made after August 10, 1993, the number of months of ineligibility for long-term care services shall be the total uncompensated value of the resources transferred divided by the average medical assistance rate for nursing facility services in the state in effect on the date of application. The amount used to calculate the average medical assistance payment rate shall be adjusted each July 1 to reflect payment rates for the previous calendar year. The period of ineligibility begins with the month in which the assets were transferred except that if one or more uncompensated transfers are made during a period of ineligibility, the total assets transferred during the ineligibility period shall be combined and a penalty period calculated to begin in the month the first uncompensated transfer was made. If the transfer was not reported to the local agency at the time of application, and the applicant received medical assistance services during what would have been the period of ineligibility if the transfer had been reported, a cause of action exists against the transferee for the cost of medical assistance services provided during the period of ineligibility, or for the uncompensated amount of the transfer, whichever is less. The action may be brought by the state or the local agency responsible for providing medical assistance under chapter 256G. The uncompensated transfer amount is the fair market value of the asset at the time it was given away, sold, or disposed of, less the amount of compensation received. Effective for transfers made on or after March 1, 1996, involving persons who apply for medical assistance on or after April 13, 1996, no cause of action exists for a transfer unless:

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

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

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

(c) If a calculation of a penalty period results in a partial month, payments for long-term care services shall be reduced in an amount equal to the fraction, except that in calculating the value of uncompensated transfers, if the total value of all uncompensated transfers made in a month not included in an existing penalty period does not exceed \$500, then such transfers shall be disregarded for each month prior to the month of application for or during receipt of medical assistance.

Sec. 9. Minnesota Statutes 2000, section 256B.0625, subdivision 9, is amended to read:

Subd. 9. [DENTAL SERVICES.] Medical assistance covers dental services. Dental services include, with prior authorization, fixed ~~cast metal restorations~~ bridges that are cost-effective for persons who cannot use removable dentures because of their medical condition.

Sec. 10. Minnesota Statutes 2000, section 256B.071, subdivision 2, is amended to read:

Subd. 2. [TECHNICAL ASSISTANCE TO PROVIDERS.] (a) The commissioner shall establish a technical assistance program to require providers of services and equipment under this section to maximize collections from the federal Medicare program. The technical assistance may include the provision of materials to help providers determine those services and equipment likely to be reimbursed by Medicare. ~~The technical assistance may also include the provision of computer software to providers to assist in this process. The commissioner may expand the technical assistance program to include providers of other services under this chapter.~~

(b) Any provider of home care services enrolled in the medical assistance program, or county public health nursing agency responsible for personal care assessments, or county case managers for alternative care or medical assistance waiver programs, is required to use the method developed and supplied by the department of human services for determining Medicare coverage for home care equipment and services provided to dual entitlements to ensure appropriate billing of Medicare. ~~The method will be developed in two phases; the first phase is a manual system effective July 1, 1996, and the second phase will automate the manual procedure by expanding the current Medicaid Management Information System (MMIS) effective January 1, 1997. Both methods will determine Medicare coverage for the dates of service and Medicare coverage for home care services, and create an audit trail including reports. Both methods will be linked to prior authorization, therefore, either method must be used before home care services are authorized and when there is a change of condition affecting medical assistance authorization. The department will conduct periodic reviews of participant performance with the method and upon demonstrating appropriate referral and billing of Medicare, participants may be determined exempt from regular performance audits.~~

Sec. 11. Minnesota Statutes 2000, section 256B.094, subdivision 6, is amended to read:

Subd. 6. [MEDICAL ASSISTANCE REIMBURSEMENT OF CASE MANAGEMENT SERVICES.] (a) Medical assistance reimbursement for services under this section shall be made on a monthly basis. Payment is based on face-to-face or telephone contacts between the case manager and the client, client's family, primary caregiver, legal representative, or other relevant person identified as necessary to the development or implementation of the goals of the individual service plan regarding the status of the client, the individual service plan, or the goals for the client. These contacts must meet the minimum standards in clauses (1) and (2):

(1) there must be a face-to-face contact at least once a month except as provided in clause (2); and

(2) for a client placed outside of the county of financial responsibility, or a client served by tribal social services placed outside the reservation, in an excluded time facility under section 256G.02, subdivision 6, or through the Interstate Compact on the Placement of Children, section 260.851, and the placement in either case is more than 60 miles beyond the county or reservation boundaries, there must be at least one contact per month and not more than two consecutive months without a face-to-face contact.

(b) Except as provided under paragraph (c), the payment rate is established using time study data on activities of provider service staff and reports required under sections 245.482, 256.01, subdivision 2, paragraph (17), and 256E.08, subdivision 8.

(c) Payments for tribes may be made according to section 256B.0625 or other relevant federally approved rate setting methodology for child welfare targeted case management provided by Indian health services and facilities operated by a tribe or tribal organization.

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

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



Separate payment rates may be established for different groups of providers to maximize reimbursement as determined by the commissioner. The payment rate will be reviewed annually and revised periodically to be consistent with the most recent time study and other data. Payment for services will be made upon submission of a valid claim and verification of proper documentation described in subdivision 7. Federal administrative revenue earned through the time study, or under paragraph (c), shall be distributed according to earnings, to counties, reservations, or groups of counties or reservations which have the same payment rate under this subdivision, and to the group of counties or reservations which are not certified providers under section 256F.10. The commissioner shall modify the requirements set out in Minnesota Rules, parts 9550.0300 to 9550.0370, as necessary to accomplish this.

Sec. 12. Minnesota Statutes 2000, section 256B.094, subdivision 8, is amended to read:

Subd. 8. [PAYMENT LIMITATION.] Services that are not eligible for payment as a child welfare targeted case management service include, but are not limited to:

- (1) assessments prior to opening a case;
- (2) therapy and treatment services;
- (3) legal services, including legal advocacy, for the client;
- (4) information and referral services that are part of a county's community social services plan, that are not provided to an eligible recipient;
- (5) outreach services including outreach services provided through the community support services program;
- (6) services that are not documented as required under subdivision 7 and Minnesota Rules, parts ~~9505.1800 to 9505.1880~~ 9505.2165 and 9505.2175;
- (7) services that are otherwise eligible for payment on a separate schedule under rules of the department of human services;
- (8) services to a client that duplicate the same case management service from another case manager;
- (9) case management services provided to patients or residents in a medical assistance facility except as described under subdivision 2, clause (9); and
- (10) for children in foster care, group homes, or residential care, payment for case management services is limited to case management services that focus on permanency planning or return to the family home and that do not duplicate the facility's discharge planning services.

Sec. 13. Minnesota Statutes 2000, section 256B.5013, subdivision 1, is amended to read:

Subdivision 1. [VARIABLE RATE ADJUSTMENTS.] For rate years beginning on or after October 1, 2000, when there is a documented increase in the resource needs of a current ICF/MR recipient or recipients, or a person is admitted to a facility who requires additional resources, the county of financial responsibility may recommend approval of a variable rate to enable the facility to meet the individual's increased needs based on the recipient's screening. Variable rate adjustments made under this subdivision replace payments for persons with special needs under section 256B.501, subdivision 8, and payments for persons with special needs for crisis intervention services under section 256B.501, subdivision 8a. Resource needs directly attributable to an individual that may be considered under the variable rate adjustment include increased direct staff hours ~~and~~ other specialized services, and equipment, ~~and human resources~~. The guidelines in paragraphs (a) to (d) apply for the payment rate adjustments under this section.

(a) All persons must be screened according to section 256B.092, subdivisions 7 and 8, prior to implementation of the new payment system, and annually thereafter, and when a variable rate is being requested due to changes in the needs of the recipient. ~~Screening data shall be analyzed to develop broad profiles of the functional characteristics of recipients. Screening data shall be used to monitor changes as follows:~~

Criteria to be used to develop these profiles shall include, but not be limited to:

- (1) the functional ability of a recipient to care for and maintain the recipient's own basic needs;
- (2) the intensity of any aggressive or destructive behavior; and
- (3) any history of obstructive behavior in combination with a diagnosis of psychosis or neurosis;

(b) A variable rate may be recommended for increased service needs such as:

~~(4)~~ (1) a need for resources due to a change in resident day program participation because the resident: (i) has reached the age of 65 or has a change in health condition that makes it difficult for the person to participate in day training and habilitation services over an extended period of time because it is medically contraindicated; and (ii) has expressed a desire for change through the ~~developmental disabilities~~ mental retardation and related conditions screening process under section 256B.092; and

~~(5)~~ (2) a need for additional resources for intensive short-term training programming which is necessary prior to a recipient's discharge to a less restrictive, more integrated setting.

~~The recipients' screenings~~ Recommendations for a variable rate shall be used to link resource needs to funding. ~~The resource profile shall determine the level of funding.~~ The variable rate must be applied to expenses related to increased direct staff hours and, other specialized services, and equipment, ~~and human resources.~~

~~(b)~~ (c) A recipient must be screened by the county of financial responsibility using the developmental disabilities screening document completed immediately prior to approval of a variable rate by the county. A comparison of the updated screening and the previous screening must demonstrate an increase in resource needs.

~~(c)~~ (d) Rate adjustments projected to exceed the authorized funding level associated with the person's profile must be submitted to the commissioner.

~~(d)~~ (e) The county of financial responsibility must indicate the projected length of time that the additional funding may be needed for the individual. The need to continue an individual variable rate must be reviewed at the end of the anticipated duration of need but at least annually through the completion of the developmental disabilities screening document.

Sec. 14. Minnesota Statutes 2000, section 256B.69, subdivision 3a, is amended to read:

Subd. 3a. [COUNTY AUTHORITY.] (a) The commissioner, when implementing the general assistance medical care, or medical assistance prepayment program within a county, must include the county board in the process of development, approval, and issuance of the request for proposals to provide services to eligible individuals within the proposed county. County boards must be given reasonable opportunity to make recommendations regarding the development, issuance, review of responses, and changes needed in the request for proposals. The commissioner must provide county boards the opportunity to review each proposal based on the identification of community needs under chapters 145A and 256E and county advocacy activities. If a county board finds that a proposal does not address certain community needs, the county board and commissioner shall continue efforts for improving the proposal and network prior to the approval of the contract. The county board shall make recommendations regarding the approval of local networks and their operations to ensure adequate availability and access to covered services. The provider or health plan must respond directly to county advocates and the state prepaid medical assistance ombudsperson regarding service delivery and must be accountable to the state regarding contracts with medical

assistance and general assistance medical care funds. The county board may recommend a maximum number of participating health plans after considering the size of the enrolling population; ensuring adequate access and capacity; considering the client and county administrative complexity; and considering the need to promote the viability of locally developed health plans. The county board or a single entity representing a group of county boards and the commissioner shall mutually select health plans for participation at the time of initial implementation of the prepaid medical assistance program in that county or group of counties and at the time of contract renewal. The commissioner shall also seek input for contract requirements from the county or single entity representing a group of county boards at each contract renewal and incorporate those recommendations into the contract negotiation process. The commissioner, in conjunction with the county board, shall actively seek to develop a mutually agreeable timetable prior to the development of the request for proposal, but counties must agree to initial enrollment beginning on or before January 1, 1999, in either the prepaid medical assistance and general assistance medical care programs or county-based purchasing under section 256B.692. At least 90 days before enrollment in the medical assistance and general assistance medical care prepaid programs begins in a county in which the prepaid programs have not been established, the commissioner shall provide a report to the chairs of senate and house committees having jurisdiction over state health care programs which verifies that the commissioner complied with the requirements for county involvement that are specified in this subdivision.

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

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

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

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

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

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

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

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

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

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

(i) risk contracts with licensed health plans;

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

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

(iv) funding from other county resources;

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

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

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

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

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

Sec. 15. 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, 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. Earned income is deemed available to family members as defined in section 256D.02, subdivision 8.

(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. 16. Minnesota Statutes 2000, section 256L.15, subdivision 1a, is amended to read:

Subd. 1a. [PAYMENT OPTIONS.] The commissioner may offer the following payment options to an enrollee:

- (1) payment by check;
- (2) payment by credit card;
- (3) payment by recurring automatic checking withdrawal;
- (4) payment by one-time electronic transfer of funds;
- (5) payment by wage withholding with the consent of the employer and the employee; or
- (6) payment by using state tax refund payments.

At application or reapplication, a MinnesotaCare applicant or enrollee may authorize the commissioner to use the Revenue Recapture Act in chapter 270A to collect funds from the applicant's or enrollee's ~~state income tax~~ refund for the purposes of meeting all or part of the applicant's or enrollee's MinnesotaCare premium obligation ~~for the forthcoming year~~. The applicant or enrollee may authorize the commissioner to apply for the state working family tax credit on behalf of the applicant or enrollee. The setoff due under this subdivision shall not be subject to the \$10 fee under section 270A.07, subdivision 1.

Sec. 17. 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. 18. Laws 1996, chapter 451, article 2, section 61, is amended to read:

Sec. 61. [REPEALER.]

Minnesota Statutes 1995 Supplement, sections ~~256B.15, subdivision 5~~; 256G.05, subdivision 1; and 256G.07, subdivision 3a, are repealed.



Sec. 19. Laws 1996, chapter 451, article 2, section 62, is amended to read:

Sec. 62. [EFFECTIVE DATE; APPLICATION.]

~~(a) Sections 12, 14, 16, 18, 29, 30, and the portion of section 61 that repeals section 256B.15, subdivision 5, are effective the day following final enactment to the extent permitted by federal law. If any provisions of these sections are prohibited by federal law, the provisions shall become effective when federal law is changed to permit their application or a waiver is received. The commissioner of human services shall notify the revisor of statutes when federal law is enacted or a waiver is received and publish a notice in the State Register. The commissioner must include the notice in the first State Register published after the effective date of the federal changes.~~

~~(b) If, by July 1, 1996, any provisions of the sections mentioned in paragraph (a) are not effective because of prohibitions in federal law, the commissioner shall apply to the federal government for a waiver of those prohibitions, and those provisions shall become effective upon receipt of a federal waiver, notification to the revisor of statutes, and publication of a notice in the State Register to that effect. If the commissioner applies for a waiver of the lookback period, the commissioner shall seek the longest lookback period the health care financing administration will approve, not to exceed 72 months.~~

~~(c) Section 54 applies to estates of decedents dying on or after its effective date. Section 55 applies to estates where the notice under Minnesota Statutes, section 524.3-801, paragraph (a), was first published on or after its effective date. Section 55 does not affect any right or duty to provide notice to known creditors, including a local agency, before its effective date.~~

(d) Sections 7, 13, 15, 17, 33, 34, 35, 38, and 60 are effective the day following final enactment.

(e) Section 11 is effective retroactive to October 1, 1993.

(f) Sections 8, 22, subdivision 3, and 34 are effective upon federal approval.

(g) Sections 10 and 31 are effective upon receipt of federal approval, retroactive to January 1, 1996.

Sec. 20. [REPEALER.]

(a) Laws 1995, chapter 178, article 2, section 46, subdivision 10; and Laws 1996, chapter 451, article 2, sections 12, 14, 16, 18, 29, and 30, are repealed.

(b) Minnesota Statutes 2000, section 256B.071, subdivision 5, is repealed."

Delete the title and insert:

"A bill for an act relating to human services; modifying provisions in health care access programs; amending Minnesota Statutes 2000, sections 245B.02, by adding a subdivision; 245B.03, subdivision 1; 252.28, subdivisions 3a and 3b; 256B.056, subdivisions 1a and 5a; 256B.0595, subdivisions 1 and 2; 256B.0625, subdivision 9; 256B.071, subdivision 2; 256B.094, subdivisions 6 and 8; 256B.5013, subdivision 1; 256B.69, subdivision 3a; 256D.03, subdivision 3; and 256L.15, subdivision 1a; Laws 1995, chapter 178, article 2, section 36; Laws 1996, chapter 451, article 2, sections 61 and 62; repealing Minnesota Statutes 2000, section 256B.071, subdivision 5; Laws 1995, chapter 178, article 2, section 46, subdivision 10; Laws 1996, chapter 451, article 2, sections 12, 14, 16, 18, 29, and 30."

The motion prevailed and the amendment was adopted.

S. F. No. 1407, A bill for an act relating to human services; modifying provisions in health care access programs; amending Minnesota Statutes 2000, sections 245B.02, by adding a subdivision; 245B.03, subdivision 1; 252.28, subdivisions 3a and 3b; 256B.056, subdivisions 1a, 4, and 5a; 256B.0595, subdivisions 1 and 2; 256B.0625, subdivision 9; 256B.0635, subdivision 1; 256B.071, subdivision 2; 256B.094, subdivisions 6 and 8; 256B.5013, subdivision 1; 256B.69, subdivision 3a; 256D.03, subdivision 3; and 256L.15, subdivision 1a; Laws 1996, chapter 451, article 2, sections 61 and 62; repealing Minnesota Statutes 2000, section 256B.071, subdivision 5; Laws 1995, chapter 178, article 2, section 46, subdivision 10; Laws 1996, chapter 451, article 2, sections 12, 14, 16, 18, 29, and 30.

The bill was read for the third time, as amended, and placed upon its final passage.

The question was taken on the passage of the bill and the roll was called. There were 132 yeas and 0 nays as follows:

Those who voted in the affirmative were:

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

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

S. F. No. 974 was reported to the House.

Solberg moved to amend S. F. No. 974 as follows:

Page 1, line 17, delete "3,000" and insert "5,000"

The motion prevailed and the amendment was adopted.

S. F. No. 974, A bill for an act relating to local government; adding exceptions to the local public officer's conflict of interest law; amending Minnesota Statutes 2000, section 471.88, by adding subdivisions.

The bill was read for the third time, as amended, and placed upon its final passage.

The question was taken on the passage of the bill and the roll was called. There were 101 yeas and 31 nays as follows:

Those who voted in the affirmative were:

Anderson, B.	Entenza	Hilty	Lenczewski	Osskopp	Slawik
Anderson, I.	Erhardt	Holsten	Leppik	Osthoff	Solberg
Bakk	Evans	Howes	Lieder	Otremba	Swapinski
Bernardy	Finseth	Huntley	Luther	Ozment	Swenson
Biernat	Folliard	Jaros	Mahoney	Paymar	Thompson
Bishop	Fuller	Jennings	Mares	Pelowski	Tingelstad
Carlson	Gleason	Johnson, J.	Mariani	Penas	Tuma
Cassell	Goodno	Johnson, R.	Marquart	Peterson	Wagenius
Clark, K.	Goodwin	Johnson, S.	McElroy	Pugh	Walker
Daggett	Gray	Juhnke	McGuire	Rhodes	Walz
Davids	Greiling	Kahn	Milbert	Rukavina	Wasiluk
Davnie	Gunther	Kalis	Mulder	Ruth	Wenzel
Dawkins	Haas	Kelliher	Mullery	Schumacher	Winter
Dehler	Hackbarth	Koskinen	Murphy	Seagren	Wolf
Dempsey	Harder	Kubly	Ness	Sertich	Workman
Dibble	Hausman	Larson	Nornes	Skoe	Spk. Sviggum
Dorn	Hilstrom	Leighton	Opatz	Skoglund	

Those who voted in the negative were:

Abrams	Eastlund	Knoblach	Olson	Stanek	Wilkin
Boudreau	Erickson	Krinkie	Paulsen	Stang	
Bradley	Gerlach	Kuisle	Pawlenty	Sykora	
Buesgens	Holberg	Lindner	Rifenberg	Vandever	
Clark, J.	Jacobson	Lipman	Seifert	Westerberg	
Dorman	Kielkucki	Molnau	Smith	Westrom	

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

H. F. No. 1292 was reported to the House.

Goodno moved that H. F. No. 1292 be returned to the General Register. The motion prevailed.

S. F. No. 491 was reported to the House.

Goodno moved to amend S. F. No. 491 as follows:

Delete everything after the enacting clause and insert the following language of H. F. No. 560, the fourth engrossment:

"Section 1. Minnesota Statutes 2000, section 45.027, subdivision 6, is amended to read:

Subd. 6. [VIOLATIONS AND PENALTIES.] The commissioner may impose a civil penalty not to exceed \$10,000 per violation upon a person who violates any law, rule, or order related to the duties and responsibilities entrusted to the commissioner unless a different penalty is specified. If a civil penalty is imposed on a health carrier as defined in section 62A.011, the commissioner must divide 50 percent of the amount among any policy holders or certificate holders affected by the violation, unless the commissioner certifies in writing that the division and distribution to enrollees would be too administratively complex or that the number of enrollees affected by the penalty would result in a distribution of less than \$50 per enrollee.

Sec. 2. Minnesota Statutes 2000, section 62D.02, subdivision 8, is amended to read:

Subd. 8. [HEALTH MAINTENANCE CONTRACT.] "Health maintenance contract" means any contract whereby a health maintenance organization agrees to provide comprehensive health maintenance services to enrollees, provided that the contract may contain ~~reasonable enrollee copayment cost-sharing provisions that comply with section 62D.099. An individual or group health maintenance contract may contain the copayment and deductible provisions specified in this subdivision.~~ Copayment and deductible provisions in group contracts shall not discriminate on the basis of age, sex, race, length of enrollment in the plan, or economic status; and during every open enrollment period in which all offered health benefit plans, including those subject to the jurisdiction of the commissioners of commerce or health, fully participate without any underwriting restrictions, copayment and deductible provisions shall not discriminate on the basis of preexisting health status. ~~In no event shall the sum of the annual copayments and deductible exceed the maximum out-of-pocket expenses allowable for a number three qualified plan under section 62E.06, nor shall that sum exceed \$5,000 per family. The annual deductible must not exceed \$1,000 per person. The annual deductible must not apply to preventive health services as described in Minnesota Rules, part 4685.0801, subpart 8.~~ Where sections 62D.01 to 62D.30 permit a health maintenance organization to contain reasonable copayment provisions for preexisting health status, these provisions may vary with respect to length of enrollment in the plan. Any contract may provide for health care services in addition to those set forth in subdivision 7.

Sec. 3. [62D.099] [ENROLLEE COST-SHARING.]

Subdivision 1. [COPAYMENTS.] (a) A health maintenance organization may impose coinsurance expressed as percentages, or flat fee copayments as provided in paragraph (b). Under the terms of the health plan, coinsurance may be imposed up to a maximum of 50 percent on the provider amount paid at the time the claim is processed irrespective of any subsequent adjustments that might be made based upon a withhold or year-end settlement. The 50 percent limitation does not apply to services that may be excluded, covered services that the enrollee elects to receive out-of-network or from a broader network, or to nonformulary prescription drugs.

(b) The health maintenance organization may establish predetermined flat fee copayments for categories of similar services or goods. Flat fee copayments based on categories of similar services or goods must be calculated independently for Medicare-related products, individual plans, and group plans. A health maintenance organization may impose a flat fee copayment of up to 50 percent of the median provider's charges for similar services or goods received by enrollees. A health maintenance organization may request the commissioner to approve a copayment which exceeds the 50 percent limitation for prescription drug benefits for Medicare-related products. The request must be made in writing to the commissioner and must include sufficient documentation to demonstrate that the requested copayment is reasonable under this section.

(c) For purposes of this section, a "category of similar services or goods" is any group of related services for which a single copayment is sought. Examples of categories include the following or any subset of the following:

(1) inpatient hospital care;

(2) inpatient physician care;

(3) outpatient health services, which may include, but are not limited to, office visits or outpatient laboratory and radiology;

(4) outpatient surgery, which may include provider and facility charges;

(5) emergency services, which may include provider and facility charges;

(6) outpatient prescription drugs;

(7) skilled nursing care; and

(8) any other nonphysician service categorized singly according to provider type.

(d) To determine the median aggregate charge for a category of similar services, the health maintenance organization must follow the following steps and submit the results to the commissioner for approval of the copayment:

(1) identify all charges for the services or goods for the relevant type of product: Medicare-related, individual, or group. The health maintenance organization may use all charges or may choose a sample of charges from the total population. Any sample used must be randomly selected and large enough to be statistically reliable. "Statistically reliable" means that any other sample drawn in the same manner would produce essentially the same results;

(2) if the health maintenance organization does not use charges that span 12 months, the health maintenance organization must explain how the time period used is sufficient to include seasonal fluctuations in the utilization of services;

(3) a statement that the sample is statistically reliable, with an explanation of how the sample is drawn so that it is representative of the larger health maintenance organization population; and

(4) a narrative description of the services included in the category.

Subd. 2. [DEDUCTIBLES.] Under the terms of the health plan, deductible amounts may be imposed as follows:

(1) for group health plans, \$5,000 per person per year and \$10,000 per family per year increased annually in accordance with the medical component of the Consumer Price Index; or

(2) for individual health plans, \$10,000 per person per year and \$20,000 per family per year increased annually in accordance with the medical component of the Consumer Price Index.

Subd. 3. [ANNUAL OUT-OF-POCKET MAXIMUM AMOUNTS.] A health maintenance organization shall provide for an out-of-pocket maximum on enrollee cost-sharing up to \$8,000 per person per year on group health plans and up to \$15,000 per person per year on individual health plans. The out-of-pocket maximum amounts shall be adjusted for inflation on an annual basis in accordance with the medical component of the Consumer Price Index.

Sec. 4. Minnesota Statutes 2000, section 62D.17, subdivision 1, is amended to read:

Subdivision 1. [ADMINISTRATIVE PENALTY.] The commissioner of health may, for any violation of statute or rule applicable to a health maintenance organization, or in lieu of suspension or revocation of a certificate of authority under section 62D.15, levy an administrative penalty in an amount up to \$25,000 for each violation. In the case of contracts or agreements made pursuant to section 62D.05, subdivisions 2 to 4, each contract or agreement entered into or implemented in a manner which violates sections 62D.01 to 62D.30 shall be considered a separate violation. In determining the level of an administrative penalty, the commissioner shall consider the following factors:

(1) the number of enrollees affected by the violation;

- (2) the effect of the violation on enrollees' health and access to health services;
- (3) if only one enrollee is affected, the effect of the violation on that enrollee's health;
- (4) whether the violation is an isolated incident or part of a pattern of violations; and
- (5) the economic benefits derived by the health maintenance organization or a participating provider by virtue of the violation.

Reasonable notice in writing to the health maintenance organization shall be given of the intent to levy the penalty and the reasons therefor, and the health maintenance organization may have 15 days within which to file a written request for an administrative hearing and review of the commissioner of health's determination. Such administrative hearing shall be subject to judicial review pursuant to chapter 14. If an administrative penalty is levied, the commissioner must divide 50 percent of the amount among any enrollees affected by the violation, unless the commissioner certifies in writing that the division and distribution to enrollees would be too administratively complex or that the number of enrollees affected by the penalty would result in a distribution of less than \$50 per enrollee.

Sec. 5. Minnesota Statutes 2000, section 62J.38, is amended to read:

62J.38 [COST CONTAINMENT DATA FROM GROUP PURCHASERS.]

(a) The commissioner shall require group purchasers to submit detailed data on total health care spending for each calendar year. Group purchasers shall submit data for the 1993 calendar year by April 1, 1994, and each April 1 thereafter shall submit data for the preceding calendar year.

(b) The commissioner shall require each group purchaser to submit data on revenue, expenses, and member months, as applicable. Revenue data must distinguish between premium revenue and revenue from other sources and must also include information on the amount of revenue in reserves and changes in reserves. Expenditure data, ~~including raw data from claims, may~~ must distinguish between costs incurred for patient care and administrative costs. Expenditure data must be provided separately for the following categories ~~or~~ and for other categories required by the commissioner: physician services, dental services, other professional services, inpatient hospital services, outpatient hospital services, emergency, pharmacy services and other nondurable medical goods, mental health, and chemical dependency services, other expenditures, subscriber liability, and administrative costs. Administrative costs must include costs for marketing; advertising; overhead; salaries and benefits of central office staff who do not provide direct patient care; underwriting; lobbying; claims processing; provider contracting and credentialing; detection and prevention of payment for fraudulent or unjustified requests for reimbursement or services; clinical quality assurance and other types of medical care quality improvement efforts; concurrent or prospective utilization review as defined in section 62M.02; costs incurred to acquire a hospital, clinic, or health care facility, or the assets thereof; capital costs incurred on behalf of a hospital or clinic; lease payments; or any other costs incurred pursuant to a partnership, joint venture, integration, or affiliation agreement with a hospital, clinic, or other health care provider. Capital costs and costs incurred must be reported according to standard accounting principles. The reports of this data must also separately identify expenses for local, state, and federal taxes, fees, and assessments. The commissioner may require each group purchaser to submit any other data, including data in unaggregated form, for the purposes of developing spending estimates, setting spending limits, and monitoring actual spending and costs. In addition to reporting administrative costs incurred to acquire a hospital, clinic, or health care facility, or the assets thereof; or any other costs incurred pursuant to a partnership, joint venture, integration, or affiliation agreement with a hospital, clinic, or other health care provider, reports submitted under this section also must include the payments made during the calendar year for these purposes.

(c) The commissioner may collect information on:

- (1) premiums, benefit levels, managed care procedures, and other features of health plan companies;

(2) prices, provider experience, and other information for services less commonly covered by insurance or for which patients commonly face significant out-of-pocket expenses; and

(3) information on health care services not provided through health plan companies, including information on prices, costs, expenditures, and utilization.

(d) All group purchasers shall provide the required data using a uniform format and uniform definitions, as prescribed by the commissioner.

Sec. 6. Minnesota Statutes 2000, section 62M.02, subdivision 21, is amended to read:

Subd. 21. [UTILIZATION REVIEW ORGANIZATION.] "Utilization review organization" means an entity including but not limited to an insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01; a health service plan licensed under chapter 62C; a health maintenance organization licensed under chapter 62D; a community integrated service network licensed under chapter 62N; an accountable provider network operating under chapter 62T; a fraternal benefit society operating under chapter 64B; a joint self-insurance employee health plan operating under chapter 62H; a multiple employer welfare arrangement, as defined in section 3 of the Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, section 1103, as amended; a third party administrator licensed under section 60A.23, subdivision 8, which conducts utilization review and determines certification of an admission, extension of stay, or other health care services for a Minnesota resident; or any entity performing utilization review that is affiliated with, under contract with, or conducting utilization review on behalf of, a business entity in this state. Utilization review organization does not include a clinic or health care system acting pursuant to a written delegation agreement with an otherwise regulated utilization review organization that contracts with the clinic or health care system. The regulated utilization review organization is accountable for the delegated utilization review activities of the clinic or health care system.

Sec. 7. [62Q.471] [EXCLUSION FOR SUICIDE ATTEMPTS PROHIBITED.]

(a) No health plan may exclude or reduce coverage for health care for an enrollee who is otherwise covered under the health plan on the basis that the need for the health care arose out of a suicide or suicide attempt by the enrollee.

(b) For purposes of this section, "health plan" has the meaning given in section 62Q.01, subdivision 3, but includes the coverages described in section 62A.011, subdivision 3, clauses (7) and (10).

[EFFECTIVE DATE.] This section is effective January 1, 2002, and applies to contracts issued or renewed on or after that date.

Sec. 8. [62Q.527] [COVERAGE OF NONFORMULARY DRUGS FOR MENTAL ILLNESS AND EMOTIONAL DISTURBANCE.]

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

(b) "Emotional disturbance" has the meaning given in section 245.4871, subdivision 15.

(c) "Mental illness" has the meaning given in section 245.462, subdivision 20, paragraph (a).

(d) "Health plan" has the meaning given in section 62Q.01, subdivision 3, but includes the coverages described in section 62A.011, subdivision 3, clauses (7) and (10).

Subd. 2. [REQUIRED COVERAGE FOR ANTIPSYCHOTIC DRUGS.] A health plan that provides drug coverage must provide coverage for an antipsychotic drug prescribed to treat emotional disturbance or mental illness regardless of whether the drug is in the health plan's drug formulary, if the health care provider prescribing the drug

indicates to the dispensing pharmacist, orally or in writing according to section 151.21, that the prescription must be dispensed as communicated and certifies in writing to the health plan company that the health care provider has considered any equivalent drug in the health plan's formulary and has determined that the drug prescribed will best treat the patient's condition. A health plan is not required to provide coverage for a drug if the drug was removed from the health plan's drug formulary for safety reasons. For drugs covered under this section, no health plan company that has received the certification from the health care provider may:

(1) impose a special deductible, copayment, coinsurance, or other special payment requirement that the health plan does not apply to drugs that are in the health plan's drug formulary; or

(2) require written certification from the prescribing provider each time a prescription is refilled or renewed that the drug prescribed will best treat the patient's condition.

Subd. 3. [CONTINUING CARE.] (a) Individuals receiving a prescribed drug to treat a diagnosed mental illness or emotional disturbance may continue to receive the prescribed drug for up to one year without the imposition of a special deductible, copayment, coinsurance, or other special payment requirements, when a health plan's drug formulary changes or an enrollee changes health plans and the medication has been shown to effectively treat the patient's condition. In order to be eligible for this continuing care benefit:

(1) the patient must have been treated with the drug for 90 days prior to a change in a health plan's drug formulary or a change in the enrollee's health plan;

(2) the health care provider prescribing the drug indicates to the dispensing pharmacist, orally or in writing according to section 151.21, that the prescription must be dispensed as communicated; and

(3) the health care provider prescribing the drug annually certifies in writing to the health plan company that the drug prescribed will best treat the patient's condition.

(b) A health plan is not required to provide coverage for a drug if the drug was removed from the health plan's drug formulary for safety reasons.

(c) The continuing care benefit shall be extended annually when the health care provider prescribing the drug:

(1) indicates to the dispensing pharmacist, orally or in writing according to section 151.21, that the prescription must be dispensed as communicated; and

(2) certifies in writing to the health plan company that the drug prescribed will best treat the patient's condition.

Subd. 4. [EXCEPTION TO FORMULARY.] A health plan must promptly grant an exception to the health plan's drug formulary for a patient when the health care provider prescribing the drug indicates to the health plan that:

(1) the formulary drug causes an adverse reaction in the patient;

(2) the formulary drug is contraindicated for the patient; or

(3) the health care provider demonstrates to the health plan that the prescription must be dispensed as written to provide maximum medical benefit to the patient.

[EFFECTIVE DATE.] This section is effective January 1, 2002, and applies to contracts issued or renewed on or after that date.



Sec. 9. [62Q.535] [COVERAGE FOR COURT-ORDERED MENTAL HEALTH SERVICES.]

Subdivision 1. [MENTAL HEALTH SERVICES.] For purposes of this section, mental health services means all covered services that are intended to treat or ameliorate an emotional, behavioral, or psychiatric condition and that are covered by the policy, contract, or certificate of coverage of the enrollee's health plan company or by law.

Subd. 2. [COVERAGE REQUIRED.] All health plan companies that provide coverage for mental health services must cover or provide mental health services ordered by a court of competent jurisdiction under a court order that is issued on the basis of a behavioral care evaluation, performed by a licensed psychiatrist or a doctoral-level licensed psychologist, which includes a diagnosis and an individual treatment plan for care in the most appropriate, least restrictive environment. The health plan company must be given a copy of the court order and behavioral evaluation. The health plan company shall be financially liable for the evaluation if performed by a participating provider of the health plan company and shall be financially liable for the care included in the court-ordered treatment plan if the care is covered by the health plan company and ordered to be provided by a participating provider or another provider as required by rule or statute. This court-ordered coverage must not be subject to a separate medical necessity determination by a health plan company under its utilization procedures.

[EFFECTIVE DATE.] This section is effective July 1, 2001, and applies to contracts issued or renewed on or after that date.

Sec. 10. Minnesota Statutes 2000, section 62Q.56, is amended to read:

62Q.56 [CONTINUITY OF CARE.]

Subdivision 1. [CHANGE IN HEALTH CARE PROVIDER.] (a) If enrollees are required to access services through selected primary care providers for coverage, the health plan company shall prepare a written plan that provides for continuity of care in the event of contract termination between the health plan company and any of the contracted primary care providers, specialists, or general hospital providers. For purposes of this section, termination includes nonrenewal. The written plan must explain:

(1) how the health plan company will inform affected enrollees, ~~insureds, or beneficiaries~~ about termination at least 30 days before the termination is effective, if the health plan company or health care network cooperative has received at least 120 days' prior notice;

(2) how the health plan company will inform the affected enrollees about what other participating providers are available to assume care and how it will facilitate an orderly transfer of its enrollees from the terminating provider to the new provider to maintain continuity of care;

(3) the procedures by which enrollees will be transferred to other participating providers, when special medical needs, special risks, or other special circumstances, such as cultural or language barriers, require them to have a longer transition period or be transferred to nonparticipating providers;

(4) who will identify enrollees with special medical needs or at special risk and what criteria will be used for this determination; and

(5) how continuity of care will be provided for enrollees identified as having special needs or at special risk, and whether the health plan company has assigned this responsibility to its contracted primary care providers.

(b) ~~If the contract termination was not for cause, enrollees can request a referral to the terminating provider for up to 120 days if they have special medical needs or have other special circumstances, such as cultural or language barriers. The health plan company can require medical records and other supporting documentation in support of the requested referral. Each request for referral to a terminating provider shall be considered by the health plan company on a case-by-case basis.;~~

(1) if the contract was terminated by the health plan company, the terminated provider and all enrollees being treated by that provider must be notified of the enrollees' rights to continuity of care with the terminated provider;

(2) the health plan company must provide, upon request, authorization to receive services that are otherwise covered under the terms of the health plan through the enrollee's current provider for up to 120 days if the enrollee is engaged in a current course of treatment for one or more of the following conditions:

(i) an acute condition;

(ii) a life-threatening mental or physical illness;

(iii) pregnancy beyond the first trimester of pregnancy;

(iv) a physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last for at least a year or can be expected to result in death; or

(v) a disabling or chronic condition that is in an acute phase; and

(3) the health plan company must provide, upon request, authorization to receive services that are otherwise covered under the terms of the health plan through the enrollee's current provider for the rest of the enrollee's life if a physician certifies that the enrollee has an expected lifetime of 180 days or less.

For all requests for authorization to receive services under this paragraph, the health plan company must grant the request unless the enrollee does not meet the criteria provided in this paragraph.

(c) The health plan company shall prepare a written plan that provides a process for coverage determinations regarding continuity of care of up to 120 days for enrollees who request continuity of care with their former provider, if the enrollee:

(1) is receiving culturally appropriate services and the health plan company does not have a provider in its preferred provider network with special expertise in the delivery of those culturally appropriate services within the time and distance requirements of section 62D.124, subdivision 1; or

(2) does not speak English and the health plan company does not have a provider in its preferred provider network who can communicate with the enrollee, either directly or through an interpreter, within the time and distance requirements of section 62D.124, subdivision 1.

The written plan must explain the criteria that will be used to determine whether a need for continuity of care exists and how it will be provided.

(d) This paragraph applies to requests under paragraph (b) or (c). The health plan company may require medical records and other supporting documentation to be submitted with the request for authorization. If an authorization is denied, the health plan company must explain the criteria it used to make its decision on the request for authorization. If an authorization is granted, the health plan company must explain how continuity of care will be provided.

(e) If the contract termination was for cause, enrollees must be notified of the change and transferred to participating providers in a timely manner so that health care services remain available and accessible to the affected enrollees. The health plan company is not required to refer an enrollee back to the terminating provider if the termination was for cause.

Subd. 2. [CHANGE IN HEALTH PLANS.] (a) The health plan company shall prepare a written plan that provides a process for coverage determinations for continuity of care for new enrollees with special needs, special risks, or other special circumstances, such as cultural or language barriers, who request continuity of care with their

former provider for up to 120 days. The written plan must explain the criteria that will be used for determining special needs cases, and how continuity of care will be provided. If an enrollee is subject to a change in health plans, the enrollee's new health plan company must provide, upon request:

(1) authorization to receive services that are otherwise covered under the terms of the new health plan through the enrollee's current provider for up to 120 days if the enrollee is engaged in a current course of treatment for one or more of the following conditions:

(i) an acute condition;

(ii) a life-threatening mental or physical illness;

(iii) pregnancy beyond the first trimester of pregnancy;

(iv) a physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last for at least a year or can be expected to result in death; or

(v) a disabling or chronic condition that is in an acute phase; and

(2) authorization to receive services that are otherwise covered under the terms of the health plan through the enrollee's current provider for the rest of the enrollee's life if a physician certifies that the enrollee has an expected lifetime of 180 days or less.

For all requests for authorization under this paragraph, the health plan company must grant the request for authorization unless the enrollee does not meet the criteria provided in this paragraph.

(b) The health plan company shall prepare a written plan that provides a process for coverage determinations regarding continuity of care of up to 120 days for new enrollees who request continuity of care with their former provider, if the new enrollee:

(1) is receiving culturally appropriate services and the health plan company does not have a provider in its preferred provider network with special expertise in the delivery of those culturally appropriate services within the time and distance requirements of section 62D.124, subdivision 1; or

(2) does not speak English and the health plan company does not have a provider in its preferred provider network who can communicate with the enrollee, either directly or through an interpreter, within the time and distance requirements of section 62D.124, subdivision 1.

The written plan must explain the criteria that will be used to determine whether a need for continuity of care exists and how it will be provided.

(c) This paragraph applies to requests under paragraph (a) or (b). The health plan company may require medical records and other supporting documentation to be submitted with the request for authorization. If an authorization is denied, the health plan company must explain the criteria it used to make its decision on the request for authorization. If an authorization is granted, the health plan company must explain how continuity of care will be provided.

~~(b)~~ (d) This subdivision applies only to group coverage and continuation and conversion coverage, and applies only to changes in health plans made by the employer.

Subd. 2a. [LIMITATIONS.] (a) Subdivisions 1 and 2 apply only if the enrollee's health care provider agrees to:

(1) accept as payment in full the lesser of the health plan company's reimbursement rate for in-network providers for the same or similar service or the enrollee's health care provider's regular fee for that service;

(2) adhere to the health plan company's preauthorization requirements; and

(3) provide the health plan company with all necessary medical information related to the care provided to the enrollee.

(b) Nothing in this section requires a health plan company to provide coverage for a health care service or treatment that is not covered under the enrollee's health plan.

Subd. 3. ~~[DISCLOSURES DISCLOSURE.] The written plans required under this section must be made available upon request to enrollees or prospective enrollees~~ Information regarding an enrollee's rights under this section must be included in member contracts or certificates of coverage and must be provided by a health plan company upon request of an enrollee or prospective enrollee.

Sec. 11. Minnesota Statutes 2000, section 62Q.58, is amended to read:

62Q.58 [ACCESS TO SPECIALTY CARE.]

Subdivision 1. [STANDING REFERRAL.] A health plan company shall establish a procedure by which an enrollee may apply for and, if appropriate, receive a standing referral to a health care provider who is a specialist if a referral to a specialist is required for coverage. This procedure for a standing referral must specify the necessary ~~criteria and conditions, which must be met in order for an enrollee to obtain a standing referral~~ managed care review and approval an enrollee must obtain before such a standing referral is permitted.

Subd. 1a. [MANDATORY STANDING REFERRAL.] An enrollee who requests a standing referral to a specialist qualified to treat the specific condition described in clauses (1) to (5) must be given a standing referral for visits to such a specialist if benefits for such treatment are provided under the health plan and the enrollee has any of the following conditions:

(1) a chronic health condition;

(2) a life-threatening mental or physical illness;

(3) pregnancy beyond the first trimester of pregnancy;

(4) a degenerative disease or disability; or

(5) any other condition or disease of sufficient seriousness and complexity to require treatment by a specialist.

Nothing in this section limits the application of section 62Q.52 specifying direct access to obstetricians and gynecologists.

Subd. 2. [COORDINATION OF SERVICES.] ~~A primary care provider or primary care group shall remain responsible for coordinating the care of an enrollee who has received a standing referral to a specialist. The specialist shall not make any secondary referrals related to primary care services without prior approval by the primary care provider or primary care group. However, An enrollee with a standing referral to a specialist may request primary care services from that specialist. The specialist, in agreement with the enrollee and primary care provider or primary care group, may elect to provide primary care services to that the enrollee, authorize tests and services, and make secondary referrals according to procedures established by the health plan company. The health plan company may limit the primary care services, tests and services, and secondary referrals authorized under this subdivision to those that are related to the specific condition or conditions for which the standing referral was made.~~

Subd. 3. [DISCLOSURE.] Information regarding referral procedures must be included in member contracts or certificates of coverage and must be provided to an enrollee or prospective enrollee by a health plan company upon request.

Subd. 4. [REFERRAL.] (a) If a standing referral is authorized under subdivision 1 or is mandatory under subdivision 1a, the health plan company must provide a referral to an appropriate participating specialist who is reasonably available and accessible to provide the treatment or to a nonparticipating specialist if the health plan company does not have an appropriate participating specialist who is reasonably available and accessible to treat the enrollee's condition or disease.

(b) If an enrollee receives services from a nonparticipating specialist because a participating specialist is not available, services must be provided at no additional cost to the enrollee beyond what the enrollee would otherwise pay for services received from a participating specialist.

Sec. 12. Minnesota Statutes 2000, section 253B.02, subdivision 10, is amended to read:

Subd. 10. [INTERESTED PERSON.] "Interested person" means:

(1) an adult, including but not limited to, a public official, including a local welfare agency acting under section 626.5561, and the legal guardian, spouse, parent, legal counsel, adult child, next of kin, or other person designated by a proposed patient; or

(2) a health plan company that is providing coverage for a proposed patient.

Sec. 13. Minnesota Statutes 2000, section 253B.045, subdivision 6, is amended to read:

Subd. 6. [COVERAGE.] A health plan company that provides coverage for mental health services must provide coverage, according to the terms of the policy, contract, or certificate of coverage, for all medically necessary covered comply with section 62Q.535 for all mental health services as determined by section 62Q.53 provided to an enrollee that are ordered by the court under this chapter. For purposes of this subdivision, "mental health services" has the meaning given in section 62Q.535, subdivision 1.

[EFFECTIVE DATE.] This section is effective July 1, 2001, and applies to contracts issued or renewed on or after that date.

Sec. 14. Minnesota Statutes 2000, section 253B.10, subdivision 4, is amended to read:

Subd. 4. [PRIVATE TREATMENT.] Patients or other responsible persons are required to pay the necessary charges for patients committed or transferred to private treatment facilities. Private treatment facilities may refuse to accept a committed person. Insurers must provide court-ordered treatment and services as ordered by the court under section 253B.045, subdivision 6, or as required under chapter 62M.

[EFFECTIVE DATE.] This section is effective July 1, 2001, and applies to contracts issued or renewed on or after that date.

Sec. 15. Minnesota Statutes 2000, section 260C.201, subdivision 1, is amended to read:

Subdivision 1. [DISPOSITIONS.] (a) If the court finds that the child is in need of protection or services or neglected and in foster care, it shall enter an order making any of the following dispositions of the case:

(1) place the child under the protective supervision of the local social services agency or child-placing agency in the home of a parent of the child under conditions prescribed by the court directed to the correction of the child's need for protection or services, or:

(i) the court may order the child into the home of a parent who does not otherwise have legal custody of the child, however, an order under this section does not confer legal custody on that parent;

(ii) if the court orders the child into the home of a father who is not adjudicated, he must cooperate with paternity establishment proceedings regarding the child in the appropriate jurisdiction as one of the conditions prescribed by the court for the child to continue in his home;

(iii) the court may order the child into the home of a noncustodial parent with conditions and may also order both the noncustodial and the custodial parent to comply with the requirements of a case plan under subdivision 2;

(2) transfer legal custody to one of the following:

(i) a child-placing agency; or

(ii) the local social services agency.

In placing a child whose custody has been transferred under this paragraph, the agencies shall follow the requirements of section 260C.193, subdivision 3;

(3) if the child has been adjudicated as a child in need of protection or services because the child is in need of special treatment and services or care for reasons of physical or mental health to treat or ameliorate a physical or mental disability, the court may order the child's parent, guardian, or custodian to provide it. If the parent, guardian, or custodian fails or is unable to provide this treatment or care, the court may order it provided. The court may also order the child's health plan company to provide mental health services to the child under section 62Q.535. Absent specific written findings by the court that the child's disability is the result of abuse or neglect by the child's parent or guardian, the court shall not transfer legal custody of the child for the purpose of obtaining special treatment or care solely because the parent is unable to provide the treatment or care. If the court's order for mental health treatment is based on a diagnosis made by a treatment professional, the court may order that the diagnosing professional not provide the treatment to the child if it finds that such an order is in the child's best interests; or

(4) if the court believes that the child has sufficient maturity and judgment and that it is in the best interests of the child, the court may order a child 16 years old or older to be allowed to live independently, either alone or with others as approved by the court under supervision the court considers appropriate, if the county board, after consultation with the court, has specifically authorized this dispositional alternative for a child.

(b) If the child was adjudicated in need of protection or services because the child is a runaway or habitual truant, the court may order any of the following dispositions in addition to or as alternatives to the dispositions authorized under paragraph (a):

(1) counsel the child or the child's parents, guardian, or custodian;

(2) place the child under the supervision of a probation officer or other suitable person in the child's own home under conditions prescribed by the court, including reasonable rules for the child's conduct and the conduct of the parents, guardian, or custodian, designed for the physical, mental, and moral well-being and behavior of the child; or with the consent of the commissioner of corrections, place the child in a group foster care facility which is under the commissioner's management and supervision;

(3) subject to the court's supervision, transfer legal custody of the child to one of the following:

(i) a reputable person of good moral character. No person may receive custody of two or more unrelated children unless licensed to operate a residential program under sections 245A.01 to 245A.16; or

(ii) a county probation officer for placement in a group foster home established under the direction of the juvenile court and licensed pursuant to section 241.021;

(4) require the child to pay a fine of up to \$100. The court shall order payment of the fine in a manner that will not impose undue financial hardship upon the child;

(5) require the child to participate in a community service project;

(6) order the child to undergo a chemical dependency evaluation and, if warranted by the evaluation, order participation by the child in a drug awareness program or an inpatient or outpatient chemical dependency treatment program;

(7) if the court believes that it is in the best interests of the child and of public safety that the child's driver's license or instruction permit be canceled, the court may order the commissioner of public safety to cancel the child's license or permit for any period up to the child's 18th birthday. If the child does not have a driver's license or permit, the court may order a denial of driving privileges for any period up to the child's 18th birthday. The court shall forward an order issued under this clause to the commissioner, who shall cancel the license or permit or deny driving privileges without a hearing for the period specified by the court. At any time before the expiration of the period of cancellation or denial, the court may, for good cause, order the commissioner of public safety to allow the child to apply for a license or permit, and the commissioner shall so authorize;

(8) order that the child's parent or legal guardian deliver the child to school at the beginning of each school day for a period of time specified by the court; or

(9) require the child to perform any other activities or participate in any other treatment programs deemed appropriate by the court.

To the extent practicable, the court shall enter a disposition order the same day it makes a finding that a child is in need of protection or services or neglected and in foster care, but in no event more than 15 days after the finding unless the court finds that the best interests of the child will be served by granting a delay. If the child was under eight years of age at the time the petition was filed, the disposition order must be entered within ten days of the finding and the court may not grant a delay unless good cause is shown and the court finds the best interests of the child will be served by the delay.

(c) If a child who is 14 years of age or older is adjudicated in need of protection or services because the child is a habitual truant and truancy procedures involving the child were previously dealt with by a school attendance review board or county attorney mediation program under section 260A.06 or 260A.07, the court shall order a cancellation or denial of driving privileges under paragraph (b), clause (7), for any period up to the child's 18th birthday.

(d) In the case of a child adjudicated in need of protection or services because the child has committed domestic abuse and been ordered excluded from the child's parent's home, the court shall dismiss jurisdiction if the court, at any time, finds the parent is able or willing to provide an alternative safe living arrangement for the child, as defined in Laws 1997, chapter 239, article 10, section 2.

#### Sec. 16. [QUALITY OF PATIENT CARE.]

The commissioner of health shall evaluate the feasibility of collecting data on the quality of patient care provided in hospitals, outpatient surgical centers, and other health care facilities. In the evaluation, the commissioner shall examine the appropriate roles of the public and private sectors and the need for risk-adjusting data. The evaluation must consider mechanisms to identify the quality of nursing care provided to consumers by examining variables such as skin breakdown and patient injuries. Any plan developed to collect data must also address issues related to the release of the data in a useful form to the public. The commissioner shall prepare and distribute a written report of the evaluation by January 15, 2002.

#### Sec. 17. [EFFECTIVE DATE.]

Sections 1 and 4 are effective for violations committed on or after August 1, 2001. Section 5 is effective beginning with the report for the 2001 calendar year. Sections 6 and 16 are effective the day following final enactment. Sections 2, 3, 10, and 11 are effective January 1, 2002, and apply to health plans issued or renewed on or after that date."

Delete the title and insert:

"A bill for an act relating to health; providing patient protections; requiring certain coverage; providing for cost-sharing; amending Minnesota Statutes 2000, sections 45.027, subdivision 6; 62D.02, subdivision 8; 62D.17, subdivision 1; 62J.38; 62M.02, subdivision 21; 62Q.56; 62Q.58; 253B.02, subdivision 10; 253B.045, subdivision 6; 253B.10, subdivision 4; 260C.201, subdivision 1; proposing coding for new law in Minnesota Statutes, chapters 62D; 62Q."

The motion prevailed and the amendment was adopted.

Goodno moved to amend S. F. No. 491, as amended, as follows:

Page 17, line 18, after the headnote, insert "(a)"

Page 17, line 30, before "Nothing" insert "(b)"

Page 17, after line 32, insert:

"(c) Paragraph (a) does not apply to health plans issued under sections 43A.23 to 43A.31."

The motion prevailed and the amendment was adopted.

Otremba moved to amend S. F. No. 491, as amended, as follows:

Pages 1 to 5, delete sections 2 and 3

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 Otremba amendment and the roll was called. There were 62 yeas and 70 nays as follows:

Those who voted in the affirmative were:

Anderson, I.	Folliard	Juhnke	Mahoney	Paymar	Swapinski
Bakk	Gleason	Kahn	Mariani	Pelowski	Thompson
Bernardy	Goodwin	Kalis	Marko	Peterson	Wagenius
Biernat	Gray	Kelliher	Marquart	Pugh	Walker
Carlson	Greiling	Koskinen	McGuire	Rukavina	Wasiluk
Clark, K.	Hausman	Kubly	Milbert	Schumacher	Wenzel
Davnie	Hilstrom	Larson	Mullery	Sertich	Winter
Dawkins	Hilty	Leighton	Murphy	Skoe	
Dibble	Jaros	Lenczewski	Opatz	Skoglund	
Dorn	Johnson, R.	Lieder	Osthoff	Slawik	
Evans	Johnson, S.	Luther	Otremba	Solberg	



Those who voted in the negative were:

Abrams	Dorman	Holberg	Lindner	Pawlenty	Tingelstad
Anderson, B.	Eastlund	Holsten	Lipman	Penas	Tuma
Bishop	Erhardt	Howes	Mares	Rhodes	Vandever
Boudreau	Erickson	Huntley	McElroy	Rifenberg	Walz
Bradley	Finseth	Jacobson	Molnau	Ruth	Westerberg
Buesgens	Fuller	Jennings	Mulder	Seagren	Westrom
Cassell	Gerlach	Johnson, J.	Ness	Seifert	Wilkin
Clark, J.	Goodno	Kielkucki	Nornes	Smith	Wolf
Daggett	Gunther	Knoblach	Olson	Stanek	Workman
Davids	Haas	Krinkie	Osskopp	Stang	Spk. Sviggum
Dehler	Hackbarth	Kuisle	Ozment	Swenson	
Dempsey	Harder	Leppik	Paulsen	Sykora	

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

Speaker pro tempore Abrams called Boudreau to the Chair.

Bradley and Huntley moved to amend S. F. No. 491, as amended, as follows:

Page 2, line 20, reinstate the second "~~The~~"

Page 2, lines 21 and 22, reinstate the stricken language

Page 3, line 12, before the period, insert ", as determined under Minnesota Rules, part 4685.0801, subpart 4"

Page 4, line 25, delete everything after "year"

Page 4, line 26, delete everything before the semicolon

Page 4, line 28, delete everything after the second "year"

Page 4, delete line 29

Page 4, line 30, delete "Index"

Page 4, line 35, delete everything after the period

Page 4, delete line 36

Page 5, delete line 1, and insert:

"Subd. 4. [CERTAIN PREVENTIVE CARE EXCEPTED.] No copayment, deductible, or annual out-of-pocket maximum amounts shall apply to section 62A.047 or preventive health care coverage as defined in Minnesota Rules, part 4685.0100, subpart 5, item E, including child health supervision, provider health screening, and prenatal care.

Subd. 5. [PUBLIC PROGRAMS.] This section does not apply to the prepaid medical assistance program, the MinnesotaCare program, the prepaid general assistance medical care program, the federal Medicare program, or health plans provided through any of those programs."

The motion prevailed and the amendment was adopted.

Winter and Otremba moved to amend S. F. No. 491, as amended, as follows:

Page 6, after line 3, insert:

"Sec. 5. Minnesota Statutes 2000, section 62J.04, is amended by adding a subdivision to read:

Subd. 1b. [RESTRICTION ON INCREASES IN PREMIUM RATES.] Effective for health plans issued or renewed during the 2002 calendar year, no health plan company may increase premium rates by more than five percent above the rate in effect during the 2001 calendar year for the same or similar health plan coverage issued by that health plan company. Section 62A.02 applies to changes in premium rates made under this subdivision. A health plan company that wishes to increase premium rates for a health plan for calendar year 2002 by more than five percent may apply to the commissioner for the authority to do so. The commissioner may approve such an application if the commissioner finds that an additional rate increase is necessary to prevent insolvency of the health plan company, or to permit adjustments to adverse events that have affected the health plan which the health plan company could not reasonably have anticipated. The commissioner's decision regarding increases in premium rates is subject to appeal under chapter 14. For purposes of this subdivision, "health plan" has the meaning given in section 62A.011, subdivision 3, but includes the coverages described in clauses (7) and (10)."

Page 23, after line 35, insert:

"Sec. 17. [RECOMMENDATIONS; LIMITING INCREASES IN PREMIUM RATES.]

The commissioners of health and commerce shall develop a schedule for limiting increases in health plan premium rates to reasonable levels in calendar years 2003, 2004, and 2005. This schedule, recommendations on its implementation, and recommendations for a process by which health plan companies may apply to raise premium rates above the levels in the schedule, must be submitted to the legislature by January 15, 2002.

Sec. 18. [COST PROVISION; RESTRICTION ON PREMIUM RATE INCREASES.]

For biennia beginning on or after July 1, 2001, any increased costs incurred by a state agency as a result of Minnesota Statutes, section 62J.04, subdivision 1b, must be absorbed internally by the state agency within its appropriation budgeted for professional and technical services."

Renumber the sections in sequence and correct internal references

Amend the title accordingly

A roll call was requested and properly seconded.

#### POINT OF ORDER

Goodno raised a point of order pursuant to rule 3.21 that the Winter and Otremba amendment was not in order. Speaker pro tempore Boudreau ruled the point of order not well taken and the Winter and Otremba amendment in order.

The question recurred on the Winter and Otremba amendment and the roll was called. There were 64 yeas and 69 nays as follows:

Those who voted in the affirmative were:

Abeler	Bernardy	Clark, K.	Dibble	Folliard	Gray
Anderson, I.	Biernat	Davnie	Dorn	Gleason	Greiling
Bakk	Carlson	Dawkins	Evans	Goodwin	Hausman

Hilstrom	Kahn	Lieder	Mullery	Schumacher	Wagenius
Hilty	Kalis	Luther	Murphy	Sertich	Walker
Howes	Kelliher	Mahoney	Osthoff	Skoe	Walz
Jaros	Koskinen	Mariani	Otremba	Skoglund	Wasiluk
Jennings	Kubly	Marko	Pelowski	Slawik	Wenzel
Johnson, R.	Larson	Marquart	Peterson	Solberg	Winter
Johnson, S.	Leighton	McGuire	Pugh	Swapinski	
Juhnke	Lenczewski	Milbert	Rukavina	Thompson	

Those who voted in the negative were:

Abrams	Dorman	Holberg	Mares	Paymar	Tingelstad
Anderson, B.	Eastlund	Holsten	McElroy	Penas	Tuma
Bishop	Erhardt	Huntley	Molnau	Rhodes	Vandever
Boudreau	Erickson	Jacobson	Mulder	Rifenberg	Westerberg
Bradley	Finseth	Johnson, J.	Ness	Ruth	Westrom
Buesgens	Fuller	Kielkucki	Nornes	Seagren	Wilkin
Cassell	Gerlach	Knoblach	Olson	Seifert	Wolf
Clark, J.	Goodno	Krinkie	Opatz	Smith	Workman
Daggett	Gunther	Kuisle	Osskopp	Stanek	Spk. Sviggum
Davids	Haas	Leppik	Ozment	Stang	
Dehler	Hackbarth	Lindner	Paulsen	Swenson	
Dempsey	Harder	Lipman	Pawlenty	Sykora	

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

Abrams moved to amend S. F. No. 491, as amended, as follows:

Page 8, after line 23, insert:

"Sec. 7. [62Q.121] [LICENSURE OF MEDICAL DIRECTORS.]

(a) No health plan company that has more than 50,000 enrollees in health plans in this state may employ a person as a medical director unless the person is licensed as a physician in this state.

(b) For purposes of this section, "medical director" means any person who makes recommendations or decisions, based upon medical training and knowledge, regarding the health plan company's medical protocols, medical policies, or treatment or coverage of treatment of a particular enrollee, regardless of whether the person's title is medical director, associate or assistant medical director, medical director for a specific subject area, chief medical officer, or similar title.

(c) This section applies only to medical directors who make recommendations or decisions that involve or affect enrollees who live in this state.

(d) Each health plan company that is subject to this section shall provide the commissioner with the names and licensure information of its medical directors and shall provide updates no later than 30 days after any changes."

Re-number 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 Abrams amendment and the roll was called. There were 128 yeas and 6 nays as follows:

Those who voted in the affirmative were:

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

Those who voted in the negative were:

Anderson, B.	Holberg	Krinkie	Olson	Smith	Wilkin
--------------	---------	---------	-------	-------	--------

The motion prevailed and the amendment was adopted.

S. F. No. 491, A bill for an act relating to health; providing patient protections; amending Minnesota Statutes 2000, sections 45.027, subdivision 6; 62D.17, subdivision 1; 62J.38; 62M.02, subdivision 21; 62Q.56; and 62Q.58; proposing coding for new law in Minnesota Statutes, chapter 62D.

The bill was read for the third time, as amended, and placed upon its final passage.

The question was taken on the passage of the bill and the roll was called. There were 134 yeas and 0 nays as follows:

Those who voted in the affirmative were:

Abeler	Bishop	Clark, K.	Dibble	Evans	Goodwin
Abrams	Boudreau	Daggett	Dorman	Finseth	Gray
Anderson, B.	Bradley	Davids	Dorn	Folliard	Greiling
Anderson, I.	Buesgens	Davnie	Eastlund	Fuller	Gunther
Bakk	Carlson	Dawkins	Entenza	Gerlach	Haas
Bernardy	Cassell	Dehler	Erhardt	Gleason	Hackbarth
Biernat	Clark, J.	Dempsey	Erickson	Goodno	Harder

Hausman	Kelliher	Mares	Osthoff	Seifert	Wagenius
Hilstrom	Kielkucki	Mariani	Otremba	Sertich	Walker
Hilty	Knoblach	Marko	Ozment	Skoe	Walz
Holberg	Koskinen	Marquart	Paulsen	Skoglund	Wasiluk
Holsten	Krinkie	McElroy	Pawlenty	Slawik	Wenzel
Howes	Kubly	McGuire	Paymar	Smith	Westerberg
Huntley	Kuisle	Milbert	Pelowski	Solberg	Westrom
Jacobson	Larson	Molnau	Penas	Stanek	Wilkin
Jaros	Leighton	Mulder	Peterson	Stang	Winter
Jennings	Lenczewski	Mullery	Pugh	Swapinski	Wolf
Johnson, J.	Leppik	Murphy	Rhodes	Swenson	Workman
Johnson, R.	Lieder	Ness	Rifenberg	Sykora	Spk. Sviggum
Johnson, S.	Lindner	Nornes	Rukavina	Thompson	
Juhnke	Lipman	Olson	Ruth	Tingelstad	
Kahn	Luther	Opatz	Schumacher	Tuma	
Kalis	Mahoney	Osskopp	Seagren	Vandever	

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

H. F. No. 905 was reported to the House.

Haas moved that H. F. No. 905 be continued on the Calendar for the Day. The motion prevailed.

S. F. No. 722 was reported to the House.

Wolf moved to amend S. F. No. 722, the second unofficial engrossment, as follows:

Page 58, line 33, after the period, insert "A utility may not be held liable to a customer for advice provided pursuant to this section."

Page 66, line 21, after "shall" insert ":(1)"

Page 66, line 23, after "116C.681" insert ":(2) recodify Minnesota Statutes, section 116.85, subdivision 1a, paragraph (e) as section 116.07, subdivision 4a, paragraph (c)"

Page 70, delete lines 27 to 31 and insert:

"Subd. 6. [COMMISSION AUTHORITY.] In addition to any other authority, the commission has the authority to resolve customer complaints against a public utility whether or not the complaint involves a violation of this chapter. The commission may delegate this authority to commission staff as it deems appropriate."

Page 73, line 1, after "rates" delete the rest of the line

Page 73, delete line 2

Page 73, line 3, delete "other appropriate mechanisms"

The motion prevailed and the amendment was adopted.

Ozment, Wolf and Jennings moved to amend S. F. No. 722, the second unofficial engrossment, as amended, as follows:

Page 32, delete lines 28 to 36, and insert:

"Sec. 3. Minnesota Statutes 2000, section 216B.241, subdivision 1, is amended to read:

Subdivision 1. [DEFINITIONS.] For purposes of this section and ~~section~~ sections 216B.16, subdivision 6b and 216B.2411, the terms defined in this subdivision have the meanings given them.

- (a) "Commission" means the public utilities commission.
- (b) "Commissioner" means the commissioner of ~~public service~~ commerce.
- (c) "Customer facility" means all buildings, structures, equipment, and installations at a single site.
- (d) "Department" means the department of ~~public service~~ commerce.
- (e) "Energy conservation improvement" means the purchase or installation of a device, method, material, or project that:
  - (1) 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) either (i) creates, converts, or actively uses energy from renewable sources such as solar, wind, and biomass, or (ii) recovers energy from heating, cooling or ventilation systems 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) 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; or
  - (4) 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.
- (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;
  - (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 such 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 20,000 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) "Load management" means an activity to change the timing or the efficiency of a customer's use of energy to reduce the demand for energy or capacity. A load management activity may be one of two types:

(1) a load management activity that increases the efficiency of energy services and that results in a demonstrable reduction in consumption of energy; or

(2) a load management activity that increases the efficiency of energy services, but that does not reduce energy consumption.

Sec. 4. Minnesota Statutes 2000, section 216B.241, subdivision 1a, is amended to read:

Subd. 1a. [INVESTMENT, EXPENDITURE, AND CONTRIBUTION; PUBLIC UTILITY.] (a) For purposes of this subdivision ~~and~~, subdivision 2 and section 216B.2411, "public utility" has the meaning given it in section 216B.02, subdivision 4. Unless a public utility has elected to be governed by the provisions of section 216B.2411, each public utility shall spend and invest for energy conservation improvements under this subdivision and subdivision 2 the following amounts:

(1) for a utility that furnishes gas service, 0.5 percent of its gross operating revenues from service provided in the state;

(2) for a utility that furnishes electric service, 1.5 percent of its gross operating revenues from service provided in the state; and

(3) for a utility that furnishes electric service and that operates a nuclear-powered electric generating plant within the state, two percent of its gross operating revenues from service provided in the state.

For purposes of this paragraph (a) and section 216B.2411, "gross operating revenues" do not include revenues from large electric customer facilities exempted by the commissioner ~~of the department of public service pursuant to~~ under paragraph (b).

(b) The owner of a large electric customer facility may petition the commissioner ~~of the department of public service~~ to exempt both electric and gas utilities serving the large energy customer facility from the investment and expenditure requirements of paragraph (a) or section 216B.2411, subdivision 3 with respect to retail revenues attributable to the facility. At a minimum, the petition must be supported by evidence relating to competitive or economic pressures on the customer and a showing by the customer of reasonable efforts to identify, evaluate, and implement cost-effective conservation improvements at the facility. 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 shall not grant an exemption if the commissioner determines that granting the exemption is contrary to the public interest. The commissioner may, after investigation, rescind any exemption granted under this paragraph upon a determination that cost-effective energy conservation improvements are available at the large electric customer facility. For the purposes of this paragraph, "cost-effective" means that the projected total cost of the energy conservation improvement at the large electric customer facility is less than the projected present value of the energy and demand savings resulting from the energy conservation improvement. 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 this paragraph.

(c) The commissioner may require investments or spending greater than the amounts required under this subdivision for a public utility whose most recent advance forecast required under section 216B.2422 or 216C.17 projects a peak demand deficit of 100 megawatts or greater within five years under mid-range forecast assumptions.

(d) A public utility or owner of a large electric customer facility may appeal a decision of the commissioner under paragraph (b) or (c) to the commission under subdivision 2. In reviewing a decision of the commissioner under paragraph (b) or (c), the commission shall rescind the decision if it finds that the required investments or spending will:

- (1) not result in cost-effective energy conservation improvements; or
- (2) otherwise not be in the public interest.

(e) Each utility shall determine what portion of the amount it sets aside for conservation improvement will be used for conservation improvements under subdivision 2 and what portion it will contribute to the energy and conservation account established in subdivision 2a. A public utility may propose to the commissioner to designate that all or a portion of funds contributed to the account established in subdivision 2a be used for research and development projects. Contributions must be remitted to the commissioner of public service by February 1 of each year. Nothing in this subdivision prohibits a public utility from spending or investing for energy conservation improvement more than required in this subdivision.

Sec. 5. Minnesota Statutes 2000, section 216B.241, subdivision 1b, is amended to read:

Subd. 1b. [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) Unless a cooperative electric association or municipality has elected to be governed by the provisions of section 216B.2411, 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 gross operating revenues from the sale of gas and one percent of its gross operating revenues from the sale of electricity not purchased from a public utility governed by subdivision 1a or a cooperative electric association governed by this subdivision, excluding gross operating revenues from electric and gas service provided in the state to large electric customer facilities; and

(2) for a cooperative electric association, 1.5 percent of its gross operating revenues from service provided in the state, excluding gross operating revenues from service provided in the state to large electric customer facilities indirectly through a distribution cooperative electric association.

(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, except that a municipality or association may not spend or invest for energy conservation improvements that directly benefit a large electric customer facility. 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. ~~Load management may be used to meet the requirements of this subdivision if it reduces the~~



~~demand for or increases the efficiency of electric services. An energy conservation improvement that is a load management activity described in subdivision 1, paragraph (h), clause (2), may only be used to meet the following percentage of the conservation investment and spending requirements of this subdivision:~~

- ~~(1) 2003 - 95 percent;~~
- ~~(2) 2004 - 85 percent;~~
- ~~(3) 2005 - 75 percent;~~
- ~~(4) 2006 and thereafter - 70 percent.~~

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.

(d) By February 1 of each year, each municipality or cooperative shall report to the commissioner its energy conservation improvement spending and investments with a brief analysis of effectiveness in reducing consumption of electricity or gas. The commissioner shall review each report and make recommendations, where appropriate, to the municipality or association to increase the effectiveness of conservation improvement activities. The commissioner shall also review each report for whether 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 are available. For the purposes of this subdivision and subdivision 2, "low-income" means an income of less than 185 percent of the federal poverty level.

(e) As part of its spending for conservation improvement, a municipality or association may contribute to the energy and conservation account. A municipality or association may propose to the commissioner to designate that all or a portion of funds contributed to the account be used for research and development projects. Any amount contributed must be remitted to the commissioner of public service by February 1 of each year.

Sec. 6. Minnesota Statutes 2000, section 216B.241, subdivision 2, is amended to read:

Subd. 2. [PROGRAMS.] (a) The commissioner may by rule or order require public utilities to make investments and expenditures in energy conservation improvements, explicitly setting forth the interest rates, prices, and terms under which the improvements must be offered to the customers. The required programs must cover a two-year period. The commissioner shall require at least one public utility to establish a pilot program to make investments in and expenditures for energy from renewable resources such as solar, wind, or biomass and shall give special consideration and encouragement to programs that bring about significant net savings through the use of energy-efficient lighting. The commissioner shall evaluate the program on the basis of cost-effectiveness and the reliability of technologies employed. The rules of the department must provide to the extent practicable for a free choice, by consumers participating in the program, of the device, method, material, or project constituting the energy conservation improvement and for a free choice of the seller, installer, or contractor of the energy conservation improvement, provided that the device, method, material, or project seller, installer, or contractor is duly licensed, certified, approved, or qualified, including under the residential conservation services program, where applicable.

(b) The commissioner may require a utility to make an energy conservation improvement investment or expenditure whenever the commissioner finds that the improvement will result in energy savings at a total cost to the utility less than the cost to the utility to produce or purchase an equivalent amount of new supply of energy. The commissioner shall nevertheless ensure that every public utility operate one or more programs under periodic review by the department.

(c) An energy conservation improvement that is a load management activity described in subdivision 1, paragraph (h), clause (1), may be used to meet the requirements for energy conservation improvements under this section if it results in a demonstrable reduction in consumption of energy.

(d) Each public utility subject to subdivision 1a 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. 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 subdivision 1a, paragraph (b). The commissioner shall consider and may require a utility to undertake a program suggested by an outside source, including a political subdivision or a nonprofit or community organization.

(e) No utility may make an energy conservation improvement under this section to a building envelope unless:

- (1) it is the primary supplier of energy used for either space heating or cooling in the building;
- (2) the commissioner determines that special circumstances, that would unduly restrict the availability of conservation programs, warrant otherwise; or
- (3) the utility has been awarded a contract under subdivision 2a.

(f) The commissioner 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 are available.

(g) A utility, a political subdivision, or a nonprofit or community organization that has suggested a program, 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 revoke a department decision under this section, and the commission may do so if it determines that the program is not 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.

Sec. 7. Minnesota Statutes 2000, section 216B.241, subdivision 2b, is amended to read:

Subd. 2b. [RECOVERY OF EXPENSES.] The commission shall allow a utility to recover expenses resulting from: (1) a conservation improvement program required by the department; (2) a conservation investment plan under section 216B.2411; and (3) contributions to the energy and conservation account, unless the recovery under clause (1), (2) or (3) 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. 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 1.75 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 of public service has issued an exemption under subdivision 1a, paragraph (b), and 0.6 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 of public service has issued an exemption under subdivision 1a, paragraph (b), for that year for energy conservation improvements under this section or section 216B.2411.

Sec. 8. Minnesota Statutes 2000, section 216B.241, subdivision 3, is amended to read:

Subd. 3. [OWNERSHIP OF ENERGY CONSERVATION IMPROVEMENT.] An energy conservation improvement made to or installed in a building in accordance with this section or section 216B.2411, 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.

Sec. 9. Minnesota Statutes 2000, section 216B.241, subdivision 5, is amended to read:

Subd. 5. [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 under this section or section 216B.2411 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 public utility, cooperative electric association, or municipal 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 are conservation improvement spending under this section or section 216B.2411.

Sec. 10. [216B.2411] [CONSERVATION INVESTMENT PROGRAM.]

Subdivision 1. [DEFINITIONS.] (a) The definitions of section 216B.241, subdivision 1, apply to this section.

(b) "Other qualifying energy conservation improvements" means the purchase or installation of a device, method, material, project, or service that either:

(1) is a renewable energy facility utilizing methane or other combustible gases derived from the processing of plant or animal wastes, or biomass fuels such as short-rotation woody or fibrous agricultural crops produced for conversion to useful energy;

(2) increases the ability of a customer to respond to price fluctuations in the wholesale power market and to control the amount and scheduling of energy consumed by the customer:

(i) through the utilization of software or other scheduling services or technology, in addition to the meter provided as part of the customer's electric service; or

(ii) through the installation of a distributed generation facility as described in section 216B.69, subdivision 2, clause (1); or

(3) is a load management activity as described in section 216B.241, subdivision 1, paragraph (h), clause (2).

Subd. 2. [ELECTION.] (a) Each utility providing conservation programs under section 216B.241 may elect to be governed by the provisions of this section in lieu of section 216B.241 by notifying the commissioner in writing by August 1 of each year. The election to provide energy conservation improvements under this section may not be rescinded by the utility without a finding by the commission that there is a good cause to do so.

(b) A public utility with an approved conservation improvement plan under section 216B.241 shall provide a plan to the commissioner with its election notice under paragraph (a), detailing how the utility plans to transition from providing conservation programs under section 216B.241 to providing programs under this section.

(c) Notwithstanding the election made under paragraph (a), each municipal utility and cooperative electric association shall provide the initial evaluation of conservation programs required under subdivision 8, paragraph (b), due by February 1, 2002.

Subd. 3. [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, 0.7 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, 2.0 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, 2.5 percent of its annual average gross operating revenues over the previous five years from service provided in the state.

"Gross operating revenues" do not include revenues from large electric customer facilities exempted by the commissioner under section 216B.241, subdivision 1a, paragraph (b), and the revenues from those facilities shall be deducted when calculating the utility's annual average gross operating revenues.

(b) An energy conservation improvement that is a load management activity described in section 216B.241, subdivision 1, paragraph (h), clause (1), may be used to meet the requirements for energy conservation improvements under this section.

(c) Up to 10 percent of the total amount required to be spent under this section may be spent on other qualifying energy conservation improvements described in subdivision 1, paragraph (b), clauses (1) to (3).

(d) Each public utility subject to subdivision 2 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. 4. [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, 0.7 percent of its annual average gross operating revenues over the previous five years from the sale of gas and 1.5 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, 2.0 percent of its annual average gross operating revenues over the previous five years from service provided in the state.

"Gross operating revenues" do not include revenues from large electric customer facilities exempted by the commissioner under section 216B.241, subdivision 1a, paragraph (b), and the revenues from those facilities shall be deducted when calculating the utility's annual average gross operating revenues.

(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) Up to 10 percent of the total amount required to be spent under this section may be spent on other qualifying energy conservation improvements described in subdivision 1, paragraph (b), clauses (1) and (2).

(f) Load management activities, as described in section 216B.241, subdivision 1, paragraph (h), clauses (1) and (2), may be used to meet the requirements for energy conservation improvements of this subdivision.

(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. 5. [PROGRAMS.] (a) The commissioner may by rule as resources allow, or by order, establish standards and criteria for the provision of energy conservation improvements under this section, 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, in proportion to the amount the utility has historically spent on such programs relative to the utility's annual gross revenues, unless an insufficient number of appropriate programs are 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 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. 6. [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. 7. [PLAN AND AUDIT; PUBLIC UTILITIES.] (a) By January 1, 2002, and every two years thereafter, each public utility shall provide the commissioner with the utility's conservation investment plan, detailing the utility's planned energy conservation improvements activities for the next two years, and the anticipated energy savings from those activities. This plan 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. The plan 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, 2004, and every two years thereafter, each public utility shall provide a report to the commissioner 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.

(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 one 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 alternative provider account under subdivision 10:

- (1) up to 25 percent of the utility's spending obligation under this section after the first negative evaluation;
- (2) up to 50 percent of the utility's conservation spending obligation under this section after the second negative evaluation; and
- (3) up to 100 percent of the utility's spending obligation under this section after the third negative evaluation.

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. 8. [PLAN AND PROGRAM EVALUATION; MUNICIPAL AND COOPERATIVE UTILITIES.] (a) By February 1, 2002, and every two years thereafter, each municipal utility and cooperative electric association shall provide the commissioner with the utility's or association's conservation investment plan for the next two years, detailing the utility's or association's planned energy conservation improvement activities and the anticipated energy savings on a biennial basis. This plan 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 plan must also indicate, for each type of activity, how much additional cost-effective conservation is likely to be achieved in subsequent years.

(b) With each filing under paragraph (a), each municipal utility or cooperative association shall also 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 cooperative electric 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. 9. [ADDITIONAL CONSERVATION ISSUES.] (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, unless the commission finds that such incentives are not in the public interest.

(c) The commissioner may request the commission to order an audit under subdivision 7, paragraph (b), or an evaluation under subdivision 8, paragraph (b), prior to the regularly scheduled audit or evaluation if the commissioner has reason to believe such an audit or evaluation is in the public interest. The commission shall grant the request if it finds the commissioner has shown sufficient cause to conduct the audit or evaluation. The commission's order may provide specific parameters for the audit or evaluation to ensure that areas of particular concern to the commissioner are addressed.

Subd. 10. [ALTERNATIVE PROVIDER FUND.] (a) An alternative provider fund is created as an account in the state treasury. Money in the fund is appropriated to the commissioner for the purposes provided in this subdivision. Earnings, such as interest, dividends, and any other earnings arising from fund assets, must be credited to the fund.

(b) The commissioner may contract with one or more private entities, following the issuance of request for proposals, to design and implement energy conservation initiatives in the service territory of a public utility that is the subject of a commission order under subdivision 7, paragraph (d). Such certification may not be for a period of longer than five years, but may be renewed. The commissioner shall establish in the contract by order the duties, standards, and procedures related to the operations of the private entity, as well as the procedures and criteria for selecting and certifying the private entity.



(c) Once certified, the private entity shall design and implement energy conservation initiatives. The initiatives must be designed and implemented to efficiently and effectively provide energy conservation services to energy consumers on a nondiscriminatory and cost-effective basis. The entity may provide services directly or under contracts with others, and may solicit and review proposals to implement energy conservation initiatives from any entity, including other private entities, local government units, community organizations, and utilities."

Delete page 33, line 1 to page 47, line 25

Page 66, after line 19, insert:

"Sec. 8. Minnesota Statutes 2000, section 216B.03, is amended to read:

216B.03 [REASONABLE RATE.]

(a) Every rate made, demanded, or received by any public utility, or by any two or more public utilities jointly, ~~shall~~ must be just and reasonable. Rates ~~shall~~ must not be unreasonably preferential; or unreasonably prejudicial or discriminatory, but ~~shall~~ must be sufficient, equitable and consistent in application to a class of consumers. To the maximum reasonable extent, the commission shall set rates to encourage energy conservation and renewable energy use and to further the goals of sections 216B.164, 216B.241, 216B.2411, and 216C.05. Any doubt as to reasonableness should be resolved in favor of the consumer.

(b) For rate-making purposes a public utility may treat two or more municipalities served by it as a single class wherever the populations are comparable in size or the conditions of service are similar.

Sec. 9. Minnesota Statutes 2000, section 216B.16, subdivision 1, is amended to read:

Subdivision 1. [NOTICE.] Unless the commission otherwise orders, no public utility shall change a rate ~~which~~ that has been duly established under this chapter, except upon 60 days' notice to the commission. The notice ~~shall~~ must include statements of facts, expert opinions, substantiating documents, and exhibits, supporting the change requested, and state the change proposed to be made in the rates then in force and the time when the modified rates will go into effect. ~~If the filing utility does not have an approved conservation improvement plan on file with the department of public service, it shall also include in its notice an energy conservation plan pursuant to section 216B.241.~~ The filing utility shall give written notice, as approved by the commission, of the proposed change to the governing body of each municipality and county in the area affected. All proposed changes ~~shall~~ must be shown by filing new schedules or ~~shall~~ be plainly indicated upon schedules on file and in force at the time.

Sec. 10. Minnesota Statutes 2000, section 216B.16, subdivision 6b, is amended to read:

Subd. 6b. [ENERGY CONSERVATION IMPROVEMENT.] (a) Except as otherwise provided in this subdivision, all investments and expenses of a public utility as defined in section 216B.241, subdivision 1, paragraph (e), incurred in connection with energy conservation improvements ~~shall~~ under either section 216B.241 or 216B.2411 must be recognized and included by the commission in the determination of just and reasonable rates as if the investments and expenses were directly made or incurred by the utility in furnishing utility service.

(b) After December 31, 1999, investments and expenses for energy conservation improvements ~~shall~~ must not be included by the commission in the determination of just and reasonable electric and gas rates for retail electric and gas service provided to large electric customer facilities that have been exempted by the commissioner ~~of the department of public service~~ pursuant to section 216B.241, subdivision 1a, paragraph (b). However, ~~no~~ a public utility ~~shall~~ may not be prevented from recovering its investment in energy conservation improvements from all customers that were made on or before December 31, 1999, in compliance with the requirements of section 216B.241.

(c) The commission may permit a public utility to file rate schedules providing for annual recovery of the costs of energy conservation improvements under either section 216B.241 or 216B.2411. These rate schedules may be applicable to less than all the customers in a class of retail customers if necessary to reflect the differing minimum spending requirements of section 216B.241, subdivision 1a. After December 31, 1999, the commission shall allow a public utility, without requiring a general rate filing under this section, to reduce the electric and gas rates applicable to large electric customer facilities that have been exempted by the commissioner of the department of public service pursuant to section 216B.241, subdivision 1a, paragraph (b), by an amount that reflects the elimination of energy conservation improvement investments or expenditures for those facilities required on or before December 31, 1999. ~~In the event that~~ If the commission has set electric or gas rates based on the use of an accounting methodology that results in the cost of conservation improvements being recovered from utility customers over a period of years, the rate reduction may occur in a series of steps to coincide with the recovery of balances due to the utility for conservation improvements made by the utility on or before December 31, 1999.

Sec. 11. Minnesota Statutes 2000, section 216B.16, subdivision 6c, is amended to read:

Subd. 6c. [INCENTIVE PLAN FOR ENERGY CONSERVATION IMPROVEMENT.] (a) The commission may order public utilities to develop and submit for commission approval incentive plans that describe the method of recovery and accounting for utility conservation expenditures and savings under either section 216B.241 or 216B.2411. In developing the incentive plans the commission shall ensure the effective involvement of interested parties.

(b) In approving incentive plans, the commission shall consider:

- (1) whether the plan is likely to increase utility investment in cost-effective energy conservation;
- (2) whether the plan is compatible with the interest of utility ratepayers and other interested parties;
- (3) whether the plan links the incentive to the utility's performance in achieving cost-effective conservation; and
- (4) whether the plan is in conflict with other provisions of this chapter.

(c) The commission may set rates to encourage the vigorous and effective implementation of utility conservation programs. The commission may:

- (1) increase or decrease any otherwise allowed rate of return on net investment based upon the utility's skill, efforts, and success in conserving energy;
- (2) share between ratepayers and utilities the net savings resulting from energy conservation programs to the extent justified by the utility's skill, efforts, and success in conserving energy; and
- (3) compensate the utility for earnings lost as a result of its conservation programs.

Sec. 12. Minnesota Statutes 2000, section 216B.162, subdivision 8, is amended to read:

Subd. 8. [ENERGY EFFICIENCY IMPROVEMENT; EXPENSE RECOVERY.] If the commission approves a competitive rate or the parties agree to a modified rate, the commission may require the electric utility to provide the customer with an energy audit and assist in implementing cost-effective energy efficiency improvements to assure that the customer's use of electricity is efficient. An investment in cost-effective energy conservation improvements required under this section must be treated as an energy conservation improvement program and included in the department's determination of significant investments under section 216B.241 or 216B.2411. The utility shall recover energy conservation improvement expenses in a rate proceeding under section 216B.16 or 216B.17 in the same manner as the commission authorizes for the recovery of conservation expenditures made under section 216B.241 or 216B.2411.

Sec. 13. Minnesota Statutes 2000, section 216B.164, subdivision 4, is amended to read:

Subd. 4. [PURCHASES; WHEELING; COSTS.] (a) Except as otherwise provided in paragraph (c), this subdivision shall apply to all qualifying facilities having 40-kilowatt capacity or more as well as qualifying facilities as defined in subdivision 3 which elect to be governed by its provisions.

(b) The utility to which the qualifying facility is interconnected shall purchase all energy and capacity made available by the qualifying facility. The qualifying facility shall be paid the utility's full avoided capacity and energy costs as negotiated by the parties, as set by the commission, or as determined through competitive bidding approved by the commission. The full avoided capacity and energy costs to be paid a qualifying facility that generates electric power by means of a renewable energy source are the utility's least cost renewable energy facility or the bid of a competing supplier of a least cost renewable energy facility, whichever is lower, unless the ~~commission's resource plan order, under section 216B.2422, subdivision 2, provides~~ commission determines that the use of a renewable resource to meet the identified capacity need is not in the public interest.

(c) For all qualifying facilities having 30-kilowatt capacity or more, the utility shall, at the qualifying facility's or the utility's request, provide wheeling or exchange agreements wherever practicable to sell the qualifying facility's output to any other Minnesota utility having generation expansion anticipated or planned for the ensuing ten years. The commission shall establish the methods and procedures to insure that except for reasonable wheeling charges and line losses, the qualifying facility receives the full avoided energy and capacity costs of the utility ultimately receiving the output.

(d) The commission shall set rates for electricity generated by renewable energy."

Page 66, line 21, delete "(a)"

Page 66, delete lines 24 to 29

Page 75, line 11, delete "sections 216B.241 and" and insert "section" and delete "are" and insert ", is"

Reorder 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.

Kubly and Kalis moved to amend S. F. No. 722, the second unofficial engrossment, as amended, as follows:

Pages 31 and 32, delete section 2 and insert:

"Sec. 2. [216B.169] [RENEWABLE ENERGY.]

Subdivision 1. [DEFINITIONS.] (a) "Renewable energy technology" means a technology that exclusively relies on an energy source that is naturally and sustainably regenerated over a short time and derived directly from the sun, indirectly from the sun, or from moving water or other natural movements and mechanisms of the environment. Renewable energy technologies include solar, wind, hydroelectric with a capacity of less than 60 megawatts, or biomass. For the purpose of this section, "biomass" does not include municipal solid waste. A renewable energy technology may not rely on energy resources derived from fossil fuels or waste products from fossil fuels.

(b) "Electric utility" means a public utility, municipal utility, cooperative electric association, or any other entity providing electric service to retail customers in Minnesota.

Subd. 2. [RENEWABLE ENERGY REQUIREMENTS.] (a) Unless the commission or governing body of a municipal utility or cooperative electric association acts under paragraph (b), each public utility, municipal utility, or cooperative electric association providing electric service to retail consumers in the state must comply with clauses (1) to (3):

(1) commencing in 2005, at least one percent of the electric energy an electric utility provides to its retail customers in Minnesota must be generated by renewable energy technologies and that amount must be increased by one percent each year until 2015;

(2) by 2015 at least 10 percent of the energy each electric utility provides to its retail customers in Minnesota must be generated by renewable energy technologies; and

(3) of the renewable energy technology generation required under clause (2), at least one percent of the energy must be generated by biomass energy technologies by 2010 and two percent by 2015.

(b) The commission or governing body shall review the requirement established in paragraph (a) annually and may decrease the requirement in any year if, for good cause and based upon independent and verifiable analysis, the commission or governing body finds the requirement will:

(1) cause rate increases to retail customers that exceed the benefits of utilizing renewable energy technology; or

(2) jeopardize electric supply reliability.

(c) An action to decrease the requirements of this section by a governing body of a municipal utility or cooperative electric association may be appealed to the voters of a municipality or the members of the cooperative association by a petition signed by five percent or more of the voting-age citizens of the municipality or an association's membership.

Subd. 3. [TRADEABLE CREDITS.] (a) To facilitate compliance with this section, the commission shall, by order, establish a program for tradeable credits for renewable energy under this section. For renewable energy other than biomass energy, the renewable credit program must allow for trading of credits for energy generated from renewable energy generation facilities operational after January 1, 2005. For biomass energy, the credit program shall allow for trading of credits for energy generated by renewable energy generation facilities operational on or after January 1, 2005. The commission shall establish separate prices for biomass renewable energy credits and nonbiomass renewable energy credits.

(b) Upon passage of a renewables portfolio standard in another state that includes the same definition of renewable energy technology and begins at a level commensurate to the existing level of renewables in that state, the department may facilitate the trading of renewable energy credits between parties located in this and that state."

Amend the title accordingly

A roll call was requested and properly seconded.

The question was taken on the Kubly and Kalis amendment and the roll was called. There were 63 yeas and 69 nays as follows:

Those who voted in the affirmative were:

Bakk	Carlson	Dawkins	Entenza	Gleason	Greiling
Bernardy	Clark, K.	Dibble	Evans	Goodwin	Hausman
Biernat	Davnie	Dorn	Folliard	Gray	Hilstrom

Hilty	Kelliher	Luther	Opatz	Skoe	Walker
Huntley	Koskinen	Mahoney	Otremba	Skoglund	Wasiluk
Jaros	Kubly	Mariani	Paymar	Slawik	Wenzel
Johnson, R.	Larson	Marko	Peterson	Solberg	Westerberg
Johnson, S.	Leighton	Marquart	Pugh	Swapinski	Winter
Juhnke	Lenczewski	McGuire	Rukavina	Thompson	
Kahn	Lieder	Mullery	Schumacher	Tuma	
Kalis	Lipman	Murphy	Sertich	Wagenius	

Those who voted in the negative were:

Abeler	Dehler	Hackbarth	Leppik	Pawlenty	Sykora
Abrams	Dempsey	Harder	Lindner	Pelowski	Tingelstad
Anderson, B.	Dorman	Holberg	Mares	Penas	Vandever
Anderson, I.	Eastlund	Holsten	McElroy	Rhodes	Walz
Bishop	Erhardt	Howes	Molnau	Rifenberg	Westrom
Boudreau	Erickson	Jacobson	Mulder	Ruth	Wilkin
Bradley	Finseth	Jennings	Ness	Seagren	Wolf
Buesgens	Fuller	Johnson, J.	Nornes	Seifert	Workman
Cassell	Gerlach	Kielkucki	Olson	Smith	Spk. Sviggum
Clark, J.	Goodno	Knoblach	Osskopp	Stanek	
Daggett	Gunther	Krinkie	Ozment	Stang	
Davids	Haas	Kuisle	Paulsen	Swenson	

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

Jennings moved to amend S. F. No. 722, the second unofficial engrossment, as amended, as follows:

Page 11, after line 30, insert:

"Sec. 12. [RECOMMENDATIONS FOR FURTHER STREAMLINING.]

As part of the energy security blueprint due by December 15, 2001, the commissioner, in consultation with the director of state planning, and the members and executive secretary of the public utilities commission, shall provide recommendations and options for further streamlining of the procedures for certificate of need, routing and siting, environmental review, and permitting of energy facilities. The commissioner shall specifically address the advantages and disadvantages of transferring the administration of the power plant siting act, Minnesota Statutes, sections 116C.51 to 116C.69 from the environmental quality board to the public utilities commission, thereby consolidating the necessary review and permitting procedures in a single agency."

Reorder the sections in sequence and correct internal references

Amend the title accordingly

The motion prevailed and the amendment was adopted.

Jennings moved to amend S. F. No. 722, the second unofficial engrossment, as amended, as follows:

Page 49, line 33, after "(5)" insert "for" and after "utility" insert a comma

Page 49, delete lines 34 to 36 and insert "the commission has authority over the activities, services and rates of the joint venture, and may exercise that authority, to the same extent the commission has authority over the activities, services and rates of the investor-owned utility itself."

The motion prevailed and the amendment was adopted.

Jennings moved to amend S. F. No. 722, the second unofficial engrossment, as amended, as follows:

Page 53, line 12, before "The" insert "(a)"

Page 53, line 20, after the period, insert:

"(b) A large electric customer facility as defined in Minnesota Statutes, section 216B.241, subdivision 1, that is exempt from the investment and expenditure requirements of Minnesota Statutes, section 216B.241, by virtue of a contract approved by the public utilities commission prior to April 15, 2001, under Minnesota Statutes, section 216B.162, shall remain exempt from those requirements until April 15, 2006.

(c)"

Page 53, line 20, delete "provision" and insert "section"

Page 53, delete lines 21 to 23 and insert "monthly peak measured demand for three consecutive months exceeds 110 percent of the annual peak measured demand of the facility in the year the exemption was granted."

The motion prevailed and the amendment was adopted.

Peterson moved to amend S. F. No. 722, the second unofficial engrossment, as amended, as follows:

Page 84, after line 9, insert:

## "ARTICLE 8

### ENERGY INDEPENDENCE TASK FORCE

Section 1. [ENERGY INDEPENDENCE GOAL; TIMELINE.]

(a) Minnesota consumers, especially commercial enterprises involved in farming, forestry products, mining, transportation, product processing, and tourism, rely heavily on the continued availability of energy supplies at a stable and predictable cost. Foreign energy sources cannot be relied upon for either availability or cost. It is therefore appropriate for Minnesota to establish a domestic energy program to ensure that the state is never held hostage to the whims of foreign energy delivery by outside interests.

(b) By July 1, 2030, the state of Minnesota intends to provide at least 50 percent of its energy needs from sources indigenous to the state.

Sec. 2. [TASK FORCE; DUTIES; CREATION.]

(a) The commissioner of commerce, in consultation with the commissioners of agriculture, transportation, and economic development shall oversee the activities of a task force of 21 members whose principal responsibility is to develop an energy policy for the state that will emphasize locally derived and locally developed energy sources to meet the energy demands of the state.

(b) Members of the task force consist of:

(1) the four commissioners identified in paragraph (a) or their designees;

(2) two citizen members appointed by each of the commissioners;

(3) three citizen members appointed by the governor;

(4) three members appointed by the senate rules and administration subcommittee on committees; and

(5) three members appointed by the speaker of the house of representatives.

(c) Terms, compensation, and removal of citizen members of the task force are governed by Minnesota Statutes, section 15.059.

(d) The task force does not have a predetermined expiration date.

Sec. 3. [ALTERNATIVE AND RENEWABLE ENERGY SOURCE DEVELOPMENT.]

(a) The task force shall evaluate options and priorities related to the goal of energy independence. Options must include:

(1) the development and production of energy from alternative, nontraditional, and renewable sources; and

(2) energy conservation measures.

(b) To the maximum extent practicable, the task force shall give priority in energy source development to resources derived from agricultural production and to energy options available in rural parts of the state. These energy sources include, but are not limited to:

(1) alternative diesel engine fuels derived from soybean and other agricultural plant oils or animal fats;

(2) ethanol derived from grains or other agricultural products or byproducts;

(3) methane or other combustible gases derived from the processing of plant or animal wastes;

(4) biomass fuels such as short-rotation woody or fibrous agricultural crops produced for conversion to useful energy; and

(5) further development of the solar, wind, and biomass energy potential in rural areas of the state.

Sec. 4. [ANNUAL REPORTS; RECOMMENDATIONS.]

By February 15, 2002, and February 15 of each year thereafter, the commissioner of commerce shall deliver a summary report to appropriate committees of the legislature on activities and recommendations of the task force, including any recommended changes in law or rule needed to accomplish the state's goal of energy independence."

Amend the title accordingly

A roll call was requested and properly seconded.

The question was taken on the Peterson amendment and the roll was called. There were 58 yeas and 75 nays as follows:

Those who voted in the affirmative were:

Anderson, I.	Entenza	Hilty	Kubly	Otremba	Solberg
Bakk	Evans	Huntley	Leighton	Paymar	Swapinski
Bernardy	Folliard	Jaros	Lieder	Pelowski	Thompson
Biernat	Gleason	Johnson, R.	Luther	Peterson	Wagenius
Carlson	Goodwin	Johnson, S.	Mariani	Pugh	Walker
Clark, K.	Gray	Juhnke	Marquart	Rukavina	Wasiluk
Davnie	Greiling	Kahn	McGuire	Sertich	Wenzel
Dawkins	Harder	Kalis	Milbert	Skoe	Winter
Dibble	Hausman	Kelliher	Mullery	Skoglund	
Dorn	Hilstrom	Koskinen	Murphy	Slawik	

Those who voted in the negative were:

Abeler	Dorman	Howes	Mahoney	Pawlenty	Tingelstad
Abrams	Eastlund	Jacobson	Mares	Penas	Tuma
Anderson, B.	Erhardt	Jennings	Marko	Rhodes	Vandever
Bishop	Erickson	Johnson, J.	McElroy	Rifenberg	Walz
Boudreau	Finseth	Kielkucki	Molnau	Ruth	Westerberg
Bradley	Fuller	Knoblach	Mulder	Schumacher	Westrom
Buesgens	Gerlach	Krinkie	Ness	Seagren	Wilkin
Cassell	Goodno	Kuisele	Nornes	Seifert	Wolf
Clark, J.	Gunther	Larson	Olson	Smith	Workman
Daggett	Haas	Lenczewski	Opatz	Stanek	Spk. Sviggum
Davids	Hackbarth	Leppik	Osskopp	Stang	
Dehler	Holberg	Lindner	Ozment	Swenson	
Dempsey	Holsten	Lipman	Paulsen	Sykora	

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

The Speaker called Abrams to the Chair.

Huntley offered an amendment to S. F. No. 722, the second unofficial engrossment, as amended.

#### POINT OF ORDER

Holsten raised a point of order pursuant to rule 4.03, relating to Ways and Means Committee; Budget Resolution; Effect on Expenditure and Revenue Bills, that the Huntley amendment was not in order. Speaker pro tempore Abrams ruled the point of order well taken and the Huntley amendment out of order.

Mariani offered an amendment to S. F. No. 722, the second unofficial engrossment, as amended.

#### POINT OF ORDER

Holsten raised a point of order pursuant to rule 3.21 that the Mariani amendment was not in order. Speaker pro tempore Abrams ruled the point of order well taken and the Mariani amendment out of order.



Ozment moved to amend S. F. No. 722, the second unofficial engrossment, as amended, as follows:

Page 75, after line 9, insert:

"Sec. 9. [ALTERNATIVE AND RENEWABLE ENERGY SOURCE DEVELOPMENT.]

(a) The electric energy task force shall evaluate options and priorities related to the goal of energy independence. Options must include:

(1) the development and production of energy from alternative, nontraditional, and renewable sources; and

(2) energy conservation measures.

(b) To the maximum extent practicable, the task force shall give priority in energy source development to resources derived from agricultural production and to energy options available in rural parts of the state. These energy sources include, but are not limited to:

(1) alternative diesel engine fuels derived from soybean and other agricultural plant oils or animal fats;

(2) ethanol derived from grains or other agricultural products or byproducts;

(3) methane or other combustible gases derived from the processing of plant or animal wastes;

(4) biomass fuels such as short-rotation woody or fibrous agricultural crops produced for conversion to useful energy; and

(5) further development of the solar, wind, and biomass energy potential in rural areas of the state."

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 Ozment amendment and the roll was called. There were 133 yeas and 0 nays as follows:

Those who voted in the affirmative were:

Abeler	Clark, K.	Evans	Hausman	Kahn	Lindner
Abrams	Daggett	Finseth	Hilstrom	Kalis	Lipman
Anderson, B.	Davids	Folliard	Hilty	Kelliher	Luther
Anderson, I.	Davnie	Fuller	Holberg	Kielkucki	Mahoney
Bakk	Dawkins	Gerlach	Holsten	Knoblach	Mares
Bernardy	Dehler	Gleason	Howes	Koskinen	Mariani
Biernat	Dempsey	Goodno	Huntley	Krinkie	Marko
Bishop	Dibble	Goodwin	Jacobson	Kubly	Marquart
Boudreau	Dorman	Gray	Jaros	Kuisle	McElroy
Bradley	Dorn	Greiling	Jennings	Larson	McGuire
Buesgens	Eastlund	Gunther	Johnson, J.	Leighton	Milbert
Carlson	Entenza	Haas	Johnson, R.	Lenczewski	Molnau
Cassell	Erhardt	Hackbarth	Johnson, S.	Leppik	Mulder
Clark, J.	Erickson	Harder	Juhnke	Lieder	Mullery

Murphy	Pawlenty	Ruth	Solberg	Vandever	Winter
Ness	Paymar	Schumacher	Stanek	Wagenius	Wolf
Nornes	Pelowski	Seagren	Stang	Walker	Workman
Olson	Penas	Seifert	Swapinski	Walz	Spk. Sviggum
Opatz	Peterson	Sertich	Swenson	Wasiluk	
Osskopp	Pugh	Skoe	Sykora	Wenzel	
Otremba	Rhodes	Skoglund	Thompson	Westerberg	
Ozment	Rifenberg	Slawik	Tingelstad	Westrom	
Paulsen	Rukavina	Smith	Tuma	Wilkin	

The motion prevailed and the amendment was adopted.

Wagenius and Hilty moved to amend S. F. No. 722, the second unofficial engrossment, as amended, as follows:

Page 32, after line 27, insert:

"Sec. 2. Minnesota Statutes 2000, section 216B.241, subdivision 1c, is amended to read:

Subd. 1c. ~~[ENERGY-SAVING GOALS REQUIREMENTS.]~~ (a) There is hereby established an annual energy capacity conservation savings goal of 200 megawatts.

(b) If the commissioner determines that conservation is more cost-effective than building new electricity supplies, the commissioner shall establish energy-saving goals develop and assign capacity and energy savings requirements for energy conservation improvement expenditures and each public utility, cooperative electric association and municipal utility providing electric service consistent with the goal established in paragraph (a). The commissioner shall evaluate and monitor each utility's energy conservation improvement program on how well it meets the goals set programs for success in meeting those requirements.

(c) The commissioner shall allocate the annual capacity savings goal among these utilities based on:

(1) the total revenues of the utility;

(2) the rate of load growth; and

(3) its past conservation activities and the potential for cost-effective conservation initiatives in its service territory.

(d) For the purposes of this section, "cost-effective" means that the cost per unit of conserved energy is less than the cost per unit of electricity from new supplies, over the term of the conservation initiative.

(e) Each utility or association shall incorporate these conservation requirements into the utility's or association's conservation plans under this section or section 216B.2411, and amounts spent to achieve the requirements under this section shall count toward the utility's or association's conservation spending obligations under those sections."

Page 53, after line 23, insert:

"Sec. 8. [ADDITIONAL CONSERVATION.]

As part of the energy security blueprint to be published by the commissioner by December 15, 2001, the commissioner shall propose to the legislature reasonable and achievable policy initiatives, activities, tax and other incentives, and requirements that, taken together, could achieve a minimum of 50 megawatts of energy capacity

conservation statewide, in addition to the energy conservation initiatives undertaken under sections 216B.241 or 216B.2411."

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 Wagenius and Hilty amendment and the roll was called. There were 60 yeas and 74 nays as follows:

Those who voted in the affirmative were:

Abeler	Evans	Jaros	Leighton	Opatz	Slawik
Bernardy	Folliard	Jennings	Lenczewski	Osthoff	Solberg
Biernat	Gleason	Johnson, R.	Lieder	Otremba	Swapinski
Carlson	Goodwin	Johnson, S.	Luther	Paymar	Thompson
Clark, K.	Gray	Kahn	Mariani	Pelowski	Vandever
Davnie	Greiling	Kalis	Marquart	Peterson	Wagenius
Dawkins	Hausman	Kelliher	McGuire	Pugh	Walker
Dibble	Hilstrom	Koskinen	Milbert	Sertich	Wasiluk
Dorn	Hilty	Kubly	Mullery	Skoe	Westerberg
Entenza	Huntley	Larson	Murphy	Skoglund	Winter

Those who voted in the negative were:

Abrams	Dempsey	Holberg	Mahoney	Penas	Tingelstad
Anderson, B.	Dorman	Holsten	Mares	Rhodes	Tuma
Anderson, I.	Eastlund	Hoves	Marko	Rifenberg	Walz
Bakk	Erhardt	Jacobson	McElroy	Rukavina	Wenzel
Bishop	Erickson	Johnson, J.	Molnau	Ruth	Westrom
Boudreau	Finseth	Juhnke	Mulder	Schumacher	Wilkin
Bradley	Fuller	Kielkucki	Ness	Seagren	Wolf
Buesgens	Gerlach	Knoblach	Nornes	Seifert	Workman
Cassell	Goodno	Krinkie	Olson	Smith	Spk. Sviggum
Clark, J.	Gunther	Kuisle	Osskopp	Stanek	
Daggett	Haas	Leppik	Ozment	Stang	
Davids	Hackbarth	Lindner	Paulsen	Swenson	
Dehler	Harder	Lipman	Pawlenty	Sykora	

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

The Speaker resumed the Chair.

Evans, Goodwin, Bernardy, Hilty, Lieder, Kalis and Walker offered an amendment to S. F. No. 722, the second unofficial engrossment, as amended.

## POINT OF ORDER

McElroy raised a point of order pursuant to rule 4.03, relating to Ways and Means Committee; Budget Resolution; Effect on Expenditure and Revenue Bills that the Evans et al amendment was not in order. The Speaker ruled the point of order well taken and the Evans et al amendment out of order.

Mariani moved to amend S. F. No. 722, the second unofficial engrossment, as amended, as follows:

Page 3, line 27, before "In" insert "(a)"

Page 3, line 32, after "with" insert "paragraph (b) and"

Page 4, after line 2, insert:

"(b) Consistent with the policy established in paragraph (a), each boiler at a coal-fired electric generating facility in a metropolitan county, as defined in section 473.121, subdivision 4, must be brought into compliance with new source performance standards and maximum achievable control technology standards adopted under the federal Clean Air Act, United States Code, Title 42, section 7401 et seq., by June 30, 2007."

Page 70, after line 31, insert:

"Sec. 6. Minnesota Statutes 2000, section 216B.16, is amended by adding a subdivision to read:

Subd. 6e. [COSTS OF COMPLIANCE RECOVERABLE.] In a determination of a rate-regulated utility's rates under this section, the commission shall recognize and allow recovery of all prudent and reasonable costs incurred by the utility in complying with the requirements of section 216B.013, paragraph (b). Alternatively, the commission may allow the utility to recover those costs by any appropriate mechanism outside of a general rate case, if it finds recovery outside of a general rate case to be consistent with the public interest."

Renumber the sections in sequence and correct internal references

Amend the title accordingly

A roll call was requested and properly seconded.

The question was taken on the Mariani amendment and the roll was called. There were 42 yeas and 87 nays as follows:

Those who voted in the affirmative were:

Abeler	Entenza	Hilstrom	Kelliher	Marko	Pugh
Bernardy	Folliard	Hilty	Koskinen	McGuire	Skoglund
Biernat	Gleason	Huntley	Larson	Milbert	Slawik
Carlson	Goodwin	Jaros	Lieder	Mullery	Swapinski
Davnie	Gray	Johnson, S.	Luther	Murphy	Wagenius
Dawkins	Greiling	Kahn	Mahoney	Paymar	Wasiluk
Dorn	Hausman	Kalis	Mariani	Peterson	Westerberg

Those who voted in the negative were:

Abrams	Bakk	Bradley	Clark, J.	Dehler	Eastlund
Anderson, B.	Bishop	Buesgens	Daggett	Dempsey	Erhardt
Anderson, I.	Boudreau	Cassell	Davids	Dorman	Erickson

Finseth	Jennings	Lipman	Otremba	Seifert	Vandever
Fuller	Johnson, J.	Mares	Ozment	Sertich	Walz
Gerlach	Juhnke	Marquart	Paulsen	Skoe	Wenzel
Goodno	Kielkucki	McElroy	Pawlenty	Smith	Westrom
Gunther	Knoblach	Molnau	Pelowski	Solberg	Wilkin
Haas	Krinkie	Mulder	Penas	Stanek	Winter
Hackbarth	Kubly	Ness	Rhodes	Stang	Wolf
Harder	Kuisle	Nornes	Rifenberg	Swenson	Workman
Holberg	Leighton	Olson	Rukavina	Sykora	Spk. Sviggum
Holsten	Lenczewski	Opatz	Ruth	Thompson	
Howes	Leppik	Osskopp	Schumacher	Tingelstad	
Jacobson	Lindner	Osthoff	Seagren	Tuma	

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

Hilty moved to amend S. F. No. 722, the second unofficial engrossment, as amended, as follows:

Page 5, line 4, before "The" insert "Subdivision 1. [GENERAL REQUIREMENTS.]"

Page 5, after line 19, insert:

"Subd. 2. [RENEWABLE ENERGY TECHNOLOGIES.] (a) At least one-third of the amount of new generation capacity and energy the commissioner forecasts under subdivision 1 is needed after 2005 to serve Minnesota consumers must be renewable energy generation. For the purposes of this section, renewable energy generation means generation technologies that utilize:

(1) methane or other combustible gases derived from the processing of agricultural plant or animal wastes;

(2) biomass fuels such as short-rotation woody or fibrous agricultural crops produced for conversion to useful energy;

(3) wind, and solar projects; or

(4) hydropower projects of less than 60 megawatts of capacity.

(b) The commission may not approve a certificate of need under section 216B.243, or a power purchase contract of greater than 5 years, and the environmental quality board may not issue a site permit under sections 116C.57 or 116C.575, for any generation project constructed and placed into service after 2005 without a determination by the commissioner that the project is consistent with the requirement of paragraph (a).

(c) Paragraph (b) does not apply:

(1) to a project that the commission, or the governing body of a municipal utility or cooperative electric association determines, based on independent analysis, that its application is not in the public interest; or

(2) after the commission certifies that at least 20 percent of the state's electricity is generated by renewable energy generation."

A roll call was requested and properly seconded.

The question was taken on the Hilty amendment and the roll was called. There were 64 yeas and 68 nays as follows:

Those who voted in the affirmative were:

Abeler	Entenza	Jaros	Lenczewski	Osthoff	Solberg
Anderson, I.	Evans	Johnson, R.	Lieder	Otremba	Swapinski
Bakk	Folliard	Johnson, S.	Luther	Paymar	Thompson
Bernardy	Gleason	Juhnke	Mariani	Peterson	Wagenius
Biernat	Goodwin	Kahn	Marko	Pugh	Walker
Carlson	Gray	Kalis	Marquart	Rukavina	Wasiluk
Clark, K.	Greiling	Kelliher	McGuire	Schumacher	Wenzel
Davnie	Hausman	Koskinen	Milbert	Sertich	Westerberg
Dawkins	Hilstrom	Kubly	Mullery	Skoe	Winter
Dibble	Hilty	Larson	Murphy	Skoglund	
Dorn	Huntley	Leighton	Opatz	Slawik	

Those who voted in the negative were:

Abrams	Dorman	Holberg	Lipman	Pelowski	Tuma
Anderson, B.	Eastlund	Holsten	Mares	Rhodes	Vandev eer
Bishop	Erhardt	Howes	McElroy	Rifenberg	Walz
Boudreau	Erickson	Jacobson	Molnau	Ruth	Westrom
Bradley	Finseth	Jennings	Mulder	Seagren	Wilkin
Buesgens	Fuller	Johnson, J.	Ness	Seifert	Wolf
Cassell	Gerlach	Kielkucki	Nornes	Smith	Workman
Clark, J.	Goodno	Knoblach	Olson	Stanek	Spk. Sviggum
Daggett	Gunther	Krinkie	Osskopp	Stang	
Davids	Haas	Kuisle	Ozment	Swenson	
Dehler	Hackbarth	Leppik	Paulsen	Sykora	
Dempsey	Harder	Lindner	Pawlenty	Tingelstad	

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

Kahn moved to amend S. F. No. 722, the second unofficial engrossment, as amended, as follows:

Page 32, after line 27, insert:

"Sec. 2. Minnesota Statutes 2000, section 216B.241, subdivision 1c, is amended to read:

Subd. 1c. [ENERGY-SAVING GOALS.] (a) If the commissioner determines that conservation is more cost-effective than building new electricity supplies, the commissioner shall establish energy-saving goals develop and assign capacity and energy savings goals for energy conservation improvement expenditures and each public utility, cooperative electric association and municipal utility providing electric service. The commissioner shall evaluate an monitor each utility's energy conservation improvement program on how well it meets the goals set programs for success in meeting those goals.

(b) The commissioner shall establish annual capacity savings goals among utilities based on:

(1) the total revenues of the utility;

(2) the rate of load growth; and

(3) its past conservation activities and the potential for cost-effective conservation initiatives in its service territory.

(c) For the purposes of this section, "cost-effective" means that the cost per unit of conserved energy is less than the cost per unit of electricity from new supplies, over the term of the conservation initiative.

(d) Each utility or association shall incorporate these conservation goals into the utility's or association's conservation plans under this section or section 216B.2411, and amounts spent to achieve the goals under this section shall count toward the utility's or association's conservation spending obligations under those sections."

Page 53, after line 23, insert:

"Sec. 8. [ADDITIONAL CONSERVATION.]

As part of the energy security blueprint to be published by the commissioner by December 15, 2001, the commissioner shall propose to the legislature reasonable and achievable policy initiatives, activities, tax and other incentives, and requirements, in addition to the energy conservation initiatives undertaken under section 216B.241 or 216B.2411."

Renumber the sections in sequence and correct internal references

Amend the title accordingly

A roll call was requested and properly seconded.

The Speaker called Boudreau to the Chair.

The question was taken on the Kahn amendment and the roll was called. There were 63 yeas and 70 nays as follows:

Those who voted in the affirmative were:

Abeler	Entenza	Jaros	Leppik	Opatz	Swapinski
Anderson, I.	Evans	Jennings	Lieder	Osthoff	Thompson
Bakk	Folliard	Johnson, R.	Luther	Otremba	Wagenius
Bernardy	Gleason	Johnson, S.	Mahoney	Paymar	Walker
Biernat	Goodwin	Kahn	Mariani	Pugh	Wasiluk
Carlson	Gray	Kalis	Marko	Rukavina	Wenzel
Clark, K.	Greiling	Kelliher	Marquart	Sertich	Westerberg
Davnie	Hausman	Koskinen	McGuire	Skoe	Winter
Dawkins	Hilstrom	Larson	Milbert	Skoglund	
Dibble	Hilty	Leighton	Mullery	Slawik	
Dorn	Huntley	Lenczewski	Murphy	Solberg	

Those who voted in the negative were:

Abrams	Clark, J.	Erhardt	Haas	Johnson, J.	Lindner
Anderson, B.	Daggett	Erickson	Hackbarth	Juhnke	Lipman
Bishop	Davids	Finseth	Harder	Kielkucki	Mares
Boudreau	Dehler	Fuller	Holberg	Knoblach	McElroy
Bradley	Dempsey	Gerlach	Holsten	Krinkie	Molnau
Buesgens	Dorman	Goodno	Howes	Kubly	Mulder
Cassell	Eastlund	Gunther	Jacobson	Kuisle	Ness

Nornes	Pelowski	Ruth	Stanek	Tuma	Wolf
Olson	Penas	Schumacher	Stang	Vandever	Workman
Osskopp	Peterson	Seagren	Swenson	Walz	Spk. Sviggum
Paulsen	Rhodes	Seifert	Sykora	Westrom	
Pawlenty	Rifenberg	Smith	Tingelstad	Wilkin	

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

Paymar, Dawkins, Hausman and Entenza offered an amendment to S. F. No. 722, the second unofficial engrossment, as amended.

#### POINT OF ORDER

Dauids raised a point of order pursuant to rule 3.21 that the Paymar et al amendment was not in order. Speaker pro tempore Boudreau ruled the point of order well taken and the Paymar et al amendment out of order.

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.

The bill was read for the third time, as amended, and placed upon its final passage.

The question was taken on the passage of the bill and the roll was called. There were 99 yeas and 34 nays as follows:

Those who voted in the affirmative were:

Abeler	Dorn	Jennings	Mahoney	Pelowski	Swenson
Abrams	Eastlund	Johnson, J.	Mares	Penas	Sykora
Anderson, B.	Erhardt	Johnson, R.	Marko	Peterson	Thompson
Anderson, I.	Erickson	Juhnke	Marquart	Rhodes	Tingelstad
Bakk	Finseth	Kalis	McElroy	Rifenberg	Tuma
Bishop	Fuller	Kielkucki	Milbert	Rukavina	Vandever
Boudreau	Gerlach	Knoblach	Molnau	Ruth	Walz
Bradley	Goodno	Krinkie	Mulder	Schumacher	Wenzel
Buesgens	Gunther	Kubly	Ness	Seagren	Westerberg
Carlson	Haas	Kuise	Nornes	Seifert	Westrom
Cassell	Hackbarth	Larson	Olson	Sertich	Wilkin
Clark, J.	Harder	Lenczewski	Opatz	Skoe	Wolf
Daggett	Holberg	Leppik	Osskopp	Slawik	Workman
Dauids	Holsten	Lieder	Osthoff	Smith	Spk. Sviggum
Dehler	Howes	Lindner	Ozment	Solberg	
Dempsey	Huntley	Lipman	Paulsen	Stanek	
Dorman	Jacobson	Luther	Pawlenty	Stang	



Those who voted in the negative were:

Bernardy	Entenza	Hausman	Kelliher	Murphy	Wagenius
Biernat	Evans	Hilstrom	Koskinen	Otremba	Walker
Clark, K.	Gleason	Hilty	Leighton	Paymar	Wasiluk
Davnie	Goodwin	Jaros	Mariani	Pugh	Winter
Dawkins	Gray	Johnson, S.	McGuire	Skoglund	
Dibble	Greiling	Kahn	Mullery	Swapinski	

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

H. F. No. 94 was reported to the House.

Haas moved to amend H. F. No. 94, the fourth engrossment, as follows:

Page 2, line 7, after "people" insert "intentionally"

Page 3, after line 34, insert:

"Sec. 4. Minnesota Statutes 2000, section 97A.345, is amended to read:

97A.345 [RESTITUTION VALUE OF WILD ANIMALS.]

Subdivision 1. [PURPOSE; REPORT.] (a) ~~The commissioner may, by rules adopted under chapter 14, prescribe the dollar value to the state of species of wild animals. The value may restitution values established under this section~~ reflect the value to other persons to legally take the wild animal, the replacement cost, or the intrinsic value to the state of the wild animals. ~~Species of wild animals with similar values may be grouped together.~~

(b) The value of a wild animal under ~~the rules adopted by the commissioner~~ this section is prima facie evidence of a wild animal's value under section 97A.341.

(c) The commissioner shall report annually to the legislature the amount of restitution collected under section 97A.341 and the manner in which the funds were expended.

Subd. 2. [GAME BIRDS.] The restitution values for game bird species are as follows:

(1) turkey (wild), \$400;

(2) pheasant, \$50;

(3) quail, \$50;

(4) chukar partridge, \$50;

(5) gray partridge, \$50;

(6) ruffed grouse, \$50;

(7) sharp-tailed grouse, \$50;

(8) spruce grouse, \$50;

- (9) greater prairie chicken, \$500;
- (10) American woodcock, \$50;
- (11) common snipe, \$50;
- (12) sora, Virginia rails, \$50;
- (13) gallinules, \$50;
- (14) coot, \$25;
- (15) ducks and mergansers, except canvasback, \$50;
- (16) canvasback, \$100;
- (17) geese, \$50;
- (18) tundra swan, \$200; and
- (19) trumpeter swan, \$1,200.

Subd. 3. [BIG GAME ANIMALS.] (a) Except as provided in paragraph (b), the restitution values for big game species are as follows:

- (1) deer, \$500;
- (2) elk, \$1,000;
- (3) caribou, \$1,000;
- (4) moose, \$1,000;
- (5) pronghorn antelope, \$500; and
- (6) black bear, \$400.

(b) The restitution values for deer, elk, moose, and bear may be increased to twice the amount listed in this subdivision if the animal is a trophy animal.

Subd. 4. [SMALL GAME.] The restitution values for small game species other than game birds are as follows:

- (1) cottontail rabbit, \$20;
- (2) jack rabbit, \$20;
- (3) snowshoe hare, \$20;
- (4) fox and gray squirrel, \$20;
- (5) red and gray fox, \$30;
- (6) wolverine, \$1,000;

(7) badger, \$100;

(8) otter, \$100;

(9) pine marten, \$100;

(10) fisher, \$100;

(11) mink, \$30;

(12) raccoon, \$30;

(13) beaver, \$30;

(14) muskrat, \$30;

(15) opossum, \$30;

(16) bobcat, \$100;

(17) lynx, \$500; and

(18) cougar, \$1,000.

Subd. 5. [ENDANGERED ANIMAL SPECIES.] The restitution values for endangered animal species are as follows:

(1) mammals and birds, \$4,000; and

(2) all other animals, \$2,000.

Subd. 6. [THREATENED ANIMAL SPECIES.] The restitution values for threatened animal species are as follows:

(1) mammals and birds, \$2,000; and

(2) all other animals, \$500.

Subd. 7. [GRAY WOLVES.] The restitution value for gray wolves is \$1,400.

Subd. 8. [FISH.] (a) Except as provided in subdivision 9 for fish species that do not have a designated quality size, or for fish that have a total length equal to or less than the designated quality size, the restitution value is the base value shown in the following table. For fish that have a length that exceeds the designated quality size, the restitution value is the base value plus \$10 for every inch over the quality size.

	<u>Base Value</u>	<u>Quality size in inches</u>
<u>(1) walleye</u>	<u>\$30</u>	<u>22</u>
<u>(2) sauger</u>	<u>30</u>	<u>15</u>
<u>(3) northern pike</u>	<u>30</u>	<u>32</u>
<u>(4) black bass (largemouth, smallmouth)</u>	<u>30</u>	<u>16</u>

<u>(5) sunfish (bluegill, pumpkinseed, green sunfish, orange spotted sunfish, longear sunfish, warmouth, hybrid sunfish)</u>	<u>5</u>	<u>8</u>
<u>(6) white and black crappie</u>	<u>5</u>	<u>11</u>
<u>(7) yellow perch</u>	<u>10</u>	<u>10</u>
<u>(8) rock bass</u>	<u>5</u>	<u>8</u>
<u>(9) white bass, yellow bass</u>	<u>5</u>	<u>9</u>
<u>(10) channel catfish</u>	<u>10</u>	<u>26</u>
<u>(11) flathead catfish</u>	<u>25</u>	<u>28</u>
<u>(12) chinook salmon</u>	<u>50</u>	<u>28</u>
<u>(13) coho, Atlantic salmon</u>	<u>30</u>	<u>20</u>
<u>(14) kokanee, pink, other salmon</u>	<u>30</u>	<u>17</u>
<u>(15) lake trout</u>	<u>50</u>	<u>22</u>
<u>(16) splake</u>	<u>50</u>	<u>15</u>
<u>(17) brook trout</u>	<u>30</u>	<u>17</u>
<u>(18) brown trout</u>	<u>30</u>	<u>21</u>
<u>(19) rainbow (steelhead) trout</u>	<u>30</u>	<u>23</u>
<u>(20) paddlefish</u>	<u>500</u>	
<u>(21) lake sturgeon</u>	<u>500</u>	
<u>(22) shovelnose sturgeon</u>	<u>200</u>	
<u>(23) sturgeon hybrids</u>	<u>same value as morphologically nearest parent</u>	

(b) The restitution values for muskellunge are as follows:

(1) 0 to less than 30 inches, \$40;

(2) 30 to less than 40 inches, \$200;

(3) 40 to less than 50 inches, \$500; and

(4) 50 inches and over, \$1,000 plus \$100 for each inch over 50 inches.

Subd. 9. [FINGERLINGS.] The restitution value for fish listed in subdivision 8 that are less than four inches in length is \$1 per fish.

Subd. 10. [MINNOWS.] The restitution values for minnows are as follows:

(1) cyprinidae, fair market value at time of violation;

(2) umbridae, 50 cents a pound;

(3) catostomidae, 50 cents a pound;

(4) bullhead (seven inches or less), 50 cents a pound;

(5) cisco (seven inches or less), 50 cents a pound;

(6) lake white fish (seven inches or less), \$1 a pound;

(7) goldeyes and mooneyes (seven inches or less), 50 cents a pound; and

(8) leeches, fair market value at time of violation."

Page 4, delete lines 1 to 4 and insert:

"Subdivision 1. [SEIZURE.] An"

Page 6, line 9, delete everything after "license" and insert "upon payment of a temporary reinstatement fee of"

Page 6, line 10, delete everything before "\$1,000"

Page 6, line 12, delete everything after the period

Page 6, delete lines 13 to 15

Page 8, delete lines 2 to 12

Renumber the sections in sequence and correct internal references

Amend the title accordingly

A roll call was requested and properly seconded.

Haas moved to amend the Haas amendment to H. F. No. 94, the fourth engrossment, as follows:

Page 2, line 29, after the period, insert:

"(c) "Trophy animal" means:

(1) for deer, elk, and moose as an animal with antlers that meet or exceed the score specified in items (i) to (iv) when measured using the Boone and Crockett Club's official scoring system for North American big game trophies (Nesbitt, W.H. and J. Reneau, eds., Records of North American Big Game, Ninth Edition, The Boone and Crockett Club, Dumfries, VA, 1988, 498 pp.). This scoring system is incorporated by reference:

(i) white-tailed deer (typical), score of 135;

(ii) white-tailed deer (nontypical), score of 160;

(iii) moose, score of 145; and

(iv) elk, score of 260; and

(2) for black bear as an animal with a skull that meets or exceeds a score of 20 using the Boone and Crockett Club's official scoring system for North American big game trophies (id.).

(d) For the purposes of this definition, the antlers or skulls may be measured at any time; no drying period is required."

Page 4, delete lines 32 to 34

Page 5, line 11, before "An" insert "(a)"

Page 5, after line 17, insert:

"Page 8, line 17, delete "and""

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

The motion prevailed and the amendment to the amendment was adopted.

The question recurred on the Haas amendment, as amended, and the roll was called. There were 13 yeas and 121 nays as follows:

Those who voted in the affirmative were:

Abeler	Evans	Haas	Osthoff	Wagenius
Clark, K.	Greiling	Jennings	Ozment	
Davids	Gunther	McGuire	Paymar	

Those who voted in the negative were:

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

The motion did not prevail and the amendment, as amended, was not adopted.

Kalis was excused for the remainder of today's session.

H. F. No. 94, A bill for an act relating to natural resources; establishing penalties for gross overlimit violations of fish and game laws; setting certain restitution values; providing criminal penalties; amending Minnesota Statutes 2000, sections 97A.225, subdivision 1; 97A.255, by adding a subdivision; 97A.421, subdivision 5, by adding a subdivision; 97C.505, by adding a subdivision; proposing coding for new law in Minnesota Statutes, chapter 97A.

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 38 yeas and 95 nays as follows:

Those who voted in the affirmative were:

Abeler	Dorman	Hilstrom	Lindner	Ozment	Sykora
Abrams	Entenza	Huntley	Lipman	Paulsen	Tuma
Bishop	Greiling	Jennings	McGuire	Pawlenty	Wagenius
Bradley	Gunther	Kelliher	Molnau	Paymar	
Clark, J.	Haas	Knoblach	Mulder	Rhodes	
Davids	Harder	Lenczewski	Osskopp	Seagren	
Dawkins	Hausman	Leppik	Osthoff	Stanek	

Those who voted in the negative were:

Anderson, B.	Eastlund	Howes	Luther	Penas	Swenson
Anderson, I.	Erhardt	Jacobson	Mahoney	Peterson	Thompson
Bakk	Erickson	Jaros	Mares	Pugh	Tingelstad
Bernardy	Evans	Johnson, J.	Mariani	Rifenberg	Vandever
Biernat	Finseth	Johnson, R.	Marko	Rukavina	Walker
Boudreau	Folliard	Johnson, S.	Marquart	Ruth	Walz
Buesgens	Fuller	Juhnke	McElroy	Schumacher	Wasiluk
Carlson	Gerlach	Kahn	Milbert	Seifert	Wenzel
Cassell	Gleason	Kielkucki	Mullery	Sertich	Westerberg
Clark, K.	Goodno	Koskinen	Murphy	Skoe	Westrom
Daggett	Goodwin	Krinkie	Ness	Skoglund	Wilkin
Davnie	Gray	Kubly	Nornes	Slawik	Winter
Dehler	Hackbarth	Kuisle	Olson	Smith	Wolf
Dempsey	Hilty	Larson	Opatz	Solberg	Workman
Dibble	Holberg	Leighton	Otremba	Stang	Spk. Sviggum
Dorn	Holsten	Lieder	Pelowski	Swapinski	

The bill was not passed.

S. F. No. 1397 was reported to the House.

Wilkin moved to amend S. F. No. 1397 as follows:

Page 9, line 27, before the semicolon, insert "or paid by a fiscal agent, fiscal intermediary, or employer of record"

Page 9, line 28, after "not" insert "otherwise"

The motion prevailed and the amendment was adopted.

Goodno moved to amend S. F. No. 1397, as amended, as follows:

Page 1, after line 15, insert:

"ARTICLE 1

BACKGROUND STUDIES FOR LICENSED PROGRAMS"

Page 38, after line 18, insert:

"Sec. 21. [EFFECTIVE DATE]

This act shall not take effect if 2001 S. F. No. 2361 is enacted.

## ARTICLE 2

### 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. [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.

Sec. 25. 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. 26. [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>Measuring systems - other</u>
<u>Gas chromatographs</u>	<u>\$1,200</u>	<u>Gas chromatographs</u>
<u>Manufacturing and distribution</u>	<u>\$14,700</u>	<u>Manufacturing and distribution - other</u>

<u>Distribution only</u>	<u>\$8,800</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</u>	<u>\$4,100</u>	<u>Research and development</u>
<u>Radioactive material possession only</u>	<u>\$1,000</u>	<u>By-product possession only</u>
<u>Source material</u>	<u>\$1,000</u>	<u>Source material shielding</u>
<u>Special nuclear material, less than 200 grams</u>	<u>\$1,000</u>	<u>Special nuclear material plutonium-neutron sources less than 200 grams</u>
<u>Pacemaker manufacturing</u>	<u>\$1,000</u>	<u>Pacemaker by-product and/or special nuclear material - medical institution</u>
<u>General license distribution</u>	<u>\$2,100</u>	<u>General license distribution</u>
<u>General license distribution, exempt</u>	<u>\$1,500</u>	<u>General license distribution - certain exempt items</u>
<u>Academic, small</u>	<u>\$1,000</u>	<u>Possession limit of ten radionuclides, not to exceed a total of one curie of activity</u>
<u>Veterinary</u>	<u>\$2,000</u>	<u>Veterinary use</u>
<u>Well logging</u>	<u>\$5,000</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. 27. 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. 28. 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. 29. 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. 30. 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.

Sec. 31. [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. 32. 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:

<u>Test Category</u>	<u>Certification Fee</u>
<u>Clean water program bacteriology</u>	<u><del>\$200</del> <u>\$600</u></u>
<u>Safe drinking water program bacteriology</u>	<u><del>\$200</del> <u>\$600</u></u>
<u>Clean water program inorganic chemistry; fewer than four constituents</u>	<u><del>\$100</del> <u>\$600</u></u>
<u>Safe drinking water program inorganic chemistry; four or more constituents</u>	<u><del>\$300</del> <u>\$600</u></u>

<u>Clean water program</u> chemistry metals; <del>fewer than four constituents</del>	\$200	\$800
<u>Safe drinking water program</u> chemistry metals; <del>four or more constituents</del>	\$500	\$800
<u>Resource conservation and recovery program</u> chemistry metals		\$800
<u>Clean water program</u> volatile organic compounds	<del>\$600</del>	\$1,200
<u>Safe drinking water program</u> volatile organic compounds		\$1,200
<u>Resource conservation and recovery program</u> volatile organic compounds		\$1,200
<u>Underground storage tank program</u> volatile organic compounds		\$1,200
<u>Clean water program</u> other organic compounds	<del>\$600</del>	\$1,200
<u>Safe drinking water program</u> other organic compounds		\$1,200
<u>Resource conservation and recovery program</u> other organic compounds		\$1,200

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

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

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

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

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

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

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

Sec. 33. 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. 34. 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. 35. 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. 36. 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. 37. 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. 38. 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.

Sec. 39. [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. 40. [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. 41. [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. 42. [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. 43. [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. 44. [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. 45. [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.

Sec. 46. 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. 47. 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. 48. Minnesota Statutes 2000, section 145.882, subdivision 7, is amended to read:

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

- (1) specifically address the highest risk populations, particularly low-income and minority groups with a high rate of infant mortality and children with low birth weight, by providing services, ~~including~~ excluding ~~prepregnancy family planning services,~~ calculated to produce measurable decreases in infant mortality rates, instances of children with low birth weight, and medical complications associated with pregnancy and childbirth, including infant mortality, low birth rates, and medical complications arising from chemical abuse by a mother during pregnancy;
- (2) specifically target pregnant women whose age, medical condition, maternal history, or chemical abuse substantially increases the likelihood of complications associated with pregnancy and childbirth or the birth of a child with an illness, disability, or special medical needs;
- (3) specifically address the health needs of young children who have or are likely to have a chronic disease or disability or special medical needs, including physical, neurological, emotional, and developmental problems that arise from chemical abuse by a mother during pregnancy;
- (4) provide ~~family planning and~~ preventive medical care, excluding ~~prepregnancy family planning services,~~ for specifically identified target populations, such as minority and low-income teenagers, in a manner calculated to ~~decrease the occurrence of inappropriate pregnancy and~~ minimize the risk of complications associated with pregnancy and childbirth; or
- (5) specifically address the frequency and severity of childhood injuries and other child and adolescent health problems in high-risk target populations by providing services, excluding ~~prepregnancy family planning services,~~ calculated to produce measurable decreases in mortality and morbidity. ~~However, money may be used for this purpose only if the community health board's application includes program components for the purposes in clauses~~

~~(1) to (4) in the proposed geographic service area and the total expenditure for injury-related programs under this clause does not exceed ten percent of the total allocation under subdivision 3:~~

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

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

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

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

Sec. 49. 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. 50. 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. 51. Minnesota Statutes 2000, section 145.925, subdivision 1, is amended to read:

Subdivision 1. [ELIGIBLE ORGANIZATIONS; PURPOSE.] The commissioner of health may make special grants to cities, counties, tribal governments, or groups of cities or counties, or nonprofit corporations or tribal governments to provide prepregnancy family planning services: targeted to low-income and minority populations. A city, county, tribal government, or group of cities, counties, or tribal governments that receives a grant is responsible for ensuring that the grant funds are used for services targeted to low-income and minority populations, and must establish a goal for reducing specific pregnancy rates in the service area. In determining populations to serve and services to provide, a city, county, tribal government, or group of cities, counties, or tribal governments must consider the spacing of pregnancies in low-income and minority populations in the service area, teen birth rates in the service area, and the needs of populations of color in the service area. A city, county, tribal government, or group of cities, counties, or tribal governments may contract for the provision of prepregnancy family planning services using grant funds provided under this section only if the contract is specifically authorized by the governing body of the city, county, or tribal government that is contracting for the services.

Any organization or an affiliate of an organization which provides abortions, promotes abortions, or directly refers for abortions, shall be ineligible to receive funds under this subdivision.

Sec. 52. 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. 53. [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. 54. [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. 55. [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. 56. 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. 57. Minnesota Statutes 2000, section 145A.15, is amended by adding a subdivision to read:

Subd. 5. [EXPIRATION.] This section expires June 30, 2003.

Sec. 58. 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. 59. Minnesota Statutes 2000, section 145A.16, is amended by adding a subdivision to read:

Subd. 10. [EXPIRATION.] This section expires December 31, 2003.

Sec. 60. [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.

(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.

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. 61. 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 64 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. 62. 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. 63. [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.

Sec. 64. [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. 65. [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.

Sec. 66. [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.

Sec. 67. [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.

Sec. 68. [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 3

#### 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 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~~ 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 14 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 4

## 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~~ income and expense report or the estimated resident days in the projected receivership period. The payment rate adjustment ~~must meet the conditions in Minnesota Rules, parts 9553.0010 to 9553.0080, and~~ remains in effect during the period of the receivership or until another date set by the commissioner. Upon the subsequent sale, closure, or transfer of the residential program, the commissioner may recover amounts that were paid as payment rate adjustments under this subdivision. This recovery shall be determined through a review of actual costs and resident days in the receivership period. The costs the commissioner finds to be allowable shall be divided by the actual resident days for the receivership period. This rate shall be compared to the rate paid throughout the receivership period, with the difference, multiplied by resident days, being the amount to be repaid to the commissioner. Allowable costs shall be determined by the commissioner as those ordinary, necessary, and related to resident care by prudent and cost-conscious management. The buyer or transferee shall repay this amount to the commissioner within 60 days after the commissioner notifies the buyer or transferee of the obligation to repay. This provision does not limit the liability of the seller to the commissioner pursuant to section 256B.0641.

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

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

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

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

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

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

Sec. 4. Minnesota Statutes 2000, section 254B.02, subdivision 3, is amended to read:

Subd. 3. [RESERVE ACCOUNT.] The commissioner shall allocate money from the reserve account to counties that, during the current fiscal year, have met or exceeded the base level of expenditures for eligible chemical dependency services from local money. The commissioner shall establish the base level for fiscal year 1988 as the amount of local money used for eligible services in calendar year 1986. In later years, the base level must be increased in the same proportion as state appropriations to implement Laws 1986, chapter 394, sections 8 to 20, are increased. The base level must be decreased if the fund balance from which allocations are made under section 254B.02, subdivision 1, is decreased in later years. The local match rate for the reserve account is the same rate as applied to the initial allocation. Reserve account payments must not be included when calculating the county adjustments made according to subdivision 2. For counties providing medical assistance or general assistance medical care through managed care plans on January 1, 1996, the base year is fiscal year 1995. For counties beginning provision of managed care after January 1, 1996, the base year is the most recent fiscal year before enrollment in managed care begins. For counties providing managed care, the base level will be increased or decreased in proportion to changes in the fund balance from which allocations are made under subdivision 2, but will be additionally increased or decreased in proportion to the change in county adjusted population made in subdivision 1, paragraphs (b) and (c). Effective July 1, 2001, funds deposited in the reserve account in excess of those needed to meet obligations for services provided during the biennium under this section and sections 254B.06 and 254B.09 shall cancel to the general fund.

Sec. 5. Minnesota Statutes 2000, section 254B.03, subdivision 1, is amended to read:

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

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

(c) The calendar year ~~1998~~ 2002 rate for vendors may not increase more than ~~three~~ two percent above the rate approved in effect on January 1, ~~1997~~ 2001. The calendar year ~~1999~~ 2003 rate for vendors may not increase more than ~~three~~ two percent above the rate in effect on January 1, ~~1998~~ 2002. The calendar years 2004 and 2005 rates may not exceed the rate in effect on January 1, 2003.

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

Sec. 6. Minnesota Statutes 2000, section 254B.04, subdivision 1, is amended to read:

Subdivision 1. [ELIGIBILITY.] (a) Persons eligible for benefits under Code of Federal Regulations, title 25, part 20, persons eligible for medical assistance benefits under sections 256B.055, 256B.056, and 256B.057, subdivisions 1, 2, 5, and 6, or who meet the income standards of section 256B.056, subdivision 4, and persons eligible for general assistance medical care under section 256D.03, subdivision 3, are entitled to chemical dependency fund services. State money appropriated for this paragraph must be placed in a separate account established for this purpose.

Persons with dependent children who are determined to be in need of chemical dependency treatment pursuant to an assessment under section 626.556, subdivision 10, or a case plan under section 260C.201, subdivision 6, or 260C.212, shall be assisted by the local agency to access needed treatment services. Treatment services must be appropriate for the individual or family, which may include long-term care treatment or treatment in a facility that allows the dependent children to stay in the treatment facility. The county shall pay for out-of-home placement costs, if applicable.

(b) A person not entitled to services under paragraph (a), but with family income that is less than the 1997 federal poverty guidelines equivalent of 60 percent of the state median income for a family of like size and composition, shall be eligible to receive chemical dependency fund services within the limit of funds ~~available after persons entitled to services under paragraph (a) have been served~~ appropriated for this group for the fiscal year. If notified by the state agency of limited funds, a county must give preferential treatment to persons with dependent children who are in need of chemical dependency treatment pursuant to an assessment under section 626.556, subdivision 10, or a case plan under section 260C.201, subdivision 6, or 260C.212. A county may spend money from its own sources to serve persons under this paragraph. State money appropriated for this paragraph must be placed in a separate account established for this purpose.

(c) Persons whose income is between the 1997 federal poverty guidelines equivalent of 60 percent and 115 percent of the state median income shall be eligible for chemical dependency services on a sliding fee basis, within the limit of funds ~~available, after persons entitled to services under paragraph (a) and persons eligible for services under paragraph (b) have been served~~ appropriated for this group for the fiscal year. Persons eligible under this paragraph must contribute to the cost of services according to the sliding fee scale established under subdivision 3. A county may spend money from its own sources to provide services to persons under this paragraph. State money appropriated for this paragraph must be placed in a separate account established for this purpose.

Sec. 7. Minnesota Statutes 2000, section 254B.09, is amended by adding a subdivision to read:

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

Sec. 8. Minnesota Statutes 2000, section 256.01, is amended by adding a subdivision to read:

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

Sec. 9. Minnesota Statutes 2000, section 256.476, subdivision 1, is amended to read:

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

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

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

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

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

Sec. 10. Minnesota Statutes 2000, section 256.476, subdivision 2, is amended to read:

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

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

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

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

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

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

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

(3) refuse any or all alternatives.

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

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

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

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

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

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

Sec. 11. Minnesota Statutes 2000, section 256.476, subdivision 3, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

Sec. 12. Minnesota Statutes 2000, section 256.476, subdivision 4, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 13. Minnesota Statutes 2000, section 256.476, subdivision 5, is amended to read:

Subd. 5. [REIMBURSEMENT, ALLOCATIONS, AND REPORTING.] (a) For the purpose of transferring persons to the consumer support grant program from specific programs or services, such as the developmental disability family support program and ~~alternative care program~~, personal care ~~attendant~~ assistant services, home



health aide services, or ~~nursing facility private duty nursing~~ services, the amount of funds transferred by the commissioner between the developmental disability family support program account, ~~the alternative care account~~; the medical assistance account, or the consumer support grant account shall be based on each county's participation in transferring persons to the consumer support grant program from those programs and services.

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

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

(2) their eligibility for current program and services;

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

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

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

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

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

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

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

(h) Grant funds unexpended by consumers shall return to the state once a year. The annual return of unexpended grant funds shall occur in the quarter following the end of the state fiscal year.

Sec. 14. Minnesota Statutes 2000, section 256.476, subdivision 8, is amended to read:

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

(1) transfer and allocate funds pursuant to this section;

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

Sec. 15. Minnesota Statutes 2000, section 256B.0625, subdivision 7, is amended to read:

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

Sec. 16. Minnesota Statutes 2000, section 256B.0625, subdivision 19a, is amended to read:

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

Notwithstanding the provisions of section 256B.0627, subdivision 4, paragraph (b), clause (4), the noncorporate legal guardian or conservator of an adult, who is not the responsible party and not the personal care provider organization, may be granted a hardship waiver under section 256B.0627, to be reimbursed to provide personal care assistant services to the recipient, and shall not be considered to have a service provider interest for purposes of participation on the screening team under section 256B.092, subdivision 7.

Sec. 17. Minnesota Statutes 2000, section 256B.0625, subdivision 19c, is amended to read:

Subd. 19c. [PERSONAL CARE.] Medical assistance covers personal care assistant services provided by an individual who is qualified to provide the services according to subdivision 19a and section 256B.0627, where the services are prescribed by a physician in accordance with a plan of treatment and are supervised by the recipient ~~under the fiscal agent option according to section 256B.0627, subdivision 10;~~ or a qualified professional. "Qualified professional" means a mental health professional as defined in section 245.462, subdivision 18, or 245.4871, subdivision 27; or a registered nurse as defined in sections 148.171 to 148.285. As part of the assessment, the county public health nurse will ~~consult with~~ assist the recipient or responsible party ~~and to~~ identify the most appropriate person to provide supervision of the personal care assistant. The qualified professional shall perform the duties described in Minnesota Rules, part 9505.0335, subpart 4.

Sec. 18. Minnesota Statutes 2000, section 256B.0625, subdivision 20, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

- (1) the costs of developing and implementing this section; and
- (2) programming the information systems.

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 43. [TARGETED CASE MANAGEMENT.] For purposes of subdivisions 43a to 43h, the following terms have the meanings given them:

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

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

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

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

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

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

Subd. 43a. [ELIGIBILITY.] The following persons are eligible for relocation targeted case management or home care targeted case management:

(1) medical assistance eligible persons residing in institutions who choose to move into the community are eligible for relocation targeted case management services; and

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

Sec. 21. Minnesota Statutes 2000, section 256B.0625, is amended by adding a subdivision to read:

Subd. 43b. [RELOCATION TARGETED CASE MANAGEMENT PROVIDER QUALIFICATIONS.] The following qualifications and certification standards must be met by providers of relocation targeted case management:

(a) The commissioner must certify each provider of relocation targeted case management before enrollment. The certification process shall examine the provider's ability to meet the requirements in this subdivision and other federal and state requirements of this service. A certified relocation targeted case management provider may subcontract with another provider to deliver relocation targeted case management services. Subcontracted providers must demonstrate the ability to provide the services outlined in subdivision 43d.

(b) A relocation targeted case management provider is an enrolled medical assistance provider who is determined by the commissioner to have all of the following characteristics:

(1) the legal authority to provide public welfare under sections 393.01, subdivision 7; and 393.07, or a federally recognized Indian tribe;

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

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

(4) the legal authority to provide complete investigative and protective services under section 626.556, subdivision 10, and child welfare and foster care services under section 393.07, subdivisions 1 and 2, or a federally recognized Indian tribe;

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

(6) the capacity to document and maintain individual case records under state and federal requirements.

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

Sec. 22. Minnesota Statutes 2000, section 256B.0625, is amended by adding a subdivision to read:

Subd. 43c. [HOME CARE TARGETED CASE MANAGEMENT PROVIDER QUALIFICATIONS.] The following qualifications and certification standards must be met by providers of home care targeted case management.

(a) The commissioner must certify each provider of home care targeted case management before enrollment. The certification process shall examine the provider's ability to meet the requirements in this subdivision and other state and federal requirements of this service.

(b) A home care targeted case management provider is an enrolled medical assistance provider who has a minimum of a bachelor's degree or a license in a health or human services field, and is determined by the commissioner to have all of the following characteristics:

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

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

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

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

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

Sec. 23. Minnesota Statutes 2000, section 256B.0625, is amended by adding a subdivision to read:

Subd. 43d. [ELIGIBLE SERVICES.] Services eligible for medical assistance reimbursement as targeted case management include:

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

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

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

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

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

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

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

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

Sec. 24. Minnesota Statutes 2000, section 256B.0625, is amended by adding a subdivision to read:

Subd. 43e. [TIME LINES.] The following time lines must be met for assigning a case manager:

(1) for relocation targeted case management, an eligible recipient must be assigned a case manager who visits the person within 20 working days of requesting a case manager from their county of financial responsibility as determined under chapter 256G. If a county agency does not provide case management services as required, the recipient may, after written notice to the county agency, obtain targeted relocation case management services from a home care targeted case management provider, as defined in subdivision 43c; and

(2) for home care targeted case management, an eligible recipient must be assigned a case manager within 20 working days of requesting a case manager from a home care targeted case management provider, as defined in subdivision 43c.

Sec. 25. Minnesota Statutes 2000, section 256B.0625, is amended by adding a subdivision to read:

Subd. 43f. [EVALUATION.] The commissioner shall evaluate the delivery of targeted case management, including, but not limited to, access to case management services, consumer satisfaction with case management services, and quality of case management services.

Sec. 26. Minnesota Statutes 2000, section 256B.0625, is amended by adding a subdivision to read:

Subd. 43g. [CONTACT DOCUMENTATION.] The case manager must document each face-to-face and telephone contact with the recipient and others involved in the recipient's individual service plan.

Sec. 27. Minnesota Statutes 2000, section 256B.0625, is amended by adding a subdivision to read:

Subd. 43h. [PAYMENT RATES.] The commissioner shall set payment rates for targeted case management under this subdivision. Case managers may bill according to the following criteria:

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

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

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

Sec. 28. Minnesota Statutes 2000, section 256B.0627, subdivision 1, is amended to read:

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

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

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

(i) (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.

(j) (j) "Personal care provider organization" means an organization enrolled to provide personal care assistant services under the medical assistance program that complies with the following: (1) owners who have a five percent interest or more, and managerial officials are subject to a background study as provided in section 245A.04. This applies to currently enrolled personal care provider organizations and those agencies seeking enrollment as a personal care provider organization. An organization will be barred from enrollment if an owner or managerial official of the organization has been convicted of a crime specified in section 245A.04, or a comparable crime in another jurisdiction, unless the owner or managerial official meets the reconsideration criteria specified in section 245A.04; (2) the organization must maintain a surety bond and liability insurance throughout the duration of

enrollment and provides proof thereof. The insurer must notify the department of human services of the cancellation or lapse of policy; and (3) the organization must maintain documentation of services as specified in Minnesota Rules, part 9505.2175, subpart 7, as well as evidence of compliance with personal care assistant training requirements.

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

(h) (l) "Service plan" means a written description of the services needed based on the assessment developed by the nurse who conducts the assessment together with the recipient or responsible party. The service plan shall include a description of the covered home care services, frequency and duration of services, and expected outcomes and goals. The recipient and the provider chosen by the recipient or responsible party must be given a copy of the completed service plan within 30 calendar days of the request for home care services by the recipient or responsible party.

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

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

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

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

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

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

Sec. 29. Minnesota Statutes 2000, section 256B.0627, subdivision 2, is amended to read:

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

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

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

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

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

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

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

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

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

Sec. 30. Minnesota Statutes 2000, section 256B.0627, subdivision 4, is amended to read:

Subd. 4. [PERSONAL CARE ASSISTANT SERVICES.] (a) The personal care assistant services that are eligible for payment are ~~the following: services and supports furnished to an individual, as needed, to assist in accomplishing activities of daily living; instrumental activities of daily living; health-related functions through hands-on assistance, supervision, and cuing; and redirection and intervention for behavior including observation and monitoring.~~

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

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

- (1) bowel and bladder care;
- (2) skin care to maintain the health of the skin;
- (3) repetitive maintenance range of motion, muscle strengthening exercises, and other tasks specific to maintaining a recipient's optimal level of function;
- (4) respiratory assistance;
- (5) transfers and ambulation;
- (6) bathing, grooming, and hairwashing necessary for personal hygiene;
- (7) turning and positioning;
- (8) assistance with furnishing medication that is self-administered;
- (9) application and maintenance of prosthetics and orthotics;
- (10) cleaning medical equipment;
- (11) dressing or undressing;
- (12) assistance with eating and meal preparation and necessary grocery shopping;
- (13) accompanying a recipient to obtain medical diagnosis or treatment;
- (14) assisting, monitoring, or prompting the recipient to complete the services in clauses (1) to (13);

(15) redirection, monitoring, and observation that are medically necessary and an integral part of completing the personal care assistant services described in clauses (1) to (14);

(16) redirection and intervention for behavior, including observation and monitoring;

(17) interventions for seizure disorders, including monitoring and observation if the recipient has had a seizure that requires intervention within the past three months;

(18) tracheostomy suctioning using a clean procedure if the procedure is properly delegated by a registered nurse. Before this procedure can be delegated to a personal care assistant, a registered nurse must determine that the tracheostomy suctioning can be accomplished utilizing a clean rather than a sterile procedure and must ensure that the personal care assistant has been taught the proper procedure; and

(19) incidental household services that are an integral part of a personal care service described in clauses (1) to (18).

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

~~(b)~~ (d) The personal care assistant services that are not eligible for payment are the following:

(1) services not ordered by the physician;

(2) assessments by personal care assistant provider organizations or by independently enrolled registered nurses;

(3) services that are not in the service plan;

(4) services provided by the recipient's spouse, legal guardian for an adult or child recipient, or parent of a recipient under age 18;

(5) services provided by a foster care provider of a recipient who cannot direct the recipient's own care, unless monitored by a county or state case manager under section 256B.0625, subdivision 19a;

(6) services provided by the residential or program license holder in a residence for more than four persons;

(7) services that are the responsibility of a residential or program license holder under the terms of a service agreement and administrative rules;

(8) sterile procedures;

(9) injections of fluids into veins, muscles, or skin;

(10) services provided by parents of adult recipients, adult children, or siblings of the recipient, unless these relatives meet one of the following hardship criteria and the commissioner waives this requirement:

(i) the relative resigns from a part-time or full-time job to provide personal care for the recipient;

(ii) the relative goes from a full-time to a part-time job with less compensation to provide personal care for the recipient;

(iii) the relative takes a leave of absence without pay to provide personal care for the recipient;

- (iv) the relative incurs substantial expenses by providing personal care for the recipient; or
- (v) because of labor conditions, special language needs, or intermittent hours of care needed, the relative is needed in order to provide an adequate number of qualified personal care assistants to meet the medical needs of the recipient;
- (11) homemaker services that are not an integral part of a personal care assistant services;
- (12) home maintenance, or chore services;
- (13) services not specified under paragraph (a); and
- (14) services not authorized by the commissioner or the commissioner's designee.

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

Sec. 31. Minnesota Statutes 2000, section 256B.0627, subdivision 5, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

(1) The amount and type of service authorized based upon the assessment and service plan will follow the recipient if the recipient chooses to change providers.

(2) If the recipient's medical need changes, the recipient's provider may assess the need for a change in service authorization and request the change from the county public health nurse. Within 30 days of the request, the public health nurse will determine whether to request the change in services based upon the provider assessment, or conduct a home visit to assess the need and determine whether the change is appropriate.

(3) To continue to receive personal care assistant services after the first year, the recipient or the responsible party, in conjunction with the public health nurse, may complete a service update on forms developed by the commissioner according to criteria and procedures in subdivision 1.

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

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

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

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

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

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

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

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

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

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

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

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

(A) daily tube feedings;

(B) daily parenteral therapy;

(C) wound or decubiti care;

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

(E) catheterization;

(F) ostomy care;

(G) quadriplegia; or

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

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

- (A) injury to the recipient's own body;
- (B) physical injury to other people; or
- (C) destruction of property.

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

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

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

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

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

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

The commissioner may authorize:

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

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

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

The commissioner may authorize up to 16 hours per day of medically necessary private duty nursing services or up to 24 hours per day of medically necessary private duty nursing services until such time as the commissioner is able to make a determination of eligibility for recipients who are cooperatively applying for home care services under



the community alternative care program developed under section 256B.49, or until it is determined by the appropriate regulatory agency that a health benefit plan is or is not required to pay for appropriate medically necessary health care services. Recipients or their representatives must cooperatively assist the commissioner in obtaining this determination. Recipients who are eligible for the community alternative care program may not receive more hours of nursing under this section than would otherwise be authorized under section 256B.49.

Beginning July 1, 2001, private duty nursing services shall be authorized for complex and regular care according to subdivision 1.

(4) [VENTILATOR-DEPENDENT RECIPIENTS.] If the recipient is ventilator-dependent, the monthly medical assistance authorization for home care services shall not exceed what the commissioner would pay for care at the highest cost hospital designated as a long-term hospital under the Medicare program. For purposes of this clause, home care services means all services provided in the home that would be included in the payment for care at the long-term hospital. "Ventilator-dependent" means an individual who receives mechanical ventilation for life support at least six hours per day and is expected to be or has been dependent for at least 30 consecutive days.

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

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

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

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

The commissioner may not authorize:

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

(2) personal care assistant services when the foster care license holder is also the personal care provider or personal care assistant unless the recipient can direct the recipient's own care, or case management is provided as required in section 256B.0625, subdivision 19a;

(3) personal care assistant services when the responsible party is an employee of, or under contract with, or has any direct or indirect financial relationship with the personal care provider or personal care assistant, unless case management is provided as required in section 256B.0625, subdivision 19a; or

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

Sec. 32. Minnesota Statutes 2000, section 256B.0627, subdivision 7, is amended to read:

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

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

Sec. 33. Minnesota Statutes 2000, section 256B.0627, subdivision 8, is amended to read:

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

(b) Recipients of personal care assistant services may share staff and the commissioner shall provide a rate system for shared personal care assistant services. For two persons sharing services, the rate paid to a provider shall not exceed 1-1/2 times the rate paid for serving a single individual, and for three persons sharing services, the rate paid

to a provider shall not exceed twice the rate paid for serving a single individual. These rates apply only to situations in which all recipients were present and received shared services on the date for which the service is billed. No more than three persons may receive shared services from a personal care assistant in a single setting.

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

- (1) the home or foster care home of one of the individual recipients; or
- (2) a child care program in which all recipients served by one personal care assistant are participating, which is licensed under chapter 245A or operated by a local school district or private school; or
- (3) outside the home or foster care home of one of the recipients when normal life activities take the recipients outside the home.

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

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

- (1) whether shared personal care assistant services is an appropriate option based on the individual needs and preferences of the recipient; and
- (2) the amount of shared services allocated as part of the overall authorization of personal care assistant services.

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

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

- (1) the additional qualifications needed by the personal care assistant to provide care to several recipients in the same setting;
- (2) the additional training and supervision needed by the personal care assistant to ensure that the needs of the recipient are met appropriately and safely. The provider must provide on-site supervision by a qualified professional within the first 14 days of shared services, and monthly thereafter, if supervision by a qualified provider has been requested by any one of the recipients or responsible parties;
- (3) the setting in which the shared services will be provided;
- (4) the ongoing monitoring and evaluation of the effectiveness and appropriateness of the service and process used to make changes in service or setting; and
- (5) a contingency plan which accounts for absence of the recipient in a shared services setting due to illness or other circumstances and staffing contingencies.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 34. Minnesota Statutes 2000, section 256B.0627, subdivision 10, is amended to read:

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

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

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

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

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

(b) The recipient or responsible party shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 35. Minnesota Statutes 2000, section 256B.0627, subdivision 11, is amended to read:

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

(b) Recipients of private duty nursing services may share nursing staff and the commissioner shall provide a rate methodology for shared private duty nursing. For two persons sharing nursing care, the rate paid to a provider shall not exceed 1.5 times the ~~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. 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. 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, ~~2004~~ 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 ~~for~~ 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 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 77. 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 78. 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 77, 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 77 and 78.

Sec. 80. [FEDERAL APPROVAL.]

The commissioner shall seek any amendments to the state Medicaid plan and any waivers necessary to permit implementation of section 77 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, 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 5

### 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 101-508.

The following criteria apply to the preadmission screening:

(1) the county must use forms and criteria developed by the commissioner of human services to identify persons who require referral for further evaluation and determination of the need for specialized services; and

(2) the evaluation and determination of the need for specialized services must be done by:

(i) a qualified independent mental health professional, for persons with a primary or secondary diagnosis of a serious mental illness; or



(ii) a qualified mental retardation professional, for persons with a primary or secondary diagnosis of mental retardation or related conditions. For purposes of this requirement, a qualified mental retardation professional must meet the standards for a qualified mental retardation professional under Code of Federal Regulations, title 42, section 483.430.

(c) The local county mental health authority or the state mental retardation authority under Public Laws Numbers 100-203 and 101-508 may prohibit admission to a nursing facility if the individual does not meet the nursing facility level of care criteria or needs specialized services as defined in Public Laws Numbers 100-203 and 101-508. For purposes of this section, "specialized services" for a person with mental retardation or a related condition means active treatment as that term is defined under Code of Federal Regulations, title 42, section 483.440, paragraph (a), clause (1).

(d) The determination of the need for nursing facility level of care must be made according to criteria developed by the commissioner of human services. In assessing a person's needs, consultation team members shall have a physician available for consultation and shall consider the assessment of the individual's attending physician, if any. The individual's physician must be included if the physician chooses to participate. Other personnel may be included on the team as deemed appropriate by the county.

Sec. 11. Minnesota Statutes 2000, section 256B.0911, is amended by adding a subdivision to read:

Subd. 4b. [EXEMPTIONS AND EMERGENCY ADMISSIONS.] (a) Exemptions from the federal screening requirements outlined in subdivision 4a, paragraphs (b) and (c), are limited to:

(1) a person who, having entered an acute care facility from a certified nursing facility, is returning to a certified nursing facility; and

(2) a person transferring from one certified nursing facility in Minnesota to another certified nursing facility in Minnesota.

(b) Persons who are exempt from preadmission screening for purposes of level of care determination include:

(1) persons described in paragraph (a);

(2) an individual who has a contractual right to have nursing facility care paid for indefinitely by the veterans' administration;

(3) an individual enrolled in a demonstration project under section 256B.69, subdivision 8, at the time of application to a nursing facility;

(4) an individual currently being served under the alternative care program or under a home and community-based services waiver authorized under section 1915(c) of the federal Social Security Act; and

(5) individuals admitted to a certified nursing facility for a short-term stay, which is expected to be 14 days or less in duration based upon a physician's certification, and who have been assessed and approved for nursing facility admission within the previous six months. This exemption applies only if the consultation team member determines at the time of the initial assessment of the six-month period that it is appropriate to use the nursing facility for short-term stays and that there is an adequate plan of care for return to the home or community-based setting. If a stay exceeds 14 days, the individual must be referred no later than the first county working day following the 14th resident day for a screening, which must be completed within five working days of the referral. The payment limitations in subdivision 7 apply to an individual found at screening to not meet the level of care criteria for admission to a certified nursing facility.

(c) Persons admitted to a Medicaid-certified nursing facility from the community on an emergency basis as described in paragraph (d) or from an acute care facility on a nonworking day must be screened the first working day after admission.

(d) Emergency admission to a nursing facility prior to screening is permitted when all of the following conditions are met:

(1) a person is admitted from the community to a certified nursing or certified boarding care facility during county nonworking hours;

(2) a physician has determined that delaying admission until preadmission screening is completed would adversely affect the person's health and safety;

(3) there is a recent precipitating event that precludes the client from living safely in the community, such as sustaining an injury, sudden onset of acute illness, or a caregiver's inability to continue to provide care;

(4) the attending physician has authorized the emergency placement and has documented the reason that the emergency placement is recommended; and

(5) the county is contacted on the first working day following the emergency admission.

Transfer of a patient from an acute care hospital to a nursing facility is not considered an emergency except for a person who has received hospital services in the following situations: hospital admission for observation, care in an emergency room without hospital admission, or following hospital 24-hour bed care.

Sec. 12. Minnesota Statutes 2000, section 256B.0911, is amended by adding a subdivision to read:

Subd. 4c. [SCREENING REQUIREMENTS.] (a) A person may be screened for nursing facility admission by telephone or in a face-to-face screening interview. Consultation team members shall identify each individual's needs using the following categories:

(1) the person needs no face-to-face screening interview to determine the need for nursing facility level of care based on information obtained from other health care professionals;

(2) the person needs an immediate face-to-face screening interview to determine the need for nursing facility level of care and complete activities required under subdivision 4a; or

(3) the person may be exempt from screening requirements as outlined in subdivision 4b, but will need transitional assistance after admission or in-person follow-along after a return home.

(b) Persons admitted on a nonemergency basis to a Medicaid-certified nursing facility must be screened prior to admission.

(c) The long-term care consultation team shall recommend a case mix classification for persons admitted to a certified nursing facility when sufficient information is received to make that classification. The nursing facility is authorized to conduct all case mix assessments for persons who have been screened prior to admission for whom the county did not recommend a case mix classification. The nursing facility is authorized to conduct all case mix assessments for persons admitted to the facility prior to a preadmission screening. The county retains the responsibility of distributing appropriate case mix forms to the nursing facility.

(d) The county screening or intake activity must include processes to identify persons who may require transition assistance as described in subdivision 3b.

Sec. 13. Minnesota Statutes 2000, section 256B.0911, subdivision 5, is amended to read:

Subd. 5. [SIMPLIFICATION OF FORMS ADMINISTRATIVE ACTIVITY.] The commissioner shall minimize the number of forms required in the preadmission screening process provision of long-term care consultation services and shall limit the screening document to items necessary for care community support plan approval, reimbursement, program planning, evaluation, and policy development.

Sec. 14. Minnesota Statutes 2000, section 256B.0911, subdivision 6, is amended to read:

Subd. 6. [~~PAYMENT FOR PREADMISSION SCREENING~~ LONG-TERM CARE CONSULTATION SERVICES.] (a) The total ~~screening~~ payment for each county must be paid monthly by certified nursing facilities in the county. The monthly amount to be paid by each nursing facility for each fiscal year must be determined by dividing the county's annual allocation for ~~screenings~~ long-term care consultation services by 12 to determine the monthly payment and allocating the monthly payment to each nursing facility based on the number of licensed beds in the nursing facility. Payments to counties in which there is no certified nursing facility must be made by increasing the payment rate of the two facilities located nearest to the county seat.

(b) The commissioner shall include the total annual payment for ~~screening~~ determined under paragraph (a) for each nursing facility according to section 256B.431, subdivision 2b, paragraph (g), 256B.434, or 256B.435.

(c) Payments for ~~screening activities~~ long-term care consultation services are available to the county or counties to cover staff salaries and expenses to provide the ~~screening function services~~ described in subdivision 1a. The ~~lead agency~~ county shall employ, or contract with other agencies to employ, within the limits of available funding, sufficient personnel to ~~conduct the preadmission screening activity~~ provide long-term care consultation services while meeting the state's long-term care outcomes and objectives as defined in section 256B.0917, subdivision 1. The ~~local agency~~ county shall be accountable for meeting local objectives as approved by the commissioner in the CSSA biennial plan.

(d) Notwithstanding section 256B.0641, overpayments attributable to payment of the screening costs under the medical assistance program may not be recovered from a facility.

(e) The commissioner of human services shall amend the Minnesota medical assistance plan to include reimbursement for the local ~~screening~~ consultation teams.

(f) The county may bill, as case management services, assessments, support planning, and follow-along provided to persons determined to be eligible for case management under Minnesota health care programs. No individual or family member shall be charged for an initial assessment or initial support plan development provided under subdivision 3a or 3b.

Sec. 15. Minnesota Statutes 2000, section 256B.0911, subdivision 7, is amended to read:

Subd. 7. [REIMBURSEMENT FOR CERTIFIED NURSING FACILITIES.] (a) Medical assistance reimbursement for nursing facilities shall be authorized for a medical assistance recipient only if a preadmission screening has been conducted prior to admission or the ~~local county agency~~ has authorized an exemption. Medical assistance reimbursement for nursing facilities shall not be provided for any recipient who the local screener has determined does not meet the level of care criteria for nursing facility placement or, if indicated, has not had a level II PASARR OBRA evaluation as required under the federal Omnibus Reconciliation Act of 1987 completed unless an admission for a recipient with mental illness is approved by the local mental health authority or an admission for a recipient with mental retardation or related condition is approved by the state mental retardation authority.

(b) The nursing facility must not bill a person who is not a medical assistance recipient for resident days that preceded the date of completion of screening activities as required under subdivisions 4a, 4b, and 4c. The nursing facility must include unreimbursed resident days in the nursing facility resident day totals reported to the commissioner.

(c) The commissioner shall make a request to the health care financing administration for a waiver allowing screening team approval of Medicaid payments for certified nursing facility care. An individual has a choice and makes the final decision between nursing facility placement and community placement after the screening team's recommendation, except as provided in ~~paragraphs (b) and (c)~~ subdivision 4a, paragraph (c).

~~(c) The local county mental health authority or the state mental retardation authority under Public Law Numbers 100-203 and 101-508 may prohibit admission to a nursing facility, if the individual does not meet the nursing facility level of care criteria or needs specialized services as defined in Public Law Numbers 100-203 and 101-508. For purposes of this section, "specialized services" for a person with mental retardation or a related condition means "active treatment" as that term is defined in Code of Federal Regulations, title 42, section 483.440(a)(1).~~

~~(e) Appeals from the screening team's recommendation or the county agency's final decision shall be made according to section 256.045, subdivision 3.~~

Sec. 16. Minnesota Statutes 2000, section 256B.0913, subdivision 1, is amended to read:

Subdivision 1. [PURPOSE AND GOALS.] The purpose of the alternative care program is to provide funding for ~~or access to~~ home and community-based services for ~~frail~~ elderly persons, in order to limit nursing facility placements. The program is designed to support ~~frail~~ elderly persons in their desire to remain in the community as independently and as long as possible and to support informal caregivers in their efforts to provide care for ~~frail~~ elderly people. Further, the goals of the program are:

(1) to contain medical assistance expenditures by providing funding care in the community ~~at a cost the same or less than nursing facility costs~~; and

(2) to maintain the moratorium on new construction of nursing home beds.

Sec. 17. Minnesota Statutes 2000, section 256B.0913, subdivision 2, is amended to read:

Subd. 2. [ELIGIBILITY FOR SERVICES.] Alternative care services are available to ~~all frail older~~ Minnesotans. ~~This includes:~~

~~(1) persons who are receiving medical assistance and served under the medical assistance program or the Medicaid waiver program;~~

~~(2) persons age 65 or older who are not eligible for medical assistance without a spenddown or waiver obligation but who would be eligible for medical assistance within 180 days of admission to a nursing facility and served under subject to subdivisions 4 to 13; and~~

~~(3) persons who are paying for their services out-of-pocket.~~

Sec. 18. Minnesota Statutes 2000, section 256B.0913, subdivision 4, is amended to read:

Subd. 4. [ELIGIBILITY FOR FUNDING FOR SERVICES FOR NONMEDICAL ASSISTANCE RECIPIENTS.]  
(a) Funding for services under the alternative care program is available to persons who meet the following criteria:

~~(1) the person has been screened by the county screening team or, if previously screened and served under the alternative care program, assessed by the local county social worker or public health nurse determined by a community assessment under section 256B.0911, to be a person who would require the level of care provided in a nursing facility, but for the provision of services under the alternative care program;~~

~~(2) the person is age 65 or older;~~

~~(3) the person would be financially eligible for medical assistance within 180 days of admission to a nursing facility;~~

~~(4) the person meets the asset transfer requirements of is not ineligible for the medical assistance program due to an asset transfer penalty;~~

(5) the screening team would recommend nursing facility admission or continued stay for the person if alternative care services were not available;

(6) the person needs services that are not available at that time in the county funded through other county, state, or federal funding sources; and

(7) (6) the monthly cost of the alternative care services funded by the program for this person does not exceed 75 percent of the statewide average monthly medical assistance payment for nursing facility care at the individual's case mix classification weighted average monthly nursing facility rate of the case mix resident class to which the individual alternative care client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, less the recipient's maintenance needs allowance as described in section 256B.0915, subdivision 1d, paragraph (a), until the first day of the state fiscal year in which the resident assessment system, under section 256B.437, for nursing home rate determination is implemented. Effective on the first day of the state fiscal year in which a resident assessment system, under section 256B.437, for nursing home rate determination is implemented and the first day of each subsequent state fiscal year, the monthly cost of alternative care services for this person shall not exceed the alternative care monthly cap for the case mix resident class to which the alternative care client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, which was in effect on the last day of the previous state fiscal year, and adjusted by the greater of any legislatively adopted home and community-based services cost-of-living percentage increase or any legislatively adopted statewide percent rate increase for nursing facilities. This monthly limit does not prohibit the alternative care client from payment for additional services, but in no case may the cost of additional services purchased under this section exceed the difference between the client's monthly service limit defined under section 256B.0915, subdivision 3, and the alternative care program monthly service limit defined in this paragraph. If medical supplies and equipment or adaptations environmental modifications are or will be purchased for an alternative care services recipient, the costs may be prorated on a monthly basis throughout the year in which they are purchased for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's other alternative care services exceeds the monthly limit established in this paragraph, the annual cost of the alternative care services shall be determined. In this event, the annual cost of alternative care services shall not exceed 12 times the monthly limit calculated described in this paragraph.

(b) Individuals who meet the criteria in paragraph (a) and who have been approved for alternative care funding are called 180-day eligible clients.

(c) The statewide average payment for nursing facility care is the statewide average monthly nursing facility rate in effect on July 1 of the fiscal year in which the cost is incurred, less the statewide average monthly income of nursing facility residents who are age 65 or older and who are medical assistance recipients in the month of March of the previous fiscal year. This monthly limit does not prohibit the 180-day eligible client from paying for additional services needed or desired.

(d) In determining the total costs of alternative care services for one month, the costs of all services funded by the alternative care program, including supplies and equipment, must be included.

(e) Alternative care funding under this subdivision is not available for a person who is a medical assistance recipient or who would be eligible for medical assistance without a spenddown, unless authorized by the commissioner or waiver obligation. A person whose initial application for medical assistance is being processed may be served under the alternative care program for a period up to 60 days. If the individual is found to be eligible for medical assistance, the county must bill medical assistance must be billed for services payable under the federally approved elderly waiver plan and delivered from the date the individual was found eligible for services reimbursable under the federally approved elderly waiver program plan. Notwithstanding this provision, upon federal approval, alternative care funds may not be used to pay for any service the cost of which is payable by medical assistance or which is used by a recipient to meet a medical assistance income spenddown or waiver obligation.

(f) (c) Alternative care funding is not available for a person who resides in a licensed nursing home or, certified boarding care home, hospital, or intermediate care facility, except for case management services which are being provided in support of the discharge planning process to a nursing home resident or certified boarding care home resident who is ineligible for case management funded by medical assistance.

Sec. 19. Minnesota Statutes 2000, section 256B.0913, subdivision 5, is amended to read:

Subd. 5. [SERVICES COVERED UNDER ALTERNATIVE CARE.] (a) Alternative care funding may be used for payment of costs of:

- (1) adult foster care;
  - (2) adult day care;
  - (3) home health aide;
  - (4) homemaker services;
  - (5) personal care;
  - (6) case management;
  - (7) respite care;
  - (8) assisted living;
  - (9) residential care services;
  - (10) care-related supplies and equipment;
  - (11) meals delivered to the home;
  - (12) transportation;
  - (13) skilled nursing;
  - (14) chore services;
  - (15) companion services;
  - (16) nutrition services;
  - (17) training for direct informal caregivers;
  - (18) telemedicine devices to monitor recipients in their own homes as an alternative to hospital care, nursing home care, or home visits; ~~and~~
  - (19) other services ~~including which includes discretionary funds and~~ direct cash payments to clients, ~~approved by the county agency following approval by the commissioner,~~ subject to the provisions of paragraph ~~(m)~~ (j). Total annual payments for "other services" for all clients within a county may not exceed either ten percent of that county's annual alternative care program base allocation or \$5,000, whichever is greater. In no case shall this amount exceed the county's total annual alternative care program base allocation; and
  - (20) environmental modifications.
- (b) The county agency must ensure that the funds are not used ~~only to supplement and not to supplant~~ services available through other public assistance or services programs.

(c) Unless specified in statute, the service definitions and standards for alternative care services shall be the same as the service definitions and standards defined specified in the federally approved elderly waiver plan. Except for the county agencies' approval of direct cash payments to clients as described in paragraph (j) or for a provider of supplies and equipment when the monthly cost of the supplies and equipment is less than \$250, persons or agencies must be employed by or under a contract with the county agency or the public health nursing agency of the local board of health in order to receive funding under the alternative care program. Supplies and equipment may be purchased from a non-Medicaid certified vendor if the cost for the item is less than that of a Medicaid vendor.

(d) The adult foster care rate shall be considered a difficulty of care payment and shall not include room and board. The adult foster care ~~daily~~ rate shall be negotiated between the county agency and the foster care provider. ~~The rate established under this section shall not exceed 75 percent of the state average monthly nursing home payment for the case mix classification to which the individual receiving foster care is assigned, and it must allow for other alternative care services to be authorized by the case manager. The alternative care payment for the foster care service in combination with the payment for other alternative care services, including case management, must not exceed the limit specified in subdivision 4, paragraph (a), clause (6).~~

(e) ~~Personal care services may be provided by a personal care provider organization; must meet the service standards defined in the federally approved elderly waiver plan, except that a county agency may contract with a client's relative of the client who meets the relative hardship waiver requirement as defined in section 256B.0627, subdivision 4, paragraph (b), clause (10), to provide personal care services; but must ensure nursing if the county agency ensures supervision of this service by a registered nurse or mental health practitioner. Covered personal care services defined in section 256B.0627, subdivision 4, must meet applicable standards in Minnesota Rules, part 9505.0335.~~

(f) ~~A county may use alternative care funds to purchase medical supplies and equipment without prior approval from the commissioner when: (1) there is no other funding source; (2) the supplies and equipment are specified in the individual's care plan as medically necessary to enable the individual to remain in the community according to the criteria in Minnesota Rules, part 9505.0210, item A; and (3) the supplies and equipment represent an effective and appropriate use of alternative care funds. A county may use alternative care funds to purchase supplies and equipment from a non-Medicaid certified vendor if the cost for the items is less than that of a Medicaid vendor. A county is not required to contract with a provider of supplies and equipment if the monthly cost of the supplies and equipment is less than \$250.~~

(~~g~~) For purposes of this section, residential care services are services which are provided to individuals living in residential care homes. Residential care homes are currently licensed as board and lodging establishments and are registered with the department of health as providing special services under section 157.17 and are not subject to registration under chapter 144D. Residential care services are defined as "supportive services" and "health-related services." "Supportive services" means the provision of up to 24-hour supervision and oversight. Supportive services includes: (1) transportation, when provided by the residential care ~~center~~ home only; (2) socialization, when socialization is part of the plan of care, has specific goals and outcomes established, and is not diversional or recreational in nature; (3) assisting clients in setting up meetings and appointments; (4) assisting clients in setting up medical and social services; (5) providing assistance with personal laundry, such as carrying the client's laundry to the laundry room. Assistance with personal laundry does not include any laundry, such as bed linen, that is included in the room and board rate. "Health-related services" are limited to minimal assistance with dressing, grooming, and bathing and providing reminders to residents to take medications that are self-administered or providing storage for medications, if requested. Individuals receiving residential care services cannot receive homemaking services funded under this section.

(~~h~~) (~~g~~) For the purposes of this section, "assisted living" refers to supportive services provided by a single vendor to clients who reside in the same apartment building of three or more units which are not subject to registration under chapter 144D and are licensed by the department of health as a class A home care provider or a class E home care provider. Assisted living services are defined as up to 24-hour supervision, and oversight, supportive services as defined in clause (1), individualized home care aide tasks as defined in clause (2), and individualized home management tasks as defined in clause (3) provided to residents of a residential center living in their units or

apartments with a full kitchen and bathroom. A full kitchen includes a stove, oven, refrigerator, food preparation counter space, and a kitchen utensil storage compartment. Assisted living services must be provided by the management of the residential center or by providers under contract with the management or with the county.

(1) Supportive services include:

(i) socialization, when socialization is part of the plan of care, has specific goals and outcomes established, and is not diversional or recreational in nature;

(ii) assisting clients in setting up meetings and appointments; and

(iii) providing transportation, when provided by the residential center only.

~~Individuals receiving assisted living services will not receive both assisted living services and homemaking services. Individualized means services are chosen and designed specifically for each resident's needs, rather than provided or offered to all residents regardless of their illnesses, disabilities, or physical conditions.~~

(2) Home care aide tasks means:

(i) preparing modified diets, such as diabetic or low sodium diets;

(ii) reminding residents to take regularly scheduled medications or to perform exercises;

(iii) household chores in the presence of technically sophisticated medical equipment or episodes of acute illness or infectious disease;

(iv) household chores when the resident's care requires the prevention of exposure to infectious disease or containment of infectious disease; and

(v) assisting with dressing, oral hygiene, hair care, grooming, and bathing, if the resident is ambulatory, and if the resident has no serious acute illness or infectious disease. Oral hygiene means care of teeth, gums, and oral prosthetic devices.

(3) Home management tasks means:

(i) housekeeping;

(ii) laundry;

(iii) preparation of regular snacks and meals; and

(iv) shopping.

~~Individuals receiving assisted living services shall not receive both assisted living services and homemaking services. Individualized means services are chosen and designed specifically for each resident's needs, rather than provided or offered to all residents regardless of their illnesses, disabilities, or physical conditions.~~ Assisted living services as defined in this section shall not be authorized in boarding and lodging establishments licensed according to sections 157.011 and 157.15 to 157.22.

(†) (h) For establishments registered under chapter 144D, assisted living services under this section means either the services described and licensed in paragraph (g) and delivered by a class E home care provider licensed by the department of health or the services described under section 144A.4605 and delivered by an assisted living home care provider or a class A home care provider licensed by the commissioner of health.



(j) For the purposes of this section, reimbursement (i) Payment for assisted living services and residential care services shall be a monthly rate negotiated and authorized by the county agency based on an individualized service plan for each resident and may not cover direct rent or food costs. ~~The rate~~

(1) The individualized monthly negotiated payment for assisted living services as described in paragraph (g) or (h), and residential care services as described in paragraph (f), shall not exceed the nonfederal share in effect on July 1 of the state fiscal year for which the rate limit is being calculated of the greater of either the statewide or any of the geographic groups' weighted average monthly ~~medical assistance~~ nursing facility payment rate of the case mix resident class to which the ~~180-day~~ alternative care eligible client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, ~~unless the less the maintenance needs allowance as described in subdivision 1d, paragraph (a), until the first day of the state fiscal year in which a resident assessment system, under section 256B.437, of nursing home rate determination is implemented. Effective on the first day of the state fiscal year in which a resident assessment system, under section 256B.437, of nursing home rate determination is implemented and the first day of each subsequent state fiscal year, the individualized monthly negotiated payment for the services described in this clause shall not exceed the limit described in this clause which was in effect on the last day of the previous state fiscal year and which has been adjusted by the greater of any legislatively adopted home and community-based services cost-of-living percentage increase or any legislatively adopted statewide percent rate increase for nursing facilities.~~

(2) The individualized monthly negotiated payment for assisted living services are provided by a home care described under section 144A.4605 and delivered by a provider licensed by the department of health as a class A home care provider or an assisted living home care provider and are provided in a building that is registered as a housing with services establishment under chapter 144D and that provides 24-hour supervision in combination with the payment for other alternative care services, including case management, must not exceed the limit specified in subdivision 4, paragraph (a), clause (6).

(k) For purposes of this section, companion services are defined as nonmedical care, supervision and oversight, provided to a functionally impaired adult. Companions may assist the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on medical care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the recipient. This service must be approved by the case manager as part of the care plan. Companion services must be provided by individuals or organizations who are under contract with the local agency to provide the service. Any person related to the waiver recipient by blood, marriage or adoption cannot be reimbursed under this service. Persons providing companion services will be monitored by the case manager.

(l) For purposes of this section, training for direct informal caregivers is defined as a classroom or home course of instruction which may include: transfer and lifting skills, nutrition, personal and physical cares, home safety in a home environment, stress reduction and management, behavioral management, long-term care decision making, care coordination and family dynamics. The training is provided to an informal unpaid caregiver of a 180-day eligible client which enables the caregiver to deliver care in a home setting with high levels of quality. The training must be approved by the case manager as part of the individual care plan. Individuals, agencies, and educational facilities which provide caregiver training and education will be monitored by the case manager.

(m) (j) A county agency may make payment from their alternative care program allocation for "other services" provided to an alternative care program recipient if those services prevent, shorten, or delay institutionalization. These services may which include use of "discretionary funds" for services that are not otherwise defined in this section and direct cash payments to the recipient client for the purpose of purchasing the recipient's services. The following provisions apply to payments under this paragraph:

(1) a cash payment to a client under this provision cannot exceed 80 percent of the monthly payment limit for that client as specified in subdivision 4, paragraph (a), clause (7) (6);

(2) a county may not approve any cash payment for a client who meets either of the following:

(i) has been assessed as having a dependency in orientation, unless the client has an authorized representative under section 256.476, subdivision 2, paragraph (g), or for a client who. An "authorized representative" means an individual who is at least 18 years of age and is designated by the person or the person's legal representative to act on the person's behalf. This individual may be a family member, guardian, representative payee, or other individual designated by the person or the person's legal representative, if any, to assist in purchasing and arranging for supports; or

(ii) is concurrently receiving adult foster care, residential care, or assisted living services;

(3) any service approved under this section must be a service which meets the purpose and goals of the program as listed in subdivision 1;

(4) cash payments must also meet the criteria of and are governed by the procedures and liability protection established in section 256.476, subdivision 4, paragraphs (b) through (h), and recipients of cash grants must meet the requirements in section 256.476, subdivision 10; and cash payments to a person or a person's family will be provided through a monthly payment and be in the form of cash, voucher, or direct county payment to vendor. Fees or premiums assessed to the person for eligibility for health and human services are not reimbursable through this service option. Services and goods purchased through cash payments must be identified in the person's individualized care plan and must meet all of the following criteria:

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

(ii) they must be directly attributable to the person's functional limitations;

(iii) they must have the potential to be effective at meeting the goals of the program;

(iv) they must be consistent with the needs identified in the individualized service plan. The service plan shall specify the needs of the person and family, the form and amount of payment, the items and services to be reimbursed, and the arrangements for management of the individual grant; and

(v) the person, the person's family, or the legal representative shall be provided sufficient information to ensure an informed choice of alternatives. The local agency shall document this information in the person's care plan, including the type and level of expenditures to be reimbursed;

(4) the county, lead agency under contract, or tribal government under contract to administer the alternative care program shall not be liable for damages, injuries, or liabilities sustained through the purchase of direct supports or goods by the person, the person's family, or the authorized representative with funds received through the cash payments under this section. Liabilities include, but are not limited to, workers' compensation, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA);

(5) persons receiving grants under this section shall have the following responsibilities:

(i) spend the grant money in a manner consistent with their individualized service plan with the local agency;

(ii) notify the local agency of any necessary changes in the grant-expenditures;

(iii) arrange and pay for supports; and

(iv) inform the local agency of areas where they have experienced difficulty securing or maintaining supports; and

(5) (6) the county shall report client outcomes, services, and costs under this paragraph in a manner prescribed by the commissioner.

(k) Upon implementation of direct cash payments to clients under this section, any person determined eligible for the alternative care program who chooses a cash payment approved by the county agency shall receive the cash payment under this section and not under section 256.476 unless the person was receiving a consumer support grant under section 256.476 before implementation of direct cash payments under this section.

Sec. 20. Minnesota Statutes 2000, section 256B.0913, subdivision 6, is amended to read:

Subd. 6. [ALTERNATIVE CARE PROGRAM ADMINISTRATION.] The alternative care program is administered by the county agency. This agency is the lead agency responsible for the local administration of the alternative care program as described in this section. However, it may contract with the public health nursing service to be the lead agency. The commissioner may contract with federally recognized Indian tribes with a reservation in Minnesota to serve as the lead agency responsible for the local administration of the alternative care program as described in the contract.

Sec. 21. Minnesota Statutes 2000, section 256B.0913, subdivision 7, is amended to read:

Subd. 7. [CASE MANAGEMENT.] Providers of case management services for persons receiving services funded by the alternative care program must meet the qualification requirements and standards specified in section 256B.0915, subdivision 1b. The case manager must ~~ensure the health and safety of the individual client and not approve alternative care funding for a client in any setting in which the case manager cannot reasonably ensure the client's health and safety.~~ The case manager is responsible for the cost-effectiveness of the alternative care individual care plan and must not approve any care plan in which the cost of services funded by alternative care and client contributions exceeds the limit specified in section 256B.0915, subdivision 3, paragraph (b). The county may allow a case manager employed by the county to delegate certain aspects of the case management activity to another individual employed by the county provided there is oversight of the individual by the case manager. The case manager may not delegate those aspects which require professional judgment including assessments, reassessments, and care plan development.

Sec. 22. Minnesota Statutes 2000, section 256B.0913, subdivision 8, is amended to read:

Subd. 8. [REQUIREMENTS FOR INDIVIDUAL CARE PLAN.] (a) The case manager shall implement the plan of care for each ~~180-day eligible alternative care~~ client and ensure that a client's service needs and eligibility are reassessed at least every 12 months. The plan shall include any services prescribed by the individual's attending physician as necessary to allow the individual to remain in a community setting. In developing the individual's care plan, the case manager should include the use of volunteers from families and neighbors, religious organizations, social clubs, and civic and service organizations to support the formal home care services. The county shall be held harmless for damages or injuries sustained through the use of volunteers under this subdivision including workers' compensation liability. ~~The lead agency shall provide documentation to the commissioner verifying that the individual's alternative care is not available at that time through any other public assistance or service program.~~ The lead agency shall provide documentation in each individual's plan of care and, if requested, to the commissioner that the most cost-effective alternatives available have been offered to the individual and that the individual was free to choose among available qualified providers, both public and private. The case manager must give the individual a ten-day written notice of any decrease in or termination of alternative care services.

(b) If the county administering alternative care services is different than the county of financial responsibility, the care plan may be implemented without the approval of the county of financial responsibility.

Sec. 23. Minnesota Statutes 2000, section 256B.0913, subdivision 9, is amended to read:

Subd. 9. [CONTRACTING PROVISIONS FOR PROVIDERS.] ~~The lead agency shall document to the commissioner that the agency made reasonable efforts to inform potential providers of the anticipated need for services under the alternative care program or waiver programs under sections 256B.0915 and 256B.49, including a minimum of 14 days' written advance notice of the opportunity to be selected as a service provider and an annual public meeting with providers to explain and review the criteria for selection. The lead agency shall also document~~

to the commissioner that the agency allowed potential providers an opportunity to be selected to contract with the county agency. Funds reimbursed to counties under this subdivision Alternative care funds paid to service providers are subject to audit by the commissioner for fiscal and utilization control.

The lead agency must select providers for contracts or agreements using the following criteria and other criteria established by the county:

- (1) the need for the particular services offered by the provider;
- (2) the population to be served, including the number of clients, the length of time services will be provided, and the medical condition of clients;
- (3) the geographic area to be served;
- (4) quality assurance methods, including appropriate licensure, certification, or standards, and supervision of employees when needed;
- (5) rates for each service and unit of service exclusive of county administrative costs;
- (6) evaluation of services previously delivered by the provider; and
- (7) contract or agreement conditions, including billing requirements, cancellation, and indemnification.

The county must evaluate its own agency services under the criteria established for other providers. ~~The county shall provide a written statement of the reasons for not selecting providers.~~

Sec. 24. Minnesota Statutes 2000, section 256B.0913, subdivision 10, is amended to read:

Subd. 10. [ALLOCATION FORMULA.] (a) The alternative care appropriation for fiscal years 1992 and beyond shall cover only ~~180-day~~ alternative care eligible clients. ~~Prior to July 1 of each year, the commissioner shall allocate to county agencies the state funds available for alternative care for persons eligible under subdivision 2.~~

~~(b) Prior to July 1 of each year, the commissioner shall allocate to county agencies the state funds available for alternative care for persons eligible under subdivision 2. The allocation for fiscal year 1992 shall be calculated using a base that is adjusted to exclude the medical assistance share of alternative care expenditures. The adjusted base is calculated by multiplying each county's allocation for fiscal year 1991 by the percentage of county alternative care expenditures for 180-day eligible clients. The percentage is determined based on expenditures for services rendered in fiscal year 1989 or calendar year 1989, whichever is greater. The adjusted base for each county is the county's current fiscal year base allocation plus any targeted funds approved during the current fiscal year. Calculations for paragraphs (c) and (d) are to be made as follows: for each county, the determination of alternative care program expenditures shall be based on payments for services rendered from April 1 through March 31 in the base year, to the extent that claims have been submitted and paid by June 1 of that year.~~

~~(c) If the county alternative care program expenditures for 180-day eligible clients as defined in paragraph (b) are 95 percent or more of its the county's adjusted base allocation, the allocation for the next fiscal year is 100 percent of the adjusted base, plus inflation to the extent that inflation is included in the state budget.~~

~~(d) If the county alternative care program expenditures for 180-day eligible clients as defined in paragraph (b) are less than 95 percent of its the county's adjusted base allocation, the allocation for the next fiscal year is the adjusted base allocation less the amount of unspent funds below the 95 percent level.~~

~~(e) For fiscal year 1992 only, a county may receive an increased allocation if annualized service costs for the month of May 1991 for 180-day eligible clients are greater than the allocation otherwise determined. A county may apply for this increase by reporting projected expenditures for May to the commissioner by June 1, 1991. The~~

amount of the allocation may exceed the amount calculated in paragraph (b). The projected expenditures for May must be based on actual 180-day eligible client caseload and the individual cost of clients' care plans. If a county does not report its expenditures for May, the amount in paragraph (c) or (d) shall be used.

~~(f) Calculations for paragraphs (c) and (d) are to be made as follows: for each county, the determination of expenditures shall be based on payments for services rendered from April 1 through March 31 in the base year, to the extent that claims have been submitted by June 1 of that year. Calculations for paragraphs (c) and (d) must also include the funds transferred to the consumer support grant program for clients who have transferred to that program from April 1 through March 31 in the base year.~~

~~(g) For the biennium ending June 30, 2001, the allocation of state funds to county agencies shall be calculated as described in paragraphs (c) and (d). If the annual legislative appropriation for the alternative care program is inadequate to fund the combined county allocations for fiscal year 2000 or 2001 a biennium, the commissioner shall distribute to each county the entire annual appropriation as that county's percentage of the computed base as calculated in ~~paragraph (f)~~ paragraphs (c) and (d).~~

Sec. 25. Minnesota Statutes 2000, section 256B.0913, subdivision 11, is amended to read:

Subd. 11. [TARGETED FUNDING.] (a) The purpose of targeted funding is to make additional money available to counties with the greatest need. Targeted funds are not intended to be distributed equitably among all counties, but rather, allocated to those with long-term care strategies that meet state goals.

(b) The funds available for targeted funding shall be the total appropriation for each fiscal year minus county allocations determined under subdivision 10 as adjusted for any inflation increases provided in appropriations for the biennium.

(c) The commissioner shall allocate targeted funds to counties that demonstrate to the satisfaction of the commissioner that they have developed feasible plans to increase alternative care spending. In making targeted funding allocations, the commissioner shall use the following priorities:

(1) counties that received a lower allocation in fiscal year 1991 than in fiscal year 1990. Counties remain in this priority until they have been restored to their fiscal year 1990 level plus inflation;

(2) counties that sustain a base allocation reduction for failure to spend 95 percent of the allocation if they demonstrate that the base reduction should be restored;

(3) counties that propose projects to divert community residents from nursing home placement or convert nursing home residents to community living; and

(4) counties that can otherwise justify program growth by demonstrating the existence of waiting lists, demographically justified needs, or other unmet needs.

(d) Counties that would receive targeted funds according to paragraph (c) must demonstrate to the commissioner's satisfaction that the funds would be appropriately spent by showing how the funds would be used to further the state's alternative care goals as described in subdivision 1, and that the county has the administrative and service delivery capability to use them.

(e) The commissioner shall request applications ~~by June 1 each year, for county agencies to apply~~ for targeted funds by November 1 of each year. The counties selected for targeted funds shall be notified of the amount of their additional funding ~~by August 1 of each year~~. Targeted funds allocated to a county agency in one year shall be treated as part of the county's base allocation for that year in determining allocations for subsequent years. No reallocations between counties shall be made.

~~(f) The allocation for each year after fiscal year 1992 shall be determined using the previous fiscal year's allocation, including any targeted funds, as the base and then applying the criteria under subdivision 10, paragraphs (c), (d), and (f), to the current year's expenditures.~~

Sec. 26. Minnesota Statutes 2000, section 256B.0913, subdivision 12, is amended to read:

Subd. 12. [CLIENT PREMIUMS.] (a) A premium is required for all ~~180-day~~ alternative care eligible clients to help pay for the cost of participating in the program. The amount of the premium for the alternative care client shall be determined as follows:

(1) when the alternative care client's income less recurring and predictable medical expenses is greater than the ~~medical assistance income standard recipient's maintenance needs allowance as defined in section 256B.0915, subdivision 1d, paragraph (a)~~, but less than 150 percent of the federal poverty guideline effective on July 1 of the state fiscal year in which the premium is being computed, and total assets are less than \$10,000, the fee is zero;

(2) when the alternative care client's income less recurring and predictable medical expenses is greater than 150 percent of the federal poverty guideline effective on July 1 of the state fiscal year in which the premium is being computed, and total assets are less than \$10,000, the fee is 25 percent of the cost of alternative care services or the difference between 150 percent of the federal poverty guideline effective on July 1 of the state fiscal year in which the premium is being computed and the client's income less recurring and predictable medical expenses, whichever is less; and

(3) when the alternative care client's total assets are greater than \$10,000, the fee is 25 percent of the cost of alternative care services.

For married persons, total assets are defined as the total marital assets less the estimated community spouse asset allowance, under section 256B.059, if applicable. For married persons, total income is defined as the client's income less the monthly spousal allotment, under section 256B.058.

All alternative care services except case management shall be included in the estimated costs for the purpose of determining 25 percent of the costs.

The monthly premium shall be calculated based on the cost of the first full month of alternative care services and shall continue unaltered until the next reassessment is completed or at the end of 12 months, whichever comes first. Premiums are due and payable each month alternative care services are received unless the actual cost of the services is less than the premium.

(b) The fee shall be waived by the commissioner when:

- (1) a person who is residing in a nursing facility is receiving case management only;
- (2) a person is applying for medical assistance;
- (3) a married couple is requesting an asset assessment under the spousal impoverishment provisions;
- (4) ~~a person is a medical assistance recipient, but has been approved for alternative care-funded assisted living services;~~
- (5) a person is found eligible for alternative care, but is not yet receiving alternative care services; or
- (6) (5) a person's fee under paragraph (a) is less than \$25.

(c) The county agency must record in the state's receivable system the client's assessed premium amount or the reason the premium has been waived. The commissioner will bill and collect the premium from the client ~~and forward the amounts collected to the commissioner in the manner and at the times prescribed by the commissioner.~~ Money collected must be deposited in the general fund and is appropriated to the commissioner for the alternative care program. The client must supply the county with the client's social security number at the time of application. ~~If a client fails or refuses to pay the premium due,~~ The county shall supply the commissioner with the client's social security number and other information the commissioner requires to collect the premium from the client. The commissioner shall collect unpaid premiums using the Revenue Recapture Act in chapter 270A and other methods available to the commissioner. The commissioner may require counties to inform clients of the collection procedures that may be used by the state if a premium is not paid.

(d) The commissioner shall begin to adopt emergency or permanent rules governing client premiums within 30 days after July 1, 1991, including criteria for determining when services to a client must be terminated due to failure to pay a premium.

Sec. 27. Minnesota Statutes 2000, section 256B.0913, subdivision 13, is amended to read:

Subd. 13. [COUNTY BIENNIAL PLAN.] The county biennial plan for ~~the preadmission screening program long-term care consultation under section 256B.0911, the alternative care program under this section, and waivers for the elderly under section 256B.0915, and waivers for the disabled under section 256B.49;~~ shall be incorporated into the biennial Community Social Services Act plan and shall meet the regulations and timelines of that plan. ~~This county biennial plan shall include:~~

~~(1) information on the administration of the preadmission screening program;~~

~~(2) information on the administration of the home and community-based services waivers for the elderly under section 256B.0915, and for the disabled under section 256B.49; and~~

~~(3) information on the administration of the alternative care program.~~

Sec. 28. Minnesota Statutes 2000, section 256B.0913, subdivision 14, is amended to read:

Subd. 14. [REIMBURSEMENT PAYMENT AND RATE ADJUSTMENTS.] (a) Reimbursement Payment for ~~expenditures for the provided~~ alternative care services as approved by the client's case manager shall be through the invoice processing procedures of the department's Medicaid Management Information System (MMIS). To receive reimbursement payment, the county or vendor must submit invoices within 12 months following the date of service. The county agency and its vendors under contract shall not be reimbursed for services which exceed the county allocation.

~~(b) If a county collects less than 50 percent of the client premiums due under subdivision 12, the commissioner may withhold up to three percent of the county's final alternative care program allocation determined under subdivisions 10 and 11.~~

~~(c)~~ The county shall negotiate individual rates with vendors and may ~~be reimbursed~~ authorize service payment for actual costs up to ~~the greater of the county's current approved rate or 60 percent of the maximum rate in fiscal year 1994 and 65 percent of the maximum rate in fiscal year 1995 for each alternative care service.~~ Notwithstanding any other rule or statutory provision to the contrary, the commissioner shall not be authorized to increase rates by an annual inflation factor, unless so authorized by the legislature.

~~(d)~~ ~~(c)~~ On July 1, 1993, the commissioner shall increase the maximum rate for home delivered meals to \$4.50 per meal. To improve access to community services and eliminate payment disparities between the alternative care program and the elderly waiver program, the commissioner shall establish statewide maximum service rate limits and eliminate county-specific service rate limits.

(1) Effective July 1, 2001, for service rate limits, except those in subdivision 5, paragraphs (d) and (j), the rate limit for each service shall be the greater of the alternative care statewide maximum rate or the elderly waiver statewide maximum rate.

(2) Counties may negotiate individual service rates with vendors for actual costs up to the statewide maximum service rate limit.

Sec. 29. Minnesota Statutes 2000, section 256B.0915, subdivision 1d, is amended to read:

Subd. 1d. [POSTELIGIBILITY TREATMENT OF INCOME AND RESOURCES FOR ELDERLY WAIVER.]  
~~(a)~~ Notwithstanding the provisions of section 256B.056, the commissioner shall make the following amendment to the medical assistance elderly waiver program effective July 1, 1999, or upon federal approval, whichever is later.

A recipient's maintenance needs will be an amount equal to the Minnesota supplemental aid equivalent rate as defined in section 256I.03, subdivision 5, plus the medical assistance personal needs allowance as defined in section 256B.35, subdivision 1, paragraph (a), when applying posteligibility treatment of income rules to the gross income of elderly waiver recipients, except for individuals whose income is in excess of the special income standard according to Code of Federal Regulations, title 42, section 435.236. Recipient maintenance needs shall be adjusted under this provision each July 1.

~~(b) The commissioner of human services shall secure approval of additional elderly waiver slots sufficient to serve persons who will qualify under the revised income standard described in paragraph (a) before implementing section 256B.0913, subdivision 16.~~

~~(c) In implementing this subdivision, the commissioner shall consider allowing persons who would otherwise be eligible for the alternative care program but would qualify for the elderly waiver with a spenddown to remain on the alternative care program.~~

Sec. 30. Minnesota Statutes 2000, section 256B.0915, subdivision 3, is amended to read:

Subd. 3. [LIMITS OF CASES, RATES, REIMBURSEMENT PAYMENTS, AND FORECASTING.] (a) The number of medical assistance waiver recipients that a county may serve must be allocated according to the number of medical assistance waiver cases open on July 1 of each fiscal year. Additional recipients may be served with the approval of the commissioner.

~~(b) The monthly limit for the cost of 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) Reimbursement for the medical assistance recipients under the approved waiver shall be made from the medical assistance account through the invoice processing procedures of the department's Medicaid Management Information System (MMIS), only with the approval of the client's case manager. The budget for the state share of the Medicaid expenditures shall be forecasted with the medical assistance budget, and shall be consistent with the approved waiver.

(k) To improve access to community services and eliminate payment disparities between the alternative care program and the elderly waiver, the commissioner shall establish statewide maximum service rate limits and eliminate county-specific service rate limits.

(1) Effective July 1, 2001, for service rate limits, except those described or defined in paragraphs (g) and (h), the rate limit for each service shall be the greater of the alternative care statewide maximum rate or the elderly waiver statewide maximum rate.

(2) Counties may negotiate individual service rates with vendors for actual costs up to the statewide maximum service rate limit.

~~(j)~~ (l) Beginning July 1, 1991, the state shall reimburse counties according to the payment schedule in section 256.025 for the county share of costs incurred under this subdivision on or after January 1, 1991, for individuals who are receiving medical assistance.

~~(k) For the community alternatives for disabled individuals waiver, and nursing facility disabled waivers, county may use waiver funds for the cost of minor adaptations to a client's residence or vehicle without prior approval from the commissioner if there is no other source of funding and the adaptation:~~

~~(1) is necessary to avoid institutionalization;~~

~~(2) has no utility apart from the needs of the client; and~~

~~(3) meets the criteria in Minnesota Rules, part 9505.0210, items A and B.~~

~~For purposes of this subdivision, "residence" means the client's own home, the client's family residence, or a family foster home. For purposes of this subdivision, "vehicle" means the client's vehicle, the client's family vehicle, or the client's family foster home vehicle.~~

~~(4) 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 6

### 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 provide 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 32, 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, determining a median, or otherwise performing a statistical measure 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, for facilities reimbursed under this section or section 256B.431, 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. 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 rate for purposes of determining future rates under this section or any other section through June 30, 2004.

Sec. 31. [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. 32. [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. 33. 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. 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.

(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. 35. 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. 36. Laws 1999, chapter 245, article 3, section 45, as amended by Laws 2000, chapter 312, section 3, is amended to read:

Sec. 45. [STATE LICENSURE CONFLICTS WITH FEDERAL REGULATIONS.]

(a) Notwithstanding the provisions of Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval.

(b) This section expires July 1, ~~2001~~ 2003.

## Sec. 37. [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. 38. [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. 39. [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. 40. [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. 41. [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. 42. [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. 43. [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. 44. [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. 45. [REPEALER.]

Minnesota Statutes 2000, sections 144.0721, subdivision 1, and 256B.434, subdivision 5, are repealed.

## ARTICLE 7

### 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 8

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 ~~(c)~~ (d), clauses (1) to (5), on forms prescribed by the commissioner. By January 1, 2000, for background studies conducted by the department of human services, the commissioner shall implement a system for the electronic transmission of: (1) background study information to the commissioner; and (2) background study results to the license holder. The commissioner may request additional information of the individual, which shall be optional for the individual to provide, such as the individual's social security number or race.

~~(f)~~ (g) Except for child foster care, adult foster care, and family day care homes, a study must include information related to names of substantiated perpetrators of maltreatment of vulnerable adults that has been received by the commissioner as required under section 626.557, subdivision 9c, paragraph (i), and the commissioner's records relating to the maltreatment of minors in licensed programs, information from juvenile courts as required in paragraph ~~(c)~~ (d) for persons listed in paragraph ~~(c)~~ (d), clause (2), and information from the bureau of criminal apprehension. For child foster care, adult foster care, and family day care homes, the study must include information from the county agency's record of substantiated maltreatment of adults, and the maltreatment of minors, information from juvenile courts as required in paragraph ~~(c)~~ (d) for persons listed in paragraph ~~(c)~~ (d), clause (2), and information from the bureau of criminal apprehension. The commissioner may also review arrest and investigative information from the bureau of criminal apprehension, the commissioner of health, a county attorney, county sheriff, county agency, local chief of police, other states, the courts, or the Federal Bureau of Investigation if the commissioner has reasonable cause to believe the information is pertinent to the disqualification of an individual listed in paragraph ~~(c)~~ (d), clauses (1) to (5). The commissioner is not required to conduct more than one review of a subject's records from the Federal Bureau of Investigation if a review of the subject's criminal history with the Federal Bureau of Investigation has already been completed by the commissioner and there has been no break in the subject's affiliation with the license holder who initiated the background studies.

When the commissioner has reasonable cause to believe that further pertinent information may exist on the subject, the subject shall provide a set of classifiable fingerprints obtained from an authorized law enforcement agency. For purposes of requiring fingerprints, the commissioner shall be considered to have reasonable cause under, but not limited to, the following circumstances:

- (1) information from the bureau of criminal apprehension indicates that the subject is a multistate offender;
- (2) information from the bureau of criminal apprehension indicates that multistate offender status is undetermined; or
- (3) the commissioner has received a report from the subject or a third party indicating that the subject has a criminal history in a jurisdiction other than Minnesota.

~~(g)~~ (h) An applicant's ~~or~~ license holder's, or registrant's failure or refusal to cooperate with the commissioner is reasonable cause to disqualify a subject, deny a license application or immediately suspend, suspend, or revoke a license or registration. Failure or refusal of an individual to cooperate with the study is just cause for denying or terminating employment of the individual if the individual's failure or refusal to cooperate could cause the applicant's application to be denied or the license holder's license to be immediately suspended, suspended, or revoked.

~~(h)~~ (i) The commissioner shall not consider an application to be complete until all of the information required to be provided under this subdivision has been received.

~~(i)~~ (j) No person in paragraph ~~(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 9

#### 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 10

### MENTAL HEALTH AND CIVIL COMMITMENT

#### Section 1. [145.56] [SUICIDE PREVENTION.]

Subdivision 1. [PUBLIC HEALTH GOAL; SUICIDE PREVENTION PLAN.] The commissioner of health shall make suicide prevention an important public health goal of the state and shall conduct suicide prevention activities to accomplish that goal using an evidence-based, public health approach focused on prevention. The commissioner shall refine, coordinate, and implement the state's suicide prevention plan, in collaboration with assigned staff from the department of human services; the department of public safety; the department of children, families, and learning; and appropriate agencies, organizations, and institutions in the community.

Subd. 2. [COMMUNITY-BASED PROGRAMS.] (a) The commissioner shall establish a grant program consistent with the policy goals of this section to fund:

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

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

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

(b) Education to populations at risk for suicide and to community helpers and gatekeepers must include information on the symptoms of depression and other psychiatric illnesses, the warning signs of suicide, skills for preventing suicides, and making or seeking effective referrals to intervention and community resources.

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

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

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

Subd. 5. [PERIODIC EVALUATIONS; BIENNIAL REPORTS.] The commissioner shall conduct periodic evaluations of the impact of and outcomes from implementation of the state's suicide prevention plan and each of the activities specified in this section. By July 1, 2002, and July 1 of each even-numbered year thereafter, the commissioner shall report the results of these evaluations to the chairs of the policy and finance committees in the house and senate with jurisdiction over health and human services issues.

Sec. 2. Minnesota Statutes 2000, section 245.462, subdivision 8, is amended to read:

Subd. 8. [DAY TREATMENT SERVICES.] "Day treatment," "day treatment services," or "day treatment program" means a structured program of treatment and care provided to an adult in or by: (1) a hospital accredited by the joint commission on accreditation of health organizations and licensed under sections 144.50 to 144.55; (2) a community mental health center under section 245.62; or (3) an entity that is under contract with the county board to operate a program that meets the requirements of section 245.4712, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475. Day treatment consists of group psychotherapy and other intensive therapeutic services that are provided at least one day a week by a multidisciplinary staff under the clinical supervision of a mental health professional. Day treatment may include education and consultation provided to families and other individuals as part of the treatment process. The services are aimed at stabilizing the adult's mental health status, providing mental health services, and developing and improving the adult's independent living and socialization skills. The goal of day treatment is to reduce or relieve mental illness and to enable the adult to live in the community. Day treatment services are not a part of inpatient or residential treatment services. Day treatment services are distinguished from day care by their structured therapeutic program of psychotherapy services. The commissioner may limit medical assistance reimbursement for day treatment to 15 hours per week per person instead of the three hours per day per person specified in Minnesota Rules, part 9505.0323, subpart 15.

Sec. 3. Minnesota Statutes 2000, section 245.462, subdivision 18, is amended to read:

Subd. 18. [MENTAL HEALTH PROFESSIONAL.] "Mental health professional" means a person providing clinical services in the treatment of mental illness who is qualified in at least one of the following ways:

(1) in psychiatric nursing: a registered nurse who is licensed under sections 148.171 to 148.285, and who is certified as a clinical specialist in adult psychiatric and mental health nursing by a national nurse certification organization or who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;

(2) in clinical social work: a person licensed as an independent clinical social worker under section 148B.21, subdivision 6, or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;

(3) in psychology: ~~a psychologist~~ an individual licensed by the board of psychology under sections 148.88 to 148.98 who has stated to the board of psychology competencies in the diagnosis and treatment of mental illness;

(4) in psychiatry: a physician licensed under chapter 147 and certified by the American board of psychiatry and neurology or eligible for board certification in psychiatry;

(5) in marriage and family therapy: the mental health professional must be a marriage and family therapist licensed under sections 148B.29 to 148B.39 with at least two years of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness; or

(6) in allied fields: a person with a master's degree from an accredited college or university in one of the behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness.

Sec. 4. Minnesota Statutes 2000, section 245.462, is amended by adding a subdivision to read:

Subd. 25a. [SIGNIFICANT IMPAIRMENT IN FUNCTIONING.] "Significant impairment in functioning" means a condition, including significant suicidal ideation or thoughts of harming self or others, which harmfully affects, recurrently or consistently, a person's activities of daily living in employment, housing, family, and social relationships, or education.

Sec. 5. Minnesota Statutes 2000, section 245.4871, subdivision 10, is amended to read:

Subd. 10. [DAY TREATMENT SERVICES.] "Day treatment," "day treatment services," or "day treatment program" means a structured program of treatment and care provided to a child in:

(1) an outpatient hospital accredited by the joint commission on accreditation of health organizations and licensed under sections 144.50 to 144.55;

(2) a community mental health center under section 245.62;

(3) an entity that is under contract with the county board to operate a program that meets the requirements of section 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475; or

(4) an entity that operates a program that meets the requirements of section 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475, that is under contract with an entity that is under contract with a county board.

Day treatment consists of group psychotherapy and other intensive therapeutic services that are provided for a minimum three-hour time block by a multidisciplinary staff under the clinical supervision of a mental health professional. Day treatment may include education and consultation provided to families and other individuals as an extension of the treatment process. The services are aimed at stabilizing the child's mental health status, and developing and improving the child's daily independent living and socialization skills. Day treatment services are distinguished from day care by their structured therapeutic program of psychotherapy services. Day treatment services are not a part of inpatient hospital or residential treatment services. Day treatment services for a child are an integrated set of education, therapy, and family interventions.

A day treatment service must be available to a child at least five days a week throughout the year and must be coordinated with, integrated with, or part of an education program offered by the child's school.

Sec. 6. Minnesota Statutes 2000, section 245.4871, subdivision 27, is amended to read:

Subd. 27. [MENTAL HEALTH PROFESSIONAL.] "Mental health professional" means a person providing clinical services in the diagnosis and treatment of children's emotional disorders. A mental health professional must have training and experience in working with children consistent with the age group to which the mental health professional is assigned. A mental health professional must be qualified in at least one of the following ways:

(1) in psychiatric nursing, the mental health professional must be a registered nurse who is licensed under sections 148.171 to 148.285 and who is certified as a clinical specialist in child and adolescent psychiatric or mental health nursing by a national nurse certification organization or who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;

(2) in clinical social work, the mental health professional must be a person licensed as an independent clinical social worker under section 148B.21, subdivision 6, or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental disorders;

(3) in psychology, the mental health professional must be ~~a psychologist~~ an individual licensed by the board of psychology under sections 148.88 to 148.98 who has stated to the board of psychology competencies in the diagnosis and treatment of mental disorders;

(4) in psychiatry, the mental health professional must be a physician licensed under chapter 147 and certified by the American board of psychiatry and neurology or eligible for board certification in psychiatry;

(5) in marriage and family therapy, the mental health professional must be a marriage and family therapist licensed under sections 148B.29 to 148B.39 with at least two years of post-master's supervised experience in the delivery of clinical services in the treatment of mental disorders or emotional disturbances; or

(6) in allied fields, the mental health professional must be a person with a master's degree from an accredited college or university in one of the behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of emotional disturbances.

Sec. 7. Minnesota Statutes 2000, section 245.4876, subdivision 1, is amended to read:

Subdivision 1. [CRITERIA.] Children's mental health services required by sections 245.487 to 245.4888 must be:

- (1) based, when feasible, on research findings;
- (2) based on individual clinical, cultural, and ethnic needs, and other special needs of the children being served;
- (3) delivered in a manner that improves family functioning when clinically appropriate;
- (4) provided in the most appropriate, least restrictive setting that meets the requirements in subdivision 1a, and that is available to the county board to meet the child's treatment needs;
- (5) accessible to all age groups of children;
- (6) appropriate to the developmental age of the child being served;
- (7) delivered in a manner that provides accountability to the child for the quality of service delivered and continuity of services to the child during the years the child needs services from the local system of care;
- (8) provided by qualified individuals as required in sections 245.487 to 245.4888;
- (9) coordinated with children's mental health services offered by other providers;
- (10) provided under conditions that protect the rights and dignity of the individuals being served; and
- (11) provided in a manner and setting most likely to facilitate progress toward treatment goals.

Sec. 8. Minnesota Statutes 2000, section 245.4876, is amended by adding a subdivision to read:

Subd. 1a. [APPROPRIATE SETTING TO RECEIVE SERVICES.] A child must be provided with mental health services in the least restrictive setting that is appropriate to the needs and current condition of the individual child. For a child to receive mental health services in a residential treatment or acute care hospital inpatient setting, the family may not be required to demonstrate that services were first provided in a less restrictive setting and that the child failed to make progress toward or meet treatment goals in the less restrictive setting.

Sec. 9. Minnesota Statutes 2000, section 245.4885, subdivision 1, is amended to read:

Subdivision 1. [SCREENING REQUIRED.] The county board shall, prior to admission, except in the case of emergency admission, screen all children referred for treatment of severe emotional disturbance to a residential treatment facility or informally admitted to a regional treatment center if public funds are used to pay for the services. The county board shall also screen all children admitted to an acute care hospital for treatment of severe emotional disturbance if public funds other than reimbursement under chapters 256B and 256D are used to pay for the services. If a child is admitted to a residential treatment facility or acute care hospital for emergency treatment or held for emergency care by a regional treatment center under section 253B.05, subdivision 1, screening must occur within three working days of admission. Screening shall determine whether the proposed treatment:

- (1) is necessary;
- (2) is appropriate to the child's individual treatment needs;
- (3) cannot be effectively provided in the child's home; and
- (4) provides a length of stay as short as possible consistent with the individual child's need.

When a screening is conducted, the county board may not determine that referral or admission to a residential treatment facility or acute care hospital is not appropriate solely because services were not first provided to the child in a less restrictive setting and the child failed to make progress toward or meet treatment goals in the less restrictive setting. Screening shall include both a diagnostic assessment and a functional assessment which evaluates family, school, and community living situations. If a diagnostic assessment or functional assessment has been completed by a mental health professional within 180 days, a new diagnostic or functional assessment need not be completed unless in the opinion of the current treating mental health professional the child's mental health status has changed markedly since the assessment was completed. The child's parent shall be notified if an assessment will not be completed and of the reasons. A copy of the notice shall be placed in the child's file. Recommendations developed as part of the screening process shall include specific community services needed by the child and, if appropriate, the child's family, and shall indicate whether or not these services are available and accessible to the child and family.

During the screening process, the child, child's family, or child's legal representative, as appropriate, must be informed of the child's eligibility for case management services and family community support services and that an individual family community support plan is being developed by the case manager, if assigned.

Screening shall be in compliance with section 256F.07 or 260C.212, whichever applies. Wherever possible, the parent shall be consulted in the screening process, unless clinically inappropriate.

The screening process, and placement decision, and recommendations for mental health services must be documented in the child's record.

An alternate review process may be approved by the commissioner if the county board demonstrates that an alternate review process has been established by the county board and the times of review, persons responsible for the review, and review criteria are comparable to the standards in clauses (1) to (4).

Sec. 10. Minnesota Statutes 2000, section 245.4886, subdivision 1, is amended to read:

Subdivision 1. [STATEWIDE PROGRAM; ESTABLISHMENT.] The commissioner shall establish a statewide program to assist counties in providing services to children with severe emotional disturbance as defined in section 245.4871, subdivision 15, and their families; and to young adults meeting the criteria for transition services in section 245.4875, subdivision 8, and their families. Services must be designed to help each child to function and remain with the child's family in the community. Transition services to eligible young adults must be designed to

foster independent living in the community. The commissioner shall make grants to counties to establish, operate, or contract with private providers to provide the following services in the following order of priority when these cannot be reimbursed under section 256B.0625:

- (1) family community support services including crisis placement and crisis respite care as specified in section 245.4871, subdivision 17;
- (2) case management services as specified in section 245.4871, subdivision 3;
- (3) day treatment services as specified in section 245.4871, subdivision 10;
- (4) professional home-based family treatment as specified in section 245.4871, subdivision 31; and
- (5) therapeutic support of foster care as specified in section 245.4871, subdivision 34.

Funding appropriated beginning July 1, 1991, must be used by county boards to provide family community support services and case management services. Additional services shall be provided in the order of priority as identified in this subdivision.

Sec. 11. Minnesota Statutes 2000, section 245.99, subdivision 4, is amended to read:

Subd. 4. [ADMINISTRATION OF CRISIS HOUSING ASSISTANCE.] The commissioner may contract with organizations or government units experienced in housing assistance to operate the program under this section. This program is not an entitlement. The commissioner may take any of the following steps whenever the commissioner projects that funds will be inadequate to meet demand in a given fiscal year:

- (1) transfer funds from mental health grants in the same appropriation; and
- (2) impose statewide restrictions as to the type and amount of assistance available to each recipient under this program including reducing the income eligibility level, limiting reimbursement to a percentage of each recipient's costs, limiting housing assistance to 60 days per recipient, or closing the program for the remainder of the fiscal year.

Sec. 12. Minnesota Statutes 2000, section 256.969, subdivision 3a, is amended to read:

Subd. 3a. [PAYMENTS.] Acute care hospital billings under the medical assistance program must not be submitted until the recipient is discharged. However, the commissioner shall establish monthly interim payments for inpatient hospitals that have individual patient lengths of stay over 30 days regardless of diagnostic category. Except as provided in section 256.9693, medical assistance reimbursement for treatment of mental illness shall be reimbursed based on diagnostic classifications. ~~The commissioner may selectively contract with hospitals for services within the diagnostic categories relating to mental illness and chemical dependency under competitive bidding when reasonable geographic access by recipients can be assured. No physician shall be denied the privilege of treating a recipient required to use a hospital under contract with the commissioner, as long as the physician meets credentialing standards of the individual hospital.~~ Individual hospital payments established under this section and sections 256.9685, 256.9686, and 256.9695, in addition to third party and recipient liability, for discharges occurring during the rate year shall not exceed, in aggregate, the charges for the medical assistance covered inpatient services paid for the same period of time to the hospital. This payment limitation shall be calculated separately for medical assistance and general assistance medical care services. The limitation on general assistance medical care shall be effective for admissions occurring on or after July 1, 1991. Services that have rates established under subdivision 11 or 12, must be limited separately from other services. After consulting with the affected hospitals, the commissioner may consider related hospitals one entity and may merge the payment rates while maintaining separate provider numbers. The operating and property base rates per admission or per day shall be derived from the best Medicare and claims data available when rates are established. The commissioner shall determine the best Medicare and claims data, taking into consideration variables of recency of the data, audit disposition, settlement status, and the ability to set rates in a timely manner. The commissioner shall notify hospitals of payment rates by December 1



of the year preceding the rate year. The rate setting data must reflect the admissions data used to establish relative values. Base year changes from 1981 to the base year established for the rate year beginning January 1, 1991, and for subsequent rate years, shall not be limited to the limits ending June 30, 1987, on the maximum rate of increase under subdivision 1. The commissioner may adjust base year cost, relative value, and case mix index data to exclude the costs of services that have been discontinued by the October 1 of the year preceding the rate year or that are paid separately from inpatient services. Inpatient stays that encompass portions of two or more rate years shall have payments established based on payment rates in effect at the time of admission unless the date of admission preceded the rate year in effect by six months or more. In this case, operating payment rates for services rendered during the rate year in effect and established based on the date of admission shall be adjusted to the rate year in effect by the hospital cost index.

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

Sec. 13. [256.9693] [CONTINUING CARE PROGRAM FOR PERSONS WITH MENTAL ILLNESS.]

The commissioner shall establish a continuing care benefit program for persons with mental illness, in which persons with mental illness may obtain acute care hospital inpatient treatment for mental illness for up to 45 days beyond that allowed by section 256.969. Persons with mental illness who are eligible for medical assistance may obtain inpatient treatment under this program in hospital beds for which the commissioner contracts under this section. The commissioner may selectively contract with hospitals to provide this benefit through competitive bidding when reasonable geographic access by recipients can be assured. Payments under this section shall not affect payments under section 256.969. The commissioner may contract externally with a utilization review organization to authorize persons with mental illness to access the continuing care benefit program. The commissioner, as part of the contracts with hospitals, shall establish admission criteria to allow persons with mental illness to access the continuing care benefit program. If a court orders acute care hospital inpatient treatment for mental illness for a person, the person may obtain the treatment under the continuing care benefit program. The commissioner shall not require, as part of the admission criteria, any commitment or petition under chapter 253B as a condition of accessing the program. This benefit is not available for people who are also eligible for Medicare and who have not exhausted their annual or lifetime inpatient psychiatric benefit under Medicare. If a recipient is enrolled in a prepaid plan, this program is included in the plan's coverage.

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

Sec. 14. [256B.0623] [ADULT REHABILITATIVE MENTAL HEALTH SERVICES.]

Subdivision 1. [SCOPE.] Medical assistance covers adult rehabilitative mental health services as defined in subdivision 2, subject to federal approval, if provided to recipients as defined in subdivision 3 and provided by a qualified provider entity meeting the standards in this section and by a qualified individual provider working within the provider's scope of practice and identified in the recipient's individual treatment plan as defined in section 245.462, subdivision 14, and if determined to be medically necessary according to section 62Q.53.

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

(a) "Adult rehabilitative mental health services" means mental health services which are rehabilitative and enable the recipient to develop and enhance psychiatric stability, social competencies, personal and emotional adjustment, and independent living and community skills, when these abilities are impaired by the symptoms of mental illness. Adult rehabilitative mental health services are also appropriate when provided to enable a recipient to retain stability and functioning, if the recipient would be at risk of significant functional decompensation or more restrictive service settings without these services.

(1) Adult rehabilitative mental health services instruct, assist, and support the recipient in areas such as: interpersonal communication skills, community resource utilization and integration skills, crisis assistance, relapse prevention skills, health care directives, budgeting and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills, transportation skills, medication education and monitoring, mental illness symptom management skills, household management skills, employment-related skills, and transition to community living services.

(2) These services shall be provided to the recipient on a one-to-one basis in the recipient's home or another community setting or in groups.

(b) "Medication education services" means services provided individually or in groups which focus on educating the recipient about mental illness and symptoms; the role and effects of medications in treating symptoms of mental illness; and the side effects of medications. Medication education is coordinated with medication management services, and does not duplicate it. Medication education services are provided by physicians, pharmacists, or registered nurses.

(c) "Transition to community living services" means services which maintain continuity of contact between the rehabilitation services provider and the recipient and which facilitate discharge from a hospital, residential treatment program under Minnesota Rules, chapter 9505, board and lodging facility, or nursing home. Transition to community living services are not intended to provide other areas of adult rehabilitative mental health services.

Subd. 3. [ELIGIBILITY.] An eligible recipient is an individual who:

(1) is age 18 or older;

(2) is diagnosed with a medical condition, such as mental illness or traumatic brain injury, for which adult rehabilitative mental health services are needed;

(3) has substantial disability and functional impairment in three or more of the areas listed in section 245.462, subdivision 11a, so that self-sufficiency is markedly reduced; and

(4) has had a recent diagnostic assessment by a qualified professional that documents adult rehabilitative mental health services are medically necessary to address identified disability and functional impairments and individual recipient goals.

Subd. 4. [PROVIDER ENTITY STANDARDS.] (a) The provider entity must be:

(1) a county operated entity certified by the state; or

(2) a noncounty entity certified by the entity's host county.

(b) The certification process is a determination as to whether the entity meets the standards in this subdivision. The certification must specify which adult rehabilitative mental health services the entity is qualified to provide.

(c) If an entity seeks to provide services outside its host county, it must obtain additional certification from each county in which it will provide services. The additional certification must be based on the adequacy of the entity's knowledge of that county's local health and human service system, and the ability of the entity to coordinate its services with the other services available in that county.

(d) Recertification must occur at least every two years.

(e) The commissioner may intervene at any time and decertify providers with cause. The decertification is subject to appeal to the state. A county board may recommend that the state decertify a provider for cause.

(f) The adult rehabilitative mental health services provider entity must meet the following standards:

(1) have capacity to recruit, hire, manage, and train mental health professionals, mental health practitioners, and mental health rehabilitation workers;

(2) have adequate administrative ability to ensure availability of services;

- (3) ensure adequate preservice and inservice training for staff;
  - (4) ensure that mental health professionals, mental health practitioners, and mental health rehabilitation workers are skilled in the delivery of the specific adult rehabilitative mental health services provided to the individual eligible recipient;
  - (5) ensure that staff is capable of implementing culturally specific services that are culturally competent and appropriate as determined by the recipient's culture, beliefs, values, and language as identified in the individual treatment plan;
  - (6) ensure enough flexibility in service delivery to respond to the changing and intermittent care needs of a recipient as identified by the recipient and the individual treatment plan;
  - (7) ensure that the mental health professional or mental health practitioner, who is under the clinical supervision of a mental health professional, involved in a recipient's services participates in the development of the individual treatment plan;
  - (8) assist the recipient in arranging needed crisis assessment, intervention, and stabilization services;
  - (9) ensure that services are coordinated with other recipient mental health services providers and the county mental health authority and the federally recognized American Indian authority and necessary others after obtaining the consent of the recipient. Services must also be coordinated with the recipient's case manager or care coordinator, if the recipient is receiving case management or care coordination services;
  - (10) develop and maintain recipient files, individual treatment plans, and contact charting;
  - (11) develop and maintain staff training and personnel files;
  - (12) submit information as required by the state;
  - (13) establish and maintain a quality assurance plan to evaluate the outcome of services provided;
  - (14) keep all necessary records required by law;
  - (15) deliver services as required by section 245.461;
  - (16) comply with all applicable laws;
  - (17) be an enrolled Medicaid provider;
  - (18) maintain a quality assurance plan to determine specific service outcomes and the recipient's satisfaction with services; and
  - (19) develop and maintain written policies and procedures regarding service provision and administration of the provider entity.
- (g) The commissioner shall develop statewide procedures for provider certification, including timelines for counties to certify qualified providers.

Subd. 5. [QUALIFICATIONS OF PROVIDER STAFF.] Adult rehabilitative mental health services must be provided by qualified individual provider staff of a certified provider entity. Individual provider staff must be qualified under one of the following criteria:

- (1) a mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (5);

(2) a mental health practitioner as defined in section 245.462, subdivision 17. The mental health practitioner must work under the clinical supervision of a mental health professional; or

(3) a mental health rehabilitation worker. A mental health rehabilitation worker means a staff person working under the direction of a mental health practitioner or mental health professional, and under the clinical supervision of a mental health professional in the implementation of rehabilitative mental health services as identified in the recipient's individual treatment plan; and who:

(i) is at least 21 years of age;

(ii) has a high school diploma or equivalent;

(iii) has successfully completed 30 hours of training during the past two years in all of the following areas: recipient rights, recipient-centered individual treatment planning, behavioral terminology, mental illness, co-occurring mental illness and substance abuse, psychotropic medications and side effects, functional assessment, local community resources, adult vulnerability, recipient confidentiality; and

(iv) meets the qualifications in (A) or (B):

(A) has an associate of arts degree in one of the behavioral sciences or human services, or is a registered nurse without a bachelor's degree, or who within the previous ten years has:

(1) three years of personal life experience with serious and persistent mental illness;

(2) three years of life experience as a primary caregiver to an adult with a serious mental illness or traumatic brain injury; or

(3) 4,000 hours of supervised paid work experience in the delivery of mental health services to adults with a serious mental illness or traumatic brain injury; or

(B)(1) be fluent in the non-English language or competent in the culture of the ethnic group to which at least 50 percent of the mental health rehabilitation worker's clients belong;

(2) receives during the first 2,000 hours of work, monthly documented individual clinical supervision by a mental health professional;

(3) has 18 hours of documented field supervision by a mental health professional or practitioner during the first 160 hours of contact work with recipients, and at least six hours of field supervision quarterly during the following year;

(4) has review and cosignature of charting of recipient contacts during field supervision by a mental health professional or practitioner; and

(5) has 40 hours of additional continuing education on mental health topics during the first year of employment.

Subd. 6. [REQUIRED TRAINING AND SUPERVISION.] (a) Mental health rehabilitation workers must receive ongoing continuing education training of at least 30 hours every two years in areas of mental illness and mental health services and other areas specific to the population being served. Mental health rehabilitation workers must also be subject to the ongoing direction and clinical supervision standards in paragraphs (c) and (d).

(b) Mental health practitioners must receive ongoing continuing education training as required by their professional license; or if the practitioner is not licensed, the practitioner must receive ongoing continuing education training of at least 30 hours every two years in areas of mental illness and mental health services. Mental health practitioners must meet the ongoing clinical supervision standards in paragraph (c).

(c) A mental health professional providing clinical supervision of staff delivering adult rehabilitative mental health services must provide the following guidance:

(1) review the information in the recipient's file;

(2) review and approve initial and updates of individual treatment plans;

(3) meet with mental health rehabilitation workers and practitioners, individually or in small groups, at least monthly to discuss treatment topics of interest to the workers and practitioners;

(4) meet with mental health rehabilitation workers and practitioners, individually or in small groups, at least monthly to discuss treatment plans of recipients, and approve by signature and document in the recipient's file any resulting plan updates;

(5) meet at least twice a month with the directing mental health practitioner, if there is one, to review needs of the adult rehabilitative mental health services program, review staff on-site observations and evaluate mental health rehabilitation workers, plan staff training, review program evaluation and development, and consult with the directing practitioner;

(6) be available for urgent consultation as the individual recipient needs or the situation necessitates; and

(7) provide clinical supervision by full- or part-time mental health professionals employed by or under contract with the provider entity.

(d) An adult rehabilitative mental health services provider entity must have a treatment director who is a mental health practitioner or mental health professional. The treatment director must ensure the following:

(1) while delivering direct services to recipients, a newly hired mental health rehabilitation worker must be directly observed delivering services to recipients by the mental health practitioner or mental health professional for at least six hours per 40 hours worked during the first 160 hours that the mental health rehabilitation worker works;

(2) the mental health rehabilitation worker must receive ongoing on-site direct service observation by a mental health professional or mental health practitioner for at least six hours for every six months of employment;

(3) progress notes are reviewed from on-site service observation prepared by the mental health rehabilitation worker and mental health practitioner for accuracy and consistency with actual recipient contact and the individual treatment plan and goals;

(4) immediate availability by phone or in person for consultation by a mental health professional or a mental health practitioner to the mental health rehabilitation services worker during service provision;

(5) oversee the identification of changes in individual recipient treatment strategies, revise the plan and communicate treatment instructions and methodologies as appropriate to ensure that treatment is implemented correctly;

(6) model service practices which: respect the recipient, include the recipient in planning and implementation of the individual treatment plan, recognize the recipient's strengths, collaborate and coordinate with other involved parties and providers;

(7) ensure that mental health practitioners and mental health rehabilitation workers are able to effectively communicate with the recipients, significant others, and providers; and

(8) oversee the record of the results of on-site observation and charting evaluation and corrective actions taken to modify the work of the mental health practitioners and mental health rehabilitation workers.

(e) A mental health practitioner who is providing treatment direction for a provider entity must receive supervision at least monthly from a mental health professional to:

- (1) identify and plan for general needs of the recipient population served;
- (2) identify and plan to address provider entity program needs and effectiveness;
- (3) identify and plan provider entity staff training and personnel needs and issues; and
- (4) plan, implement, and evaluate provider entity quality improvement programs.

Subd. 7. [PERSONNEL FILE.] The adult rehabilitative mental health services provider entity must maintain a personnel file on each staff. Each file must contain:

- (1) an annual performance review;
- (2) a summary of on-site service observations and charting review;
- (3) a criminal background check of all direct service staff;
- (4) evidence of academic degree and qualifications;
- (5) a copy of professional license;
- (6) any job performance recognition and disciplinary actions;
- (7) any individual staff written input into own personnel file;
- (8) all clinical supervision provided; and
- (9) documentation of compliance with continuing education requirements.

Subd. 8. [DIAGNOSTIC ASSESSMENT.] Providers of adult rehabilitative mental health services must complete a diagnostic assessment as defined in section 245.462, subdivision 9, within five days after the recipient's second visit or within 30 days after intake, whichever occurs first. In cases where a diagnostic assessment is available that reflects the recipient's current status, and has been completed within 180 days preceding admission, an update must be completed. An update shall include a written summary by a mental health professional of the recipient's current mental health status and service needs. If the recipient's mental health status has changed significantly since the adult's most recent diagnostic assessment, a new diagnostic assessment is required.

Subd. 9. [FUNCTIONAL ASSESSMENT.] Providers of adult rehabilitative mental health services must complete a written functional assessment as defined in section 245.462, subdivision 11a, for each recipient. The functional assessment must be completed within 30 days of intake, and reviewed and updated at least every six months after it is developed, unless there is a significant change in the functioning of the recipient. If there is a significant change in functioning, the assessment must be updated. A single functional assessment can meet case management and adult rehabilitative mental health services requirements, if agreed to by the recipient. Unless the recipient refuses, the recipient must have significant participation in the development of the functional assessment.

Subd. 10. [INDIVIDUAL TREATMENT PLAN.] All providers of adult rehabilitative mental health services must develop and implement an individual treatment plan for each recipient. The provisions in clauses (1) and (2) apply:

(1) Individual treatment plan means a plan of intervention, treatment, and services for an individual recipient written by a mental health professional or by a mental health practitioner under the clinical supervision of a mental health professional. The individual treatment plan must be based on diagnostic and functional assessments. To the

extent possible, the development and implementation of a treatment plan must be a collaborative process involving the recipient, and with the permission of the recipient, the recipient's family and others in the recipient's support system. Providers of adult rehabilitative mental health services must develop the individual treatment plan within 30 calendar days of intake. The treatment plan must be updated at least every six months thereafter, or more often when there is significant change in the recipient's situation or functioning, or in services or service methods to be used, or at the request of the recipient or the recipient's legal guardian.

(2) The individual treatment plan must include:

(i) a list of problems identified in the assessment;

(ii) the recipient's strengths and resources;

(iii) concrete, measurable goals to be achieved, including time frames for achievement;

(iv) specific objectives directed toward the achievement of each one of the goals;

(v) documentation of participants in the treatment planning. The recipient, if possible, must be a participant. The recipient or the recipient's legal guardian must sign the treatment plan, or documentation must be provided why this was not possible. A copy of the plan must be given to the recipient or legal guardian. Referral to formal services must be arranged, including specific providers where applicable;

(vi) cultural considerations, resources, and needs of the recipient must be included;

(vii) planned frequency and type of services must be initiated; and

(viii) clear progress notes on outcome of goals.

(3) The individual community support plan defined in section 245.462, subdivision 12, may serve as the individual treatment plan if there is involvement of a mental health case manager, and with the approval of the recipient. The individual community support plan must include the criteria in clause (2).

Subd. 11. [RECIPIENT FILE.] Providers of adult rehabilitative mental health services must maintain a file for each recipient that contains the following information:

(1) diagnostic assessment or verification of its location, that is current and that was reviewed by a mental health professional who is employed by or under contract with the provider entity;

(2) functional assessments;

(3) individual treatment plans signed by the recipient and the mental health professional, or if the recipient refused to sign the plan, the date and reason stated by the recipient as to why the recipient would not sign the plan;

(4) recipient history;

(5) signed release forms;

(6) recipient health information and current medications;

(7) emergency contacts for the recipient;

(8) case records which document the date of service, the place of service delivery, signature of the person providing the service, nature, extent and units of service, and place of service delivery;

(9) contacts, direct or by telephone, with recipient's family or others, other providers, or other resources for service coordination;

(10) summary of recipient case reviews by staff; and

(11) written information by the recipient that the recipient requests be included in the file.

Subd. 12. [ADDITIONAL REQUIREMENTS.] (a) Providers of adult rehabilitative mental health services must comply with the requirements relating to referrals for case management in section 245.467, subdivision 4.

(b) Adult rehabilitative mental health services are provided for most recipients in the recipient's home and community. Services may also be provided at the home of a relative or significant other, job site, psychosocial clubhouse, drop-in center, social setting, classroom, or other places in the community. Except for "transition to community services," the place of service does not include a regional treatment center, nursing home, residential treatment facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0670 (Rule 36), or an acute care hospital.

(c) Adult rehabilitative mental health services may be provided in group settings if appropriate to each participating recipient's needs and treatment plan. A group is defined as two to ten clients, at least one of whom is a recipient, who is concurrently receiving a service which is identified in this section. The service and group must be specified in the recipient's treatment plan. No more than two qualified staff may bill Medicaid for services provided to the same group of recipients. If two adult rehabilitative mental health workers bill for recipients in the same group session, they must each bill for different recipients.

Subd. 13. [EXCLUDED SERVICES.] The following services are excluded from reimbursement as adult rehabilitative mental health services:

(1) recipient transportation services;

(2) a service provided and billed by a provider who is not enrolled to provide adult rehabilitative mental health service;

(3) adult rehabilitative mental health services performed by volunteers;

(4) provider performance of household tasks, chores, or related activities, such as laundering clothes, moving the recipient's household, housekeeping, and grocery shopping for the recipient;

(5) direct billing of time spent "on call" when not delivering services to recipients;

(6) activities which are primarily social or recreational in nature, rather than rehabilitative, for the individual recipient, as determined by the individual's needs and treatment plan;

(7) job-specific skills services, such as on-the-job training;

(8) provider service time included in case management reimbursement;

(9) outreach services to potential recipients;

(10) a mental health service that is not medically necessary; and

(11) any services provided by a hospital, board and lodging, or residential facility to an individual who is a patient in or resident of that facility.

Subd. 14. [BILLING WHEN SERVICES ARE PROVIDED BY QUALIFIED STATE STAFF.] When rehabilitative services are provided by qualified state staff who are assigned to pilot projects under section 245.4661, the county or other local entity to which the qualified state staff are assigned may consider these staff part of the local



provider entity for which certification is sought under this section, and may bill the medical assistance program for qualifying services provided by the qualified state staff. Notwithstanding section 256.025, subdivision 2, payments for services provided by state staff who are assigned to adult mental health initiatives shall only be made from federal funds.

Sec. 15. [256B.0624] [ADULT MENTAL HEALTH CRISIS RESPONSE SERVICES.]

Subdivision 1. [SCOPE.] Medical assistance covers adult mental health crisis response services as defined in subdivision 2, paragraphs (c) to (e), subject to federal approval, if provided to a recipient as defined in subdivision 3 and provided by a qualified provider entity as defined in this section and by a qualified individual provider working within the provider's scope of practice and as defined in this subdivision and identified in the recipient's individual crisis treatment plan as defined in subdivision 10 and if determined to be medically necessary.

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

(a) "Mental health crisis" is an adult behavioral, emotional, or psychiatric situation which, but for the provision of crisis response services, would likely result in significantly reduced levels of functioning in primary activities of daily living, or in an emergency situation, or in the placement of the recipient in a more restrictive setting, including, but not limited to, inpatient hospitalization.

(b) "Mental health emergency" is an adult behavioral, emotional, or psychiatric situation which causes an immediate need for mental health services and is consistent with section 62Q.55.

A mental health crisis or emergency is determined for medical assistance service reimbursement by a physician, a mental health professional, or crisis mental health practitioner with input from the recipient whenever possible.

(c) "Mental health crisis assessment" means an immediate face-to-face assessment by a physician, a mental health professional, or mental health practitioner under the clinical supervision of a mental health professional, following a screening that suggests that the adult may be experiencing a mental health crisis or mental health emergency situation.

(d) "Mental health mobile crisis intervention services" means face-to-face, short-term intensive mental health services initiated during a mental health crisis or mental health emergency to help the recipient cope with immediate stressors, identify and utilize available resources and strengths, and begin to return to the recipient's baseline level of functioning.

(1) This service is provided on-site by a mobile crisis intervention team outside of an inpatient hospital setting. Mental health mobile crisis intervention services must be available 24 hours a day, seven days a week.

(2) The initial screening must consider other available services to determine which service intervention would best address the recipient's needs and circumstances.

(3) The mobile crisis intervention team must be available to meet promptly face-to-face with a person in mental health crisis or emergency in a community setting.

(4) The intervention must consist of a mental health crisis assessment and a crisis treatment plan.

(5) The treatment plan must include recommendations for any needed crisis stabilization services for the recipient.

(e) "Mental health crisis stabilization services" means individualized mental health services provided to a recipient following crisis intervention services which are designed to restore the recipient to the recipient's prior functional level. Mental health crisis stabilization services may be provided in the recipient's home, the home of a family member or friend of the recipient, another community setting, or a short-term supervised, licensed residential program. Mental health crisis stabilization does not include partial hospitalization or day treatment.

Subd. 3. [ELIGIBILITY.] An eligible recipient is an individual who:

(1) is age 18 or older;

(2) is screened as possibly experiencing a mental health crisis or emergency where a mental health crisis assessment is needed; and

(3) is assessed as experiencing a mental health crisis or emergency, and mental health crisis intervention or crisis intervention and stabilization services are determined to be medically necessary.

Subd. 4. [PROVIDER ENTITY STANDARDS.] (a) A provider entity is an entity that meets the standards listed in paragraph (b) and:

(1) is a county board operated entity; or

(2) is a provider entity that is under contract with the county board in the county where the potential crisis or emergency is occurring. To provide services under this section, the provider entity must directly provide the services; or if services are subcontracted, the provider entity must maintain responsibility for services and billing.

(b) The adult mental health crisis response services provider entity must meet the following standards:

(1) has the capacity to recruit, hire, and manage and train mental health professionals, practitioners, and rehabilitation workers;

(2) has adequate administrative ability to ensure availability of services;

(3) is able to ensure adequate preservice and in-service training;

(4) is able to ensure that staff providing these services are skilled in the delivery of mental health crisis response services to recipients;

(5) is able to ensure that staff are capable of implementing culturally specific treatment identified in the individual treatment plan that is meaningful and appropriate as determined by the recipient's culture, beliefs, values, and language;

(6) is able to ensure enough flexibility to respond to the changing intervention and care needs of a recipient as identified by the recipient during the service partnership between the recipient and providers;

(7) is able to ensure that mental health professionals and mental health practitioners have the communication tools and procedures to communicate and consult promptly about crisis assessment and interventions as services occur;

(8) is able to coordinate these services with county emergency services and mental health crisis services;

(9) is able to ensure that mental health crisis assessment and mobile crisis intervention services are available 24 hours a day, seven days a week;

(10) is able to ensure that services are coordinated with other mental health service providers, county mental health authorities, or federally recognized American Indian authorities and others as necessary, with the consent of the adult. Services must also be coordinated with the recipient's case manager if the adult is receiving case management services;

(11) is able to ensure that crisis intervention services are provided in a manner consistent with sections 245.461 to 245.486;

(12) is able to submit information as required by the state;

(13) maintains staff training and personnel files;

(14) is able to establish and maintain a quality assurance and evaluation plan to evaluate the outcomes of services and recipient satisfaction;

(15) is able to keep records as required by applicable laws;

(16) is able to comply with all applicable laws and statutes;

(17) is an enrolled medical assistance provider; and

(18) develops and maintains written policies and procedures regarding service provision and administration of the provider entity including safety of staff and recipients in high risk situations.

Subd. 5. [MOBILE CRISIS INTERVENTION STAFF QUALIFICATIONS.] For provision of adult mental health mobile crisis intervention services, a mobile crisis intervention team is comprised of at least two mental health professionals as defined in section 245.462, subdivision 18, clauses (1) to (5), or a combination of at least one mental health professional and one mental health practitioner as defined in section 245.462, subdivision 17, with the required mental health crisis training and under the clinical supervision of a mental health professional on the team. The team must have at least two people with at least one member providing on-site crisis intervention services when needed. Team members must be experienced in mental health assessment, crisis intervention techniques, and clinical decision-making under emergency conditions and have knowledge of local services and resources. The team must recommend and coordinate the team's services with appropriate local resources such as the county social services agency, mental health services, and local law enforcement when necessary.

Subd. 6. [INITIAL SCREENING, CRISIS ASSESSMENT, AND MOBILE INTERVENTION TREATMENT PLANNING.] (a) Prior to initiating mobile crisis intervention services, a screening of the potential crisis situation must be conducted. The screening may use the resources of crisis assistance and emergency services as defined in sections 245.462, subdivision 6, and 245.469, subdivisions 1 and 2. The screening must gather information, determine whether a crisis situation exists, identify parties involved, and determine an appropriate response.

(b) If a crisis exists, a crisis assessment must be completed. A crisis assessment evaluates any immediate needs for which emergency services are needed and, as time permits, the recipient's current life situation, sources of stress, mental health problems and symptoms, strengths, cultural considerations, support network, vulnerabilities, and current functioning.

(c) If the crisis assessment determines mobile crisis intervention services are needed, the intervention services must be provided promptly. As opportunity presents during the intervention, at least two members of the mobile crisis intervention team must confer directly or by telephone about the assessment, treatment plan, and actions taken and needed. At least one of the team members must be on-site providing crisis intervention services. If providing on-site crisis intervention services, a mental health practitioner must seek clinical supervision as required in subdivision 8.

(d) The mobile crisis intervention team must develop an initial, brief crisis treatment plan as soon as appropriate but no later than 24 hours after the initial face-to-face intervention. The plan must address the needs and problems noted in the crisis assessment and include measurable short-term goals, cultural considerations, and frequency and type of services to be provided to achieve the goals and reduce or eliminate the crisis. The treatment plan must be updated as needed to reflect current goals and services.

(e) The team must document which short-term goals have been met, and when no further crisis intervention services are required.

(f) If the recipient's crisis is stabilized, but the recipient needs a referral to other services, the team must provide referrals to these services. If the recipient has a case manager, planning for other services must be coordinated with the case manager.

Subd. 7. [CRISIS STABILIZATION SERVICES.] (a) Crisis stabilization services must be provided by qualified staff of a crisis stabilization services provider entity and must meet the following standards:

(1) a crisis stabilization treatment plan must be developed which meets the criteria in subdivision 11;

(2) staff must be qualified as defined in subdivision 8; and

(3) services must be delivered according to the treatment plan and include face-to-face contact with the recipient by qualified staff for further assessment, help with referrals, updating of the crisis stabilization treatment plan, supportive counseling, skills training, and collaboration with other service providers in the community.

(b) If crisis stabilization services are provided in a supervised, licensed residential setting, the recipient must be contacted face-to-face daily by a qualified mental health practitioner or mental health professional. The program must have 24-hour-a-day residential staffing which may include staff who do not meet the qualifications in subdivision 8. The residential staff must have 24-hour-a-day immediate direct or telephone access to a qualified mental health professional or practitioner.

(c) If crisis stabilization services are provided in a supervised, licensed residential setting that serves no more than four adult residents, and no more than two are recipients of crisis stabilization services, the residential staff must include, for at least eight hours per day, at least one individual who meets the qualifications in subdivision 8.

(d) If crisis stabilization services are provided in a supervised, licensed residential setting that serves more than four adult residents, and one or more are recipients of crisis stabilization services, the residential staff must include, for 24 hours a day, at least one individual who meets the qualifications in subdivision 8. During the first 48 hours that a recipient is in the residential program, the residential program must have at least two staff working 24 hours a day. Staffing levels may be adjusted thereafter according to the needs of the recipient as specified in the crisis stabilization treatment plan.

Subd. 8. [ADULT CRISIS STABILIZATION STAFF QUALIFICATIONS.] (a) Adult mental health crisis stabilization services must be provided by qualified individual staff of a qualified provider entity. Individual provider staff must have the following qualifications:

(1) be a mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (5);

(2) be a mental health practitioner as defined in section 245.462, subdivision 17. The mental health practitioner must work under the clinical supervision of a mental health professional; or

(3) be a mental health rehabilitation worker who meets the criteria in section 256B.0623, subdivision 5, clause (3); works under the direction of a mental health practitioner as defined in section 245.462, subdivision 17, or under direction of a mental health professional; and works under the clinical supervision of a mental health professional.

(b) Mental health practitioners and mental health rehabilitation workers must have completed at least 30 hours of training in crisis intervention and stabilization during the past two years.

Subd. 9. [SUPERVISION.] Mental health practitioners may provide crisis assessment and mobile crisis intervention services if the following clinical supervision requirements are met:

(1) the mental health provider entity must accept full responsibility for the services provided;

(2) the mental health professional of the provider entity, who is an employee or under contract with the provider entity, must be available by phone or in person for clinical supervision;

(3) the mental health professional is consulted, in person or by phone, during the first three hours when a mental health practitioner provides on-site service;

(4) the mental health professional must:

(i) review and approve of the tentative crisis assessment and crisis treatment plan;

(ii) document the consultation; and

(iii) sign the crisis assessment and treatment plan within the next business day;

(5) if the mobile crisis intervention services continue into a second calendar day, a mental health professional must contact the recipient face-to-face on the second day to provide services and update the crisis treatment plan; and

(6) the on-site observation must be documented in the recipient's record and signed by the mental health professional.

Subd. 10. [RECIPIENT FILE.] Providers of mobile crisis intervention or crisis stabilization services must maintain a file for each recipient containing the following information:

(1) individual crisis treatment plans signed by the recipient, mental health professional, and mental health practitioner who developed the crisis treatment plan, or if the recipient refused to sign the plan, the date and reason stated by the recipient as to why the recipient would not sign the plan;

(2) signed release forms;

(3) recipient health information and current medications;

(4) emergency contacts for the recipient;

(5) case records which document the date of service, place of service delivery, signature of the person providing the service, and the nature, extent, and units of service. Direct or telephone contact with the recipient's family or others should be documented;

(6) required clinical supervision by mental health professionals;

(7) summary of the recipient's case reviews by staff; and

(8) any written information by the recipient that the recipient wants in the file.

Documentation in the file must comply with all requirements of the commissioner.

Subd. 11. [TREATMENT PLAN.] The individual crisis stabilization treatment plan must include, at a minimum:

(1) a list of problems identified in the assessment;

(2) a list of the recipient's strengths and resources;

(3) concrete, measurable short-term goals and tasks to be achieved, including time frames for achievement;

(4) specific objectives directed toward the achievement of each one of the goals;

(5) documentation of the participants involved in the service planning. The recipient, if possible, must be a participant. The recipient or the recipient's legal guardian must sign the service plan or documentation must be provided why this was not possible. A copy of the plan must be given to the recipient and the recipient's legal guardian. The plan should include services arranged, including specific providers where applicable;

(6) planned frequency and type of services initiated;

(7) a crisis response action plan if a crisis should occur;

(8) clear progress notes on outcome of goals;

(9) a written plan must be completed within 24 hours of beginning services with the recipient; and

(10) a treatment plan must be developed by a mental health professional or mental health practitioner under the clinical supervision of a mental health professional. The mental health professional must approve and sign all treatment plans.

Subd. 12. [EXCLUDED SERVICES.] The following services are excluded from reimbursement under this section:

(1) room and board services;

(2) services delivered to a recipient while admitted to an inpatient hospital;

(3) recipient transportation costs may be covered under other medical assistance provisions, but transportation services are not an adult mental health crisis response service;

(4) services provided and billed by a provider who is not enrolled under medical assistance to provide adult mental health crisis response services;

(5) services performed by volunteers;

(6) direct billing of time spent "on call" when not delivering services to a recipient;

(7) provider service time included in case management reimbursement. When a provider is eligible to provide more than one type of medical assistance service, the recipient must have a choice of provider for each service, unless otherwise provided for by law;

(8) outreach services to potential recipients; and

(9) a mental health service that is not medically necessary.

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

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

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

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

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

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

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

(e) Payment for mental health case management provided by Indian health services or by agencies operated by Indian tribes may be made according to this section or other relevant federally approved rate setting methodology.

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

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

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

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

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

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

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

- (1) the costs of developing and implementing this section; and
- (2) programming the information systems.

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

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

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

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

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

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

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

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

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

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



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

Subd. 43. [APPEAL PROCESS.] If a county contract or certification is required to enroll as an authorized provider of mental health services under medical assistance, and if a county refuses to grant the necessary contract or certification, the provider may appeal the county decision to the commissioner. A recipient may initiate an appeal on behalf of a provider who has been denied certification. The commissioner shall determine whether the provider meets applicable standards under state laws and rules based on an independent review of the facts, including comments from the county review. If the commissioner finds that the provider meets the applicable standards, the commissioner shall enroll the provider as an authorized provider. The commissioner shall develop procedures for providers and recipients to appeal a county decision to refuse to enroll a provider. After the commissioner makes a decision regarding an appeal, the county, provider, or recipient may request that the commissioner reconsider the commissioner's initial decision. The commissioner's reconsideration decision is final and not subject to further appeal.

Sec. 18. Minnesota Statutes 2000, section 256B.0625, is amended by adding a subdivision to read:

Subd. 44. [MENTAL HEALTH PROVIDER TRAVEL TIME.] Medical assistance covers provider travel time if a recipient's individual treatment plan requires the provision of mental health services outside of the provider's normal place of business. This does not include any travel time which is included in other billable services, and is only covered when the mental health service being provided to a recipient is covered under medical assistance.

Sec. 19. [256B.761] [REIMBURSEMENT FOR MENTAL HEALTH SERVICES.]

Payment for medication management provided to psychiatric patients, outpatient mental health services, day treatment services, home-based mental health services, and family community support services shall be paid at:

(1) for services rendered on or after July 1, 2001, and before July 1, 2002, the lower of (i) submitted charges, or (ii) the 73rd percentile of the 50th percentile of 1999 charges; and

(2) for services rendered on or after July 1, 2002, the lower of (i) submitted charges, or (ii) the 75th percentile of the 50th percentile of 1999 charges.

Sec. 20. [299A.76] [SUICIDE STATISTICS.]

(a) The commissioner of public safety shall not:

(1) include any statistics on committing suicide or attempting suicide in any compilation of crime statistics published by the commissioner; or

(2) label as a crime statistic, any data on committing suicide or attempting suicide.

(b) This section does not apply to the crimes of aiding suicide under section 609.215, subdivision 1, or aiding attempted suicide under section 609.215, subdivision 2, or to statistics directly related to the commission of a crime.

Sec. 21. [NOTICE REGARDING ESTABLISHMENT OF CONTINUING CARE BENEFIT PROGRAM.]

When the continuing care benefit program for persons with mental illness under Minnesota Statutes, section 256.9693 is established, the commissioner of human services shall notify counties, health plan companies with prepaid medical assistance contracts, health care providers, and enrollees of the benefit program through bulletins, workshops, and other meetings.

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

## Sec. 22. [STUDY; LENGTH OF STAY FOR MEDICARE-ELIGIBLE PERSONS.]

The commissioner of human services shall study and make recommendations on how Medicare-eligible persons with mental illness may obtain acute care hospital inpatient treatment for mental illness for a length of stay beyond that allowed by the diagnostic classifications for mental illness according to Minnesota Statutes, section 256.969, subdivision 3a. The study and recommendations shall be reported to the legislature by January 15, 2002.

## Sec. 23. [DEVELOPMENT OF PAYMENT SYSTEM FOR ADULT RESIDENTIAL SERVICES GRANTS.]

The commissioner of human services shall review funding methods for adult residential services grants under Minnesota Rules, parts 9535.2000 to 9535.3000, and shall develop a payment system that takes into account client difficulty of care as manifested by client physical, mental, or behavioral conditions. The payment system must provide reimbursement for education, consultation, and support services provided to families and other individuals as an extension of the treatment process. The commissioner shall present recommendations and draft legislation for an adult residential services payment system to the legislature by January 15, 2002. The recommendations must address whether additional funding for adult residential services grants is necessary for the provision of high quality services under a payment reimbursement system.

## ARTICLE 11

## 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. [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. 3. 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. 4. 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. 5. 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. 6. 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. 7. 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. 8. 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. 9. 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. 10. 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. 11. 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. 12. 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. 13. 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. 14. [256J.425] [HARDSHIP EXTENSIONS.]

Subdivision 1. [ELIGIBILITY.] An assistance unit subject to the time limit under section 256J.42, subdivision 1, in which any participant has received 60 counted months of assistance is not eligible to receive months of assistance beyond the first 60 months under a hardship extension, if the participant is not in compliance. If there is more than one participant in the household, each participant must be in compliance to be eligible for a hardship extension. For purposes of determining eligibility for a hardship extension, a participant is in compliance in any month that the participant has not been sanctioned under section 256J.46, subdivision 1, or under 256J.26, subdivision 1.

Subd. 2. [ILL OR INCAPACITATED PARTICIPANTS; DEPENDENT HOUSEHOLD MEMBER.] (a) An assistance unit subject to the time limit in section 256J.42, subdivision 1, in which any participant has received 60 counted months of assistance, is eligible to receive months of assistance under a hardship extension if the participant belongs to any of the following groups:

(1) participants who are suffering from a professionally certified illness, injury, or incapacity which is expected to continue for more than 30 days and which prevents the person from obtaining or retaining employment and who are following the treatment recommendations of the health care provider certifying the illness, injury, or incapacity;

(2) participants whose presence in the home is required because of the professionally certified illness or incapacity of another member in the assistance unit, a relative in the household, or a foster child in the household and the illness or incapacity is expected to continue for more than 30 days; or

(3) caregivers with a child or an adult in the household who meets the disability or medical criteria for home care services under section 256B.0627, subdivision 1, paragraph (c), or a home and community-based waiver services program under chapter 256B, or meets the criteria for severe emotional disturbance under section 245.4871, subdivision 6, or for serious and persistent mental illness under section 245.462, subdivision 20, paragraph (c). Caregivers in this category are presumed to be prevented from obtaining or retaining employment.

(b) An assistance unit receiving assistance under a hardship extension under this subdivision may continue to receive assistance under MFIP as long as the participant meets the criteria in paragraph (a), clause (1), (2), or (3). A county agency or job counselor must, on a quarterly basis, review the case file of an assistance unit receiving assistance under this subdivision to determine if the participant still meets the criteria in paragraph (a), clause (1), (2), or (3).

Subd. 3. [CERTAIN HARD-TO-EMPLOY PARTICIPANTS.] (a) An assistance unit subject to the time limit in section 256J.42, subdivision 1, in which any participant has received 60 counted months of assistance, is eligible to receive months of assistance under a hardship extension if the participant belongs to any of the following groups:

(1) a person who is diagnosed by a licensed physician, psychological practitioner, or other qualified professional, as mentally retarded or mentally ill, and that condition prevents the person from obtaining or retaining employment;

(2) a person who has been assessed by a vocational specialist, job counselor, or the county agency to be unemployable for purposes of this subdivision; a person is considered employable if positions of employment in the local labor market exist, regardless of the current availability of openings for those positions, that the person is capable of performing. The person's eligibility under this category must be reassessed at least annually; or

(3) a person who is determined by the county agency, according to Minnesota Rules, part 9500.1251, subpart 2, item I, to be learning disabled, provided that if a rehabilitation plan for the person is developed or approved by the county agency, the person is following the plan. A rehabilitation plan does not replace the requirement to develop and comply with an employment plan under section 256J.52.

(b) An assistance unit receiving assistance under a hardship extension under this subdivision may continue to receive assistance under MFIP as long as the participant meets the criteria in paragraph (a), clause (1), (2), or (3), and all participants in the assistance unit remain in compliance with, or are exempt from, the employment and training services requirements in sections 256J.52 to 256J.55.

Subd. 4. [VICTIMS OF FAMILY VIOLENCE.] A participant who received TANF assistance that counted towards the federal 60-month time limit while the participant complied with a safety plan or, after October 1, 2001, an alternative employment plan under the MFIP employment and training component is eligible for assistance under a hardship extension for a period of time equal to the number of months that were counted toward the federal 60-month time limit while the participant complied with a safety plan or, after October 1, 2001, an alternative employment plan under the MFIP employment and training component.

Subd. 5. [ACCRUAL OF CERTAIN EXEMPT MONTHS.] (a) A participant who received TANF assistance that counted towards the federal 60-month time limit while the participant was or would have been exempt under section 256J.56, paragraph (a), clause (7), from employment and training services requirements and who is no longer eligible for assistance under a hardship extension under subdivision 2, paragraph (a), clause (3), is eligible for



assistance under a hardship extension for a period of time equal to the number of months that were counted toward the federal 60-month time limit while the participant was or would have been exempt under section 256J.56, paragraph (a), clause (7), from the employment and training services requirements.

(b) A participant who received TANF assistance that counted towards the federal 60-month time limit while the participant met the state time limit exemption criteria under section 256J.42, subdivision 5, is eligible for assistance under a hardship extension for a period of time equal to the number of months that were counted toward the federal 60-month time limit while the participant met the state time limit exemption criteria under section 256J.42, subdivision 5.

Sec. 15. 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. 16. 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. 17. 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 ~~(e)~~ (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. 18. 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. 19. 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. 20. 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. 21. 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~~ (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. 22. 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. 23. 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. 24. 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. 25. 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. 26. 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. 27. Minnesota Statutes 2000, section 256J.751, is amended to read:

256J.751 [COUNTY PERFORMANCE MANAGEMENT.]

~~(a)~~ Subdivision 1. [QUARTERLY COUNTY CASELOAD REPORT.] The commissioner shall report quarterly to ~~all counties~~ each county on the county's performance on the following measures:

- (1) ~~percent of MFIP caseload working in paid employment;~~
- ~~(2)~~ percent number of MFIP caseload cases receiving only the food portion of assistance;
- ~~(2)~~ number of child-only cases;
- ~~(3)~~ number of minor caregivers;
- ~~(4)~~ number of cases that are exempt from the 60-month time limit by the exemption category under section 256J.42;
- ~~(5)~~ number of participants who are exempt from employment and training services requirements by the exemption category under section 256J.56;
- ~~(6)~~ number of assistance units receiving assistance under a hardship extension under section 256J.425;
- ~~(7)~~ number of participants and number of months spent in each level of sanction under section 256J.46, subdivision 1;
- ~~(3)~~ (8) number of MFIP cases that have left assistance;
- ~~(4)~~ (9) federal participation requirements as specified in title 1 of Public Law Number 104-193; and
- ~~(5)~~ (10) median placement wage rate; and
- ~~(b)~~ (11) of each county's total MFIP caseload less the number of cases in clauses (1) to (6):
  - (i) number of one-parent cases;
  - (ii) number of two-parent cases;



(iii) percent of one-parent cases that are working more than 20 hours per week;

(iv) percent of two-parent cases that are working more than 20 hours per week; and

(v) percent of cases that have received more than 36 months of assistance.

Subd. 2. [QUARTERLY COMPARISON REPORT.] The commissioner shall report quarterly to all counties on each county's performance on the following measures:

(1) percent of MFIP caseload working in paid employment;

(2) percent of MFIP caseload receiving only the food portion of assistance;

(3) number of MFIP cases that have left assistance;

(4) federal participation requirements as specified in Title 1 of Public Law Number 104-193;

(5) median placement wage rate; and

(6) caseload by months of TANF assistance.

Subd. 3. [ANNUAL REPORT.] The commissioner must report to all counties and to the legislature on each county's annual performance on the measures required under subdivision 1 by racial and ethnic group and, to the extent consistent with state and federal law, must include each county's performance on:

(1) the number of out-of-wedlock births and births to teen mothers; and

(2) number of cases by racial and ethnic group.

The report must be completed by January 1, 2002, and January 1 of each year thereafter and must comply with sections 3.195 and 3.197.

Subd. 4. [DEVELOPMENT OF PERFORMANCE MEASURES.] By January 1, 2002, the commissioner shall, in consultation with counties, develop measures for county performance in addition to those in ~~paragraph (a)~~ subdivision 1 and 2. In developing these measures, the commissioner must consider:

(1) a measure for MFIP cases that leave assistance due to employment;

(2) job retention after participants leave MFIP; and

(3) participant's earnings at a follow-up point after the participant has left MFIP; and

(4) the appropriateness of services provided to minority groups.

(⇌) 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.

(⇌) (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. 28. 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. 29. 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. 30. 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. 31. 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. 32. 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. 33. 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.

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 12

## ADDITIONAL LICENSING PROVISIONS

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 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 256.022.

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

Sec. 3. 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. 4. 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. 5. 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 ~~firm~~ 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. 6. Minnesota Statutes 2000, section 245A.04, subdivision 3a, is amended to read:

Subd. 3a. [NOTIFICATION TO SUBJECT AND LICENSE HOLDER OF STUDY RESULTS; DETERMINATION OF RISK OF HARM.] (a) The commissioner shall notify the applicant ~~or~~ license holder, or registrant 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. 7. Minnesota Statutes 2000, section 245A.04, subdivision 3b, is amended to read:

Subd. 3b. [RECONSIDERATION OF DISQUALIFICATION.] (a) The individual who is the subject of the disqualification may request a reconsideration of the disqualification.

The individual must submit the request for reconsideration to the commissioner in writing. A request for reconsideration for an individual who has been sent a notice of disqualification under subdivision 3a, paragraph (b), clause (1) or (2), must be submitted within 30 calendar days of the disqualified individual's receipt of the notice of disqualification. A request for reconsideration for an individual who has been sent a notice of disqualification under subdivision 3a, paragraph (b), clause (3), must be submitted within 15 calendar days of the disqualified individual's receipt of the notice of disqualification. An individual who was determined to have maltreated a child under section 626.556 or a vulnerable adult under section 626.557, and who was disqualified under this section on the basis of serious or recurring maltreatment, may request reconsideration of both the maltreatment and the disqualification determinations. The request for reconsideration of the maltreatment determination and the disqualification must be submitted within 30 calendar days of the individual's receipt of the notice of disqualification. Removal of a disqualified individual from direct contact shall be ordered if the individual does not request reconsideration within the prescribed time, and for an individual who submits a timely request for reconsideration, if the disqualification is not set aside. The individual must present information showing that:

(1) the information the commissioner relied upon is incorrect or inaccurate. If the basis of a reconsideration request is that a maltreatment determination or disposition under section 626.556 or 626.557 is incorrect, and the commissioner has issued a final order in an appeal of that determination or disposition under section 256.045 or 245A.08, subdivision 5, the commissioner's order is conclusive on the issue of maltreatment. If the individual did not request reconsideration of the maltreatment determination, the maltreatment determination is deemed conclusive; or

(2) the subject of the study does not pose a risk of harm to any person served by the applicant or license holder, or registrant.

(b) The commissioner shall rescind the disqualification if the commissioner finds that the information relied on to disqualify the subject is incorrect. The commissioner may set aside the disqualification under this section if the commissioner finds that the ~~information the commissioner relied upon is incorrect or~~ the individual does not pose a risk of harm to any person served by the applicant or license holder, or registrant. In determining that an individual does not pose a risk of harm, the commissioner shall consider the consequences of the event or events that lead to disqualification, whether there is more than one disqualifying event, the vulnerability of the victim at the time of the event, the time elapsed without a repeat of the same or similar event, documentation of successful completion by the individual studied of training or rehabilitation pertinent to the event, and any other information relevant to reconsideration. In reviewing a disqualification under this section, the commissioner shall give preeminent weight to the safety of each person to be served by the license holder or applicant, or registrant over the interests of the license holder or applicant, or registrant.

(c) Unless the information the commissioner relied on in disqualifying an individual is incorrect, the commissioner may not set aside the disqualification of an individual in connection with a license to provide family day care for children, foster care for children in the provider's own home, or foster care or day care services for adults in the provider's own home if:

(1) less than ten years have passed since the discharge of the sentence imposed for the offense; and the individual has been convicted of a violation of any offense listed in sections 609.20 (manslaughter in the first degree), 609.205 (manslaughter in the second degree), criminal vehicular homicide under 609.21 (criminal vehicular homicide and injury), 609.215 (aiding suicide or aiding attempted suicide), felony violations under 609.221 to 609.2231 (assault in the first, second, third, or fourth degree), 609.713 (terroristic threats), 609.235 (use of drugs to injure or to facilitate crime), 609.24 (simple robbery), 609.245 (aggravated robbery), 609.25 (kidnapping), 609.255 (false imprisonment), 609.561 or 609.562 (arson in the first or second degree), 609.71 (riot), burglary in the first or second degree under 609.582 (burglary), 609.66 (dangerous weapon), 609.665 (spring guns), 609.67 (machine guns and short-barreled shotguns), 609.749 (harassment; stalking), 152.021 or 152.022 (controlled substance crime in the first or second degree), 152.023, subdivision 1, clause (3) or (4), or subdivision 2, clause (4) (controlled substance crime in the third degree), 152.024, subdivision 1, clause (2), (3), or (4) (controlled substance crime in the fourth degree), 609.224, subdivision 2, paragraph (c) (fifth-degree assault by a caregiver against a vulnerable adult), 609.228 (great bodily harm caused by distribution of drugs), 609.23 (mistreatment of persons confined), 609.231 (mistreatment of residents or patients), 609.2325 (criminal abuse of a vulnerable adult), 609.233 (criminal neglect of a vulnerable adult), 609.2335 (financial exploitation of a vulnerable adult), 609.234 (failure to report), 609.265 (abduction), 609.2664 to 609.2665 (manslaughter of an unborn child in the first or second degree), 609.267 to 609.2672 (assault of an unborn child in the first, second, or third degree), 609.268 (injury or death of an unborn child in the commission of a crime), 617.293 (disseminating or displaying harmful material to minors), a gross misdemeanor offense under 609.324, subdivision 1 (other prohibited acts), a gross misdemeanor offense under 609.378 (neglect or endangerment of a child), a gross misdemeanor offense under 609.377 (malicious punishment of a child), 609.72, subdivision 3 (disorderly conduct against a vulnerable adult); or an attempt or conspiracy to commit any of these offenses, as each of these offenses is defined in Minnesota Statutes; or an offense in any other state, the elements of which are substantially similar to the elements of any of the foregoing offenses;

(2) regardless of how much time has passed since the discharge of the sentence imposed for the offense, the individual was convicted of a violation of any offense listed in sections 609.185 to 609.195 (murder in the first, second, or third degree), 609.2661 to 609.2663 (murder of an unborn child in the first, second, or third degree), a felony offense under 609.377 (malicious punishment of a child), a felony offense under 609.324, subdivision 1 (other prohibited acts), a felony offense under 609.378 (neglect or endangerment of a child), 609.322 (solicitation, inducement, and promotion of prostitution), 609.342 to 609.345 (criminal sexual conduct in the first, second, third, or fourth degree), 609.352 (solicitation of children to engage in sexual conduct), 617.246 (use of minors in a sexual performance), 617.247 (possession of pictorial representations of a minor), 609.365 (incest), a felony offense under sections 609.2242 and 609.2243 (domestic assault), a felony offense of spousal abuse, a felony offense of child abuse

or neglect, a felony offense of a crime against children, or an attempt or conspiracy to commit any of these offenses as defined in Minnesota Statutes, or an offense in any other state, the elements of which are substantially similar to any of the foregoing offenses;

(3) within the seven years preceding the study, the individual committed an act that constitutes maltreatment of a child under section 626.556, subdivision 10e, and that resulted in substantial bodily harm as defined in section 609.02, subdivision 7a, or substantial mental or emotional harm as supported by competent psychological or psychiatric evidence; or

(4) within the seven years preceding the study, the individual was determined under section 626.557 to be the perpetrator of a substantiated incident of maltreatment of a vulnerable adult that resulted in substantial bodily harm as defined in section 609.02, subdivision 7a, or substantial mental or emotional harm as supported by competent psychological or psychiatric evidence.

In the case of any ground for disqualification under clauses (1) to (4), if the act was committed by an individual other than the applicant ~~or~~ license holder, ~~or~~ registrant residing in the applicant's ~~or~~ license holder's, ~~or~~ registrant's home, the applicant ~~or~~ license holder, ~~or~~ registrant may seek reconsideration when the individual who committed the act no longer resides in the home.

The disqualification periods provided under clauses (1), (3), and (4) are the minimum applicable disqualification periods. The commissioner may determine that an individual should continue to be disqualified from licensure ~~or~~ registration because the license holder ~~or~~ applicant, ~~or~~ registrant poses a risk of harm to a person served by that individual after the minimum disqualification period has passed.

(d) The commissioner shall respond in writing or by electronic transmission to all reconsideration requests for which the basis for the request is that the information relied upon by the commissioner to disqualify is incorrect or inaccurate within 30 working days of receipt of a request and all relevant information. If the basis for the request is that the individual does not pose a risk of harm, the commissioner shall respond to the request within 15 working days after receiving the request for reconsideration and all relevant information. If the request is based on both the correctness or accuracy of the information relied on to disqualify the individual and the risk of harm, the commissioner shall respond to the request within 45 working days after receiving the request for reconsideration and all relevant information. If the disqualification is set aside, the commissioner shall notify the applicant or license holder in writing or by electronic transmission of the decision.

(e) ~~Except as provided in subdivision 3c, the commissioner's decision to disqualify an individual, including the decision to grant or deny a rescission or set aside a disqualification under this section, is the final administrative agency action and shall not be subject to further review in a contested case under chapter 14 involving a negative licensing appeal taken in response to the disqualification or involving an accuracy and completeness appeal under section 13.04; if a disqualification is not set aside or is not rescinded, an individual who was disqualified on the basis of a preponderance of evidence that the individual committed an act or acts that meet the definition of any of the crimes lists in subdivision 3d, paragraph (a), clauses (1) to (4); or for failure to make required reports under section 626.556, subdivision 3, or 626.557, subdivision 3, pursuant to subdivision 3d, paragraph (a), clause (4), may request a fair hearing under section 256.045. Except as provided under subdivision 3c, the commissioner's final order for an individual under this paragraph is conclusive on the issue of disqualification, including for purposes of subsequent studies conducted under section 245A.04, subdivision 3, and is the only administrative appeal of the final agency determination, specifically, including a challenge to the accuracy and completeness of data under section 13.04.~~

(f) Except as provided under subdivision 3c, if an individual was disqualified on the basis of a determination of maltreatment under section 626.556 or 626.557, which was serious or recurring, and the individual has requested reconsideration of the maltreatment determination under section 626.556, subdivision 10i, or 626.557, subdivision 9d, and also requested reconsideration of the disqualification under this subdivision, reconsideration of the maltreatment determination and reconsideration of the disqualification shall be consolidated into a single reconsideration. For maltreatment and disqualification determinations made by county agencies, the consolidated reconsideration shall be conducted by the county agency. Except as provided under subdivision 3c, if an individual

who was disqualified on the basis of serious or recurring maltreatment requests a fair hearing on the maltreatment determination under section 626.556, subdivision 10i, or 626.557, subdivision 9d, the scope of the fair hearing under section 256.045 shall include the maltreatment determination and the disqualification. Except as provided under subdivision 3c, the commissioner's final order for an individual under this paragraph is conclusive on the issue of maltreatment and disqualification, including for purposes of subsequent studies conducted under subdivision 3, and is the only administrative appeal of the final agency determination, specifically, including a challenge to the accuracy and completeness of data under section 13.04.

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

Sec. 8. Minnesota Statutes 2000, section 245A.04, subdivision 3c, is amended to read:

Subd. 3c. [CONTESTED CASE.] (a) Notwithstanding subdivision 3b, paragraphs (e) and (f), if a disqualification is not set aside, a person who is an employee of an employer, as defined in section 179A.03, subdivision 15, may request a contested case hearing under chapter 14. If the disqualification which was not set aside or was not rescinded was based on a maltreatment determination, the scope of the contested case hearing 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. 9. Minnesota Statutes 2000, section 245A.04, subdivision 3d, is amended to read:

Subd. 3d. [DISQUALIFICATION.] (a) Except as provided in paragraph (b), when a background study completed under subdivision 3 shows any of the following: a conviction of one or more crimes listed in clauses (1) to (4); the individual has admitted to or a preponderance of the evidence indicates the individual has committed an act or acts that meet the definition of any of the crimes listed in clauses (1) to (4); or an investigation results in an administrative determination listed under clause (4), the individual shall be disqualified from any position allowing direct contact with persons receiving services from the license holder, 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. 10. Minnesota Statutes 2000, section 245A.05, is amended to read:

245A.05 [DENIAL OF APPLICATION.]

The commissioner may deny a license if an applicant fails to comply with applicable laws or rules, or knowingly withholds relevant information from or gives false or misleading information to the commissioner in connection with an application for a license or during an investigation. An applicant whose application has been denied by the commissioner must be given notice of the denial. Notice must be given by certified mail. The notice must state the reasons the application was denied and must inform the applicant of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8510 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. 11. Minnesota Statutes 2000, section 245A.06, is amended to read:

245A.06 [CORRECTION ORDER AND ~~FINES~~ CONDITIONAL LICENSE.]

Subdivision 1. [~~CONTENTS OF CORRECTION ORDERS OR FINES AND CONDITIONAL LICENSES.~~] (a) If the commissioner finds that the applicant or license holder has failed to comply with an applicable law or rule and this failure does not imminently endanger the health, safety, or rights of the persons served by the program, the commissioner may issue a correction order and an order of conditional license to ~~or impose a fine on~~ the applicant or license holder. When issuing a conditional license, the commissioner shall consider the nature, chronicity, or severity of the violation of law or rule and the effect of the violation on the health, safety, or rights of persons served by the program. The correction order or ~~fine~~ conditional license must state:

(1) the conditions that constitute a violation of the law or rule;

(2) the specific law or rule violated;

(3) the time allowed to correct each violation; and

(4) if a ~~fine is imposed, the amount of the fine~~ license is made conditional, the length and terms of the conditional license.

(b) Nothing in this section prohibits the commissioner from proposing a sanction as specified in section 245A.07, prior to issuing a correction order or ~~fine~~ conditional license.

Subd. 2. [RECONSIDERATION OF CORRECTION ORDERS.] If the applicant or license holder believes that the contents of the commissioner's correction order are in error, the applicant or license holder may ask the department of human services to reconsider the parts of the correction order that are alleged to be in error. The request for reconsideration must be in writing and received by the commissioner within 20 calendar days after receipt of the correction order by the applicant or license holder, and:

(1) specify the parts of the correction order that are alleged to be in error;

(2) explain why they are in error; and

(3) include documentation to support the allegation of error.

A request for reconsideration does not stay any provisions or requirements of the correction order. The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14.

Subd. 3. [FAILURE TO COMPLY.] If the commissioner finds that the applicant or license holder has not corrected the violations specified in the correction order or conditional license, the commissioner may impose a fine and order other licensing sanctions pursuant to section 245A.07. ~~If a fine was imposed and the violation was not corrected, the commissioner may impose an additional fine. This section does not prohibit the commissioner from seeking a court order, denying an application, or suspending, revoking, or making conditional the license in addition to imposing a fine.~~

Subd. 4. [NOTICE OF ~~FINE~~ CONDITIONAL LICENSE; RECONSIDERATION OF ~~FINE~~ CONDITIONAL LICENSE.] ~~A license holder who is ordered to pay a fine~~ If a license is made conditional, the license holder must be notified of the order by certified mail. The notice must be mailed to the address shown on the application or the last known address of the license holder. The notice must state the reasons the ~~fine~~ conditional license was ordered and must inform the license holder of the ~~responsibility for payment of fines in subdivision 7 and the right to request reconsideration of the fine~~ conditional license by the commissioner. The license holder may request reconsideration of the order ~~to forfeit a fine of conditional license~~ by notifying the commissioner by certified mail within 20 calendar days after receiving the order. The request must be in writing and must be received by the commissioner within ten

calendar days after the license holder received the order. The license holder may submit with the request for reconsideration written argument or evidence in support of the request for reconsideration. A timely request for reconsideration shall stay ~~forfeiture of the fine imposition of the terms of the conditional license~~ until the commissioner issues a decision on the request for reconsideration. ~~The request for reconsideration must be in writing and:~~

- ~~(1) specify the parts of the violation that are alleged to be in error;~~
- ~~(2) explain why they are in error;~~
- ~~(3) include documentation to support the allegation of error; and~~
- ~~(4) any other information relevant to the fine or the amount of the fine.~~

The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14.

~~Subd. 5. [FORFEITURE OF FINES.] The license holder shall pay the fines assessed on or before the payment date specified in the commissioner's order. If the license holder fails to fully comply with the order, the commissioner shall issue a second fine or suspend the license until the license holder complies. If the license holder receives state funds, the state, county, or municipal agencies or departments responsible for administering the funds shall withhold payments and recover any payments made while the license is suspended for failure to pay a fine.~~

~~Subd. 5a. [ACCRUAL OF FINES.] A license holder shall promptly notify the commissioner of human services, in writing, when a violation specified in an order to forfeit is corrected. If upon reinspection the commissioner determines that a violation has not been corrected as indicated by the order to forfeit, the commissioner may issue a second fine. The commissioner shall notify the license holder by certified mail that a second fine has been assessed. The license holder may request reconsideration of the second fine under the provisions of subdivision 4.~~

~~Subd. 6. [AMOUNT OF FINES.] Fines shall be assessed as follows:~~

~~(1) the license holder shall forfeit \$1,000 for each occurrence of violation of law or rule prohibiting the maltreatment of children or the maltreatment of vulnerable adults, including but not limited to corporal punishment, illegal or unauthorized use of physical, mechanical, or chemical restraints, and illegal or unauthorized use of aversive or deprivation procedures;~~

~~(2) the license holder shall forfeit \$200 for each occurrence of a violation of law or rule governing matters of health, safety, or supervision, including but not limited to the provision of adequate staff to child or adult ratios; and~~

~~(3) the license holder shall forfeit \$100 for each occurrence of a violation of law or rule other than those included in clauses (1) and (2).~~

~~For the purposes of this section, "occurrence" means each violation identified in the commissioner's forfeiture order.~~

~~Subd. 7. [RESPONSIBILITY FOR PAYMENT OF FINES.] When a fine has been assessed, the license holder may not avoid payment by closing, selling, or otherwise transferring the licensed program to a third party. In such an event, the license holder will be personally liable for payment. In the case of a corporation, each controlling individual is personally and jointly liable for payment.~~

~~Fines for child care centers must be assessed according to this section.~~

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

Sec. 12. Minnesota Statutes 2000, section 245A.07, is amended to read:

245A.07 [SANCTIONS.]

Subdivision 1. [SANCTIONS AVAILABLE.] In addition to ~~ordering forfeiture of fines making a license conditional under section 245A.06,~~ the commissioner may propose to suspend; or revoke; or ~~make conditional~~ the license, impose a fine, or secure an injunction against the continuing operation of the program of a license holder who does not comply with applicable law or rule. When applying sanctions authorized under this section, the commissioner shall consider the nature, chronicity, or severity of the violation of law or rule and the effect of the violation on the health, safety, or rights of persons served by the program.

Subd. 2. [~~IMMEDIATE SUSPENSION IN CASES OF IMMINENT DANGER TO HEALTH, SAFETY, OR RIGHTS~~ TEMPORARY IMMEDIATE SUSPENSION.] (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. 13. Minnesota Statutes 2000, section 245A.08, is amended to read:

245A.08 [HEARINGS.]

Subdivision 1. [RECEIPT OF APPEAL; CONDUCT OF HEARING.] Upon receiving a timely appeal or petition pursuant to section 245A.04, subdivision 3c, 245A.05, or 245A.07, subdivision 3, the commissioner shall issue a notice of and order for hearing to the appellant under chapter 14 and Minnesota Rules, parts 1400.8510 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. 14. Minnesota Statutes 2000, section 245A.16, subdivision 1, is amended to read:

Subdivision 1. [DELEGATION OF AUTHORITY TO AGENCIES.] (a) County agencies and private agencies that have been designated or licensed by the commissioner to perform licensing functions and activities under section 245A.04, to recommend denial of applicants under section 245A.05, to issue correction orders, to issue variances, and recommend ~~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. 15. Minnesota Statutes 2000, section 245B.08, subdivision 3, is amended to read:

Subd. 3. [SANCTIONS AVAILABLE.] Nothing in this subdivision shall be construed to limit the commissioner's authority to suspend; or revoke 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. 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.

Sec. 17. 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. 18. 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. 19. 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. 20. 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.

Sec. 21. 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. 22. 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;~~

~~(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~~

~~(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. 23. 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.

Sec. 24. 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.

Sec. 25. Minnesota Statutes 2000, section 626.556, subdivision 10b, is amended to read:

Subd. 10b. [DUTIES OF COMMISSIONER; NEGLECT OR ABUSE IN FACILITY.] (a) This section applies to the commissioners of human services, health, and children, families, and learning. The commissioner of the agency responsible for assessing or investigating the report shall immediately investigate if the report alleges that:

(1) a child who is in the care of a facility as defined in subdivision 2 is neglected, physically abused, ~~or~~ sexually abused, or is the victim of maltreatment in a facility by an individual in that facility, or has been so neglected or abused, or been the victim of maltreatment in a facility by an individual in that facility within the three years preceding the report; or

(2) a child was neglected, physically abused, ~~or~~ sexually abused, or is the victim of maltreatment in a facility by an individual in a facility defined in subdivision 2, while in the care of that facility within the three years preceding the report.

The commissioner of the agency responsible for assessing or investigating the report shall arrange for the transmittal to the commissioner of reports received by local agencies and may delegate to a local welfare agency the duty to investigate reports. In conducting an investigation under this section, the commissioner has the powers and duties specified for local welfare agencies under this section. The commissioner of the agency responsible for assessing or investigating the report or local welfare agency may interview any children who are or have been in the care of a facility under investigation and their parents, guardians, or legal custodians.

(b) Prior to any interview, the commissioner of the agency responsible for assessing or investigating the report or local welfare agency shall notify the parent, guardian, or legal custodian of a child who will be interviewed in the manner provided for in subdivision 10d, paragraph (a). If reasonable efforts to reach the parent, guardian, or legal custodian of a child in an out-of-home placement have failed, the child may be interviewed if there is reason to believe the interview is necessary to protect the child or other children in the facility. The commissioner of the agency responsible for assessing or investigating the report or local agency must provide the information required in this subdivision to the parent, guardian, or legal custodian of a child interviewed without parental notification as soon as possible after the interview. When the investigation is completed, any parent, guardian, or legal custodian notified under this subdivision shall receive the written memorandum provided for in subdivision 10d, paragraph (c).

(c) In conducting investigations under this subdivision the ~~commissioner or local welfare~~ agency 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. 26. 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. 27. 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. 28. 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 256.022.

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

Sec. 29. 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; REVIEW PANEL.] (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 an interested person acting on behalf of the child, regardless of the determination, who contests the investigating agency's final determination regarding maltreatment, may request the investigating agency to reconsider its final determination regarding maltreatment. The request for reconsideration must be submitted in writing to the investigating agency within 15 calendar days after receipt of

notice of the final determination regarding maltreatment or, if the request is made by an interested person who is not entitled to notice, within 15 days after receipt of the notice by the parent or guardian of the child. Effective January 1, 2002, 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. 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 256.022 if the investigating agency denies the request or fails to act upon the request or if the interested person contests a reconsidered determination. The investigating agency shall notify persons who request reconsideration of their rights under this paragraph. The request must be submitted in writing to the review panel and a copy sent to the investigating agency within 30 calendar days of receipt of notice of a denial of a request for reconsideration or of a reconsidered determination. The request must specifically identify the aspects of the agency determination with which the person is dissatisfied.

(c) If, as a result of the a reconsideration or review, the investigating agency changes the final determination of maltreatment, that agency shall notify the parties specified in subdivisions 10b, 10d, and 10f.

(d) 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) Effective January 1, 2002, 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) Effective January 1, 2002, 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.

(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.

Sec. 30. 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 256.022 if the data are pertinent and necessary for a review requested under section 256.022. 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. 31. 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.

Sec. 32. 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 August 1, 2001.

Sec. 33. 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. 34. 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. 35. 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.

Sec. 36. [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. 37. [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 13

### 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. [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.

Sec. 15. Minnesota Statutes 2000, section 260C.307, subdivision 3, is amended to read:

Subd. 3. [NOTICE.] The court shall have notice of the time, place, and purpose of the hearing served on the parents, as defined in sections 257.51 to 257.74 or 259.49, subdivision 1, clause (2), and upon the child's grandparent ~~if the child has lived with the grandparent within the two years immediately preceding the filing of the petition.~~ Notice must be served in the manner provided in sections 260C.151 and 260C.152, except that personal service shall be made at least ten days before the day of the hearing. Published notice shall be made for three weeks, the last publication to be at least ten days before the day of the hearing; and notice sent by certified mail shall be mailed at least 20 days before the day of the hearing. A parent who consents to the termination of parental rights under the provisions of section 260C.301, subdivision 2, clause (a), may waive in writing the notice required by this subdivision; however, if the parent is a minor or incompetent the waiver shall be effective only if the parent's guardian ad litem concurs in writing.

Sec. 16. 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. 17. 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. 18. Minnesota Statutes 2000, section 260C.317, is amended by adding a subdivision to read:

Subd. 5. [GRANDPARENT VISITATION.] In all proceedings for termination of parental rights, after notification of a grandparent under section 260C.307, subdivision 3, or at any time after completion of the proceeding and continuing during the minority of the child, a grandparent may seek an order of the court granting visitation rights to the grandparent under section 257.022, subdivision 2.

[EFFECTIVE DATE.] This section applies to proceedings commenced or completed before the effective date of this section.

Sec. 19. [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. 20. [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. 21. [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.

Sec. 22. [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 commissioner also shall study and determine if there are decision-making points in the child welfare system that lead to different outcomes for children and how those decision-making points affect outcomes for children. The commissioner shall report and make legislative recommendations on the following:

(1) amending the child welfare statutes to reduce any identified disparities in the child welfare system relating to outcomes for children of color, as compared to white children;

(2) reducing any identified bias in the child welfare system;

(3) reducing the number and duration of out-of-home placements for African American children; and

(4) improving the long-term outcomes for African American children in out-of-home placements.

(b) The commissioner of human services shall submit the report and recommended legislation to the chairs and ranking minority members of the committees in the house of representatives and senate with jurisdiction over child protection and out-of-home placement issues by January 15, 2002.

Sec. 23. [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. 24. [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.

Sec. 25. [REPEALER.]

Minnesota Statutes 2000, section 252A.111, subdivision 3, is repealed.

#### ARTICLE 14

#### 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

	2002	2003	APPROPRIATIONS BIENNIAL TOTAL
General	\$3,083,463,000	\$3,390,947,000	\$6,474,410,000
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	\$3,653,029,000	\$3,976,717,000	\$7,629,746,000

APPROPRIATIONS  
Available for the Year  
Ending June 30  
2002                      2003

Sec. 2. COMMISSIONER OF HUMAN SERVICES

Subdivision 1. Total Appropriation    \$3,475,621,000                      \$3,799,990,000

Summary by Fund

General	2,962,827,000	3,272,668,000
State Government Special Revenue	507,000	507,000
Health Care Access	207,884,000	263,095,000
Federal TANF	303,103,000	262,420,000
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

[NONFEDERAL SHARE TRANSFERS.] The nonfederal share of activities for which federal administrative reimbursement is appropriated to the commissioner may be transferred to the special revenue fund. Any balance from this appropriation remaining at the end of the biennium shall be transferred to the general fund.

[MAJOR SYSTEMS TRANSFER.] (1) \$21,550,000 of funds available in the state systems account authorized in Minnesota Statutes, section 256.014, is transferred to the general fund for the biennium ending June 30, 2003.

(2) \$2,450,000 of funds available in the state systems account authorized in Minnesota Statutes, section 256.014, is transferred to the general fund for the biennium ending June 30, 2005. Notwithstanding section 13 of this article, this rider does not expire on June 30, 2003.

[TANF FUNDS APPROPRIATED TO OTHER ENTITIES.] Any expenditures from the TANF block grant shall be expended in accordance with the requirements and limitations of part A of title IV of the Social Security Act, as amended, and any other applicable federal requirement or limitation. Prior to any expenditure of these funds, the commissioner shall assure that funds are expended in compliance with the requirements and limitations of federal law and that any reporting requirements of federal law are met. It shall be the responsibility of any entity to which these funds are appropriated to implement a memorandum of understanding with the commissioner that provides the necessary assurance of compliance prior to any expenditure of funds. The commissioner shall receipt TANF funds appropriated to other state agencies and coordinate all related interagency accounting transactions necessary to implement these appropriations. Unexpended TANF funds appropriated to any state, local, or nonprofit entity cancel at the end of the state fiscal year unless appropriating language permits otherwise.

[TANF FUNDS TRANSFERRED TO OTHER FEDERAL GRANTS.] The commissioner must authorize transfers from TANF to other federal block grants so that funds are available to meet the annual expenditure needs as appropriated. Transfers may be authorized prior to the expenditure year with the agreement of the receiving entity. Transferred funds must be expended in the year for which the funds were appropriated unless appropriation language permits otherwise. In accelerating transfer authorizations, the commissioner must aim to preserve the future potential transfer capacity from TANF to other block grants.

[TANF MAINTENANCE OF EFFORT.] (a) In order to meet the

APPROPRIATIONS  
Available for the Year  
Ending June 30  
2002 2003

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 13 of this article, paragraphs (a) to (h) expire June 30, 2005.

Subd. 2. Agency Management

General	34,546,000	33,003,000
State Government		
Special Revenue	392,000	392,000
Health Care		
Access	3,591,000	3,602,000
Federal TANF	546,000	454,000

The amounts that may be spent from the appropriation for each purpose are as follows:



APPROPRIATIONS  
Available for the Year  
Ending June 30  
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.

[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).

(c) Management Operations

General	19,110,000	17,958,000
---------	------------	------------

Health Care Access	2,555,000	2,555,000
-----------------------	-----------	-----------

Subd. 3. Administrative Reimbursement/ Pass Through

Federal TANF	60,565	51,992
--------------	--------	--------

Subd. 4. Children's Services Grants

General	59,320,000	59,833,000
---------	------------	------------

Federal TANF	6,290,000	6,290,000
--------------	-----------	-----------

[ADOPTION ASSISTANCE INCENTIVE GRANTS.] Federal funds available during fiscal year 2002 and fiscal year 2003, for adoption incentive grants are appropriated to the commissioner for these purposes.

[TANF TRANSFER TO SOCIAL SERVICES.] \$4,650,000 is appropriated to the commissioner in fiscal year 2002 and in fiscal year 2003 for purposes of increasing services for families with children whose incomes are at or below 200 percent of the federal poverty guidelines. The commissioner shall authorize a sufficient transfer of funds from the state's federal TANF block grant to the state's federal social services block grant to meet this appropriation.

[SOCIAL SERVICES BLOCK GRANT FUNDS FOR CONCURRENT PERMANENCY PLANNING.] Notwithstanding Minnesota Statutes, section 256E.07, \$4,650,000 in fiscal year 2002 and \$4,650,000 in fiscal year 2003 in social services block



APPROPRIATIONS  
Available for the Year  
Ending June 30  
2002                      2003

obtained, the commissioner shall use all resulting savings to provide services under the home and community-based waiver for persons with mental retardation and related conditions.

(d) General Assistance Medical Care

General	155,744,000	176,748,000
---------	-------------	-------------

(e) Health Care Grants - Other Assistance

General	13,032,000	18,879,000
---------	------------	------------

Health Care Access	750,000	750,000
-----------------------	---------	---------

[PURCHASING ALLIANCE STOP-LOSS FUNDING.] Of the general fund appropriation, \$150,000 in fiscal year 2002 and \$500,000 in fiscal year 2003 are appropriated to the commissioner for the cost of establishing the Purchasing Alliance Stop-loss fund under Minnesota Statutes, section 256.956.

Subd. 7. Basic Health Care Management

General	20,730,000	20,715,000
---------	------------	------------

Health Care Access	13,583,000	13,583,000
-----------------------	------------	------------

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) Health Care Policy Administration

General	2,822,000	2,862,000
---------	-----------	-----------

Health Care Access	562,000	562,000
-----------------------	---------	---------

(b) Health Care Operations

General	17,908,000	17,853,000
---------	------------	------------

Health Care Access	13,021,000	13,021,000
-----------------------	------------	------------

[PREPAID MEDICAL PROGRAMS.] The nonfederal share of the prepaid medical assistance program fund, which has been appropriated to fund county managed care advocacy and enrollment operating costs, shall be disbursed as grants using either a reimbursement or block grant mechanism.





APPROPRIATIONS  
Available for the Year  
Ending June 30  
2002                      2003

Lottery Cash		
Flow	1,158,000	1,158,000

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) Community Social Services Block Grants

	48,718,000	49,695,000
--	------------	------------

[CSSA TRADITIONAL APPROPRIATION.] Notwithstanding Minnesota Statutes, section 256E.06, subdivisions 1 and 2, the appropriations available under that section in fiscal years 2002 and 2003 must be distributed to each county proportionately to the aid received by the county in calendar year 2000.

(b) Aging Adult Service Grants

	13,500,000	13,732,000
--	------------	------------

[COUNTY PLANNING AND SERVICE DEVELOPMENT.] Of this appropriation, \$1,200,000 in fiscal year 2002 and \$1,600,000 in fiscal year 2003 are for distribution to county boards for planning and development of community services for the elderly as required under Minnesota Statutes, section 256B.437, subdivision 2. For Phase I funding to develop the initial biennial plan addendum, the commissioner shall distribute a minimum of \$10,000 to each county on July 1, 2001. In a county with more than 10,000 persons over 65 years, the funding allocation shall be \$15,000; with more than 30,000 persons over 65 years - \$20,000; with more than 50,000 persons over 65 years - \$25,000; and with more than 100,000 persons over 65 years - \$30,000. Upon submission of the completed biennial plan addendum, the commissioner shall distribute Phase II funding to each county for development of community-based services no later than January 1, 2002. For counties with less than 4,500 persons under 65 years, the Phase II allocation shall be \$10,000. For counties with more than 4,500 persons over 65 years, the Phase II allocation shall be \$2.23 per person over 65 years. Any remaining funds shall be available as targeted funds distributed to counties with designated critical access sites. Phase I funding may be carried over by the county into 2002 and 2003 for the development of services.

[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;







APPROPRIATIONS  
Available for the Year  
Ending June 30  
2002                      2003

[ALTERNATIVE CARE TRANSFER.] Any money allocated to the alternative care program that is not spent for the purposes indicated does not cancel but shall be transferred to the medical assistance account.

[ALTERNATIVE CARE APPROPRIATION.] The commissioner may expend the money appropriated for the alternative care program for that purpose in either year of the biennium.

(i) Group Residential Housing

General	78,712,000	86,807,000
---------	------------	------------

(j) Chemical Dependency Entitlement Grants

General	39,459,000	41,045,000
---------	------------	------------

(k) Chemical Dependency Nonentitlement Grants

General	5,941,000	5,918,000
---------	-----------	-----------

[CONSOLIDATED CHEMICAL DEPENDENCY TREATMENT FUND ONE-TIME TRANSFER.] \$9,367,000 of funds available in the consolidated chemical dependency treatment fund general reserve account is transferred in fiscal year 2002 to the general fund.

Subd. 10. Continuing Care Management

General	24,546,000	23,928,000
---------	------------	------------

State Government Special Revenue	115,000	115,000
-------------------------------------	---------	---------

Lottery Cash Flow	142,000	142,000
----------------------	---------	---------

[COUNTY INVOLVEMENT COSTS.] Of this appropriation, up to \$481,000 in fiscal year 2002 and up to \$642,000 in fiscal year 2003 are for the commissioner to allocate to counties for resident relocation costs resulting from planned closures under Minnesota Statutes, section 256B.437, and resident relocations under Minnesota Statutes, section 144A.161. Unexpended funds for fiscal year 2002 do not cancel but are available to the commissioner for this purpose in fiscal year 2003.

[REGION 10 QUALITY ASSURANCE COMMISSION.] (1) Of the appropriation from the general fund for the biennium ending June 30, 2003, \$548,000 is to the commissioner of human services









APPROPRIATIONS  
Available for the Year  
Ending June 30  
2002                      2003

payment center must be deposited in the state systems account authorized under Minnesota Statutes, section 256.014. These payments are appropriated to the commissioner for the operation of the child support payment center or system, according to Minnesota Statutes, section 256.014.

(e) General Assistance

General	17,156,000	15,700,000
---------	------------	------------

[GENERAL ASSISTANCE STANDARD.] The commissioner shall set the monthly standard of assistance for general assistance units consisting of an adult recipient who is childless and unmarried or living apart from his or her parents or a legal guardian at \$203. The commissioner may reduce this amount in accordance with Laws 1997, chapter 85, article 3, section 54.

(f) Minnesota Supplemental Aid

General	29,678,000	31,351,000
---------	------------	------------

(g) Refugee Services

General	250,000	250,000
---------	---------	---------

Subd. 12. Economic Support Management

General	37,775,000	37,405,000
---------	------------	------------

Health Care Access	1,318,000	1,318,000
-----------------------	-----------	-----------

Federal TANF	2,493,000	943,000
--------------	-----------	---------

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) Economic Support Policy Administration

General	6,528,000	6,191,000
---------	-----------	-----------

Federal TANF	2,493,000	943,000
--------------	-----------	---------

[FOOD STAMP ADMINISTRATIVE REIMBURSEMENT.] The commissioner shall reduce quarterly food stamp administrative reimbursement to counties in fiscal years 2002 and 2003 by the amount that the United States Department of Health and Human Services determines to be the county random moment study share



APPROPRIATIONS  
Available for the Year  
Ending June 30  
2002                      2003

Sec. 3. COMMISSIONER OF HEALTH

Subdivision 1. Total Appropriation		130,391,000	130,516,000
Summary by Fund			
General	84,419,000	82,960,000	
State Government Special Revenue	24,144,000	25,728,000	
Health Care Access	6,828,000	6,828,000	
Federal TANF	15,000,000	15,000,000	
Subd. 2. Family and Community Health		64,335,000	64,647,000
Summary by Fund			
General	44,743,000	44,056,000	
State Government Special Revenue	936,000	1,935,000	
Health Care Access	3,656,000	3,656,000	
Federal TANF	15,000,000	15,000,000	

[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.

APPROPRIATIONS  
Available for the Year  
Ending June 30  
2002 2003

(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.] \$10,000,000 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) \$1,750,000 in fiscal year 2002 and \$2,500,000 in fiscal year 2003 are for teen pregnancy prevention disparity grants under Minnesota Statutes, section 145.9257, subdivision 6.

(2) \$1,500,000 in fiscal year 2002 and \$1,500,000 in fiscal year 2003 are for high-risk community teen pregnancy prevention grants under Minnesota Statutes, section 145.9257, subdivision 7.

(3) \$1,000,000 in fiscal year 2002 and \$1,000,000 in fiscal year 2003 are for transfer to the commissioner of children, families, and learning to increase the number of adolescent parenting grants.

(4) \$750,000 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.

APPROPRIATIONS  
Available for the Year  
Ending June 30  
2002 2003

[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.

APPROPRIATIONS  
Available for the Year  
Ending June 30  
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

[HEALTH CARE SAFETY NET.] (1) Of the general fund appropriation, \$5,000,000 each year is for a grant program to aid safety net community clinics.

(2) \$5,000,000 each year is for a grant program to provide rural hospital capital improvement grants described in Minnesota Statutes, section 144.148.

[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.

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

APPROPRIATIONS  
Available for the Year  
Ending June 30  
2002                      2003

[EMERGING HEALTH THREATS.] (a) Of the general fund appropriation, \$2,200,000 in the first year and \$2,400,000 in the second year are to increase the state capacity to identify and respond to emerging health threats.

(b) Of these amounts, \$1,900,000 in the first year and \$2,100,000 in the second year are to expand state laboratory capacity to identify infectious disease organisms, evaluate environmental contaminants, develop new analytical techniques, provide emergency response, and support local government by training health care system workers to deal with biological and chemical health threats.

(c) \$300,000 each year is to train, consult, and otherwise assist local officials responding to clandestine drug laboratories and minimizing health risks to responders and the public.

Subd. 5. Management and Support Services	4,964,000	4,962,000
Summary by Fund		
General	4,817,000	4,815,000
State Government		
Special Revenue	147,000	147,000
Sec. 4. VETERANS NURSING HOMES BOARD	30,943,000	30,019,000

[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.

[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

APPROPRIATIONS  
Available for the Year  
Ending June 30  
2002                      2003

commissioner of finance. Approval of the commissioner of finance is contingent upon review of the board's submittal of a report outlining the following:

- (1) a long-term revenue outlook for the homes;
- (2) a review and recommendation of alternative funding sources for the homes' operations; and
- (3) administrative and service options to bring cost growth in line with revenues.

Sec. 5. HEALTH-RELATED BOARDS

Subdivision 1. Total Appropriation	10,800,000	10,892,000
------------------------------------	------------	------------

[STATE GOVERNMENT SPECIAL REVENUE FUND.] The appropriations in this section are from the state government special revenue fund.

[NO SPENDING IN EXCESS OF REVENUES.] The commissioner of finance shall not permit the allotment, encumbrance, or expenditure of money appropriated in this section in excess of the anticipated biennial revenues or accumulated surplus revenues from fees collected by the boards. Neither this provision nor Minnesota Statutes, section 214.06, applies to transfers from the general contingent account.

Subd. 2. Board of Chiropractic Examiners	361,000	361,000
Subd. 3. Board of Dentistry	806,000	806,000
Subd. 4. Board of Dietetic and Nutrition Practice	95,000	95,000
Subd. 5. Board of Marriage and Family Therapy	111,000	111,000
Subd. 6. Board of Medical Practice	3,270,000	3,270,000
Subd. 7. Board of Nursing	2,704,000	2,772,000

[HEALTH PROFESSIONAL SERVICES ACTIVITY.] Of these appropriations, \$534,000 in fiscal year 2002 and \$566,000 in fiscal year 2003 are for the Health Professional Services Activity.

Subd. 8. Board of Nursing Home Administrators	194,000	186,000
Subd. 9. Board of Optometry	90,000	90,000



			APPROPRIATIONS	
			Available for the Year	
			Ending June 30	
			2002	2003
Subd. 10. Board of Pharmacy			1,301,000	1,316,000
<p>[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.</p>				
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
<p>[COMPREHENSIVE ADVANCED LIFE SUPPORT (CALIS).] \$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.</p>				
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



(1) provide to the public authority a list containing only the names and other necessary personal identifying information of all account holders for the public authority to compare against its list of child support obligors for the purpose of identifying which obligors maintain an account at the financial institution; the names of the obligors who maintain an account at the institution shall then be transmitted to the financial institution which shall provide the public authority with account information on those obligors; or

(2) must obtain a list of child support obligors from the public authority and compare that data to the data maintained at the financial institution to identify which of the identified obligors maintains an account at the financial institution.

A financial institution shall elect either method in writing upon written request of the public authority, and the election remains in effect unless the public authority agrees in writing to a change.

~~The commissioner shall keep track of the number of financial institutions that elect to report under clauses (1) and (2) respectively and shall report this information to the legislature by December 1, 1999.~~

Sec. 16. [246.141] [PROJECT LABOR.]

Wages for project labor may be paid by the commissioner out of repairs and betterments money if the individual is to be engaged in a construction project or a repair project of short-term and nonrecurring nature. Compensation for project labor shall be based on the prevailing wage rates, as defined in section 177.42, subdivision 6. Project laborers are excluded from the provisions of sections 43A.22 to 43A.30, and shall not be eligible for state-paid insurance and benefits.

Sec. 17. [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 the internal references

Amend the title accordingly

#### 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	Clark, K.	Evans	Hausman	Kahn	Lipman
Abrams	Daggett	Finseth	Hilstrom	Kelliher	Luther
Anderson, B.	Davids	Folliard	Hilty	Kielkucki	Mahoney
Anderson, I.	Davnie	Fuller	Holberg	Knoblach	Mares
Bakk	Dawkins	Gerlach	Holsten	Koskinen	Mariani
Bernardy	Dehler	Gleason	Howes	Krinkie	Marko
Biernat	Dempsey	Goodno	Huntley	Kubly	Marquart
Bishop	Dibble	Goodwin	Jacobson	Kuisle	McElroy
Boudreau	Dorman	Gray	Jaros	Larson	McGuire
Bradley	Dorn	Greiling	Jennings	Leighton	Milbert
Buesgens	Eastlund	Gunther	Johnson, J.	Lenczewski	Molnau
Carlson	Entenza	Haas	Johnson, R.	Leppik	Mulder
Cassell	Erhardt	Hackbarth	Johnson, S.	Lieder	Mullery
Clark, J.	Erickson	Harder	Juhnke	Lindner	Murphy

Ness	Paulsen	Rifenberg	Skoglund	Sykora	Wenzel
Nornes	Pawlenty	Rukavina	Slawik	Thompson	Westerberg
Olson	Paymar	Ruth	Smith	Tingelstad	Westrom
Opatz	Pelowski	Schumacher	Solberg	Tuma	Wilkin
Osskopp	Penas	Seagren	Stanek	Vandever	Winter
Osthoff	Peterson	Seifert	Stang	Walker	Wolf
Otremba	Pugh	Sertich	Swapinski	Walz	Workman
Ozment	Rhodes	Skoe	Swenson	Wasiluk	Spk. Sviggum

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.

#### POINT OF ORDER

Entenza raised a point of order pursuant to rule 3.21 that the Goodno amendment was not in order.

Pursuant to rule 3.21, Speaker pro tempore Boudreau submitted the following question to the House: "Is it the judgment of the House that the Entenza point of order is well taken?"

A roll call was requested and properly seconded.

Kahn moved that the House recess until 6:59 a.m.

Pursuant to rule 1.50, Speaker pro tempore Boudreau ruled the Kahn motion out of order.

Kahn moved that the House adjourn.

A roll call was requested and properly seconded.

The question was taken on the Kahn motion and the roll was called. There were 53 yeas and 80 nays as follows:

Those who voted in the affirmative were:

Anderson, I.	Dorn	Hilstrom	Kelliher	McGuire	Skoglund
Bakk	Entenza	Hilty	Koskinen	Milbert	Slawik
Bernardy	Evans	Huntley	Larson	Mullery	Solberg
Biernat	Folliard	Jaros	Leighton	Osthoff	Swapinski
Carlson	Gleason	Jennings	Lieder	Paymar	Thompson
Clark, K.	Goodwin	Johnson, R.	Luther	Pugh	Wagenius
Davnie	Gray	Johnson, S.	Mahoney	Rukavina	Walker
Dawkins	Greiling	Juhnke	Mariani	Sertich	Wasiluk
Dibble	Hausman	Kahn	Marko	Skoe	

Those who voted in the negative were:

Abeler	Eastlund	Jacobson	Molnau	Peterson	Vandever
Abrams	Erhardt	Johnson, J.	Mulder	Rhodes	Walz
Anderson, B.	Erickson	Kielkucki	Murphy	Rifenberg	Wenzel
Bishop	Finseth	Knoblach	Ness	Ruth	Westerberg
Boudreau	Fuller	Krinkie	Nornes	Schumacher	Westrom
Bradley	Gerlach	Kubly	Olson	Seagren	Wilkin
Buesgens	Goodno	Kuisle	Opatz	Seifert	Winter
Cassell	Gunther	Lenczewski	Osskopp	Smith	Wolf
Clark, J.	Haas	Leppik	Otremba	Stanek	Workman
Daggett	Hackbarth	Lindner	Ozment	Stang	Spk. Sviggum
Dauids	Harder	Lipman	Paulsen	Swenson	
Dehler	Holberg	Mares	Pawlenty	Sykora	
Dempsey	Holsten	Marquart	Pelowski	Tingelstad	
Dorman	Howes	McElroy	Penas	Tuma	

The motion did not prevail.

The question recurred on the Entenza point of order and the roll was called.

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

There were 53 yeas and 80 nays as follows:

Those who voted in the affirmative were:

Abrams	Dibble	Greiling	Kahn	Marko	Skoglund
Bakk	Dorn	Hausman	Kelliher	McGuire	Slawik
Bernardy	Entenza	Hilstrom	Koskinen	Mullery	Solberg
Biernat	Erhardt	Hilty	Larson	Osthoff	Swapinski
Bishop	Evans	Huntley	Leighton	Paymar	Thompson
Carlson	Folliard	Jaros	Leppik	Pugh	Wagenius
Clark, K.	Gleason	Jennings	Luther	Rhodes	Walker
Davnie	Goodwin	Johnson, R.	Mahoney	Rukavina	Wasiluk
Dawkins	Gray	Johnson, S.	Mariani	Sertich	

Those who voted in the negative were:

Abeler	Dehler	Haas	Knoblach	McElroy	Otremba
Anderson, B.	Dempsey	Hackbarth	Krinkie	Milbert	Ozment
Anderson, I.	Dorman	Harder	Kubly	Molnau	Paulsen
Boudreau	Eastlund	Holberg	Kuisle	Mulder	Pawlenty
Bradley	Erickson	Holsten	Lenczewski	Murphy	Pelowski
Buesgens	Finseth	Howes	Lieder	Ness	Penas
Cassell	Fuller	Jacobson	Lindner	Nornes	Peterson
Clark, J.	Gerlach	Johnson, J.	Lipman	Olson	Rifenberg
Daggett	Goodno	Juhnke	Mares	Opatz	Ruth
Dauids	Gunther	Kielkucki	Marquart	Osskopp	Schumacher

Seagren	Stanek	Tingelstad	Wenzel	Winter
Seifert	Stang	Tuma	Westerberg	Wolf
Skoe	Swenson	Vandever	Westrom	Workman
Smith	Sykora	Walz	Wilkin	Spk. Sviggum

So it was the judgment of the House that the Entenza point of order was not well taken and the Goodno amendment was in order.

The question recurred on the Goodno amendment to S. F. No. 1397, as amended. The motion prevailed and the amendment was adopted.

S. F. No. 1397, A bill for an act relating to health and human services; changing requirements to background studies for licensed programs; amending Minnesota Statutes 2000, sections 13.46, subdivision 4; 144.057; 245A.02, subdivisions 1, 9, by adding a subdivision; 245A.03, subdivision 2, by adding a subdivision; 245A.035, subdivision 1; 245A.04, subdivisions 3, 3a, 3b, 3d, 6, 11, by adding a subdivision; 245A.06, subdivision 6; 245A.16, subdivision 1; proposing coding for new law in Minnesota Statutes, chapter 245A; repealing Minnesota Rules, parts 9543.3000; 9543.3010; 9543.3020; 9543.3030; 9543.3040; 9543.3050; 9543.3060; 9543.3080; 9543.3090.

The bill was read for the third time, as amended, and placed upon its final passage.

The question was taken on the passage of the bill and the roll was called. There were 84 yeas and 49 nays as follows:

Those who voted in the affirmative were:

Abeler	Eastlund	Jacobson	Mares	Pawlenty	Sykora
Anderson, B.	Erickson	Johnson, J.	Marquart	Pelowski	Thompson
Anderson, I.	Finseth	Juhnke	Milbert	Penas	Tingelstad
Bakk	Fuller	Kielkucki	Molnau	Peterson	Tuma
Boudreau	Gerlach	Knoblach	Mulder	Rifenberg	Vandever
Bradley	Goodno	Krinkie	Murphy	Ruth	Walz
Buesgens	Greiling	Kubly	Ness	Schumacher	Wenzel
Cassell	Gunther	Kuisele	Nornes	Seagren	Westerberg
Clark, J.	Haas	Larson	Olson	Seifert	Westrom
Daggett	Hackbarth	Lenczewski	Opatz	Skoe	Wilkin
Davids	Harder	Lieder	Osskopp	Smith	Winter
Dehler	Holberg	Lindner	Otremba	Stanek	Wolf
Dempsey	Holsten	Lipman	Ozment	Stang	Workman
Dorman	Howes	Luther	Paulsen	Swenson	Spk. Sviggum

Those who voted in the negative were:

Abrams	Carlson	Dibble	Evans	Gray	Huntley
Bernardy	Clark, K.	Dorn	Folliard	Hausman	Jaros
Biernat	Davnie	Entenza	Gleason	Hilstrom	Jennings
Bishop	Dawkins	Erhardt	Goodwin	Hilty	Johnson, R.

Johnson, S.	Leppik	McGuire	Rhodes	Solberg
Kahn	Mahoney	Mullery	Rukavina	Swapinski
Kelliher	Mariani	Osthoff	Sertich	Wagenius
Koskinen	Marko	Paymar	Skoglund	Walker
Leighton	McElroy	Pugh	Slawik	Wasiluk

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

Pawlenty moved that the remaining bills on the Calendar for the Day be continued. The motion prevailed.

There being no objection, the order of business reverted to Messages from the Senate.

### MESSAGES FROM THE SENATE

The following message was received from the Senate:

Mr. Speaker:

I hereby announce the passage by the Senate of the following Senate File, herewith transmitted:

S. F. No. 1541.

PATRICK E. FLAHAVEN, Secretary of the Senate

### FIRST READING OF SENATE BILLS

S. F. No. 1541, A bill for an act relating to commerce; regulating currency exchanges, real estate brokers, real property appraisers, residential contractors, notaries public, and collection agencies; modifying certain continuing education requirements; regulating certain fees, costs, duties, rights, and penalties; regulating nonprofit corporations; requiring a study; appropriating money; amending Minnesota Statutes 2000, sections 45.0295; 53A.081, subdivision 2; 58.10, subdivision 1, by adding a subdivision; 60K.19, subdivision 8; 72B.04, subdivisions 6, 7; 80B.03, subdivision 4a; 82.195, subdivision 2; 82.196, subdivision 2; 82.197, subdivisions 1, 4, by adding a subdivision; 82.22, subdivision 13; 82.24, subdivision 8; 82.27, subdivision 3; 82.34, subdivision 15, by adding a subdivision; 82B.14; 317A.203; 326.91, subdivision 1; 326.975, subdivision 1; 332.41; 359.02; 507.45, subdivision 3.

The bill was read for the first time.

Entenza moved that S. F. No. 1541 and H. F. No. 1270, now on the Calendar for the Day, be referred to the Chief Clerk for comparison. The motion prevailed.

**ANNOUNCEMENTS BY THE SPEAKER**

The Speaker announced the appointment of the following members of the House to a Conference Committee on H. F. No. 707:

Skoglund, Mulder and Clark, J.

The Speaker announced the appointment of the following members of the House to a Conference Committee on H. F. No. 1153:

Mulder, Fuller and Wenzel.

The Speaker announced the appointment of the following members of the House to a Conference Committee on H. F. No. 1155:

Abeler, Davids and Lieder.

The Speaker announced the appointment of the following members of the House to a Conference Committee on H. F. No. 1487:

Haas, Finseth and Bakk.

The Speaker announced the appointment of the following members of the House to a Conference Committee on H. F. No. 1507:

Bishop, Dempsey and Milbert.

The Speaker announced the appointment of the following members of the House to a Conference Committee on S. F. No. 229:

McGuire, Tuma and Walz.

**MOTIONS AND RESOLUTIONS**

Buesgens moved that the names of Erickson, Lipman and Wilkin be added as authors on H. F. No. 2523. The motion prevailed.

Wilkin moved that the name of Goodno be added as chief author on H. F. No. 1381. The motion prevailed.

**MOTION FOR RECONSIDERATION**

Seifert moved that the vote whereby H. F. No. 94 was not passed earlier today, be now reconsidered.



A roll call was requested and properly seconded.

The question was taken on the Seifert motion and the roll was called. There were 96 yeas and 36 nays as follows:

Those who voted in the affirmative were:

Abeler	Dorn	Howes	Lieder	Osthoff	Stanek
Abrams	Eastlund	Huntley	Lindner	Ozment	Stang
Anderson, B.	Entenza	Jacobson	Lipman	Paulsen	Swapinski
Bakk	Erhardt	Jennings	Mahoney	Pawlenty	Swenson
Bishop	Erickson	Johnson, J.	Mares	Paymar	Sykora
Boudreau	Finseth	Johnson, R.	Marquart	Pelowski	Thompson
Bradley	Fuller	Kahn	McElroy	Penas	Tingelstad
Buesgens	Gerlach	Kelliher	McGuire	Pugh	Tuma
Cassell	Goodno	Kielkucki	Molnau	Rhodes	Wagenius
Clark, J.	Greiling	Knoblach	Mulder	Rifenberg	Walz
Daggett	Gunther	Krinkie	Mullery	Ruth	Westerberg
Dauids	Haas	Kuisle	Murphy	Seagren	Westrom
Dawkins	Harder	Larson	Ness	Seifert	Wilkin
Dehler	Hilty	Leighton	Nornes	Sertich	Wolf
Dempsey	Holberg	Lenczewski	Olson	Skoe	Workman
Dorman	Holsten	Leppik	Osskopp	Solberg	Spk. Sviggum

Those who voted in the negative were:

Anderson, I.	Dibble	Hackbarth	Kubly	Otremba	Smith
Bernardy	Evans	Hilstrom	Luther	Peterson	Vandever
Biernat	Folliard	Jaros	Mariani	Rukavina	Walker
Carlson	Gleason	Johnson, S.	Marko	Schumacher	Wasiluk
Clark, K.	Goodwin	Juhnke	Milbert	Skoglund	Wenzel
Davnie	Gray	Koskinen	Opatz	Slawik	Winter

The motion prevailed.

Seifert moved that H. F. No. 94 be returned to the General Register. The motion prevailed.

#### ADJOURNMENT

Pawlenty moved that when the House adjourns today it adjourn until 9:00 a.m., Tuesday, May 15, 2001. The motion prevailed.

Pawlenty moved that the House adjourn. The motion prevailed, and Speaker pro tempore Boudreau declared the House stands adjourned until 9:00 a.m., Tuesday, May 15, 2001.

EDWARD A. BURDICK, Chief Clerk, House of Representatives

