FIRST SPECIAL SESSION LAWS
of the
STATE OF MINNESOTA

Enacted by the Seventy-Eighth Legislature
at the 1993 First Special Session,
May 27, 1993

Proclamation

WHEREAS: The Seventy-Eighth Legislature adjourned without enacting essential legislation to provide for the orderly financial management of state government; and

WHEREAS: The time permitted by law for passage of such legislation during the 1993 Session of the Legislature has expired, and an extraordinary occasion is thereby created; and

WHEREAS: Article IV, Section 12 of the Constitution of the State of Minnesota provides that a special session of the Legislature may be called on extraordinary occasions; and

WHEREAS: The people of Minnesota are best served by an orderly conclusion of legislative business, with a limited agenda and prior agreement on laws to be enacted; and

WHEREAS: Elected leaders of the Legislature have agreed on an agenda and procedures to complete a special session on May 27, 1993;

NOW, THEREFORE, I, ARNE H. CARLSON, Governor of the State of Minnesota, do hereby summon you, members of the Legislature, to convene in Special Session on Thursday, May 27, 1993 at 10:00 a.m. at the Capitol in Saint Paul, Minnesota.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of Minnesota to be affixed at the State Capitol this twenty-sixth day of May in the year of our Lord one thousand nine hundred and ninety-three, and of the State the one hundred thirty-fifth.

JOAN ANDERSON GROWE

SECRETARY OF STATE

ARNE H. CARLSON

GOVERNOR

SESSION LAWS

of the

STATE OF MINNESOTA

ENACTED BY THE SEVENTY-EIGHTH LEGISLATURE

AT THE 1993 FIRST SPECIAL SESSION

MAY 27, 1993

CHAPTER 1—H.F.No. 1

An act relating to human services; appropriating money for human services; amending Minnesota Statutes 1992, sections 62A.045; 116.76, subdivision 14; 116.78, subdivisions 4 and 7; 116.79, subdivisions 1 and 4; 116.80, subdivisions 1 and 2; 116.81, subdivision 1; 116.82, subdivision 3; 116.83, subdivisions 1 and 3; 144.122; 144.123, subdivision 1; 144.215, subdivision 3, and by adding a subdivision; 144.226, subdivision 2; 144.3831, subdivision 2; 144.802, subdivision 1; 144.8091, subdivision 1; 144.871, subdivisions 2, 6, 7a, 7b, 9, and by adding subdivisions; 144.872, subdivisions 2, 3, 4, and by adding a subdivision; 144.873; 144.874, subdivisions 1, 2, 3, 4, 5, 6, 9, and by adding subdivisions; 144.876, by adding a subdivision; 144.878, subdivisions 2, 2a, and 5; 144.98, subdivision 5; 144A.04, subdivision 7; 144A.071; 144A.073, subdivisions 2, 3, and by adding a subdivision; 145.883, subdivision 5; 147.01, subdivision 6; 147.02, subdivision 1; 148C.01, subdivisions 3 and 6; 148C.02; 148C.03, subdivisions 1, 2, and 3; 148C.04, subdivisions 2, 3, and 4; 148C.05, subdivision 2; 148C.06; 148C.11, subdivision 3, and by adding a subdivision; 149.04; 157.045; 198.34; 214.01, subdivision 2; 214.04, subdivision 1; 214.06, subdivision 1, and by adding a subdivision; 245.462, subdivisions 4 and 20; 245.464, subdivision 1; 245.466, subdivision 1; 245.474; 245.484; 245.4871, subdivision 4; 245.4873, subdivision 2; 245.4882, subdivision 5; 245.652, subdivisions 1 and 4; 245.73, subdivisions 2, 3, and by adding a subdivision; 246.0135; 246.02, subdivision 2; 246.151, subdivision 1; 246.18, subdivision 4; 252.025, subdivision 4, and by adding subdivisions; 252.275, subdivisions 1 and 8; 252.41, subdivision 3; 252.46; 252.47; 252.50, by adding a subdivision; 252A.101, subdivision 7; 252A.111, subdivision 4; 253.015, subdivision 1, and by adding subdivisions; 253.202; 254.04; 254.05; 254A.17, subdivision 3; 254B.06, subdivision 3; 256.015, subdivision 4; 256.025, subdivisions 1, 2, 3, and 4; 256.032, subdivision 11; 256.73, subdivisions 2, 3a, 5, and 8; 256.736, subdivisions 10, 10a, 14, 16, and by adding a subdivision; 256.737, subdivisions 1, 1a, 2, and by adding subdivisions; 256.74, subdivision 1; 256.78; 256.9657, subdivisions 1, 2, 3, 7, and by adding subdivi-

sions; 256.9685, subdivision 1; 256.969, subdivisions 1, 8, 9, as amended, 9a, as amended, 20, as amended, 22, as amended, and by adding subdivisions; 256.9695, subdivision 3; 256.983, subdivision 3; 256B.04, subdivision 16; 256B.042, subdivision 4; 256B.055, subdivision 1; 256B.056, subdivisions 1a and 2; 256B.0575; 256B.059, subdivisions 3 and 5; 256B.0595; 256B.0625, subdivisions 3, 6a, 7, 11, 13, 13a, 14, 15, 17, 19a, 20, 27, 28, 29, and by adding subdivisions; 256B.0627, subdivisions 1, 4, and 5; 256B.0628, subdivision 2; 256B.0629, subdivision 4; 256B.0911, subdivisions 2, 3, 4, 6, 7, and by adding a subdivision; 256B.0913, subdivisions 4, 5, 9, 12, 13, and 14; 256B.0915, subdivisions 1, 3, and by adding subdivisions; 256B.0917, subdivisions 1, 2, 3, 4, 5, 11, and 12; 256B.093, subdivisions 1 and 3; 256B.15, subdivisions 1 and 2; 256B.19, subdivision 1b, and by adding subdivisions; 256B.37, subdivisions 3, 5, and by adding a subdivision; 256B.431, subdivisions 2b, 2o, 13, 14, 15, 21, and by adding subdivisions; 256B.432, subdivision 5, and by adding a subdivision; 256B.47, subdivision 3; 256B.48, subdivisions 1 and 2; 256B.49, by adding a subdivision; 256B.50, subdivision 1b, and by adding subdivisions; 256B.501, subdivisions 3g, 3i, 12, and by adding a subdivision; 256D.01, subdivision 1a; 256D.02, subdivision 5; 256D.03, subdivisions 3, 4, and 8; 256D.04; 256D.05, by adding a subdivision; 256D.051, subdivisions 1 and 6; 256D.35, subdivision 3a; 256D.44, subdivisions 2 and 3; 256F.06, subdivision 2; 256I.01; 256I.02; 256I.03, subdivisions 2, 3, and by adding subdivisions; 256I.04, subdivisions 1, 2, 3, and by adding subdivisions; 256I.05, subdivisions 1, 1a, 2, 8, and by adding a subdivision; 256I.06; 257.3573, by adding a subdivision; 257.54; 257.541; 257.55, subdivision 1; 257.57, subdivision 2; 257.59, subdivision 3; 257.73, subdivision 1; 257.74, subdivision 1; 257.803, subdivision 1; 259.40, subdivisions 1, 2, 3, 4, 5, 7, 8, and 9; 259.431, subdivision 5; 273.1392; 273.1398, subdivision 5b; 275.07, subdivision 3; 326.44; 326.75, subdivision 4; 388.23, subdivision 1; 393.07, subdivisions 3 and 10; 462A.03, subdivision 15; 518.156, subdivision 1; 518.551, subdivision 5; 518.611, subdivisions 1, 2, 6, and by adding a subdivision; 518.613, subdivisions 2, 3, and 4; 518.64, subdivision 2; 525.539, subdivision 2; 525.551, subdivision 7; 609.821, subdivisions 1 and 2; 626.559, by adding a subdivision; Laws 1991, chapter 292, article 6, sections 54; and 57, subdivisions 1 and 3; Laws 1992, chapter 513, article 7, section 131; and Laws 1993, chapter 20, by adding a section; proposing coding for new law in Minnesota Statutes, chapters 115C; 116; 144; 198; 214; 245; 252; 254A; 256; 256B; 256E; 256F; 257; 514; proposing coding for new law as Minnesota Statutes, chapters 144C; and 246B; repealing Minnesota Statutes 1992, sections 116.76, subdivision 7; 116.79, subdivision 3; 116.81, subdivision 2; 116.83, subdivision 2; 144.8721; 144.874, subdivision 10; 144.878, subdivision 2a; 148B.72; 214.141; 245.711; 245.712; 252.46, subdivisions 12, 13, and 14; 252.478; 256.985; 256I.03, subdivision 4; 256I.05, subdivisions 4, 9, and 10; 256I.051; 273.1398, subdivisions 5a and 5c.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

ARTICLE 1

APPROPRIATIONS

Section 1. **HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "APPROPRIATIONS" are appropriated from the general fund, or any other fund named, to the agencies and for the purposes specified in the following sections of this article, to be available for the fiscal years indicated for each purpose. The figures "1994" and "1995" where used in this article, mean that the appropriation or appropriations listed under them are available for the fiscal year ending June 30, 1994, or June 30, 1995, respectively.

SUMMARY BY FUND

1993 DEFICIENCY
General
$13,286,000

APPROPRIATIONS	1994	1995	BIENNIAL TOTAL
General	$2,126,783,000	$2,249,286,000	$4,376,069,000
State Government Special Revenue	21,166,000	20,367,000	41,533,000
Metropolitan Landfill Contingency Action Fund	191,000	204,000	395,000
Trunk Highway	1,488,000	1,510,000	2,998,000
TOTAL	2,149,628,000	2,271,367,000	4,420,995,000
REVENUE			
General	36,219,000	53,308,000	89,527,000

	APPROPRIATIONS Available for the Year Ending June 30	
	1994	1995
Sec. 2. COMMISSIONER OF HUMAN SERVICES		
Subdivision 1. Appropriation by Fund		
General Fund	2,071,736,000	2,192,990,000

Federal receipts as shown in the biennial budget document to be used for financing activities, programs, and projects under the supervision and jurisdiction of the commissioner must be credited to and become a part of the appropriations provided for in this section.

The 1996-1997 general fund spending in the department of human services is limited to $2,340,864,000 in fiscal year 1996 and $2,522,864,000 in fiscal year 1997. Expenditures in the department may exceed these estimates only if forecast caseloads increase, base forecast spending increases, acuity or casemix results in increases, or other adjustments are made in accordance with the department of finance forecast methodology. After consultation with the legislature, the commissioner of finance may also adjust these limits to recognize any errors or omissions in the workpapers used to generate the figure. If the commissioner determines in the November or March forecast for fiscal year 1996-1997 that the program expenditures will exceed the above limit, then in fiscal years 1996 or 1997 the commissioner may withhold provider payments, rateably reduce payments under the general assistance medical care program or the medical assistance program or propose statutory remedies to the legislature that will bring expenditures within this limit.

Subd. 2. Finance and Management Administration

General

$21,815,000 $20,871,000

Federal money received in excess of the estimates shown in the 1994-1995 department of human services budget document reduces the state appropriation by the amount of the excess receipts, unless the governor directs otherwise, after consulting with the legislative advisory commission.

If the amount of federal money anticipated to be received is less than the estimates shown in the 1994-1995 proposed biennial budget document for the department of human services, the com-

missioner of finance shall reduce the amount available from the direct appropriation by a corresponding amount. The reductions must be noted in the budget document submitted to the 79th legislature, in addition to an estimate of similar federal money anticipated for the biennium ending June 30, 1997. At the end of fiscal years 1994 and 1995, the chairs of the human services division of the house health and human services committee and the health care and family services finance division of the senate committees on health care and family services shall receive written notification explaining these reductions.

The commissioner of human services, with the approval of the commissioner of finance and by direction of the governor after consulting with the legislative advisory commission, may transfer unencumbered appropriation balances among the aid to families with dependent children, aid to families with dependent children child care, Minnesota family investment, general assistance, general assistance medical care, medical assistance, Minnesota supplemental aid, group residential housing, and work readiness programs, and the entitlement portion of the chemical dependency consolidated treatment fund, and between fiscal years of the biennium.

Effective the day following final enactment, the commissioner may transfer unencumbered appropriation balances for fiscal year 1993 among the aid to families with dependent children, general assistance, general assistance medical care, medical assistance, Minnesota supplemental aid, and work readiness programs, and the entitlement portion of the chemical dependency consolidated treatment fund, with the approval

of the commissioner of finance after notification of the chair of the senate family services and health care division and the chair of the house of representatives human services division.

Appropriations and federal receipts for information system projects for MAXIS, child support enforcement, and the Minnesota Medicaid information system must be deposited in the state systems account authorized in Minnesota Statutes, section 256.014. Money appropriated for computer projects approved by the information policy office, funded by the legislature, and approved by the commissioner of finance may be transferred from one project to another and from development to operations as the commissioner of human services considers necessary. Any unexpended balance in the appropriation for these projects does not cancel but is available for ongoing development and operations.

Any reduction in the base for GA or GAMC attributed to the movements of clients from those programs to the work readiness pilot projects creating the work experience component shall be reinstated as part of the base in the governor's proposed budget for 1996-1997.

$75,000 is available in the fiscal year ending June 30, 1994, and $250,000 is available for the fiscal year ending June 30, 1995, for the crisis nursery program. Unexpended money appropriated for the crisis nursery program in fiscal year 1994 does not cancel but is available for fiscal year 1995.

The commissioner of human services shall establish a special revenue fund account to manage shared communication costs necessary for the operation 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 system usage. Costs may include acquisition, licensing, insurance, maintenance, repair, staff time, and other direct costs as determined by the commissioner. The commissioner of human services may accept for and on behalf of the state any gift, bequest, devise, or personal property of any kind or money tendered to the state for any purpose pertaining to the communication activities of the department. Any money so received must be deposited in the state communication systems account. 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.

Before hardware or software valued in excess of $100,000 can be purchased by the department of human services, there must be information policy office approval that all appropriate policies, standards, and budget review requirements and recommendations have been met.

Subd. 3. Social Services Administration

General
$68,565,000 $70,103,000

All of the fees paid to the commissioner for interpreter referral services for people with hearing impairments shall be used for direct client referral activities. None of the fees shall be used to pay for state agency administrative and support costs.

The supplemental funding for nutrition

programs serving counties where congregate and home-delivered meals were locally financed prior to participation in the nutrition program of the Older Americans Act shall be awarded at no less than the same levels as in fiscal year 1993.

The Minnesota board on aging, in cooperation with the area agencies on aging and statewide senior citizen organizations, shall develop and present to the legislature by February 1, 1994, a plan for operating the Aging Ombudsman programs through grants to private, nonprofit organizations, wherever possible. The plan shall specify a request for proposals process to solicit applications for areas currently unserved by grantees. Goals of the plan and its implementation are to improve advocacy services for nursing home residents, acute care patients, and home care clients by strengthening quality, access, and independence, as well as by taking full advantage of local matching funds. The plan must include a formula and rationale for the allocation of state and federal ombudsman funds among regions within the state.

For the purpose of transferring certain persons from the SILS program to the home and community-based waivered services program for persons with mental retardation or related conditions, the amount of funds transferred between the semi-independent living services (SILS) account or the state community social services account and the state medical assistance account shall be based on each county's participation in transferring persons to the waivered services program. No person for whom these funds are transferred shall be required to obtain a new living arrangement, notwithstanding Minnesota Stat-

utes, section 252.28, subdivision 3, paragraph (4), and Minnesota Rules, parts 9525.1800, subpart 25a, and 9525.1869, subpart 6. When supported living services are provided to persons for whom these funds are transferred, the commissioner may substitute the licensing standards of Minnesota Rules, parts 9525.0500 to 9525.0660, for parts 9525.2000 to 2525.2140, if the services remain nonresidential as defined in Minnesota Statutes, section 245A.02, subdivision 10. For the purpose of Minnesota Statutes, chapter 256G, when a service is provided under these substituted licensing standards, the status of residence of the recipient of that service shall continue to be considered excluded time.

Contingent upon federal approval of expanding eligibility for home and community-based services for persons with mental retardation or related conditions, the commissioner shall reduce the state semi-independent living services (SILS) payments to each county by the total medical assistance expenditures for nonresidential services attributable to former SILS recipients transferred by the county to the home and community-based services program for persons with mental retardation or related conditions. Of the reduced SILS payments determined above, the commissioner shall transfer to the state medical assistance account an amount equal to the nonfederal share of the nonresidential services under the home and community-based services for persons with mental retardation or related conditions. Of the remaining reduced SILS payments, 80 percent shall be returned to the SILS grant program to provide additional SILS services and 20 percent shall be transferred to the general fund.

An additional $20,000 each year is appropriated from the children's trust fund to the special revenue fund for administration and indirect costs of the children's trust fund program.

From the money appropriated in this subdivision, the commissioner shall transfer $25,000 to the commissioner of trade and economic development to be used for an area action planning grant to a city which has at least 30 percent renter-occupied housing. The planning grant must address an area within the city containing at least 20 percent of the city's population and at least three percent of its land. The median household income of the area must be 80 percent of the county median, or less. The residential buildings in the area must be at least 50 percent renter-occupied and at least 50 percent of them must have been built before 1970.

The commissioner of human services shall study and report on the adequacy and effectiveness of investigations of child maltreatment in day care centers licensed under Minnesota Rules, parts 9503.0005 to 9503.0175. The commissioner shall report back to the legislature by February 1, 1994, with recommendations on whether the county or state agency should conduct such investigations. In preparing the study, the commissioner shall consult with providers and representatives of county social service agencies.

$54,000 of the funds appropriated to the commissioner of human services for operation of the Early Childhood Care and Education Council under Minnesota Statutes, section 256H.195, shall be used to enable the commissioner to contract with the greater Minneapolis day care association to establish a pilot pro-

gram for training child care workers. The program shall be subject to the provisions of Minnesota Statutes, chapter 178, regarding masters and apprentices, including but not limited to, the requirements for an apprenticeship agreement, the approval and registration of apprenticeship programs, and the certification of completion of apprenticeship.

The pilot project shall be designed to provide (1) in-service training, (2) coursework, and (3) salary upgrades, for child care workers employed in facilities licensed by the commissioner of human services under Minnesota Rules, chapters 9502 and 9503. Projects shall be designed to train child care workers to qualify as assistant teachers, teachers, and in-service trainers or mentors, in a sequenced professional development program. The commissioner shall evaluate the pilot projects and shall present a report to the legislature by February 15, 1995.

The report shall contain recommendations on the feasibility of establishing a statewide program for training child care workers.

Of this appropriation, $250,000 is available for the planning and design stage for the social services information system, which shall include:

(a) general requirements definition for the county-based system and the state system;

(b) detailed design specifications;

(c) system life cycle analysis, including detailed analysis of system size and scope during its life cycle; and

(d) implementation plan, including

detailed estimates of costs to implement and operate the system.

The department shall prepare a report to the legislature in January 1994 specifying the costs required to implement and operate the system and the federal financial participation rates expected, and seeking approval for continuation of development and implementation.

Of this appropriation, $100,000 each year is for a grant to the New Chance demonstration project that provides comprehensive services to young AFDC recipients who became pregnant as teenagers and dropped out of high school. The commissioner shall provide an annual report on the progress of the demonstration project, including specific data on participant outcomes in comparison to a control group that received no services. The commissioner shall also include recommendations on whether strategies or methods that have proven successful in the demonstration project should be incorporated into the STRIDE employment program for AFDC recipients.

Of the appropriation for aging services grants, $50,000 each year is to increase the appropriation for home delivered meals.

Of this appropriation, $3,500,000 is for collaboratives to be spent as follows: (1) $1,500,000 in fiscal year 1994 for planning grants to collaboratives, to be awarded according to procedures published by the children's cabinet; and (2) $1,000,000 each year of the biennium for implementation grants to collaboratives that have plans approved by the children's cabinet. The commissioner may transfer any unspent portion of the appropriation for planning grants to the

fiscal year 1995 appropriation for program grants with the approval of the commissioner of finance. None of this appropriation shall become part of the base for the 1996-1997 biennium.

Subd. 4. Health Care Administration

General
$1,370,722,000 $1,514,593,000

Notwithstanding Minnesota Statutes, section 13.03, subdivision 5, the rate-setting computer program except the edits and screens for nursing home payment rates is not trade secret information and is public data not on individuals. If a person requests this data, the commissioner of human services shall require the requesting person to pay no more than the actual costs of searching for and retrieving the data, including the cost of employee time, and for making, certifying, compiling, and electronically transmitting the copies of the data or the data, but may not charge for separating public data from not public data.

Medical assistance and general assistance medical care payments for mental health services provided by masters-prepared mental health professionals, except services provided by community mental health centers, shall be 75 percent of the rate paid to doctoral-prepared professionals for fiscal year 1994 and shall be 80 percent of the rate paid to doctoral-prepared professionals for fiscal year 1995.

Money appropriated for preadmission screening and the alternative care program for fiscal year 1995 may be used for these purposes in fiscal year 1994.

In the event that a large community-based facility licensed under Minnesota

Rules, parts 9525.0215 to 9525.0355, for more than 16 beds, but not certified as an intermediate care facility for persons with mental retardation or related conditions, closes and alternative services for the residents are necessary, the commissioner may transfer on a quarterly basis to the state medical assistance account from each affected county's community social service allocation an amount equal to the state share of medical assistance reimbursement for such residential and day habilitation services funded by the medical assistance program and provided to clients for whom the county is financially responsible.

The commissioner is authorized to collect information from providers of ICF/MR, MR waiver, SILS, and day training and habilitation services regarding the total compensation paid to individuals who claim reimbursement of all or part of that compensation in any of those programs, including non-Minnesota services for developmentally disabled, if that individual's total compensation is in excess of $50,000. The information shall be provided in a manner specified by the commissioner within 90 days of its request.

For this purpose, an individual's total compensation includes wages, salary, wages or salaries from consultant contracts whether or not from related organizations, board of director fees, bonuses, deferred compensation, retirement plans such as IRA's, pension, and profit sharing plans, fringe benefits such as life insurance and health insurance, or other employee benefits such as use of a vehicle. The commissioner shall also collect the hours worked by the individual, the number facilities or programs served and the number of clients

served within those facilities or programs by the individual.

The commissioner shall collect this information for calendar years 1992 and 1993, and shall analyze and report the results of this study to the legislature on January 31, 1994, and January 31, 1995, respectively. If the total compensation information is not provided either in the manner specified by the commissioner or within 90 days of the commissioner's request, the commissioner shall reduce that provider's payment rates by 5 percent until the information is provided. Upon submittal of the information, the commissioner shall retroactively reinstate the provider's 5 percent payment rate reductions.

The nonfederal share of the costs of case management services provided to persons with mental retardation or related conditions who are relocated from nursing facilities as required by federal law and who receive home- and community-based services that are funded through the waiver granted under section 1915(c)(7)(B) of the Social Security Act may be provided from state-appropriated funding for medical assistance grants. The division of cost is subject to Minnesota Statutes, section 256B.19, and the services are included as covered programs and services under Minnesota Statutes, section 256.025, subdivision 2.

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.

In the event that federal financial participation in the Minnesota medical

assistance program is reduced as a result of a determination that Minnesota is out of compliance with Public Law Number 102-234 or its implementing regulations or with any other federal law designed to restrict provider tax programs or intergovernmental transfers, the commissioner of human services shall appeal the determination to the fullest extent permitted by law and may rateably reduce all medical assistance and general assistance medical care payments to providers other than the state of Minnesota by a like amount in order to eliminate any shortfall resulting from the reduced federal funding. Any amount later recovered through the appeals process shall be used to reimburse providers for any rateable reductions taken.

Effective for money received on or after March 25, 1993, and during the biennium ending June 30, 1995, the state share of the settlement from the Sandoz company clozaril litigation shall be dedicated to the commissioner of human services to supplement the HIV drug program that is funded through the federal Ryan White Act and is available until expended.

The pharmacy dispensing fee shall be $4.10 per prescription.

Medical assistance inpatient rates identified in Minnesota Statutes, sections 256.9685 to 256.9695, shall be increased as follows: for inpatient admissions to (1) a children's hospital, nine percent; (2) a public hospital with calendar year 1991 noncapitation medical assistance inpatient dollar volume in excess of 13 percent of total calendar year 1991 noncapitation medical assistance inpatient dollar volume, six percent; and (3) a teaching hospital

operated by the University of Minnesota and having calendar year 1991 noncapitation medical assistance inpatient dollar volume in excess of eight percent of total calendar year 1991 noncapitation medical assistance dollar volume, three percent. For the purposes of this paragraph, a children's hospital is defined as one that is engaged in furnishing services to inpatients who are predominantly individuals under 18 years of age.

Up to $40,000 of the appropriation for preadmission screening and alternative care for fiscal year 1994 may be transferred to the health care administration account to pay the state's share of county claims for conducting nursing home assessments for persons with mental illness or mental retardation as required by Public Law Number 100-203.

Money appropriated in fiscal year 1994 for the administration and handling of vaccinations purchased from the Centers for Disease Control shall be transferred to the commissioner of health and is available until expended. The administration and handling must be done in a cost-effective manner, either by using existing storage capacity at the department of health, or by contracting out to a private vendor.

For the fiscal year ending June 30, 1994, a newly constructed or newly established intermediate care facility for the mentally retarded that is developed and financed during that period shall not be subject to the equity requirements in Minnesota Statutes, section 256B.501, subdivision 11, paragraph (d), or in Minnesota Rules, part 9553.0060, subpart 3, item F, provided that the provider's interest rate does not

exceed the interest rate available through state agency tax-exempt financing.

For the fiscal year ending June 30, 1994, if a facility which is in receivership under Minnesota Statutes, section 245A.12 or 245A.13, is sold to an unrelated organization: (a) notwithstanding Minnesota Statutes, section 256B.501, subdivision 11, the facility shall be considered a new facility for rate setting purposes; and (b) the facility's historical basis for the physical plant, land, and land improvements for each facility must not exceed the prior owner's aggregate historical basis for these same assets for each facility. The allocation of the purchase price between land, land improvements, and physical plant shall be based on the real estate appraisal using the depreciated replacement cost method.

The preadmission screening payment to a county not participating in projects under Minnesota Statutes, section 256B.0917, shall be the greater of the county's fiscal year 1993 payment or the county's fiscal year 1993 estimate as provided to the commissioner of human services by February 15, 1992. Counties participating in projects under Minnesota Statutes, section 256B.0917, and that did not receive an inflation adjustment for fiscal year 1993 shall receive a one-time five percent inflation adjustment to the payment that they were allotted in fiscal year 1993.

The commissioner of human services shall grant inflation adjustments for nursing facilities with rate years beginning during the biennium according to Minnesota Statutes, section 256B.431, subdivision 21, and shall grant inflation adjustments for intermediate care facili-

ties for persons with mental retardation or related conditions with rate years beginning during the biennium according to Minnesota Statutes, section 256B.501, subdivision 3c.

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. 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 that are not provided under the direction of an occupational therapist who is not on the premises shall be reimbursed at 65 percent of the occupational therapist rate.

Notwithstanding statutory provisions to the contrary, the commissioner of human services shall increase reimbursement rates for the following by three percent for the fiscal year ending June 30, 1995: nursing services and home health aide services under Minnesota Statutes, section 256B.0625, subdivision 6a; personal care services, and nursing supervision of personal care services, under Minnesota Statutes, section 256B.0625, subdivision 19a; private duty nursing services under Minnesota Statutes, section 256B.0625, subdivi-

sion 7; home- and community-based services waiver for persons with mental retardation and related conditions under Minnesota Statutes, section 256B.501; community alternatives for disabled individuals waiver under Minnesota Statutes, section 256B.49; community alternative care waiver under Minnesota Statutes, section 256B.49; home- and community-based services waiver for the elderly under Minnesota Statutes, section 256B.0915; alternative care program under Minnesota Statutes, section 256B.0913; traumatic brain injury waiver under Minnesota Statutes, section 256B.093; adult residential program grants, under rule 12, under Minnesota Rules, parts 9535.2000 to 9535.3000; adult and family community support grants, under rules 14 and 78, under Minnesota Rules, parts 9535.1700 to 9535.1760; day training and habilitation services for adults with mental retardation and related conditions under Minnesota Statutes, sections 252.40 to 252.47; and semi-independent living services under Minnesota Statutes, section 252.275.

$25,000 is appropriated for the biennium to the commissioner of human services for a planning grant for the 30-bed hospital located in Chisago county.

The commissioner shall implement a point-of-sale electronic claims management system to process claims for medical assistance payment from pharmacy providers. The system must be able to perform on-line, real-time eligibility verifications, and enhanced claims data capture, for pharmacy providers by January 31, 1994. No later than 60 days after that date the system must be able to perform on-line real-time adjudication of pharmacy claims. If the system is not able to perform the claims adjudi-

cation within 60 days after January 31, 1994, the commissioner must, as soon as possible thereafter, enter into a contract with a private vendor for a similar system.

The commissioner of human services may implement demonstration projects designed to create alternative delivery systems for acute and long-term care services to elderly and disabled persons which provide increased coordination, improve access to quality services, and mitigate future cost increases. Before implementing the projects, the commissioner must provide information regarding the projects to the appropriate committees of the house and senate.

Money appropriated for the interagency long-term care planning committee (INTERCOM) activity may be transferred among all agencies specified in Minnesota Statutes, section 144A.31, subdivision 1, with the approval of the members and the commissioner of finance.

The commissioner shall study modifications to Minnesota Rules, parts 9553.0010 to 9553.0080, governing the reimbursement system for intermediate care facilities for persons with mental retardation, and shall solicit advice from the public, including provider groups, advocates, and legislators when developing rule amendments. The commissioner shall report to the legislature by January 31, 1994, on the status of revision to these rule parts.

Community social services act grant funds for case management shall be increased by $600,000 and the medical assistance account shall be decreased by the total amount appropriated to the medical assistance account for the pur-

poses of preplacement planning for persons with mental retardation or related conditions.

The commissioner shall study and report to the legislature by February 1, 1994, recommendations on the feasibility of developing a Medicaid inpatient hospital payment system similar to the current Medicare methodology. The study shall examine at least the following reimbursement options: (1) Medicare diagnostic related grouping methodology, (2) reimbursement of small volume Medicaid providers on a percentage-of-charges basis rather than on a prospective basis; (3) equitable methods for reimbursing the additional costs incurred by teaching hospitals, children's hospitals, and high-volume Medicaid hospitals; and (4) contracting with an outside agency for the administration of the Medicaid program. The study shall also develop a plan to combine the medical assistance inpatient hospital reimbursement system with the reimbursement system to be developed by the health care commission. The commissioner shall establish a task force including department staff, hospital industry representatives, and health care commission representatives to assist with the preparation of the report and recommendations. The report shall include recommendations on the feasibility of implementing a new reimbursement system on July 1, 1994, and an estimate of the cost or savings associated with any recommended changes.

The commissioner may not adjust hospital reimbursement rates to provide a new hospital payment for short length of stay mental health patients without the prior approval of the legislature unless the adjustment will result in budget savings.

The commissioner shall apply to the federal government for a waiver from Code of Federal Regulations, parts 441.206 and 441.256, which require certain attachments be included with Medicaid provider billings, in order to enable the commissioner to allow providers to submit most or all bills electronically.

The commissioner shall allocate money for home and community-based services to meet the needs of developmentally disabled individuals on the following priority basis: (1) to serve individuals on county waiting lists; and (2) to serve individuals who have been screened for discharge from regional treatment centers. In allocating waiver slots to counties under Minnesota Statutes, sections 256B.092 and 256B.501, the commissioner shall ensure that at least as many individuals are served from county waiting lists as the net census reduction from regional treatment centers.

The commissioner of finance shall transfer $50,000 in fiscal year 1994 and $50,000 in 1995 from the department of human services' training budget to the state technical college system. This transfer is to be used for customized training of staff who work directly with persons with developmental disabilities. Any unexpended money shall revert to the general fund.

Effective for services rendered on or after July 1, 1993, the current medical assistance payment rate for ambulance services shall be increased by three percent.

Money appropriated for a peer grouping study in fiscal year 1994 but not expended does not cancel but is available for this purpose in fiscal year 1995.

Subd. 5. Family Self-Sufficiency Administration

General
$350,863,000 $327,109,000

Effective the day following final enactment, the appropriation in Laws 1991, chapter 292, article 1, section 2, subdivision 4, is increased by $13,286,000. Of this amount, $13,186,000 is to cover MAXIS operating deficiencies in fiscal year 1993 and $100,000 is to be transferred to the department of administration information policy office for an independent information system review of MAXIS. The appropriation to the information policy office does not cancel but shall be available until June 30, 1994. The review shall determine if operating expenses can be reduced, if distributed processing can be used, and if system performance can be improved. Findings of the review shall be reported to the legislature by February 1, 1994.

The commissioner shall set the monthly standard of assistance for general assistance and work readiness 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.

Federal food stamp employment and training funds received for the work readiness program are appropriated to the commissioner to reimburse counties for work readiness service expenditures.

Of the appropriation for aid to families with dependent children, the commissioner shall provide supplementary grants not to exceed $200,000 a year for aid to families with dependent children. The commissioner shall include the following costs in determining the amount of the supplementary grants: major

home repairs; repair of major home appliances; utility recaps; supplementary dietary needs not covered by medical assistance; and replacements of furnishings and essential major appliances.

Any federal money remaining from receipt of state legalization impact assistance grants, after reimbursing the department of education for actual expenditures, must be deposited in the aid to families with dependent children account.

Unexpended money appropriated for (1) project STRIDE work experience activities under Minnesota Statutes, section 256.737; (2) work readiness employment and training services; (3) the Minnesota family investment plan; or (4) the child support restructuring initiative for fiscal year 1994 does not cancel but is available for fiscal year 1995.

Of the appropriation for child support enforcement, $2,570,000 in fiscal year 1994 and $3,233,000 in fiscal year 1995 is for implementation of the child support restructuring initiative. Unexpended funds for fiscal year 1994 do not cancel but are available to the commissioner for fiscal year 1995.

The commissioner may accept on behalf of the state any gift or bequest of money tendered to the state for the purpose of financing an evaluation of the Minnesota family investment plan. Any money so received must be deposited in the MFIP evaluation account in the department and is appropriated to the commissioner for financing of this evaluation.

For the food stamp program error rate

sanction for federal fiscal year 1986, the commissioner is granted an exception to the provisions of Minnesota Statutes, section 256.01, subdivision 2, clause (14), requiring allocation of sanctions to county human service agencies.

Payments to the commissioner from other governmental units and private enterprises for services performed by the issuance operations center shall be deposited in the state systems account authorized in Minnesota Statutes, section 256.014. The payments so received by the commissioner are appropriated for the purposes of that section for the operation of the issuance center, and are to be used according to the provisions of that section.

The commissioner of the department of human services is authorized to receive Hennepin county conversion contributions of $400,000 per year in calendar years 1994 and 1995 to be used for the expansion of electronic benefit transfer systems to Hennepin county. Money received from the county shall be added to the appropriation. Money received will be applied directly to project costs and shall not cancel, but shall remain available for expenditure until expansion is complete.

The commissioner may accept assignment of an existing contract for electronic benefit transfer services, under terms and conditions approved by the attorney general. The term of any contract assigned to the state may not extend beyond June 30, 1995, and the commissioner must publish a request for proposals for succeeding electronic benefit services in the State Register before January 1, 1995.

The commissioner shall prepare materi-

als for submission to the secretary of the United States Department of Health and Human Services and to the Minnesota congressional delegation to urge the congress to amend federal law to permit payment of AFDC benefits to otherwise eligible families with children in foster care, as was permitted prior to 1986 under Title IV-E of the Social Security Act.

The commissioner shall submit electronic benefit transfer project plans to the information policy office for its review and approval. The plans shall include an evaluation of the Ramsey county system and a life cycle analysis of the project. The department shall examine ways to share network development and operating costs with businesses participating in the electronic benefits program, and ways that the system can be used for the delivery of other government services.

Beginning July 1, 1993, the commissioner of human services shall develop an intensive training program for county workers who do general assistance intake work. The program shall be designed to provide county workers with expertise in implementing the restrictions on eligibility in general assistance that will take effect on October 1, 1993. Those restrictions will affect the eligibility of undocumented aliens and nonimmigrants for these programs. The training programs must be provided to all county social workers who do general assistance intake. The programs shall include training in the following: federal immigration law, state and federal human rights and civil rights standards, and multi-cultural awareness and sensitivity. The commissioner shall report to the legislature by February 15, 1994, on the status of these training programs.

Effective the day following final enactment, fiscal year 1993 appropriations made to the commissioner of human services for computer projects may be transferred between operations and development. A transfer under this paragraph may be made at the discretion of the commissioner, but must not be made to any project not previously approved by the commissioner of finance and the information policy office.

For the fiscal year ending June 30, 1995, $268,000 is transferred from the general assistance grants and $195,000 is transferred from the MSA grants to Hennepin county social services grants. This amount represents group residential housing payments for 32 persons receiving services in Hennepin county from a provider that on August 1, 1984, was licensed under Minnesota Rules, parts 9525.0520 to 9525.0660, but funded as a group residence under general assistance or Minnesota supplemental aid. These 32 beds are to be permanently removed from the group residential census and not replaced by other group residential housing agreements.

Subd. 6. Mental Health and Regional Treatment Center Administration

General
$259,771,000 $260,314,000

For purposes of restructuring the regional treatment centers and state nursing homes, any regional treatment center or state nursing home employee whose position is to be eliminated shall be afforded the options provided in applicable collective bargaining agreements. All salary and mitigation allocations from fiscal year 1994 shall be carried forward into fiscal year 1995.

Provided there is no conflict with any collective bargaining agreement, any regional treatment center or state nursing home position reduction must only be accomplished through mitigation, attrition, transfer, and other measures as provided in state or applicable collective bargaining agreements and in Minnesota Statutes, section 252.50, subdivision 11, and not through layoff.

If the resident population at the regional treatment centers is projected to be higher than the estimates upon which the medical assistance forecast and budget recommendations for the 1994-95 biennium were based, the amount of the medical assistance appropriation that is attributable to the cost of services that would have been provided as an alternative to regional treatment center services, including resources for community placements and waivered services for persons with mental retardation and related conditions, is transferred to the residential facilities appropriation.

The commissioner of human services is prohibited from transferring any building on the campus of the Faribault regional treatment center to any other state agency, or from declaring any building or acreage on the campus to be surplus, unless specifically authorized to do so by the legislature.

The commissioner may determine the need for conversion of a state-operated home and community-based service program to a state-operated intermediate care facility for persons with mental retardation if the conversion will produce a net savings to the state general fund and the persons receiving home and community-based services choose to receive services in an intermediate

care facility for persons with mental retardation. After the commissioner has determined the need to convert the program, the commissioner of health shall certify the program as an intermediate care facility for persons with mental retardation if the program meets applicable certification standards.

Of the state enhanced waiver slots authorized for regional treatment center downsizing, 32 in fiscal year 1994 and an additional 36 in fiscal year 1995 shall be for state-operated services. Of these a minimum of eight in fiscal year 1994 and an additional four in fiscal year 1995 shall be utilized by the Cambridge Regional Treatment Center and a minimum of eight in fiscal year 1994 and an additional four in fiscal year 1995 shall be utilized at the Fergus Falls regional treatment center.

Of the enhanced waiver slots authorized for the Faribault regional treatment center, 64 shall be for state-operated services.

Of the enhanced waiver slots authorized for the Moose Lake regional treatment center, 12 shall be for state-operated services.

Any unexpended appropriations from the regional treatment center supplements for state enhanced waiver slots shall be transferred into the regional treatment center salary account.

The commissioner may transfer unencumbered appropriation balances between fiscal years for the state residential facilities repairs and betterments account and special equipment.

Wages for project labor may be paid by the commissioner of human services 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 Minnesota Statutes, section 177.42, subdivision 6. Project laborers are excluded from the provisions of Minnesota Statutes, sections 43A.22 to 43A.30, and shall not be eligible for state-paid insurance and benefits.

When the operations of the regional treatment center chemical dependency fund created in Minnesota Statutes, section 246.18, subdivision 2, are impeded by projected cash deficiencies resulting from delays in the receipt of grants, dedicated income or other similar receivables, and when the deficiencies would be corrected within the budget period involved, the commissioner of finance shall transfer general fund cash reserves into this account as necessary to meet cash demands. The cash flow transfers must be returned to the general fund as soon as sufficient cash balances are available in the account to which the transfer was made. Any interest earned on general fund cash flow transfers accrues to the general fund and not the regional treatment center chemical dependency fund.

Money is appropriated from the mental health special projects account for adults and children with mental illness from across the state, for a camping program which utilizes the Boundary Waters Canoe Area and is cooperatively sponsored by client advocacy, mental health treatment, and outdoor recreation agencies.

Of this appropriation, $560,000 the first year is for children's integrated mental health grants. Any money not expended

in the first year is available the second year. The three positions to provide technical assistance to counties are unclassified.

Funds received by the commissioner of human services from the state lottery director shall be used for the compulsive gambling treatment programs authorized by Minnesota Statutes, section 245.98, subdivision 2, including programs operated at the following facilities: St. Mary's hospital, Minneapolis; Gamblers Choice, Intervention Institute, Minneapolis; Upper Mississippi Health Service, Bemidji; Gamestar, St. Cloud; Lake Superior Area Family Services, Duluth; and Project Turnabout, Granite Falls. In determining the amount of money to be given to each facility the commissioner shall consider the projected number of clients to be served, quality of services and whether the treatment will be inpatient or outpatient.

Of the appropriation for compulsive gambling treatment programs and the council on compulsive gambling under Minnesota Statutes, section 349.212, subdivision 2, $25,000 each year shall be designated for the Minnesota council on compulsive gambling for the development of an information gathering and dissemination network. Any money allocated or contributed for the compulsive gambling treatment programs does not cancel but shall be available for compulsive gambling treatment programs.

The legislature recognizes that orderly transfer of buildings at the Moose Lake regional center from the commissioner of human services to the commissioner of corrections is necessary to assure the welfare of vulnerable persons, to facili-

tate a shared campus, and to abide by legislated policies concerning the future of regional treatment centers and state correctional facilities.

In accordance with legislative policies, the transfer of buildings at the Moose Lake regional center from the commissioner of human services to the commissioner of corrections during fiscal year 1994 shall be carried out as follows:

(1) The commissioner of human services shall transfer buildings at the Moose Lake campus housing persons with mental illness and psychogeriatric patients to the commissioner of corrections upon the commencement of planning and design for construction of a 100-bed psychopathic personality treatment facility at the Moose Lake regional treatment center;

(2) buildings that house developmentally disabled persons may be transferred by the commissioner of human services to the commissioner of corrections when the commissioner of human services certifies that all persons with developmental disabilities from the Moose Lake regional center have been placed in appropriate community-based programs and that at least 12 of the same residents have been placed in state operated community services; and

(3) buildings housing programs for chemically dependent persons at the Moose Lake regional center may be transferred by the commissioner of human services to the commissioner of corrections after alternative facilities for state operated chemical dependency programs have been located off campus in the Moose Lake catchment area and all program residents and staff have

been relocated to the new state operated community-based program.

Construction on the 100 unit facility at Moose Lake for psychopathic personality patients may not be commenced until after construction has been commenced on the 50 bed facility at St. Peter, except that this limitation shall not restrict site preparation. The commissioner of administration shall report to the legislature by February 1, 1994, on the progress on both of the authorized facilities for psychopathic personality patients and other bonding projects related to regional treatment centers.

It is the intent of the legislature that the transfer of vulnerable persons, construction of the psychiatric hospital, and the conversion of existing buildings at Moose Lake for use by the department of corrections shall be coordinated in order to minimize any disruptive impact on the care and treatment of vulnerable persons.

$50,000 is appropriated for the biennium to the commissioner of human services for costs associated with establishing a consolidated financial record management facility at the Cambridge regional treatment center. This facility must be operational by July 1, 1994. By July 1, 1994, the commissioner shall report to the legislature on other opportunities to consolidate department records at the regional treatment center.

The transfer of the hospital building at the Faribault regional treatment center to the department of administration, to the department of corrections, or to any other state agency, may take place only after alternative, state-operated, skilled nursing facility, or intermediate care

facility for persons with mental retardation and infirmary space has been developed for residents of the Faribault regional treatment center.

Agreements between the commissioner of corrections and the commissioner of human services concerning operation of a correctional facility on the Moose Lake regional treatment center campus shall include provisions for the utilization of the regional laundry facilities at the Brainerd regional treatment center.

Sec. 3. COMMISSIONER OF HEALTH

Subdivision 1. Total Appropriation		54,162,000	53,469,000
Summary by Fund			
General	37,723,000	37,787,000	
Metropolitan Landfill Contingency Action Fund	191,000	204,000	
State Government Special Revenue	14,760,000	13,968,000	
Trunk Highway	1,488,000	1,510,000	

The appropriation from the Metropolitan Landfill Contingency Action Fund is for monitoring well water supplies and conducting health assessments in the metropolitan area.

The appropriation from the trunk highway fund is for emergency medical services activities.

Subd. 2. Health Protection		16,741,000	15,825,000
Summary by Fund			
General	7,124,000	6,978,000	
State Government Special Revenue	9,448,000	8,665,000	
Metropolitan Landfill Contingency Action Fund	169,000	182,000	

Of this appropriation, $150,000 is an increase for lead activities and programs of which $25,000 must be used to provide safe housing, under Minnesota Statutes, section 144.874, subdivision 4,

to meet the relocation requirements of residential lead abatement and $25,000 must be used to provide grants to nonprofit community-based organizations in areas at high risk for toxic lead exposure, for lead cleanup equipment and material grants under Minnesota Statutes, section 144.872, subdivision 4.

Of this appropriation, $40,000 is appropriated each year to maintain lead inspector services outside the seven-county metropolitan area.

Of this appropriation, $75,000 is for a grant to the World Health Organization collaborating center for reference and research on streptococci at the University of Minnesota to conduct a study to determine the efficacy of conducting throat cultures for evidence of streptococcal infection in selected symptomatic students. The study must be conducted in four schools, one of which is in rural Minnesota and one of which is in a core city. The study must be conducted with students in grades K-12. * **(The preceding paragraph starting "Of" was vetoed by the governor.)**

Subd. 3. Health Care Resources and Systems		3,680,000	3,671,000
	Summary by Fund		
General	350,000	350,000	
State Government Special Revenue	3,330,000	3,321,000	

Of this appropriation, $75,000 is appropriated each year to the commissioner of health for the purposes of occupational analysis under Minnesota Statutes, chapter 214. The commissioner may convene an advisory committee to assist in developing recommendations.

Any efforts undertaken by the Minnesota departments of health or human services to conduct periodic educational

programs for nursing home residents shall build on and be coordinated with the resident and family advisory council education program established in Minnesota Statutes, section 144A.33.

Notwithstanding the provisions of Minnesota Statutes, sections 144.122 and 144.53, the commissioner of health shall increase the annual licensure fee charged to a hospital accredited by the joint commission on accreditation of health care organizations by $520 and shall increase the annual licensure fee charged to nonaccredited hospitals by $225.

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.

The commissioner shall adjust the fees for hospital licensure renewal in such a way that fees for hospitals not accredited by the joint commission on accreditation of health care organizations are capped at $2,000, plus $100 per bed. Any loss of revenue that results from this cap must be evenly distributed to hospitals which are accredited by the joint commission.

The commissioner shall report to the chairs of the house of representatives health and housing finance division and the senate health and family services finance division by January 1, 1995, on progress in developing a revised cost allocation system to determine licensing fees for health care facilities and shall recommend language to modify hospital and nursing home fees accordingly.

Effective the day following final enactment, in the event that the commissioner of health is ordered by a court or otherwise agrees to assume responsibility for the handling of patient's medical records from a closed hospital, such records shall be considered as medical data under the provisions of Minnesota Statutes, section 13.42, subdivision 3. The commissioner of health is authorized to handle and to provide access to these records in accordance with the provisions of Minnesota Statutes, sections 145.30 to 145.32 and 144.335. A written certification by the commissioner of health or the commissioner's designee that a photographic or photostatic copy of a record is a complete and correct copy shall have the same force and effect as a comparable certification of an officer or employee in charge of the records of the closed hospital. Costs incurred for the handling of these records pursuant to Minnesota Statutes, sections 145.30 to 145.32, shall be con-

sidered as a lien on the property of the closed hospital in accordance with the provisions of Minnesota Statutes, section 514.67. At the commissioner of health's discretion, all or a portion of this lien may be released in consideration for payment of a reasonable portion of the costs incurred by the commissioner. Any costs incurred by the commissioner for the handling of or providing access to the medical records must be recovered through charges for the access to records under Minnesota Statutes, section 144.335. The commissioner may contract for services for the handling of the medical records pursuant to Minnesota Statutes, sections 145.30 to 145.32, and for the provision of access to these records. Any revenues received by the commissioner through collections from the closed hospital or from charges for access shall be used to cover any contractual costs. Any remaining money shall be deposited into the state government special revenue fund.

Minnesota Rules, parts 4655.1070 to 4655.1098, as in effect on September 1, 1989, are adopted as an emergency rule of the department of health. The commissioner of health shall publish in the State Register a notice of intent to adopt Minnesota Rules, parts 4655.1070 to 4655.1098 [Emergency]. The same notice shall be mailed to all persons registered with the agency to receive notice of any rulemaking proceedings. The emergency rule is exempt from the requirements of Minnesota Statutes, sections 14.32 to 14.35, and shall take effect five working days after publication in the State Register. Those rules shall govern the process for granting exceptions to the moratorium on nursing homes under Minnesota Stat-

utes, section 144A.073, during the biennium.

Subd. 4. Health Delivery Systems		29,648,000	29,822,000
	Summary by Fund		
General	28,242,000	28,394,000	
Trunk Highway	1,406,000	1,428,000	

Of this appropriation, $4,200,000 is an increase over the base for the WIC program.

$150,000 in fiscal year 1995 is appropriated to the ambulance service personnel longevity award and incentive trust account. Of this appropriation, $40,000 is appropriated from the ambulance service personnel longevity award and incentive trust account to the commissioner of health to administer the ambulance service personnel longevity award and incentive program. Of this appropriation, $45,000 is appropriated from the ambulance service personnel longevity award and incentive trust account to the commissioner of health to redesign and consolidate the volunteer ambulance attendant reimbursement database, to establish the database for the personnel longevity award and incentive program, and to purchase computer equipment for fiscal year 1995.

General fund appropriations for the women, infants and children food supplement program (WIC) are available for either year of the biennium. Transfers of appropriations between fiscal years must be for the purpose of maximizing federal funds or minimizing fluctuations in the number of participants.

When cost effective, the commissioner may use money received for the services for children with handicaps program to purchase health coverage for eligible children.

In the event that Minnesota is required to comply with the provision in the federal maternal and child health block grant law, which requires 30 percent of the allocation to be spent on primary services for children, federal funds allocated to the commissioner of health under Minnesota Statutes, section 145.882, subdivision 2, may be transferred to the commissioner of human services for the purchase of primary services for children covered by MinnesotaCare. The commissioner of human services shall transfer an equal amount of the money appropriated for MinnesotaCare to the commissioner of health to assure access to quality child health services under Minnesota Statutes, section 145.88.

General fund appropriations for treatment services in the services for children with handicaps program are available for either year of the biennium.

Up to $50,000 of the appropriation for treatment services in the services for children with handicaps program may be used to conduct a needs assessment of children with special health care needs and their families, and $105,000 must be used to avoid reducing the nursing staff due to inflationary increases to the extent possible with this appropriation.

Of this appropriation, $50,000 is to establish and administer a financial data collection program on ambulance services licensed in the state. The commissioner shall coordinate this program with the data collection initiatives of Minnesota Statutes, chapter 62J. In designing the data collection program, the commissioner shall consult with the Minnesota Ambulance Association and

regional emergency medical services programs.

The financial data collection program must include, but is not limited to, ambulance charges, third-party reimbursements, sources of direct and indirect subsidies, and other costs involved in providing ambulance care in Minnesota.

All licensed ambulance services shall be required to cooperate and report information requested by the commissioner. Information collected on individuals is nonpublic data. The commissioner may provide summary data under Minnesota Statutes, section 13.05, subdivision 7, and may release summary data in reports.

The commissioner shall report to the legislature by February 1, 1995. The report must include an analysis of the financial condition of licensed ambulance services in Minnesota, including a description of:

(1) the various organization models used to finance and deliver ambulance services;

(2) the factors influencing the total revenues, rates charged, operational and other expenses;

(3) limitations and barriers in collecting data on revenues and expenses;

(4) the range of revenues collected and rates charged by type of organizational model and by region of the state;

(5) any other significant findings relevant to the financial condition of ambulance services in the state.

The commissioner may contract for the

collection of data and the creation of the financial data collection system. The commissioner shall report to the legislature on January 15 in each odd-numbered year all of the above information. The commissioner shall assist ambulance services which are unable to comply with data requests. Money appropriated is available in either year of the biennium. For purposes of establishing the base for the next biennium, the commissioner of finance shall assume $70,000 to be available for each biennium.

The commissioner may sell at market value, all nonsmoking or tobacco use prevention advertising materials. Proceeds from the sale of the advertising materials are appropriated to the department of health for its nonsmoking program.

Effective the day following final enactment, fiscal year 1993 appropriations for emergency medical technician training reimbursement under Minnesota Statutes, section 144.8091, do not cancel and are available until expended.

Subd. 5. Health Support Services		4,093,000	4,151,000
Summary by Fund			
General	2,007,000	2,065,000	
Metropolitan Landfill Contingency Action Fund	22,000	22,000	
Trunk Highway	82,000	82,000	
State Government Special Revenue	1,982,000	1,982,000	
Sec. 4. VETERANS NURSING HOMES BOARD		15,877,000	17,063,000

The board may set costs of care at the Silver Bay and Luverne facilities based on costs of average skilled nursing care provided to residents of the Minneapolis veterans home.

The veterans homes board shall limit the total administrative expenditures for the board and all the homes to no more than 17 percent of total expenditures in fiscal year ending June 30, 1994, and 16 percent of total expenditures in fiscal year ending June 30, 1995. The board may transfer money between facilities after notifying the chairs of the health and housing finance division of the health and human services committee in the house of representatives and the chair of the health and family services finance division in the senate.

The veterans homes board shall conduct an alternative site study for the Minneapolis veterans home.

Of this appropriation, $100,000 in fiscal year 1995 is for an information system. All information policy office requirements must be met before hardware and software are purchased.

The commissioner of health shall not apply the provisions of Minnesota Statutes, section 144.55, subdivision 6, paragraph (b), to the Minnesota veterans home at Hastings.

The commissioner of health shall not reduce the licensed bed capacity for the Minneapolis veterans home in lieu of presentation to the legislature of building needs and options by the veterans homes board of directors.

Sec. 5. HEALTH-RELATED BOARDS

Subdivision 1. Total Appropriation	6,406,000	6,399,000

The appropriations in this section are from the state government special revenue fund.

A board named in this article may transfer appropriated funds to the

health-related licensing board administrative services unit within the board of chiropractic examiners for additional administrative support services.		
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 from fees collected by the boards. Neither this provision nor Minnesota Statutes, section 214.06, applies to transfers from the general contingent account, if the amount transferred does not exceed the amount of surplus revenue accumulated by the transferee during the previous five years.		
Subd. 2. Board of Chiropractic Examiners	368,000	368,000
Of this appropriation from the state government special revenue fund, $63,000 the first year and $63,000 the second year is to provide administrative services to all health-related licensing boards.		
Subd. 3. Board of Dentistry	665,000	652,000
Subd. 4. Board of Marriage and Family Therapy	94,000	94,000
Subd. 5. Board of Medical Practice	2,045,000	2,045,000
Subd. 6. Board of Nursing	1,501,000	1,504,000
Subd. 7. Board of Nursing Home Administrators	171,000	171,000
Subd. 8. Board of Optometry	71,000	72,000
Subd. 9. Board of Pharmacy	600,000	602,000
Subd. 10. Board of Podiatry	30,000	30,000
Subd. 11. Board of Psychology	315,000	315,000
Subd. 12. Board of Social Work	438,000	438,000
Subd. 13. Board of Veterinary Medicine	108,000	108,000
Sec. 6. COUNCIL ON DISABILITY	566,000	566,000

Sec. 7. OMBUDSMAN FOR MENTAL HEALTH AND MENTAL RETARDATION	881,000	880,000

Sec. 8. CARRYOVER LIMITATION

None of the appropriations in this act which are allowed to be carried forward from fiscal year 1994 to fiscal year 1995 shall become part of the base level funding for the 1995-1997 biennial budget.

Sec. 9. TRANSFERS

Subdivision 1. Approval Required

Transfers may be made by the commissioners of human services and health and the veterans nursing homes board to salary accounts and unencumbered salary money may be transferred to the next fiscal year in order to avoid layoffs with the advance approval of the commissioner of finance and upon notification of the chairs of the senate health care and family services finance division and the house of representatives human services finance and health and housing finance divisions. Amounts transferred to fiscal year 1995 shall not increase the base funding level for the 1996-1997 appropriation. The commissioners and the board shall not transfer money to or from the object of expenditure "grants and aid" without the written approval of the governor after consulting with the legislative advisory commission.

Subd. 2. Transfers of Unencumbered Appropriations

Positions and administrative money may be transferred within the departments of human services and health and within the programs operated by the veterans homes board as the commissioners or the board consider necessary,

with the advance approval of the commissioner of finance. The commissioners and the board shall inform the chairs of the human services finance division of the house of representatives and the health care and family services division of the senate quarterly about transfers made under this provision.

Sec. 10. PROVISIONS

Money appropriated to the commissioner of human services and to the veterans nursing homes board for the purchase of provisions within the item "current expense" must be used solely for that purpose. Money provided and not used for the purchase of provisions must be canceled into the fund from which appropriated, except that money provided and not used for the purchase of provisions because of population decreases may be transferred and used for the purchase of medical and hospital supplies with the written approval of the governor after consultation with the legislative advisory commission.

The allowance for food may be adjusted annually to reflect changes in the producer price index, as prepared by the United States Bureau of Labor Statistics, with the approval of the commissioner of finance. Adjustments for fiscal year 1994 and fiscal year 1995 must be based on the June 1993 and June 1994 producer price index respectively, but the adjustment must be prorated if the wholesale food price index adjustment would require money in excess of this appropriation.

Sec. 11. SUNSET OF UNCODIFIED LANGUAGE

All uncodified language contained in this article expires on June 30, 1995, unless a different expiration is explicit.

All uncodified language contained in Laws 1992, chapter 513, article 5, expires on June 30, 1993, unless a different expiration is explicit.

ARTICLE 2

DEPARTMENT OF HUMAN SERVICES

FINANCE AND ADMINISTRATION

Section 1. Minnesota Statutes 1992, section 256.025, subdivision 3, is amended to read:

Subd. 3. **PAYMENT METHODS.** (a) Beginning July 1, 1991, the state will reimburse counties for the county share of county agency expenditures for benefits and services distributed under subdivision 2 ~~and funded by the human services account established under section 273.1392~~.

(b) Payments under subdivision 4 are only for client benefits and services distributed under subdivision 2 and do not include reimbursement for county administrative expenses.

(c) The state and the county agencies shall pay for assistance programs as follows:

(1) Where the state issues payments for the programs, the county shall monthly advance to the state, as required by the department of human services, the portion of program costs not met by federal and state funds. The advance shall be an estimate that is based on actual expenditures from the prior period and that is sufficient to compensate for the county share of disbursements as well as state and federal shares of recoveries;

(2) Where the county agencies issue payments for the programs, the state shall monthly advance to counties all federal funds available for those programs together with an amount of state funds equal to the state share of expenditures; and

(3) Payments made under this paragraph are subject to section 256.017. Adjustment of any overestimate or underestimate in advances shall be made by the state agency in any succeeding month.

Sec. 2. Minnesota Statutes 1992, section 256.025, subdivision 4, is amended to read:

Subd. 4. **PAYMENT SCHEDULE.** Except as provided for in subdivision 3, beginning July 1, 1991, the state will reimburse counties, according to the fol-

lowing payment schedule, for the county share of county agency expenditures for the programs specified in subdivision 2.

(a) Beginning July 1, 1991, the state will reimburse or pay the county share of county agency expenditures according to the reporting cycle as established by the commissioner, for the programs identified in subdivision 2. Payments for the period of January 1 through July 31, for calendar years 1991, 1992, ~~and~~ 1993, 1994, and 1995 shall be made on or before July 10 in each of those years. Payments for the period August through December for calendar years 1991, 1992, ~~and~~ 1993, 1994, and 1995 shall be made on or before the third of each month thereafter through December 31 in each of those years.

(b) Payment for 1/24 of the base amount and the January ~~1994~~ 1996 county share of county agency expenditures growth amount for the programs identified in subdivision 2 shall be made on or before January 3, ~~1994~~ 1996. For the period of February 1, ~~1994~~ 1996, through July 31, ~~1994~~ 1996, payment of the base amount shall be made on or before July 10, ~~1994~~ 1996, and payment of the growth amount over the base amount shall be made on or before July 10, ~~1994~~ 1996. Payments for the period August ~~1994~~ 1996 through December ~~1994~~ 1996 shall be made on or before the third of each month thereafter through December 31, ~~1994~~ 1996.

(c) Payment for the county share of county agency expenditures during January ~~1995~~ 1997 shall be made on or before January 3, ~~1995~~ 1997. Payment for 1/24 of the base amount and the February ~~1995~~ 1997 county share of county agency expenditures growth amount for the programs identified in subdivision 2 shall be made on or before February 3, ~~1995~~ 1997. For the period of March 1, ~~1995~~ 1997, through July 31, ~~1995~~ 1997, payment of the base amount shall be made on or before July 10, ~~1995~~ 1997, and payment of the growth amount over the base amount shall be made on or before July 10, ~~1995~~ 1997. Payments for the period August ~~1995~~ 1997 through December ~~1995~~ 1997 shall be made on or before the third of each month thereafter through December 31, ~~1995~~ 1997.

(d) Monthly payments for the county share of county agency expenditures from January ~~1996~~ 1998 through February ~~1996~~ 1998 shall be made on or before the third of each month through February ~~1996~~ 1998. Payment for 1/24 of the base amount and the March ~~1996~~ 1998 county share of county agency expenditures growth amount for the programs identified in subdivision 2 shall be made on or before March ~~1996~~ 1998. For the period of April 1, ~~1996~~ 1998, through July 31, ~~1996~~ 1998, payment of the base amount shall be made on or before July 10, ~~1996~~ 1998, and payment of the growth amount over the base amount shall be made on or before July 10, ~~1996~~ 1998. Payments for the period August ~~1996~~ 1998 through December ~~1996~~ 1998 shall be made on or before the third of each month thereafter through December 31, ~~1996~~ 1998.

(e) Monthly payments for the county share of county agency expenditures from January ~~1997~~ 1999 through March ~~1997~~ 1999 shall be made on or before

the third of each month through March ~~1997~~ 1999. Payment for 1/24 of the base amount and the April ~~1997~~ 1999 county share of county agency expenditures growth amount for the programs identified in subdivision 2 shall be made on or before April 3, ~~1997~~ 1999. For the period of May 1, ~~1997~~ 1999, through July 31, ~~1997~~ 1999, payment of the base amount shall be made on or before July 10, ~~1997~~ 1999, and payment of the growth amount over the base amount shall be made on or before July 10, ~~1997~~ 1999. Payments for the period August ~~1997~~ 1999 through December ~~1997~~ 1999 shall be made on or before the third of each month thereafter through December 31, ~~1997~~ 1999.

(f) Monthly payments for the county share of county agency expenditures from January ~~1998~~ 2000 through April ~~1998~~ 2000 shall be made on or before the third of each month through April ~~1998~~ 2000. Payment for 1/24 of the base amount and the May ~~1998~~ 2000 county share of county agency expenditures growth amount for the programs identified in subdivision 2 shall be made on or before May 3, ~~1998~~ 2000. For the period of June 1, ~~1998~~ 2000, through July 31, ~~1998~~ 2000, payment of the base amount shall be made on or before July 10, ~~1998~~ 2000, and payment of the growth amount over the base amount shall be made on or before July 10, ~~1998~~ 2000. Payments for the period August ~~1998~~ 2000 through December ~~1998~~ 2000 shall be made on or before the third of each month thereafter through December 31, ~~1998~~ 2000.

(g) Monthly payments for the county share of county agency expenditures from January ~~1999~~ 2001 through May ~~1999~~ 2001 shall be made on or before the third of each month through May ~~1999~~ 2001. Payment for 1/24 of the base amount and the June ~~1999~~ 2001 county share of county agency expenditures growth amount for the programs identified in subdivision 2 shall be made on or before June 3, ~~1999~~ 2001. Payments for the period July ~~1999~~ 2001 through December ~~1999~~ 2001 shall be made on or before the third of each month thereafter through December 31, ~~1999~~ 2001.

(h) Effective January 1, ~~2000~~ 2002, monthly payments for the county share of county agency expenditures shall be made subsequent to the first of each month.

Payments under this subdivision are subject to the provisions of section 256.017.

Sec. 3. **[256.026] ANNUAL APPROPRIATION.**

(a) There shall be appropriated from the general fund to the commissioner of human services in fiscal year 1994 and each fiscal year thereafter the amount of $142,339,359, which is the sum of the amount of human services aid determined for all counties in Minnesota for calendar year 1992 under Minnesota Statutes 1992, section 273.1398, subdivision 5a, before any adjustments for calendar year 1991.

(b) In addition to the amount in paragraph (a), there shall also be annually appropriated from the general fund to the commissioner of human services in fiscal years 1996, 1997, 1998, 1999, 2000, and 2001 the amount of $5,930,807.

(c) The amounts appropriated under paragraphs (a) and (b) shall be used with other appropriations to make payments required under section 256.025 for fiscal year 1994 and thereafter.

Sec. 4. Minnesota Statutes 1992, section 273.1392, is amended to read:

273.1392 **PAYMENT; SCHOOL DISTRICTS; ~~COUNTIES~~.**

~~(1) AIDS TO SCHOOL DISTRICTS.~~ The amounts of conservation tax credits under section 273.119; disaster or emergency reimbursement under section 273.123; attached machinery aid under section 273.138; homestead credit under section 273.13; aids and credits under section 273.1398; enterprise zone property credit payments under section 469.171; and metropolitan agricultural preserve reduction under section 473H.10, shall be certified to the department of education by the department of revenue. The amounts so certified shall be paid according to section 124.195, subdivisions 6 and 10.

~~(2) AIDS TO COUNTIES. The amounts of human services aid increase determined under section 273.1398, subdivision 5b, shall be deposited in a human services aid account hereby created as an account within the state's general fund. The amount within the account shall annually be transferred to the department of human services by the department of revenue. The amounts so transferred shall be paid according to section 256.025.~~

Sec. 5. Minnesota Statutes 1992, section 273.1398, subdivision 5b, is amended to read:

Subd. 5b. **STATE AID FOR COUNTY HUMAN SERVICES COSTS.** (a) Human services aid increase for each county equals an amount representing the county's costs for human services programs cited in subdivision 1, paragraph (i). The amount of the aid increase is calculated as provided in this section. ~~The aid increase shall be deposited in the human services account created pursuant to section 273.1392.~~

(b) On July 15, 1990, each county shall certify to the department of revenue the estimated difference between the county's base amount costs as defined in section 256.025 for human services programs cited in subdivision 1, paragraph (i), for calendar year 1990 and human services program revenues from all non-property tax sources excluding revenue from state and federal payments for the programs listed in subdivision 1, paragraph (i), and revenue from incentive programs pursuant to sections 256.019, 256.98, subdivision 7, 256D.06, subdivision 5, 256D.15, and 256D.54, subdivision 3, used at the time the levy was certified in 1989. At that time each county may revise its estimate for taxes payable in 1990 for purposes of this subdivision. The human services program estimates provided pursuant to this clause shall only include those costs and related revenues up to the extent the county provides benefits within statutory mandated standards. This amount shall be the county's human services aid amount under this section.

(c) On July 15, 1991, each county shall certify to the department of revenue the actual difference between the county's human services program costs and nonproperty tax revenues as provided in paragraph (b) for calendar year 1990. If the actual difference is larger than the estimated difference as calculated in paragraph (b), the aid amount for the county shall be increased by that amount. If the actual difference is smaller than the estimated difference as calculated in paragraph (b), the aid amount to the county shall be reduced by that amount.

~~(d) On January 1, 1991, the department of finance shall certify to the department of revenue the estimated amount of county receipts deducted from county human services expenditures pursuant to Minnesota Statutes 1988, section 287.12, in calendar year 1990. This amount shall be added to the human services aid increase amount under this section.~~

Sec. 6. Minnesota Statutes 1992, section 275.07, subdivision 3, is amended to read:

Subd. 3. The county auditor shall adjust each local government's levy certified under subdivision 1, except for the equalization levies defined in section 273.1398, subdivision 2a, paragraph (a), by the amount of homestead and agricultural credit aid certified by section 273.1398, subdivision 2~~, reduced by the amount under section 273.1398, subdivision 5a~~; fiscal disparity homestead and agricultural credit aid under section 273.1398, subdivision 2b; and equalization aid certified by section 477A.013, subdivision 5.

Sec. 7. **REPEALER.**

Minnesota Statutes 1992, section 273.1398, subdivisions 5a and 5c, are repealed.

ARTICLE 3

SOCIAL SERVICES AND CHILD WELFARE PROGRAMS

Section 1. Minnesota Statutes 1992, section 145.883, subdivision 5, is amended to read:

Subd. 5. **LOW INCOME.** "Low income" means an individual or family ~~with an~~ income determined to be at or below 175 percent of the ~~income~~ official poverty line ~~defined~~ established by the office of management and budget and revised annually in accordance with United States Code, title 42, section 9902, as amended ~~through December 31, 1982~~. With respect to an individual who is a high risk person, "low income" means that the income of the high risk person or the person's family is determined to be at or below 200 percent of the ~~income~~ official poverty line ~~defined~~ established by the office of management and budget and revised annually in accordance with United States Code, title 42, section 9902, as amended ~~through December 31, 1982~~, or ~~that the person is pregnant~~

~~and~~ determined ~~eligible for~~ to meet the income eligibility requirements of medical assistance, MinnesotaCare, or the special supplemental food program for women, infants and children (WIC). The commissioner shall establish the low income level for eligibility for services to children with handicaps.

Sec. 2. Minnesota Statutes 1992, section 148C.01, subdivision 3, is amended to read:

Subd. 3. **OTHER TITLES.** For the purposes of sections 148C.01 to 148C.11 and 595.02, subdivision 1, all individuals, except as provided in section 148C.11, who practice~~, as their main vocation,~~ chemical dependency counseling as defined in subdivision 2, regardless of their titles, shall be covered by sections 148C.01 to 148C.11. This includes, but is not limited to, individuals who may refer to themselves as "alcoholism counselor," "drug abuse therapist," "chemical dependency recovery counselor," "chemical dependency relapse prevention planner," "addiction therapist," "chemical dependency intervention specialist," "family chemical dependency counselor," "chemical health specialist," "chemical health coordinator," and "substance abuse counselor."

Sec. 3. Minnesota Statutes 1992, section 148C.01, subdivision 6, is amended to read:

Subd. 6. **COMMISSIONER.** "Commissioner" means the commissioner of ~~human services~~ health.

Sec. 4. Minnesota Statutes 1992, section 148C.02, is amended to read:

148C.02 **CHEMICAL DEPENDENCY COUNSELING LICENSING ADVISORY COUNCIL.**

Subdivision 1. **MEMBERSHIP; STAFF.** (a) The chemical dependency counseling licensing advisory council consists of 13 members. The ~~governor~~ commissioner shall appoint:

(1) except for those members initially appointed, seven members who must be licensed chemical dependency counselors;

(2) three members who must be public members as defined by section 214.02;

(3) one member who must be a director or coordinator of an accredited chemical dependency training program; and

(4) one member who must be a former consumer of chemical dependency counseling service and who must have received the service more than three years before the person's appointment.

The American Indian advisory committee to the department of human services chemical dependency office shall appoint the remaining member.

(b) The provision of staff, administrative services, and office space are as provided in chapter 214.

Subd. 2. **DUTIES.** ~~The council shall study the provision of chemical dependency counseling and advise the commissioner, the profession, and the public.~~ The commissioner, after consultation with the advisory council, shall:

(1) develop rules for the licensure of chemical dependency counselors; and

(2) administer or contract for the competency testing, licensing, and ethical review of chemical dependency counselors.

Sec. 5. Minnesota Statutes 1992, section 148C.03, subdivision 1, is amended to read:

Subdivision 1. **GENERAL.** The commissioner shall:

(a) adopt and enforce rules for licensure of chemical dependency counselors and for regulation of professional conduct. The rules must be designed to protect the public;

(b) adopt rules establishing standards and methods of determining whether applicants and licensees are qualified under section 148C.04. The rules must provide for examinations ~~and must;~~ establish standards for professional conduct, including adoption of a professional code of ethics; and provide for sanctions as described in section 148C.09;

(c) hold examinations at least twice a year to assess applicants' knowledge and skills. The examinations ~~may~~ must be written ~~or~~ and oral and may be administered by the commissioner or by a nonprofit agency under contract with the commissioner to administer the licensing examinations. Examinations must minimize cultural bias and must be balanced in various theories relative to practice of chemical dependency;

(d) issue licenses to individuals qualified under sections 148C.01 to 148C.11;

(e) issue copies of the rules for licensure to all applicants;

(f) establish and implement procedures, including a standard disciplinary process and a code of ethics, to ensure that individuals licensed as chemical dependency counselors will comply with the commissioner's rules;

(g) establish, maintain, and publish annually a register of current licensees;

(h) establish initial and renewal application and examination fees sufficient to cover operating expenses of the commissioner;

(i) educate the public about the existence and content of the rules for chemical dependency counselor licensing to enable consumers to file complaints against licensees who may have violated the rules; and

(j) evaluate the rules in order to refine and improve the methods used to enforce the commissioner's standards.

Sec. 6. Minnesota Statutes 1992, section 148C.03, subdivision 2, is amended to read:

Subd. 2. **CONTINUING EDUCATION COMMITTEE.** The commissioner shall appoint or contract for a continuing education committee of five persons, including a chair, which shall advise the commissioner on the administration of continuing education requirements in section 148C.05, subdivision 2.

Sec. 7. Minnesota Statutes 1992, section 148C.03, subdivision 3, is amended to read:

Subd. 3. **RESTRICTIONS ON MEMBERSHIP.** A member or an employee of the ~~department~~ entity that carries out the functions under this section may not be an officer, employee, or paid consultant of a trade association in the counseling services industry.

Sec. 8. Minnesota Statutes 1992, section 148C.04, subdivision 2, is amended to read:

Subd. 2. **FEE.** Each applicant shall pay a nonrefundable fee set by the commissioner. Fees paid to the commissioner shall be deposited in the ~~general~~ special revenue fund.

Sec. 9. Minnesota Statutes 1992, section 148C.04, subdivision 3, is amended to read:

Subd. 3. **LICENSING REQUIREMENTS FOR CHEMICAL DEPENDENCY COUNSELOR; EVIDENCE.** (a) To be licensed as a chemical dependency counselor, an applicant must meet the requirements in clauses (1) to (3).

(1) Except as provided in subdivision 4, the applicant must have received an associate degree including 270 clock hours of chemical dependency education and 880 clock hours of chemical dependency practicum.

(2) The applicant must have completed a written ~~and oral~~ case presentation and oral examination that demonstrates competence in the 12 core functions.

(3) The applicant must have satisfactorily passed a written examination as established by the commissioner.

(b) To be licensed as a chemical dependency counselor, an applicant must furnish evidence satisfactory to the commissioner that the applicant has met the requirements of paragraph (a).

Sec. 10. Minnesota Statutes 1992, section 148C.04, subdivision 4, is amended to read:

Subd. 4. **ADDITIONAL LICENSING REQUIREMENTS.** Beginning five years after the effective date of ~~sections 148C.01 to 148C.11~~ the rules authorized in section 148C.03, subdivision 1, an applicant for licensure must have received a bachelor's degree in a human services area, and must have completed 480 clock hours of chemical dependency education and 880 clock hours of chemical dependency practicum.

Sec. 11. Minnesota Statutes 1992, section 148C.05, subdivision 2, is amended to read:

Subd. 2. **CONTINUING EDUCATION.** At the time of renewal, each licensee shall furnish evidence satisfactory to the commissioner that the licensee has completed ~~annually~~ at least the equivalent of 40 clock hours of continuing professional postdegree education every two years, in programs approved by the commissioner, and that the licensee continues to be qualified to practice under sections 148C.01 to 148C.11.

Sec. 12. Minnesota Statutes 1992, section 148C.06, is amended to read:

148C.06 ~~**LICENSE WITHOUT EXAMINATION;**~~ **TRANSITION PERIOD.**

For two years from ~~July 1, 1993~~ the effective date of the rules authorized in section 148C.03, subdivision 1, the commissioner shall issue a license without examination to an applicant if the applicant meets one of the following qualifications:

(a) is credentialed as a certified chemical dependency counselor (CCDC) or certified chemical dependency counselor reciprocal (CCDCR) by the Institute for Chemical Dependency Professionals of Minnesota, Inc.;

(b) has three years or 6,000 hours of supervised chemical dependency counselor experience as defined by the 12 core functions, 270 clock hours of chemical dependency training, 300 hours of chemical dependency practicum, and has successfully completed ~~a written and oral test~~ the requirements in section 148C.04, subdivision 3, paragraph (a), clauses (2) and (3);

(c) has five years or 10,000 hours of chemical dependency counselor experience as defined by the 12 core functions, 270 clock hours of chemical dependency training, and has successfully completed ~~a written or oral test~~ the requirements in section 148C.04, subdivision 3, paragraph (a), clause (2) or (3), or is credentialed as a certified chemical dependency practitioner (CCDP) by the Institute for Chemical Dependency Professionals of Minnesota, Inc.; or

(d) has seven years or 14,000 hours of supervised chemical dependency counselor experience as defined by the 12 core functions and 270 clock hours of chemical dependency training with 60 hours of this training occurring within the past five years.

~~After July 1, 1995,~~ Beginning two years after the effective date of the rules authorized in section 148C.03, subdivision 1, no person may be licensed without ~~passing the examination~~ meeting the requirements in section 148C.04, subdivision 3, paragraph (a), clauses (2) and (3).

Sec. 13. Minnesota Statutes 1992, section 148C.11, subdivision 3, is amended to read:

Subd. 3. **FEDERALLY RECOGNIZED TRIBES AND PRIVATE NONPROFIT AGENCIES WITH A MINORITY FOCUS.** (a) The licensing of chemical dependency counselors who are employed by federally recognized tribes shall be voluntary.

(b) The commissioner shall develop special licensing criteria for issuance of a license to chemical dependency counselors who: (1) are members of ethnic minority groups; and (2) are employed by private, nonprofit agencies, including agencies operated by private, nonprofit hospitals, whose primary agency service focus addresses ethnic minority populations. These licensing criteria may differ from the licensing criteria specified in section 148C.04. To develop these criteria, the commissioner shall establish a committee comprised of but not limited to representatives from the council on hearing impaired, the council on affairs of Spanish-speaking people, the council on Asian-Pacific Minnesotans, the council on Black Minnesotans, and the Indian affairs council.

Sec. 14. Minnesota Statutes 1992, section 148C.11, is amended by adding a subdivision to read:

Subd. 5. **CITY, COUNTY, AND STATE AGENCY CHEMICAL DEPENDENCY COUNSELORS.** The licensing of city, county, and state agency chemical dependency counselors shall be voluntary. City, county, and state agencies employing chemical dependency counselors shall not be required to employ licensed chemical dependency counselors, nor shall they require their chemical dependency counselors to be licensed.

Sec. 15. Minnesota Statutes 1992, section 214.01, subdivision 2, is amended to read:

Subd. 2. **HEALTH-RELATED LICENSING BOARD.** "Health-related licensing board" means the board of examiners of nursing home administrators established pursuant to section 144A.19, the board of medical practice created pursuant to section 147.01, the board of nursing created pursuant to section 148.181, the board of chiropractic examiners established pursuant to section 148.02, the board of optometry established pursuant to section 148.52, the board of psychology established pursuant to section 148.90, the social work licensing board pursuant to section 148B.19, the board of marriage and family therapy pursuant to section 148B.30, the mental health practitioner advisory council established pursuant to section 148B.62, the chemical dependency counseling licensing advisory council established pursuant to section 148C.02, the

board of dentistry established pursuant to section 150A.02, the board of pharmacy established pursuant to section 151.02, the board of podiatric medicine established pursuant to section 153.02, and the board of veterinary medicine, established pursuant to section 156.01.

Sec. 16. Minnesota Statutes 1992, section 252A.101, subdivision 7, is amended to read:

Subd. 7. **LETTERS OF GUARDIANSHIP.** Letters of guardianship or conservatorship must be issued by the court and contain:

(1) ~~the name, address, and telephone number of the person delegated by the commissioner to act as the guardian or conservator;~~

~~(2)~~ the name, address, and telephone number of the ward or conservatee; and

~~(3)~~ (2) the powers to be exercised on behalf of the ward or conservatee.

The letters must be served by mail upon the ward or conservatee, the ward's counsel, the commissioner, and the local agency.

Sec. 17. Minnesota Statutes 1992, section 252A.111, subdivision 4, is amended to read:

Subd. 4. **APPOINTMENT OF GUARDIAN OR CONSERVATOR OF THE ESTATE.** If the ward has a personal estate beyond that which is necessary for the ward's personal and immediate needs, the commissioner shall determine whether a guardian of the estate ~~has been~~ should be appointed ~~for the ward. If no guardian of the estate has been appointed,~~ The commissioner~~, after consulting~~ shall consult with the parents, spouse, or nearest relative of the ward~~.~~. The commissioner may petition the probate court for the appointment of a private guardian or conservator of the estate of the ward. The commissioner cannot act as guardian or conservator of the estate for public wards or public conservatees.

Sec. 18. **[254A.085] HENNEPIN COUNTY PILOT ALTERNATIVE FOR CHEMICAL DEPENDENCY SERVICES.**

The commissioner of human services shall grant variances from the requirements of Minnesota Rules, parts 9530.4100 to 9530.4450, and the commissioner of health shall grant variances from the requirements of Minnesota Rules, parts 4665.0100 to 4665.9900, that are consistent with the provisions of this section and do not compromise the health or safety of the clients, to establish a nonmedical detoxification pilot program in Hennepin county. The program shall be designed to provide care in a secure shelter for persons diverted or referred from detoxification facilities, so as to prevent chronic recidivism and ensure appropriate treatment referrals for persons who are chemically dependent. For purposes of this section, a "secure shelter" is a facility licensed by the commissioner of human services under Minnesota Rules, parts 9530.4100 to 9530.4450, and this

section, and by the commissioner of health as a supervised living facility to provide care for chemically dependent persons. A secure shelter is considered a treatment facility under section 253B.02, subdivision 19. The secure facility authorized by this section shall be licensed by the commissioner of human services only after the county has entered into a contract for the detoxification program authorized by section 254A.086.

The pilot program established under this section must have standards for using video and advocacy group members for monitoring and surveillance to ensure the safety of clients and staff. In addition, in hiring staff, the program must ensure that the criminal background check requirements of Minnesota Rules, part 9543.3040, are met; and the commissioner of human services must ensure compliance with Minnesota Rules, parts 9543.3000 to 9543.3090. The program administrator and all staff of a secure shelter who observe or have personal knowledge of violations of section 626.556 or 626.557 must report to the office of the ombudsman for mental health and mental retardation within 24 hours of its occurrence, any serious injury, as defined in section 245.91, subdivision 6, or the death of a person admitted to the shelter. The ombudsman shall acknowledge in writing the receipt of all reports made to the ombudsman's office under this section. Acknowledgment must be mailed to the facility and to the county social service agency within five working days of the day the report was made. In addition, the program administrator and staff of the facility must comply with all of the requirements of section 626.557, the vulnerable adults act. If the program administrator does not suspend the alleged perpetrator during the pendency of the investigation, reasons for not doing so must be given to the ombudsman in writing.

The licenseholder, in coordination with the commissioner of human services, shall keep detailed records of admissions, length of stay, client outcomes according to standards set by the commissioner, discharge destinations, referrals, and costs of the program. The commissioner of human services shall report to the legislature by February 15, 1996, on the operation of the program and shall include recommendations on whether such a program has been shown to be an effective, safe, and cost-efficient way to serve clients.

Sec. 19. **[254A.086] CULTURALLY TARGETED DETOXIFICATION PROGRAM.**

The commissioner of human services shall provide technical assistance to enable development of a special program designed to provide culturally targeted detoxification services in accordance with section 254A.08, subdivision 2. The program must meet the standards of Minnesota Rules, parts 9530.4100 to 9530.4450, as they apply to detoxification programs. The program established under this section must have standards for using video and advocacy group members for monitoring and surveillance to ensure the safety of clients and staff. In addition, in hiring staff, the program must ensure that the criminal background check requirements of Minnesota Rules, part 9543.3040, are met;

and the commissioner of human services must ensure compliance with Minnesota Rules, parts 9543.3000 to 9543.3090. The program administrator and all staff of the facility must report to the office of the ombudsman for mental health and mental retardation within 24 hours of its occurrence, any serious injury, as defined in section 245.91, subdivision 6, or the death of a person admitted to the shelter. The ombudsman shall acknowledge in writing the receipt of all reports made to the ombudsman's office under this section. Acknowledgment must be mailed to the facility and to the county social service agency within five working days of the day the report was made. In addition, the program administrator and staff of the facility must comply with all of the requirements of section 626.557, the vulnerable adults act. The program shall be designed with a community outreach component and shall provide services to clients in a safe environment and in a culturally specific manner.

Sec. 20. Minnesota Statutes 1992, section 254A.17, subdivision 3, is amended to read:

Subd. 3. **STATEWIDE DETOXIFICATION TRANSPORTATION PROGRAM.** The commissioner shall provide grants to counties, Indian reservations, other nonprofit agencies, or local detoxification programs for provision of transportation of intoxicated individuals to detoxification programs, to open shelters, and to secure shelters as defined in section 254A.085 and shelters serving intoxicated persons. In state fiscal years 1994 and 1995, funds shall be allocated to counties in proportion to each county's allocation in fiscal year 1993. In subsequent fiscal years, funds shall be allocated among counties annually in proportion to each county's average number of detoxification admissions for the prior two years, except that no county shall receive less than $400. Unless a county has approved a grant of funds under this section, the commissioner shall make quarterly payments of detoxification funds to a county only after receiving an invoice describing the number of persons transported and the cost of transportation services for the previous quarter. The program administrator and all staff of the program must report to the office of the ombudsman for mental health and mental retardation within 24 hours of its occurrence, any serious injury, as defined in section 245.91, subdivision 6, or the death of a person admitted to the shelter. The ombudsman shall acknowledge in writing the receipt of all reports made to the ombudsman's office under this section. Acknowledgment must be mailed to the facility and to the county social service agency within five working days of the day the report was made. In addition, the program administrator and staff of the program must comply with all of the requirements of section 626.557, the vulnerable adults act.

Sec. 21. Minnesota Statutes 1992, section 254B.06, subdivision 3, is amended to read:

Subd. 3. **PAYMENT; DENIAL.** The commissioner shall pay eligible vendors for placements made by local agencies under section 254B.03, subdivision 1, and placements by tribal designated agencies according to section 254B.09.

The commissioner may reduce or deny payment of the state share when services are not provided according to the placement criteria established by the commissioner. The commissioner may pay for all or a portion of improper county chemical dependency placements and bill the county for the entire payment made when the placement did not comply with criteria established by the commissioner. The commissioner may make payments to vendors and charge the county 100 percent of the payments if documentation of a county approved placement is received more than 30 working days, exclusive of weekends and holidays, after the date services began; or if the county approved invoice is received by the commissioner more than 120 days after the last date of service provided. The commissioner shall not pay vendors until private insurance company claims have been settled.

Sec. 22. **[256.8711] EMERGENCY ASSISTANCE; INTENSIVE FAMILY PRESERVATION SERVICES.**

Subdivision 1. **SCOPE OF SERVICES.** For a family experiencing an emergency as defined in subdivision 2, and for whom the county authorizes services under subdivision 3, intensive family preservation services authorized under this section are:

(1) crisis family-based services;

(2) counseling family-based services; and

(3) mental health family-based services.

Intensive family preservation services also include family-based life management skills when it is provided in conjunction with any of the three family-based services in this subdivision. The intensive family preservation services in clauses (1), (2), and (3) and life management skills have the meanings given in section 256F.03, subdivision 5, paragraphs (a), (b), (c), and (e).

Subd. 2. **DEFINITION OF EMERGENCY.** For the purposes of this section, an emergency is a situation in which the dependent children are at risk for out of home placement due to abuse, neglect, or delinquency; or when the children are returning home from placements but need services to prevent another placement; or when the parents are unable to provide care.

Subd. 3. **COUNTY AUTHORIZATION.** The county agency shall assess current and prospective client families with a dependent under 21 years of age to determine if there is an emergency, as defined in subdivision 2, and to determine if there is a need for intensive family preservation services. Upon such determinations, during the period October 1, 1993 to September 30, 1995, counties shall authorize intensive family preservation services for up to 90 days for eligible families under this section and under section 256.871, subdivisions 1 and 3. Effective October 1, 1995, the counties' obligations to continue the base level of expenditures and to expand family preservation services as defined in

section 256F.03, subdivision 5, are eliminated, with the termination of the federal revenue earned under this section.

Subd. 4. **COST TO FAMILIES.** Family preservation services provided under this section or sections 256F.01 to 256F.07 shall be provided at no cost to the client and without regard to the client's available income or assets.

Subd. 5. **EMERGENCY ASSISTANCE RESERVE.** The commissioner shall establish an emergency assistance reserve for families who receive intensive family preservation services under this section. A family is eligible to receive assistance once from the emergency assistance reserve if it received intensive family preservation services under this section within the past 12 months, but has not received emergency assistance under section 256.871 during that period. The emergency assistance reserve shall cover the cost of the federal share of the assistance that would have been available under section 256.871, except for the provision of intensive family preservation services provided under this section. The emergency assistance reserve shall be authorized and paid in the same manner as emergency assistance is provided under section 256.871. Funds set aside for the emergency assistance reserve that are not needed as determined by the commissioner shall be distributed by the terms of subdivision 6, paragraph (a).

Subd. 6. **DISTRIBUTION OF NEW FEDERAL REVENUE.** (a) All federal funds not set aside under paragraph (b), and at least 50 percent of all federal funds earned under this section and earned through assessment activity under subdivision 3, shall be paid to each county based on its earnings and assessment activity, respectively, and shall be used by each county to expand family preservation services as defined in section 256F.03, subdivision 5, and may be used to expand crisis nursery services. If a county joins a local children's mental health collaborative as authorized by the 1993 legislature, then the federal reimbursement received under this paragraph by the county for providing intensive family preservation services to children served by the local collaborative shall be transferred by the county to the integrated fund. The federal reimbursement transferred to the integrated fund by the county must be used for intensive family preservation services as defined in section 256F.03, subdivision 5, to the target population.

(b) The commissioner shall set aside a portion, not to exceed 50 percent, of the federal funds earned under this section and earned through assessment activity described under subdivision 3. The set aside funds shall be used to expand intensive family preservation services statewide and establish an emergency assistance reserve as provided in subdivision 5. Except for the portion needed for the emergency assistance reserve provided in subdivision 5, the commissioner may distribute the funds set aside through grants to a county or counties to establish and maintain approved intensive family preservation services statewide. Funds available for crisis family-based services through section 256F.05, subdivision 8, shall be considered in establishing intensive family preservation services statewide. The commissioner may phase in intensive family preserva-

tion services in a county or group of counties as new federal funds become available. The commissioner's priority is to establish a minimum level of intensive family preservation services statewide.

Subd. 7. **EXPANSION OF SERVICES AND BASE LEVEL OF EXPENDITURES.** (a) Counties must continue the base level of expenditures for family preservation services as defined in section 256F.03, subdivision 5, from any state, county, or federal funding source, which, in the absence of federal funds earned under this section and earned through assessment activity described under subdivision 3, would have been available for these services. The commissioner shall review the county expenditures annually, using reports required under sections 245.482, 256.01, subdivision 2, paragraph (17), and 256E.08, subdivision 8, to ensure that the base level of expenditures for family preservation services as defined in section 256F.03, subdivision 5, is continued from sources other than the federal funds earned under this section and earned through assessment activity described under subdivision 3.

(b) The commissioner may reduce, suspend, or eliminate either or both of a county's obligations to continue the base level of expenditures and to expand family preservation services as defined in section 256F.03, subdivision 5, if the commissioner determines that one or more of the following conditions apply to that county:

(1) imposition of levy limits that significantly reduce available social service funds;

(2) reduction in the net tax capacity of the taxable property within a county that significantly reduces available social service funds;

(3) reduction in the number of children under age 19 in the county by 25 percent when compared with the number in the base year using the most recent data provided by the state demographer's office; or

(4) termination of the federal revenue earned under this section.

(c) The commissioner may suspend for one year either or both of a county's obligations to continue the base level of expenditures and to expand family preservation services as defined in section 256F.03, subdivision 5, if the commissioner determines that in the previous year one or more of the following conditions applied to that county:

(1) the unduplicated number of families who received family preservation services under section 256F.03, subdivision 5, paragraphs (a), (b), (c), and (e), equals or exceeds the unduplicated number of children who entered placement under sections 257.071 and 393.07, subdivisions 1 and 2 during the year;

(2) the total number of children in placement under sections 257.071 and 393.07, subdivisions 1 and 2, has been reduced by 50 percent from the total number in the base year; or

(3) the average number of children in placement under sections 257.071 and 393.07, subdivisions 1 and 2, on the last day of each month is equal to or less than one child per 1,000 children in the county.

(d) For the purposes of this section, the base year is calendar year 1992. For the purposes of this section, the base level of expenditures is the level of county expenditures in the base year for eligible family preservation services under section 256F.03, subdivision 5, paragraphs (a), (b), (c), and (e).

Subd. 8. **COUNTY RESPONSIBILITIES.** (a) Notwithstanding section 256.871, subdivision 6, for intensive family preservation services provided under this section, the county agency shall submit quarterly fiscal reports as required under section 256.01, subdivision 2, clause (17), and provide the nonfederal share.

(b) County expenditures eligible for federal reimbursement under this section must not be made from federal funds or funds used to match other federal funds.

(c) The commissioner may suspend, reduce, or terminate the federal reimbursement to a county that does not meet the reporting or other requirements of this section.

Subd. 9. **PAYMENTS.** Notwithstanding section 256.025, subdivision 2, payments to counties for social service expenditures for intensive family preservation services under this section shall be made only from the federal earnings under this section and earned through assessment activity described under subdivision 3. Counties may use up to ten percent of federal earnings received under subdivision 6, paragraph (a), to cover costs of income maintenance activities related to the operation of this section and sections 256B.094 and 256F.10.

Subd. 10. **COMMISSIONER RESPONSIBILITIES.** The commissioner in consultation with counties shall analyze state funding options to cover costs of counties' base level expenditures and any expansion of the nonfederal share of intensive family preservation services resulting from implementation of this section. The commissioner shall also study problems of implementation, barriers to maximizing federal revenue, and the impact on out-of-home placements of implementation of this section. The commissioner shall report to the legislature on the results of this analysis and study, together with recommendations, by February 15, 1995.

Sec. 23. Minnesota Statutes 1992, section 256B.0625, is amended by adding a subdivision to read:

Subd. 33. **CHILD WELFARE TARGETED CASE MANAGEMENT.** Medical assistance, subject to federal approval, covers child welfare targeted case management services as defined in section 256B.094 to children under age 21 who have been assessed and determined in accordance with section 256F.11 to be:

(1) at risk of placement or in placement as defined in section 257.071, subdivision 1;

(2) at risk of maltreatment or experiencing maltreatment as defined in section 626.556, subdivision 10e; or

(3) in need of protection or services as defined in section 260.015, subdivision 2a.

Sec. 24. **[256B.094] CHILD WELFARE TARGETED CASE MANAGEMENT SERVICES.**

Subdivision 1. **DEFINITION.** "Child welfare targeted case management services" means activities that coordinate social and other services designed to help the child under age 21 and the child's family gain access to needed social services, mental health services, habilitative services, educational services, health services, vocational services, recreational services, and related services including, but not limited to, the areas of volunteer services, advocacy, transportation, and legal services. Case management services include developing an individual service plan and assisting the child and the child's family in obtaining needed services through coordination with other agencies and assuring continuity of care. Case managers must assess the delivery, appropriateness, and effectiveness of services on a regular basis.

Subd. 2. **ELIGIBLE SERVICES.** Services eligible for medical assistance reimbursement include:

(1) assessment of the recipient's need for case management services to gain access to medical, social, educational, and other related services;

(2) development, completion, and regular review of a written individual service plan based on the assessment of need for case management services to ensure access to medical, social, educational, and other related services;

(3) routine contact or other communication with the client, the client'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, regarding the status of the client, the individual service plan, or the goals for the client, exclusive of transportation of the child;

(4) coordinating referrals for, and the provision of, case management services for the client 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;

(6) monitoring and evaluating services on a regular basis to ensure appropriateness and continued need;

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

(8) traveling to conduct a visit with the client or other relevant person necessary to the development or implementation of the goals of the individual service plan; and

(9) coordinating with the medical assistance facility discharge planner in the 30-day period before the client's discharge into the community. This case management service provided to patients or residents in a medical assistance facility is limited to a maximum of two 30-day periods per calendar year.

Subd. 3. **COORDINATION AND PROVISION OF SERVICES.** (a) In a county where a prepaid medical assistance provider has contracted under section 256B.031 or 256B.69 to provide mental health services, the case management provider shall coordinate with the prepaid provider to ensure that all necessary mental health services required under the contract are provided to recipients of case management services.

(b) When the case management provider determines that a prepaid provider is not providing mental health services as required under the contract, the case management provider shall assist the recipient to appeal the prepaid provider's denial pursuant to section 256.045, and may make other arrangements for provision of the covered services.

(c) The case management provider may bill the provider of prepaid health care services for any mental health services provided to a recipient of case management services which the county arranges for or provides and which are included in the prepaid provider's contract, and which were determined to be medically necessary as a result of an appeal pursuant to section 256.045. The prepaid provider must reimburse the mental health provider, at the prepaid provider's standard rate for that service, for any services delivered under this subdivision.

(d) If the county has not obtained prior authorization for this service, or an appeal results in a determination that the services were not medically necessary, the county may not seek reimbursement from the prepaid provider.

Subd. 4. **CASE MANAGEMENT PROVIDER.** To be eligible to receive medical assistance reimbursement, the case management provider must meet all provider qualification and certification standards under section 256F.10.

Subd. 5. **CASE MANAGER.** To provide case management services, a case manager must be employed by and authorized by the case management provider to provide case management services and meet all requirements under section 256F.10.

Subd. 6. **MEDICAL ASSISTANCE REIMBURSEMENT OF CASE**

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

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

(2) for a client placed outside of the county of financial responsibility in an excluded time facility under section 256G.02, subdivision 6, or through the interstate compact on the placement of children, section 257.40, and the placement in either case is more than 60 miles beyond the county boundaries, there must be at least one contact per month and not more than two consecutive months without a face-to-face contact.

(b) 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.

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 shall be distributed according to earnings, to counties or groups of counties which have the same payment rate under this subdivision, and to the group of counties 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.

Subd. 7. **DOCUMENTATION FOR CASE RECORD AND CLAIM.** (a) The assessment, case finding, and individual service plan shall be maintained in the individual case record under the data practices act, chapter 13. The individual service plan must be reviewed at least annually and updated as necessary. Each individual case record must maintain documentation of routine, ongoing, contacts and services. Each claim must be supported by written documentation in the individual case record.

(b) Each claim must include:

(1) the name of the recipient;

(2) the date of the service;

(3) the name of the provider agency and the person providing service;

(4) the nature and extent of services; and

(5) the place of the services.

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;

(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. 25. Minnesota Statutes 1992, section 256F.06, subdivision 2, is amended to read:

Subd. 2. **USES OF GRANTS.** The grant must be used exclusively for family-based services. ~~The grant may not be used as a match for other federal money or to meet the requirements of section 256E.06, subdivision 5.~~

Sec. 26. **[256F.10] CHILD WELFARE TARGETED CASE MANAGEMENT.**

Subdivision 1. **ELIGIBILITY.** Persons under 21 years of age who are eligi-

ble to receive medical assistance are eligible for child welfare targeted case management services under section 256B.094 and this section if they have received an assessment and have been determined by the local county agency to be:

(1) at risk of placement or in placement as described in section 257.071, subdivision 1;

(2) at risk of maltreatment or experiencing maltreatment as defined in section 626.556, subdivision 10e; or

(3) in need of protection or services as defined in section 260.015, subdivision 2a.

Subd. 2. **AVAILABILITY OF SERVICES.** Child welfare targeted case management services are available from providers meeting qualification requirements and the certification standards specified in subdivision 4. Eligible recipients may choose any certified provider of child welfare targeted case management services.

Subd. 3. **VOLUNTARY PROVIDER PARTICIPATION.** Providers may seek certification for medical assistance reimbursement to provide child welfare targeted case management services. The certification process is initiated by submitting a written statement of interest to the commissioner.

Certified providers may elect to discontinue participation by a written notice to the commissioner at least 120 days before the end of the final calendar quarter of participation.

Subd. 4. **PROVIDER QUALIFICATIONS AND CERTIFICATION STANDARDS.** The commissioner must certify each provider before enrolling it as a child welfare targeted case management provider of services under section 256B.094 and this section. The certification process shall examine the provider's ability to meet the qualification requirements and certification standards in this subdivision and other federal and state requirements of this service. A certified child welfare targeted case management provider is an enrolled medical assistance provider who is determined by the commissioner to have all of the following:

(1) the legal authority to provide public welfare under sections 393.01, subdivision 7, and 393.07;

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

(3) administrative capacity and experience in serving the target population for whom it will provide services and in ensuring quality of services under state and federal requirements;

(4) the legal authority to provide complete investigative and protective services under section 626.556, subdivision 10, and child welfare and foster care services under section 393.07, subdivisions 1 and 2;

(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.

Subd. 5. **CASE MANAGERS.** Case managers are individuals employed by and authorized by the certified child welfare targeted case management provider to provide case management services under section 256B.094 and this section. A case manager must have:

(1) skills in identifying and assessing a wide range of children's needs;

(2) knowledge of local child welfare and a variety of community resources and effective use of those resources for the benefit of the child; and

(3) a bachelor's degree in social work, psychology, sociology, or a closely related field from an accredited four-year college or university; or a bachelor's degree from an accredited four-year college or university in a field other than social work, psychology, sociology or a closely related field, plus one year of experience in the delivery of social services to children as a supervised social worker in a public or private social services agency.

Subd. 6. **DISTRIBUTION OF NEW FEDERAL REVENUE.** (a) Except for portion set aside in paragraph (b), the federal funds earned under this section and section 256B.094 by counties shall be paid to each county based on its earnings, and must be used by each county to expand preventive child welfare services.

If a county chooses to be a provider of child welfare targeted case management and if that county also joins a local children's mental health collaborative as authorized by the 1993 legislature, then the federal reimbursement received by the county for providing child welfare targeted case management services to children served by the local collaborative shall be transferred by the county to the integrated fund. The federal reimbursement transferred to the integrated fund by the county must not be used for residential care other than respite care described under subdivision 7, paragraph (d).

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

(1) the costs of developing and implementing this section and sections 256.8711 and 256B.094;

(2) programming the information systems; and

(3) the lost federal revenue for the central office claim directly caused by the implementation of these sections.

Any unexpended funds from the set aside under this paragraph shall be distributed to counties according to paragraph (a).

Subd. 7. **EXPANSION OF SERVICES AND BASE LEVEL OF EXPENDITURES.** (a) Counties must continue the base level of expenditures for preventive child welfare services from either or both of any state, county, or federal funding source, which, in the absence of federal funds earned under this section, would have been available for these services. The commissioner shall review the county expenditures annually using reports required under sections 245.482, 256.01, subdivision 2, paragraph 17, and 256E.08, subdivision 8, to ensure that the base level of expenditures for preventive child welfare services is continued from sources other than the federal funds earned under this section.

(b) The commissioner may reduce, suspend, or eliminate either or both of a county's obligations to continue the base level of expenditures and to expand child welfare preventive services if the commissioner determines that one or more of the following conditions apply to that county:

(1) imposition of levy limits that significantly reduce available social service funds;

(2) reduction in the net tax capacity of the taxable property within a county that significantly reduces available social service funds;

(3) reduction in the number of children under age 19 in the county by 25 percent when compared with the number in the base year using the most recent data provided by the state demographer's office; or

(4) termination of the federal revenue earned under this section.

(c) The commissioner may suspend for one year either or both of a county's obligations to continue the base level of expenditures and to expand child welfare preventive services if the commissioner determines that in the previous year one or more of the following conditions applied to that county:

(1) the total number of children in placement under sections 257.071 and 393.07, subdivisions 1 and 2, has been reduced by 50 percent from the total number in the base year; or

(2) the average number of children in placement under sections 257.071 and 393.07, subdivisions 1 and 2, on the last day of each month is equal to or less than one child per 1,000 children in the county.

(d) For the purposes of this section, child welfare preventive services are

those services directed toward a specific child or family that further the goals of section 256F.01 and include assessments, family preservation services, service coordination, community-based treatment, crisis nursery services when the parents retain custody and there is no voluntary placement agreement with a child placing agency, respite care except when it is provided under a medical assistance waiver, home-based services, and other related services. For the purposes of this section, child welfare preventive services shall not include shelter care placements under the authority of the court or public agency to address an emergency, residential services except for respite care, child care for the purposes of employment and training, adult services, services other than child welfare targeted case management when they are provided under medical assistance, placement services, or activities not directed toward a specific child or family. Respite care must be planned, routine care to support the continuing residence of the child with its family or long-term primary caretaker and must not be provided to address an emergency.

(e) For the counties beginning to claim federal reimbursement for services under this section and section 256B.094, the base year is the calendar year ending at least two calendar quarters before the first calendar quarter in which the county begins claiming reimbursement. For the purposes of this section, the base level of expenditures is the level of county expenditures in the base year for eligible child welfare preventive services described in this subdivision.

Subd. 8. **PROVIDER RESPONSIBILITIES.** (a) Notwithstanding section 256B.19, subdivision 1, for the purposes of child welfare targeted case management under section 256B.094 and this section, the nonfederal share of costs shall be provided by the provider of child welfare targeted case management from sources other than federal funds or funds used to match other federal funds.

(b) Provider expenditures eligible for federal reimbursement under this section must not be made from federal funds or funds used to match other federal funds.

(c) The commissioner may suspend, reduce, or terminate the federal reimbursement to a provider that does not meet the reporting or other requirements of section 256B.094 and this section.

Subd. 9. **PAYMENTS.** Notwithstanding section 256.025, subdivision 2, payments to certified providers for child welfare targeted case management expenditures under section 256B.094 and this section shall only be made of federal earnings from services provided under section 256B.094 and this section.

Subd. 10. **CENTRALIZED DISBURSEMENT OF MEDICAL ASSISTANCE PAYMENTS.** Notwithstanding section 256B.041, county payments for the cost of child welfare targeted case management services shall not be made to the state treasurer. For the purposes of child welfare targeted case management services under section 256B.094 and this section, the centralized disbursement of payments to providers under section 256B.041 consists only of federal earnings from services provided under section 256B.094 and this section.

Sec. 27. **[256F.11] GRANT PROGRAM FOR CRISIS NURSERIES.**

Subdivision 1. **CRISIS NURSERIES.** The commissioner of human services shall establish a grant program to assist private and public agencies and organizations to provide crisis nurseries to offer temporary care for children who are abused, neglected, and those children at high risk of abuse and neglect, and children who are in families receiving child protective services. This service shall be provided without fee for a maximum of 30 days in any year. Crisis nurseries shall provide referral to support services and provide family support services as needed.

Subd. 2. **FUND DISTRIBUTION.** In distributing funds, the commissioner shall give priority consideration to agencies and organizations with experience in working with abused or neglected children and their families, and with children at high risk of abuse and neglect and their families, and serve communities which demonstrate the greatest need for these services.

(a) The crisis nurseries must:

(1) be available 24 hours a day, seven days a week;

(2) provide services for children up to three days at any one time;

(3) make referrals for parents to counseling services and other community resources to help alleviate the underlying cause of the precipitating stress or crisis;

(4) provide services without a fee for a maximum of 30 days in any year;

(5) provide services to children from birth to 12 years of age;

(6) provide an initial assessment and intake interview conducted by a skilled professional who will identify the presenting problem and make an immediate referral to an appropriate agency or program to prevent maltreatment and out-of-home placement of children;

(7) maintain the clients' confidentiality to the extent required by law, and also comply with statutory reporting requirements which may mandate a report to child protective services;

(8) contain a volunteer component;

(9) provide preservice training and ongoing training to providers and volunteers;

(10) evaluate the services provided by documenting use of services, the result of family referrals made to community resources, and how the services reduced the risk of maltreatment;

(11) provide age appropriate programming;

(12) provide developmental assessments;

(13) provide medical assessments as determined by using a risk screening tool;

(14) meet United States Department of Agriculture regulations concerning meals and provide three meals a day and three snacks during a 24-hour period; and

(15) provide appropriate sleep and nap arrangements for children.

(b) The crisis nurseries are encouraged to provide:

(1) on-site support groups for facility model programs, or agency sponsored parent support groups for volunteer family model programs;

(2) parent education classes or programs that include parent-child interaction; and

(3) opportunities for parents to volunteer, if appropriate, to assist with child care in a supervised setting in order to enhance their parenting skills and self-esteem, in addition to providing them the opportunity to give something back to the program.

(c) Parents shall retain custody of their children during placement in a crisis facility.

The crisis nurseries are encouraged to include one or more parents who have used the crisis nursery services on the program's multidisciplinary advisory board.

Subd. 3. **EVALUATIONS.** The commissioner of human services shall submit an annual report to the legislature evaluating the program. The report must include information concerning program costs, the number of program participants, the program's impact on family stability, the incidence of abuse and neglect, and all other relevant information determined by the commissioner.

Sec. 28. **[256F.12] GRANT PROGRAM FOR RESPITE CARE.**

Subdivision 1. **RESPITE CARE PROGRAM.** The commissioner of human services shall establish a grant program to provide respite care services to families or caregivers who are under stress and at risk of abusing or neglecting their children, families with children suffering from emotional problems, and families receiving child protective services.

Subd. 2. **SERVICE GOALS.** Respite care programs shall provide temporary services for families or caregivers in order to:

(1) allow the family to engage in the family's usual daily activities;

(2) maintain family stability during crisis situations;

(3) help preserve the family unit by lessening pressures that might lead to divorce, institutionalization, neglect, or child abuse;

(4) provide the family with rest and relaxation;

(5) improve the family's ability to cope with daily responsibilities; and

(6) make it possible for individuals with disabilities to establish independence and enrich their own growth and development.

Subd. 3. **DEFINITION.** "Respite care" means in-home or out-of-home temporary, nonmedical child care for families and caregivers who are under stress and at risk of abusing or neglecting their children, and families with children suffering from emotional problems. Respite care shall be available for time periods varying from one hour to two weeks.

In-home respite care is provided in the home of the person needing care.

Out-of-home respite care will be given in the provider's home or other facility. In these cases, the provider's home or facility must be currently licensed for day care or foster home care.

Subd. 4. **SLIDING FEE SCALE.** The commissioner shall establish a sliding fee scale that takes into account family income, expenses, and ability to pay. Grant funds shall be used to subsidize the respite care of children. Funded projects must:

(1) prevent and reduce mental, physical, and emotional stress on parents and children;

(2) provide training for caregivers;

(3) establish a network of community support groups and resources for families;

(4) conduct an intake assessment in order to identify the presenting problems and make appropriate referrals;

(5) provide age appropriate programming; and

(6) ensure that respite care providers complete at least 120 hours of training in child development, child care, and related issues.

Subd. 5. **EVALUATIONS.** The commissioner of human services shall submit an annual report to the legislature evaluating funded programs. The report must include information concerning program costs, the number of program participants, the impact on family stability, the incidence of abuse and neglect, and all other relevant information determined by the commissioner.

Sec. 29. **[256F.13] FAMILY SERVICES COLLABORATIVE.**

Subdivision 1. **FEDERAL REVENUE ENHANCEMENT. (a) DUTIES OF THE COMMISSIONER OF HUMAN SERVICES.** The commissioner of human services may enter into an agreement with one or more family services collaboratives to enhance federal reimbursement under Title IV-E of the Social Security Act and federal administrative reimbursement under Title XIX of the Social Security Act. The commissioner shall have the following authority and responsibilities regarding family services collaboratives:

(1) the commissioner shall submit amendments to state plans and seek waivers as necessary to implement the provisions of this section;

(2) the commissioner shall pay the federal reimbursement earned under this subdivision to each collaborative based on their earnings. Notwithstanding section 256.025, subdivision 2, payments to collaboratives for expenditures under this subdivision will only be made of federal earnings from services provided by the collaborative;

(3) the commissioner shall review expenditures of family services collaboratives using reports specified in the agreement with the collaborative to ensure that the base level of expenditures is continued and new federal reimbursement is used to expand education, social, health, or health-related services to young children and their families;

(4) the commissioner may reduce, suspend, or eliminate a family services collaborative's obligations to continue the base level of expenditures or expansion of services if the commissioner determines that one or more of the following conditions apply:

(i) imposition of levy limits that significantly reduce available funds for social, health, or health-related services to families and children;

(ii) reduction in the net tax capacity of the taxable property eligible to be taxed by the lead county or subcontractor that significantly reduces available funds for education, social, health, or health-related services to families and children;

(iii) reduction in the number of children under age 19 in the county, collaborative service delivery area, subcontractor's district, or catchment area when compared to the number in the base year using the most recent data provided by the state demographer's office; or

(iv) termination of the federal revenue earned under the family services collaborative agreement;

(5) the commissioner shall not use the federal reimbursement earned under this subdivision in determining the allocation or distribution of other funds to counties or collaboratives;

(6) the commissioner may suspend, reduce, or terminate the federal reimbursement to a provider that does not meet the reporting or other requirements of this subdivision;

(7) the commissioner shall recover from the family services collaborative any federal fiscal disallowances or sanctions for audit exceptions directly attributable to the family services collaborative's actions in the integrated fund, or the proportional share if federal fiscal disallowances or sanctions are based on a statewide random sample; and

(8) the commissioner shall establish criteria for the family services collaborative for the accounting and financial management system that will support claims for federal reimbursement.

(b) **FAMILY SERVICES COLLABORATIVE RESPONSIBILITIES.** The family services collaborative shall have the following authority and responsibilities regarding federal revenue enhancement:

(1) the family services collaborative shall be the party with which the commissioner contracts. A lead county shall be designated as the fiscal agency for reporting, claiming, and receiving payments;

(2) the family services collaboratives may enter into subcontracts with other counties, school districts, special education cooperatives, municipalities, and other public and nonprofit entities for purposes of identifying and claiming eligible expenditures to enhance federal reimbursement, or to expand education, social, health, or health-related services to families and children;

(3) the family services collaborative must continue the base level of expenditures for education, social, health, or health-related services to families and children from any state, county, federal, or other public or private funding source which, in the absence of the new federal reimbursement earned under this subdivision, would have been available for those services, except as provided in subdivision 1, clause (4). The base year for purposes of this subdivision shall be the four-quarter calendar year ending at least two calendar quarters before the first calendar quarter in which the new federal reimbursement is earned;

(4) the family services collaborative must use all new federal reimbursement resulting from federal revenue enhancement to expand expenditures for education, social, health, or health-related services to families and children beyond the base level, except as provided in subdivision 1, clause (4);

(5) the family services collaborative must ensure that expenditures submitted for federal reimbursement are not made from federal funds or funds used to match other federal funds. Notwithstanding section 256B.19, subdivision 1, for the purposes of family services collaborative expenditures under agreement with the department, the nonfederal share of costs shall be provided by the family services collaborative from sources other than federal funds or funds used to match other federal funds;

(6) the family services collaborative must develop and maintain an accounting and financial management system adequate to support all claims for federal reimbursement, including a clear audit trail and any provisions specified in the agreement; and

(7) the family services collaborative shall submit an annual report to the commissioner as specified in the agreement.

Subd. 2. **AGREEMENTS WITH FAMILY SERVICES COLLABORATIVES.** At a minimum, the agreement between the commissioner and the family services collaborative shall include the following provisions:

(1) specific documentation of the expenditures eligible for federal reimbursement;

(2) the process for developing and submitting claims to the commissioner;

(3) specific identification of the education, social, health, or health-related services to families and children which are to be expanded with the federal reimbursement;

(4) reporting and review procedures ensuring that the family services collaborative must continue the base level of expenditures for the education, social, health, or health-related services for families and children as specified in subdivision 2, clause (3);

(5) reporting and review procedures to ensure that federal revenue earned under this section is spent specifically to expand education, social, health, or health-related services for families and children as specified in subdivision 2, clause (4);

(6) the period of time, not to exceed three years, governing the terms of the agreement and provisions for amendments to, and renewal of the agreement; and

(7) an annual report prepared by the family services collaborative.

Subd. 3. **WAIVER OF RULE REQUIREMENTS.** (a) **REQUESTING WAIVERS OF STATE OR FEDERAL RULES.** Local family services collaboratives, including collaboratives in Becker, Cass, and Ramsey counties, shall be encouraged to seek waivers of state or federal rules, as necessary to carry out the purposes of this section. For purposes of this section, "family services collaborative" has the meaning given it in section 121.8355, subdivision 1a.

(b) **WAIVER OF STATE RULES.** In order to receive a waiver of the requirements of any state rule, the collaborative shall submit a request for a variance to the appropriate commissioner. The request shall contain assurances that the waiver will not affect client entitlements to services, will not abridge any rights guaranteed to the client by state or federal law, and will not jeopardize the health or safety of the client. The commissioner shall grant or deny all waiver

requests within 30 days of receiving those requests, by notice to the collaborative and published notice in the State Register.

(c) **WAIVER OF FEDERAL RULES.** A local collaborative seeking a waiver from a federal rule shall submit a request, in writing, to the appropriate commissioner who shall submit the waiver request to the relevant policy committees of the legislature. If the legislative committees approve the request, they shall direct the appropriate state agency to make a reasonable effort to negotiate a waiver of the federal rule. If the legislative committees deny the request for a waiver, they shall jointly notify the local collaborative of the reason for denying the waiver. If a waiver request is approved for submission to federal authorities, the commissioner shall submit all necessary materials to the appropriate federal authorities. The commissioner shall notify the collaborative and the legislative committees of the outcome of the federal waiver request. In every instance in which a federal waiver is granted, the commissioner shall publish notice of receipt of the waiver in the State Register.

Sec. 30. Minnesota Statutes 1992, section 257.3573, is amended by adding a subdivision to read:

Subd. 3. **REVENUE ENHANCEMENT.** The commissioner shall submit claims for federal reimbursement earned through the activities and services supported through Indian child welfare grants. The commissioner may set aside a portion of the federal funds earned under this subdivision to establish and support a new Indian child welfare position in the department of human services to provide program development. The commissioner shall use any federal revenue not set aside to expand services under section 257.3571. The federal revenue earned under this subdivision is available for these purposes until the funds are expended.

Sec. 31. Minnesota Statutes 1992, section 257.803, subdivision 1, is amended to read:

Subdivision 1. **AUTHORITY TO DISBURSE FUNDS.** The commissioner, with the advice and consent of the advisory council established under this section, may disburse trust fund money to any public or private nonprofit agency to fund a child abuse prevention program. State funds appropriated for child maltreatment prevention grants may be transferred to the children's trust fund special revenue account and are available to carry out this section.

Sec. 32. Minnesota Statutes 1992, section 259.40, subdivision 1, is amended to read:

Subdivision 1. ~~**SUBSIDY PAYMENTS**~~ **ADOPTION ASSISTANCE.** The commissioner of human services ~~may make subsidy payments as necessary after the subsidized adoption agreement is approved to~~ shall enter into an adoption assistance agreement with an adoptive parent or parents who adopt a child who meets the eligibility requirements under title IV-E of the Social Security Act,

United States Code, title 42, ~~section~~ sections 670 to 679a, or who otherwise meets the requirements in subdivision 4~~, is a Minnesota resident and is under guardianship of the commissioner or of a licensed child placing agency after the final decree of adoption is issued. The subsidy payments and any subsequent modifications to the subsidy payments shall be based on the needs of the adopted person that the commissioner has determined cannot be met using other resources including programs available to the adopted person and the adoptive parent or parents~~.

Sec. 33. Minnesota Statutes 1992, section 259.40, subdivision 2, is amended to read:

Subd. 2. ~~**SUBSIDY**~~ **ADOPTION ASSISTANCE AGREEMENT.** The placing agency shall certify a child as eligible for ~~a subsidy~~ adoption assistance according to rules promulgated by the commissioner. When a parent or parents are found and approved for adoptive placement of a child certified as eligible for ~~a subsidy~~ adoption assistance, and before the final decree of adoption is issued, a written agreement must be entered into by the commissioner, the adoptive parent or parents, and the placing agency. The written agreement must be in the form prescribed by the commissioner and must set forth the responsibilities of all parties, the anticipated duration of the ~~subsidy~~ adoption assistance payments, and the payment terms. The ~~subsidy~~ adoption assistance agreement shall be subject to the commissioner's approval.

The ~~commissioner shall provide adoption subsidies to the adoptive parent or parents according to the terms of the subsidy agreement. The subsidy may include payment for basic maintenance expenses of food, clothing, and shelter;~~ amount of adoption assistance is subject to the availability of state and federal funds and shall be determined through agreement with the adoptive parents. The agreement shall take into consideration the circumstances of the adopting parent or parents, the needs of the child being adopted and may provide ongoing monthly assistance, supplemental maintenance expenses related to the adopted person's special needs~~;~~, nonmedical expenses periodically necessary for purchase of services, items, or equipment related to the special needs~~;~~, and medical expenses. The placing agency or the adoptive parent or parents shall provide written documentation to support ~~requests~~ the need for ~~subsidy~~ adoption assistance payments. The commissioner may require periodic reevaluation of ~~subsidy~~ adoption assistance payments. The amount of ~~the subsidy payment~~ ongoing monthly adoption assistance granted may in no case exceed that which would be allowable for the child under foster family care and is subject to the availability of state and federal funds.

Sec. 34. Minnesota Statutes 1992, section 259.40, subdivision 3, is amended to read:

Subd. 3. **ANNUAL AFFIDAVIT.** When ~~subsidies~~ adoption assistance agreements are for more than one year, the adoptive parents or guardian or con-

servator shall annually present an affidavit stating whether the adopted person remains under their care and whether the need for ~~subsidy~~ adoption assistance continues to exist. The commissioner may verify the affidavit. The ~~subsidy~~ adoption assistance agreement shall continue in accordance with its terms as long as the need for ~~subsidy~~ adoption assistance continues and the adopted person ~~is under 22 years of age and~~ is the legal or financial dependent of the adoptive parent or parents or guardian or conservator and is under 18 years of age. The adoption assistance agreement may be extended to age 22 as allowed by rules adopted by the commissioner. Termination or modification of the ~~subsidy~~ adoption assistance agreement may be requested by the adoptive parents or subsequent guardian or conservator at any time. When the commissioner determines that a child is eligible for adoption assistance under Title IV-E of the Social Security Act, United States Code, title 42, sections 670 to ~~676~~ 679a, the commissioner shall modify the ~~subsidy~~ adoption assistance agreement in order to obtain the funds under that act.

Sec. 35. Minnesota Statutes 1992, section 259.40, subdivision 4, is amended to read:

Subd. 4. **ELIGIBILITY CONDITIONS.** The placing agency shall determine the child's eligibility for adoption assistance under title IV-E of the Social Security Act. If the child does not qualify, the placing agency shall certify a child as eligible for ~~a state-funded subsidy~~ state funded adoption assistance only if the following criteria are met:

(a) ~~A placement agency has made reasonable efforts to place the child for adoption without subsidy, but has been unsuccessful; or~~ Due to the child's characteristics or circumstances it would be difficult to provide the child and adoptive home without adoption assistance.

(b)(1) A placement agency has made reasonable efforts to place the child for adoption without subsidy adoption assistance, but has been unsuccessful; or

~~(b)~~(2) the child's licensed foster parents desire to adopt the child and it is determined by the placing agency that:

~~(1)~~ the adoption is in the best interest of the child; ~~and~~

~~(2) due to the child's characteristics or circumstances it would be difficult to provide the child an adoptive home without subsidy; and.~~

(c) The child has been a ward of the commissioner or ~~licensed~~ a Minnesota-licensed child placing agency.

Sec. 36. Minnesota Statutes 1992, section 259.40, subdivision 5, is amended to read:

Subd. 5. **DETERMINATION OF RESIDENCY.** A child who is a resident of any county in this state when eligibility for ~~subsidy~~ adoption assistance is cer-

tified shall remain eligible and receive ~~the subsidy~~ adoption assistance in accordance with the terms of the ~~subsidy~~ adoption assistance agreement, regardless of the domicile or residence of the adopting parents at the time of application for adoptive placement, legal decree of adoption, or thereafter.

Sec. 37. Minnesota Statutes 1992, section 259.40, subdivision 7, is amended to read:

Subd. 7. **REIMBURSEMENT OF COSTS.** Subject to rules of the commissioner, and the provisions of this subdivision a Minnesota-licensed child placing agency or county social service agency shall receive a reimbursement from the commissioner equal to 100 percent of the reasonable and appropriate cost of providing ~~or purchasing~~ adoption services for a child certified as eligible for ~~a subsidy, including~~ adoption assistance. Such assistance may include adoptive family recruitment, counseling, and special training when needed. A Minnesota-licensed child placing agency shall receive reimbursement for adoption services it purchases for or directly provides to an eligible child. A county social service agency shall receive such reimbursement only for adoption services it purchases for an eligible child.

A Minnesota-licensed child placing agency or county social service agency seeking reimbursement under this subdivision shall enter into a reimbursement agreement with the commissioner before providing adoption services for which reimbursement is sought. No reimbursement under this subdivision shall be made to an agency for services provided prior to entering a reimbursement agreement. Separate reimbursement agreements shall be made for each child and separate records shall be kept on each child for whom a reimbursement agreement is made. Funds encumbered and obligated under such an agreement for the child remain available until the terms of the agreement are fulfilled or the agreement is terminated.

Sec. 38. Minnesota Statutes 1992, section 259.40, subdivision 8, is amended to read:

Subd. 8. **INDIAN CHILDREN.** The commissioner is encouraged to work with American Indian organizations to assist in the establishment of American Indian child adoption organizations able to be licensed as child placing agencies. Children certified as eligible for ~~a subsidy~~ adoption assistance under this section who are protected under the Federal Indian Child Welfare Act of 1978 should, whenever possible, be served by the tribal governing body, tribal courts, or a licensed Indian child placing agency.

Sec. 39. Minnesota Statutes 1992, section 259.40, subdivision 9, is amended to read:

Subd. 9. **EFFECT ON OTHER AID.** ~~Subsidy~~ Adoption assistance payments received under this section shall not affect eligibility for any other financial payments to which a person may otherwise be entitled.

Sec. 40. Minnesota Statutes 1992, section 525.539, subdivision 2, is amended to read:

Subd. 2. "Guardian" means a person or entity who is appointed by the court to exercise all of the powers and duties designated in section 525.56 for the care of an incapacitated person or that person's estate, or both.

Sec. 41. Minnesota Statutes 1992, section 525.551, subdivision 7, is amended to read:

Subd. 7. **NOTIFICATION ~~OF COMMISSIONER OF HUMAN SERVICES~~.** If ~~the ward or conservatee is~~ a patient of a state hospital ~~for the mentally ill, or committed to the~~, regional center, or any state-operated service has a guardianship or conservatorship established, modified, or terminated, the head of the state hospital, regional center, or state-operated service shall be notified. If a ward or conservatee is under the guardianship or conservatorship of the commissioner of human services as mentally retarded or dependent and neglected or is under the temporary custody of the commissioner of human services, the court shall notify the commissioner of human services ~~of the appointment of a guardian, conservator or successor guardian or conservator of the estate of the ward or conservatee~~ if the public guardianship or conservatorship is established, modified, or terminated.

Sec. 42. Minnesota Statutes 1992, section 626.559, is amended by adding a subdivision to read:

Subd. 5. **TRAINING REVENUE.** The commissioner of human services shall submit claims for federal reimbursement earned through the activities and services supported through department of human services child protection or child welfare training funds. Federal revenue earned must be used to improve and expand training services by the department. The department expenditures eligible for federal reimbursement under this section must not be made from federal funds or funds used to match other federal funds. The federal revenue earned under this subdivision is available for these purposes until the funds are expended.

Sec. 43. **BASIC SLIDING FEE; ALLOCATION.**

In fiscal year 1993 only, a maximum of $600,000 in federal funds designated for the basic sliding fee program shall be distributed to counties that, due to the allocation formula change in section 256H.03, subdivision 4, paragraphs (a) to (c), do not have sufficient funds available in the basic sliding fee program to continue services in fiscal year 1993 to families participating in the basic sliding fee program in fiscal year 1992. This maximum of $600,000 increase for the sliding fee child care fund in fiscal year 1993 is a one-time increase and does not increase the allocation base for the 1994-1995 biennium. The funds shall be distributed as a supplemental fiscal year 1993 allocation to counties without regard to the allocation formula identified in this section. The amount distributed to a

county shall be based on earnings in excess of its original fiscal year 1993 allocation after the maintenance of effort requirements in section 256H.12. The sum of a county's original and supplemental fiscal year 1993 allocations may not exceed its fiscal year 1992 allocation. If the amount of funds earned under section 256H.12 is in excess of $600,000, the distribution shall be prorated to each county based on the ratio of the county's earnings in excess of its allocation to the total of all counties' earnings in excess of their allocations.

Sec. 44. **PINE COUNTY SOCIAL SERVICE GRANT APPLICATION PROCESS.**

Subdivision 1. **AUTHORIZATION FOR DEMONSTRATION PROJECT.** The commissioner of human services shall allow Pine county to send a letter of intent in lieu of completing a grant application to apply for categorical social service funding as part of a four-year intergovernmental agreement demonstration project. The demonstration project is an alternative method of obtaining social service funding which is part of a larger project to simplify and consolidate social services planning and reporting in Pine county. The demonstration project is an effort to streamline planning and remove administrative burdens on smaller counties.

Subd. 2. **SOCIAL SERVICE PLAN.** Pine county must amend its social service plan within 12 months of receiving funding to incorporate the requirements of the grant application process into the social service plan.

Subd. 3. **COMPLIANCE AND MONITORING.** The commissioner may terminate the demonstration project if Pine county is not using the categorical funding for the intended purpose. The commissioner shall send Pine county a 60-day notice and provide an opportunity for Pine county to appeal before terminating the project.

Subd. 4. **REPORT.** The commissioner shall report to the legislature annually beginning January 1, 1995. The report shall evaluate Pine county's intergovernmental agreements project and also the advantages of the alternative funding process for counties with a population under 30,000.

Sec. 45. **EFFECTIVE DATES.**

Sections 31 and 43 are effective the day following final enactment.

ARTICLE 4

DEVELOPMENTAL DISABILITIES

Section 1. Minnesota Statutes 1992, section 252.275, subdivision 1, is amended to read:

Subdivision 1. **PROGRAM.** The commissioner of human services shall establish a statewide program to provide support for persons with mental retardation or related conditions to live as independently as possible in the community. An objective of the program is to reduce unnecessary use of intermediate care facilities for persons with mental retardation or related conditions and home and community-based services. The commissioner shall reimburse county boards for ~~the provision of~~ semi-independent living services ~~licensed by the commissioner pursuant to~~ provided by agencies or individuals that meet the applicable standards of sections 245A.01 to 245A.16 and 252.28, and for the provision of one-time living allowances to secure and furnish a home for a person who will receive semi-independent living services under this section, if other public funds are not available for the allowance.

For the purposes of this section, "semi-independent living services" means training and assistance in managing money, preparing meals, shopping, maintaining personal appearance and hygiene, and other activities which are needed to maintain and improve an adult with mental retardation or a related condition's capability to live in the community. Eligible persons: (1) must be age 18 or older; ~~must need less than a 24-hour plan of care; and~~; (2) must be unable to function independently without semi-independent living services; and (3) must not be at risk of placement in an intermediate care facility for persons with mental retardation in the absence of less restrictive services.

Semi-independent living services costs and one-time living allowance costs may be paid directly by the county, or may be paid by the recipient with a voucher or cash issued by the county.

Sec. 2. Minnesota Statutes 1992, section 252.275, subdivision 8, is amended to read:

Subd. 8. **USE OF FEDERAL FUNDS AND TRANSFER OF FUNDS TO MEDICAL ASSISTANCE.** (a) The commissioner shall make every reasonable effort to maximize the use of federal funds for semi-independent living services.

(b) The commissioner shall reduce the payments to be made under this section to each county from January 1, 1994 to June 30, 1996, by the amount of the state share of medical assistance reimbursement for services other than residential services provided under the home- and community-based waiver program under section 256B.092 from January 1, 1994 to June 30, 1996, for clients for whom the county is financially responsible and who have been transferred by the county from the semi-independent living services program to the home- and community-based waiver program. Unless otherwise specified, all reduced amounts shall be transferred to the medical assistance state account.

(c) For fiscal year 1997, the base appropriation available under this section shall be reduced by the amount of the state share of medical assistance reimbursement for services other than residential services provided under the home- and community-based waiver program authorized in section 256B.092 from January 1, 1995 to December 31, 1995, for persons who have been transferred from the semi-independent living services program to the home- and community-based waiver program. The base appropriation for the medical assistance state account shall be increased by the same amount.

(d) For purposes of calculating the guaranteed floor under subdivision 4b and to establish the calendar year 1996 allocations, each county's original allocation for calendar year 1995 shall be reduced by the amount transferred to the state medical assistance account under paragraph (b) during the six months ending on June 30, 1995. For purposes of calculating the guaranteed floor under subdivision 4b and to establish the calendar year 1997 allocations, each county's original allocation for calendar year 1996 shall be reduced by the amount transferred to the state medical assistance account under paragraph (b) during the six months ending on June 30, 1996.

Sec. 3. Minnesota Statutes 1992, section 252.41, subdivision 3, is amended to read:

Subd. 3. **DAY TRAINING AND HABILITATION SERVICES FOR ADULTS WITH MENTAL RETARDATION, RELATED CONDITIONS.** "Day training and habilitation services for adults with mental retardation and related conditions" means services that:

(1) include supervision, training, assistance, and supported employment, work-related activities, or other community-integrated activities designed and implemented in accordance with the individual service and individual habilitation plans required under Minnesota Rules, parts 9525.0015 to 9525.0165, to help an adult reach and maintain the highest possible level of independence, productivity, and integration into the community;

(2) are provided under contract with the county where the services are delivered by a vendor licensed under sections 245A.01 to 245A.16 and 252.28, subdivision 2, to provide day training and habilitation services; and

(3) are regularly provided to one or more adults with mental retardation or related conditions in a place other than the adult's own home or residence unless medically contraindicated.

Day training and habilitation services reimbursable under this section do not include special education and related services as defined in the Education of the Handicapped Act, United States Code, title 20, chapter 33, section 1401, clauses (6) and (17), or vocational services funded under section 110 of the Rehabilitation Act of 1973, United States Code, title 29, section 720, as amended.

Sec. 4. **[252.451] AGREEMENTS WITH BUSINESSES TO PROVIDE SUPPORT AND SUPERVISION OF PERSONS WITH MENTAL RETARDATION OR RELATED CONDITIONS IN COMMUNITY-BASED EMPLOYMENT.**

Subdivision 1. **DEFINITION.** For the purposes of this section, "qualified business" means a business that employs primarily nondisabled persons and will employ persons with mental retardation or related conditions. For purposes of this section, licensed providers of residential services for persons with mental retardation or related conditions are not a qualified business. A qualified business and its employees are exempt from Minnesota Rules, parts 9525.1500 to 9525.1690 and 9525.1800 to 9525.1930.

Subd. 2. **VENDOR PARTICIPATION AND REIMBURSEMENT.** Notwithstanding requirements in chapter 245A, and sections 252.28, 252.40 to 252.46, and 256B.501, vendors of day training and habilitation services may enter into written agreements with qualified businesses to provide additional training and supervision needed by individuals to maintain their employment.

Subd. 3. **AGREEMENT SPECIFICATIONS.** Agreements must include the following:

(1) the type and amount of supervision and support to be provided by the business to the individual in accordance with their needs as identified in their individual service plan;

(2) the methods used to periodically assess the individual's satisfaction with their work, training, and support;

(3) the measures taken by the qualified business and the vendor to ensure the health, safety, and protection of the individual during working hours, including the reporting of abuse and neglect under state law and rules;

(4) the training and support services the vendor will provide to the qualified business, including the frequency of on-site supervision and support; and

(5) any payment to be made to the qualified business by the vendor. Payment to the business must be limited to:

(i) additional costs of training coworkers and managers that exceed ordinary and customary training costs and are a direct result of employing a person with mental retardation or a related condition; and

(ii) additional costs for training, supervising, and assisting the person with mental retardation or a related condition that exceed normal and customary costs required for performing similar tasks or duties.

Payments made to a qualified business under this section must not include incentive payments to the qualified business or salary supplementation for the person with mental retardation or a related condition.

Subd. 4. **CLIENT PROTECTION.** Persons receiving training and support under this section may not be denied their rights or procedural protections under section 256.045, subdivision 4a, or 256B.092, including the county agency's responsibility to arrange for appropriate services, as necessary, in the event that persons lose their job or the contract with the qualified business is terminated.

Subd. 5. **VENDOR PAYMENT.** (a) For purposes of this section, the vendor shall bill and the commissioner shall reimburse for full-day or partial-day services that would otherwise have been paid to the vendor for providing direct services provided that:

(1) the vendor provides services and payments to the business that enable the business to perform services for the client that the vendor would otherwise need to perform; and

(2) any client for whom a rate will be billed was receiving full-time services from the vendor on or before July 1, 1993, and a rate will allow the client to work with support in a community business instead of receiving any other service from the vendor.

(b) Medical assistance reimbursement of services provided to persons receiving day training and habilitation services under this section is subject to the limitations on reimbursement for vocational services under federal law and regulation.

Sec. 5. **[252.452] VENDOR REQUIREMENTS.**

The requirements of Minnesota Rules, parts 9525.1500 to 9525.1690 governing vendors of day training and habilitation services are amended as provided in paragraphs (a) to (f).

(a) Notwithstanding Minnesota Rules, part 9525.1620, subpart 2, item B, orientation must be completed within the first 60 days of employment.

(b) Employees of a business who are subsequently employed by the day training and habilitation program to provide job supports to a client at the business site are exempt from the requirements of Minnesota Rules, part 9525.1620 except for the explanation required in subpart 2, item A, subitem (4).

(c) Notwithstanding Minnesota Rules, part 9525.1590, subpart 2, vendors must annually collect data for each person receiving employment services that is current as of the last day of the calendar year and includes:

(1) the type of employment activity, location, and job title;

(2) the number of hours the person worked per week;

(3) the number of disabled coworkers receiving vendor services at the same work site where the person for whom the data is reported is working; and

(4) the number of nondisabled and nonsubsidized coworkers employed at the work site.

(d) Space owned or leased by a vendor that is used solely as office space for a community-integrated program is exempt from Minnesota Rules, parts 9525.1520, subpart 2, item B, subitems (1), (2), and (4); and 9525.1650.

(e) If any of the conditions in clauses (1) to (4) are met, the vendor may provide support at the office site for five or fewer persons at any time and be exempt from Minnesota Rules, parts 9525.1520, subpart 2, item B, subitems (1), (2), and (4); and 9525.1650, except that the vendor must document that the building satisfactorily meets local fire regulations. The documentation may be a copy of the routine fire inspection of the building. If a routine inspection has not been completed, a separate inspection must be completed. The conditions are:

(1) the services are temporary, with an anticipated duration of not more than 60 calendar days, for example when a person begins services or is between community jobs and must spend some portion of each service day involved in the community;

(2) at least 75 percent of the service week is provided outside the office site in the community;

(3) the use of the space is for planning meetings or other individualized meetings with persons receiving support; or

(4) the person is in transit to a job site or other community-based site.

(f) Notwithstanding Minnesota Rules, part 9525.1630, subparts 4 and 5, the vendor is required to assess and reassess persons in the areas specified in Minnesota Rules, part 9525.1630, subpart 4, items B to E, as authorized by the case manager. Items not specifically authorized are not required.

This section expires on the effective date of the consolidated licensing rules.

Sec. 6. Minnesota Statutes 1992, section 252.46, is amended to read:

252.46 **PAYMENT RATES.**

Subdivision 1. **RATES.** Payment rates to vendors, except regional centers, for county-funded day training and habilitation services and transportation provided to persons receiving day training and habilitation services established by a county board are governed by subdivisions 2 to ~~11~~ 19. ~~"Payment rate" as used in subdivisions 2 to 11 refers to three kinds of payment rates~~ The commissioner shall approve the following three payment rates for services provided by a vendor:

(1) a full-day service rate for persons who receive at least six service hours a day, including the time it takes to transport the person to and from the service site;

(2) a partial-day service rate that must not exceed 75 percent of the full-day service rate for persons who receive less than a full day of service; and

(3) a transportation rate for providing, or arranging and paying for, transportation of a person to and from the person's residence to the service site.

Medical assistance rates for home and community-based service provided under section 256B.501, subdivision 4, by licensed vendors of day training and habilitation services must not be greater than the rates for the same services established by counties under sections 252.40 to 252.47. For very dependent persons with special needs the commissioner may approve an exception to the approved payment rate under section 256B.501, subdivision 4 or 8.

Subd. 2. **RATE MINIMUM.** Unless a variance is granted under subdivision 6, the minimum payment rates set by a county board for each vendor must be equal to the payment rates approved by the commissioner for that vendor in effect January 1 of the previous calendar year.

Subd. 3. **RATE MAXIMUM.** Unless a variance is granted under subdivision 6, the maximum payment rates for each vendor for a calendar year must be equal to the payment rates approved by the commissioner for that vendor in effect December 1 of the previous calendar year. The commissioner of finance shall include as a budget change request in each biennial detailed expenditure budget submitted to the legislature under section 16A.11 annual inflation adjustments in reimbursement rates for each vendor, based upon the projected percentage change in the urban consumer price index, all items, published by the United States Department of Labor, for the upcoming calendar year over the current calendar year. The commissioner shall not provide an annual inflation adjustment for the biennium ending June 30, 1993.

Subd. 4. **NEW VENDORS.** (a) Payment rates established by a county for a new vendor for which there were no previous rates must not exceed 95 percent of the greater of 125 percent of the statewide median rates or 125 percent of the average payment rates in the regional development commission district under sections 462.381 to 462.396 in which the new vendor is located unless the criteria in paragraph (b) are met. ~~When at least 50 percent of the persons to be served by the new vendor are persons discharged from a regional treatment center on or after January 1, 1990, the recommended payment rates for the new vendor shall not exceed twice the current statewide average payment rates.~~

~~For purposes of this subdivision, persons discharged from the regional treatment center do not include persons who received temporary care under section 252A.111, subdivision 3.~~

(b) A payment rate equal to 200 percent of the statewide average rates shall be assigned to persons served by the new vendor when those persons are persons with very severe self-injurious or assaultive behaviors, persons with medical conditions requiring delivery of physician-prescribed medical interventions at one-

to-one staffing for at least 15 minutes each time they are performed, or persons discharged from a regional treatment center after May 1, 1993, to the vendor's program. All other persons for whom the new service is needed must be assigned a rate equal to 95 percent of the greater of 125 percent of the statewide median rates or 125 percent of the regional average rates, whichever is higher, and the maximum payment rate that may be recommended is determined by multiplying the number of clients at each limit by the rate corresponding to that limit and dividing the sum by the total number of clients. When the recommended payment rates exceed 95 percent of 125 percent of the greater of the statewide median or regional average rates, whichever is higher, the county must include documentation verifying the medical or behavioral needs of clients. The approved payment rates must be based on 12 months budgeted expenses divided by at least 90 percent of authorized service units associated with the new vendor's licensed capacity. The county must include documentation verifying the person's discharge from a regional treatment center and that admission of new clients to existing services eligible for a rate variance under subdivision 6 was considered before recommending payment rates for a new vendor. Nothing in this subdivision permits development of a new program that primarily results in refinancing of services for individuals already receiving services in existing programs.

Subd. 5. **SUBMITTING RECOMMENDED RATES.** The county board shall submit recommended payment rates to the commissioner on forms supplied by the commissioner at least 60 days before revised payment rates or payment rates for new vendors are to be effective. The forms must ~~require~~ include the county board's written verification of the individual documentation required under section 252.44, clause (a). ~~If the number of days of service provided by a licensed vendor are projected to increase, the county board must recommend payment rates based on the projected increased days of attendance and resulting lower per unit fixed costs. Recommended increases in payment rates for vendors whose approved payment rates are ten or more than ten percent below the statewide median payment rates must be equal to the maximum increases allowed for that vendor under subdivision 3.~~ If a vendor provides services at more than one licensed site, the county board may recommend the same payment rates for each site based on the average rate for all sites. The county board may also recommend differing payment rates for each licensed site if it would result in a total annual payment to the vendor that is equal to or less than the total annual payment that would result if the average rates had been used for all sites. For purposes of this subdivision, the average payment rate for all service sites used by a vendor must be computed by adding the amounts that result when the payment rates for each licensed site are multiplied by the projected annual number of service units to be provided at that site and dividing the sum of those amounts by the total units of service to be provided by the vendor at all sites.

Subd. 6. **VARIANCES.** (a) A variance from the minimum or maximum payment rates in subdivisions 2 and 3 may be granted by the commissioner when the vendor requests and the county board submits to the commissioner a

written variance request on forms supplied by the commissioner with the recommended payment rates. ~~The commissioner shall develop by October 1, 1989, a uniform format for submission of documentation for the variance requests. This format shall be used by each vendor requesting a variance. The form shall be developed by the commissioner and shall be reviewed by representatives of advocacy and provider groups and counties.~~ A variance to the rate maximum may be utilized for costs associated with compliance with state administrative rules, compliance with court orders, capital costs required for continued licensure, increased insurance costs, start-up and conversion costs for supported employment, direct service staff salaries and benefits, ~~and~~ transportation. ~~The county board shall review all vendors' payment rates that are ten or more than ten percent lower than the statewide median payment rates. If the county determines that the payment rates do not provide sufficient revenue to the vendor for authorized service delivery the county must recommend a variance under this section. When the county board contracts for increased services from any vendor for some or all individuals receiving services from the vendor, the county board shall review the vendor's payment rates to determine whether the increase requires that a variance to the minimum rates be recommended under this section to reflect the vendor's lower per unit fixed costs.~~, and other program related costs when any of the criteria in clauses (1) to (3) is also met:

(1) change is necessary to comply with licensing citations;

(2) a significant change is approved by the commissioner under section 252.28 that is necessary to provide authorized services to new clients with very severe self-injurious or assaultive behavior, or medical conditions requiring delivery of physician-prescribed medical interventions requiring one-to-one staffing for at least 15 minutes each time they are performed, or to new clients directly discharged to the vendor's program from a regional treatment center; or

(3) a significant increase in the average level of staffing is needed to provide authorized services approved by the commissioner under section 252.28, that is necessitated by a decrease in licensed capacity or loss of clientele when counties choose alternative services under Laws 1992, chapter 513, article 9, section 41.

A variance under this paragraph may be approved only if the costs to the medical assistance program do not exceed the medical assistance costs for all clients served by the alternatives and all clients remaining in the existing services.

(b) A variance to the rate minimum may be granted when (1) the county board contracts for increased services from a vendor for some or all individuals receiving services from the vendor lower per unit fixed costs result or (2) when the actual costs of delivering authorized service over a 12-month contract period have decreased.

(c) The written variance request under this subdivision must include documentation that all the following criteria have been met:

(1) The commissioner and the county board have both conducted a review and have identified a need for a change in the payment rates and recommended an effective date for the change in the rate.

(2) ~~The proposed changes are required for the vendor to deliver authorized individual services in an effective and efficient manner.~~

~~(3) The proposed changes are necessary to demonstrate compliance with minimum licensing standards.~~

~~(4)~~ The vendor documents ~~that the changes cannot be achieved by reallocating~~ efforts to reallocate current staff ~~or by reallocating financial resources.~~

~~(5) The county board submits evidence that the need for~~ and any additional ~~staff~~ staffing needs cannot be met by using temporary special needs rate exceptions under Minnesota Rules, parts 9510.1020 to 9510.1140.

(3) The vendor documents that financial resources have been reallocated before applying for a variance. No variance may be granted for equipment, supplies, or other capital expenditures when depreciation expense for repair and replacement of such items is part of the current rate.

(4) For variances related to loss of clientele, the vendor documents the other program and administrative expenses, if any, that have been reduced.

~~(6)~~ (5) The county board submits verification of the conditions for which the variance is requested, a description of the nature and cost of the proposed changes, and how the county will monitor the use of money by the vendor to make necessary changes in services.

~~(7)~~ (6) The county board's recommended payment rates do not exceed 95 percent of the greater of 125 percent of the current ~~calendar year's~~ statewide median or 125 percent of the regional average payment rates~~.~~, whichever is higher, for each of the regional commission districts under sections 462.381 to 462.396 in which the vendor is located except for the following: when a variance is recommended to allow authorized service delivery to new clients with severe self-injurious or assaultive behaviors or with medical conditions requiring delivery of physician prescribed medical interventions, or to persons being directly discharged from a regional treatment center to the vendor's program, those persons must be assigned a payment rate of 200 percent of the current statewide average rates. All other clients receiving services from the vendor must be assigned a payment rate equal to the vendor's current rate unless the vendor's current rate exceeds 95 percent of 125 percent of the statewide median or 125 percent of the regional average payment rates, whichever is higher. When the vendor's rates exceed 95 percent of 125 percent of the statewide median or 125 percent of the regional average rates, the maximum rates assigned to all other clients must be equal to the greater of 95 percent of 125 percent of the statewide median or 125 percent of the regional average rates. The maximum payment

rate that may be recommended for the vendor under these conditions is determined by multiplying the number of clients at each limit by the rate corresponding to that limit and then dividing the sum by the total number of clients.

(7) The vendor has not received a variance under this subdivision in the past 12 months.

(d) The commissioner shall have 60 calendar days from the date of the receipt of the complete request to accept or reject it, or the request shall be deemed to have been granted. If the commissioner rejects the request, the commissioner shall state in writing the specific objections to the request and the reasons for its rejection.

Subd. 7. ~~TIME REQUIREMENTS AND APPEALS PROCESS FOR VARIANCES~~ RATE RECONSIDERATIONS. ~~The commissioner shall notify in writing county boards requesting variances within 60 days of receiving the variance request from the county board. The notification shall give reasons for denial of the variance, if it is denied.~~ A host county that disagrees with a rate decision of the commissioner under subdivision 6 or 9 may request reconsideration by the commissioner within 45 days after the date the host county received notification of the commissioner's decision. The request must state the reasons why the host county is requesting reconsideration of the rate decision and present evidence explaining the host county's disagreement with the rate decision.

The commissioner shall review the host county's evidence and provide the host county with written notification of the decision on the request within 60 days. The commissioner's decision on the request is final.

Until a reconsideration request is decided, payments must continue at a rate the commissioner determines complies with this section. If a higher rate is approved, the commissioner shall order a retroactive payment as determined in the commissioner's decision.

Subd. 8. **COMMISSIONER'S NOTICE TO BOARDS, VENDORS.** The commissioner shall notify the county boards and vendors of:

~~(1)~~ the average regional payment rates ~~and~~, 95 percent of 125 percent of the average regional payments rates for each of the regional development commission districts designated in sections 462.381 to 462.396; ~~and~~, 95 percent of 125 percent of the statewide median rates, and 200 percent of the statewide average rates.

~~(2) the projected inflation rate for the year in which the rates will be effective equal to the most recent projected change in the urban consumer price index, all items, published by the United States Department of Labor, for the upcoming calendar year over the current calendar year.~~

Subd. 9. **APPROVAL OR DENIAL OF RATES.** The commissioner shall

approve the county board's recommended payment rates when the rates and verification justifying the projected service units comply with subdivisions 2 to ~~10~~ 18. The commissioner shall notify the county board in writing of the approved payment rates within 60 days of receipt of the rate recommendations. If the rates are not approved, or if rates different from those originally recommended are approved, the commissioner shall within 60 days of receiving the rate recommendation notify the county board in writing of the reasons for denying or substituting a different rate for the recommended rates. Approved payment rates remain effective until the commissioner approves different rates in accordance with subdivisions 2 and 3.

Subd. 10. **VENDOR'S REPORT; AUDIT.** The vendor shall report to the commissioner and the county board on forms prescribed by the commissioner at times specified by the commissioner. The reports shall include programmatic and fiscal information. Fiscal information shall be provided in accordance with an annual audit that complies with the requirements of Minnesota Rules, parts 9550.0010 to 9550.0092. The audit must be done in accordance with generally accepted auditing standards to result in statements that include a balance sheet, income statement, changes in financial position, and the certified public accountant's opinion. The audit must provide supplemental statements for each day training and habilitation program with an approved unique set of rates.

Subd. 11. **IMPROPER TRANSACTIONS.** Transactions that have the effect of circumventing subdivisions 1 to ~~10~~ 18 must not be considered by the commissioner for the purpose of payment rate approval under the principle that the substance of the transaction prevails over the form.

~~Subd. 12. RATES ESTABLISHED AFTER 1990. Unless a variance is granted under subdivision 6, payment rates established by a county for calendar year 1990 and which are in effect December 31, 1990, remain in effect until June 30, 1991. Payment rates established by a county board to be paid to a vendor on or after July 1, 1991, must be determined under permanent rules adopted by the commissioner. Until permanent rules are adopted, the payment rates must be determined according to subdivisions 1 to 11 except for the period from July 1, 1991, through December 31, 1991, when the increase determined under subdivision 3 must not exceed the projected percentage change in the urban consumer price index, all items, published by the United States Department of Labor, for the current calendar year over the previous calendar year. No county shall pay a rate that is less than the minimum rate determined by the commissioner.~~

~~In developing procedures for setting minimum payment rates and procedures for establishing payment rates, the commissioner shall consider the following factors:~~

~~(1) a vendor's payment rate and historical cost in the previous year;~~

~~(2) current economic trends and conditions;~~

~~(3) costs that a vendor must incur to operate efficiently, effectively and economically and still provide training and habilitation services that comply with quality standards required by state and federal regulations;~~

~~(4) increased liability insurance costs;~~

~~(5) costs incurred for the development and continuation of supported employment services;~~

~~(6) cost variations in providing services to people with different needs;~~

~~(7) the adequacy of reimbursement rates that are more than 15 percent below the statewide average; and~~

~~(8) other appropriate factors.~~

~~The commissioner may develop procedures to establish differing hourly rates that take into account variations in the number of clients per staff hour, to assess the need for day training and habilitation services, and to control the utilization of services.~~

~~In developing procedures for setting transportation rates, the commissioner may consider allowing the county board to set those rates or may consider developing a uniform standard.~~

~~Medical assistance rates for home and community-based services provided under section 256B.501 by licensed vendors of day training and habilitation services must not be greater than the rates for the same services established by counties under sections 252.40 to 252.47.~~

~~Subd. 13. REVIEW AND REVISION OF PROCEDURES FOR RATE EXCEPTIONS FOR VERY DEPENDENT PERSONS WITH SPECIAL NEEDS. The commissioner shall review the procedures established in Minnesota Rules, parts 9510.1020 to 9510.1140, that counties must follow to seek authorization for a medical assistance rate exception for services for very dependent persons with special needs. The commissioner shall appoint an advisory task force to work with the commissioner. Members of the task force must include vendors, providers, advocates, and consumers. After considering the recommendations of the advisory task force and county rate setting procedures developed under this section, the commissioner shall:~~

~~(1) revise administrative procedures as necessary;~~

~~(2) implement new review procedures for county applications for medical assistance rate exceptions for services for very dependent persons with special needs in a manner that accounts for services available to the person within the approved payment rates of the vendor;~~

~~(3) provide training and technical assistance to vendors, providers, and counties in use of procedures governing medical assistance rate exceptions for~~

~~very dependent persons with special needs and in county rate setting procedures established under this subdivision; and~~

~~(4) develop a strategy and implementation plan for uniform data collection for use in establishing equitable payment rates and medical assistance rate exceptions for services provided by vendors.~~

~~Subd. 14. PILOT STUDY. The commissioner may initiate a pilot payment rate system under section 252.47. The pilot project may establish training and demonstration sites. The pilot payment rate system must include actual transfers of funds, not simulated transfers. The pilot payment rate system may involve vendors representing different geographic regions and rates of reimbursement. Participation in the pilot project is voluntary. Selection of participants by the commissioner is based on the vendor's submission of a complete application form provided by the commissioner. The application must include letters of agreement from the host county, counties of financial responsibility, and residential service providers. Evaluation of the pilot project must include consideration of the effectiveness of procedures governing establishment of equitable payment rates. Implementation of the pilot payment rate system is contingent upon federal approval and systems feasibility. The policies and procedures governing administration, participation, evaluation, service utilization, and payment for services under the pilot payment rate system are not subject to the rulemaking requirements of chapter 14.~~

Subd. 16. **PAYMENT RATE CRITERIA; ALLOCATION OF EXPENDITURES.** Payment rates approved under subdivision 9 must reflect the payment rate criteria in paragraphs (a) and (b) and the allocation principles in paragraph (c).

(a) Payment rates must be based on reasonable costs that are ordinary, necessary, and related to delivery of authorized client services.

(b) The commissioner shall not pay for: (i) unauthorized service delivery; (ii) services provided in accordance with receipt of a special grant; (iii) services provided under contract to a local school district; (iv) extended employment services under Minnesota Rules, parts 3300.1950 to 3300.3050, or vocational rehabilitation services provided under Title I, section 110 or Title VI-C, Rehabilitation Act Amendments of 1992, as amended, and not through use of medical assistance or county social service funds; or (v) services provided to a client by a licensed medical, therapeutic, or rehabilitation practitioner or any other vendor of medical care which are billed separately on a fee for service basis.

(c) On an annual basis, actual and projected contract year expenses must be allocated to standard budget line items corresponding to direct and other program and administrative expenses as submitted to the commissioner with the host county's recommended payment rates. Central or corporate office costs must be allocated to licensed vendor sites within the group served by the central or corporate office according to the cost allocation principles under section 256B.432.

(d) The vendor must maintain records documenting that clients received the billed services.

Subd. 17. **HOURLY RATE STRUCTURE.** Counties participating as host counties under the pilot study of hourly rates established under Laws 1988, chapter 689, article 2, section 117, may recommend continuation of the hourly rates for participating vendors. The recommendation must be made annually under subdivision 5 and according to the methods and standards provided by the commissioner. The commissioner shall approve the hourly rates when service authorization, billing, and payment for services is possible through the Medicaid management information system and the other criteria in this subdivision are met.

Subd. 18. **PILOT STUDY RATES.** By January 1, 1994, counties and vendors operating under the pilot study of hourly rates established under Laws 1988, chapter 689, article 2, section 117, shall work with the commissioner to translate the hourly rates and actual expenditures into rates meeting the criteria in subdivisions 1 to 16 unless hourly rates are approved under subdivision 17.

Sec. 7. Minnesota Statutes 1992, section 252.47, is amended to read:

252.47 **RULES.**

To implement sections 252.40 to 252.47, the commissioner shall adopt permanent rules under sections 14.01 to 14.38, by July 1, 1995. ~~The rules may include a plan for phasing in implementation of the procedures and rates established by the rules. The phase-in may occur prior to calendar year 1991.~~ The commissioner shall establish an advisory task force to advise and make recommendations to the commissioner during the rulemaking process. The advisory task force must include legislators, vendors, residential service providers, counties, consumers, department personnel, and others as determined by the commissioner.

Sec. 8. **[256B.0916] EXPANSION OF HOME- AND COMMUNITY-BASED SERVICES.**

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

(b) Upon federal approval, county boards are not responsible for funding

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

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

Sec. 9. **[256E.15] TRANSFER OF FUNDS TO MEDICAL ASSISTANCE.**

(a) The commissioner shall reduce the payment to be made under sections 256E.06 and 256E.14 to each county on July 1, 1994, by the amount of the state share of medical assistance reimbursement for residential services provided under the home- and community-based waiver program authorized in section 256B.092 from January 1, 1994 to March 31, 1994, for clients for whom the county is financially responsible and have transferred from the semi-independent living services program to the home- and community-based waiver program. For the purposes of this section, residential services include supervised living, in-home support, and respite care services. The commissioner shall similarly reduce the payments to be made between October 1, 1994 and December 31, 1996, for the quarters between April 1, 1994 and June 30, 1996. All reduced amounts shall be transferred to the medical assistance state account.

(b) Beginning fiscal year 1997, the appropriation under sections 256E.06 and 256E.14 shall be reduced by the amount of the state share of medical assistance reimbursement for residential services provided under the home- and community-based waiver program under section 256B.092 from January 1, 1995 to December 31, 1995, for persons who have transferred from the semi-independent living services program to the home- and community-based waiver program. The base appropriation for the medical assistance state account shall be increased by the same amount.

Sec. 10. **EXEMPTION FROM RULES GOVERNING DAY TRAINING AND HABILITATION SERVICES FOR PERSONS WITH MENTAL RETARDATION OR RELATED CONDITIONS.**

Until the commissioner of human services adopts amended licensing rules governing these services, providers of day training and habilitation services are exempt from the following Minnesota Rules:

(1) part 9525.1540;

(2) part 9525.1550, subparts 2, items C and D; 3; 4, items B to E; 5; 9 to 11; and 13;

(3) part 9525.1590, subpart 2, item C;

(4) part 9525.1600, subpart 9;

(5) part 9525.1610, subpart 2;

(6) part 9525.1640, subparts 1, items A and F; and 2;

(7) part 9525.1650, subpart 1;

(8) part 9525.1660, subparts 8 and 12; and

(9) part 9525.1670, subparts 1 to 3 and 5.

Sec. 11. **DEMONSTRATION PROJECT.**

(a) The commissioner may establish a demonstration project to improve the efficiency and effectiveness of service provision for recipients of services from intermediate care facilities for persons with mental retardation or related conditions.

The commissioner shall establish procedures to implement the project. The demonstration project may be coordinated with other projects authorized in other areas. Participation by providers in the demonstration project is voluntary. The commissioner shall seek any necessary federal waivers to implement the pilot project.

(b) The commissioner may waive rules relating to the provision of residential services for persons with mental retardation or related conditions to the extent necessary to implement the demonstration project. In waiving rules, the commissioner shall consider the recommendations of persons who are and who represent consumers and providers of service and of representatives of state and local agencies administering services. Individuals receiving services under the demonstration project may not be denied rights or procedural protections under Minnesota Statutes, sections 245.825; 245.91 to 245.97; 252.41, subdivision 9; 256.045; 256B.092; 626.556; and 626.557, including the county agency's responsibility to arrange for appropriate services and procedures for the monitoring of psychotropic medications.

(c) The project must meet the following requirements:

(1) persons and their legal representatives, if any, must be provided with information about the project;

(2) the project must comply with applicable federal requirements;

(3) the project proposal must include specific measures to be taken to ensure the health, safety, and protection of the persons participating; and

(4) persons participating in the project must be informed when any part of Minnesota Rules is waived.

(d) The commissioner shall request and evaluate proposals from county agencies and provider organizations to participate. Upon federal approval, the commissioner shall enter into a performance-based contract with counties and existing licensed ICF/MR providers that specifies the amount and conditions of reimbursement, requirements for monitoring and evaluation, and expected client-based outcomes. Counties and providers shall present potential outcome indicators for consideration in the following areas:

(1) personal health, safety, and comfort;

(2) personal growth, independence, and productivity;

(3) client choice and control over daily life decisions;

(4) consumer, family, and the case manager's satisfaction with services; and

(5) community inclusion, including social relationships and participation in valued community roles.

Outcome indicators must be determined by the person and the legal representative, if any, with assistance from the county case manager and provider.

(e) The cost of services for intermediate care facilities for persons with mental retardation paid for under the contract must not exceed 95 percent of the cost of the services that would otherwise have been paid to the intermediate care facility or group of intermediate care facilities during a biennium, including applicable special needs rates and rate adjustments, under the reimbursement system in effect at the time the contracted rate is effective. An intermediate care facility participating in the demonstration project must continue to be licensed. After participation in the project, the facility may be recertified as an intermediate care facility for persons with mental retardation, notwithstanding the provisions of Minnesota Statutes, section 252.291, or the services provided under the demonstration project may be converted to home- and community-based services authorized under Minnesota Statutes, section 256B.092, if the applicable standards are met. The rate paid to a recertified facility must not be greater than the rate paid to the facility before participation in the project. The commissioner may establish emergency rate setting procedures to allow for the transition back to intermediate care services for persons with mental retardation or related conditions.

Sec. 12. **AUTHORITY TO SEEK FEDERAL WAIVER.**

Subdivision 1. **AUTHORITY.** The commissioner of human services may seek federal waivers necessary to implement an integrated management and planning system for persons with mental retardation or related conditions that would enable the commissioner to achieve the goals in subdivisions 2 to 4.

Subd. 2. **COMPREHENSIVE REFORM.** The system shall include new methods of administering services for persons with mental retardation or related conditions that support the needs of the persons and their families in the community to the maximum extent possible.

Subd. 3. **SERVICE ACCESS AND COORDINATION.** The system must include procedural requirements for accessing services that are simple and easily understood by the person or their legal representative, if any. Where duplicative, the requirements shall be unified or streamlined, as appropriate. Service coordination activities shall be flexible to allow the person's needs and preferences to be met.

Subd. 4. **REGULATORY STANDARDS AND QUALITY ASSURANCE.** Regulatory standards requiring unnecessary paperwork, determined to be duplicative, or which are ineffective in establishing accountability in service delivery must be eliminated. Quality assurance methods must continue to include safeguards to ensure the health and welfare of persons receiving services.

Subd. 5. **REPORT.** The commissioner shall report to the legislature by January 1, 1994, on the results of the waiver request. If the waiver is approved, the report must include recommendations to implement the waiver, including budget recommendations, proposed strategies, and implementation timelines.

Sec. 13. **DOWNSIZING PILOT PROJECT.**

(a) The commissioner of human services shall establish a pilot project in Cottonwood county to downsize to 21 beds an existing 45-bed intermediate care facility for persons with mental retardation or related conditions. The project must be approved by the commissioner under Minnesota Statutes, section 252.28, and must include criteria for determining how individuals are selected for alternative services and the use of a request for proposal process in selecting the vendors for alternative services. The project must include:

(1) alternative services for the residents being relocated;

(2) timelines for resident relocation and decertification of beds; and

(3) adjustment of the facility's operating cost rate under Minnesota Rules, part 9553.0050, as necessary to implement the project.

(b) The facility's aggregate investment-per-bed limit in effect before downsizing must be the facility's investment-per-bed limit after downsizing. The facility's total revenues after downsizing must not increase as a result of the downsizing project. The facility's total revenues before downsizing are determined by multiplying the payment rate in effect the day before the downsizing is effective by the number of resident days for the reporting year preceding the downsizing project. For the purpose of this project, the average medical assistance rate for home- and community-based services must not exceed the rate made available under Laws 1992, chapter 513, article 5, section 2.

Sec. 14. **REPEALER.**

Minnesota Statutes 1992, section 252.46, subdivisions 12, 13, and 14, are repealed.

Sec. 15. **EFFECTIVE DATE.**

Section 13 is effective July 1, 1994.

ARTICLE 5

HEALTH CARE ADMINISTRATION

Section 1. Minnesota Statutes 1992, section 62A.045, is amended to read:

62A.045 **PAYMENTS ON BEHALF OF WELFARE RECIPIENTS.**

No policy of accident and sickness insurance regulated under this chapter; vendor of risk management services regulated under section 60A.23; nonprofit health service plan corporation regulated under chapter 62C; health maintenance organization regulated under chapter 62D; or self-insured plan regulated under chapter 62E shall contain any provision denying or reducing benefits because services are rendered to a person who is eligible for or receiving medical benefits pursuant to chapter 256; 256B; or 256D or services pursuant to section 252.27; 256.9351 to 256.9361; 260.251, subdivision 1a; or 393.07, subdivision 1 or 2. No insurer providing benefits under policies covered by this section shall use eligibility for medical programs named in this section as an underwriting guideline or reason for nonacceptance of the risk.

Notwithstanding any law to the contrary, when a person covered under a policy of accident and sickness insurance, risk management plan, nonprofit health service plan, health maintenance organization, or self-insured plan receives medical benefits according to any statute listed in this section, payment for covered services or notice of denial for services billed by the provider must be issued directly to the provider. If a person was receiving medical benefits through the department of human services at the time a service was provided, the provider must indicate this benefit coverage on any claim forms submitted by the provider to the insurer for those services. If the commissioner of human services notifies the insurer that the commissioner has made payments to the provider, payment for benefits or notices of denials issued by the insurer must be issued directly to the commissioner. Submission by the department to the insurer of the claim on a department of human services claim form is proper notice and shall be considered proof of payment of the claim to the provider and supersedes any contract requirements of the insurer relating to the form of submission. Liability to the insured for coverage is satisfied to the extent that payments for those benefits are made by the insurer to the provider or the commissioner.

Sec. 2. Minnesota Statutes 1992, section 144A.071, is amended to read:

144A.071 **MORATORIUM ON CERTIFICATION OF NURSING HOME BEDS.**

Subdivision 1. **FINDINGS.** ~~The legislature finds that medical assistance expenditures are increasing at a much faster rate than the state's ability to pay them; that reimbursement for nursing home care and ancillary services comprises over half of medical assistance costs; and, therefore, controlling expenditures for nursing home care is essential to prudent management of the state's budget; that construction of new nursing homes and the addition of more nursing home beds to the state's long-term care resources inhibits the ability to control expenditures; that Minnesota already leads the nation in nursing home expenditures per capita, has the fifth highest number of beds per capita elderly, and that private paying individuals and medical assistance recipients have equivalent access to nursing home care; and that in the absence of a moratorium the increased numbers of nursing homes and nursing home beds will consume resources that would otherwise be available to develop a comprehensive long-term care system that includes a continuum of care. Unless action is taken, this expansion of bed capacity is likely to accelerate with the repeal of the certificate of need program effective March 15, 1984. The legislature also finds that Minnesota's dependence on institutional care for elderly persons is due in part to the dearth of alternative services in the home and community. The legislature also finds that further increases in the number of licensed nursing home beds, especially in nursing homes not certified for participation in the medical assistance program, is contrary to public policy, because: (1) nursing home residents with limited resources may exhaust their resources more rapidly in these facilities, creating the need for a transfer to a certified nursing home, with the concomitant risk of transfer trauma; (2) a continuing increase in the number of nursing home beds will foster continuing reliance on institutional care to meet the long-term care needs of residents of the state; (3) a further expansion of nursing home beds will diminish incentives to develop more appropriate and cost-effective alternative services and divert community resources that would otherwise be available to fund alternative services; (4) through corporate reorganization resulting in the separation of certified and licensed beds, a nursing home may evade the provisions of section 256B.48, subdivision 1, clause (a); and (5) it is in the best interests of the state to ensure that the long-term care system is designed to protect the private resources of individuals as well as to use state resources most effectively and efficiently.~~

The legislature declares that a moratorium on the licensure and medical assistance certification of new nursing home beds and construction projects that exceed the lesser of $500,000 or 25 percent of a facility's appraised value 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.

New language is indicated by underline, deletions by ~~strikeout~~.

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.

Subd. 2. **MORATORIUM.** The commissioner of health, in coordination with the commissioner of human services, shall deny each request ~~by a nursing home or boarding care home, except an intermediate care facility for the mentally retarded,~~ for ~~addition of~~ new licensed or certified nursing home or certified boarding care beds ~~or for a change or changes in the certification status of existing beds~~ except as provided in subdivision 3 or 4a, or section 144A.073. ~~The total number of certified beds in the state shall remain at or decrease from the number of beds certified on May 23, 1983, except as allowed under subdivision 3.~~ "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 ~~sections 245A.01 to 245A.16 and~~ 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. ~~The commissioner of health shall deny each request for licensure of nursing home beds except as provided in subdivision 3.~~

In addition, the commissioner of health must not approve any construction project whose cost exceeds $500,000, or 25 percent of the facility's appraised value, whichever is less, unless:

(a) any construction costs exceeding the lesser of $500,000 or 25 percent of the facility's appraised value 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 destroyed by fire, lightning, or other hazards provided that the provisions of subdivision ~~3~~ 4a, clause ~~(g)~~ (a), are met; ~~or~~

(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 ~~3~~ 1a, clause ~~(b)~~ (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 ~~project~~ 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 ~~actual~~ 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 $500,000 or 25 percent of appraised value, whichever is less. 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 emergency or permanent rules to implement this section or to amend the emergency rules for granting exceptions to the moratorium on nursing homes under section 144A.073. The authority to adopt emergency rules continues to December 30, 1992.

Subd. 3. **EXCEPTIONS AUTHORIZING AN INCREASE IN BEDS.** The commissioner of health, in coordination with the commissioner of human services, may approve the addition of a new certified bed or the addition of a new licensed nursing home bed, under the following conditions:

(a) to ~~replace a bed~~ license or certify a new bed in place of one decertified after ~~May 23, 1983~~ July 1, 1993, as long as the number of certified plus newly certified or recertified beds does not exceed the number of beds licensed or certified on July 1, 1993, or to address an extreme hardship situation, in a particular county that, together with all contiguous Minnesota counties, has fewer nursing home beds per 1,000 elderly than the number that is ten percent higher than the national average of nursing home beds per 1,000 elderly individuals. For the purposes of this section, the national average of nursing home beds shall be the most recent figure that can be supplied by the federal health care financing administration and the number of elderly in the county or the nation shall be determined by the most recent federal census or the most recent estimate of the state demographer as of July 1, of each year of persons age 65 and older, whichever is the most recent at the time of the request for replacement. ~~In allowing replacement of a decertified bed, the commissioners shall ensure that the number of added or recertified beds does not exceed the total number of decertified beds in the state in that level of care.~~ An extreme hardship situation can only be found after the county documents the existence of unmet medical needs that cannot be addressed by any other alternatives;

~~(b) to certify a new bed in a facility that commenced construction before May 23, 1983. For the purposes of this section, "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 secured;~~

~~(c) to certify beds in a new nursing home that is needed in order to meet the special dietary needs of its residents, if: the nursing home proves to the commissioner's satisfaction that the needs of its residents cannot otherwise be met; elements of the special diet are not available through most food distributors; and proper preparation of the special diet requires incurring various operating expenses, including extra food preparation or serving items, not incurred to a similar extent by most nursing homes;~~

~~(d) to license a new nursing home bed in a facility that meets one of the exceptions contained in clauses (a) to (c);~~

~~(e) to license nursing home beds in a facility that has submitted either a completed licensure application or a written request for licensure to the commissioner before March 1, 1985, and has either commenced any required construction as defined in clause (b) before May 1, 1985, or has, before May 1, 1985, received from the commissioner approval of plans for phased-in construction and written authorization to begin construction on a phased-in basis. For the~~

~~purpose of this clause, "construction" means any erection, building, alteration, reconstruction, modernization, or improvement necessary to comply with the nursing home licensure rules;~~

~~(f)~~ (b) to certify or license new beds in a new facility that is to be operated by the commissioner of veterans affairs or when the costs of constructing and operating the new beds are to be reimbursed by the commissioner of veterans affairs or the United States Veterans Administration; or

~~(g) to license or certify beds in a new facility constructed to replace a facility that was destroyed after June 30, 1987, by fire, lightning, or other hazard provided:~~

~~(1) destruction was not caused by the intentional act of or at the direction of a controlling person of the facility;~~

~~(2) at the time the facility was destroyed 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;~~

~~(3) the net proceeds from an insurance settlement for the damages caused by the hazard are applied to the cost of the new facility;~~

~~(4) 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; and~~

~~(5) 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;~~

~~(h) 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 25 percent of the appraised value of the facility or $500,000, whichever is less, or to license or certify beds in a facility for which the total costs of remodeling or renovation exceed 25 percent of the appraised value of the facility or $500,000, whichever is less, if 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 remodeling or renovation;~~

~~(i)~~ (c) to license or certify beds in a facility that has been involuntarily delicensed or decertified for participation in the medical assistance program, provided that an application for relicensure or recertification is submitted to the commissioner within 120 days after delicensure or decertification;.

~~(j) to license or certify beds in a project recommended for approval by the interagency long-term care planning committee under section 144A.073;~~

~~(k) to license nursing home beds in a hospital facility that are relocated from a different hospital facility under common ownership or affiliation, provided:~~

New language is indicated by underline, deletions by ~~strikeout~~.

~~(1) the nursing home beds are not certified for participation in the medical assistance program; and~~

~~(2) the relocation of nursing home beds under this clause should not exceed a radius of six miles;~~

~~(l) to license or certify beds that are moved from one location to another within an existing identifiable complex of hospital buildings, from a hospital-attached nursing home to the hospital building, or from a separate nursing home to a building formerly used as a hospital, provided the original nursing home building will no longer be operated as a nursing home and the building to which the beds are moved will no longer be operated as a hospital. 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 relocation. At the time of the licensure and certification of the nursing home beds, the commissioner of health shall delicense the same number of acute care beds within the existing complex of hospital buildings or building. Relocation of nursing home beds under this clause is subject to the limitations in section 144A.073, subdivision 5;~~

~~(m) 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. The relocated beds need not be licensed and certified at the new location simultaneously with the delicensing and decertification of the old beds and may be licensed and certified at any time after the old beds are delicensed and decertified;~~

~~(n) to license new nursing home beds in a continuing care retirement community affiliated with 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 residents from outside the state for the purpose of meeting contractual obligations to residents of the retirement community, provided the facility makes a written commitment to the commissioner of human services that it will not seek medical assistance certification for the new beds;~~

~~(o) to certify or license new beds in a new facility on the Red Lake Indian Reservation for which payments will be made under the Indian Health Care Improvement Act, Public Law Number 94-437, at the rates specified in United States Code, title 42, section 1396d(b);~~

~~(p) 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 25 percent of the appraised value of the facility or $500,000, whichever is less; or to license as nursing home beds boarding care beds in a facility with~~

~~an addendum to its provider agreement effective beginning July 1, 1983, if the boarding care beds to be upgraded meet the standards for nursing home licensure. If boarding care beds are licensed as nursing home beds, the number of boarding care beds in the facility must not increase in the future. The provisions contained in section 144A.073 regarding the upgrading of the facilities do not apply to facilities that satisfy these requirements;~~

~~(q) 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 Saint 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 clause;~~

~~(r) 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;~~

~~(s) to license or certify beds that are moved from a nursing home to a separate facility under common ownership or control that was formerly licensed as a hospital and is currently licensed as a nursing facility and that is located within eight miles of the original facility, provided the original nursing home building will no longer be operated as a nursing home. 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 relocation;~~

~~(t) 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;~~

~~(u) 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;~~

~~(v) to license and certify new nursing home beds to replace beds in a facility condemned as part of an economic redevelopment plan in a city of the first class, provided the new facility is located within one mile of the site of the old facility. Operating and property costs for the new facility must be determined and allowed under existing reimbursement rules; or~~

~~(w) 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.~~

Subd. 4. **MONITORING EXCEPTIONS FOR REPLACEMENT BEDS.** The commissioner of health, in coordination with the commissioner of human services, shall implement mechanisms to monitor and analyze the effect of the moratorium in the different geographic areas of the state. The commissioner of health shall submit to the legislature, no later than January 15, 1984, and annually thereafter, an assessment of the impact of the moratorium by geographic area, with particular attention to service deficits or problems and a corrective action plan.

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 25 percent of the appraised value of the facility or $500,000, whichever is less;

(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 25 percent of the appraised value of the facility or $500,000, whichever is less. 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 condemned as part of an economic redevelopment plan in a city of the first class, provided the new facility is located within one mile of the site of the old facility. Operating and property costs for the new facility must be determined and allowed under existing reimbursement rules;

(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 25 percent of the appraised value of the facility or $500,000, whichever is less;

(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, 1995;

(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; or

(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 (d). 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.

Subd. 5. **REPORT.** The ~~commissioner of the state planning agency, in consultation with the~~ commissioners of health and human services~~,~~ shall report to the senate health ~~and human services~~ care committee and the house health and ~~welfare~~ human services committee by January 15, 1986 and biennially thereafter regarding:

(1) projections on the number of elderly Minnesota residents including medical assistance recipients;

(2) the number of residents most at risk for nursing home placement;

(3) the needs for long-term care and alternative home and noninstitutional services;

(4) availability of and access to alternative services by geographic region; and

(5) the necessity or desirability of continuing, modifying, or repealing the moratorium in relation to the availability and development of the continuum of long-term care services.

Subd. 6. **PROPERTY-RELATED PAYMENT RATES OF NEW BEDS.** The property-related payment rates of nursing home or boarding care home beds certified or recertified under subdivision 3 or 4a, shall be adjusted according to Minnesota nursing facility reimbursement laws and rules unless the facility has made a commitment in writing to the commissioner of human services not to seek adjustments to these rates due to property-related expenses incurred as a result of the certification or recertification. Any licensure or certification action authorized under repealed statutes which were approved by the commissioner of health prior to July 1, 1993, shall remain in effect. Any conditions pertaining to property rate reimbursement covered by these repealed statutes prior to July 1, 1993, remain in effect.

Subd. 7. **SUBMISSION OF COST INFORMATION.** Before approval of final construction plans for a nursing home or a certified boarding care home construction project, the licensee shall submit to the commissioner of health an itemized statement of the project construction cost estimates.

If the construction project includes a capital asset addition, replacement, remodeling, or renovation of space such as a hospital, apartment, or shared or common areas, the facility must submit to the commissioner an allocation of

capital asset costs, soft costs, and debt information prepared according to Minnesota Rules, part 9549.

Project construction cost estimates must be prepared by a contractor or architect and other licensed participants in the development of the project.

Subd. 8. **FINAL APPROVAL.** Before conducting the final inspection of the construction project required by Minnesota Rules, part 4660.0100, and issuing final clearances for use, the licensee shall provide to the commissioner of health the total project construction costs of the construction project. If total costs are not available, the most recent cost figures shall be provided. Final cost figures shall be submitted to the commissioner when available. The commissioner shall provide a copy of this information to the commissioner of human services.

Sec. 3. Minnesota Statutes 1992, section 144A.073, subdivision 2, is amended to read:

Subd. 2. **REQUEST FOR PROPOSALS.** At the intervals specified in rules, 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 ~~3~~ 4a, clause ~~(j)~~ (c). 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 notice for that year must state that proposals will not be requested because no appropriations were made. To be considered for approval, a proposal must include the following information:

(1) whether the request is for renovation, replacement, upgrading, or conversion;

(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, including initial construction and remodeling costs, site preparation costs, financing costs, 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; and

(8) other information required by rule of the commissioner of health.

Sec. 4. Minnesota Statutes 1992, section 144A.073, subdivision 3, is amended to read:

Subd. 3. **REVIEW AND APPROVAL OF PROPOSALS.** Within the limits of money specifically appropriated to the medical assistance program for this purpose, the interagency long-term care planning committee ~~for quality assurance~~ may recommend that the commissioner of health grant exceptions to the nursing home licensure or certification moratorium for proposals that satisfy the requirements of this section. The interagency committee shall appoint an advisory review panel composed of representatives of 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 interagency committee shall hold a public hearing before submitting recommendations to the commissioner of health on project requests. The committee shall submit recommendations within 150 days of the date of the publication of the notice, based on a comparison and ranking of proposals using the criteria in subdivision 4. The commissioner of health shall approve or disapprove a project within 30 days after receiving the committee's recommendations. The cost to the medical assistance program of the proposals approved must be within the limits of the appropriations specifically made for this purpose. Approval of a proposal expires 18 months after approval by the commissioner of health unless the facility has commenced construction as defined in section 144A.071, subdivision ~~3~~ 1a, paragraph ~~(b)~~ (d). The committee's report to the legislature, as required under section 144A.31, must include the projects approved, the criteria used to recommend proposals for approval, and the estimated costs of the projects, including the costs of initial construction and remodeling, and the estimated operating costs during the first two years after the project is completed.

Sec. 5. Minnesota Statutes 1992, section 144A.073, is amended by adding a subdivision to read:

Subd. 3b. **AMENDMENTS TO APPROVED PROJECTS.** (a) Nursing facilities that have received approval on or after July 1, 1993, for exceptions to the moratorium on nursing homes through the process described in this section may request amendments to the designs of the projects by writing the commissioner within 18 months of receiving approval. Applicants shall submit supporting materials that demonstrate how the amended projects meet the criteria described in paragraph (b).

(b) The commissioner shall approve requests for amendments for projects approved on or after July 1, 1993, according to the following criteria:

(1) the amended project designs must provide solutions to all of the problems addressed by the original application that are at least as effective as the original solutions;

(2) the amended project designs may not reduce the space in each resident's living area or in the total amount of common space devoted to resident and family uses by more than five percent;

(3) the costs recognized for reimbursement of amended project designs shall be the threshold amount of the original proposal as identified according to section 144A.071, subdivision 2, except under conditions described in clause (4); and

(4) total costs up to ten percent greater than the cost identified in clause (3) may be recognized for reimbursement if the proposer can document that one of the following circumstances is true:

(i) changes are needed due to a natural disaster;

(ii) conditions that affect the safety or durability of the project that could not have reasonably been known prior to approval are discovered;

(iii) state or federal law require changes in project design; or

(iv) documentable circumstances occur that are beyond the control of the owner and require changes in the design.

(c) Approval of a request for an amendment does not alter the expiration of approval of the project according to subdivision 3.

Sec. 6. Minnesota Statutes 1992, section 147.01, subdivision 6, is amended to read:

Subd. 6. **LICENSE SURCHARGE.** In addition to any fee established under section 214.06, the board shall assess an annual license surcharge of $400 against each physician licensed under this chapter. The surcharge applies to a physician who is licensed as of or after the effective date of this section in Laws 1992, and whose license is issued or renewed on or after April 1, 1992, and is assessed as follows:

(1) a physician whose license is issued or renewed between April 1 and September 30 shall be billed on or before November 15, and the physician must pay the surcharge by December 15; and

(2) a physician whose license is issued or renewed between October 1 and March 31 shall be billed on or before May 15, and the physician must pay the surcharge by June 15.

The board shall provide that the surcharge payment must be remitted to the commissioner of human services to be deposited in the general fund under section 256.9656. The board shall not renew the license of a physician who has not paid the surcharge required under this section. The board shall promptly provide to the commissioner of human services upon request information available

to the board and specifically required by the commissioner to operate the provider surcharge program. The board shall limit the surcharge to physicians residing in Minnesota and the states contiguous to Minnesota upon notification from the commissioner of human services that the federal government has approved a waiver to allow the surcharge to be applied in that manner.

Sec. 7. Minnesota Statutes 1992, section 147.02, subdivision 1, is amended to read:

Subdivision 1. **UNITED STATES OR CANADIAN MEDICAL SCHOOL GRADUATES.** The board shall, with the consent of six of its members, issue a license to practice medicine to a person who meets the following requirements:

(a) An applicant for a license shall file a written application on forms provided by the board, showing to the board's satisfaction that the applicant is of good moral character and satisfies the requirements of this section.

(b) The applicant shall present evidence satisfactory to the board of being a graduate of a medical or osteopathic school located in the United States, its territories or Canada, and approved by the board based upon its faculty, curriculum, facilities, accreditation by a recognized national accrediting organization approved by the board, and other relevant data, or is currently enrolled in the final year of study at the school.

(c) The applicant must have passed a comprehensive examination for initial licensure prepared and graded by the national board of medical examiners or the federation of state medical boards. The board shall by rule determine what constitutes a passing score in the examination.

(d) The applicant shall present evidence satisfactory to the board of the completion of one year of graduate, clinical medical training in a program accredited by a national accrediting organization approved by the board or other graduate training approved in advance by the board as meeting standards similar to those of a national accrediting organization.

(e) The applicant shall make arrangements with the executive director to appear in person before the board or its designated representative to show that the applicant satisfies the requirements of this section. The board may establish as internal operating procedures the procedures or requirements for the applicant's personal presentation.

(f) The applicant shall pay a fee established by the board by rule. The fee may not be refunded. Upon application or notice of license renewal, the board must provide notice to the applicant and to the person whose license is scheduled to be issued or renewed of any additional fees, surcharges, or other costs which the person is obligated to pay as a condition of licensure. The notice must:

(1) state the dollar amount of the additional costs;

(2) clearly identify to the applicant the payment schedule of additional costs; and

(3) advise the applicant of the right to apply to be excused from the surcharge if a waiver is granted under section 256.9657, subdivision 1b, or relinquish the license to practice medicine in lieu of future payment if applicable.

(g) The applicant must not have engaged in conduct warranting disciplinary action against a licensee. If the applicant does not satisfy the requirements of this paragraph, the board may refuse to issue a license unless it determines that the public will be protected through issuance of a license with conditions and limitations the board considers appropriate.

Sec. 8. Minnesota Statutes 1992, section 246.18, subdivision 4, is amended to read:

Subd. 4. **COLLECTIONS DEPOSITED IN ~~MEDICAL ASSISTANCE ACCOUNT~~ THE GENERAL FUND.** Except as provided in subdivisions 2 and 5, all receipts from collection efforts for the regional treatment centers, state nursing homes, and other state facilities as defined in section 246.50, subdivision 3, must be deposited in the ~~medical assistance account and are appropriated for that purpose~~ general fund. The commissioner shall ensure that the departmental financial reporting systems and internal accounting procedures comply with federal standards for reimbursement for program and administrative expenditures and fulfill the purpose of this paragraph.

Sec. 9. Minnesota Statutes 1992, section 256.015, subdivision 4, is amended to read:

Subd. 4. **NOTICE.** The state agency must be given notice of monetary claims against a person, firm, or corporation that may be liable in damages to the injured person when the state agency has paid for or become liable for the cost of medical care or payments related to the injury. Notice must be given as follows:

(a) Applicants for public assistance shall notify the state or county agency of any possible claims they may have against a person, firm, or corporation when they submit the application for assistance. Recipients of public assistance shall notify the state or county agency of any possible claims when those claims arise.

(b) A person providing medical care services to a recipient of public assistance shall notify the state agency when the person has reason to believe that a third party may be liable for payment of the cost of medical care.

(c) A person who is a party to a claim upon which the state agency may be entitled to a lien under this section shall notify the state agency of its potential lien claim before filing a claim, commencing an action, or negotiating a settle-

ment. A person who is a party to a claim includes the plaintiff, the defendants, and any other party to the cause of action.

Notice given to the county agency is not sufficient to meet the requirements of paragraphs (b) and (c).

Sec. 10. **[256.027] USE OF VANS PERMITTED.**

The commissioner, after consultation with the commissioner of public safety, shall prescribe procedures to permit the occasional use of lift-equipped vans that have been financed, in whole or in part, by public money to transport an individual whose own lift-equipped vehicle is unavailable because of equipment failure and who is thus unable to complete a trip home or to a medical facility. For purposes of prescribing these procedures, the commissioner is exempt from the provisions of chapter 14. The commissioner shall encourage publicly financed lift-equipped vans to be made available to a county sheriff's department, and to other persons who are qualified to drive the vans and who are also qualified to assist the individual in need of transportation, for this purpose.

Sec. 11. Minnesota Statutes 1992, section 256.9657, subdivision 1, is amended to read:

Subdivision 1. **NURSING HOME LICENSE SURCHARGE.** (a) Effective ~~October 1, 1992~~ July 1, 1993, each non-state-operated nursing home licensed under chapter 144A shall pay to the commissioner an annual surcharge according to the schedule in subdivision 4. The surcharge shall be calculated as ~~$535~~ $620 per licensed bed ~~licensed on the previous July 1, except that.~~ If the number of licensed beds is reduced ~~after July 1 but prior to August 1~~, the surcharge shall be based on the number of remaining licensed beds the second month following the receipt of timely notice by the commissioner of human services that beds have been delicensed. ~~A nursing home entitled to a reduction in the number of beds subject to the surcharge under this provision must demonstrate to the satisfaction of the commissioner by August 5 that the number of beds has been reduced.~~ The nursing home must notify the commissioner of health in writing when beds are delicensed. The commissioner of health must notify the commissioner of human services within ten working days after receiving written notification. If the notification is received by the commissioner of human services by the 15th of the month, the invoice for the second following month must be reduced to recognize the delicensing of beds. Beds on layaway status continue to be subject to the surcharge. The commissioner of human services must acknowledge a medical care surcharge appeal within 30 days of receipt of the written appeal from the provider.

(b) Effective July 1, 1994, the surcharge in paragraph (a) shall be increased to $625.

Sec. 12. Minnesota Statutes 1992, section 256.9657, is amended by adding a subdivision to read:

Subd. 1b. **PHYSICIAN SURCHARGE WAIVER REQUEST.** (a) The commissioner shall request a waiver from the secretary of health and human services to exclude from the surcharge under section 147.01, subdivision 6, a physician whose license is issued or renewed on or after April 1, 1993, and who:

(1) provides physician services at a free clinic, community clinic, or in an underdeveloped foreign nation and does not charge for any physician services;

(2) has taken a leave of absence of at least one year from the practice of medicine but who intends to return to the practice in the future;

(3) is unable to practice medicine because of terminal illness or permanent disability as certified by an attending physician;

(4) is unemployed; or

(5) is retired.

(b) If a waiver is approved under this subdivision, the commissioner shall direct the board of medical practice to adjust the physician license surcharge under section 147.01, subdivision 6, accordingly.

Sec. 13. Minnesota Statutes 1992, section 256.9657, is amended by adding a subdivision to read:

Subd. 1c. **WAIVER IMPLEMENTATION.** If a waiver is approved under subdivision 1b, the commissioner shall implement subdivision 1b as follows:

(a) The commissioner, in cooperation with the board of medical practice, shall notify each physician whose license is scheduled to be issued or renewed between April 1 and September 30 that an application to be excused from the surcharge must be received by the commissioner prior to September 1 of that year for the period of 12 consecutive calendar months beginning December 15. For each physician whose license is scheduled to be issued or renewed between October 1 and March 31, the application must be received from the physician by March 1 for the period of 12 consecutive calendar months beginning June 15. For each physician whose license is scheduled to be issued or renewed between April 1 and September 30, the commissioner shall make the notification required in this paragraph by July 1. For each physician whose license is scheduled to be issued or renewed between October 1 and March 31, the commissioner shall make the notification required in this paragraph by January 1.

(b) The commissioner shall establish an application form for waiver applications. Each physician who applies to be excused from the surcharge under subdivision 1b, paragraph (a), clause (1), must include with the application:

(1) a statement from the operator of the facility at which the physician provides services, that the physician provides services without charge; and

(2) a statement by the physician that the physician will not charge for any physician services during the period for which the exemption from the surcharge is granted.

Each physician who applies to be excused from the surcharge under subdivision 1b, paragraph (a), clauses (2) to (5), must include with the application:

(i) the physician's own statement certifying that the physician does not intend to practice medicine and will not charge for any physician services during the period for which the exemption from the surcharge is granted;

(ii) the physician's own statement describing in general the reason for the leave of absence from the practice of medicine and the anticipated date when the physician will resume the practice of medicine, if applicable;

(iii) an attending physician's statement certifying that the applicant has a terminal illness or permanent disability, if applicable; and

(iv) the physician's own statement indicating on what date the physician retired or became unemployed, if applicable.

(c) The commissioner shall notify in writing the physicians who are excused from the surcharge under subdivision 1b.

(d) A physician who decides to charge for physician services prior to the end of the period for which the exemption from the surcharge has been granted under subdivision 1b, paragraph (a), clause (1), or to return to the practice of medicine prior to the end of the period for which the exemption from the surcharge has been granted under subdivision 1b, paragraph (a), clause (2), (4), or (5), may do so by notifying the commissioner and shall be responsible for payment of the full surcharge for that period.

(e) Whenever the commissioner determines that the number of physicians likely to be excused from the surcharge under subdivision 1b may cause the physician surcharge to violate the requirements of Public Law Number 102-234 or regulations adopted under that law, the commissioner shall immediately notify the chairs of the senate health care committee and health care and family services funding division and the house of representatives human services committee and human services funding division.

Sec. 14. Minnesota Statutes 1992, 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.

Sec. 15. Minnesota Statutes 1992, section 256.9657, subdivision 3, is amended to read:

Subd. 3. **HEALTH MAINTENANCE ORGANIZATION SURCHARGE.** (a) Effective October 1, 1992, each health maintenance organization with a certificate of authority issued by the commissioner of health under chapter 62D shall pay to the commissioner of human services a surcharge equal to six-tenths of one percent of the total premium revenues of the health maintenance organization as reported to the commissioner of health according to the schedule in subdivision 4.

(b) For purposes of this subdivision, total premium revenue means:

(1) premium revenue recognized on a prepaid basis from individuals and groups for provision of a specified range of health services over a defined period of time which is normally one month, excluding premiums paid to a health maintenance organization from the Federal Employees Health Benefit Program;

(2) premiums from Medicare wrap-around subscribers for health benefits which supplement Medicare coverage;

(3) Medicare revenue, as a result of an arrangement between a health maintenance organization and the health care financing administration of the federal Department of Health and Human Services, for services to a Medicare beneficiary; and

(4) medical assistance revenue, as a result of an arrangement between a health maintenance organization and a Medicaid state agency, for services to a medical assistance beneficiary.

If advance payments are made under clause (1) or (2) to the health maintenance organization for more than one reporting period, the portion of the payment that has not yet been earned must be treated as a liability.

Sec. 16. Minnesota Statutes 1992, section 256.9657, subdivision 7, is amended to read:

Subd. 7. **COLLECTION; CIVIL PENALTIES.** The provisions of sections 289A.35 to 289A.50 relating to the authority to audit, assess, collect, and pay refunds of other state taxes may be implemented by the commissioner of human services with respect to the tax, penalty, and interest imposed by this section and section 147.01, subdivision 6. The commissioner of human services shall impose civil penalties for violation of this section or section 147.01, subdivision 6, as provided in section 289A.60, and the tax and penalties are subject to interest at the rate provided in section 270.75. The commissioner of human services shall have the power to abate penalties and interest when discrepancies occur

resulting from, but not limited to, circumstances of error and mail delivery. The commissioner of human services shall bring appropriate civil actions to collect provider payments due under this section and section 147.01, subdivision 6.

Sec. 17. Minnesota Statutes 1992, section 256.9685, subdivision 1, is amended to read:

Subdivision 1. **AUTHORITY.** The commissioner shall establish procedures for determining medical assistance and general assistance medical care payment rates under a prospective payment system for inpatient hospital services in hospitals that qualify as vendors of medical assistance. The commissioner shall establish, by rule, procedures for implementing this section and sections 256.9686, 256.969, and 256.9695. The medical assistance payment rates must be based on methods and standards that the commissioner finds are adequate to provide for the costs that must be incurred for the care of recipients in efficiently and economically operated hospitals. Services must meet the requirements of section 256B.04, subdivision 15, or 256D.03, subdivision 7, paragraph (b), to be eligible for payment except the commissioner may establish exemptions to specific requirements based on diagnosis, procedure, or service after notice in the State Register and a 30-day comment period.

Subd. 1a. **ADMINISTRATIVE RECONSIDERATION.** Notwithstanding sections 256B.04, subdivision 15, and 256D.03, subdivision 7, the commissioner ~~may~~ shall establish an administrative reconsideration process for appeals of inpatient hospital services determined to be medically unnecessary. The reconsideration process shall take place prior to the ~~contested case~~ procedures of ~~chapter 14~~ subdivision 1b and shall be conducted by physicians that are independent of the case under reconsideration. A majority decision by the physicians is necessary to make a determination that the services were not medically necessary.

Subd. 1b. **APPEAL OF RECONSIDERATION.** Notwithstanding section 256B.72, the commissioner may recover inpatient hospital payments for services that have been determined to be medically unnecessary ~~under~~ after the reconsideration ~~process~~ and determinations. A physician or hospital may appeal the result of the reconsideration process by submitting a written request for review to the commissioner within 30 days after receiving notice of the action. The commissioner shall review the medical record and information submitted during the reconsideration process and the medical review agent's basis for the determination that the services were not medically necessary for inpatient hospital services. The commissioner shall issue an order upholding or reversing the decision of the reconsideration process based on the review. A hospital or physician who is aggrieved by an order of the commissioner may appeal the order to the district court of the county in which the physician or hospital is located by serving a written copy of the notice of appeal upon the commissioner within 30 days after the date the commissioner issued the order.

Sec. 18. Minnesota Statutes 1992, section 256.969, subdivision 1, is amended to read:

Subdivision 1. **HOSPITAL COST INDEX.** (a) The hospital cost index shall be obtained from an independent source and shall represent a weighted average of historical, as limited to statutory maximums, and projected cost change estimates determined for expense categories to include wages and salaries, employee benefits, medical and professional fees, raw food, utilities, insurance including malpractice insurance, and other applicable expenses as determined by the commissioner. The index shall reflect Minnesota cost category weights. Individual indices shall be specific to Minnesota if the commissioner determines that sufficient accuracy of the hospital cost index is achieved. The hospital cost index may be used to adjust the base year operating payment rate through the rate year on an annually compounded basis. Notwithstanding section 256.9695, subdivision 3, paragraph (c), the hospital cost index shall not be effective under the general assistance medical care program and shall be limited to five percent under the medical assistance program for admissions occurring during the biennium ending June 30, ~~1993, and the hospital cost index under medical assistance, excluding general assistance medical care, shall be increased by one percentage point to reflect changes in technology for admissions occurring after September 30, 1992~~ 1995.

(b) For fiscal years beginning on or after July 1, 1993, the commissioner of human services shall not provide automatic annual inflation adjustments for hospital payment rates under medical assistance, ~~excluding the technology factor under paragraph (a),~~ nor under general assistance medical care. The commissioner of finance shall include as a budget change request in each biennial detailed expenditure budget submitted to the legislature under section 16A.11 annual adjustments in hospital payment rates under medical assistance and general assistance medical care, based upon the hospital cost index.

Sec. 19. Minnesota Statutes 1992, section 256.969, subdivision 8, is amended to read:

Subd. 8. **UNUSUAL ~~COST OR~~ LENGTH OF STAY EXPERIENCE.** The commissioner shall establish day ~~and cost~~ outlier thresholds for each diagnostic category established under subdivision 2 at two standard deviations beyond the mean length of stay ~~or allowable cost~~. Payment for the days ~~and cost~~ beyond the outlier threshold shall be in addition to the operating and property payment rates per admission established under subdivisions 2, 2b, and 2c. Payment for outliers shall be at 70 percent of the allowable operating cost, after adjustment by the case mix index, hospital cost index, relative values and the disproportionate population adjustment. The outlier threshold for neonatal and burn diagnostic categories shall be established at one standard deviation beyond the mean length of stay ~~or allowable cost~~, and payment shall be at 90 percent of allowable operating cost calculated in the same manner as other outliers. A hospital may choose an alternative to the 70 percent outlier payment that is at a minimum of

60 percent and a maximum of 80 percent if the commissioner is notified in writing of the request by October 1 of the year preceding the rate year. The chosen percentage applies to all diagnostic categories except burns and neonates. The percentage of allowable cost that is unrecognized by the outlier payment shall be added back to the base year operating payment rate per admission. ~~Cost outliers shall be calculated using hospital specific allowable cost data. If a stay is both a day and a cost outlier, outlier payments shall be based on the higher outlier payment.~~

Sec. 20. Minnesota Statutes, section 256.969, subdivision 9, as amended by Laws 1993, chapter 20, section 1, is amended to read:

Subd. 9. **DISPROPORTIONATE NUMBERS OF LOW-INCOME PATIENTS SERVED.** (a) For admissions occurring on or after October 1, 1992, through December 31, 1992, the medical assistance disproportionate population adjustment shall comply with federal law and shall be paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined as follows:

(1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service but less than or equal to one standard deviation above the mean, the adjustment must be determined by multiplying the total of the operating and property payment rates by the difference between the hospital's actual medical assistance inpatient utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service; and

(2) for a hospital with a medical assistance inpatient utilization rate above one standard deviation above the mean, the adjustment must be determined by multiplying the adjustment that would be determined under clause (1) for that hospital by 1.1. If federal matching funds are not available for all adjustments under this subdivision, the commissioner shall reduce payments on a pro rata basis so that all adjustments qualify for federal match. The commissioner may establish a separate disproportionate population operating payment rate adjustment under the general assistance medical care program. For purposes of this subdivision medical assistance does not include general assistance medical care. The commissioner shall report annually on the number of hospitals likely to receive the adjustment authorized by this ~~section~~ paragraph. The commissioner shall specifically report on the adjustments received by public hospitals and public hospital corporations located in cities of the first class.

(b) For admissions occurring on or after July 1, 1993, the medical assistance disproportionate population adjustment shall comply with federal law and shall be paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined as follows:

(1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service but less than or equal to one standard deviation above the mean, the adjustment must be determined by multiplying the total of the operating and property payment rates by the difference between the hospital's actual medical assistance inpatient utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service.

(2) for a hospital with a medical assistance inpatient utilization rate above one standard deviation above the mean, the adjustment must be determined by multiplying the adjustment that would be determined under clause (1) for that hospital by 1.1. The commissioner may establish a separate disproportionate population operating payment rate adjustment under the general assistance medical care program. For purposes of this subdivision, medical assistance does not include general assistance medical care. The commissioner shall report annually on the number of hospitals likely to receive the adjustment authorized by this paragraph. The commissioner shall specifically report on the adjustments received by public hospitals and public hospital corporations located in cities of the first class; and

(3) for a hospital that (i) had medical assistance fee-for-service payment volume during calendar year 1991 in excess of 13 percent of total medical assistance fee-for-service payment volume; or (ii) had medical assistance fee-for-service payment volume during calendar year 1991 in excess of eight percent of total medical assistance fee-for-service payment volume and is affiliated with the University of Minnesota, a medical assistance disproportionate population adjustment shall be paid in addition to any other disproportionate payment due under this subdivision as follows: $1,010,000 due on the 15th of each month after noon, beginning July 15, 1993.

(c) The commissioner shall adjust rates paid to a health maintenance organization under contract with the commissioner to reflect rate increases provided in paragraph (b), clauses (1) and (2) on a nondiscounted hospital-specific basis, but shall not adjust those rates to reflect payments provided in clause (3).

(d) If federal matching funds are not available for all adjustments under paragraph (b), the commissioner shall reduce payments under paragraph (b), clauses (1) and (2), on a pro rata basis so that all adjustments under paragraph (b) qualify for federal match.

(e) For purposes of this subdivision, medical assistance does not include general assistance medical care.

Sec. 21. Minnesota Statutes 1992, section 256.969, subdivision 9a, as amended by Laws 1993, chapter 20, section 2, is amended to read:

Subd. 9a. **DISPROPORTIONATE POPULATION ADJUSTMENTS**

~~AFTER JANUARY~~ UNTIL JULY 1, 1993. (a) For admissions occurring between January 1, 1993, and June 30, 1993, the adjustment under this subdivision shall be paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of one standard deviation above the arithmetic mean. The adjustment must be determined by multiplying the total of the operating and property payment rates by the difference between the hospital's actual medical assistance inpatient utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service, and the result must be multiplied by 1.1.

~~(b) For admissions occurring on or after July 1, 1993, the medical assistance disproportionate population adjustment shall comply with federal law and shall be paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of one standard deviation above the arithmetic mean. The adjustment must be determined by multiplying the operating payment rate by the difference between the hospital's actual medical assistance inpatient utilization rate and one standard deviation above the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service.~~

~~(c) If federal matching funds are not available for all adjustments under this subdivision, the commissioner shall reduce payments on a pro rata basis so that all adjustments qualify for federal match. The commissioner may establish a separate disproportionate population operating payment rate adjustment under the general assistance medical care program. For purposes of this subdivision, medical assistance does not include general assistance medical care. The commissioner shall report annually on the number of hospitals likely to receive the adjustment authorized by this section. The commissioner shall specifically report on the adjustments received by public hospitals and public hospital corporations located in cities of the first class.~~ The provisions of this paragraph are effective only if federal matching funds are not available for all adjustments under this subdivision and it is necessary to implement ratable reductions under subdivision 9b.

Sec. 22. Minnesota Statutes 1992, section 256.969, subdivision 20, as amended by Laws 1993, chapter 20, section 4, is amended to read:

Subd. 20. **INCREASES IN MEDICAL ASSISTANCE INPATIENT PAYMENTS; CONDITIONS.** (a) Medical assistance inpatient payments shall increase 20 percent for inpatient hospital originally paid admissions, excluding Medicare crossovers, that occurred between July 1, 1988, and December 31, 1990, if: (i) the hospital had 100 or fewer Minnesota medical assistance annualized paid admissions, excluding Medicare crossovers, that were paid by March 1, 1988, for the period January 1, 1987, to June 30, 1987; (ii) the hospital had 100 or fewer licensed beds on March 1, 1988; (iii) the hospital is located in Minnesota; and (iv) the hospital is not located in a city of the first class as defined in

section 410.01. For purposes of this paragraph, medical assistance does not include general assistance medical care.

(b) Medical assistance inpatient payments shall increase 15 percent for inpatient hospital originally paid admissions, excluding Medicare crossovers, that occurred between July 1, 1988, and December 31, 1990, if: (i) the hospital had more than 100 but fewer than 250 Minnesota medical assistance annualized paid admissions, excluding Medicare crossovers, that were paid by March 1, 1988, for the period January 1, 1987, to June 30, 1987; (ii) the hospital had 100 or fewer licensed beds on March 1, 1988; (iii) the hospital is located in Minnesota; and (iv) the hospital is not located in a city of the first class as defined in section 410.01. For purposes of this paragraph, medical assistance does not include general assistance medical care.

(c) Medical assistance inpatient payment rates shall increase 20 percent for inpatient hospital originally paid admissions, excluding Medicare crossovers, that occur on or after October 1, 1992, if: (i) the hospital had 100 or fewer Minnesota medical assistance annualized paid admissions, excluding Medicare crossovers, that were paid by March 1, 1988, for the period January 1, 1987, to June 30, 1987; (ii) the hospital had 100 or fewer licensed beds on March 1, 1988; (iii) the hospital is located in Minnesota; and (iv) the hospital is not located in a city of the first class as defined in section 410.01. For a hospital that qualifies for an adjustment under this paragraph and under subdivision 9~~, 9a, or 22~~ or 23, the hospital must be paid the adjustment under subdivisions 9~~, 9a, and 22~~ and 23, as applicable, plus any amount by which the adjustment under this paragraph exceeds the adjustment under those subdivisions. For this paragraph, medical assistance does not include general assistance medical care.

(d) Medical assistance inpatient payment rates shall increase 15 percent for inpatient hospital originally paid admissions, excluding Medicare crossovers, that occur after September 30, 1992, if: (i) the hospital had more than 100 but fewer than 250 Minnesota medical assistance annualized paid admissions, excluding Medicare crossovers, that were paid by March 1, 1988, for the period January 1, 1987, to June 30, 1987; (ii) the hospital had 100 or fewer licensed beds on March 1, 1988; (iii) the hospital is located in Minnesota; and (iv) the hospital is not located in a city of the first class as defined in section 410.01. For a hospital that qualifies for an adjustment under this paragraph and under subdivision 9~~, 9a, or 22~~ or 23, the hospital must be paid the adjustment under subdivisions 9~~, 9a, and 22~~ and 23, as applicable, plus any amount by which the adjustment under this paragraph exceeds the adjustment under those subdivisions. For purposes of this paragraph, medical assistance does not include general assistance medical care.

Sec. 23. Minnesota Statutes 1992, section 256.969, subdivision 22, as amended by Laws 1993, chapter 20, section 5, is amended to read:

Subd. 22. **HOSPITAL PAYMENT ADJUSTMENT.** For admissions

occurring from January 1, 1993, until June 30, 1993, the commissioner shall adjust the medical assistance payment paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined as follows:

(1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service, the adjustment must be determined by multiplying the total of the operating and property payment rates by the difference between the hospital's actual medical assistance inpatient utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service; and

(2) for a hospital with a medical assistance inpatient utilization rate above one standard deviation above the mean, the adjustment must be determined by multiplying the adjustment under clause (1) for that hospital by 1.1. Any payment under this clause must be reduced by the amount of any payment received under subdivision 9a. For purposes of this subdivision, medical assistance does not include general assistance medical care.

This subdivision is effective only if federal matching funds are not available for all adjustments under this subdivision and it is necessary to implement ratable reductions under subdivision 9b.

Sec. 24. Minnesota Statutes 1992, section 256.969, is amended by adding a subdivision to read:

Subd. 23. **HOSPITAL PAYMENT ADJUSTMENT AFTER JUNE 30, 1993.** (a) For admissions occurring after June 30, 1993, the commissioner shall adjust the medical assistance payment paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined as follows:

(1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service, the adjustment must be determined by multiplying the total of the operating and property payment rates by the difference between the hospital's actual medical assistance inpatient utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service; and

(2) for a hospital with a medical assistance inpatient utilization rate above one standard deviation above the mean, the adjustment must be determined by multiplying the adjustment under clause (1) for that hospital by 1.1.

(b) Any payment under this subdivision must be reduced by the amount of

any payment received under subdivision 9, paragraph (b), clause (1) or (2). For purposes of this subdivision, medical assistance does not include general assistance medical care.

(c) The commissioner shall adjust rates paid to a health maintenance organization under contract with the commissioner to reflect rate increases provided in this section. The adjustment must be made on a nondiscounted hospital-specific basis.

Sec. 25. Minnesota Statutes 1992, section 256.969, is amended by adding a subdivision to read:

Subd. 24. **HOSPITAL PEER GROUPS.** For admissions occurring on or after the later of July 1, 1994, or the implementation date of the upgrade to the Medicaid management information system, payment rates of each hospital shall be limited to the payment rates within its peer group so that the statewide payment level is reduced by ten percent under the medical assistance program and by 15 percent under the general assistance medical care program. For subsequent rate years, the limits shall be adjusted by the hospital cost index. The commissioner shall contract for the development of criteria for and the establishment of the peer groups. Peer groups must be established based on variables that affect medical assistance cost such as scope and intensity of services, acuity of patients, location, and capacity. Rates shall be standardized by the case mix index and adjusted, if applicable, for the variable outlier percentage. The peer groups may exclude and have separate limits or be standardized for operating cost differences that are not common to all hospitals in order to establish a minimum number of groups.

Sec. 26. Minnesota Statutes 1992, section 256.9695, subdivision 3, is amended to read:

Subd. 3. **TRANSITION.** Except as provided in section 256.969, subdivision 8, the commissioner shall establish a transition period for the calculation of payment rates from July 1, 1989, to the implementation date of the upgrade to the Medicaid management information system or July 1, 1992, whichever is earlier.

During the transition period:

(a) Changes resulting from section 256.969, subdivisions 7, 9, 10, 11, and 13, shall not be implemented, except as provided in section 256.969, subdivisions 12 and 20.

(b) The beginning of the 1991 rate year shall be delayed and the rates notification requirement shall not be applicable.

(c) Operating payment rates shall be indexed from the hospital's most recent fiscal year ending prior to January 1, 1991, by prorating the hospital cost index

methodology in effect on January 1, 1989. For payments made for admissions occurring on or after June 1, 1990, until the implementation date of the upgrade to the Medicaid management information system the hospital cost index excluding the technology factor shall not exceed five percent. This hospital cost index limitation shall not apply to hospitals that meet the requirements of section 256.969, subdivision 20, paragraphs (a) and (b).

(d) Property and pass-through payment rates shall be maintained at the most recent payment rate effective for June 1, 1990. However, all hospitals are subject to the hospital cost index limitation of subdivision 2c, for two complete fiscal years. Property and pass-through costs shall be retroactively settled through the transition period. The laws in effect on the day before July 1, 1989, apply to the retroactive settlement.

(e) If the upgrade to the Medicaid management information system has not been completed by July 1, 1992, the commissioner shall make adjustments for admissions occurring on or after that date as follows:

(1) provide a ten percent increase to hospitals that meet the requirements of section 256.969, subdivision 20, or, upon written request from the hospital to the commissioner, 50 percent of the rate change that the commissioner estimates will occur after the upgrade to the Medicaid management information system; and

(2) adjust the Minnesota and local trade area rebased payment rates that are established after the upgrade to the Medicaid management information system to compensate for a rebasing effective date of July 1, 1992. The adjustment shall be ~~based on the change in rates from July 1, 1992, to the rebased rates in effect under~~ determined using claim specific payment changes that result from the rebased rates and revised methodology in effect after the systems upgrade. ~~The~~ Any adjustment that is greater than zero shall be rateably reduced by 20 percent. In addition, every adjustment shall ~~reflect~~ be reduced for payments under clause (1), and differences in the hospital cost index ~~and dissimilar rate establishment procedures such as the variable outlier and the treatment of births and.~~ Hospitals shall revise claims so that services provided by rehabilitation units of hospitals are reported separately. The adjustment shall be in effect ~~for a period not to exceed the amount of time from July 1, 1992, to the systems upgrade~~ until the amount due to or owed by the hospital is fully paid over a number of admissions that is equal to the number of admissions under adjustment multiplied by 1.5. The adjustment for admissions occurring from July 1, 1992, to December 31, 1992, shall be based on claims paid as of August 1, 1993, and the adjustment shall begin with the effective date of rules governing rebasing. The adjustment for admissions occurring from January 1, 1993, to the effective date of the rules shall be based on claims paid as of February 1, 1994, and shall begin after the first adjustment period is fully paid. For purposes of appeals under subdivision 1, the adjustment shall be considered payment at the time of admission.

New language is indicated by underline, deletions by ~~strikeout~~.

Sec. 27. **[256B.037] PROSPECTIVE PAYMENT OF DENTAL SERVICES.**

Subdivision 1. **CONTRACT FOR DENTAL SERVICES.** The commissioner may conduct a demonstration project to contract, on a prospective per capita payment basis, with an organization or organizations licensed under chapter 62C or 62D, for the provision of all dental care services beginning July 1, 1994, under the medical assistance, general assistance medical care, and MinnesotaCare programs, or when necessary waivers are granted by the secretary of health and human services, whichever occurs later. The commissioner shall identify a geographic area or areas, including both urban and rural areas, where access to dental services has been inadequate, in which to conduct demonstration projects. The commissioner shall seek any federal waivers or approvals necessary to implement this section from the secretary of health and human services.

The commissioner may exclude from participation in the demonstration project any or all groups currently excluded from participation in the prepaid medical assistance program under section 256B.69.

Subd. 2. **ESTABLISHMENT OF PREPAYMENT RATES.** The commissioner shall consult with an independent actuary to establish prepayment rates, but shall retain final authority over the methodology used to establish the rates. The prepayment rates shall not result in payments that exceed the per capita expenditures that would have been made for dental services by the programs under a fee-for-service reimbursement system. The package of dental benefits provided to individuals under this subdivision shall not be less than the package of benefits provided under the medical assistance fee-for-service reimbursement system for dental services.

Subd. 3. **APPEALS.** All recipients of services under this section have the right to appeal to the commissioner under section 256.045.

Subd. 4. **INFORMATION REQUIRED BY COMMISSIONER.** A contractor shall submit encounter-specific information as required by the commissioner, including, but not limited to, information required for assessing client satisfaction, quality of care, and cost and utilization of services.

Subd. 5. **OTHER CONTRACTS PERMITTED.** Nothing in this section prohibits the commissioner from contracting with an organization for comprehensive health services, including dental services, under section 256B.031, 256B.035, 256B.69, or 256D.03, subdivision 4, paragraph (c).

Sec. 28. Minnesota Statutes 1992, section 256B.04, subdivision 16, is amended to read:

Subd. 16. **PERSONAL CARE SERVICES.** (a) Notwithstanding any contrary language in this paragraph, the commissioner of human services and the

commissioner of health shall jointly promulgate rules to be applied to the licensure of personal care services provided under the medical assistance program. The rules shall consider standards for personal care services that are based on the World Institute on Disability's recommendations regarding personal care services. These rules shall at a minimum consider the standards and requirements adopted by the commissioner of health under section 144A.45, which the commissioner of human services determines are applicable to the provision of personal care services, in addition to other standards or modifications which the commissioner of human services determines are appropriate.

The commissioner of human services shall establish an advisory group including personal care consumers and providers to provide advice regarding which standards or modifications should be adopted. The advisory group membership must include not less than 15 members, of which at least 60 percent must be consumers of personal care services and representatives of recipients with various disabilities and diagnoses and ages. At least 51 percent of the members of the advisory group must be recipients of personal care.

The commissioner of human services may contract with the commissioner of health to enforce the jointly promulgated licensure rules for personal care service providers.

Prior to final promulgation of the joint rule the commissioner of human services shall report preliminary findings along with any comments of the advisory group and a plan for monitoring and enforcement by the department of health to the legislature by February 15, 1992.

Limits on the extent of personal care services that may be provided to an individual must be based on the cost-effectiveness of the services in relation to the costs of inpatient hospital care, nursing home care, and other available types of care. The rules must provide, at a minimum:

(1) that agencies be selected to contract with or employ and train staff to provide and supervise the provision of personal care services;

(2) that agencies employ or contract with a qualified applicant that a qualified recipient proposes to the agency as the recipient's choice of assistant;

(3) that agencies bill the medical assistance program for a personal care service by a personal care assistant and supervision by the registered nurse supervising the personal care assistant;

(4) that agencies establish a grievance mechanism; and

(5) that agencies have a quality assurance program.

(b) The commissioner may waive the requirement for the provision of personal care services through an agency in a particular county, when there are less than two agencies providing services in that county and shall waive the requirement for personal care assistants required to join an agency for the first time

during 1993 when personal care services are provided under a relative hardship waiver under section 256B.0627, subdivision 4, paragraph (b), clause (7), and at least two agencies providing personal care services have refused to employ or contract with the independent personal care assistant.

Sec. 29. Minnesota Statutes 1992, section 256B.042, subdivision 4, is amended to read:

Subd. 4. **NOTICE.** The state agency must be given notice of monetary claims against a person, firm, or corporation that may be liable to pay part or all of the cost of medical care when the state agency has paid or become liable for the cost of that care. Notice must be given as follows:

(a) Applicants for medical assistance shall notify the state or local agency of any possible claims when they submit the application. Recipients of medical assistance shall notify the state or local agency of any possible claims when those claims arise.

(b) A person providing medical care services to a recipient of medical assistance shall notify the state agency when the person has reason to believe that a third party may be liable for payment of the cost of medical care.

(c) A person who is a party to a claim upon which the state agency may be entitled to a lien under this section shall notify the state agency of its potential lien claim before filing a claim, commencing an action, or negotiating a settlement. A person who is a party to a claim includes the plaintiff, the defendants, and any other party to the cause of action.

Notice given to the local agency is not sufficient to meet the requirements of paragraphs (b) and (c).

Sec. 30. Minnesota Statutes 1992, section 256B.055, subdivision 1, is amended to read:

Subdivision 1. **CHILDREN ELIGIBLE FOR SUBSIDIZED ADOPTION ASSISTANCE.** Medical assistance may be paid for a child eligible for or receiving adoption assistance payments under title IV-E of the Social Security Act, United States Code, title 42, sections 670 to 676, and to any child who is not title IV-E eligible but who was determined eligible for adoption assistance under Minnesota Statutes, section 259.40 ~~or 259.431~~, subdivision 4, clauses (a) to (c), and has a special need for medical or rehabilitative care.

Sec. 31. Minnesota Statutes 1992, section 256B.056, subdivision 2, is amended to read:

Subd. 2. **HOMESTEAD; EXCLUSION FOR INSTITUTIONALIZED PERSONS.** The homestead shall be excluded for the first six calendar months of a person's stay in a long-term care facility and shall continue to be excluded for as long as the recipient can be reasonably expected to return~~, as provided under~~

~~the methodologies for the supplemental security income program~~ to the homestead. For purposes of this subdivision, "reasonably expected to return to the homestead" means the recipient's attending physician has certified that the expectation is reasonable, and the recipient can show that the cost of care upon returning home will be met through medical assistance or other sources. The homestead shall continue to be excluded for persons residing in a long-term care facility if it is used as a primary residence by one of the following individuals:

(a) the spouse;

(b) a child under age 21;

(c) a child of any age who is blind or permanently and totally disabled as defined in the supplemental security income program;

(d) a sibling who has equity interest in the home and who resided in the home for at least one year immediately before the date of the person's admission to the facility; or

(e) a child of any age, or, subject to federal approval, a grandchild of any age, who resided in the home for at least two years immediately before the date of the person's admission to the facility, and who provided care to the person that permitted the person to reside at home rather than in an institution.

Sec. 32. Minnesota Statutes 1992, section 256B.0575, is amended to read:

256B.0575 **AVAILABILITY OF INCOME FOR INSTITUTIONALIZED PERSONS.**

When an institutionalized person is determined eligible for medical assistance, the income that exceeds the deductions in paragraphs (a) and (b) must be applied to the cost of institutional care.

(a) The following amounts must be deducted from the institutionalized person's income in the following order:

(1) the personal needs allowance under section 256B.35 or, for a veteran who does not have a spouse or child, or a surviving spouse of a veteran having no child, the amount of ~~any veteran's pension~~ an improved pension received from the veteran's administration not exceeding $90 per month;

(2) the personal allowance for disabled individuals under section 256B.36;

(3) if the institutionalized person has a legally appointed guardian or conservator, five percent of the recipient's gross monthly income up to $100 as reimbursement for guardianship or conservatorship services;

(4) a monthly income allowance determined under section 256B.058, subdivision 2, but only to the extent income of the institutionalized spouse is made available to the community spouse;

(5) a monthly allowance for children under age 18 which, together with the net income of the children, would provide income equal to the medical assistance standard for families and children according to section 256B.056, subdivision 4, for a family size that includes only the minor children. This deduction applies only if the children do not live with the community spouse and only if the children resided with the institutionalized person immediately prior to admission;

(6) a monthly family allowance for other family members, equal to one-third of the difference between 122 percent of the federal poverty guidelines and the monthly income for that family member;

(7) reparations payments made by the Federal Republic of Germany; and

(8) amounts for reasonable expenses incurred for necessary medical or remedial care for the institutionalized spouse that are not medical assistance covered expenses and that are not subject to payment by a third party.

For purposes of clause (6), "other family member" means a person who resides with the community spouse and who is a minor or dependent child, dependent parent, or dependent sibling of either spouse. "Dependent" means a person who could be claimed as a dependent for federal income tax purposes under the Internal Revenue Code.

(b) Income shall be allocated to an institutionalized person for a period of up to three calendar months, in an amount equal to the medical assistance standard for a family size of one if:

(1) a physician certifies that the person is expected to reside in the long-term care facility for three calendar months or less;

(2) if the person has expenses of maintaining a residence in the community; and

(3) if one of the following circumstances apply:

(i) the person was not living together with a spouse or a family member as defined in paragraph (a) when the person entered a long-term care facility; or

(ii) the person and the person's spouse become institutionalized on the same date, in which case the allocation shall be applied to the income of one of the spouses.

For purposes of this paragraph, a person is determined to be residing in a licensed nursing home, regional treatment center, or medical institution if the person is expected to remain for a period of one full calendar month or more.

Sec. 33. Minnesota Statutes 1992, section 256B.059, subdivision 3, is amended to read:

Subd. 3. **COMMUNITY SPOUSE ASSET ALLOWANCE.** ~~(a)~~ An institutionalized spouse may transfer assets to the community spouse solely for the benefit of the community spouse. Except for increased amounts allowable under subdivision 4, the maximum amount of assets allowed to be transferred is the amount which, when added to the assets otherwise available to the community spouse, is ~~the greater of~~ as follows:

(1) ~~$12,000~~ prior to July 1, 1994, the greater of:

(i) $14,148;

~~(2)~~ (ii) the lesser of the spousal share or ~~$60,000~~ $70,740; or

~~(3)~~ (iii) the amount required by court order to be paid to the community spouse; and

(2) for persons who begin their first continuous period of institutionalization on or after July 1, 1994, the greater of:

(i) $20,000;

(ii) the lesser of the spousal share or $70,740; or

(iii) the amount required by court order to be paid to the community spouse.

If the assets available to the community spouse are already at the limit permissible under this section, or the higher limit attributable to increases under subdivision 4, no assets may be transferred from the institutionalized spouse to the community spouse. The transfer must be made as soon as practicable after the date the institutionalized spouse is determined eligible for medical assistance, or within the amount of time needed for any court order required for the transfer. On January 1, ~~1990~~ 1994, and every January 1 thereafter, the ~~$12,000 and $60,000~~ limits in this subdivision shall be adjusted by the same percentage change in the consumer price index for all urban consumers (all items; United States city average) between the two previous Septembers. These adjustments shall also be applied to the ~~$12,000 and $60,000~~ limits in subdivision 5.

Sec. 34. Minnesota Statutes 1992, section 256B.059, subdivision 5, is amended to read:

Subd. 5. **ASSET AVAILABILITY.** (a) At the time of application for medical assistance benefits, assets considered available to the institutionalized spouse shall be the total value of all assets in which either spouse has an ownership interest, reduced by the ~~greater of~~ following:

(1) ~~$12,000; or~~ prior to July 1, 1994, the greater of:

(i) $14,148;

~~(2)~~ (ii) the lesser of the spousal share or ~~$60,000~~ $70,740; or

~~(3)~~ (iii) the amount required by court order to be paid to the community spouse;

(2) for persons who begin their first continuous period of institutionalization on or after July 1, 1994, the greater of:

(i) $20,000;

(ii) the lesser of the spousal share or $70,740; or

(iii) the amount required by court order to be paid to the community spouse.

If the community spouse asset allowance has been increased under subdivision 4, then the assets considered available to the institutionalized spouse under this subdivision shall be further reduced by the value of additional amounts allowed under subdivision 4.

(b) An institutionalized spouse may be found eligible for medical assistance even though assets in excess of the allowable amount are found to be available under paragraph (a) if the assets are owned jointly or individually by the community spouse, and the institutionalized spouse cannot use those assets to pay for the cost of care without the consent of the community spouse, and if: (i) the institutionalized spouse assigns to the commissioner the right to support from the community spouse under section 256B.14, subdivision ~~2~~ 3; (ii) the institutionalized spouse lacks the ability to execute an assignment due to a physical or mental impairment; or (iii) the denial of eligibility would cause an imminent threat to the institutionalized spouse's health and well-being.

(c) After the month in which the institutionalized spouse is determined eligible for medical assistance, during the continuous period of institutionalization, no assets of the community spouse are considered available to the institutionalized spouse, unless the institutionalized spouse has been found eligible under clause (b).

(d) Assets determined to be available to the institutionalized spouse under this section must be used for the health care or personal needs of the institutionalized spouse.

(e) For purposes of this section, assets do not include assets excluded under section 256B.056, without regard to the limitations on total value in that section.

Sec. 35. Minnesota Statutes 1992, section 256B.0595, is amended to read:

256B.0595 **PROHIBITIONS ON TRANSFER; EXCEPTIONS.**

Subdivision 1. **PROHIBITED TRANSFERS.** (a) 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 section 256B.056, subdivision 3, 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 on or after July 1, 1993, or upon federal approval, whichever is later, a person, a person's spouse, or a person's authorized representative 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 medical assistance, any transfer of an asset within 60 months preceding application for medical assistance or during the period of medical assistance eligibility, including assets excluded under section 256B.056, subdivision 3, for less than fair market value may be considered. Any transfer for less than fair market value made within 60 months preceding application for medical assistance or during the period of medical assistance eligibility is presumed to have been made for the purpose of establishing or maintaining medical assistance eligibility and the person is ineligible for medical assistance 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 subdivisions 3 or 4.

~~(b)~~ (c) This section applies to transfers, for less than fair market value, of income or assets that are considered income in the month received, such as inheritances, court settlements, and retroactive benefit payments.

~~(c)~~ (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.

~~(d)~~ (e) This section applies to the portion of any asset or interest that a person or a person's spouse transfers to an irrevocable trust, annuity, or other instrument, 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.

~~(e)~~ (f) For purposes of this section, long-term care services include nursing facility services, and home- and community-based services provided pursuant to section 256B.491. 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 who is receiving home- and community-based services under section 256B.491.

Subd. 2. **PERIOD OF INELIGIBILITY.** (a) For any uncompensated transfer, 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 on or after July 1, 1993, or upon federal approval, whichever is later, the number of months of ineligibility, including partial months, for medical assistance 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. If a calculation of a penalty period results in a partial month, payments for medical assistance services will be reduced in an amount equal to the fraction, except that in calculating the value of uncompensated transfers, uncompensated transfers not to exceed $1,000 in total value per month shall be disregarded for each month prior to the month of application for medical assistance. 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. The penalty in this paragraph shall not apply to uncompensated transfers of assets not to exceed a total of $1,000 per month during a medical assistance eligibility certification period. 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.

(c) If the total value of all uncompensated transfers made in a month exceeds $1,000, the disregards allowed under paragraph (b) do not apply.

Subd. 3. **HOMESTEAD EXCEPTION TO TRANSFER PROHIBITION.** (a) An institutionalized person is not ineligible for long-term care services due to a transfer of assets for less than fair market value if the asset transferred was a homestead and:

(1) title to the homestead was transferred to the individual's

(i) spouse;

(ii) child who is under age 21;

(iii) blind or permanently and totally disabled child as defined in the supplemental security income program;

(iv) sibling who has equity interest in the home and who was residing in the home for a period of at least one year immediately before the date of the individual's admission to the facility; or

(v) son or daughter who was residing in the individual's home for a period of at least two years immediately before the date of the individual's admission to the facility, and who provided care to the individual that permitted the individual to reside at home rather than in an institution or facility;

(2) a satisfactory showing is made that the individual intended to dispose of the homestead at fair market value or for other valuable consideration; or

(3) the local agency grants a waiver of the excess resources created by the uncompensated transfer because denial of eligibility would cause undue hardship for the individual, based on imminent threat to the individual's health and well-being.

(b) When a waiver is granted under paragraph (a), clause (3), a cause of action exists against the person to whom the homestead was transferred for that portion of long-term care services granted within 30 months of the transfer or the amount of the uncompensated transfer, whichever is less, together with the costs incurred due to the action. The action may be brought by the state or the local agency responsible for providing medical assistance under chapter 256G.

(c) Effective for transfers made on or after July 1, 1993, or upon federal approval, whichever is later, an institutionalized person is not ineligible for medical assistance services due to a transfer of assets for less than fair market value if the asset transferred was a homestead and:

(1) title to the homestead was transferred to the individual's

(i) spouse;

(ii) child who is under age 21;

(iii) blind or permanently and totally disabled child as defined in the supplemental security income program;

(iv) sibling who has equity interest in the home and who was residing in the home for a period of at least one year immediately before the date of the individual's admission to the facility; or

(v) son or daughter who was residing in the individual's home for a period of at least two years immediately before the date of the individual's admission to the facility, and who provided care to the individual that permitted the individual to reside at home rather than in an institution or facility;

(2) a satisfactory showing is made that the individual intended to dispose of the homestead at fair market value or for other valuable consideration; or

(3) the local agency grants a waiver of the excess resources created by the uncompensated transfer because denial of eligibility would cause undue hardship for the individual, based on imminent threat to the individual's health and well-being.

(d) When a waiver is granted under paragraph (c), clause (3), a cause of action exists against the person to whom the homestead was transferred for that portion of medical assistance services granted during the period of ineligibility under subdivision 2, or the amount of the uncompensated transfer, whichever is less, together with the costs incurred due to the action. The action may be brought by the state or the local agency responsible for providing medical assistance under chapter 256G.

Subd. 4. **OTHER EXCEPTIONS TO TRANSFER PROHIBITION.** (a) An institutionalized person who has made, or whose spouse has made a transfer prohibited by subdivision 1, is not ineligible for long-term care services if one of the following conditions applies:

(1) the assets were transferred to the community spouse, as defined in section 256B.059; or

(2) the institutionalized spouse, prior to being institutionalized, transferred assets to a spouse, provided that the spouse to whom the assets were transferred does not then transfer those assets to another person for less than fair market value. (At the time when one spouse is institutionalized, assets must be allocated between the spouses as provided under section 256B.059); or

(3) the assets were transferred to the individual's child who is blind or per-

manently and totally disabled as determined in the supplemental security income program; or

(4) a satisfactory showing is made that the individual intended to dispose of the assets either at fair market value or for other valuable consideration; or

(5) the local agency determines that denial of eligibility for long-term care services would work an undue hardship and grants a waiver of excess assets. When a waiver is granted, a cause of action exists against the person to whom the assets were transferred for that portion of long-term care services granted within 30 months of the transfer, or the amount of the uncompensated transfer, whichever is less, together with the costs incurred due to the action. The action may be brought by the state or the local agency responsible for providing medical assistance under this chapter.

(b) Effective for transfers made on or after July 1, 1993, or upon federal approval, whichever is later, an institutionalized person who has made, or whose spouse has made a transfer prohibited by subdivision 1, is not ineligible for medical assistance services if one of the following conditions applies:

(1) the assets were transferred to the community spouse, as defined in section 256B.059; or

(2) the institutionalized spouse, prior to being institutionalized, transferred assets to a spouse, provided that the spouse to whom the assets were transferred does not then transfer those assets to another person for less than fair market value. (At the time when one spouse is institutionalized, assets must be allocated between the spouses as provided under section 256B.059); or

(3) the assets were transferred to the individual's child who is blind or permanently and totally disabled as determined in the supplemental security income program; or

(4) a satisfactory showing is made that the individual intended to dispose of the assets either at fair market value or for other valuable consideration; or

(5) the local agency determines that denial of eligibility for medical assistance services would work an undue hardship and grants a waiver of excess assets. When a waiver is granted, a cause of action exists against the person to whom the assets were transferred for that portion of medical assistance services granted during the period of ineligibility determined under subdivision 2 or the amount of the uncompensated transfer, whichever is less, together with the costs incurred due to the action. The action may be brought by the state or the local agency responsible for providing medical assistance under this chapter.

Subd. 5. **NOTICE OF RECEIPT OF FEDERAL WAIVER.** In every instance in which a federal waiver that allows the implementation of a provision in this section is granted, the commissioner shall publish notice of receipt of the waiver in the state register.

Sec. 36. Minnesota Statutes 1992, section 256B.0625, subdivision 3, is amended to read:

Subd. 3. **PHYSICIANS' SERVICES.** Medical assistance covers physicians' services. Rates paid for anesthesiology services provided by physicians shall be according to the formula utilized in the Medicare program and shall use a conversion factor "at percentile of calendar year set by legislature."

Sec. 37. Minnesota Statutes 1992, section 256B.0625, subdivision 6a, is amended to read:

Subd. 6a. **HOME HEALTH SERVICES.** Home health services are those services specified in Minnesota Rules, part 9505.0290. Medical assistance covers home health services at a recipient's home residence. Medical assistance does not cover home health services ~~at~~ for residents of a hospital, nursing facility, intermediate care facility, or a health care facility licensed by the commissioner of health, unless the program is funded under a home- and community-based services waiver or unless the commissioner of human services has prior authorized skilled nurse visits for less than 90 days for a resident at an intermediate care facility for persons with mental retardation, to prevent an admission to a hospital or nursing facility or unless a resident who is otherwise eligible is on leave from the facility and the facility either pays for the home health services or forgoes the facility per diem for the leave days that home health services are used. Home health services must be provided by a Medicare certified home health agency. All nursing and home health aide services must be provided according to section 256B.0627.

Sec. 38. Minnesota Statutes 1992, 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. Medical assistance does not cover private duty nursing services ~~at~~ 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. 39. Minnesota Statutes 1992, section 256B.0625, subdivision 11, is amended to read:

Subd. 11. **NURSE ANESTHETIST SERVICES.** Medical assistance covers nurse anesthetist services. Rates paid for anesthesiology services provided by certified registered nurse anesthetists shall be according to the formula utilized in the Medicare program and shall use the conversion factor that is used by the Medicare program.

Sec. 40. Minnesota Statutes 1992, section 256B.0625, subdivision 13, is amended to read:

Subd. 13. **DRUGS.** (a) Medical assistance covers drugs if prescribed by a licensed practitioner and dispensed by a licensed pharmacist, or by a physician enrolled in the medical assistance program as a dispensing physician. The commissioner, after receiving recommendations from ~~the Minnesota~~ professional medical ~~association~~ associations and ~~the Minnesota pharmacists association~~ 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 commissioner shall appoint the formulary committee members no later than 30 days following July 1, 1981.~~ 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 ~~two-year~~ three-year terms and shall serve without compensation. Members may be reappointed once. 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: drugs or products for which there is no federal funding; over-the-counter drugs, except for antacids, acetaminophen, family planning products, aspirin, insulin, products for the treatment of lice, and vitamins for children under the age of seven and pregnant or nursing women; or 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, the administrative procedure act; ~~nutritional products, except for those products needed for treatment of phenylketonuria, hyperlysinemia, maple syrup urine disease, a combined allergy to human milk, cow milk, and soy formula, or any other childhood or adult diseases, conditions, or disorders identified by the commissioner as requiring a similarly necessary nutritional product;~~ anorectics; and drugs for which medical value has not been established. ~~Nutritional products needed for the treatment of a combined allergy to human milk, cow's milk, and soy formula require prior authorization. Separate payment shall not be made for nutritional products for residents of long-term care facilities; payment for dietary requirements is a component of the per diem rate paid to these facilities. Payment to drug vendors shall not be modified before the formulary is established except that the commissioner shall not permit payment for any drugs which may not by law be included in the formulary, and the commissioner's determination shall not be subject to chapter 14, the administrative procedure act.~~ The commissioner shall publish conditions for prohibiting payment for specific drugs after considering the formulary committee's recommendations.

(b) 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 established by the commissioner, 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. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. The actual acquisition cost of a drug may be estimated by the commissioner. 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. 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. Implementation of any change in the fixed dispensing fee that has not been subject to the administrative procedure act is limited to not more than 180 days, unless, during that time, the commissioner initiates rulemaking through the administrative procedure act.

(c) Until ~~January 4, 1993, or~~ the date the on-line, real-time Medicaid Management Information System (MMIS) upgrade is successfully implemented, as determined by the commissioner of administration, ~~whichever occurs last,~~ a pharmacy provider may require individuals who seek to become eligible for medical assistance under a one-month spend-down, as provided in section 256B.056, subdivision 5, to pay for services to the extent of the spend-down amount at the time the services are provided. A pharmacy provider choosing this option shall file a medical assistance claim for the pharmacy services provided. If medical assistance reimbursement is received for this claim, the pharmacy provider shall return to the individual the total amount paid by the individual for the pharmacy services reimbursed by the medical assistance program. If the claim is not eligible for medical assistance reimbursement because of the provider's failure to comply with the provisions of the medical assistance program, the pharmacy provider shall refund to the individual the total amount paid by the individual. Pharmacy providers may choose this option only if they apply similar credit restrictions to private pay or privately insured individuals. A pharmacy provider choosing this option must inform individuals who seek to become eligible for medical assistance under a one-month spend-down of (1) their right to appeal the denial of services on the grounds that they have satisfied the spend-down requirement, and (2) their potential eligibility for the health right program or the children's health plan.

Sec. 41. Minnesota Statutes 1992, section 256B.0625, subdivision 13a, is amended to read:

Subd. 13a. **DRUG UTILIZATION REVIEW BOARD.** A 12-member drug utilization review board is established. The board is comprised of six licensed physicians actively engaged in the practice of medicine in Minnesota; five licensed pharmacists actively engaged in the practice of pharmacy in Minnesota; and one consumer representative. 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 physician members shall be selected from ~~a list~~ lists submitted by ~~the Minnesota~~ professional medical ~~association~~ associations. The pharmacist members shall be selected from ~~a list~~ lists submitted by ~~the Minnesota~~ professional pharmacist ~~Association~~ associations. The commissioner shall appoint the initial members of the board for terms expiring as follows: four members for terms expiring June 30, 1995; four members for terms expiring June 30, 1994; and four members for terms expiring June 30, 1993. 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 con-

tract 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 December 1. 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.

Sec. 42. Minnesota Statutes 1992, section 256B.0625, subdivision 15, is amended to read:

Subd. 15. **HEALTH PLAN PREMIUMS AND COPAYMENTS.** Medical assistance covers health care prepayment plan premiums ~~and~~, insurance premiums ~~if paid directly to a vendor and supplementary medical insurance benefits under Title XVIII of the Social Security Act~~, and copayments if determined to be cost-effective by the commissioner. For purposes of obtaining Medicare part A and part B, and copayments, expenditures may be made even if federal funding is not available.

Sec. 43. Minnesota Statutes 1992, 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. The commissioner shall establish maximum medical assistance reimbursement rates for special transportation services for persons who need a wheelchair lift van or stretcher-equipped vehicle and for those who do not need a wheelchair lift van or stretcher-equipped vehicle. The average of these two rates must not exceed ~~$13~~ $14 for the base rate and ~~$1~~ $1.10 per mile. Special transportation provided to nonambulatory 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. 44. Minnesota Statutes 1992, section 256B.0625, subdivision 19a, is amended to read:

Subd. 19a. **PERSONAL CARE SERVICES.** Medical assistance covers personal care services in a recipient's home. Recipients who can direct their own care, or persons who cannot direct their own care when authorized by the responsible party, may use approved hours 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. Medical assistance does not cover personal care services ~~at~~ for residents of a hospital, nursing facility, intermediate care facility ~~or a~~, health care facility licensed by the commissioner of health, or unless a resident who is otherwise eligible is on leave from the facility and the facility either pays for the personal care services or forgoes the facility per diem for the leave days that personal care services are used except as authorized in section 256B.64 for ventilator-dependent recipients in hospitals. Total hours of service and payment allowed for services outside the home cannot exceed that which is otherwise allowed for personal care services in an in-home setting according to section 256B.0627. All personal care services must be provided according to section 256B.0627. Personal care services may not be reimbursed if the personal care assistant is the spouse of the recipient or the parent of a recipient under age 18, the responsible party or the foster care provider of a recipient who cannot direct the recipient's own care or the recipient's legal guardian unless, in the case of a foster provider, a county or state case manager visits the recipient as needed, but no less than every six months, to monitor the health and safety of the recipient and to ensure the goals of the care plan are met. Parents of adult recipients, adult children of the recipient or adult siblings of the recipient may be reimbursed for personal care services if they are granted a waiver under section 256B.0627.

Sec. 45. Minnesota Statutes 1992, section 256B.0625, subdivision 27, is amended to read:

Subd. 27. **ORGAN AND TISSUE TRANSPLANTS.** Medical assistance coverage for organ ~~and tissue~~ transplant procedures is limited to those procedures covered by the Medicare program~~, provided those~~; heart-lung transplants for persons with primary pulmonary hypertension and performed at Minnesota transplant centers meeting united network for organ sharing criteria to perform heart-lung transplants; lung transplants using cadaveric donors and performed at Minnesota transplant centers meeting united network for organ sharing criteria to perform lung transplants; pancreas transplants for uremic diabetic recipients of kidney transplants and performed at Minnesota facilities meeting united network for organ sharing criteria to perform pancreas transplants; and allogeneic bone marrow transplants for persons with stage III or IV Hodgkin's disease. Transplant procedures must comply with all applicable laws, rules, and regulations governing (1) coverage by the Medicare program, (2) federal financial participation by the Medicaid program, and (3) coverage by the Minnesota medical assistance program. Transplant centers must meet american society of hematology and clinical oncology criteria for bone marrow transplants and be located in Minnesota to receive reimbursement for bone marrow transplants.

Sec. 46. Minnesota Statutes 1992, section 256B.0625, subdivision 28, is amended to read:

Subd. 28. **CERTIFIED NURSE PRACTITIONER SERVICES.** Medical assistance covers services performed by a certified pediatric nurse practitioner, a certified family nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological nurse practitioner, or a certified geriatric nurse practitioner in independent practice, if the services are otherwise covered under this chapter as a physician service, and if the service is within the scope of practice of the nurse practitioner's license as a registered nurse, as defined in section 148.171.

Sec. 47. Minnesota Statutes 1992, section 256B.0625, subdivision 29, is amended to read:

Subd. 29. **PUBLIC HEALTH NURSING CLINIC SERVICES.** Medical assistance covers the 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 or registered nurse's license as a registered nurse, as defined in section 148.171.

Sec. 48. Minnesota Statutes 1992, section 256B.0625, is amended by adding a subdivision to read:

Subd. 34. **NUTRITIONAL PRODUCTS.** Medical assistance covers nutritional products needed for treatment of phenylketonuria, hyperlysinemia, maple syrup urine disease, a combined allergy to human milk, cow's milk, and soy formula, or any other childhood or adult diseases, conditions, or disorders identified by the commissioner as requiring a similarly necessary nutritional product. Nutritional products needed for the treatment of a combined allergy to human milk, cow's milk, and soy formula require prior authorization. Separate payment shall not be made for nutritional products for residents of long-term care facilities; payment for dietary requirements is a component of the per diem rate paid to these facilities.

Sec. 49. Minnesota Statutes 1992, section 256B.0625, is amended by adding a subdivision to read:

Subd. 35. **AMERICAN INDIAN HEALTH SERVICES FACILITIES.** Medical assistance payments to American Indian health services facilities for outpatient medical services billed after June 30, 1990, must be 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 American Indian health services facilities 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 an American Indian health service facility.

Sec. 50. **[256B.0626] ESTIMATION OF 50TH PERCENTILE OF PREVAILING CHARGES.**

(a) The 50th percentile of the prevailing charge for the base year identified in statute must be estimated by the commissioner in the following situations:

(1) there were less than ten billings in the calendar year specified in legislation governing maximum payment rates;

(2) the service was not available in the calendar year specified in legislation governing maximum payment rates;

(3) the payment amount is the result of a provider appeal;

(4) the procedure code description has changed since the calendar year specified in legislation governing maximum payment rates, and, therefore, the prevailing charge information reflects the same code but a different procedure description; or

(5) the 50th percentile reflects a payment which is grossly inequitable when compared with payment rates for procedures or services which are substantially similar.

(b) When one of the situations identified in paragraph (a) occurs, the commissioner shall use the following methodology to reconstruct a rate comparable to the 50th percentile of the prevailing rate:

(1) refer to information which exists for the first nine billings in the calendar year specified in legislation governing maximum payment rates; or

(2) refer to surrounding or comparable procedure codes; or

(3) refer to the 50th percentile of years subsequent to the calendar year specified in legislation governing maximum payment rates, and reduce that amount by applying an appropriate Consumer Price Index formula; or

(4) refer to relative value indexes; or

(5) refer to reimbursement information from other third parties, such as Medicare.

Sec. 51. Minnesota Statutes 1992, section 256B.0627, subdivision 1, is amended to read:

Subdivision 1. **DEFINITION.** (a) "Home care services" means a health service, determined by the commissioner as medically necessary, that is ordered by a physician and documented in a care plan that is reviewed by the physician at least once every 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.

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

(c) "Care plan" means a written description of the services needed which is ~~signed~~ developed by the supervisory nurse together with the recipient or responsible party and includes a detailed description of the covered home care services, who is providing the services, frequency and duration of services, and expected outcomes and goals ~~including expected date of goal accomplishment~~. The provider must give the recipient or responsible party a copy of the completed care plan within 30 days of beginning home care services.

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

Sec. 52. Minnesota Statutes 1992, section 256B.0627, subdivision 4, is amended to read:

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

(1) bowel and bladder care;

(2) skin care to maintain the health of the skin;

(3) delegated therapy tasks specific to maintaining a recipient's optimal level of functioning, including range of motion and muscle strengthening exercises;

(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 normally self-administered;

(9) application and maintenance of prosthetics and orthotics;

(10) cleaning medical equipment;

(11) dressing or undressing;

(12) assistance with food, nutrition, and diet activities;

(13) accompanying a recipient to obtain medical diagnosis or treatment;

(14) ~~helping the recipient to complete daily living skills such as personal and oral hygiene and medication schedules~~ assisting, monitoring, or prompting the recipient to complete the services in clauses (1) to (13);

(15) ~~supervision~~ redirection, monitoring, and observation that are medically necessary ~~because of the recipient's diagnosis or disability; and~~ and an integral part of completing the personal cares 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; and

(18) incidental household services that are an integral part of a personal care service described in clauses (1) to ~~(15)~~ (17).

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.

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

(1) personal care services that are not in the care plan developed by the supervising registered nurse in consultation with the personal care assistants and the recipient or the responsible party directing the care of the recipient;

(2) services that are not supervised by the registered nurse;

(3) services provided by the recipient's spouse, legal guardian, or parent of a minor child;

(4) services provided by a foster care provider of a recipient who cannot direct their own care, unless monitored by a county or state case manager under section 256B.0625, subdivision 19a;

(5) services provided by the residential or program license holder in a residence for more than four persons;

(6) services that are the responsibility of a residential or program license holder under the terms of a service agreement and administrative rules;

~~(5)~~ (7) sterile procedures;

~~(6)~~ (8) injections of fluids into veins, muscles, or skin;

~~(7)~~ (9) services provided by parents of adult recipients, adult children, or siblings, 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, the relative is needed in order to provide an adequate number of qualified personal care assistants to meet the medical needs of the recipient;

~~(8)~~ (10) homemaker services that are not an integral part of a personal care services; and

~~(9)~~ (11) home maintenance, or chore services.

Sec. 53. Minnesota Statutes 1992, 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) **EXEMPTION FROM PAYMENT LIMITATIONS.** The level, or the number of hours or visits of a specific service, of home care services to a recipient that began before and is continued without increase on or after December 1987, shall be exempt from the payment limitations of this section, as long as the services are medically necessary.

(b) **LIMITS ON SERVICES WITHOUT PRIOR AUTHORIZATION.** A recipient may receive the following amounts of home care services during a calendar year:

(1) a total of 40 home health aide visits or skilled nurse visits under section 256B.0625, subdivision 6a; and

(2) ~~a total of ten hours of nursing supervision under section 256B.0625, subdivision 7 or 19a~~ up to two assessments by a supervising registered nurse to determine a recipient's need for personal care services, develop a care plan, and obtain prior authorization. Additional visits may be authorized by the commissioner if there are circumstances that necessitate a change in provider.

(c) **PRIOR AUTHORIZATION; EXCEPTIONS.** All home care services above the limits in paragraph (b) 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; ~~or~~

(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; or

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

(d) **RETROACTIVE AUTHORIZATION.** A request for retroactive authorization under paragraph (c) will be evaluated according to the same criteria applied to prior authorization requests. Implementation of this provision shall begin no later than October 1, 1991, except that recipients who are currently receiving medically necessary services above the limits established under this subdivision may have a reasonable amount of time to arrange for waivered services under section 256B.49 or to establish an alternative living arrangement. All current recipients shall be phased down to the limits established under paragraph (b) on or before April 1, 1992.

(e) **ASSESSMENT AND CARE PLAN.** The home care provider shall conduct ~~an~~ initially, and at least annually thereafter, a face-to-face assessment of the recipient and complete a care plan using forms specified by the commissioner. For the recipient to receive, or continue to receive, home care services, the pro-

vider must submit evidence necessary for the commissioner to determine the medical necessity of the home care services. The provider shall submit to the commissioner the assessment, the care 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. To continue to receive home care services when the recipient displays no significant change, the supervising nurse has the option to review with the commissioner, or the commissioner's designee, the care plan on record and receive authorization for up to an additional 12 months.

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

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

(2) **PERSONAL CARE SERVICES.** (i) All personal care services must be prior authorized by the commissioner or the commissioner's designee except for the limits on supervision established in paragraph (b). The amount of personal care services authorized must be based on the recipient's ~~case mix classification according to section 256B.0911, except that~~ 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, plus any inflation adjustment provided, for care provided in a regional treatment center for recipients who have ~~complex behaviors~~ Level I behavior; or

(D) up to the amount the commissioner would pay, as of July 1, 1991, plus any inflation adjustment provided, 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 necessary provision of nursing supervision of personal care services.

(ii) The number of direct care hours shall be determined according to the annual cost ~~reports which are~~ report submitted to the department by nursing facilities ~~each year~~. 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 ~~each year~~, 1992. These limits shall be calculated to the nearest quarter hour.

(iii) The ~~case mix level~~ home care rating shall be determined by the commissioner or the commissioner's designee based on information submitted to the commissioner by the personal care provider on forms specified by the commissioner. The ~~forms~~ 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 children and nonelderly adults who need home care. The commissioner shall establish these forms and protocols under this section and shall use the advisory group established in section 256B.04, subdivision 16, for consultation in establishing the forms and protocols by October 1, 1991.

(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 the recipient's condition or treatment requires more training~~ 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 ~~complex~~ Level I behavior if there is reasonable supporting evidence that the recipient exhibits ~~on a daily basis~~, 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) ~~self-injurious behavior~~ injury to his or her own body;

(B) ~~unusual or repetitive habits~~ physical injury to other people; or

(C) ~~withdrawal behavior;~~

~~(D) hurtful behavior to others;~~

~~(E) socially offensive behavior;~~

~~(F)~~ destruction of property~~; or~~

~~(G) a need for constant one-to-one supervision for self-preservation~~.

(vi) ~~The complex behaviors in clauses (A) to (G) have the meanings developed under section 256B.501~~ Time authorized for personal care relating to Level I behavior in subclause (v), items (A) to (C), shall be based on the predictability, frequency, and amount of intervention required.

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

(A) unusual or repetitive habits;

(B) withdrawn behavior; or

(C) offensive behavior.

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

(3) **PRIVATE DUTY NURSING SERVICES.** All private duty nursing services shall be prior authorized by the commissioner or the commissioner's desig-

nee. Prior authorization for private duty nursing services shall be based on medical necessity and cost-effectiveness when compared with alternative care options. The commissioner may authorize medically necessary private duty nursing services in quarter-hour units when:

(i) the recipient requires more individual and continuous care than can be provided during a nurse visit; or

(ii) the cares are outside of the scope of services that can be provided by a home health aide or personal care assistant.

The commissioner may authorize:

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

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

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

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

(4) **VENTILATOR-DEPENDENT RECIPIENTS.** If the recipient is ventilator-dependent, the monthly medical assistance authorization for home care services shall not exceed what the commissioner would pay for care at the highest cost hospital designated as a long-term hospital under the Medicare program. For purposes of this clause, home care services means all services provided in the home that would be included in the payment for care at the long-term hospital. "Ventilator-dependent" means an individual who receives mechanical ventilation for life support at least six hours per day and is expected to be or has been dependent for at least 30 consecutive days.

(g) **PRIOR AUTHORIZATION; TIME LIMITS.** The commissioner or the commissioner's designee shall determine the time period for which a prior authorization shall ~~remain valid~~ 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 through the process described above. Under no circumstances, other than the exceptions in subdivision 5, paragraph (c), 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 ~~request that the~~ continue previously authorized services, other than temporary services under paragraph (i), ~~be continued~~ pending an appeal under section 256.045~~, subdivision 10~~. The commissioner must provide a detailed explanation of why the authorized services are reduced in amount from those requested by the home care provider.

(h) **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, the care 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.

(i) **PRIOR AUTHORIZATION REQUESTS; TEMPORARY SERVICES.** Providers 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 care plan information provided by an appropriately licensed nurse. Authorization for a temporary level of home care services is limited to the time specified by the commissioner, but shall not exceed ~~30~~ 45 days. The level of services authorized under this provision shall have no bearing on a future prior authorization.

(j) **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 (b).

The commissioner may not authorize:

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

(2) personal care services when the foster care license holder is also the personal care provider or personal care assistant unless the recipient can direct the recipient's own care, or case management is provided as required in section 256B.0625, subdivision 19a;

(3) personal care services when the responsible party is an employee of, or under contract with, or has any direct or indirect financial relationship with the personal care provider or personal care assistant, unless case management is provided as required in section 256B.0625, subdivision 19a;

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

(5) home care services when combined with foster care payments, other than room and board payments plus the cost of home- and community-based waivered services unless the costs of home care services and waivered services are combined and managed under the waiver program, that exceed the total amount that public funds would pay for the recipient's care in a medical institution.

Sec. 54. Minnesota Statutes 1992, section 256B.0628, subdivision 2, is amended to read:

Subd. 2. ~~CONTRACTOR~~ **DUTIES.** (a) The commissioner may contract with or employ qualified registered nurses and necessary support staff, or contract with qualified agencies, to provide home care prior authorization and review services for medical assistance recipients who are receiving home care services.

(b) Reimbursement for the prior authorization function shall be made through the medical assistance administrative authority. The state shall pay the nonfederal share. The ~~contractor must~~ functions will be to:

(1) assess the recipient's individual need for services required to be cared for safely in the community;

(2) ensure that a care plan that meets the recipient's needs is developed by the appropriate agency or individual;

(3) ensure cost-effectiveness of medical assistance home care services;

(4) recommend ~~to the commissioner~~ the approval or denial of the use of medical assistance funds to pay for home care services when home care services exceed thresholds established by the commissioner under Minnesota Rules, parts 9505.0170 to 9505.0475;

(5) reassess the recipient's need for and level of home care services at a frequency determined by the commissioner; and

(6) conduct on-site assessments when determined necessary by the commissioner and recommend changes to care plans that will provide more efficient and appropriate home care.

(c) In addition, the ~~contractor may be requested by the~~ commissioner ~~to~~ or the commissioner's designee may:

(1) review care plans and reimbursement data for utilization of services that exceed community-based standards for home care, inappropriate home care services, medical necessity, home care services that do not meet quality of care standards, or unauthorized services and make appropriate referrals ~~to the commissioner~~ within the department or to other appropriate entities based on the findings;

(2) assist the recipient in obtaining services necessary to allow the recipient to remain safely in or return to the community;

(3) coordinate home care services with other medical assistance services under section 256B.0625;

(4) assist the recipient with problems related to the provision of home care services; and

(5) assure the quality of home care services.

(d) For the purposes of this section, "home care services" means medical assistance services defined under section 256B.0625, subdivisions 6a, 7, and 19a.

Sec. 55. Minnesota Statutes 1992, section 256B.0629, subdivision 4, is amended to read:

Subd. 4. **RESPONSIBILITIES OF THE COMMISSIONER.** (a) The commissioner shall periodically:

(1) Recommend to the legislature criteria governing the eligibility of organ and tissue transplant procedures for reimbursement from medical assistance and general assistance medical care. Procedures approved by Medicare are automatically eligible for medical assistance and general assistance medical care reimbursement. Additional procedures are eligible for reimbursement only ~~upon approval by the legislature. Only procedures~~ if they are recommended by both the task force and the commissioner ~~may be considered by the legislature~~.

(2) Recommend to the legislature criteria for certifying transplant centers within and outside of Minnesota where Minnesotans receiving medical assistance and general assistance medical care may obtain transplants. Additional centers may be certified only upon approval of the legislature. Only centers recommended by the task force and the commissioner may be considered by the legislature.

Sec. 56. Minnesota Statutes 1992, section 256B.0911, subdivision 2, is amended to read:

Subd. 2. **PERSONS REQUIRED TO BE SCREENED; EXEMPTIONS.** All applicants to Medicaid certified nursing facilities must be screened prior to admission, regardless of income, assets, or funding sources, except the following:

(1) patients who, having entered acute care facilities from certified nursing facilities, are returning to a certified nursing facility;

(2) residents transferred from other certified nursing facilities;

(3) ~~individuals whose length of stay is expected to be 30 days or less based on a physician's certification, if the facility notifies the screening team prior to admission and provides an update to the screening team on the 30th day after admission;~~

~~(4)~~ individuals who have a contractual right to have their nursing facility care paid for indefinitely by the veteran's administration; or

~~(5)~~ (4) individuals who are enrolled in the Ebenezer/Group Health social health maintenance organization project at the time of application to a nursing home~~; or~~

~~(6) individuals who are screened by another state within three months before admission to a certified nursing facility.~~

Regardless of the exemptions in clauses (2) to ~~(6)~~ (4), persons who have a diagnosis or possible diagnosis of mental illness, mental retardation, or a related condition must be screened before admission 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.

~~Persons transferred from an acute care facility to a certified nursing facility may be admitted to the nursing facility before screening, if authorized by the county agency; however, the person must be screened within ten working days after the admission.~~ Before admission to a Medicaid certified nursing home or boarding care home, all persons must be screened and approved for admission through an assessment process. The nursing facility is authorized to conduct case mix assessments which are not conducted by the county public health nurse under Minnesota Rules, part 9549.0059. The designated county agency is responsible for distributing the quality assurance and review form for all new applicants to nursing homes.

Other persons who are not applicants to nursing facilities must be screened if a request is made for a screening.

Sec. 57. Minnesota Statutes 1992, section 256B.0911, is amended by adding a subdivision to read:

Subd. 2a. **SCREENING REQUIREMENTS.** Persons may be screened by

telephone or in a face-to-face consultation. The screener will identify each individual's needs according to the following categories: (1) needs no face-to-face screening; (2) needs an immediate face-to-face screening interview; or (3) needs a face-to-face screening interview after admission to a certified nursing facility or after a return home. Persons who are not admitted to a Medicaid certified nursing facility must be screened within ten working days after the date of referral. Persons admitted on a nonemergency basis to a Medicaid certified nursing facility must be screened prior to the certified nursing facility admission. Persons admitted to the Medicaid certified nursing facility from the community on an emergency basis or from an acute care facility on a nonworking day must be screened the first working day after admission and the reason for the emergency admission must be certified by the attending physician in the person's medical record.

Sec. 58. Minnesota Statutes 1992, section 256B.0911, subdivision 3, is amended to read:

Subd. 3. **PERSONS RESPONSIBLE FOR CONDUCTING THE PREADMISSION SCREENING.** (a) A local screening team shall be established by the county ~~agency and the county public health nursing service of the local board of health~~ board of commissioners. Each local screening team shall ~~be composed~~ consist of screeners who are a social worker and a public health nurse from their respective county agencies. 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. Two or more counties may collaborate to establish a joint local screening team or teams.

(b) ~~Both members of the team must conduct the screening. However, individuals who are being transferred from an acute care facility to a certified nursing facility and individuals who are admitted to a certified nursing facility on an emergency basis may be screened by only one member of the screening team in consultation with the other member.~~

~~(c)~~ In assessing a person's needs, ~~each screening team~~ 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 ~~on the screening team~~ if the physician chooses to participate. Other personnel may be included on the team as deemed appropriate by the county agencies.

~~(d) If a person who has been screened must be reassessed to assign a case mix classification because admission to a nursing facility occurs later than the time allowed by rule following the initial screening and assessment, the reassessment may be completed by the public health nurse member of the screening team.~~

Sec. 59. Minnesota Statutes 1992, section 256B.0911, subdivision 4, is amended to read:

Subd. 4. **RESPONSIBILITIES OF THE COUNTY ~~AGENCY~~ AND THE SCREENING TEAM.** (a) The county ~~ageney~~ shall:

(1) provide information and education to the general public regarding availability of the preadmission screening program;

(2) accept referrals from individuals, families, human service and health professionals, and hospital and nursing facility personnel;

(3) assess the health, psychological, and social needs of referred individuals and identify services needed to maintain these persons in the least restrictive environments;

(4) determine if the individual screened needs nursing facility level of care;

(5) assess ~~active treatment~~ specialized service needs ~~in cooperation with~~ based upon an evaluation by:

(i) a qualified independent mental health professional for persons with a primary or secondary diagnosis of a serious mental illness; and

(ii) a qualified mental retardation professional for persons with a primary or secondary diagnosis of mental retardation or related conditions. For purposes of this clause, a qualified mental retardation professional must meet the standards for a qualified mental retardation professional in Code of Federal Regulations, title 42, section 483.430;

(6) make recommendations for individuals screened regarding cost-effective community services which are available to the individual;

(7) make recommendations for individuals screened regarding nursing home placement when there are no cost-effective community services available;

(8) develop an individual's community care plan and provide follow-up services as needed; and

(9) prepare and submit reports that may be required by the commissioner of human services.

~~The county agency may determine in cooperation with the local board of health that the public health nursing agency of the local board of health is the lead agency which is responsible for all of the activities above except clause (5).~~

(b) The ~~screening team~~ screener shall document that the most cost-effective alternatives available were offered to the individual or the individual's legal representative. For purposes of this section, "cost-effective alternatives" means community services and living arrangements that cost the same or less than nursing facility care.

~~The screening shall be conducted within ten working days after the date of~~

~~referral or, for those approved for transfer from an acute care facility to a certified nursing facility, within ten working days after admission to the nursing facility.~~

(c) For persons who are eligible for medical assistance or who would be eligible within 180 days of admission to a nursing facility and who are admitted to a nursing facility, the nursing facility must include ~~the screening team~~ a screener or the case manager in the discharge planning process for those individuals who the team has determined have discharge potential. The ~~screening team~~ screener or the case manager must ensure a smooth transition and follow-up for the individual's return to the community.

~~Local screening teams~~ Screeners shall cooperate with other public and private agencies in the community, in order to offer a variety of cost-effective services to the disabled and elderly. The ~~screening team~~ screeners shall encourage the use of volunteers from families, religious organizations, social clubs, and similar civic and service organizations to provide services.

Sec. 60. Minnesota Statutes 1992, section 256B.0911, subdivision 6, is amended to read:

Subd. 6. **~~REIMBURSEMENT~~ PAYMENT FOR PREADMISSION SCREENING.** (a) The total screening ~~cost~~ 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 ~~estimate of the total~~ annual ~~cost of~~ allocation for screenings ~~allowed in the county for the following rate year~~ by 12 to determine the monthly ~~cost estimate~~ payment and allocating the monthly ~~cost estimate~~ payment to each nursing facility based on the number of licensed beds in the nursing facility.

~~(b) The rate allowed for a screening where two team members are present shall be the actual costs up to $195. The rate allowed for a screening where only one team member is present shall be the actual costs up to $117. Annually on July 1, the commissioner shall adjust the rate up to the percentage change forecast in the fourth quarter of the prior calendar year by the Home Health Agency Market Basket of Operating Costs, unless otherwise adjusted by statute. The Home Health Agency Market Basket of Operating Costs is published by Data Resources, Inc.~~

~~(c) The monthly cost estimate for each certified nursing facility must be submitted to the state by the county no later than February 15 of each year for inclusion in the nursing facility's payment rate on the following rate year. The commissioner shall include the reported annual estimated cost of screenings for each nursing facility as an operating cost of that nursing facility in accordance with section 256B.431, subdivision 2b, paragraph (g). The monthly cost estimates approved by the commissioner must be sent to the nursing facility by the county no later than April 15 of each year.~~

New language is indicated by underline, deletions by ~~strikeout~~.

~~(d) If in more than ten percent of the total number of screenings performed by a county in a fiscal year for all individuals regardless of payment source, the screening timelines were not met because a county was late in screening the individual, the county is solely responsible for paying the cost of those delayed screenings that exceed ten percent.~~

(b) Payments for screening activities are available to the county or counties to cover staff salaries and expenses to provide the screening function. The lead agency shall employ, or contract with other agencies to employ, within the limits of available funding, sufficient personnel to conduct the preadmission screening activity while meeting the state's long-term care outcomes and objectives as defined in section 256B.0917, subdivision 1. The local agency shall be accountable for meeting local objectives as approved by the commissioner in the CSSA biennial plan.

~~(e)~~ (c) Notwithstanding section 256B.0641, overpayments attributable to payment of the screening costs under the medical assistance program may not be recovered from a facility.

~~(f)~~ (d) The commissioner of human services shall amend the Minnesota medical assistance plan to include reimbursement for the local screening teams.

Sec. 61. Minnesota Statutes 1992, 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 ~~screening team~~ 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 evaluation 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. 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). ~~However,~~

(b) The local county mental health authority or the ~~local~~ 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 ~~does need active treatment~~ 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).

(c) Upon the receipt by the commissioner of approval by the secretary of health and human services of the waiver requested under paragraph (a), the local screener shall deny medical assistance reimbursement for nursing facility care for an individual whose long-term care needs can be met in a community-based setting and whose cost of community-based home care services is less than 75 percent of the average payment for nursing facility care for that individual's case mix classification, and who is either:

(i) a current medical assistance recipient being screened for admission to a nursing facility; or

(ii) an individual who would be eligible for medical assistance within 180 days of entering a nursing facility and who meets a nursing facility level of care.

(d) 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. 62. Minnesota Statutes 1992, section 256B.0913, subdivision 4, is amended to read:

Subd. 4. **ELIGIBILITY FOR FUNDING FOR SERVICES FOR NON-MEDICAL 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;

(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 the medical assistance program;

(5) the screening team would recommend nursing facility admission or continued stay for the person if alternative care services were not available;

~~(5)~~ (6) the person needs services that are not available at that time in the county through other county, state, or federal funding sources; and

~~(6)~~ (7) 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 to which the individual would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059.

(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 spend-down if the person applied, unless authorized by the commissioner. ~~The commissioner may authorize alternative care money to be used to meet a portion of a medical assistance income spend-down for persons residing in adult foster care who would otherwise be served under the alternative care program. The alternative care payment is limited to the difference between the recipient's negotiated foster care room and board rate and the medical assistance income standard for one elderly person plus the medical assistance personal needs allowance for a person residing in a long-term care facility.~~ A person whose 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 ~~retroactive to~~ from the date ~~of eligibility~~ the individual was found eligible for the medical assistance services provided that are reimbursable under the elderly waiver program.

(f) Alternative care funding is not available for a person who resides in a licensed nursing home or boarding care home, except for case management services which are being provided in support of the discharge planning process.

Sec. 63. Minnesota Statutes 1992, 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; ~~and~~

(9) residential care services;

(10) care-related supplies and equipment~~.~~;

~~(b) The county agency may use up to ten percent of the annual allocation of alternative care funding for payment of costs of~~

(11) meals delivered to the home~~,~~;

(12) transportation~~,~~;

(13) skilled nursing~~,~~;

(14) chore services~~,~~;

(15) companion services~~,~~;

(16) nutrition services~~,~~; and

(17) training for direct informal caregivers.

~~The commissioner shall determine the impact on alternative care costs of allowing these additional services to be provided and shall report the findings to the legislature by February 15, 1993, including any recommendations regarding provision of the additional services.~~

~~(c)~~ (b) The county agency must ensure that the funds are used only to supplement and not supplant services available through other public assistance or services programs.

~~(d) These services must be provided by a licensed provider, a home health agency certified for reimbursement under Titles XVIII and XIX of the Social Security Act, or by~~ (c) Unless specified in statute, the service standards for alternative care services shall be the same as the service standards defined in the elderly waiver. Persons or agencies must be employed by or ~~contracted~~ 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.

~~(e)~~ (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.

~~(f)~~ (e) Personal care services may be provided by a personal care provider organization. A county agency may contract with a relative of the client to provide personal care services, but must ensure nursing supervision. Covered personal care services defined in section 256B.0627, subdivision 4, must meet applicable standards in Minnesota Rules, part 9505.0335.

~~(g)~~ (f) Costs for supplies and equipment that exceed $150 per item per month must have prior approval from the commissioner. 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.

(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. 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 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 both personal care services and residential care services.

(h) For the purposes of this section, "assisted living" refers to supportive services provided by a single vendor to ~~two or more alternative care~~ clients who reside in the same apartment building of ~~ten~~ three or more units. ~~These services may include care coordination, the costs of preparing one or more nutritionally balanced meals per day, general oversight, and other supportive services which the vendor is licensed to provide according to sections 144A.43 to 144A.49, and which would otherwise be available to individual alternative care clients. Reimbursement from the lead agency shall be made to the vendor as a monthly capitated rate negotiated with the county agency. The capitated rate shall not exceed the state 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 180-day eligible client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059. The capitated rate may not cover rent and direct food costs.~~ 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 or personal care 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.

A person's eligibility to reside in the building must not be contingent on the person's acceptance or use of the assisted living services. Assisted living services as defined in this section shall not be authorized in boarding and lodging establishments licensed according to sections 157.01 to 157.031.

Reimbursement for assisted living services and residential care services shall be made by the lead agency to the vendor as a monthly rate negotiated with the county agency. 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 180-day eligible client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, except for alternative care assisted living projects established under chapter 256 whose rates may not exceed 65 percent 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 eligible client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059. The rate may not cover rent and direct food costs.

(i) 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 nonprofit 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.

(j) 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.

Sec. 64. Minnesota Statutes 1992, 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 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. 65. Minnesota Statutes 1992, section 256B.0913, subdivision 12, is amended to read:

Subd. 12. **CLIENT PREMIUMS.** (a) A premium is required for all 180-day eligible clients to help pay for the cost of participating in the program. The amount of the premium for the alternative care client shall be determined as follows:

(1) when the alternative care client's ~~gross~~ income less recurring and predictable medical expenses is greater than the medical assistance income standard but less than 150 percent of the federal poverty guideline, and total assets are less than $6,000, the fee is zero;

(2) when the alternative care client's ~~gross~~ income less recurring and predictable medical expenses is greater than 150 percent of the federal poverty guideline and total assets are less than $6,000, the fee is 25 percent of the cost of alternative care services or the difference between 150 percent of the federal poverty guideline and the client's ~~gross~~ income less recurring and predictable medical expenses, whichever is less; and

(3) when the alternative care client's total assets are greater than $6,000, 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 and be payable in the month in which the alternative care services begin and shall continue unaltered for six months until the semiannual reassessment unless the actual cost of services falls below the fee.

(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;

(6) a person is an adult foster care resident for whom alternative care funds are being used to meet a portion of the person's medical assistance spend-down, as authorized in subdivision 4; and

(7) a person's fee under paragraph (a) is less than $25.

(c) The county agency must collect the premium from the client and forward the amounts collected to the commissioner in the manner and at the times prescribed by the commissioner. Money collected must be deposited in the general fund and is appropriated to the commissioner for the alternative care pro-

gram. 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. 66. Minnesota Statutes 1992, section 256B.0913, subdivision 13, is amended to read:

Subd. 13. **COUNTY ~~ALTERNATIVE CARE~~ BIENNIAL PLAN.** ~~The commissioner shall establish by rule, in accordance with chapter 14, procedures for the submittal and approval of a biennial county plan for the administration of the alternative care program and the coordination with other planning processes for the older adult. In addition to the procedures in rule,~~ The county biennial plan for the preadmission screening program, the alternative care program, 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 ~~also~~ 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) ~~an application for targeted funds under subdivision 11; and~~

~~(4) an optional notice of intent to apply to participate in the long-term care projects under section 256B.0917~~ information on the administration of the alternative care program.

Sec. 67. Minnesota Statutes 1992, section 256B.0913, subdivision 14, is amended to read:

Subd. 14. **REIMBURSEMENT AND RATE ADJUSTMENTS.** (a) Reimbursement for expenditures for the alternative care services shall be through the invoice processing procedures of the department's Medicaid Management Information System (MMIS), only with the approval of the client's case manager. To

receive reimbursement, the county or vendor must submit invoices within 120 days following the month 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) Beginning July 1, 1991, the state will reimburse counties, up to the limits of state appropriations, 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 would be eligible for medical assistance within 180 days of admission to a nursing home.

(d) For fiscal years beginning on or after July 1, 1993, the commissioner of human services shall not provide automatic annual inflation adjustments for alternative care services. The commissioner of finance shall include as a budget change request in each biennial detailed expenditure budget submitted to the legislature under section 16A.11 annual adjustments in reimbursement rates for alternative care services based on the forecasted percentage change in the Home Health Agency Market Basket of Operating Costs, for the fiscal year beginning July 1, compared to the previous fiscal year, unless otherwise adjusted by statute. The Home Health Agency Market Basket of Operating Costs is published by Data Resources, Inc. The forecast to be used is the one published for the calendar quarter beginning January 1, six months prior to the beginning of the fiscal year for which rates are set.

(e) The county shall negotiate individual rates with vendors and may be reimbursed for actual costs up to the greater of the county's current approved rate or 60 percent of the maximum rate in fiscal year 1994 and 65 percent of the maximum rate in fiscal year 1995 for each alternative care service. Notwithstanding any other rule or statutory provision to the contrary, the commissioner shall not be authorized to increase rates by an annual inflation factor, unless so authorized by the legislature.

(f) On July 1, 1993, the commissioner shall increase the maximum rate for home delivered meals to $4.50 per meal.

Sec. 68. Minnesota Statutes 1992, section 256B.0915, subdivision 1, is amended to read:

Subdivision 1. **AUTHORITY.** The commissioner is authorized to apply for a home- and community-based services waiver for the elderly, authorized under section 1915(c) of the Social Security Act, in order to obtain federal financial participation to expand the availability of services for persons who are eligible for medical assistance. The commissioner may apply for additional waivers or pursue other federal financial participation which is advantageous to the state

for funding home care services for the frail elderly who are eligible for medical assistance. The provision of waivered services to elderly and disabled medical assistance recipients must comply with the criteria approved in the waiver.

Sec. 69. Minnesota Statutes 1992, section 256B.0915, is amended by adding a subdivision to read:

Subd. 1a. **ELDERLY WAIVER CASE MANAGEMENT SERVICES.** Elderly case management services under the home and community-based services waiver for elderly individuals are available from providers meeting qualification requirements and the standards specified in subdivision 1b. Eligible recipients may choose any qualified provider of elderly case management services.

Sec. 70. Minnesota Statutes 1992, section 256B.0915, is amended by adding a subdivision to read:

Subd. 1b. **PROVIDER QUALIFICATIONS AND STANDARDS.** The commissioner must enroll qualified providers of elderly case management services under the home and community-based waiver for the elderly under section 1915(c) of the Social Security Act. The enrollment process shall ensure the provider's ability to meet the qualification requirements and standards in this subdivision and other federal and state requirements of this service. A elderly 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 for alternative care program administration under section 256B.0913;

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

(3) administrative capacity and experience in serving the target population for whom it will provide services and in ensuring quality of services under state and federal requirements;

(4) the legal authority to provide preadmission screening under section 256B.0911, subdivision 4;

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

(6) the capacity to document and maintain individual case records under state and federal requirements.

Sec. 71. Minnesota Statutes 1992, section 256B.0915, is amended by adding a subdivision to read:

Subd. 1c. **CASE MANAGEMENT ACTIVITIES UNDER THE STATE PLAN.** The commissioner shall seek an amendment to the home and community-based services waiver for the elderly to implement the provisions of subdivisions 1a and 1b. If the commissioner is unable to secure the approval of the secretary of health and human services for the requested waiver amendment by December 31, 1993, the commissioner shall amend the medical assistance state plan to provide that case management provided under the home and community-based services waiver for the elderly is performed by counties as an administrative function for the proper and effective administration of the state medical assistance plan. Notwithstanding section 256.025, subdivision 3, the state shall reimburse counties for the nonfederal share of costs for case management performed as an administrative function under the home and community-based services waiver for the elderly.

Sec. 72. Minnesota Statutes 1992, section 256B.0915, subdivision 3, is amended to read:

Subd. 3. **LIMITS OF CASES, RATES, REIMBURSEMENT, AND FORECASTING.** (a) The number of medical assistance waiver recipients that a county may serve must be allocated according to the number of medical assistance waiver cases open on July 1 of each fiscal year. Additional recipients may be served with the approval of the commissioner.

(b) The monthly limit for the cost of waivered services to an individual waiver client shall be the statewide average payment rate of the case mix resident class to which the waiver client would be assigned under medical assistance case mix reimbursement system. 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 following costs must be included in determining the total monthly costs for the waiver client:

(1) cost of all waivered services, including extended medical supplies and equipment; and

(2) cost of skilled nursing, home health aide, and personal care services reimbursable by medical assistance.

(c) Medical assistance funding for skilled nursing services, 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) Expenditures for extended medical supplies and equipment that cost over $150 per month for both the elderly waiver and the disabled waiver must have the commissioner's prior approval.

(e) For the fiscal year beginning on July 1, 1993, and for subsequent fiscal years, the commissioner of human services shall not provide automatic annual inflation adjustments for home- and community-based waivered services. The commissioner of finance shall include as a budget change request in each biennial detailed expenditure budget submitted to the legislature under section 16A.11 annual adjustments in reimbursement rates for home- and community-based waivered services, based on the forecasted percentage change in the Home Health Agency Market Basket of Operating Costs, for the fiscal year beginning July 1, compared to the previous fiscal year, unless otherwise adjusted by statute. The Home Health Agency Market Basket of Operating Costs is published by Data Resources, Inc. The forecast to be used is the one published for the calendar quarter beginning January 1, six months prior to the beginning of the fiscal year for which rates are set. The adult foster care rate shall be considered a difficulty of care payment and shall not include room and board.

(f) The adult foster care daily rate for the elderly and disabled waivers 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, and it must allow for other waiver and medical assistance home care services to be authorized by the case manager.

(g) The assisted living and residential care service rates for elderly and disabled waivers shall be made to the vendor as a monthly rate negotiated with the county agency. 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. The rate may not cover direct rent or food costs.

(h) The county shall negotiate individual rates with vendors and may be reimbursed for actual costs up to the greater of the county's current approved rate or 60 percent of the maximum rate in fiscal year 1994 and 65 percent of the maximum rate in fiscal year 1995 for each service within each program.

(i) On July 1, 1993, the commissioner shall increase the maximum rate for home-delivered meals to $4.50 per meal.

~~(f)~~ (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.

~~(g)~~ (k) 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.

New language is indicated by underline, deletions by ~~strikeout~~.

Sec. 73. Minnesota Statutes 1992, section 256B.0917, subdivision 1, is amended to read:

Subdivision 1. **PURPOSE, MISSION, GOALS, AND OBJECTIVES.** (a) The purpose of implementing seniors' agenda for independent living (SAIL) projects under this section is to demonstrate a new cooperative strategy for the long-term care system in the state of Minnesota.

The projects are part of the initial ~~biennial~~ plan for a 20-year strategy. The mission of the 20-year strategy is to create a new community-based care paradigm for long-term care in Minnesota in order to maximize independence of the older adult population, and to ensure cost-effective use of financial and human resources. The goals for the 20-year strategy are to:

(1) achieve a broad awareness and use of low-cost home care and other residential alternatives to nursing homes;

(2) develop a statewide system of information and assistance to enable easy access to long-term care services;

(3) develop sufficient alternatives to nursing homes to serve the increased number of people needing long-term care;

(4) maintain the moratorium on new construction of nursing home beds and to lower the percentage of elderly persons served in institutional settings; and

(5) build a community-based approach and community commitment to delivering long-term care services for elderly persons in their homes.

(b) The objective for the fiscal years ~~1992~~ 1994 and ~~1993~~ 1995 biennial plan is to ~~implement~~ continue at least four but not more than six projects in anticipation of a statewide program. These projects will ~~begin~~ continue the process of implementing: (1) a coordinated planning and administrative process; (2) a refocused function of the preadmission screening program; (3) the development of additional home, community, and residential alternatives to nursing homes; (4) a program to support the informal caregivers for elderly persons; (5) programs to strengthen the use of volunteers; and (6) programs to support the building of community commitment to provide long-term care for elderly persons.

This is done in conjunction with an expanded role of the interagency long-term care planning committee as described in section 144A.31. The services offered through these projects will be available to those who have their own funds to pay for services, as well as to persons who are eligible for medical assistance and to persons who are 180-day eligible clients to the extent authorized in this section.

Sec. 74. Minnesota Statutes 1992, section 256B.0917, subdivision 2, is amended to read:

Subd. 2. **DESIGN OF SAIL PROJECTS; LOCAL LONG-TERM CARE COORDINATING TEAM.** (a) The commissioner of human services in conjunction with the interagency long-term care planning committee's long-range strategic plan shall ~~establish~~ contract with SAIL projects in four to six counties or groups of counties to demonstrate the feasibility and cost-effectiveness of a local long-term care strategy that is consistent with the state's long-term care goals identified in subdivision 1. The commissioner shall publish a notice in the State Register announcing the availability of project funding and giving instructions for making an application. The instructions for the application shall identify the amount of funding available for project components.

(b) To be selected for the project, a county board or boards must establish a long-term care coordinating team consisting of county social service agencies, public health nursing service agencies, local boards of health, and the area agencies on aging in a geographic area which is responsible for:

(1) developing a local long-term care strategy consistent with state goals and objectives;

(2) submitting an application to be selected as a project;

(3) coordinating planning for funds to provide services to elderly persons, including funds received under Title III of the Older Americans Act, Community Social Services Act, Title XX of the Social Security Act and the Local Public Health Act; and

(4) ensuring efficient services provision and nonduplication of funding.

(c) The board or boards shall designate a public agency to serve as the lead agency. The lead agency receives and manages the project funds from the state and is responsible for the implementation of the local strategy. If selected as a project, the local long-term care coordinating team must semiannually evaluate the progress of the local long-term care strategy in meeting state measures of performance and results as established in the contract.

(d) Each member of the local coordinating team must indicate its endorsement of the local strategy. The local long-term care coordinating team may include in its membership other units of government which provide funding for services to the frail elderly. The team must cooperate with consumers and other public and private agencies, including nursing homes, in the geographic area in order to develop and offer a variety of cost-effective services to the elderly and their caregivers.

(e) The board or boards shall apply to be selected as a project. If the project is selected, the commissioner of human services shall contract with the lead agency for the project and shall provide additional administrative funds for implementing the provisions of the contract, within the appropriation available for this purpose.

(f) Projects shall be selected according to the following conditions:.

~~(1)~~ No project may be selected unless it demonstrates that:

(i) the objectives of the local project will help to achieve the state's long-term care goals as defined in subdivision 1;

(ii) in the case of a project submitted jointly by several counties, all of the participating counties are contiguous;

(iii) there is a designated local lead agency that is empowered to make contracts with the state and local vendors on behalf of all participants;

(iv) the project proposal demonstrates that the local cooperating agencies have the ability to perform the project as described and that the implementation of the project has a reasonable chance of achieving its objectives;

(v) the project will serve an area that covers at least four counties or contains at least 2,500 persons who are 85 years of age or older, according to the projections of the state demographer or the census if the data is more recent; and

(vi) the local coordinating team documents efforts of cooperation with consumers and other agencies and organizations, both public and private, in planning for service delivery.

~~(2) If only two projects are selected, at least one of them must be from a metropolitan statistical area as determined by the United States Census Bureau; if three or four projects are selected, at least one but not more than two projects must be from a metropolitan statistical area; and if more than four projects are selected, at least two but not more than three projects must be from a metropolitan statistical area.~~

~~(3) Counties or groups of counties that submit a proposal for a project shall be assigned to types defined by institutional utilization rate and population growth rate in the following manner:~~

~~(i) Each county or group of counties shall be measured by the utilization rate of nursing homes and boarding care homes and by the projected growth rate of its population aged 85 and over between 1990 and 2000. For the purposes of this section, "utilization rate" means the proportion of the seniors aged 65 or older in the county or group of counties who reside in a licensed nursing home or boarding care home as determined by the most recent census of residents available from the department of health and the population estimates of the state demographer or the census, whichever is more recent. The "projected growth rate" is the rate of change in the county or group of counties of the population group aged 85 or older between 1990 and 2000 according to the projections of the state demographer.~~

New language is indicated by underline, deletions by ~~strikeout~~.

~~(ii) The institutional utilization rate of a county or group of counties shall be converted to a category by assigning a "high utilization" category if the rate is above the median rate of all counties, and a "low utilization" category otherwise. The projected growth rate of a county or group of counties shall be converted to a category by assigning a score of "high growth" category if the rate is above the median rate of all counties, and a "low growth" category otherwise.~~

~~(iii) Types of areas shall be defined by the four combinations of the scores defined in item (ii): type 1 is low utilization - high growth, type 2 is high utilization - high growth, type 3 is high utilization - low growth, and type 4 is low utilization - low growth. Each county or group of counties making a proposal shall be assigned to one of these types.~~

~~(4) Projects shall be selected from each of the types in the order that the types are listed in paragraph (3), item (iii), with available funding allocated to projects until it is exhausted, with no more than 30 percent of available funding allocated to any one project. Available funding includes state administrative funds which have been appropriated for screening functions in subdivision 4, paragraph (b), clause (3), and for service developers and incentive grants in subdivision 5.~~

~~(5) If more than one county or group of counties within one of the types defined by paragraph (3) proposes a special project that meets all of the other conditions in paragraphs (1) and (2), the project that demonstrates the most cost-effective proposals in terms of the number of nursing home placements that can be expected to be diverted or converted to alternative care services per unit of cost shall be selected.~~

~~(6) If more than one county applies for a specific project under this subdivision, all participating county boards must indicate intent to work cooperatively through individual board resolutions or a joint powers agreement.~~

Sec. 75. Minnesota Statutes 1992, section 256B.0917, subdivision 3, is amended to read:

Subd. 3. **LOCAL LONG-TERM CARE STRATEGY.** The local long-term care strategy must list performance outcomes and indicators which meet the state's objectives. The local strategy must provide for:

(1) accessible information, assessment, and preadmission screening activities as described in subdivision 4;

(2) an ~~application for expansion~~ increase in numbers of alternative care ~~targeted funds~~ clients served under section 256B.0913, ~~for serving 180-day eligible clients,~~ including those who are relocated from nursing homes, which results in a reduction of the medical assistance nursing home caseload; and

(3) the development of additional services such as adult family foster care

homes; family adult day care; assisted living projects and congregate housing service projects in apartment buildings; expanded home care services for evenings and weekends; expanded volunteer services; and caregiver support and respite care projects.

The county or groups of counties selected for the projects shall be required to comply with federal regulations, alternative care funding policies in section 256B.0913, and the federal waiver programs' policies in section 256B.0915. The requirements for preadmission screening ~~as~~ are defined in section 256B.0911, subdivisions 1 to 6~~; are waived for those counties selected as part of a long-term care strategy project. For persons who are eligible for medical assistance or who are 180-day eligible clients and who are screened after nursing facility admission, the nursing facility must include a screener in the discharge planning process for those individuals who the screener has determined have discharge potential. The agency responsible for the screening function in subdivision 4 must ensure a smooth transition and follow-up for the individual's return to the community~~. Requirements for an access, screening, and assessment function ~~replace the preadmission screening requirements and~~ are defined in subdivision 4. Requirements for the service development and service provision are defined in subdivision 5.

Sec. 76. Minnesota Statutes 1992, section 256B.0917, subdivision 4, is amended to read:

Subd. 4. **ACCESSIBLE INFORMATION, SCREENING, AND ASSESSMENT FUNCTION.** (a) The projects selected by and under contract with the commissioner shall establish an accessible information, screening, and assessment function for persons who need assistance and information regarding long-term care. This accessible information, screening, and assessment activity shall include information and referral, early intervention, follow-up contacts, telephone ~~triage as defined in paragraph (f)~~ screening, home visits, assessments, preadmission screening, and relocation case management for the frail elderly and their caregivers in the area served by the county or counties. The purpose is to ensure that information and help is provided to elderly persons and their families in a timely fashion, when they are making decisions about long-term care. These functions may be split among various agencies, but must be coordinated by the local long-term care coordinating team.

(b) Accessible information, screening, and assessment functions shall be reimbursed as follows:

(1) The screenings of all persons entering nursing homes shall be reimbursed ~~by the nursing homes in the counties of the project, through the same policy that is in place in fiscal year 1992 as established~~ as defined in section 256B.0911~~. The amount a nursing home pays to the county agency is that amount identified and approved in the February 15, 1991, estimated number of screenings and associated expenditures. This amount remains the same for fiscal year 1993~~, subdivision 6; and

(2) ~~The level I screenings and the level II assessments required by Public Law Numbers 100-203 and 101-508 (OBRA) for persons with mental illness, mental retardation, or related conditions, are reimbursed through administrative funds with 75 percent federal funds and 25 percent state funds, as allowed by federal regulations and established in the contract; and~~

~~(3)~~ Additional state administrative funds shall be available for the access, screening, and assessment activities that are not reimbursed under ~~clauses~~ clause (1) ~~and (2)~~. This amount shall not exceed the amount authorized in the guidelines and in instructions for the application and must be within the amount appropriated for this activity.

(c) ~~The amounts available under paragraph (b) are available to the county or counties involved in the project to cover staff salaries and expenses to provide the services in this subdivision. The lead agency shall employ, or contract with other agencies to employ, within the limits of available funding, sufficient personnel to provide the services listed in this subdivision.~~

~~(d)~~ Any information and referral functions funded by other sources, such as Title III of the Older Americans Act and Title XX of the Social Security Act and the Community Social Services Act, shall be considered by the local long-term care coordinating team in establishing this function to avoid duplication and to ensure access to information for persons needing help and information regarding long-term care.

~~(e) The staffing for the screening and assessment function must include, but is not limited to, a county social worker and a county public health nurse. The social worker and public health nurse are responsible for all assessments that are required to be completed by a professional. However, only one of these professionals is required to be present for the assessment. 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 of experience in home care to conduct the assessment.~~

~~(f) All persons entering a Medicaid certified nursing home or boarding care home must be screened through an assessment process, although the decision to conduct a face-to-face interview is left with the county social worker and the county public health nurse. All applicants to nursing homes must be screened and approved for admission by the county social worker or the county public health nurse named by the lead agency or the agencies which are under contract with the lead agency to manage the access, screening, and assessment functions. For applicants who have a diagnosis of mental illness, mental retardation, or a related condition, and are subject to the provisions of Public Law Numbers 100-203 and 101-508, their admission must be approved by the local mental health authority or the local developmental disabilities case manager.~~

~~The commissioner shall develop instructions and assessment forms for telephone triage and on-site screenings to ensure that federal regulations and waiver provisions are met.~~

New language is indicated by underline, deletions by ~~strikeout~~.

~~For purposes of this section, the term "telephone triage" refers to a telephone or face-to-face consultation between health care and social service professionals during which the clients' circumstances are reviewed and the county agency professional sorts the individual into categories: (1) needs no screening, (2) needs an immediate screening, or (3) needs a screening after admission to a nursing home or after a return home. The county agency professional shall authorize admission to a nursing home according to the provisions in section 256B.0911, subdivision 7.~~

~~(g) The requirements for case mix assessments by a preadmission screening team may be waived and the nursing home shall complete the case mix assessments which are not conducted by the county public health nurse according to the procedures established under Minnesota Rules, part 9549.0059. The appropriate county or the lead agency is responsible for distributing the quality assurance and review form for all new applicants to nursing homes.~~

~~(h)~~ (d) The lead agency or the agencies under contract with the lead agency which are responsible for the accessible information, screening, and assessment function must complete the forms and reports required by the commissioner as specified in the contract.

Sec. 77. Minnesota Statutes 1992, section 256B.0917, subdivision 5, is amended to read:

Subd. 5. **SERVICE DEVELOPMENT AND SERVICE DELIVERY.** (a) In addition to the access, screening, and assessment activity, each local strategy may include provisions for the following:

(1) ~~expansion of alternative care to serve an increased caseload, over the fiscal year 1991 average caseload, of at least 100 persons each year who are assessed prior to nursing home admission and persons who are relocated from nursing homes, which results in a reduction of the medical assistance nursing home caseload;~~

~~(2)~~ the addition of a full-time staff person who is responsible to develop the following services and recruit providers as established in the contract:

(i) additional adult family foster care homes;

(ii) family adult day care providers as defined in section 256B.0919, subdivision 2;

(iii) an assisted living program in an apartment;

(iv) a congregate housing service project in a subsidized housing project; and

(v) the expansion of evening and weekend coverage of home care services as deemed necessary by the local strategic plan;

~~(3)~~ (2) small incentive grants to new adult family care providers for renovations needed to meet licensure requirements;

~~(4)~~ (3) a plan to apply for a congregate housing service project as identified in section 256.9751, authorized by the Minnesota board on aging, to the extent that funds are available;

~~(5)~~ (4) a plan to divert new applicants to nursing homes and to relocate a targeted population from nursing homes, using the individual's own resources or the funding available for services;

~~(6)~~ (5) one or more caregiver support and respite care projects, as described in subdivision 6; and

~~(7)~~ (6) one or more living-at-home/block nurse projects, as described in subdivisions 7 to 10.

(b) The expansion of alternative care clients under paragraph (a) shall be accomplished with the funds provided under section 256B.0913, and includes the allocation of targeted funds. The funding for all participating counties must be coordinated by the local long-term care coordinating team and must be part of the local long-term care strategy. ~~Targeted~~ Alternative care funds ~~received through the SAIL project approval process~~ may be transferred from one SAIL county to another within a designated SAIL project area during a fiscal year as authorized by the local long-term care coordinating team and approved by the commissioner. The base allocation used for a future year shall reflect the final transfer. Each county retains responsibility for reimbursement as defined in section 256B.0913, subdivision 12. All other requirements for the alternative care program must be met unless an exception is provided in this section. The commissioner may establish by contract a reimbursement mechanism for alternative care that does not require invoice processing through the Medical Assistance Management Information System (MMIS). The commissioner and local agencies must assure that the same client and reimbursement data is obtained as is available under MMIS.

(c) The administration of these components is the responsibility of the agencies selected by the local coordinating team and under contract with the local lead agency. However, administrative funds for paragraph (a), clauses (2) to (5), and grant funds for paragraph (a), clauses (6) and (7), shall be granted to the local lead agency. The funding available for each component is based on the plan submitted and the amount negotiated in the contract.

Sec. 78. Minnesota Statutes 1992, section 256B.0917, subdivision 11, is amended to read:

Subd. 11. **SAIL EVALUATION AND EXPANSION.** The commissioner shall evaluate the success of the SAIL projects against the objective stated in subdivision 1, paragraph (b), and recommend to the legislature the continuation or expansion of the long-term care strategy by February 15, ~~1993~~ 1995.

Sec. 79. Minnesota Statutes 1992, section 256B.0917, subdivision 12, is amended to read:

Subd. 12. **PUBLIC AWARENESS CAMPAIGN.** The commissioner, with assistance from the commissioner of health and with the advice of the long-term care planning committee, shall contract for a public awareness campaign to educate the general public, seniors, consumers, caregivers, and professionals about the aging process, the long-term care system, and alternatives available including alternative care and residential alternatives. Particular emphasis will be given to informing consumers on how to access the alternatives and obtain information on the long-term care system. The commissioner shall pursue the development of new names for preadmission screening, alternative care, ~~and~~ foster care, and other services as deemed necessary for the public awareness campaign.

Sec. 80. Minnesota Statutes 1992, section 256B.093, subdivision 1, is amended to read:

Subdivision 1. **STATE TRAUMATIC BRAIN INJURY ~~CASE MANAGEMENT~~ PROGRAM.** The commissioner of human services shall:

(1) establish and maintain statewide traumatic brain injury ~~case management~~ program;

(2) designate a full-time position to supervise and coordinate services and policies for persons with traumatic brain injuries;

(3) contract with qualified agencies or employ staff to provide statewide administrative case management; ~~and~~

(4) establish an advisory committee to provide recommendations in a report to the ~~department~~ commissioner regarding program and service needs of persons with traumatic brain injuries. The advisory committee shall consist of no less than ten members and no more than 30 members. The commissioner shall appoint all advisory committee members to one- or two-year terms and appoint one member as chair; and

(5) investigate the need for the development of rules or statutes for:

(i) traumatic brain injury home and community-based services waiver; and

(ii) traumatic brain injury services not covered by any other statute or rule.

Sec. 81. Minnesota Statutes 1992, section 256B.093, subdivision 3, is amended to read:

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

(1) assessing the person's individual needs for services required to prevent institutionalization;

(2) ensuring that a care plan that addresses the person's needs is developed, implemented, and monitored on an ongoing basis by the appropriate agency or individual;

(3) assisting the person in obtaining services necessary to allow the person to remain in the community;

(4) coordinating home care services with other medical assistance services under section 256B.0625;

(5) ensuring appropriate, accessible, and cost-effective medical assistance services;

(6) recommending to the commissioner the approval or denial of the use of medical assistance funds to pay for home care services when home care services exceed thresholds established by the commissioner under section 256B.0627;

(7) assisting the person with problems related to the provision of home care services;

(8) ensuring the quality of home care services;

(9) reassessing the person's need for and level of home care services at a frequency determined by the commissioner; ~~and~~

(10) recommending to the commissioner 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;

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

(12) approving traumatic brain injury waiver care plans.

Sec. 82. Minnesota Statutes 1992, section 256B.15, subdivision 1, is amended to read:

Subdivision 1. **DEFINITION.** For purposes of this section, "medical assistance" includes the medical assistance program under this chapter and the general assistance medical care program under chapter 256D, but does not include the alternative care program ~~under this chapter~~ for nonmedical assistance recipients under section 256B.0913, subdivision 4.

Sec. 83. Minnesota Statutes 1992, section 256B.15, subdivision 2, is amended to read:

Subd. 2. **LIMITATIONS ON CLAIMS.** The claim shall include only the total amount of medical assistance rendered after age 65 or during a period of institutionalization described in subdivision ~~1~~ 1a, clause (b), and the total amount of general assistance medical care rendered, and shall not include interest. Claims that have been allowed but not paid shall bear interest according to section 524.3-806, paragraph (d). A claim against the estate of a surviving spouse who did not receive medical assistance, for medical assistance rendered for the predeceased spouse, is limited to the value of the assets of the estate that were marital property or jointly owned property at any time during the marriage.

Sec. 84. Minnesota Statutes 1992, section 256B.19, subdivision 1b, is amended to read:

Subd. 1b. **PORTION OF NONFEDERAL SHARE TO BE PAID BY GOVERNMENT HOSPITALS.** (a) In addition to the percentage contribution paid by a county under 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 subdivision, "designated governmental unit" means Hennepin county~~, and the public corporation known as Ramsey Health Care, Inc. which is operated under the authority of chapter 246A~~ and the University of Minnesota. For purposes of this subdivision, "public hospital" means the Hennepin County Medical Center~~,~~ and the University of Minnesota hospital ~~and the St. Paul-Ramsey Medical Center~~.

(b) ~~Each of the governmental units designated in this subdivision~~ From July 1, 1993 through June 30, 1994, Hennepin county shall on a monthly basis transfer an amount equal to ~~two~~ 1.8 percent of the public hospital's net patient revenues, excluding net Medicare revenue to the state Medicaid agency.

(c) Effective July 1, 1994, each of the governmental units designated in paragraph (a) shall on a monthly basis transfer an amount equal to 1.8 percent of the public hospital's net patient revenues, excluding net Medicare revenue, to the state Medicaid agency.

(d) These sums shall be part of the ~~local~~ designated governmental unit's portion of the nonfederal share of medical assistance costs, but shall not be subject to payback provisions of section 256.025.

Sec. 85. Minnesota Statutes 1992, section 256B.19, is amended by adding a subdivision to read:

Subd. 1c. **ADDITIONAL PORTION OF NONFEDERAL SHARE.** In addition to any payment required under subdivision 1b, Hennepin county and the University of Minnesota shall be responsible for a monthly transfer payment of $1,000,000, due before noon on the 15th of each month beginning July 15, 1993. These sums shall be part of the designated governmental unit's portion of the nonfederal share of medical assistance costs, but shall not be subject to payback provisions of section 256.025.

Sec. 86. Minnesota Statutes 1992, section 256B.19, is amended by adding a subdivision to read:

Subd. 1d. **PORTION OF NONFEDERAL SHARE TO BE PAID BY CERTAIN COUNTIES.** In addition to the percentage contribution paid by a county under subdivision 1, the governmental units designated in this subdivision shall be responsible for an additional portion of the nonfederal share of medical assistance cost. For purposes of this subdivision, "designated governmental unit" means the counties of Becker, Beltrami, Clearwater, Cook, Dodge, Hubbard, Itasca, Lake, Mahnomen, Pennington, Pipestone, Ramsey, St. Louis, Steele, Todd, Traverse, and Wadena.

Beginning in 1994, each of the governmental units designated in this subdivision shall transfer before noon on May 31 to the state Medicaid agency an amount equal to the number of licensed beds in any nursing home owned by the county multiplied by $5,723. If two or more counties own a nursing home, the payment shall be prorated. These sums shall be part of the designated governmental unit's portion of the nonfederal share of medical assistance costs, but shall not be subject to payback provisions of section 256.025.

Sec. 87. Minnesota Statutes 1992, section 256B.37, subdivision 3, is amended to read:

Subd. 3. **NOTICE.** The state agency must be given notice of monetary claims against a person, firm, or corporation that may be liable in damages, or otherwise obligated to pay part or all of the cost of medical care when the state agency has paid or become liable for the cost of care. Notice must be given as follows:

(a) Applicants for medical assistance shall notify the state or local agency of any possible claims when they submit the application. Recipients of medical assistance shall notify the state or local agency of any possible claims when those claims arise.

(b) A person providing medical care services to a recipient of medical assistance shall notify the state agency when the person has reason to believe that a third party may be liable for payment of the cost of medical care.

(c) A person who is party to a claim upon which the state agency may be entitled to subrogation under this section shall notify the state agency of its potential subrogation claim before filing a claim, commencing an action, or negotiating a settlement. A person who is a party to a claim includes the plaintiff, the defendants, and any other party to the cause of action.

Notice given to the local agency is not sufficient to meet the requirements of paragraphs (b) and (c).

Sec. 88. Minnesota Statutes 1992, section 256B.37, subdivision 5, is amended to read:

Subd. 5. **PRIVATE BENEFITS TO BE USED FIRST.** Private accident and health care coverage for medical services is primary coverage and must be exhausted before medical assistance is paid. When a person who is otherwise eligible for medical assistance has private accident or health care coverage, including a prepaid health plan, the private health care benefits available to the person must be used first and to the fullest extent. ~~Supplemental payment may be made by medical assistance, but the combined total amount paid must not exceed the amount payable under medical assistance in the absence of other coverage. Medical assistance must not make supplemental payment for covered services rendered by a vendor who participates or contracts with a health coverage plan if the plan requires the vendor to accept the plan's payment as payment in full.~~

Sec. 89. Minnesota Statutes 1992, section 256B.37, is amended by adding a subdivision to read:

Subd. 5a. **SUPPLEMENTAL PAYMENT BY MEDICAL ASSISTANCE.** Medical assistance payment will not be made when either covered charges are paid in full by a third party or the provider has an agreement to accept payment for less than charges as payment in full. Payment for patients that are simultaneously covered by medical assistance and a liable third party other than Medicare will be determined as the lesser of clauses (1) to (3):

(1) the patient liability according to the provider/insurer agreement;

(2) covered charges minus the third party payment amount; or

(3) the medical assistance rate minus the third party payment amount.

A negative difference will not be implemented.

Sec. 90. Minnesota Statutes 1992, section 256B.431, subdivision 2b, is amended to read:

Subd. 2b. **OPERATING COSTS, AFTER JULY 1, 1985.** (a) For rate years beginning on or after July 1, 1985, the commissioner shall establish procedures for determining per diem reimbursement for operating costs.

(b) The commissioner shall contract with an econometric firm with recognized expertise in and access to national economic change indices that can be applied to the appropriate cost categories when determining the operating cost payment rate.

(c) The commissioner shall analyze and evaluate each nursing facility's cost report of allowable operating costs incurred by the nursing facility during the reporting year immediately preceding the rate year for which the payment rate becomes effective.

(d) The commissioner shall establish limits on actual allowable historical operating cost per diems based on cost reports of allowable operating costs for

the reporting year that begins October 1, 1983, taking into consideration relevant factors including resident needs, geographic location, size of the nursing facility, and the costs that must be incurred for the care of residents in an efficiently and economically operated nursing facility. In developing the geographic groups for purposes of reimbursement under this section, the commissioner shall ensure that nursing facilities in any county contiguous to the Minneapolis-St. Paul seven-county metropolitan area are included in the same geographic group. The limits established by the commissioner shall not be less, in the aggregate, than the 60th percentile of total actual allowable historical operating cost per diems for each group of nursing facilities established under subdivision 1 based on cost reports of allowable operating costs in the previous reporting year. For rate years beginning on or after July 1, 1989, facilities located in geographic group I as described in Minnesota Rules, part 9549.0052, on January 1, 1989, may choose to have the commissioner apply either the care related limits or the other operating cost limits calculated for facilities located in geographic group II, or both, if either of the limits calculated for the group II facilities is higher. The efficiency incentive for geographic group I nursing facilities must be calculated based on geographic group I limits. The phase-in must be established utilizing the chosen limits. For purposes of these exceptions to the geographic grouping requirements, the definitions in Minnesota Rules, parts 9549.0050 to 9549.0059 (Emergency), and 9549.0010 to 9549.0080, apply. The limits established under this paragraph remain in effect until the commissioner establishes a new base period. Until the new base period is established, the commissioner shall adjust the limits annually using the appropriate economic change indices established in paragraph (e). In determining allowable historical operating cost per diems for purposes of setting limits and nursing facility payment rates, the commissioner shall divide the allowable historical operating costs by the actual number of resident days, except that where a nursing facility is occupied at less than 90 percent of licensed capacity days, the commissioner may establish procedures to adjust the computation of the per diem to an imputed occupancy level at or below 90 percent. The commissioner shall establish efficiency incentives as appropriate. The commissioner may establish efficiency incentives for different operating cost categories. The commissioner shall consider establishing efficiency incentives in care related cost categories. The commissioner may combine one or more operating cost categories and may use different methods for calculating payment rates for each operating cost category or combination of operating cost categories. For the rate year beginning on July 1, 1985, the commissioner shall:

(1) allow nursing facilities that have an average length of stay of 180 days or less in their skilled nursing level of care, 125 percent of the care related limit and 105 percent of the other operating cost limit established by rule; and

(2) exempt nursing facilities licensed on July 1, 1983, by the commissioner to provide residential services for the physically handicapped under Minnesota Rules, parts 9570.2000 to 9570.3600, from the care related limits and allow 105 percent of the other operating cost limit established by rule.

For the purpose of calculating the other operating cost efficiency incentive for nursing facilities referred to in clause (1) or (2), the commissioner shall use the other operating cost limit established by rule before application of the 105 percent.

(e) The commissioner shall establish a composite index or indices by determining the appropriate economic change indicators to be applied to specific operating cost categories or combination of operating cost categories.

(f) Each nursing facility shall receive an operating cost payment rate equal to the sum of the nursing facility's operating cost payment rates for each operating cost category. The operating cost payment rate for an operating cost category shall be the lesser of the nursing facility's historical operating cost in the category increased by the appropriate index established in paragraph (e) for the operating cost category plus an efficiency incentive established pursuant to paragraph (d) or the limit for the operating cost category increased by the same index. If a nursing facility's actual historic operating costs are greater than the prospective payment rate for that rate year, there shall be no retroactive cost settle-up. In establishing payment rates for one or more operating cost categories, the commissioner may establish separate rates for different classes of residents based on their relative care needs.

(g) The commissioner shall include the reported actual real estate tax liability or payments in lieu of real estate tax of each nursing facility as an operating cost of that nursing facility. Allowable costs under this subdivision for payments made by a nonprofit nursing facility that are in lieu of real estate taxes shall not exceed the amount which the nursing facility would have paid to a city or township and county for fire, police, sanitation services, and road maintenance costs had real estate taxes been levied on that property for those purposes. For rate years beginning on or after July 1, 1987, the reported actual real estate tax liability or payments in lieu of real estate tax of nursing facilities shall be adjusted to include an amount equal to one-half of the dollar change in real estate taxes from the prior year. The commissioner shall include a reported actual special assessment, and reported actual license fees required by the Minnesota department of health, for each nursing facility as an operating cost of that nursing facility. For rate years beginning on or after July 1, 1989, the commissioner shall include a nursing facility's reported public employee retirement act contribution for the reporting year as apportioned to the care-related operating cost categories and other operating cost categories multiplied by the appropriate composite index or indices established pursuant to paragraph (e) as costs under this paragraph. Total adjusted real estate tax liability, payments in lieu of real estate tax, actual special assessments paid, the indexed public employee retirement act contribution, and license fees paid as required by the Minnesota department of health, for each nursing facility (1) shall be divided by actual resident days in order to compute the operating cost payment rate for this operating cost category, (2) shall not be used to compute the care-related operating cost limits or other operating cost limits established by the commissioner, and (3) shall not be

increased by the composite index or indices established pursuant to paragraph (e), unless otherwise indicated in this paragraph.

(h) For rate years beginning on or after July 1, 1987, the commissioner shall adjust the rates of a nursing facility that meets the criteria for the special dietary needs of its residents ~~as specified in section 144A.071, subdivision 3, clause (c),~~ and the requirements in section 31.651. The adjustment for raw food cost shall be the difference between the nursing facility's allowable historical raw food cost per diem and 115 percent of the median historical allowable raw food cost per diem of the corresponding geographic group.

The rate adjustment shall be reduced by the applicable phase-in percentage as provided under subdivision 2h.

Sec. 91. Minnesota Statutes 1992, section 256B.431, subdivision 2o, is amended to read:

Subd. 2o. **SPECIAL PAYMENT RATES FOR SHORT-STAY NURSING FACILITIES.** Notwithstanding contrary provisions of this section and rules adopted by the commissioner, for the rate years beginning on or after July 1, ~~1992~~ 1993, a nursing facility whose average length of stay for the ~~rate~~ preceding reporting year ~~beginning July 1, 1991,~~ is (1) less than 180 days; or (2) less than 225 days in a nursing facility with more than 315 licensed beds must be reimbursed for allowable costs up to 125 percent of the total care-related limit and 105 percent of the other-operating-cost limit for hospital-attached nursing facilities. ~~The~~ A nursing facility that received the benefit of this limit during the rate year beginning July 1, 1992, continues to receive this rate during the rate year beginning July 1, 1993, even if the facility's average length of stay is more than 180 days in the rate years subsequent to the rate year beginning July 1, 1991. For purposes of this subdivision, a nursing facility shall compute its average length of stay by dividing the nursing facility's actual resident days for the reporting year by the nursing facility's total resident discharges for that reporting year.

Sec. 92. Minnesota Statutes 1992, section 256B.431, is amended by adding a subdivision to read:

Subd. 2r. **PAYMENT RESTRICTIONS ON LEAVE DAYS.** Effective July 1, 1993, the commissioner shall limit payment for leave days in a nursing facility to 79 percent of that nursing facility's total payment rate for the involved resident.

Sec. 93. Minnesota Statutes 1992, section 256B.431, subdivision 13, is amended to read:

Subd. 13. **HOLD-HARMLESS PROPERTY-RELATED RATES.** (a) Terms used in subdivisions 13 to 21 shall be as defined in Minnesota Rules, parts 9549.0010 to 9549.0080, and this section.

(b) Except as provided in this subdivision, for rate periods beginning on October 1, 1992, and for rate years beginning after June 30, 1993, the property-related rate for a nursing facility shall be the greater of $4 or the property-related payment rate in effect on September 30, 1992. In addition, the incremental increase in the nursing facility's rental rate will be determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section.

(c) Notwithstanding Minnesota Rules, part 9549.0060, subpart 13, item F, a nursing facility that has a sale permitted under subdivision 14 after June 30, 1992, shall receive the property-related payment rate in effect at the time of the sale or reorganization. For rate periods beginning after October 1, 1992, and for rate years beginning after June 30, 1993, a nursing facility shall receive, in addition to its property-related payment rate in effect at the time of the sale, the incremental increase allowed under subdivision 14.

(d) For rate years beginning after June 30, 1993, the property-related rate for a nursing facility licensed after July 1, 1989, after relocating its beds from a separate nursing home to a building formerly used as a hospital and sold during the cost reporting year ending September 30, 1991, shall be its property-related rate prior to the sale in addition to the incremental increases provided under this section effective on October 1, 1992, of 29 cents per day, and any incremental increases after October 1, 1992, calculated by using its rental rate under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section, recognizing the current appraised value of the facility at the new location, and including as allowable debt otherwise allowable debt incurred to remodel the facility in the new location prior to the relocation of beds.

Sec. 94. Minnesota Statutes 1992, section 256B.431, subdivision 14, is amended to read:

Subd. 14. **LIMITATIONS ON SALES OF NURSING FACILITIES.** (a) For rate periods beginning on October 1, 1992, and for rate years beginning after June 30, 1993, a nursing facility's property-related payment rate as established under subdivision 13 shall be adjusted by either paragraph (b) or (c) for the sale of the nursing facility, including sales occurring after June 30, 1992, as provided in this subdivision.

(b) If the nursing facility's property-related payment rate under subdivision 13 prior to sale is greater than the nursing facility's rental rate under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section prior to sale, the nursing facility's property-related payment rate after sale shall be the greater of its property-related payment rate under subdivision 13 prior to sale or its rental rate under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section calculated after sale.

(c) If the nursing facility's property-related payment rate under subdivision 13 prior to sale is equal to or less than the nursing facility's rental rate under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section prior to sale,

the nursing facility's property-related payment rate after sale shall be the nursing facility's property-related payment rate under subdivision 13 plus the difference between its rental rate calculated under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section prior to sale and its rental rate calculated under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section calculated after sale.

(d) For purposes of this subdivision, "sale" means the purchase of a nursing facility's capital assets with cash or debt. The term sale does not include a stock purchase of a nursing facility or any of the following transactions:

(1) a sale and leaseback to the same licensee that does not constitute a change in facility license;

(2) a transfer of an interest to a trust;

(3) gifts or other transfers for no consideration;

(4) a merger of two or more related organizations;

(5) a change in the legal form of doing business, other than a publicly held organization that becomes privately held or vice versa;

(6) the addition of a new partner, owner, or shareholder who owns less than 20 percent of the nursing facility or the issuance of stock; and

(7) a sale, merger, reorganization, or any other transfer of interest between related organizations other than those permitted in this section.

(e) For purposes of this subdivision, "sale" includes the sale or transfer of a nursing facility to a close relative as defined in Minnesota Rules, part 9549.0020, subpart 38, item C, upon the death of an owner, due to serious illness or disability, as defined under the Social Security Act, under United States Code, title 42, section 423(d)(1)(A), or upon retirement of an owner from the business of owning or operating a nursing home at 62 years of age or older. For sales to a close relative allowed under this paragraph, otherwise nonallowable debt resulting from seller financing of all or a portion of the debt resulting from the sale shall be allowed and shall not be subject to Minnesota Rules, part 9549.0060, subpart 5, item E, provided that in addition to existing requirements for allowance of debt and interest, the debt is subject to repayment through annual principal payments and the interest rate on the related organization debt does not exceed three percentage points above the posted yield for standard conventional fixed rate mortgages of the Federal Home Loan Mortgage Corporation for delivery in 60 days in effect on the day of sale. If at any time, the seller forgives the related organization debt allowed under this paragraph for other than equal amount of payment on that debt, then the buyer shall pay to the state the total revenue received by the nursing facility after the sale attributable to the amount of allowable debt which has been forgiven. Any assignment, sale, or

transfer of the debt instrument entered into by the close relatives, either directly or indirectly, which grants to the close relative buyer the right to receive all or a portion of the payments under the debt instrument shall, effective on the date of the transfer, result in the prospective reduction in the corresponding portion of the allowable debt and interest expense. Upon the death of the close relative seller, any remaining balance of the close relative debt must be refinanced and such refinancing shall be subject to the provisions of Minnesota Rules, part 9549.0060, subpart 7, item G. This paragraph shall not apply to sales occurring on or after June 30, 1997.

~~(e)~~ (f) For purposes of this subdivision, "effective date of sale" means the later of either the date on which legal title to the capital assets is transferred or the date on which closing for the sale occurred.

~~(f)~~ (g) The effective day for the property-related payment rate determined under this subdivision shall be the first day of the month following the month in which the effective date of sale occurs or October 1, 1992, whichever is later, provided that the notice requirements under section 256B.47, subdivision 2, have been met.

~~(g)~~ (h) Notwithstanding Minnesota Rules, part 9549.0060, subparts 5, item A, subitems (3) and (4), and 7, items E and F, the commissioner shall limit the total allowable debt and related interest for sales occurring after June 30, 1992, to the sum of clauses (1) to (3):

(1) the historical cost of capital assets, as of the nursing facility's most recent previous effective date of sale or, if there has been no previous sale, the nursing facility's initial historical cost of constructing capital assets;

(2) the average annual capital asset additions after deduction for capital asset deletions, not including depreciations; and

(3) one-half of the allowed inflation on the nursing facility's capital assets. The commissioner shall compute the allowed inflation as described in paragraph (h).

~~(h)~~ (i) For purposes of computing the amount of allowed inflation, the commissioner must apply the following principles:

(1) the lesser of the Consumer Price Index for all urban consumers or the Dodge Construction Systems Costs for Nursing Homes for any time periods during which both are available must be used. If the Dodge Construction Systems Costs for Nursing Homes becomes unavailable, the commissioner shall substitute the index in subdivision 3f, or such other index as the secretary of the health care financing administration may designate;

(2) the amount of allowed inflation to be applied to the capital assets in paragraph (g), clauses (1) and (2), must be computed separately;

(3) the amount of allowed inflation must be determined on an annual basis, prorated on a monthly basis for partial years and if the initial month of use is not determinable for a capital asset, then one-half of that calendar year shall be used for purposes of prorating;

(4) the amount of allowed inflation to be applied to the capital assets in paragraph (g), clauses (1) and (2), must not exceed 300 percent of the total capital assets in any one of those clauses; and

(5) the allowed inflation must be computed starting with the month following the nursing facility's most recent previous effective date of sale or, if there has been no previous sale, the month following the date of the nursing facility's initial occupancy, and ending with the month preceding the effective date of sale.

~~(i)~~ (j) If the historical cost of a capital asset is not readily available for the date of the nursing facility's most recent previous sale or if there has been no previous sale for the date of the nursing facility's initial occupancy, then the commissioner shall limit the total allowable debt and related interest after sale to the extent recognized by the Medicare intermediary after the sale. For a nursing facility that has no historical capital asset cost data available and does not have allowable debt and interest calculated by the Medicare intermediary, the commissioner shall use the historical cost of capital asset data from the point in time for which capital asset data is recorded in the nursing facility's audited financial statements.

~~(j)~~ (k) The limitations in this subdivision apply only to debt resulting from a sale of a nursing facility occurring after June 30, 1992, including debt assumed by the purchaser of the nursing facility.

Sec. 95. Minnesota Statutes 1992, section 256B.431, subdivision 15, is amended to read:

Subd. 15. **CAPITAL REPAIR AND REPLACEMENT COST REPORTING AND RATE CALCULATION.** For rate years beginning after June 30, 1993, a nursing facility's capital repair and replacement payment rate shall be established annually as provided in paragraphs (a) to (d).

(a) Notwithstanding Minnesota Rules, part 9549.0060, subpart 12, the costs of acquiring any of the following items, including cash payment for equity investment and principal and interest expense for debt financing, shall be reported in the capital repair and replacement cost category when the cost of the item exceeds $500:

(1) wall coverings;

(2) paint;

(3) floor coverings;

(4) window coverings;

(5) roof repair;

(6) heating or cooling system repair or replacement;

(7) window repair or replacement;

(8) initiatives designed to reduce energy usage by the facility if accompanied by an energy audit prepared by a professional engineer or architect registered in Minnesota, or by an auditor certified under Minnesota Rules, part 7635.0130, to do energy audits and the energy audit identifies the initiative as a conservation measure; and

(9) ~~capitalized~~ repair or replacement of capital assets not included in the equity incentive computations under subdivision 16.

(b) To compute the capital repair and replacement payment rate, the allowable annual repair and replacement costs for the reporting year must be divided by actual resident days for the reporting year. The annual allowable capital repair and replacement costs shall not exceed $150 per licensed bed. The excess of the allowed capital repair and replacement costs over the capital repair and replacement limit shall be a cost carryover to succeeding cost reporting periods, except that sale of a facility, under subdivision 14, shall terminate the carryover of all costs except those incurred in the most recent cost reporting year. The termination of the carryover shall have effect on the capital repair and replacement rate on the same date as provided in subdivision 14, paragraph (f), for the sale. For rate years beginning after June 30, 1994, the capital repair and replacement limit shall be subject to the index provided in subdivision 3f, paragraph (a). For purposes of this subdivision, the number of licensed beds shall be the number used to calculate the nursing facility's capacity days. The capital repair and replacement rate must be added to the nursing facility's total payment rate.

(c) Capital repair and replacement costs under this subdivision shall not be counted as either care-related or other operating costs, nor subject to care-related or other operating limits.

(d) If costs otherwise allowable under this subdivision are incurred as the result of a project approved under the moratorium exception process in section 144A.073, or in connection with an addition to or replacement of buildings, attached fixtures, or land improvements for which the total historical cost of these assets exceeds the lesser of $150,000 or ten percent of the nursing facility's appraised value, these costs must be claimed under subdivision 16 or 17, as appropriate.

Sec. 96. Minnesota Statutes 1992, section 256B.431, subdivision 21, is amended to read:

Subd. 21. **INDEXING ~~THRESHHOLDS~~ THRESHOLDS.** Beginning Jan-

uary 1, 1993, and each January 1 thereafter, the commissioner shall annually update the dollar ~~threshholds~~ thresholds in subdivisions 15, paragraph (d), 16, and 17, and in section 144A.071, ~~subdivision~~ subdivisions 2 and ~~3~~ 4a, clauses ~~(h)~~ (b) and ~~(p)~~ (e), by the inflation index referenced in subdivision 3f, paragraph (a).

Sec. 97. Minnesota Statutes 1992, section 256B.431, is amended by adding a subdivision to read:

Subd. 22. **CHANGES TO NURSING FACILITY REIMBURSEMENT.** The nursing facility reimbursement changes in paragraphs (a) to (e) apply to Minnesota Rules, parts 9549.0010 to 9549.0080, and this section, and are effective for rate years beginning on or after July 1, 1993, unless otherwise indicated.

(a) In addition to the approved pension or profit sharing plans allowed by the reimbursement rule, the commissioner shall allow those plans specified in Internal Revenue Code, sections 403(b) and 408(k).

(b) The commissioner shall allow as workers' compensation insurance costs under section 256B.421, subdivision 14, the costs of workers' compensation coverage obtained under the following conditions:

(1) a plan approved by the commissioner of commerce as a Minnesota group or individual self-insurance plan as provided in sections 79A.03;

(2) a plan in which:

(i) the nursing facility, directly or indirectly, purchases workers' compensation coverage in compliance with section 176.181, subdivision 2, from an authorized insurance carrier;

(ii) a related organization to the nursing facility reinsures the workers' compensation coverage purchased, directly or indirectly, by the nursing facility; and

(iii) all of the conditions in clause (4) are met;

(3) a plan in which:

(i) the nursing facility, directly or indirectly, purchases workers' compensation coverage in compliance with section 176.181, subdivision 2, from an authorized insurance carrier;

(ii) the insurance premium is calculated retrospectively, including a maximum premium limit, and paid using the paid loss retro method; and

(iii) all of the conditions in clause (4) are met;

(4) additional conditions are:

(i) the costs of the plan are allowable under the federal Medicare program;

(ii) the reserves for the plan are maintained in an account controlled and administered by a person which is not a related organization to the nursing facility;

(iii) the reserves for the plan cannot be used, directly or indirectly, as collateral for debts incurred or other obligations of the nursing facility or related organizations to the nursing facility;

(iv) if the plan provides workers' compensation coverage for non-Minnesota nursing facilities, the plan's cost methodology must be consistent among all nursing facilities covered by the plan, and if reasonable, is allowed notwithstanding any reimbursement laws regarding cost allocation to the contrary;

(v) central, affiliated, corporate, or nursing facility costs related to their administration of the plan are costs which must remain in the nursing facility's administrative cost category and must not be allocated to other cost categories; and

(vi) required security deposits, whether in the form of cash, investments, securities, assets, letters of credit, or in any other form are not allowable costs for purposes of establishing the facilities payment rate.

(5) any costs allowed pursuant to clauses (1) to (3) are subject to the following requirements:

(i) If the nursing facility is sold or otherwise ceases operations, the plan's reserves must be subject to an actuarially based settle-up after 36 months from the date of sale or the date on which operations ceased. The facility's medical assistance portion of the total excess plan reserves must be paid to the state within 30 days following the date on which excess plan reserves are determined.

(ii) Any distribution of excess plan reserves made to or withdrawals made by the nursing facility or a related organization are applicable credits and must be used to reduce the nursing facility's workers' compensation insurance costs in the reporting period in which a distribution or withdrawal is received.

(iii) If reimbursement for the plan is sought under the federal Medicare program, and is audited pursuant to the Medicare program, the nursing facility must provide a copy of Medicare's final audit report, including attachments and exhibits, to the commissioner within 30 days of receipt by the nursing facility or any related organization. The commissioner shall implement the audit findings associated with the plan upon receipt of Medicare's final audit report. The department's authority to implement the audit findings is independent of its authority to conduct a field audit.

(6) the commissioner shall have authority to adopt emergency rules to implement this paragraph.

(c) In the determination of incremental increases in the nursing facility's

rental rate as required in subdivisions 14 to 21, except for a refinancing permitted under subdivision 19, the commissioner must adjust the nursing facility's property-related payment rate for both incremental increases and decreases in recomputations of its rental rate.

(d) A nursing facility's administrative cost limitation must be modified as follows:

(1) if the nursing facility's licensed beds exceed 195 licensed beds, the general and administrative cost category limitation shall be 13 percent;

(2) if the nursing facility's licensed beds are more than 150 licensed beds, but less than 196 licensed beds, the general and administrative cost category limitation shall be 14 percent; or

(3) if the nursing facility's licensed beds is less than 151 licensed beds, the general and administrative cost category limitation shall remain at 15 percent.

(e) The care related operating rate shall be increased by eight cents to reimburse facilities for unfunded federal mandates, including costs related to hepatitis B vaccinations.

Sec. 98. Minnesota Statutes 1992, section 256B.431 is amended by adding a subdivision to read:

Subd. 23. **COUNTY NURSING HOME PAYMENT ADJUSTMENTS.** (a) Beginning in 1994, the commissioner shall pay a nursing home payment adjustment on May 31 after noon to a county in which is located a nursing home that, as of January 1 of the previous year, was county-owned and had over 40 beds and medical assistance occupancy in excess of 50 percent during the reporting year ending September 30, 1991. The adjustment shall be an amount equal to $16 per calendar day multiplied by the number of beds licensed in the facility as of September 30, 1991.

(b) Payments under paragraph (a) are excluded from medical assistance per diem rate calculations. These payments are required notwithstanding any rule prohibiting medical assistance payments from exceeding payments from private pay residents. A facility receiving a payment under paragraph (a) may not increase charges to private pay residents by an amount equivalent to the per diem amount payments under paragraph (a) would equal if converted to a per diem.

Sec. 99. Minnesota Statutes 1992, section 256B.431, is amended by adding a subdivision to read:

Subd. 24. **MODIFIED EFFICIENCY INCENTIVE.** Notwithstanding section 256B.74, subdivision 3, for the rate year beginning July 1, 1993, the maximum efficiency incentive is $2.20, and for rate years beginning on or after July 1, 1994, the commissioner shall determine a nursing facility's efficiency incentive by first computing the amount by which the facility's other operating cost limit exceeds its nonadjusted other operating cost per diem for that rate year. The commissioner shall then use the following table to compute the nursing facility's efficiency incentive. Each increment or partial increment the nursing

facility's nonadjusted other operating per diem is below its other operating cost limit shall be multiplied by the corresponding percentage for that per diem increment. The sum of each of those computations shall be the nursing facility's efficiency incentive.

Other Operating Cost Per Diem Increment Below Facility Limit	Percentage Applied to Each Per Diem Increment
Less than $0.50	70 percent
$0.50 to less than $0.70	10 percent
$0.70 to less than $0.90	15 percent
$0.90 to less than $1.10	20 percent
$1.10 to less than $1.30	25 percent
$1.30 to less than $1.50	30 percent
$1.50 to less than $1.70	35 percent
$1.70 to less than $1.90	40 percent
$1.90 to less than $2.10	45 percent
$2.10 to less than $2.30	50 percent
$2.30 to less than $2.50	55 percent
$2.50 to less than $2.70	60 percent
$2.70 to less than $2.90	65 percent
$2.90 to less than $3.10	70 percent
$3.10 to less than $3.30	75 percent
$3.30 to less than $3.50	80 percent
$3.50 to less than $3.70	85 percent
$3.70 to less than $3.90	90 percent
$3.90 to less than $4.10	95 percent
$4.10 to less than $4.30	100 percent

The maximum efficiency incentive is $2.44 per resident day.

Sec. 100. Minnesota Statutes 1992, section 256B.432, subdivision 5, is amended to read:

Subd. 5. **ALLOCATION OF REMAINING COSTS; ALLOCATION RATIO.** (a) After the costs that can be directly identified according to subdivisions 3 and 4 have been allocated, the remaining central, affiliated, or corporate office costs must be allocated between the long-term care facility operations and the other activities or facilities unrelated to the long-term care facility operations based on the ratio of ~~expenses~~ total operating costs.

(b) For purposes of allocating these remaining central, affiliated, or corporate office costs, the numerator for the allocation ratio shall be determined as follows:

(1) for long-term care facilities that are related organizations or are controlled by a central, affiliated, or corporate office under a management agreement, the numerator of the allocation ratio shall be equal to the sum of the total

operating costs incurred by each related organization or controlled long-term care facility;

(2) for a central, affiliated, or corporate office providing goods or services to related organizations that are not long-term care facilities, the numerator of the allocation ratio shall be equal to the sum of the total operating costs incurred by the non-long-term care related organizations;

(3) for a central, affiliated, or corporate office providing goods or services to unrelated long-term care facilities under a consulting agreement, the numerator of the allocation ratio shall be equal to the greater of directly identified central, affiliated, or corporate costs or the contracted amount; or

(4) for business activities that involve the providing of goods or services to unrelated parties which are not long-term care facilities, the numerator of the allocation ratio shall be equal to the greater of directly identified costs or revenues generated by the activity or function.

(c) The denominator for the allocation ratio is the sum of the numerators in paragraph (b), clauses (1) to (4).

Sec. 101. Minnesota Statutes 1992, section 256B.432, is amended by adding a subdivision to read:

Subd. 8. **ADEQUATE DOCUMENTATION SUPPORTING LONG-TERM CARE FACILITY PAYROLLS.** Beginning July 1, 1993, payroll records supporting compensation costs claimed by long-term care facilities must be supported by affirmative time and attendance records prepared by each individual at intervals of not more than one month. The affirmative time and attendance record must identify the individual's name; the days worked during each pay period; the number of hours worked each day; and the number of hours taken each day by the individual for vacation, sick, and other leave. The affirmative time and attendance record must include a signed verification by the individual and the individual's supervisor, if any, that the entries reported on the record are correct.

Sec. 102. Minnesota Statutes 1992, section 256B.47, subdivision 3, is amended to read:

Subd. 3. **ALLOCATION OF COSTS.** To ensure the avoidance of double payments as required by section 256B.433, the direct and indirect reporting year costs of providing residents of nursing facilities that are not hospital attached with therapy services that are billed separately from the nursing facility payment rate or according to Minnesota Rules, parts 9500.0750 to 9500.1080, must be determined and deducted from the appropriate cost categories of the annual cost report as follows:

(a) The costs of wages and salaries for employees providing or participating

in providing and consultants providing services shall be allocated to the therapy service based on direct identification.

(b) The costs of fringe benefits and payroll taxes relating to the costs in paragraph (a) must be allocated to the therapy service based on direct identification or the ratio of total costs in paragraph (a) to the sum of total allowable salaries and the costs in paragraph (a).

(c) The costs of housekeeping, plant operations and maintenance, real estate taxes, special assessments, and insurance, other than the amounts classified as a fringe benefit, must be allocated to the therapy service based on the ratio of service area square footage to total facility square footage.

(d) The costs of bookkeeping and medical records must be allocated to the therapy service either by the method in paragraph (e) or based on direct identification. Direct identification may be used if adequate documentation is provided to, and accepted by, the commissioner.

(e) The costs of administrators, bookkeeping, and medical records salaries, except as provided in paragraph (d), must be allocated to the therapy service based on the ratio of the total costs in paragraphs (a) to (d) to the sum of total allowable nursing facility costs and the costs in paragraphs (a) to (d).

(f) The cost of property must be allocated to the therapy service and removed from the ~~rental per diem~~ nursing facility's property-related payment rate, based on the ratio of service area square footage to total facility square footage multiplied by the ~~building capital allowance~~ property-related payment rate.

Sec. 103. Minnesota Statutes 1992, section 256B.48, subdivision 1, is amended to read:

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

(a) Charging private paying residents rates for similar services which exceed those which are approved by the state agency for medical assistance recipients as determined by the prospective desk audit rate, except under the following circumstances: the nursing facility may (1) charge private paying residents a higher rate for a private room, and (2) charge for special services which are not included in the daily rate if medical assistance residents are charged separately at the same rate for the same services in addition to the daily rate paid by the commissioner. Services covered by the payment rate must be the same regardless of payment source. Special services, if offered, must be available to all residents in all areas of the nursing facility and charged separately at the same rate. Residents are free to select or decline special services. Special services must not include services which must be provided by the nursing facility in order to com-

ply with licensure or certification standards and that if not provided would result in a deficiency or violation by the nursing facility. Services beyond those required to comply with licensure or certification standards must not be charged separately as a special service if they were included in the payment rate for the previous reporting year. A nursing facility that charges a private paying resident a rate in violation of this clause is subject to an action by the state of Minnesota or any of its subdivisions or agencies for civil damages. A private paying resident or the resident's legal representative has a cause of action for civil damages against a nursing facility that charges the resident rates in violation of this clause. The damages awarded shall include three times the payments that result from the violation, together with costs and disbursements, including reasonable attorneys' fees or their equivalent. A private paying resident or the resident's legal representative, the state, subdivision or agency, or a nursing facility may request a hearing to determine the allowed rate or rates at issue in the cause of action. Within 15 calendar days after receiving a request for such a hearing, the commissioner shall request assignment of an administrative law judge under sections 14.48 to 14.56 to conduct the hearing as soon as possible or according to agreement by the parties. The administrative law judge shall issue a report within 15 calendar days following the close of the hearing. The prohibition set forth in this clause shall not apply to facilities licensed as boarding care facilities which are not certified as skilled or intermediate care facilities level I or II for reimbursement through medical assistance.

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

(c) Requiring any resident of the nursing facility to utilize a vendor of health care services ~~who is a licensed physician or pharmacist~~ chosen by the nursing facility.

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

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

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

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

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

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

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

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

(1) is owned and operated by an organization tax-exempt under section 290.05, subdivision 1, clause (i); and

(2) accounts for all of the applicant's assets which are required to be assigned to the facility so that only expenses for the cost of care of the applicant may be charged against the account; and

(3) agrees in writing at the time of admission to the facility to permit the applicant, or the applicant's guardian, or conservator, to examine the records relating to the applicant's account upon request, and to receive an audited statement of the expenditures charged against the applicant's individual account upon request; and

(4) agrees in writing at the time of admission to the facility to permit the applicant to withdraw from the facility at any time and to receive, upon withdrawal, the balance of the applicant's individual account.

For a period not to exceed 180 days, the commissioner may continue to make medical assistance payments to a nursing facility or boarding care home which is in violation of this section if extreme hardship to the residents would result. In these cases the commissioner shall issue an order requiring the nursing

facility to correct the violation. The nursing facility shall have 20 days from its receipt of the order to correct the violation. If the violation is not corrected within the 20-day period the commissioner may reduce the payment rate to the nursing facility by up to 20 percent. The amount of the payment rate reduction shall be related to the severity of the violation and shall remain in effect until the violation is corrected. The nursing facility or boarding care home may appeal the commissioner's action pursuant to the provisions of chapter 14 pertaining to contested cases. An appeal shall be considered timely if written notice of appeal is received by the commissioner within 20 days of notice of the commissioner's proposed action.

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

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

Sec. 104. Minnesota Statutes 1992, section 256B.48, subdivision 2, is amended to read:

Subd. 2. **REPORTING REQUIREMENTS.** No later than December 31 of each year, a skilled nursing facility or intermediate care facility, including boarding care facilities, which receives medical assistance payments or other reimbursements from the state agency shall:

(a) Provide the state agency with a copy of its audited financial statements. The audited financial statements must include a balance sheet, income statement, statement of the rate or rates charged to private paying residents, statement of retained earnings, statement of cash flows, notes to the financial statements, audited applicable supplemental information, and the certified public accountant's or licensed public accountant's opinion. The examination by the certified public accountant or licensed public accountant shall be conducted in accordance with generally accepted auditing standards as promulgated and adopted by the American Institute of Certified Public Accountants. Beginning with the reporting year which begins October 1, 1992, a nursing facility is no longer required to have a certified audit of its financial statements. The cost of a certified audit shall not be an allowable cost in that reporting year, nor in subsequent reporting years unless the nursing facility submits its certified audited financial statements in the manner otherwise specified in this subdivision. A nursing facility which does not submit a certified audit must submit its working trial balance;

(b) Provide the state agency with a statement of ownership for the facility;

(c) Provide the state agency with separate, audited financial statements as specified in clause (a) for every other facility owned in whole or part by an individual or entity which has an ownership interest in the facility;

(d) Upon request, provide the state agency with separate, audited financial statements as specified in clause (a) for every organization with which the facility conducts business and which is owned in whole or in part by an individual or entity which has an ownership interest in the facility;

(e) Provide the state agency with copies of leases, purchase agreements, and other documents related to the lease or purchase of the nursing facility;

(f) Upon request, provide the state agency with copies of leases, purchase agreements, and other documents related to the acquisition of equipment, goods, and services which are claimed as allowable costs; and

(g) Permit access by the state agency to the certified public accountant's and licensed public accountant's audit workpapers which support the audited financial statements required in clauses (a), (c), and (d).

Documents or information provided to the state agency pursuant to this subdivision shall be public. If the requirements of clauses (a) to (g) are not met, the reimbursement rate may be reduced to 80 percent of the rate in effect on the first day of the fourth calendar month after the close of the reporting year, and the reduction shall continue until the requirements are met.

Both nursing facilities and intermediate care facilities for the mentally retarded must maintain statistical and accounting records in sufficient detail to support information contained in the facility's cost report for at least ~~five~~ six years, including the year following the submission of the cost report. For computerized accounting systems, the records must include copies of electronically generated media such as magnetic discs and tapes.

Sec. 105. Minnesota Statutes 1992, section 256B.49, is amended by adding a subdivision to read:

Subd. 5. **PROVIDE WAIVER ELIGIBILITY FOR CERTAIN CHRONICALLY ILL AND CERTAIN DISABLED PERSONS.** Chronically ill or disabled individuals, who are likely to reside in acute care if waiver services were not provided, could be found eligible for services under this section without regard to age.

Sec. 106. Minnesota Statutes 1992, section 256B.50, subdivision 1b, is amended to read:

Subd. 1b. **FILING AN APPEAL.** To appeal, the provider shall file with the commissioner a written notice of appeal; the appeal must be postmarked or received by the commissioner within 60 days of the date the determination of the payment rate was mailed or personally received by a provider, whichever is

earlier. The notice of appeal must specify each disputed item; the reason for the dispute; the total dollar amount in dispute for each separate disallowance, allocation, or adjustment of each cost item or part of a cost item; the computation that the provider believes is correct; the authority in statute or rule upon which the provider relies for each disputed item; the name and address of the person or firm with whom contacts may be made regarding the appeal; and other information required by the commissioner. The commissioner shall review an appeal by a nursing facility, if the appeal was sent by certified mail and postmarked prior to August 1, 1991, and would have been received by the commissioner within the 60-day deadline if it had not been delayed due to an error by the postal service.

Sec. 107. Minnesota Statutes 1992, section 256B.50, is amended by adding a subdivision to read:

Subd. 1h. **APPEALS REVIEW PROJECT.** (a) The appeals review procedure described in this subdivision is effective for desk audit appeals for rate years beginning between July 1, 1993, and June 30, 1997, and for field audit appeals filed during that time period. For appeals reviewed under this subdivision, subdivision 1c applies only to contested case demands under paragraph (d) and subdivision 1d does not apply.

(b) The commissioner shall review appeals and issue a written determination on each appealed item within one year of the due date of the appeal. Upon mutual agreement, the commissioner and the provider may extend the time for issuing a determination for a specified period. The commissioner shall notify the provider by first class mail of the determination. The determination takes effect 30 days following the date of issuance specified in the determination.

(c) In reviewing the appeal, the commissioner may request additional written or oral information from the provider. The provider has the right to present information by telephone or in person concerning the appeal to the commissioner prior to the issuance of the determination if a conference is requested within six months of the date the appeal was received by the commissioner. Statements made during the review process are not admissible in a contested case hearing under paragraph (d) absent an express stipulation by the parties to the contested case.

(d) For an appeal item on which the provider disagrees with the determination, the provider may file with the commissioner a written demand for a contested case hearing to determine the proper resolution of specified appeal items. The demand must be postmarked or received by the commissioner within 30 days of the date of issuance specified in the determination. The commissioner shall refer any contested case demand to the office of the attorney general. When a contested case demand is referred to the office of the attorney general, the contested case procedures described in subdivision 1c apply and the written determination issued by the commissioner is of no effect.

(e) The commissioner has discretion to issue to the provider a proposed resolution for specified appeal items upon a request from the provider filed separately from the notice of appeal. The proposed resolution is final upon written acceptance by the provider within 30 days of the date the proposed resolution was mailed to or personally received by the provider, whichever is earlier.

(f) The commissioner may use the procedures described in this subdivision to resolve appeals filed prior to July 1, 1993.

Sec. 108. Minnesota Statutes 1992, section 256B.50, is amended by adding a subdivision to read:

Subd. 3. **TIME AND ATTENDANCE DISPUTED ITEMS.** The commissioner shall settle unresolved appeals by a nursing facility of disallowances or adjustments of compensation costs for rate years beginning prior to June 30, 1994, by recognizing the compensation costs reported by the nursing facility when the appealed disallowances or adjustments were based on a determination of inadequate documentation of time and attendance or equivalent records to support payroll costs. The recognition of costs provided in this subdivision pertains only to appeals of disallowances and adjustments based solely on disputed time and attendance or equivalent records. Appeals of disallowances and adjustments of compensation costs based on other grounds, including misrepresentation of costs or failure to meet the general cost criteria under Minnesota Rules, parts 9549.0010 to 9549.0080, are not governed by this subdivision.

Sec. 109. Minnesota Statutes 1992, section 256B.501, subdivision 3g, is amended to read:

Subd. 3g. **ASSESSMENT OF RESIDENTS.** ~~For rate years beginning on or after October 1, 1990, the commissioner shall establish program operating cost rates for care of residents in facilities that take into consideration service characteristics of residents in those facilities.~~ To establish the service characteristics of residents, the quality assurance and review teams in the department of health shall assess all residents annually beginning January 1, 1989, using a uniform assessment instrument developed by the commissioner. This instrument shall include assessment of the ~~client's~~ services identified as needed and provided to each client to address behavioral needs, integration into the community, ability to perform activities of daily living, medical and therapeutic needs, and other relevant factors determined by the commissioner. ~~The commissioner may adjust the program operating cost rates of facilities based on a comparison of client service characteristics, resource needs, and costs. The commissioner may adjust a facility's payment rate during the rate year when accumulated changes in the facility's average service units exceed the minimums established in the rules required by subdivision 3j.~~ By January 30, 1994, the commissioner shall report to the legislature on:

(1) the assessment process and scoring system utilized;

(2) possible utilization of assessment information by facilities for management purposes; and

(3) possible application of the assessment for purposes of adjusting the operating cost rates of facilities based on a comparison of client services characteristics, resource needs, and costs.

Sec. 110. Minnesota Statutes 1992, section 256B.501, subdivision 3i, is amended to read:

Subd. 3i. **SCOPE.** Subdivisions 3a to 3e and 3h do not apply to facilities whose payment rates are governed by Minnesota Rules, part 9553.0075.

Sec. 111. Minnesota Statutes 1992, section 256B.501, is amended by adding a subdivision to read:

Subd. 5a. **CHANGES TO ICF/MR REIMBURSEMENT.** The reimbursement rule changes in paragraphs (a) to (e) apply to Minnesota Rules, parts 9553.0010 to 9553.0080, and this section, and are effective for rate years beginning on or after October 1, 1993, unless otherwise specified.

(a) The maximum efficiency incentive shall be $1.50 per resident per day.

(b) If a facility's capital debt reduction allowance is greater than 50 cents per resident per day, that facility's capital debt reduction allowance in excess of 50 cents per resident day shall be reduced by 25 percent.

(c) Beginning with the biennial reporting year which begins January 1, 1993, a facility is no longer required to have a certified audit of its financial statements. The cost of a certified audit shall not be an allowable cost in that reporting year, nor in subsequent reporting years unless the facility submits its certified audited financial statements in the manner otherwise specified in this subdivision. A nursing facility which does not submit a certified audit must submit its working trial balance.

(d) In addition to the approved pension or profit sharing plans allowed by the reimbursement rule, the commissioner shall allow those plans specified in Internal Revenue Code, sections 403(b) and 408(k).

(e) The commissioner shall allow as workers' compensation insurance costs under this section, the costs of workers' compensation coverage obtained under the following conditions:

(1) a plan approved by the commissioner of commerce as a Minnesota group or individual self-insurance plan as provided in sections 79A.03;

(2) a plan in which:

(i) the facility, directly or indirectly, purchases workers' compensation coverage in compliance with section 176.181, subdivision 2, from an authorized insurance carrier;

(ii) a related organization to the facility reinsures the workers' compensation coverage purchased, directly or indirectly, by the facility; and

(iii) all of the conditions in clause (4) are met;

(3) a plan in which:

(i) the facility, directly or indirectly, purchases workers' compensation coverage in compliance with section 176.181, subdivision 2, from an authorized insurance carrier;

(ii) the insurance premium is calculated retrospectively, including a maximum premium limit, and paid using the paid loss retro method; and

(iii) all of the conditions in clause (4) are met;

(4) additional conditions are:

(i) the reserves for the plan are maintained in an account controlled and administered by a person which is not a related organization to the facility;

(ii) the reserves for the plan cannot be used, directly or indirectly, as collateral for debts incurred or other obligations of the facility or related organizations to the facility;

(iii) if the plan provides workers' compensation coverage for non-Minnesota facilities, the plan's cost methodology must be consistent among all facilities covered by the plan, and if reasonable, is allowed notwithstanding any reimbursement laws regarding cost allocation to the contrary;

(iv) central, affiliated, corporate, or nursing facility costs related to their administration of the plan are costs which must remain in the nursing facility's administrative cost category, and must not be allocated to other cost categories; and

(v) required security deposits, whether in the form of cash, investments, securities, assets, letters of credit, or in any other form are not allowable costs for purposes of establishing the facilities payment rate;

(5) any costs allowed pursuant to clauses (1) to (3) are subject to the following requirements:

(i) If the facility is sold or otherwise ceases operations, the plan's reserves must be subject to an actuarially based settle-up after 36 months from the date of sale or the date on which operations ceased. The facility's medical assistance portion of the total excess plan reserves must be paid to the state within 30 days following the date on which excess plan reserves are determined;

(ii) Any distribution of excess plan reserves made to or withdrawals made by the facility or a related organization are applicable credits and must be used to reduce the facility's workers' compensation insurance costs in the reporting period in which a distribution or withdrawal is received; and

(iii) If the plan is audited pursuant to the Medicare program, the facility must provide a copy of Medicare's final audit report, including attachments and exhibits, to the commissioner within 30 days of receipt by the facility or any related organization. The commissioner shall implement the audit findings associated with the plan upon receipt of Medicare's final audit report. The department's authority to implement the audit findings is independent of its authority to conduct a field audit; and

(6) the commissioner shall have authority to adopt emergency rules to implement this paragraph.

Sec. 112. Minnesota Statutes 1992, section 256B.501, subdivision 12, is amended to read:

Subd. 12. **ICF/MR SALARY ADJUSTMENTS.** For the rate period beginning January 1, 1992, and ending September 30, 1993, the commissioner shall add the appropriate salary adjustment cost per diem calculated in paragraphs (a) to (d) to the total operating cost payment rate of each facility. The salary adjustment cost per diem must be determined as follows:

(a) **COMPUTATION AND REVIEW GUIDELINES.** Except as provided in paragraph (c), a state-operated community service, and any facility whose payment rates are governed by closure agreements, receivership agreements, or Minnesota Rules, part 9553.0075, are not eligible for a salary adjustment otherwise granted under this subdivision. For purposes of the salary adjustment per diem computation and reviews in this subdivision, the term "salary adjustment cost" means the facility's allowable program operating cost category employee training expenses, and the facility's allowable salaries, payroll taxes, and fringe benefits. The term does not include these same salary-related costs for both administrative or central office employees.

For the purpose of determining the amount of salary adjustment to be granted under this subdivision, the commissioner must use the reporting year ending December 31, 1990, as the base year for the salary adjustment per diem computation. For the purpose of ~~each year's~~ both years' salary adjustment cost review, the commissioner must use the facility's salary adjustment cost for the reporting year ending December 31, 1991, as the base year. If the base year and the reporting ~~year~~ years subject to review include salary cost reclassifications made by the department, the commissioner must reconcile those differences before completing the salary adjustment per diem review.

(b) **SALARY ADJUSTMENT PER DIEM COMPUTATION.** For the rate period beginning January 1, 1992, each facility shall receive a salary adjustment cost per diem equal to its salary adjustment costs multiplied by 1-1/2 percent, and then divided by the facility's resident days.

(c) **ADJUSTMENTS FOR NEW FACILITIES.** For newly constructed or newly established facilities, except for state-operated community services, whose

payment rates are governed by Minnesota Rules, part 9553.0075, if the settle-up cost report includes a reporting year which is subject to review under this subdivision, the commissioner shall adjust the rule provision governing the maximum settle-up payment rate by increasing the .4166 percent for each full month of the settle-up cost report to .7083. For any subsequent rate period which is authorized for salary adjustments under this subdivision, the commissioner shall compute salary adjustment cost per diems by annualizing the salary adjustment costs for the settle-up cost report period and treat that period as the base year for purposes of reviewing salary adjustment cost per diems.

(d) **SALARY ADJUSTMENT PER DIEM REVIEW.** The commissioner shall review the implementation of the salary adjustments on a per diem basis. For reporting years ending December 31, 1992, and December 31, 1993, the commissioner must review and determine the amount of change in salary adjustment costs in ~~each~~ both of the above reporting years over the base year after the reporting year ending December 31, 1993. ~~In the case of each review,~~ The commissioner must inflate the base year's salary adjustment costs by the cumulative percentage increase granted in paragraph (b), plus three percentage points for each of the two years reviewed. The commissioner must then compare each facility's salary adjustment costs for the reporting year divided by the facility's resident days for ~~that~~ both reporting ~~year~~ years to the base year's inflated salary adjustment cost divided by the facility's resident days for the base year. If the facility has had a one-time program operating cost adjustment settle-up during any of the reporting years subject to review, the commissioner must remove the per diem effect of the one-time program adjustment before completing the review and per diem comparison.

The review and per diem comparison must be done by the commissioner ~~each year following~~ after the reporting ~~years subject to review~~ year ending December 31, 1993. If the salary adjustment cost per diem for the reporting ~~year~~ years being reviewed is less than the base year's inflated salary adjustment cost per diem, the commissioner must recover the difference within 120 days after the date of written notice. The amount of the recovery shall be equal to the per diem difference multiplied by the facility's resident days in the reporting ~~year~~ years being reviewed. Written notice of the amount subject to recovery must be given by the commissioner following ~~each~~ both reporting ~~year~~ years reviewed. Interest charges must be assessed by the commissioner after the 120th day of that notice at the same interest rate the commissioner assesses for other balance outstanding.

Sec. 113. Minnesota Statutes 1992, 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:

(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) case management services for a person with serious and persistent mental illness who would be eligible for medical assistance except that the person resides in an institution for mental diseases;

(19) psychological services, medical supplies and equipment, and Medicare premiums, coinsurance and deductible payments; ~~and~~

(20) 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; and

(21) services performed by a certified pediatric nurse practitioner, a certified

family nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological nurse practitioner, or a certified geriatric nurse practitioner in independent practice, if the services are otherwise covered under this chapter as a physician service, and if the service is within the scope of practice of the nurse practitioner's license as a registered nurse, as defined in section 148.171.

(b) 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) 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.

(d) The commissioner of human services may reduce payments provided under sections 256D.01 to 256D.21 and 261.23 in order to remain within the amount appropriated for general assistance medical care, within the following restrictions.

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

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

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

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

For the period July 1, 1988, to June 30, 1989, reductions below the cost per service unit allowable under section 256.966 are permitted only as follows: payments for inpatient and outpatient hospital care provided in response to a primary diagnosis of chemical dependency or mental illness may be reduced no more than 15 percent; payments for all other inpatient hospital care may not be reduced. Reductions below the payments allowable under medical assistance for the remaining general assistance medical care services allowable under this subdivision may be reduced no more than five percent.

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.

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

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

(g) 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.

(h) 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. 114. Minnesota Statutes 1992, section 256D.03, subdivision 8, is amended to read:

Subd. 8. **PRIVATE INSURANCE POLICIES.** (a) Private accident and health care coverage for medical services is primary coverage and must be exhausted before general assistance medical care is paid. When a person who is otherwise eligible for general assistance medical care has private accident or health care coverage, including a prepaid health plan, the private health care benefits available to the person must be used first and to the fullest extent. ~~Supplemental payment may be made by general assistance medical care, but the combined total amount paid must not exceed the amount payable under general assistance medical care in the absence of other coverage. General assistance medical care must not make supplemental payment for covered services rendered by a vendor who participates or contracts with any health coverage plan if the plan requires the vendor to accept the plan's payment as payment in full.~~ General assistance medical care payment will not be made when either covered charges are paid in full by a third party or the provider has an agreement to accept payment for less than charges as payment in full. Payment for patients that are simultaneously covered by general assistance medical care and a liable third party other than Medicare will be determined as the lesser of clauses (1) to (3):

(1) the patient liability according to the provider/insurer agreement;

(2) covered charges minus the third party payment amount; or

(3) the general assistance medical care rate minus the third party payment amount.

A negative difference will not be implemented.

(b) When a parent or a person with an obligation of support has enrolled in a prepaid health care plan under section 518.171, subdivision 1, the commissioner of human services shall limit the recipient of general assistance medical care to the benefits payable under that prepaid health care plan to the extent that services available under general assistance medical care are also available under the prepaid health care plan.

(c) Upon furnishing general assistance medical care or general assistance to

any person having private accident or health care coverage, or having a cause of action arising out of an occurrence that necessitated the payment of assistance, the state agency shall be subrogated, to the extent of the cost of medical care, subsistence, or other payments furnished, to any rights the person may have under the terms of the coverage or under the cause of action.

This right of subrogation includes all portions of the cause of action, notwithstanding any settlement allocation or apportionment that purports to dispose of portions of the cause of action not subject to subrogation.

(d) To recover under this section, the attorney general or the appropriate county attorney, acting upon direction from the attorney general, may institute or join a civil action to enforce the subrogation rights established under this section.

(e) The state agency must be given notice of monetary claims against a person, firm, or corporation that may be liable in damages, or otherwise obligated to pay part or all of the costs related to an injury when the state agency has paid or become liable for the cost of care or payments related to the injury. Notice must be given as follows:

(i) Applicants for general assistance or general assistance medical care shall notify the state or county agency of any possible claims when they submit the application. Recipients of general assistance or general assistance medical care shall notify the state or county agency of any possible claims when those claims arise.

(ii) A person providing medical care services to a recipient of general assistance medical care shall notify the state agency when the person has reason to believe that a third party may be liable for payment of the cost of medical care.

(iii) A person who is party to a claim upon which the state agency may be entitled to subrogation under this section shall notify the state agency of its potential subrogation claim before filing a claim, commencing an action, or negotiating a settlement. A person who is a party to a claim includes the plaintiff, the defendants, and any other party to the cause of action.

Notice given to the county agency is not sufficient to meet the requirements of paragraphs (b) and (c).

(f) Upon any judgment, award, or settlement of a cause of action, or any part of it, upon which the state agency has a subrogation right, including compensation for liquidated, unliquidated, or other damages, reasonable costs of collection, including attorney fees, must be deducted first. The full amount of general assistance or general assistance medical care paid to or on behalf of the person as a result of the injury must be deducted next and paid to the state agency. The rest must be paid to the public assistance recipient or other plaintiff. The plaintiff, however, must receive at least one-third of the net recovery after attorney fees and collection costs.

Sec. 115. Minnesota Statutes 1992, section 259.431, subdivision 5, is amended to read:

Subd. 5. **MEDICAL ASSISTANCE; DUTIES OF THE COMMISSIONER OF HUMAN SERVICES.** The commissioner of human services shall:

(a) Issue a medical assistance identification card to any child with special needs who is title IV-E eligible, or who is not title IV-E eligible but was determined by another state to have a special need for medical or rehabilitative care, and who is a resident in this state and is the subject of an adoption assistance agreement with another state when a certified copy of the adoption assistance agreement obtained from the adoption assistance state has been filed with the commissioner. The adoptive parents shall be required at least annually to show that the agreement is still in force or has been renewed.

(b) Consider the holder of a medical assistance identification card under this subdivision as any other recipient of medical assistance under chapter 256B; process and make payment on claims for the recipient in the same manner as for other recipients of medical assistance.

(c) Provide coverage and benefits for a child who is title IV-E eligible or who is not title IV-E eligible but was determined to have a special need for medical or rehabilitative care and who is in another state and who is covered by an adoption assistance agreement made by the commissioner for the coverage or benefits, if any, which is not provided by the resident state. The adoptive parents acting for the child may submit evidence of payment for services or benefit amounts not payable in the resident state and shall be reimbursed. However, there shall be no reimbursement for services or benefit amounts covered under any insurance or other third party medical contract or arrangement held by the child or the adoptive parents.

(d) Publish emergency and permanent rules implementing this subdivision. Such rules shall include procedures to be followed in obtaining prior approvals for services which are required for the assistance.

Sec. 116. Minnesota Statutes 1992, section 393.07, subdivision 3, is amended to read:

Subd. 3. **FEDERAL SOCIAL SECURITY.** The county welfare board shall be charged with the duties of administration of all forms of public assistance and public child welfare or other programs within the purview of the federal Social Security Act, other than public health nursing and home health services, and which now are, or hereafter may be, imposed on the commissioner of human services by law, of both children and adults. The duties of such county welfare board shall be performed in accordance with the standards and rules which may be promulgated by the commissioner of human services in order to achieve the purposes of the law and to comply with the requirements of the federal Social Security Act needed to qualify the state to obtain grants-in-aid avail-

able under that act. Notwithstanding the provisions of any other law to the contrary, the welfare board ~~may~~ shall delegate to the director the authority to determine eligibility and disburse funds without first securing board action, provided that the director shall present to the board, at the next scheduled meeting, any such action taken for ratification by the board.

Sec. 117. **[514.980] MEDICAL ASSISTANCE LIENS; DEFINITIONS.**

Subdivision 1. **APPLICABILITY.** The definitions in this section apply to sections 514.980 to 514.985.

Subd. 2. **MEDICAL ASSISTANCE AGENCY OR AGENCY.** "Medical assistance agency" or "agency" means the state or any county medical assistance agency that provides a medical assistance benefit.

Subd. 3. **MEDICAL ASSISTANCE BENEFIT.** "Medical assistance benefit" means a benefit provided under chapter 256B to a person while in a medical institution. A "medical institution" is defined as a nursing facility, intermediate care facility for persons with mental retardation, or inpatient hospital.

Sec. 118. **[514.981] MEDICAL ASSISTANCE LIEN.**

Subdivision 1. **PROPERTY SUBJECT TO LIEN; LIEN AMOUNT.** (a) Subject to sections 514.980 to 514.985, payments made by a medical assistance agency to provide medical assistance benefits to a medical assistance recipient who owns property in this state or to the recipient's spouse constitute a lien in favor of the agency upon all real property that is owned by the medical assistance recipient on or after the time when the recipient is institutionalized.

(b) The amount of the lien is limited to the same extent as a claim against the estate under section 256B.15, subdivision 2.

Subd. 2. **ATTACHMENT.** (a) A medical assistance lien attaches and becomes enforceable against specific real property as of the date when the following conditions are met:

(1) payments have been made by an agency for a medical assistance benefit;

(2) notice and an opportunity for a hearing have been provided under paragraph (b);

(3) a lien notice has been filed as provided in section 514.982;

(4) if the property is registered property, the lien notice has been memorialized on the certificate of title of the property affected by the lien notice; and

(5) all restrictions against enforcement have ceased to apply.

(b) An agency may not file a medical assistance lien notice until the medical assistance recipient and the recipient's spouse or their legal representatives have been sent, by certified or registered mail, written notice of the agency's lien

rights and there has been an opportunity for a hearing under section 256.045. In addition, the agency may not file a lien notice unless the agency determines as medically verified by the recipient's attending physician that the medical assistance recipient cannot reasonably be expected to be discharged from a medical institution and return home.

(c) An agency may not file a medical assistance lien notice against real property while it is the home of the recipient's spouse.

(d) An agency may not file a medical assistance lien notice against real property that was the homestead of the medical assistance recipient or the recipient's spouse when the medical assistance recipient received medical institution services if any of the following persons are lawfully residing in the property:

(1) a child of the medical assistance recipient if the child is under age 21 or is blind or permanently and totally disabled according to the supplemental security income criteria;

(2) a child of the medical assistance recipient if the child resided in the homestead for at least two years immediately before the date the medical assistance recipient received medical institution services, and the child provided care to the medical assistance recipient that permitted the recipient to live without medical institution services; or

(3) a sibling of the medical assistance recipient if the sibling has an equity interest in the property and has resided in the property for at least one year immediately before the date the medical assistance recipient began receiving medical institution services.

(e) A medical assistance lien applies only to the specific real property described in the lien notice.

Subd. 3. **CONTINUATION OF LIEN NOTICE AND LIEN.** A medical assistance lien notice remains effective from the time it is filed until it can be disregarded under sections 514.980 to 514.985. A medical assistance lien that has attached to specific real property continues until the lien is satisfied, becomes unenforceable under subdivision 6, or is released and discharged under subdivision 5.

Subd. 4. **LIEN PRIORITY.** A medical assistance lien that attaches to specific real property is subject to the rights of any other person whose interest in the real property is perfected before a lien notice has been filed under section 514.982, including:

(a) an owner, other than the recipient or recipient's spouse;

(b) a purchaser;

(c) a holder of a mortgage or security interest; or

(d) a judgment lien creditor.

The rights of the other person have the same protections against a medical assistance lien as are afforded against a judgment lien that arises out of an unsecured obligation and that arises as of the time of the filing of the medical assistance lien notice under section 514.982. A medical assistance lien is inferior to a lien for taxes or special assessments or other lien that would be superior to the perfected lien of a judgment creditor.

Subd. 5. **RELEASE.** (a) An agency that files a medical assistance lien notice shall release and discharge the lien in full if:

(1) the medical assistance recipient is discharged from the medical institution and returns home;

(2) the medical assistance lien is satisfied;

(3) the agency has received reimbursement for the amount secured by the lien or a legally enforceable agreement has been executed providing for reimbursement of the agency for that amount; or

(4) the medical assistance recipient, if single, or the recipient's surviving spouse, has died, and a claim may not be filed against the estate of the decedent under section 256B.15, subdivision 3.

(b) Upon request, the agency that files a medical assistance lien notice shall release a specific parcel of real property from the lien if:

(1) the property is or was the homestead of the recipient's spouse during the time of the medical assistance recipient's institutionalization, or the property is or was attributed to the spouse under section 256B.059, subdivision 3 or 4, and the spouse is not receiving medical assistance benefits;

(2) the property would be exempt from a claim against the estate under section 256B.15, subdivision 4;

(3) the agency receives reimbursement, or other collateral sufficient to secure payment of reimbursement, in an amount equal to the lesser of the amount secured by the lien, or the amount the agency would be allowed to recover upon enforcement of the lien against the specific parcel of property if the agency attempted to enforce the lien on the date of the request to release the lien; or

(4) the medical assistance lien cannot lawfully be enforced against the property because of an error, omission, or other material defect in procedure, description, identity, timing, or other prerequisite to enforcement.

(c) The agency that files a medical assistance lien notice may release the lien if the attachment or enforcement of the lien is determined by the agency to be contrary to the public interest.

(d) The agency that files a medical assistance lien notice shall execute the release of the lien and file the release as provided in section 514.982, subdivision 2.

Subd. 6. **TIME LIMITS; CLAIM LIMITS.** (a) A medical assistance lien is not enforceable against specific real property if any of the following occurs:

(1) the lien is not satisfied or proceedings are not lawfully commenced to foreclose the lien within 18 months of the agency's receipt of notice of the death of the medical assistance recipient or the death of the surviving spouse, whichever occurs later; or

(2) the lien is not satisfied or proceedings are not lawfully commenced to foreclose the lien within three years of the death of the medical assistance recipient or the death of the surviving spouse, whichever occurs later. This limitation is tolled during any period when the provisions of section 514.983, subdivision 2, apply to delay enforcement of the lien.

(b) A medical assistance lien is not enforceable against the real property of an estate to the extent there is a determination by a court of competent jurisdiction, or by an officer of the court designated for that purpose, that there are insufficient assets in the estate to satisfy the agency's medical assistance lien in whole or in part in accordance with the priority of claims established by chapters 256B and 524. The agency's lien remains enforceable to the extent that assets are available to satisfy the agency's lien, subject to the priority of other claims, and to the extent that the agency's claim is allowed against the estate under chapters 256B and 524.

Sec. 119. **[514.982] MEDICAL ASSISTANCE LIEN NOTICE.**

Subdivision 1. **CONTENTS.** A medical assistance lien notice must be dated and must contain:

(1) the full name, last known address, and social security number of the medical assistance recipient and the full name, address, and social security number of the recipient's spouse;

(2) a statement that medical assistance payments have been made to or for the benefit of the medical assistance recipient named in the notice, specifying the first date of eligibility for benefits;

(3) a statement that all interests in real property owned by the persons named in the notice may be subject to or affected by the rights of the agency to be reimbursed for medical assistance benefits; and

(4) the legal description of the real property upon which the lien attaches, and whether the property is registered property.

Subd. 2. **FILING.** Any notice, release, or other document required to be

filed under sections 514.980 to 514.985 must be filed in the office of the county recorder or registrar of titles, as appropriate, in the county where the real property is located. Notwithstanding section 386.77, the agency shall pay the applicable filing fee for any document filed under sections 514.980 to 514.985. The commissioner of human services shall reimburse the county agency for filing fees paid under this section. An attestation, certification, or acknowledgment is not required as a condition of filing. Upon filing of a medical assistance lien notice, the registrar of titles shall record it on the certificate of title of each parcel of property described in the lien notice. The county recorder of each county shall establish an index of medical assistance lien notices, other than those that affect only registered property, showing the names of all persons named in the medical assistance lien notices filed in the county, arranged alphabetically. The index must be combined with the index of state tax lien notices. The filing or mailing of any notice, release, or other document under sections 514.980 to 514.985 is the responsibility of the agency. The agency shall send a copy of the medical assistance lien notice by registered or certified mail to each record owner and mortgagee of the real property.

Sec. 120. **[514.983] LIEN ENFORCEMENT; LIMITATION.**

Subdivision 1. **FORECLOSURE PROCEDURE.** Subject to subdivision 2, a medical assistance lien may be enforced by the agency that filed it by foreclosure in the manner provided for foreclosure of a judgment lien under chapter 550.

Subd. 2. **HOMESTEAD PROPERTY.** (a) A medical assistance lien may not be enforced against homestead property of the medical assistance recipient or the spouse while it remains the lawful residence of the medical assistance recipient's spouse.

(b) A medical assistance lien remains enforceable as provided in sections 514.980 to 514.985, notwithstanding any law limiting the enforceability of a judgment.

Sec. 121. **[514.984] LIEN DOES NOT AFFECT OTHER REMEDIES.**

Sections 514.980 to 514.985 do not limit the right of an agency to file a claim against the estate of a medical assistance recipient or the estate of the spouse or limit any other claim for reimbursement of agency expenses or the availability of any other remedy provided to the agency.

Sec. 122. **[514.985] AMOUNTS RECEIVED TO SATISFY LIEN.**

Amounts received by the state to satisfy a medical assistance lien filed by the state must be deposited in the state treasury and credited to the fund from which the medical assistance payments were made. Amounts received by a county medical assistance agency to satisfy a medical assistance lien filed by the county medical assistance agency must be deposited in the county treasury and credited to the fund from which the medical assistance payments were made.

Sec. 123. Laws 1992, chapter 513, article 7, section 131, is amended to read:

Sec. 131. **PHYSICIAN AND DENTAL REIMBURSEMENT.**

(a) The physician reimbursement increase provided in Minnesota Statutes, section 256B.74, subdivision 2, shall not be implemented. Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for physician services as follows:

(1) payment for level one Health Care Finance Administration's common procedural coding system (HCPCS) codes titled "office and other outpatient services," "preventive medicine new and established patient," "delivery, antepartum, and postpartum care," "critical care," caesarean delivery and pharmacologic management provided to psychiatric patients, and HCPCS level three codes for enhanced services for prenatal high risk, shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992. If the rate on any procedure code within these categories is different than the rate that would have been paid under the methodology in Minnesota Statutes, section 256B.74, subdivision 2, then the larger rate shall be paid;

(2) payments for all other services shall be paid at the lower of (i) submitted charges, or (ii) 15.4 percent above the rate in effect on June 30, 1992; and

(3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases except that payment rates for home health agency services shall be the rates in effect on September 30, 1992.

(b) The dental reimbursement increase provided in Minnesota Statutes, section 256B.74, subdivision 5, shall not be implemented. Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for dental services as follows:

(1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992; and

(2) dental rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases.

(c) An entity that operates both a Medicare certified comprehensive outpatient rehabilitation facility and a facility which was certified prior to January 1, 1993, that is licensed under Minnesota Rules, parts 9570.2000 to 9570.3600, and for whom at least 33 percent of the clients receiving rehabilitation services in the most recent calendar year are medical assistance recipients, shall be reimbursed by the commissioner for rehabilitation services at rates that are 38 percent greater than the maximum reimbursement rate allowed under paragraph (a), clause (2), when those services are (1) provided within the comprehensive

outpatient rehabilitation facility and (2) provided to residents of nursing facilities owned by the entity.

Sec. 124. Laws 1993, chapter 20, is amended by adding a section to read:

Sec. 7. **HOSPITAL REIMBURSEMENT FOR INPATIENT SERVICES.**

The commissioner may consider indigent care payments as disproportionate population adjustments for eligible hospitals, if so permitted by the secretary of health and human services.

Sec. 125. **REPORT ON LONG-TERM CARE INSURANCE.**

The interagency long-term care planning committee must report to the legislature by January 15, 1994, on the feasibility of implementing a long-term care insurance program. The report shall evaluate the potential impact on the medical assistance budget of allowing persons with at least two years of long-term care insurance coverage to waive the asset test for medical assistance eligibility, or of other incentives to encourage the purchase of long term care insurance. The report shall also evaluate the availability of private long-term care insurance, and the feasibility of state-sponsored long-term care insurance if inadequate private long-term care insurance exists.

Sec. 126. **REPORT ON HOSPITAL PEER GROUPING.**

The commissioner of human services shall report to the legislature by November 15, 1993, on the peer grouping plan developed under Minnesota Statutes, section 256.969, subdivision 24. The report shall describe the peer grouping plan in detail, including the variables used to create the groups and the treatment of operating cost differences that are not common to all hospitals. The report must also indicate how the peer grouping plan will affect each individual hospital. The commissioner shall form a task force of representatives from the department of human services and from the hospital industry to provide technical assistance in the development of the peer grouping plan.

Sec. 127. **PHYSICIAN SURCHARGE STUDY.**

The commissioner of human services, in cooperation with the commissioner of revenue, shall study and recommend to the legislature by January 15, 1994, a plan to replace the physician license surcharge with a surcharge on the tax levied on physicians under Minnesota Statutes, section 295.52. The plan must be designed to take effect July 1, 1994, and to raise an amount of revenue equal to the amount anticipated from the current surcharge.

Sec. 128. **STUDY OF BED REDISTRIBUTION.**

The interagency long-term care planning committee shall present to the legislature, by January 15, 1994, recommendations for redistributing existing nursing home beds and certified boarding care home beds to meet demographic

need. The recommendations must include, but are not limited to, comment on the concepts of bed layaway and bed transfer. The interagency long-term care planning committee shall convene a task force comprised of providers, consumers, and state agency staff to develop these recommendations.

Sec. 129. **LEGISLATIVE INTENT.**

Sections 6 and 15, paragraph (b); and the amendment to paragraph (a), clause (3), in section 123, are intended to clarify, rather than to change, the original intent of the statutes amended.

Sec. 130. **WAIVER REQUEST TO LIMIT ASSET TRANSFERS.**

The commissioner of human services shall seek federal law changes and federal waivers necessary to implement the amendments to Minnesota Statutes, section 256B.0595.

Sec. 131. **NURSING HOME SURCHARGE DISCLOSURE.**

A nursing home licensed under Minnesota Statutes, chapter 144A, and not certified to participate in the medical assistance program shall include the following in 10-point type in any rate notice issued after the effective date of this section: THE NURSING HOME SURCHARGE THAT APPLIES TO THIS FACILITY EFFECTIVE OCTOBER 1, 1992, THROUGH JUNE 30, 1993, IS $535 PER BED PER YEAR, OR $1.47 PER DAY. THE SURCHARGE IS INCREASED EFFECTIVE JULY 1, 1993, TO $620 PER BED PER YEAR, OR A TOTAL OF $1.70 PER DAY AND EFFECTIVE JULY 1, 1994, TO $625 PER BED PER YEAR, OR A TOTAL OF $1.72 PER DAY. ANY RATE IN EXCESS OF THESE AMOUNTS IS NOT DUE TO THE NURSING HOME SURCHARGE.

Sec. 132. **REPORT TO THE LEGISLATURE.**

The commissioner of human services, in coordination with the commissioner of finance, shall study and report to the legislature by January 15, 1994, on the following: (1) recommendations on how to phase out provider surcharge collections, and (2) an evaluation of compliance by the commissioner of finance with the paragraph in Laws 1992, chapter 513, article 5, section 2, subdivision 1, which required the commissioner of finance to (i) prepare a biennial budget for fiscal years 1994-95 that did not include provider surcharge revenues in excess of the estimated costs associated with the MinnesotaCare program, and (ii) prepare a plan to phase out the non-MinnesotaCare surcharges by June 30, 1995.

Sec. 133. **ALTERNATIVE CARE PROGRAM PILOT PROJECTS.**

Subdivision 1. **PROJECT PURPOSE.** (a) By September 1, 1993, the commissioner of human services shall select up to six pilot projects for the alternative care program. The purpose of the pilot projects is to simplify program administration and reduce documentation, increase service flexibility, and more clearly identify program outcomes. The pilot projects must begin January 1, 1994, and expire June 30, 1995.

(b) Projects must be selected based on their ability to improve client outcomes, broaden service choices, and reduce average per client costs and administrative costs. If sufficient satisfactory applications are received, the commissioner shall approve three projects in the seven-county metropolitan area and three projects outside the metropolitan area. If sufficient satisfactory applications are not received, more than three projects may be approved in either the metropolitan or nonmetropolitan areas. Up to two projects may include SAIL counties.

Subd. 2. **TERMS.** A county or counties may apply to participate in the pilot project by submitting to the commissioner an amendment to the biennial plan that identifies measurable outcomes to be achieved under the pilot project. Participating counties shall determine the types of services to be reimbursed with alternative care program grant funds and any individual client reimbursement limits. Participating counties shall determine the payment rates for all services under the pilot project. Participating counties will maintain their average monthly alternative care expenditures per client at their calendar 1993 averages adjusted for any overall increase in the case mix complexity of their caseload. A county may spend up to five percent of grant funds for needed client services that are not listed under Minnesota Statutes, section 256B.0913, subdivision 5. The average expenditure per client in a pilot project must not exceed 75 percent of the statewide individual average nursing home costs.

Subd. 3. **DOCUMENTATION.** Beginning January 1, 1994, a county or counties participating in a pilot project shall not submit invoices for processing through the medical assistance management information system (MMIS) or other individual client service and reimbursement data for services delivered after December 31, 1993. A pilot project county must provide to the commissioner the minimum client-specific characteristics required to make nursing facility occupancy and alternative care program cost forecasts and the minimum client-specific data necessary for long-term care planning and alternative care pilot project evaluation. The client-specific characteristics must be submitted to the commissioner quarterly. The commissioner shall minimize the reporting required from counties.

Subd. 4. **FUNDING.** On March 1, 1994, and monthly thereafter until June 30, 1994, the commissioner shall issue to counties participating in the pilot projects an amount of money equal to one-sixth of each county's unexpended allocation of base and targeted alternative care appropriations under Minnesota Statutes, section 256B.0913, subdivisions 10 and 11. On July 1, 1994, and monthly thereafter, the commissioner shall issue an amount of money equal to one-twelfth of the fiscal year 1994 allocation. Additional targeted funds may be allocated based on the criteria established in Minnesota Statutes, section 256B.0913, to the extent that money is available. Targeted funds will be equally distributed over the remaining months of the fiscal year. Counties participating in the pilot projects must submit to the commissioner quarterly expenditure reports and reconcile the actual expenditure on September 1, 1995.

Subd. 5. **REPORT.** The commissioner must evaluate the pilot projects and report findings to the legislature by February 1, 1995. The report must evaluate client outcomes and service utilization, total spending and average per client costs, administrative cost reductions, changes in the types of services provided, and any border problems with contiguous nonpilot counties.

Sec. 134. **REPEALER.**

Minnesota Statutes 1992, section 252.478 is repealed.

Sec. 135. **EFFECTIVE DATES.**

Subdivision 1. Sections 7, 28, and 45 are effective the day following final enactment. Sections 12 and 131 are effective the day following final enactment.

Subd. 2. Section 127 is effective the day following final enactment.

Subd. 3. Section 126 is effective the day following final enactment.

Subd. 4. Section 35 is effective for transfers made for less than fair market value on or after July 1, 1993, or after the effective date of any applicable federal waivers, whichever is later, except that those portions of section 35 that may be implemented without federal waivers are effective for transfers made for less than fair market value on or after July 1, 1993.

Subd. 5. Section 32 is effective retroactive to October 1, 1992.

Subd. 6. Section 61, paragraph (c), is effective upon the receipt by the commissioner of human services of the requested waiver from the secretary of human services, for persons screened for admission to a nursing facility on or after the date the waiver is received.

Subd. 7. Sections 6 and 129 are effective the day following final enactment and apply to cases pending or brought on or after their effective date.

Subd. 8. Section 42 is effective retroactive to July 1, 1992.

Subd. 9. The definition of total premium revenue in section 15, paragraph (b), applies to all health maintenance organization surcharges effective October 1, 1992.

ARTICLE 6

FAMILY SELF-SUFFICIENCY AND CHILD SUPPORT ENFORCEMENT

Section 1. Minnesota Statutes 1992, section 144.215, subdivision 3, is amended to read:

Subd. 3. **FATHER'S NAME; CHILD'S NAME.** In any case in which paternity of a child is determined by a court of competent jurisdiction, ~~or upon compliance with the provisions of~~ a declaration of parentage is executed under section ~~257.55, subdivision 1, clause (c)~~ 257.34, or a recognition of parentage is executed under section 257.75, the name of the father shall be entered on the birth certificate. If the order of the court declares the name of the child, it shall also be entered on the birth certificate. If the order of the court does not declare the name of the child, or there is no court order, then upon the request of both parents in writing, the surname of the child shall be that of the father.

Sec. 2. Minnesota Statutes 1992, section 144.215, is amended by adding a subdivision to read:

Subd. 4. **SOCIAL SECURITY NUMBER REGISTRATION.** (a) Parents of a child born within this state shall give their social security numbers to the office of vital statistics at the time of filing the birth certificate, but the numbers shall not appear on the certificate.

(b) The social security numbers are classified as private data, as defined in section 13.02, subdivision 12, on individuals, but the office of vital statistics shall provide the social security number to the public authority responsible for child support services upon request by the public authority for use in the establishment of parentage and the enforcement of child support obligations.

Sec. 3. Minnesota Statutes 1992, section 256.032, subdivision 11, is amended to read:

Subd. 11. **SIGNIFICANT CHANGE.** "Significant change" means a ~~change in income available to the family so that the sum of the income and the grant for the current month would be less than the transitional standard as defined in subdivision 13~~ decline in gross income of 38 percent or more from the income used to determine the grant for the current month.

Sec. 4. Minnesota Statutes 1992, section 256.73, subdivision 2, is amended to read:

Subd. 2. **ALLOWANCE BARRED BY OWNERSHIP OF PROPERTY.** Ownership by an assistance unit of property as follows is a bar to any allowance under sections 256.72 to 256.87:

(1) The value of real property other than the homestead, which when combined with other assets exceeds the limits of paragraph (2), unless the assistance unit is making a good faith effort to sell the nonexcludable real property. The time period for disposal must not exceed nine consecutive months ~~and~~. The assistance unit ~~shall execute~~ must sign an agreement to dispose of the property and to repay assistance received during the nine months ~~up to~~ that would not have been paid had the property been sold at the beginning of such period, but not to exceed the amount of the net sale proceeds. The ~~payment must be made when the property is sold~~ family has five working days from the date it realizes cash from the sale of the property to repay the overpayment. If the property is not sold within the required time or the assistance unit becomes ineligible for any reason ~~the entire amount received during the nine months is an overpayment and subject to recovery~~ during the nine-month period, the amount payable under the agreement will not be determined and recovery will not begin until the property is in fact sold. If the property is intentionally sold at less than fair market value or if a good faith effort to sell the property is not being made, the overpayment amount shall be computed using the fair market value determined at the beginning of the nine-month period. For the purposes of this section, "homestead" means the home that is owned by, and is the usual residence of, the child, relative, or other member of the assistance unit together with the surrounding property which is not separated from the home by intervening property owned by others. "Usual residence" includes the home from which the child, relative, or other members of the assistance unit is temporarily absent due to an employability development plan approved by the local human service agency, which includes education, training, or job search within the state but outside of the immediate geographic area. Public rights-of-way, such as roads which run through the surrounding property and separate it from the home, will not affect the exemption of the property; or

(2) Personal property of an equity value in excess of $1,000 for the entire assistance unit, exclusive of personal property used as the home, one motor vehicle of an equity value not exceeding $1,500 or the entire equity value of a motor vehicle determined to be necessary for the operation of a self-employment business, one burial plot for each member of the assistance unit, one prepaid burial contract with an equity value of no more than $1,000 for each member of the assistance unit, clothing and necessary household furniture and equipment and other basic maintenance items essential for daily living, in accordance with rules promulgated by and standards established by the commissioner of human services.

Sec. 5. Minnesota Statutes 1992, section 256.73, subdivision 3a, is amended to read:

Subd. 3a. **PERSONS INELIGIBLE.** No assistance shall be given under sections 256.72 to 256.87:

(1) on behalf of any person who is receiving supplemental security income

under title XVI of the Social Security Act unless permitted by federal regulations;

(2) for any month in which the assistance unit's gross income, without application of deductions or disregards, exceeds 185 percent of the standard of need for a family of the same size and composition; except that the earnings of a dependent child who is a full-time student may be disregarded for six ~~calendar~~ months per calendar year and the earnings of a dependent child ~~who is a full-time student~~ that are derived from the jobs training and partnership act (JTPA) may be disregarded for six ~~calendar~~ months per calendar year. These two earnings disregards cannot be combined to allow more than a total of six months per calendar year when the earned income of a full-time student is derived from participation in a program under the JTPA. If a stepparent's income is taken into account in determining need, the disregards specified in section 256.74, subdivision 1a, shall be applied to determine income available to the assistance unit before calculating the unit's gross income for purposes of this paragraph;

(3) to any assistance unit for any month in which any caretaker relative with whom the child is living is, on the last day of that month, participating in a strike;

(4) on behalf of any other individual in the assistance unit, nor shall the individual's needs be taken into account for any month in which, on the last day of the month, the individual is participating in a strike;

(5) on behalf of any individual who is the principal earner in an assistance unit whose eligibility is based on the unemployment of a parent when the principal earner, without good cause, fails or refuses to accept employment, or to register with a public employment office, unless the principal earner is exempt from these work requirements.

Sec. 6. Minnesota Statutes 1992, section 256.73, subdivision 5, is amended to read:

Subd. 5. **AID FOR ~~UNBORN CHILDREN~~ PREGNANT WOMEN.** (a) For the purposes of sections 256.72 to 256.87, assistance payments shall be made ~~during the final three months of pregnancy~~ to a pregnant woman ~~who has~~ with no other children ~~but who otherwise qualifies for assistance except for medical assistance payments which shall be made at the time that pregnancy is confirmed by a physician if the pregnant woman has no other children and otherwise qualifies for assistance as provided in sections 256B.055 and 256B.056~~ who are receiving assistance. It must be medically verified that the unborn child is expected to be born in the month the payment is made or within the three-month period following the month of payment. Eligibility must be determined as if the unborn child had been born and was living with her, considering the needs, income, and resources of all individuals in the filing unit. If eligibility exists for this fictional unit, the pregnant woman is eligible and her payment amount is determined based solely on her needs, income, including deemed

income, and resources. No payments shall be made for the needs of the unborn or for any special needs occasioned by the pregnancy except as provided in ~~clause~~ paragraph (b). The commissioner of human services shall promulgate, pursuant to the administrative procedures act, rules to implement this subdivision.

(b) The commissioner may, according to rules, make payments for the purpose of meeting special needs occasioned by or resulting from pregnancy both for a pregnant woman with no other children receiving assistance as well as for a pregnant woman receiving assistance as provided in sections 256.72 to 256.87. The special needs payments shall be dependent upon the needs of the pregnant woman and the resources allocated to the county by the commissioner and shall be limited to payments for medically recognized special or supplemental diet needs and the purchase of a crib and necessary clothing for the future needs of the unborn child at birth. ~~The commissioner shall, according to rules, make payments for medically necessary prenatal care of the pregnant woman and the unborn child.~~

Sec. 7. Minnesota Statutes 1992, section 256.73, subdivision 8, is amended to read:

Subd. 8. **RECOVERY OF OVERPAYMENTS.** (a) If an amount of aid to families with dependent children assistance is paid to a recipient in excess of the payment due, it shall be recoverable by the county agency. The agency shall give written notice to the recipient of its intention to recover the overpayment.

(b) When an overpayment occurs, the county agency shall recover the overpayment from a current recipient by reducing the amount of aid payable to the assistance unit of which the recipient is a member for one or more monthly assistance payments until the overpayment is repaid. ~~For any month in which an overpayment must be recovered, recoupment may be made by reducing the grant but only if the reduced assistance payment, together with the assistance unit's total income after deducting work expenses as allowed under section 256.74, subdivision 1, clauses (3) and (4), equals at least 95 percent of the standard of need for the assistance unit, except that if the overpayment is due solely to agency error, this total after deducting allowable work expenses must equal at least 99 percent of the standard of need. Notwithstanding the preceding sentence, beginning on the date on which the commissioner implements a computerized client eligibility and information system in one or more counties,~~ All county agencies in the state shall reduce the assistance payment by three percent of the assistance unit's standard of need or the amount of the monthly payment, whichever is less, for all overpayments whether or not the overpayment is due solely to agency error. If the overpayment is due solely to having wrongfully obtained assistance, whether based on a court order, the finding of an administrative fraud disqualification hearing or a waiver of such a hearing, or a confession of judgment containing an admission of an intentional program violation, the amount of this reduction shall be ten percent. In cases when there is both an

overpayment and underpayment, the county agency shall offset one against the other in correcting the payment.

(c) Overpayments may also be voluntarily repaid, in part or in full, by the individual, in addition to the above aid reductions, until the total amount of the overpayment is repaid.

(d) The county agency shall make reasonable efforts to recover overpayments to persons no longer on assistance in accordance with standards adopted in rule by the commissioner of human services. The county agency need not attempt to recover overpayments of less than $35 paid to an individual no longer on assistance if the individual does not receive assistance again within three years, unless the individual has been convicted of fraud under section 256.98.

Sec. 8. **[256.734] WAIVER OF AFDC BARRIERS TO EMPLOYMENT.**

Subdivision 1. **REQUEST.** (a) The commissioner of human services shall seek from the United States Department of Health and Human Services a waiver of the existing requirements of the AFDC program as described below, in order to eliminate barriers to employment for AFDC recipients.

(b) The commissioner shall seek a waiver to set the maximum equity value of a licensed motor vehicle which can be excluded as a resource under United States Code, title 42, section 602(a)(7)(B), at $4,500 because of the need of AFDC recipients for reliable transportation to participate in education, work, and training to become economically self-sufficient.

(c) The commissioner shall seek a waiver of the counting of the earned income of dependent children and minor caretakers who are attending school at least half time, in order to encourage them to save at least part of their earnings for future education or employment needs. Savings set aside in a separate account under this paragraph shall be excluded from the AFDC resource limits in Code of Federal Regulations, title 45, section 233.20(a)(3).

Subd. 2. **IMPLEMENTATION.** If approval from the Department of Health and Human Services indicates that the requested program changes are cost neutral to the federal government and the state, the commissioner shall implement the program changes authorized by this section promptly. If approval indicates that the program changes are not cost neutral, the commissioner shall report the costs to the 1994 legislature and delay implementation until such time as an appropriation to cover additional costs becomes available.

Subd. 3. **EVALUATION.** If the federal waiver is granted, the commissioner shall evaluate the program changes according to federal waiver requirements and submit a report to the legislature within a time frame consistent with the evaluation criteria that are established.

Sec. 9. Minnesota Statutes 1992, section 256.736, subdivision 10, is amended to read:

Subd. 10. **COUNTY DUTIES.** (a) To the extent of available state appropriations, county boards shall:

(1) refer all mandatory and eligible volunteer caretakers ~~required to register~~ permitted to participate under subdivision ~~3~~ 3a to an employment and training service provider for participation in employment and training services;

(2) identify to the employment and training service provider ~~caretakers who fall into the targeted groups~~ the target group of which the referred caretaker is a member;

(3) provide all caretakers with an orientation which meets the requirements in subdivisions 10a and 10b;

(4) work with the employment and training service provider to encourage voluntary participation by caretakers in the ~~targeted~~ target groups;

(5) work with the employment and training service provider to collect data as required by the commissioner;

(6) to the extent permissible under federal law, require all caretakers coming into the AFDC program to attend orientation;

(7) encourage ~~nontargeted~~ nontarget caretakers to develop a plan to obtain self-sufficiency;

(8) notify the commissioner of the caretakers required to participate in employment and training services;

(9) inform appropriate caretakers of opportunities available through the head start program and encourage caretakers to have their children screened for enrollment in the program where appropriate;

(10) provide transportation assistance using available funds to caretakers who participate in employment and training programs;

(11) ensure that orientation, job search, services to custodial parents under the age of 20, educational activities and work experience for AFDC-UP families, and case management services are made available to appropriate caretakers under this section, except that payment for case management services is governed by subdivision 13;

(12) explain in its local service unit plan under section 268.88 how it will ensure that ~~targeted~~ target caretakers determined to be in need of social services are provided with such social services. The plan must specify how the case manager and the county social service workers will ensure delivery of needed services;

(13) to the extent allowed by federal laws and regulations, provide a job search program as defined in subdivision 14 ~~and at least one of the following~~

~~employment and training services:~~, a community work experience program ~~(CWEP)~~ as defined in section 256.737, grant diversion as defined in section 256.739, and on-the-job training as defined in section 256.738~~; or~~. A county may also provide another work and training program approved by the commissioner and the secretary of the United States Department of Health and Human Services. Planning and approval for employment and training services listed in this clause must be obtained through submission of the local service unit plan as specified under section 268.88. ~~Each county is urged to adopt grant diversion as the second program required under this clause~~ A county is not required to provide a community work experience program if the county agency is successful in placing at least 40 percent of the monthly average of all caretakers who are subject to the job search requirements of subdivision 14 in grant diversion or on-the-job training program;

(14) prior to participation, provide an assessment of each AFDC recipient who is required or volunteers to participate in an approved employment and training service. The assessment must include an evaluation of the participant's (i) educational, child care, and other supportive service needs; (ii) skills and prior work experience; and (iii) ability to secure and retain a job which, when wages are added to child support, will support the participant's family. The assessment must also include a review of the results of the early and periodic screening, diagnosis and treatment (EPSDT) screening and preschool screening under chapter 123, if available; the participant's family circumstances; and, in the case of a custodial parent under the age of 18, a review of the effect of a child's development and educational needs on the parent's ability to participate in the program;

(15) develop an employability development plan for each recipient for whom an assessment is required under clause (14) which: (i) reflects the assessment required by clause (14); (ii) takes into consideration the recipient's physical capacity, skills, experience, health and safety, family responsibilities, place of residence, proficiency, child care and other supportive service needs; (iii) is based on available resources and local employment opportunities; (iv) specifies the services to be provided by the employment and training service provider; (v) specifies the activities the recipient will participate in, including the worksite to which the caretaker will be assigned, if the caretaker is subject to the requirements of section 256.737, subdivision 2; (vi) specifies necessary supportive services such as child care; (vii) to the extent possible, reflects the preferences of the participant; and (viii) specifies the recipient's long-term employment goal which shall lead to self-sufficiency; ~~and~~

(16) obtain the written or oral concurrence of the appropriate exclusive bargaining representatives with respect to job duties covered under collective bargaining agreements to assure that no work assignment under this section or sections 256.737, 256.738, and 256.739 results in: (i) termination, layoff, or reduction of the work hours of an employee for the purpose of hiring an individual under this section or sections 256.737, 256.738, and 256.739; (ii) the hiring

of an individual if any other person is on layoff from the same or a substantially equivalent job; (iii) any infringement of the promotional opportunities of any currently employed individual; (iv) the impairment of existing contracts for services or collective bargaining agreements; or (v) except for on-the-job training under section 256.738, a participant filling an established unfilled position vacancy~~.~~; and

(17) assess each caretaker in an AFDC-UP family who is under age 25, has not completed high school or a high school equivalency program, and who would otherwise be required to participate in a work experience placement under section 256.737 to determine if an appropriate secondary education option is available for the caretaker. If an appropriate secondary education option is determined to be available for the caretaker, the caretaker must, in lieu of participating in work experience, enroll in and meet the educational program's participation and attendance requirements. "Secondary education" for this paragraph means high school education or education designed to prepare a person to qualify for a high school equivalency certificate, basic and remedial education, and English as a second language education. A caretaker required to participate in secondary education who, without good cause, fails to participate shall be subject to the provisions of subdivision 4a and the sanction provisions of subdivision 4, clause (6). For purposes of this clause, "good cause" means the inability to obtain licensed or legal nonlicensed child care services needed to enable the caretaker to attend, inability to obtain transportation needed to attend, illness or incapacity of the caretaker or another member of the household which requires the caretaker to be present in the home, or being employed for more than 30 hours per week.

(b) Funds available under this subdivision may not be used to assist, promote, or deter union organizing.

(c) A county board may provide other employment and training services that it considers necessary to help caretakers obtain self-sufficiency.

(d) Notwithstanding section 256G.07, when a ~~targeted~~ target caretaker relocates to another county to implement the provisions of the caretaker's case management contract or other written employability development plan approved by the county human service agency, its case manager or employment and training service provider, the county that approved the plan is responsible for the costs of case management and other services required to carry out the plan, including employment and training services. The county agency's responsibility for the costs ends when all plan obligations have been met, when the caretaker loses AFDC eligibility for at least 30 days, or when approval of the plan is withdrawn for a reason stated in the plan, whichever occurs first. Responsibility for the costs of child care must be determined under chapter 256H. A county human service agency may pay for the costs of case management, child care, and other services required in an approved employability development plan when the ~~nontargeted~~ nontarget caretaker relocates to another county or when a ~~targeted~~ tar-

get caretaker again becomes eligible for AFDC after having been ineligible for at least 30 days.

Sec. 10. Minnesota Statutes 1992, section 256.736, subdivision 10a, is amended to read:

Subd. 10a. **ORIENTATION.** (a) Each county agency must provide an orientation to all caretakers within its jurisdiction ~~who are determined eligible for AFDC on or after July 1, 1989, and who are required to attend an orientation. The county agency shall require attendance at orientation of all caretakers except~~ in the time limits described in this paragraph:

(1) ~~caretakers who are exempt from registration under subdivision 3~~ within 60 days of being determined eligible for AFDC for caretakers with a continued absence or incapacitated parent basis of eligibility; ~~and~~ or

(2) ~~caretakers who are not~~ within 30 days of being determined eligible for AFDC for caretakers with an unemployed parent basis of eligibility.

(b) Caretakers are required to attend an in-person orientation if the caretaker is a member of one of the groups listed in subdivision 3a, paragraph (a), ~~and who are either responsible for the care of an incapacitated person or a dependent child under the age of six or enrolled at least half time in any recognized school, training program, or institution of higher learning~~ unless the caretaker is exempt from registration under subdivision 3 and the caretaker's exemption basis will not expire within 60 days of being determined eligible for AFDC, or the caretaker is enrolled at least half time in any recognized school, training program, or institution of higher learning and the in-person orientation cannot be scheduled at a time that does not interfere with the caretaker's school or training schedule. The county agency shall require attendance at orientation of caretakers described in subdivision 3a, paragraph (b) or (c), if ~~they become~~ the commissioner determines that the groups are eligible for participation in employment and training services.

~~(b) Except as provided in paragraph (c),~~ (c) The orientation must consist of a presentation that informs caretakers of:

(1) the identity, location, and phone numbers of employment and training and support services available in the county;

(2) the types and locations of child care services available through the county agency that are accessible to enable a caretaker to participate in educational programs or employment and training services;

(3) the child care resource and referral program designated by the commissioner providing education and assistance to select child care services and a referral to the child care resource and referral when assistance is requested;

(4) the obligations of the county agency and service providers under contract to the county agency;

(5) the rights, responsibilities, and obligations of participants;

(6) the grounds for exemption from mandatory employment and training services or educational requirements;

(7) the consequences for failure to participate in mandatory services or requirements;

(8) the method of entering educational programs or employment and training services available through the county;

(9) the availability and the benefits of the early and periodic, screening, diagnosis and treatment (EPSDT) program and preschool screening under chapter 123;

(10) their eligibility for transition year child care assistance when they lose eligibility for AFDC due to their earnings; ~~and~~

(11) their eligibility for extended medical assistance when they lose eligibility for AFDC due to their earnings; and

(12) the availability and benefits of the Head Start program.

~~(c)~~ (d) Orientation must encourage recipients to view AFDC as a temporary program providing grants and services to individuals who set goals and develop strategies for supporting their families without AFDC assistance. The content of the orientation must not imply that a recipient's eligibility for AFDC is time limited. Orientation may be provided through audio-visual methods, but the caretaker must be given an opportunity for face-to-face interaction with staff of the county agency or the entity providing the orientation, and an opportunity to express the desire to participate in educational programs and employment and training services offered through the county agency.

~~(d)~~ (e) County agencies shall not require caretakers to attend orientation for more than three hours during any period of 12 continuous months. The county agency shall also arrange for or provide needed transportation and child care to enable caretakers to attend.

~~(e) Orientation for caretakers not eligible for participation in employment and training services under the provisions of subdivision 3a, paragraphs (a) and (b), shall present information only on those employment, training, and support services available to those caretakers, and information on clauses (2), (3), (9), (10), and (11) of paragraph (a) and all of paragraph (c), and may not last more than two hours.~~ The county or, under contract, the county's employment and training service provider shall mail written orientation materials containing the information specified in paragraph (c), clauses (1) to (3) and (8) to (12), to each caretaker exempt from attending an in-person orientation or who has good cause for failure to attend after at least two dates for their orientation have been scheduled. The county or the county's employment and training service provider

shall follow up with a phone call or in writing within two weeks after mailing the material.

(f) Persons required to attend orientation must be informed of the penalties for failure to attend orientation, support services to enable the person to attend, what constitutes good cause for failure to attend, and rights to appeal. Persons required to attend orientation must be offered a choice of at least two dates for their first scheduled orientation. No person may be sanctioned for failure to attend orientation until after a second failure to attend.

(g) Good cause for failure to attend an in-person orientation exists when a caretaker cannot attend because of:

(1) temporary illness or injury of the caretaker or of a member of the caretaker's family that prevents the caretaker from attending an orientation during the hours when the orientation is offered;

(2) a judicial proceeding that requires the caretaker's presence in court during the hours when orientation is scheduled; or

(3) a nonmedical emergency that prevents the caretaker from attending an orientation during the hours when orientation is offered. "Emergency" for the purposes of this paragraph means a sudden, unexpected occurrence or situation of a serious or urgent nature that requires immediate action.

(h) Caretakers must receive a second orientation only when:

(1) there has been a 30-day break in AFDC eligibility; and

(2) the caretaker has not attended an orientation within the previous 12-month period, excluding the month of reapplication for AFDC.

Sec. 11. Minnesota Statutes 1992, section 256.736, subdivision 14, is amended to read:

Subd. 14. **JOB SEARCH.** (a) ~~The commissioner of human services shall~~ Each county agency must establish and operate a job search program as provided under ~~Public Law Number 100-485~~ this section. Unless exempt, the principal wage earner in an AFDC-UP assistance unit must be referred to and begin participation in the job search program within 30 days of being determined eligible for AFDC~~, and must begin participation within four months of being determined eligible~~. If the principal wage earner is exempt from participation in job search, the other caretaker must be referred to and begin participation in the job search program within 30 days of being determined eligible for AFDC. The principal wage earner or the other caretaker is exempt from job search participation if:

(1) ~~the caretaker is already participating in another approved employment and training service;~~

~~(2) the caretaker's employability plan specifies other activities;~~

~~(3)~~ the caretaker is exempt from registration under subdivision 3; or

~~(4) the caretaker is unable to secure employment due to inability to communicate in the English language, is participating in an English as a second language course, and is making satisfactory progress towards completion of the course. If an English as a second language course is not available to the caretaker, the caretaker is exempt from participation until a course becomes available~~ (2) the caretaker is under age 25, has not completed a high school diploma or an equivalent program, and is participating in a secondary education program as defined in subdivision 10, paragraph (a), clause (17), which is approved by the employment and training service provider in the employability development plan.

(b) The job search program must provide ~~the following services:~~

~~(1) an initial period of up to~~ four consecutive weeks of job search activities for no less than 20 hours per week but not more than 32 hours per week. The employment and training service provider shall specify for each participating caretaker the number of weeks and hours of job search to be conducted and shall report to the county ~~board~~ agency if the caretaker fails to cooperate with the job search requirement; ~~and~~

~~(2) an additional period of job search following the first period at the discretion of the employment and training service provider. The total of these two periods of job search may not exceed eight weeks for any 12 consecutive month period beginning with the month of application.~~

(c) The job search program may provide services to non-AFDC-UP caretakers.

(d) After completion of job search requirements in this section, nonexempt caretakers shall be placed in and must participate in and cooperate with the work experience program under section 256.737, the on-the-job training program under section 256.738, or the grant diversion program under section 256.739. Caretakers must be offered placement in a grant diversion or on-the-job training program, if either such employment is available, before being required to participate in a community work experience program under section 256.737.

Sec. 12. Minnesota Statutes 1992, section 256.736, subdivision 16, is amended to read:

Subd. 16. **ALLOCATION AND USE OF MONEY.** (a) State money appropriated for employment and training services under this section must be allocated to counties as specified in paragraphs (b) to ~~(i)~~ (j).

(b) For purposes of this ~~section~~ subdivision, "targeted caretaker" means a recipient who:

(1) is a custodial parent under the age of 24 who: (i) has not completed a high school education and at the time of application for AFDC is not enrolled in high school or in a high school equivalency program; or (ii) had little or no work experience in the preceding year;

(2) is a member of a family in which the youngest child is within two years of being ineligible for AFDC due to age; or

(3) has received 36 months or more of AFDC over the last 60 months.

(c) One hundred percent of the money appropriated for case management services as described in subdivision 11 must be allocated to counties based on the average number of cases in each county described in clause (1). Money appropriated for employment and training services as described in subdivision 1a, paragraph (d), other than case management services, must be allocated to counties as follows:

(1) Forty percent of the state money must be allocated based on the average number of cases receiving AFDC in the county which either have been open for 36 or more consecutive months or have a caretaker who is under age 24 and who has no high school or general equivalency diploma. The average number of cases must be based on counts of these cases as of March 31, June 30, September 30, and December 31 of the previous year.

(2) Twenty percent of the state money must be allocated based on the average number of cases receiving AFDC in the county which are not counted under clause (1). The average number of cases must be based on counts of cases as of March 31, June 30, September 30, and December 31 of the previous year.

(3) Twenty-five percent of the state money must be allocated based on the average monthly number of assistance units in the county receiving AFDC-UP for the period ending December 31 of the previous year.

(4) Fifteen percent of the state money must be allocated at the discretion of the commissioner based on participation levels for ~~targeted~~ target group members in each county.

(d) No more than 15 percent of the money allocated under paragraph (b) and no more than 15 percent of the money allocated under paragraph (c) may be used for administrative activities.

(e) At least 55 percent of the money allocated to counties under paragraph (c) must be used for employment and training services for caretakers in the ~~targeted~~ target groups, and up to 45 percent of the money may be used for employment and training services for ~~nontargeted~~ nontarget caretakers. One hundred percent of the money allocated to counties for case management services must be used to provide those services to caretakers in the ~~targeted~~ target groups.

(f) Money appropriated to cover the nonfederal share of costs for bilingual

case management services to refugees for the employment and training programs under this section are allocated to counties based on each county's proportion of the total statewide number of AFDC refugee cases. However, counties with less than one percent of the statewide number of AFDC refugee cases do not receive an allocation.

(g) Counties ~~and~~, the department of jobs and training, and entities under contract with either the department of jobs and training or the department of human services for provision of Project STRIDE related services shall bill the commissioner of human services for any expenditures incurred by the county, the county's employment and training service provider, or the department of jobs and training that may be reimbursed by federal money. The commissioner of human services shall bill the United States Department of Health and Human Services and the United States Department of Agriculture for the reimbursement and appropriate the reimbursed money to the county, the department of jobs and training, or employment and training service provider that submitted the original bill. The reimbursed money must be used to expand employment and training services.

(h) The commissioner of human services shall review county expenditures of case management and employment and training block grant money at the end of the ~~fourth~~ third quarter of the biennium and each quarter after that, and may reallocate unencumbered or unexpended money allocated under this section to those counties that can demonstrate a need for additional money. Reallocation of funds must be based on the formula set forth in paragraph (a), excluding the counties that have not demonstrated a need for additional funds.

(i) The county agency may continue to provide case management and supportive services to a participant for up to 90 days after the participant loses AFDC eligibility and may continue providing a specific employment and training service for the duration of that service to a participant if funds for the service are obligated or expended prior to the participant losing AFDC eligibility.

(j) One hundred percent of the money appropriated for an unemployed parent work experience program under section 256.737 must be allocated to counties based on the average monthly number of assistance units in the county receiving AFDC-UP for the period ending December 31 of the previous year.

Sec. 13. Minnesota Statutes 1992, section 256.736, is amended by adding a subdivision to read:

Subd. 19. **EVALUATION.** In order to evaluate the services provided under this section, the commissioner may randomly assign no more than 2,500 families to a control group. Families assigned to the control group shall not participate in services under this section, except that families participating in services under this section at the time they are assigned to the control group may continue such participation. Recipients assigned to the control group who are included under subdivision 3a, paragraph (a), shall be guaranteed child care

assistance under chapter 256H for an educational plan authorized by the county. Once assigned to the control group, a family must remain in that group for the duration of the evaluation period. The evaluation period shall coincide with the demonstration authorized in section 256.031, subdivision 3.

Sec. 14. **[256.7366] FEDERAL WAIVER.**

The commissioner of human services shall make changes in the state plan and seek waivers or demonstration authority needed to minimize the barriers to effective and efficient use of grant diversion under section 256.739 as a method of placing AFDC recipients in suitable employment. The commissioner shall implement the federally approved changes as soon as possible.

Sec. 15. Minnesota Statutes 1992, section 256.737, subdivision 1, is amended to read:

Subdivision 1. **ESTABLISHMENT AND PURPOSE.** ~~In order that persons receiving aid under this chapter may be assisted in achieving self-sufficiency by enhancing their employability through meaningful work experience and training and the development of job search skills, the commissioner of human services shall continue the pilot community work experience demonstration programs that were approved by January 1, 1984. The commissioner may establish additional community work experience programs in as many counties as necessary to comply with the participation requirements of the Family Support Act of 1988, Public Law Number 100-485. Programs established on or after July 1, 1989, must be operated on a volunteer basis and must be operated according to the Family Support Act of 1988, Public Law Number 100-485.~~ To the degree required by federal law or regulation, each county agency must establish and operate a community work experience program to assist nonexempt caretakers in AFDC-UP households achieve self-sufficiency by enhancing their employability through participation in meaningful work experience and training, the development of job search skills and the development of marketable job skills. This subdivision does not apply to AFDC recipients participating in the Minnesota family investment plan under sections 256.031 to 256.0361.

Sec. 16. Minnesota Statutes 1992, section 256.737, subdivision 1a, is amended to read:

Subd. 1a. **COMMISSIONER'S DUTIES.** The commissioner shall: (a) assist counties in the design and implementation of these programs; (b) promulgate, in accordance with chapter 14, emergency rules necessary for the implementation of this section, except that the time restrictions of section 14.35 shall not apply and the rules may be in effect until June 30, 1993, unless superseded by permanent rules; (c) seek any federal waivers necessary for proper implementation of this section in accordance with federal law; and (d) prohibit the use of participants in the programs to do work that was part or all of the duties or responsibilities of an authorized public employee bargaining unit position established as of January 1, ~~1989~~ 1993. The exclusive bargaining representative shall

be notified no less than 14 days in advance of any placement by the community work experience program. Written or oral concurrence with respect to job duties of persons placed under the community work experience program shall be obtained from the appropriate exclusive bargaining representative within seven days. The appropriate oversight committee shall be given monthly lists of all job placements under a community work experience program.

Sec. 17. Minnesota Statutes 1992, section 256.737, subdivision 2, is amended to read:

Subd. 2. **PROGRAM REQUIREMENTS.** (a) ~~Programs~~ Worksites developed under this section are limited to projects that serve a useful public service such as: health, social service, environmental protection, education, urban and rural development and redevelopment, welfare, recreation, public facilities, public safety, community service, services to aged or disabled citizens, and child care. To the extent possible, the prior training, skills, and experience of a recipient must be used in making appropriate work experience assignments.

(b) As a condition to placing a person receiving aid to families with dependent children in a program under this subdivision, the county agency shall first provide the recipient the opportunity ~~to participate in the following services~~:

(1) for placement in suitable subsidized or unsubsidized employment through participation in job search under section 256.736, subdivision 14; or

(2) ~~basic educational or vocational or occupational training for an identifiable job opportunity~~ for placement in suitable employment through participation in on-the-job training under section 256.738 or grant diversion under section 256.739, if such employment is available.

(c) A ~~recipient who has completed a~~ caretaker referred to job search under section 256.736, subdivision 14, and who ~~is unable~~ has failed to secure suitable employment~~, and who is not enrolled in an approved training program may~~ must participate in a community work experience program.

(d) The county agency shall limit the maximum number of hours any participant under this section may work in any month to:

(1) for counties operating an approved mandatory community work experience program as of January 1, 1993, who elect this method for countywide operations, a number equal to the amount of the aid to families with dependent children payable to the family divided by the greater of the federal minimum wage or the applicable state minimum wage; or

(2) for all other counties, a caretaker must participate in any week 20 hours with no less than 16 hours spent participating in a work experience placement and no more than four of the hours spent in alternate activities as described in the caretaker's employability development plan. Placement in a work experience worksite must be based on the assessment required under section 256.736 and the caretaker's employability development plan. Caretakers participating under

this clause may be allowed excused absences from the assigned job site of up to eight hours per month. For the purposes of this clause, "excused absence" means absence due to temporary illness or injury of the caretaker or a member of the caretaker's family, the unavailability of licensed child care or transportation needed to participate in the work experience placement, a job interview, or a nonmedical emergency. For purposes of this clause, "emergency" has the meaning given it in section 256.736, subdivision 10a, paragraph (g).

(e) After a participant has been assigned to a position under ~~this section~~ paragraph (d), clause (1), for nine months, the participant may not continue in that assignment unless the maximum number of hours a participant works is no greater than the amount of the aid to families with dependent children payable with respect to the family divided by the higher of (1) the federal minimum wage or the applicable state minimum wage, whichever is greater, or (2) the rate of pay for individuals employed in the same or similar occupations by the same employer at the same site.

(f) After each six months of a recipient's participation in an assignment, and at the conclusion of each assignment under this section, the county agency shall reassess and revise, as appropriate, each participant's employability development plan.

(g) Structured, supervised volunteer work with an agency or organization which is monitored by the county service provider may, with the approval of the commissioner of jobs and training, be used as a work experience placement.

Sec. 18. Minnesota Statutes 1992, section 256.737, is amended by adding a subdivision to read:

Subd. 3. **EXEMPTIONS.** A caretaker is exempt from participation in a work experience placement under this section if the caretaker is exempt from participation in job search under section 256.736, subdivision 14, or the caretaker is suitably employed in a grant diversion or an on-the-job training placement. Caretakers who, as of October 1, 1993, are participating in an education or training activity approved under a Project STRIDE employability development plan are exempt from participation in a work experience placement until July 1, 1994.

Sec. 19. Minnesota Statutes 1992, section 256.737, is amended by adding a subdivision to read:

Subd. 4. **GOOD CAUSE.** A caretaker shall have good cause for failure to cooperate if:

(1) the worksite participation adversely affects the caretaker's physical or mental health as verified by a physician, licensed or certified psychologist, physical therapist, vocational expert, or by other sound medical evidence; or

(2) the caretaker does not possess the skill or knowledge required for the work.

Sec. 20. Minnesota Statutes 1992, section 256.737, is amended by adding a subdivision to read:

Subd. 5. **FAILURE TO COMPLY.** A caretaker required to participate under this section who has failed without good cause to participate shall be provided with notices, appeal opportunities, and offered a conciliation conference under the provisions of section 256.736, subdivision 4a, and shall be subject to the sanction provisions of section 256.736, subdivision 4, clause (6).

Sec. 21. Minnesota Statutes 1992, section 256.737, is amended by adding a subdivision to read:

Subd. 6. **FEDERAL REQUIREMENTS.** If the Family Support Act of 1988, Public Law Number 100-485, is revised or if federal implementation of that law is revised so that Minnesota is no longer obligated to operate a mandatory work experience program for AFDC-UP families, the commissioner shall operate the work experience program under this section as a volunteer program, and shall utilize the funding authorized for work experience to improve and expand the availability of other employment and training services authorized under this section.

Sec. 22. Minnesota Statutes 1992, section 256.74, subdivision 1, is amended to read:

Subdivision 1. **AMOUNT.** The amount of assistance which shall be granted to or on behalf of any dependent child and mother or other needy eligible relative caring for the dependent child shall be determined by the county agency in accordance with rules promulgated by the commissioner and shall be sufficient, when added to all other income and support available to the child, to provide the child with a reasonable subsistence compatible with decency and health. The amount shall be based on the method of budgeting required in Public Law Number 97-35, section 2315, United States Code, title 42, section 602, as amended and federal regulations at Code of Federal Regulations, title 45, section 233. Nonrecurring lump sum income received by an ~~assistance unit~~ AFDC family must be budgeted in the normal retrospective cycle. ~~The number of months of ineligibility is determined by dividing the amount of the lump sum income and all other~~ When the family's income, after application of the applicable disregards, ~~by~~ exceeds the ~~standard of~~ need standard for the ~~assistance unit~~ family because of receipt of earned or unearned lump sum income, the family will be ineligible for the full number of months derived by dividing the sum of the lump sum income and other income by the monthly need standard for a family of that size. ~~An amount~~ Any income remaining ~~after~~ from this calculation is income in the first month following the period of ~~eligibility~~ ineligibility. ~~If the total monthly income including the lump sum income is larger than the standard of need for a single month~~ The first month of ineligibility is the payment month

that corresponds with the budget month in which the lump sum income was received. For purposes of applying the lump sum provision, family includes those persons defined in the Code of Federal Regulations, title 45, section 233.20(a)(3)(ii)(F). A period of ineligibility must be shortened when the standard of need increases and the amount the family would have received also changes, an amount is documented as stolen, an amount is unavailable because a member of the family left the household with that amount and has not returned, an amount is paid by the family during the period of ineligibility to cover a cost that would otherwise qualify for emergency assistance, or the family incurs and pays for medical expenses which would have been covered by medical assistance if eligibility existed. In making its determination the county agency shall disregard the following from family income:

(1) all the earned income of each dependent child applying for AFDC if the child is a full-time student and all of the earned income of each dependent child receiving ~~aid to families with dependent children~~ AFDC who is a full-time student or is a part-time student~~, and~~ who is not a full-time employee~~,~~. A student is one who is attending a school, college, or university, or a course of vocational or technical training designed to fit students for gainful employment ~~as well as~~ and includes a participant in the Job Corps program under the Job Training Partnership Act (JTPA). The county agency shall also disregard all ~~the earned~~ income ~~derived from the job training and partnership act (JTPA) for a~~ of each dependent child ~~for~~ applying for or receiving AFDC when the income is derived from a program carried out under JTPA, except that disregard of earned income may not exceed six ~~calendar~~ months per calendar year~~, together with unearned income derived from the job training and partnership act~~;

(2) all educational grants and loans;

(3) the first $90 of each individual's earned income. For self-employed persons, the expenses directly related to producing goods and services and without which the goods and services could not be produced shall be disregarded pursuant to rules promulgated by the commissioner;

(4) thirty dollars plus one-third of each individual's earned income for individuals found otherwise eligible to receive aid or who have received aid in one of the four months before the month of application. With respect to any month, the county welfare agency shall not disregard under this clause any earned income of any person who has: (a) reduced earned income without good cause within 30 days preceding any month in which an assistance payment is made; (b) refused without good cause to accept an offer of suitable employment; (c) left employment or reduced earnings without good cause and applied for assistance so as to be able later to return to employment with the advantage of the income disregard; or (d) failed without good cause to make a timely report of earned income in accordance with rules promulgated by the commissioner of human services. Persons who are already employed and who apply for assistance shall have their needs computed with full account taken of their earned and other

income. If earned and other income of the family is less than need, as determined on the basis of public assistance standards, the county agency shall determine the amount of the grant by applying the disregard of income provisions. The county agency shall not disregard earned income for persons in a family if the total monthly earned and other income exceeds their needs, unless for any one of the four preceding months their needs were met in whole or in part by a grant payment. The disregard of $30 and one-third of earned income in this clause shall be applied to the individual's income for a period not to exceed four consecutive months. Any month in which the individual loses this disregard because of the provisions of subclauses (a) to (d) shall be considered as one of the four months. An additional $30 work incentive must be available for an eight-month period beginning in the month following the last month of the combined $30 and one-third work incentive. This period must be in effect whether or not the person has earned income or is eligible for AFDC. To again qualify for the earned income disregards under this clause, the individual must not be a recipient of aid for a period of 12 consecutive months. When an assistance unit becomes ineligible for aid due to the fact that these disregards are no longer applied to income, the assistance unit shall be eligible for medical assistance benefits for a 12-month period beginning with the first month of AFDC ineligibility;

(5) an amount equal to the actual expenditures for the care of each dependent child or incapacitated individual living in the same home and receiving aid, not to exceed: (a) $175 for each individual age two and older, and $200 for each individual under the age of two~~, when the family member whose needs are included in the eligibility determination is employed for 30 or more hours per week; or (b) $174 for each individual age two or older, and $199 for each individual under the age of two, when the family member whose needs are included in the eligibility determination is not employed throughout the month or when employment is less than 30 hours per week~~. The dependent care disregard must be applied after all other disregards under this subdivision have been applied;

(6) the first $50 per assistance unit of the monthly support obligation collected by the support and recovery (IV-D) unit. The first $50 of periodic support payments collected by the public authority responsible for child support enforcement from a person with a legal obligation to pay support for a member of the assistance unit must be paid to the assistance unit within 15 days after the end of the month in which the collection of the periodic support payments occurred and must be disregarded when determining the amount of assistance. A review of a payment decision under this clause must be requested within 30 days after receiving the notice of collection of assigned support or within 90 days after receiving the notice if good cause can be shown for not making the request within the 30-day limit;

(7) that portion of an insurance settlement earmarked and used to pay medical expenses, funeral and burial costs, or to repair or replace insured property; and

(8) all earned income tax credit payments received by the family as a refund of federal income taxes or made as advance payments by an employer.

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

Sec. 23. Minnesota Statutes 1992, section 256.78, is amended to read:

256.78 **ASSISTANCE GRANTS RECONSIDERED.**

All assistance granted under sections 256.72 to 256.87 shall be reconsidered as frequently as may be required by the rules of the state agency. After such further investigation as the county agency may deem necessary or the state agency may require, the amount of assistance may be changed or assistance may be entirely withdrawn if the state or county agency find that the child's circumstances have altered sufficiently to warrant such action. ~~The period of ineligibility for AFDC which results when an assistance unit receives lump sum income must be reduced when:~~

~~(1) the assistance unit's standard of need increases due to changes in state law or due to changes in the size or composition of the assistance unit, so that the amount of aid the assistance unit would have received would have increased had it not become ineligible;~~

~~(2) the lump sum income, or a portion of it becomes unavailable to the assistance unit due to expenditures to avoid a life-threatening circumstance, theft, or dissipation which is beyond the family's control by a member of the family who is no longer part of the assistance unit when the lump sum income is not used to meet the needs of members of the assistance unit; or~~

~~(3) the assistance unit incurs and pays medical expenses for care and services specified in sections 256B.02, subdivision 8, and 256B.0625.~~

The county agency may for cause at any time revoke, modify, or suspend any order for assistance previously made. When assistance is thus revoked, modified, or suspended the county agency shall at once report to the state agency such decision together with supporting evidence required by the rules of the state agency. All such decisions shall be subject to appeal and review by the state agency as provided in section 256.045.

Sec. 24. Minnesota Statutes 1992, section 256.983, subdivision 3, is amended to read:

Subd. 3. **DEPARTMENT RESPONSIBILITIES.** The commissioner shall

establish training programs which shall be attended by all investigative and supervisory staff of the involved county agencies. The commissioner shall also develop the necessary operational guidelines, forms, and reporting mechanisms, which shall be used by the involved county agencies. An individual's application or redetermination form shall include an authorization for release by the individual to obtain documentation for any information on that form which is involved in a fraud prevention investigation. The authorization for release would be effective until six months after public assistance benefits have ceased.

Sec. 25. Minnesota Statutes 1992, 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 ~~shall be as follows: (a)~~ 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~~; and (b)~~, except that payments made pursuant to a court order for the support of children shall be excluded from income in an amount not to exceed the difference between the applicable income standard used in the state's medical assistance program for aged, blind, and disabled persons and the applicable income standard used in the state's medical assistance program for families with children. Exclusion of court-ordered child support payments is subject to the condition that if there has been a change in the financial circumstances of the person with the legal obligation to pay support since the support order was entered, the person with the legal obligation to pay support has petitioned for modification of the support order. For families and children, which includes all other eligibility categories, the methodologies for the aid to families with dependent children program under section 256.73 shall be used. For these purposes, a "methodology" does not include an asset or income standard, or accounting method, or method of determining effective dates.

Sec. 26. Minnesota Statutes 1992, section 256D.01, subdivision 1a, is amended to read:

Subd. 1a. **STANDARDS.** (a) A principal objective in providing general assistance is to provide for persons ineligible for federal programs who are unable to provide for themselves. The minimum standard of assistance determines the total amount of the general assistance grant without separate standards for shelter, utilities, or other needs.

(b) The commissioner shall set the standard of assistance for an assistance unit consisting of an adult recipient who is childless and unmarried or living apart from children and spouse and who does not live with a parent or parents or a legal custodian. When the other standards specified in this subdivision increase, this standard must also be increased by the same percentage.

(c) For an assistance unit consisting of a single adult who lives with a parent or parents, the general assistance standard of assistance is the amount that the aid to families with dependent children standard of assistance would increase if the recipient were added as an additional minor child to an assistance unit consisting of the recipient's parent and all of that parent's family members, except that the standard may not exceed the standard for a general assistance recipient living alone. Benefits received by a responsible relative of the assistance unit under the supplemental security income program, a workers' compensation program, the Minnesota supplemental aid program, or any other program based on the responsible relative's disability, and any benefits received by a responsible relative of the assistance unit under the social security retirement program, may not be counted in the determination of eligibility or benefit level for the assistance unit. Except as provided below, the assistance unit is ineligible for general assistance if the available resources or the countable income of the assistance unit and the parent or parents with whom the assistance unit lives are such that a family consisting of the assistance unit's parent or parents, the parent or parents' other family members and the assistance unit as the only or additional minor child would be financially ineligible for general assistance. For the purposes of calculating the countable income of the assistance unit's parent or parents, the calculation methods, income deductions, exclusions, and disregards used when calculating the countable income for a single adult or childless couple must be used.

(d) For an assistance unit consisting of a childless couple, the standards of assistance are the same as the first and second adult standards of the aid to families with dependent children program. If one member of the couple is not included in the general assistance grant, the standard of assistance for the other is the second adult standard of the aid to families with dependent children program.

(e) For an assistance unit consisting of all members of a family, the standards of assistance are the same as the standards of assistance that apply to a family under the aid to families with dependent children program if that family had the same number of parents and children as the assistance unit under general assistance and if all members of that family were eligible for the aid to families with dependent children program. If one or more members of the family are not included in the assistance unit for general assistance, the standards of assistance for the remaining members are the same as the standards of assistance that apply to an assistance unit composed of the entire family, less the standards of assistance for a family of the same number of parents and children as those members of the family who are not in the assistance unit for general assistance. In no case shall the standard for family members who are in the assistance unit for general assistance, when combined with the standard for family members who are not in the general assistance unit, total more than the standard for the entire family if all members were in an AFDC assistance unit. A child may not be excluded from the assistance unit unless income intended for its benefit is received from a federally aided categorical assistance program or supplemental

security income. The income of a child who is excluded from the assistance unit may not be counted in the determination of eligibility or benefit level for the assistance unit.

(f) An assistance unit consisting of one or more members of a family must have its grant determined using the policies and procedures of the aid to families with dependent children program, except that, until June 30, 1995, in cases where a county agency has developed or approved a case plan that includes reunification with the children, foster care maintenance payments made under state or local law for a child who is temporarily absent from the assistance unit must not be considered income to the child and the payments must not be counted in the determination of the eligibility or benefit level of the assistance unit. ~~However~~ Otherwise, the standard of assistance must be determined according to paragraph (e)~~;~~; the first $50 of total child support received by an assistance unit in a month must be excluded and the balance counted as unearned income~~;~~; and nonrecurring lump sums received by the family must be considered income in the month received and a resource in the following months.

Sec. 27. Minnesota Statutes 1992, section 256D.02, subdivision 5, is amended to read:

Subd. 5. "Family" means the applicant or recipient and the following persons who reside with the applicant or recipient:

(1) the applicant's spouse;

(2) any minor child of whom the applicant is a parent, stepparent, or legal custodian, and that child's minor siblings, including half-siblings and stepsiblings;

(3) the other parent of the applicant's minor child or children together with that parent's minor children, and, if that parent is a minor, his or her parents, stepparents, legal guardians, and minor siblings; and

(4) if the applicant or recipient is a minor, the minor's parents, stepparents, or legal guardians, and any other minor children for whom those parents, stepparents, or legal guardians are financially responsible.

A minor child who is temporarily absent from the applicant's or recipient's home due to placement in foster care paid for from state or local funds, but who is expected to return within six months of the month of departure, is considered to be residing with the applicant or recipient.

A "family" must contain at least one minor child and at least one of that child's natural or adoptive parents, stepparents, or legal custodians.

Sec. 28. Minnesota Statutes 1992, 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 spend-down of excess income according to section 256B.056, subdivision 5, and:

(1) who is receiving assistance under section 256D.05 or 256D.051; 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 pursuant to section 256B.056, subdivision 5, using a six-month budget period, except that a one-month budget period must be used for recipients residing in a long-term care facility. The method for calculating earned income disregards and deductions for a person who resides with a dependent child under age 21 shall be as specified in section 256.74, subdivision 1. However, if a disregard of $30 and one-third of the remainder described in section 256.74, subdivision 1, clause (4), 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 aid to families with dependent children 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; or

(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.

(b) Eligibility is available for the month of application, and for three months prior to application if the person was eligible in those prior months. A redetermination of eligibility must occur every 12 months.

(c) 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.

(d) 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.

(e) 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 30 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.

(f)(1) Beginning October 1, 1993, an undocumented alien 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 alien is an individual who resides in the United States without the approval or acquiescence of the Immigration and Naturalization Service.

(2) This subdivision 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 an alien who is aged, blind, or disabled as defined in United States Code, title 42, section 1382c(a)(1).

(3) For purposes of paragraph (f), "emergency services" has the meaning given in Code of Federal Regulations, title 42, section 440.255(b)(1).

Sec. 29. Minnesota Statutes 1992, section 256D.04, is amended to read:

256D.04 **DUTIES OF THE COMMISSIONER.**

In addition to any other duties imposed by law, the commissioner shall:

(1) Supervise according to section 256.01 the administration of general assistance and general assistance medical care by county agencies as provided in sections 256D.01 to 256D.21;

(2) Promulgate uniform rules consistent with law for carrying out and enforcing the provisions of sections 256D.01 to 256D.21, including section 256D.05, subdivision 3, and section 256.01, subdivision 2, paragraph (16), to the end that general assistance may be administered as uniformly as possible throughout the state; rules shall be furnished immediately to all county agencies and other interested persons; in promulgating rules, the provisions of sections 14.001 to 14.69, shall apply;

(3) Allocate money appropriated for general assistance and general assistance medical care to county agencies as provided in section 256D.03, subdivisions 2 and 3;

(4) Accept and supervise the disbursement of any funds that may be provided by the federal government or from other sources for use in this state for general assistance and general assistance medical care;

(5) Cooperate with other agencies including any agency of the United States or of another state in all matters concerning the powers and duties of the commissioner under sections 256D.01 to 256D.21;

(6) Cooperate to the fullest extent with other public agencies empowered by law to provide vocational training, rehabilitation, or similar services;

(7) Gather and study current information and report at least annually to the governor and legislature on the nature and need for general assistance and general assistance medical care, the amounts expended under the supervision of each county agency, and the activities of each county agency and publish such reports for the information of the public; ~~and~~

(8) Specify requirements for general assistance and general assistance medical care reports, including fiscal reports, according to section 256.01, subdivision 2, paragraph (17); and

(9) Ensure that every notice of eligibility for general assistance or work readiness includes a notice that women who are pregnant may be eligible for medical assistance benefits.

Sec. 30. Minnesota Statutes 1992, section 256D.05, is amended by adding a subdivision to read:

Subd. 8. **PERSONS INELIGIBLE.** (a) Beginning October 1, 1993, an undocumented alien or a nonimmigrant is ineligible for work readiness and general assistance benefits. 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 alien is an individual who resides in the

United States without the approval or acquiescence of the Immigration and Naturalization Service.

(b) This subdivision 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 an alien who is aged, blind, or disabled as defined in United States Code, title 42, section 1382c(a)(1).

Sec. 31. Minnesota Statutes 1992, section 256D.051, subdivision 1, is amended to read:

Subdivision 1. **WORK REGISTRATION.** (a) Except as provided in this subdivision, persons who are residents of the state and whose income and resources are less than the standard of assistance established by the commissioner, but who are not categorically eligible under section 256D.05, subdivision 1, are eligible for the work readiness program for a maximum period of six calendar months during any 12 consecutive calendar month period, subject to the provisions of paragraph (d), subdivision 3, and section 256D.052, subdivision 4. The person's eligibility period begins on the first day of the calendar month following the date of application for assistance or following the date all eligibility factors are met, whichever is later; however, the person may voluntarily continue to participate in work readiness services for up to three additional consecutive months immediately following the last month of benefits to complete the provisions of the person's employability development plan. After July 1, 1992, if orientation is available within three weeks after the date eligibility is determined, initial payment will not be made until the registrant attends orientation to the work readiness program. Prior to terminating work readiness assistance the county agency must provide advice on the person's eligibility for general assistance medical care and must assess the person's eligibility for general assistance under section 256D.05 to the extent possible, using information in the case file, and determine the person's eligibility for general assistance. A determination that the person is not eligible for general assistance must be stated in the notice of termination of work readiness benefits.

(b) Persons, families, and married couples who are not state residents but who are otherwise eligible for work readiness assistance may receive emergency assistance to meet emergency needs.

(c) Except for family members who must participate in work readiness services under the provisions of section 256D.05, subdivision 1, clause ~~(14)~~ (15), any person who would be defined for purposes of the food stamp program as being enrolled or participating at least half-time in an institution of higher education or a post-secondary program is ineligible for the work readiness program. Post-secondary education does not include the following programs: (1) high school equivalency; (2) adult basic education; (3) English as a second language; (4) literacy training; and (5) skill-specific technical training that has a course of study of less than three months, that is not paid for using work readiness funds, and that is specified in the work readiness employability development plan developed with the recipient prior to the recipient beginning the training course.

(d) Notwithstanding the provisions of sections 256.045 and 256D.10, during the pendency of an appeal, work readiness payments and services shall not continue to a person who appeals the termination of benefits due to exhaustion of the period of eligibility specified in paragraph (a) or (d).

Sec. 32. Minnesota Statutes 1992, section 256D.051, subdivision 6, is amended to read:

Subd. 6. **SERVICE COSTS.** The commissioner shall reimburse 92 percent of county agency expenditures for providing work readiness services including direct participation expenses and administrative costs, except as provided in section 256.017. State work readiness funds shall be used only to pay the county agency's and work readiness service provider's actual costs of providing participant support services, direct program services, and program administrative costs for persons who participate in work readiness services. ~~Beginning January 1, 1991, the average reimbursable cost per recipient must not exceed $283 annually.~~ Beginning July 1, 1991, the average annual reimbursable cost for providing work readiness services to a recipient for whom an individualized employability development plan is not completed must not exceed $60 for the work readiness services, and $223 for necessary recipient support services such as transportation or child care needed to participate in work readiness services. If an individualized employability development plan has been completed, the average annual reimbursable cost for providing work readiness services must not exceed $283, except that the total annual average reimbursable cost shall not exceed $804 for recipients who participate in a pilot project work experience program under section 56, for all services and costs necessary to implement the plan, including the costs of training, employment search assistance, placement, work experience, on-the-job training, other appropriate activities, the administrative and program costs incurred in providing these services, and necessary recipient support services such as tools, clothing, and transportation needed to participate in work readiness services. Beginning July 1, 1991, the state will reimburse counties, up to the limit of state appropriations, 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. Payment to counties under this subdivision is subject to the provisions of section 256.017.

Sec. 33. Minnesota Statutes 1992, section 257.54, is amended to read:

257.54 **HOW PARENT AND CHILD RELATIONSHIP ESTABLISHED.**

The parent and child relationship between a child and

(a) the biological mother may be established by proof of her having given birth to the child, or under sections 257.51 to 257.74 or section 257.75;

(b) the biological father may be established under sections 257.51 to 257.74 or section 257.75; or

(c) an adoptive parent may be established by proof of adoption.

Sec. 34. Minnesota Statutes 1992, section 257.541, is amended to read:

257.541 **CUSTODY AND VISITATION OF CHILDREN BORN OUTSIDE OF MARRIAGE.**

Subdivision 1. **MOTHER'S RIGHT TO CUSTODY.** The biological mother of a child born to a mother who was not married to the child's father neither when the child was born nor when the child was conceived has sole custody of the child until paternity has been established under sections 257.51 to 257.74, or until custody is determined in a separate proceeding under section 518.156.

Subd. 2. **FATHER'S RIGHT TO VISITATION AND CUSTODY.** (a) If paternity has been acknowledged under section 257.34 and paternity has been established under sections 257.51 to 257.74, the father's rights of visitation or custody are determined under sections 518.17 and 518.175.

(b) If paternity has not been acknowledged under section 257.34 and paternity has been established under sections 257.51 to 257.74, the biological father may petition for rights of visitation or custody in the paternity proceeding or in a separate proceeding under section 518.156.

Subd. 3. **FATHER'S RIGHT TO VISITATION AND CUSTODY; RECOGNITION OF PATERNITY.** If paternity has been recognized under section 257.75, the father may petition for rights of visitation or custody in an independent action under section 518.156. The proceeding must be treated as an initial determination of custody under section 518.17. The provisions of chapter 518 apply with respect to the granting of custody and visitation. These proceedings may not be combined with any proceeding under chapter 518B.

Sec. 35. Minnesota Statutes 1992, section 257.55, subdivision 1, is amended to read:

Subdivision 1. **PRESUMPTION.** A man is presumed to be the biological father of a child if:

(a) He and the child's biological mother are or have been married to each other and the child is born during the marriage, or within 280 days after the marriage is terminated by death, annulment, declaration of invalidity, dissolution, or divorce, or after a decree of legal separation is entered by a court;

(b) Before the child's birth, he and the child's biological mother have attempted to marry each other by a marriage solemnized in apparent compliance with law, although the attempted marriage is or could be declared void, voidable, or otherwise invalid, and,

(1) if the attempted marriage could be declared invalid only by a court, the

child is born during the attempted marriage, or within 280 days after its termination by death, annulment, declaration of invalidity, dissolution or divorce; or

(2) if the attempted marriage is invalid without a court order, the child is born within 280 days after the termination of cohabitation;

(c) After the child's birth, he and the child's biological mother have married, or attempted to marry, each other by a marriage solemnized in apparent compliance with law, although the attempted marriage is or could be declared void, voidable, or otherwise invalid, and,

(1) he has acknowledged his paternity of the child in writing filed with the state registrar of vital statistics;

(2) with his consent, he is named as the child's father on the child's birth certificate; or

(3) he is obligated to support the child under a written voluntary promise or by court order;

(d) While the child is under the age of majority, he receives the child into his home and openly holds out the child as his biological child; ~~or~~

(e) He and the child's biological mother acknowledge his paternity of the child in a writing signed by both of them under section 257.34 and filed with the state registrar of vital statistics. If another man is presumed under this clause to be the child's father, acknowledgment may be effected only with the written consent of the presumed father or after the presumption has been rebutted~~.~~;

(f) Evidence of statistical probability of paternity based on blood testing establishes ~~that~~ the likelihood that ~~the man~~ he is the father of the child, calculated with a prior probability of no more than 0.5 (50 percent), is 99 percent or greater;

(g) He and the child's biological mother have executed a recognition of parentage in accordance with section 257.75 and another man is presumed to be the father under this subdivision; or

(h) He and the child's biological mother have executed a recognition of parentage in accordance with section 257.75 and another man and the child's mother have executed a recognition of parentage in accordance with section 257.75.

Sec. 36. Minnesota Statutes 1992, section 257.57, subdivision 2, is amended to read:

Subd. 2. The child, the mother, or personal representative of the child, the public authority chargeable by law with the support of the child, the personal representative or a parent of the mother if the mother has died or is a minor, a

man alleged or alleging himself to be the father, or the personal representative or a parent of the alleged father if the alleged father has died or is a minor may bring an action:

(1) at any time for the purpose of declaring the existence of the father and child relationship presumed under section 257.55, subdivision 1, clause (d), (e), ~~or~~ (f), (g), or (h), or the nonexistence of the father and child relationship presumed under clause (d) of that subdivision;

(2) for the purpose of declaring the nonexistence of the father and child relationship presumed under section 257.55, subdivision 1, clause (e) or (g), only if the action is brought within three years after the date of the execution of the declaration or recognition of parentage; or

(3) for the purpose of declaring the nonexistence of the father and child relationship presumed under section 257.55, subdivision 1, paragraph (f), only if the action is brought within three years after the party bringing the action, or the party's attorney of record, has been provided the blood test results.

Sec. 37. Minnesota Statutes 1992, section 257.59, subdivision 3, is amended to read:

Subd. 3. The action may be brought in the county in which the child or the ~~alleged~~ ~~father~~ defendant resides or is found or, if the ~~father~~ defendant is deceased, in which proceedings for probate of ~~his~~ the defendant's estate have been or could be commenced.

Sec. 38. Minnesota Statutes 1992, section 257.73, subdivision 1, is amended to read:

Subdivision 1. Upon compliance with the provisions of section 257.55, subdivision 1, clause (e), 257.75, or upon order of a court of this state or upon request of a court of another state, the local registrar of vital statistics shall prepare a new certificate of birth consistent with the acknowledgment or the findings of the court and shall substitute the new certificate for the original certificate of birth.

Sec. 39. Minnesota Statutes 1992, section 257.74, subdivision 1, is amended to read:

Subdivision 1. If a mother relinquishes or proposes to relinquish for adoption a child who has

(a) a presumed father under section 257.55, subdivision 1,

(b) a father whose relationship to the child has been determined by a court or established under section 257.75, or

(c) a father as to whom the child is a legitimate child under prior law of this

state or under the law of another jurisdiction, the father shall be given notice of the adoption proceeding as provided in section 259.26.

Sec. 40. **[257.75] RECOGNITION OF PARENTAGE.**

Subdivision 1. **RECOGNITION BY PARENTS.** The mother and father of a child born to a mother who was not married to the child's father nor to any other man when the child was conceived nor when the child was born may, in a writing signed by both of them before a notary public and filed with the state registrar of vital statistics, state and acknowledge under oath that they are the biological parents of the child and wish to be recognized as the biological parents. The recognition must be in the form prepared by the commissioner of human services under subdivision 5.

Subd. 2. **REVOCATION OF RECOGNITION.** A recognition may be revoked in a writing signed by the mother or father before a notary public and filed with the state registrar of vital statistics within 30 days after the recognition is executed. Upon receipt of a revocation of the recognition of parentage, the state registrar of vital statistics shall forward a copy of the revocation to the nonrevoking parent.

Subd. 3. **EFFECT OF RECOGNITION.** Subject to subdivision 2 and section 257.55, subdivision 1, paragraph (g) or (h), the recognition has the force and effect of a judgment or order determining the existence of the parent and child relationship under section 257.66. If the conditions in section 257.55, subdivision 1, paragraph (g) or (h), exist, the recognition creates only a presumption of paternity for purposes of sections 257.51 to 257.74. Until an order is entered granting custody to another, the mother has sole custody. The recognition is:

(1) a basis for bringing an action to award custody or visitation rights to either parent, establishing a child support obligation, ordering a contribution by a parent under section 256.87, or ordering a contribution to the reasonable expenses of the mother's pregnancy and confinement, as provided under section 257.66, subdivision 3;

(2) determinative for all other purposes related to the existence of the parent and child relationship; and

(3) entitled to full faith and credit in other jurisdictions.

Subd. 4. **ACTION TO VACATE RECOGNITION.** An action to vacate a recognition of paternity may be brought by the mother, father, or child. A mother or father must bring the action within one year of the execution of the recognition or within six months after discovery of evidence in support of the action, whichever is later. A child must bring an action to vacate within six months of discovery of evidence, in support of the action or within one year of reaching the age of majority, whichever is later. If the court finds a prima facie basis for vacating the recognition, the court shall order the child, mother, and father to submit to blood tests. If the court issues an order for the taking of

blood tests, the court shall require the party seeking to vacate the recognition to make advance payment for the costs of the blood tests. If the party fails to pay for the costs of the blood tests, the court shall dismiss the action to vacate with prejudice. The court may also order the party seeking to vacate the recognition to pay the other party's reasonable attorney fees, costs, and disbursements. If the results of the blood tests establish that the man who executed the recognition is not the father, the court shall vacate the recognition. The court shall terminate the obligation of a party to pay ongoing child support based on the recognition. A modification of child support based on a recognition may be made retroactive with respect to any period during which the moving party has pending a motion to vacate the recognition but only from the date of service of notice of the motion on the responding party.

Subd. 5. **RECOGNITION FORM.** The commissioner of human services shall prepare a form for the recognition of parentage under this section. In preparing the form, the commissioner shall consult with the individuals specified in subdivision 6. The recognition form must be drafted so that the force and effect of the recognition and the benefits and responsibilities of establishing paternity are clear and understandable. The form must include a notice regarding the finality of a recognition and the revocation procedure under subdivision 2. The form must include a provision for each parent to verify that the parent has read or viewed the educational materials prepared by the commissioner of human services describing the recognition of paternity. Each parent must receive a copy of the recognition.

Subd. 6. **PATERNITY EDUCATIONAL MATERIALS.** The commissioner of human services shall prepare educational materials for new and prospective parents that describe the benefits and effects of establishing paternity. The materials must include a description and comparison of the procedures for establishment of paternity through a recognition of parentage under this section and an adjudication of paternity under sections 257.51 to 257.74. The commissioner shall consider the use of innovative audio or visual approaches to the presentation of the materials to facilitate understanding and presentation. In preparing the materials, the commissioner shall consult with child advocates and support workers, battered women's advocates, social service providers, educators, attorneys, hospital representatives, and people who work with parents in making decisions related to paternity. The commissioner shall consult with representatives of communities of color. On and after January 1, 1994, the commissioner shall make the materials available without cost to hospitals, requesting agencies, and other persons for distribution to new parents.

Subd. 7. **HOSPITAL DISTRIBUTION OF EDUCATIONAL MATERIALS; RECOGNITION FORM.** Hospitals that provide obstetric services shall distribute the educational materials and recognition of parentage forms prepared by the commissioner of human services to new parents and shall assist parents in understanding the recognition of parentage form. On and after January 1, 1994, hospitals may not distribute the declaration of parentage forms.

Subd. 8. **NOTICE.** If the state registrar of vital statistics receives more than one recognition of parentage for the same child, the registrar shall notify both signatories on each recognition that the recognition is no longer final and that each man has only a presumption of paternity under section 257.55, subdivision 1.

Sec. 41. Minnesota Statutes 1992, section 388.23, subdivision 1, is amended to read:

Subdivision 1. **AUTHORITY.** The county attorney, or any deputy or assistant county attorney whom the county attorney authorizes in writing, has the authority to subpoena and require the production of any records of telephone companies, cellular phone companies, paging companies, electric companies, gas companies, water utilities, chemical suppliers, hotels and motels, airlines, buses, taxis, and other entities engaged in the business of transporting people, and freight companies, warehousing companies, package delivery companies, and other entities engaged in the businesses of transport, storage, or delivery, and records of the existence of safe deposit box account numbers and customer savings and checking account numbers maintained by financial institutions and safe deposit companies, insurance records relating to the monetary payment or settlement of claims, and wage and employment records of an applicant or recipient of public assistance who is the subject of a welfare fraud investigation relating to eligibility information for public assistance programs. Subpoenas may only be issued for records that are relevant to an ongoing legitimate law enforcement investigation or welfare fraud investigation and there is probable cause that a crime has been committed. This provision applies only to the records of business entities and does not extend to private individuals or their dwellings. Subpoenas may only be served by peace officers as defined by section 626.84, subdivision 1, paragraph (c).

Sec. 42. Minnesota Statutes 1992, section 393.07, subdivision 10, is amended to read:

Subd. 10. **FEDERAL FOOD STAMP PROGRAM.** (a) The county welfare board shall establish and administer the food stamp program pursuant to rules of the commissioner of human services, the supervision of the commissioner as specified in section 256.01, and all federal laws and regulations. The commissioner of human services shall monitor food stamp program delivery on an ongoing basis to ensure that each county complies with federal laws and regulations. Program requirements to be monitored include, but are not limited to, number of applications, number of approvals, number of cases pending, length of time required to process each application and deliver benefits, number of applicants eligible for expedited issuance, length of time required to process and deliver expedited issuance, number of terminations and reasons for terminations, client profiles by age, household composition and income level and sources, and the use of phone certification and home visits. The commissioner shall determine the county-by-county and statewide participation rate.

(b) On July 1 of each year, the commissioner of human services shall determine a statewide and county-by-county food stamp program participation rate. The commissioner may designate a different agency to administer the food stamp program in a county if the agency administering the program fails to increase the food stamp program participation rate among families or eligible individuals, or comply with all federal laws and regulations governing the food stamp program. The commissioner shall review agency performance annually to determine compliance with this paragraph.

(c) A person who commits any of the following acts has violated section 256.98 or 609.821, or both, and is subject to both the criminal and civil penalties provided under ~~that section~~ those sections:

(1) Obtains or attempts to obtain, or aids or abets any person to obtain by means of a willfully false statement or representation, or intentional concealment of a material fact, food stamps to which the person is not entitled or in an amount greater than that to which that person is entitled; or

(2) Presents or causes to be presented, coupons for payment or redemption knowing them to have been received, transferred or used in a manner contrary to existing state or federal law; ~~or~~

(3) Willfully uses, possesses, or transfers food stamp coupons or authorization to purchase cards in any manner contrary to existing state or federal law, rules, or regulations; or

(4) Buys or sells food stamp coupons, authorization to purchase cards or other assistance transaction devices for cash or consideration other than eligible food.

(d) A peace officer or welfare fraud investigator may confiscate food stamps, authorization to purchase cards, or other assistance transaction devices found in the possession of any person who is neither a recipient of the food stamp program nor otherwise authorized to possess and use such materials. Confiscated property shall be disposed of as the commissioner may direct and consistent with state and federal food stamp law. The confiscated property must be retained for a period of not less than 30 days to allow any affected person to appeal the confiscation under section 256.045.

Sec. 43. Minnesota Statutes 1992, section 518.156, subdivision 1, is amended to read:

Subdivision 1. In a court of this state which has jurisdiction to decide child custody matters, a child custody proceeding is commenced:

(a) by a parent

(1) by filing a petition for dissolution or legal separation; or

(2) where a decree of dissolution or legal separation has been entered or where none is sought, or when paternity has been recognized under section 257.75, by filing a petition or motion seeking custody or visitation of the child in the county where the child is permanently resident or where the child is found or where an earlier order for custody of the child has been entered; or

(b) by a person other than a parent, where a decree of dissolution or legal separation has been entered or where none is sought by filing a petition or motion seeking custody or visitation of the child in the county where the child is permanently resident or where the child is found or where an earlier order for custody of the child has been entered. A person seeking visitation pursuant to this paragraph must qualify under one of the provisions of section 257.022.

Sec. 44. Minnesota Statutes 1992, section 518.551, subdivision 5, is amended to read:

Subd. 5. **NOTICE TO PUBLIC AUTHORITY; GUIDELINES.** (a) The petitioner shall notify the public authority of all proceedings for dissolution, legal separation, determination of parentage or for the custody of a child, if either party is receiving aid to families with dependent children or applies for it subsequent to the commencement of the proceeding. After receipt of the notice, the court shall set child support as provided in this subdivision. The court may order either or both parents owing a duty of support to a child of the marriage to pay an amount reasonable or necessary for the child's support, without regard to marital misconduct. The court shall approve a child support stipulation of the parties if each party is represented by independent counsel, unless the stipulation does not meet the conditions of paragraph (h). In other cases the court shall determine and order child support in a specific dollar amount in accordance with the guidelines and the other factors set forth in paragraph (b) and any departure therefrom. The court may also order the obligor to pay child support in the form of a percentage share of the obligor's net bonuses, commissions, or other forms of compensation, in addition to, or if the obligor receives no base pay, in lieu of, an order for a specific dollar amount.

The court shall derive a specific dollar amount by multiplying the obligor's net income by the percentage indicated by the following guidelines:

Net Income Per Month of Obligor	Number of Children						
	1	2	3	4	5	6	7 or more
$400 and Below	Order based on the ability of the obligor to provide support at these income levels, or at higher levels, if the obligor has the earning ability.						
$401 - 500	14%	17%	20%	22%	24%	26%	28%
$501 - 550	15%	18%	21%	24%	26%	28%	30%

$551 - 600	16%	19%	22%	25%	28%	30%	32%
$601 - 650	17%	21%	24%	27%	29%	32%	34%
$651 - 700	18%	22%	25%	28%	31%	34%	36%
$701 - 750	19%	23%	27%	30%	33%	36%	38%
$751 - 800	20%	24%	28%	31%	35%	38%	40%
$801 - 850	21%	25%	29%	33%	36%	40%	42%
$851 - 900	22%	27%	31%	34%	38%	41%	44%
$901 - 950	23%	28%	32%	36%	40%	43%	46%
$951 - 1000	24%	29%	34%	38%	41%	45%	48%
$1001- 4000	25%	30%	35%	39%	43%	47%	50%

Guidelines for support for an obligor with a monthly income of $4,001 or more shall be the same dollar amounts as provided for in the guidelines for an obligor with a monthly income of $4,000.

Net Income defined as:

Total monthly income less	*(i) Federal Income Tax
	*(ii) State Income Tax
	(iii) Social Security Deductions
	(iv) Reasonable Pension Deductions
*Standard Deductions apply- use of tax tables recommended	(v) Union Dues
	(vi) Cost of Dependent Health Insurance Coverage
	(vii) Cost of Individual or Group Health/Hospitalization Coverage or an Amount for Actual Medical Expenses
	(viii) A Child Support or Maintenance Order that is Currently Being Paid.

"Net income" does not include:

(1) the income of the obligor's spouse, but does include in-kind payments received by the obligor in the course of employment, self-employment, or operation of a business if the payments reduce the obligor's living expenses; or

(2) compensation received by a party for employment in excess of a 40-hour work week, provided that:

(i) support is nonetheless ordered in an amount at least equal to the guidelines amount based on income not excluded under this clause; and

(ii) the party demonstrates, and the court finds, that:

(A) the excess employment began after the filing of the petition for dissolution;

(B) the excess employment reflects an increase in the work schedule or hours worked over that of the two years immediately preceding the filing of the petition;

(C) the excess employment is voluntary and not a condition of employment;

(D) the excess employment is in the nature of additional, part-time or overtime employment compensable by the hour or fraction of an hour; and

(E) the party's compensation structure has not been changed for the purpose of affecting a support or maintenance obligation.

(b) In addition to the child support guidelines, the court shall take into consideration the following factors in setting or modifying child support:

(1) all earnings, income, and resources of the parents, including real and personal property, but excluding income from excess employment of the obligor or obligee that meets the criteria of paragraph (a), clause (2)(ii);

(2) the financial needs and resources, physical and emotional condition, and educational needs of the child or children to be supported;

(3) the standards of living the child would have enjoyed had the marriage not been dissolved, but recognizing that the parents now have separate households;

(4) the amount of the aid to families with dependent children grant for the child or children;

(5) which parent receives the income taxation dependency exemption and what financial benefit the parent receives from it; ~~and~~

(6) the parents' debts as provided in paragraph (c); and

(7) the obligor's receipt of assistance under sections 256.72 to 256.87 or 256B.01 to 256B.40.

(c) In establishing or modifying a support obligation, the court may consider debts owed to private creditors, but only if:

(1) the right to support has not been assigned under section 256.74;

(2) the court determines that the debt was reasonably incurred for necessary support of the child or parent or for the necessary generation of income. If the debt was incurred for the necessary generation of income, the court shall con-

sider only the amount of debt that is essential to the continuing generation of income; and

(3) the party requesting a departure produces a sworn schedule of the debts, with supporting documentation, showing goods or services purchased, the recipient of them, the amount of the original debt, the outstanding balance, the monthly payment, and the number of months until the debt will be fully paid.

(d) Any schedule prepared under paragraph (c), clause (3), shall contain a statement that the debt will be fully paid after the number of months shown in the schedule, barring emergencies beyond the party's control.

(e) Any further departure below the guidelines that is based on a consideration of debts owed to private creditors shall not exceed 18 months in duration, after which the support shall increase automatically to the level ordered by the court. Nothing in this section shall be construed to prohibit one or more step increases in support to reflect debt retirement during the 18-month period.

(f) Where payment of debt is ordered pursuant to this section, the payment shall be ordered to be in the nature of child support.

(g) Nothing shall preclude the court from receiving evidence on the above factors to determine if the guidelines should be exceeded or modified in a particular case.

(h) The guidelines in this subdivision are a rebuttable presumption and shall be used in all cases when establishing or modifying child support. If the court does not deviate from the guidelines, the court shall make written findings concerning the amount of the obligor's income used as the basis for the guidelines calculation and any other significant evidentiary factors affecting the determination of child support. If the court deviates from the guidelines, the court shall make written findings giving the amount of support calculated under the guidelines, the reasons for the deviation, and shall specifically address the criteria in paragraph (b) and how the deviation serves the best interest of the child. The provisions of this paragraph apply whether or not the parties are each represented by independent counsel and have entered into a written agreement. The court shall review stipulations presented to it for conformity to the guidelines and the court is not required to conduct a hearing, but the parties shall provide the documentation of earnings required under subdivision 5b.

Sec. 45. Minnesota Statutes 1992, section 518.611, subdivision 1, is amended to read:

Subdivision 1. **ORDER.** Whenever an obligation for support of a dependent child or maintenance of a spouse, or both, is determined and ordered by a court of this state, the amount of child support or maintenance as determined by court order must be withheld from the income, regardless of source, of the person obligated to pay the support or maintenance. Every order for maintenance or support must include:

(1) the obligor's social security number and date of birth and the name and address of the obligor's employer or other payor of funds; and

(2) provisions for the obligor to keep the public authority informed of the name and address of the obligor's current employer or payor of funds, and whether the obligor has access to employment-related health insurance coverage and, if so, the health insurance policy information.

Sec. 46. Minnesota Statutes 1992, section 518.611, subdivision 2, is amended to read:

Subd. 2. **CONDITIONS OF INCOME WITHHOLDING.** (a) Withholding shall result ~~whenever~~ when:

(1) the obligor requests it in writing to the public authority;

(2) the custodial parent requests it by making a motion to the court; or

(3) the obligor fails to make the maintenance or support payments, and the following conditions are met:

~~(1)~~ (i) the obligor is at least 30 days in arrears;

~~(2)~~ (ii) the obligee or the public authority serves written notice of income withholding, showing arrearage, on the obligor at least 15 days before service of the notice of income withholding and a copy of the court's order on the payor of funds;

~~(3)~~ (iii) within the 15-day period, the obligor fails to move the court to deny withholding on the grounds that an arrearage of at least 30 days does not exist as of the date of the notice of income withholding, or on other grounds limited to mistakes of fact, and, ex parte, to stay service on the payor of funds until the motion to deny withholding is heard;

~~(4)~~ (iv) the obligee or the public authority serves a copy of the notice of income withholding, a copy of the court's order or notice of order, and the provisions of this section on the payor of funds; and

~~(5)~~ (v) the obligee serves on the public authority a copy of the notice of income withholding, a copy of the court's order, an application, and the fee to use the public authority's collection services.

For those persons not applying for the public authority's IV-D services, a monthly service fee of $15 must be charged to the obligor in addition to the amount of child support ordered by the court and withheld through automatic income withholding, or for persons applying for the public authority's IV-D services, the service fee under section 518.551, subdivision 7, applies. The county agency shall explain to affected persons the services available and encourage the applicant to apply for IV-D services.

New language is indicated by underline, deletions by ~~strikeout~~.

(b) To pay the arrearage specified in the notice of income withholding, the employer or payor of funds shall withhold from the obligor's income an additional amount equal to 20 percent of the monthly child support or maintenance obligation until the arrearage is paid.

(c) ~~The obligor may, at any time, waive the written notice required by this subdivision.~~

~~(d)~~ The obligor may move the court, under section 518.64, to modify the order respecting the amount of maintenance or support.

~~(e)~~ (d) Every order for support or maintenance shall provide for a conspicuous notice of the provisions of this subdivision. An order without this notice remains subject to this subdivision.

~~(f)~~ (e) Absent a court order to the contrary, if an arrearage exists at the time an order for ongoing support or maintenance would otherwise terminate, income withholding shall continue in effect in an amount equal to the former support or maintenance obligation plus an additional amount equal to 20 percent of the monthly child support obligation, until all arrears have been paid in full.

Sec. 47. Minnesota Statutes 1992, section 518.611, subdivision 6, is amended to read:

Subd. 6. **PRIORITY.** An order for withholding under this section or execution or garnishment upon a judgment for child support arrearages or preadjudicated expenses shall have priority over an attachment, execution, garnishment, or wage assignment and shall not be subject to the statutory limitations on amounts levied against the income of the obligor. Amounts withheld from an employee's income must not exceed the maximum permitted under the Consumer Credit Protection Act, United States Code, title 15, section 1673(b)(2). If there is more than one withholding order on a single employee, ~~the employer shall put them into effect, giving priority first to amounts currently due and not in arrears and then to other amounts, in the sequence in which the withholding orders were received up to the maximum allowed in the Consumer Credit Protection Act.~~ the payor of funds shall comply with all of the orders to the extent that the total amount withheld from the payor's income does not exceed the limits imposed under the Consumer Credit Protection Act, giving priority to amounts designated in each order as current support as follows:

(1) If the total of the amounts designated in the orders as current support exceeds the amount available for income withholding, the payor of funds shall allocate to each order an amount for current support equal to the amount designated in that order as current support, divided by the total of the amounts designated in the orders as current support, multiplied by the amount of the income available for income withholding; and

New language is indicated by underline, deletions by ~~strikeout~~.

(2) If the total of the amounts designated in the orders as current support does not exceed the amount available for income withholding, the payor of funds shall pay the amounts designated as current support, and shall allocate to each order an amount for past due support equal to the amount designated in that order as past due support, divided by the total of the amounts designated in the orders as past due support, multiplied by the amount of income remaining available for income withholding after the payment of current support.

Notwithstanding any law to the contrary, funds from income sources included in section 518.54, subdivision 6, whether periodic or lump sum, are not exempt from attachment or execution upon a judgment for child support arrearages.

Sec. 48. Minnesota Statutes 1992, section 518.611, is amended by adding a subdivision to read:

Subd. 12. **INTERSTATE INCOME WITHHOLDING.** Upon receipt of an order for support entered in another state, with the specified documentation from an authorized agency, the public authority shall implement income withholding under subdivision 2. If the obligor requests a hearing under subdivision 3 to contest withholding, the court administrator shall enter the order. Entry of the order shall not confer jurisdiction on the courts or administrative agencies of this state for any purpose other than contesting implementation of income withholding.

Sec. 49. Minnesota Statutes 1992, section 518.613, subdivision 2, is amended to read:

Subd. 2. **ORDER; COLLECTION SERVICES.** Every order for child support must include the obligor's social security number and date of birth and the name and address of the obligor's employer or other payor of funds. In addition, every order must contain provisions requiring the obligor to keep the public authority informed of the name and address of the obligor's current employer, or other payor of funds and whether the obligor has access to employment-related health insurance coverage and, if so, the health insurance policy information. Upon entry of the order for support or maintenance, the court shall mail a copy of the court's automatic income withholding order and the provisions of section 518.611 and this section to the obligor's employer or other payor of funds and to the public authority responsible for child support enforcement. An obligee who is not a recipient of public assistance ~~shall~~ must decide to either apply for the IV-D collection services of the public authority or obtain income withholding only services when an order for support is entered unless the requirements of this section have been waived under subdivision 7. ~~No later than January 1, 1990,~~ The supreme court shall develop a standard automatic income withholding form to be used by all Minnesota courts. This form shall be made a part of any order for support or decree by reference.

Sec. 50. Minnesota Statutes 1992, section 518.613, subdivision 3, is amended to read:

Subd. 3. **WITHHOLDING.** The employer or other payor shall withhold and forward the child support or maintenance ordered in the manner and within the time limits provided in section 518.611. Amounts received from employers or other payors under this section by the public agency responsible for child support enforcement that are in excess of public assistance received by the obligee must be remitted to the obligee. ~~The public agency must remit payments to the obligee at least once monthly on a standard payment date set by the agency.~~ A county in which this section applies may contract for services to carry out the provisions of this section.

Sec. 51. Minnesota Statutes 1992, section 518.613, subdivision 4, is amended to read:

Subd. 4. **APPLICATION.** ~~On and after August 1, 1989, this section applies in a county selected under Laws 1987, chapter 403, article 3, section 93, and in a county that chooses to have this section apply by resolution of a majority vote of its county board.~~ On and after November 1, 1990, this section applies to all child support and maintenance obligations that are initially ordered or modified on and after November 1, 1990, and that are being enforced by the public authority. Effective January 1, 1994, this section applies to all child support and maintenance obligations ordered or modified by the court. Those persons not applying for the public authority's IV-D services must pay a monthly service fee of $15. The fee will be charged to the obligor in addition to the amount of the child support which was ordered by the court. Persons applying for the public authority's IV-D services will pay the service fee under section 518.551, subdivision 7.

Sec. 52. Minnesota Statutes 1992, section 518.64, subdivision 2, is amended to read:

Subd. 2. **MODIFICATION.** (a) The terms of an order respecting maintenance or support may be modified upon a showing of one or more of the following: (1) substantially increased or decreased earnings of a party; (2) substantially increased or decreased need of a party or the child or children that are the subject of these proceedings; (3) receipt of assistance under sections 256.72 to 256.87 or 256B.01 to 256B.40; or (4) a change in the cost of living for either party as measured by the federal bureau of statistics, any of which makes the terms unreasonable and unfair.

The terms of a current support order shall be rebuttably presumed to be unreasonable and unfair if the application of the child support guidelines in section 518.551, subdivision 5, to the current circumstances of the parties results in a calculated court order that is at least 20 percent and at least $50 per month higher or lower than the current support order.

(b) On a motion for modification of maintenance, including a motion for the extension of the duration of a maintenance award, the court shall apply, in addition to all other relevant factors, the factors for an award of maintenance

under section 518.552 that exist at the time of the motion. On a motion for modification of support, the court:

(1) shall apply section 518.551, subdivision 5, and shall not consider the financial circumstances of each party's spouse, if any; and

(2) shall not consider compensation received by a party for employment in excess of a 40-hour work week, provided that the party demonstrates, and the court finds, that:

(i) the excess employment began after entry of the existing support order;

(ii) the excess employment is voluntary and not a condition of employment;

(iii) the excess employment is in the nature of additional, part-time employment, or overtime employment compensable by the hour or fractions of an hour;

(iv) the party's compensation structure has not been changed for the purpose of affecting a support or maintenance obligation;

(v) in the case of an obligor, current child support payments are at least equal to the guidelines amount based on income not excluded under this clause; and

(vi) in the case of an obligor who is in arrears in child support payments to the obligee, any net income from excess employment must be used to pay the arrearages until the arrearages are paid in full.

(c) A modification of support or maintenance may be made retroactive only with respect to any period during which the petitioning party has pending a motion for modification but only from the date of service of notice of the motion on the responding party and on the public authority if public assistance is being furnished or the county attorney is the attorney of record. However, modification may be applied to an earlier period if the court makes express findings that the party seeking modification was precluded from serving a motion by reason of a significant physical or mental disability, a material misrepresentation of another party, or fraud upon the court and that the party seeking modification, when no longer precluded, promptly served a motion.

(d) Except for an award of the right of occupancy of the homestead, provided in section 518.63, all divisions of real and personal property provided by section 518.58 shall be final, and may be revoked or modified only where the court finds the existence of conditions that justify reopening a judgment under the laws of this state, including motions under section 518.145, subdivision 2. The court may impose a lien or charge on the divided property at any time while the property, or subsequently acquired property, is owned by the parties or either of them, for the payment of maintenance or support money, or may sequester the property as is provided by section 518.24.

(e) The court need not hold an evidentiary hearing on a motion for modification of maintenance or support.

(f) Section 518.14 shall govern the award of attorney fees for motions brought under this subdivision.

Sec. 53. Minnesota Statutes 1992, section 609.821, subdivision 1, is amended to read:

Subdivision 1. **DEFINITIONS.** For the purposes of this section, the following terms have the meanings given them:

(a) "Financial transaction card" means any instrument or device, whether known as a credit card, credit plate, charge plate, courtesy card, bank services card, banking card, check guarantee card, debit card, electronic benefit system (EBS) card, electronic benefit transfer (EBT) card, assistance transaction card, or by any other name, issued with or without fee by an issuer for the use of the cardholder in obtaining credit, money, goods, services, public assistance benefits, or anything else of value, and includes the account or identification number or symbol of a financial transaction card.

(b) "Cardholder" means a person in whose name a card is issued.

(c) "Issuer" means a person ~~or~~, firm, or governmental agency, or a duly authorized agent or designee, that issues a financial transaction card.

(d) "Property" includes money, goods, services, public assistance benefit, or anything else of value.

(e) "Public assistance benefit" means any money, goods or services, or anything else of value, issued under chapters 256, 256B, 256D, or section 393.07, subdivision 10.

Sec. 54. Minnesota Statutes 1992, section 609.821, subdivision 2, is amended to read:

Subd. 2. **VIOLATIONS; PENALTIES.** A person who does any of the following commits financial transaction card fraud:

(1) without the consent of the cardholder, and knowing that the cardholder has not given consent, uses or attempts to use a card to obtain the property of another, or a public assistance benefit issued for the use of another;

(2) uses or attempts to use a card knowing it to be forged, false, fictitious, or obtained in violation of clause (6);

(3) sells or transfers a card knowing that the cardholder and issuer have not authorized the person to whom the card is sold or transferred to use the card, or that the card is forged, false, fictitious, or was obtained in violation of clause (6);

(4) without a legitimate business purpose, and without the consent of the cardholders, receives or possesses, with intent to use, or with intent to sell or transfer in violation of clause (3), two or more cards issued in the name of another, or two or more cards knowing the cards to be forged, false, fictitious, or obtained in violation of clause (6);

(5) being authorized by an issuer to furnish money, goods, services, or anything else of value, knowingly and with an intent to defraud the issuer or the cardholder:

(i) furnishes money, goods, services, or anything else of value upon presentation of a financial transaction card knowing it to be forged, expired, or revoked, or knowing that it is presented by a person without authority to use the card; or

(ii) represents in writing to the issuer that the person has furnished money, goods, services, or anything else of value which has not in fact been furnished;

(6) upon applying for a financial transaction card to an issuer, or for a public assistance benefit which is distributed by means of a financial transaction card:

(i) knowingly gives a false name or occupation; ~~or~~

(ii) knowingly and substantially overvalues assets or substantially undervalues indebtedness for the purpose of inducing the issuer to issue a financial transaction card; or

(iii) knowingly makes a false statement or representation for the purpose of inducing an issuer to issue a financial transaction card used to obtain a public assistance benefit;

(7) with intent to defraud, falsely notifies the issuer or any other person of a theft, loss, disappearance, or nonreceipt of a financial transaction card; or

(8) without the consent of the cardholder and knowing that the cardholder has not given consent, falsely alters, makes, or signs any written document pertaining to a card transaction to obtain or attempt to obtain the property of another.

Sec. 55. **PILOT PROJECT; WORK EXPERIENCE COMPONENT OF WORK READINESS.**

Subdivision 1. **DUTIES OF COMMISSIONER.** The commissioner of human services may establish a pilot project to implement the work experience component in subdivision 2 for persons participating in work readiness. The commissioner may select one county within the seven-county metropolitan area and one or more counties outside the seven-county metropolitan area to participate in the pilot project. The commissioner may grant waivers to any county,

whether or not it is selected, to establish and implement a comprehensive work readiness pilot project. The commissioner shall allocate a proportionate number of participant slots to each pilot county based on the amount of funding available and the estimated per participant cost. Pilot counties shall assign recipients to participate in the project who have no recent work experience or local work reference on a first-come, first-served basis, or who the county determines will benefit from the work experience component by improving their employability. Recipients assigned to project participation shall be eligible for work readiness benefits and services for a maximum period of eight months during any 12-consecutive-calendar-month period rather than the six-month period specified in Minnesota Statutes, section 256D.051, subdivision 1. The work experience pilot project may not begin before January 1, 1994. The funds for the project are limited to the amount appropriated by the legislature.

Subd. 2. **WORK EXPERIENCE COMPONENT.** (a) The purpose of the pilot project is to develop a work experience component that helps recipients achieve self-sufficiency.

(b) Recipients selected to participate in the pilot project must cooperate with all work readiness requirements, including the requirement to participate in a work experience component. Work readiness recipients who would be required to participate in the work experience component for less than eight hours per month under the provisions of paragraph (d), or who are attending high school, or who are functionally illiterate and participating in literacy training, and family general assistance recipients who are required to participate in work readiness services under Minnesota Statutes, section 256D.05, subdivision 1, clause (15), may not participate in the pilot project and must instead participate in standard work readiness employment and training services.

(c) Selected recipients shall be referred to the work experience component at the end of their third month of work readiness eligibility and must participate in the component until the recipient finds suitable employment or until work readiness benefits terminate. Permanent suitable employment offered through grant diversion under Minnesota Statutes, section 256D.09, subdivision 3, during this time period shall substitute for work experience participation. The participant's employability development plan must specify the type of work experience position the recipient will be placed in, the beginning date of mandatory participation in work experience, and identify other services necessary to help the participant become employed, including the requirement to participate for a minimum of eight hours per week in job search activities if the participant is not suitably employed.

(d) Each project recipient is required to participate in a work experience job placement for that number of hours calculated by dividing the assistance unit's work readiness assistance payment by the state minimum wage. The county shall provide for a participant's support services costs of transportation, child care, and other work related expenses incurred in order to participate in the work experience activity.

(e) The county shall assign work to the participant that the participant is able to perform. Work experience positions may be developed with public and private nonprofit employers. Structured, supervised volunteer work with an agency or organization which is monitored by the county service provider may be used as a work experience placement. The county must provide workers' compensation or other comparable protection for a work experience participant. A participant is not eligible for unemployment compensation, and is not an employee of the state of Minnesota within the meaning of Minnesota Statutes, section 43A.02, subdivision 2. The commissioner of jobs and training shall assist in the design and implementation of the work experience program.

(f) An eligible employer may not terminate, lay off, or reduce the regular working hours of an employee for the purpose of hiring an individual with money available under this program. An eligible employer may not hire an individual with money available through this program if any other person is on layoff from the same or substantially equivalent job or to fill an established vacant position. Written or oral concurrence shall be obtained from the appropriate exclusive bargaining representative with respect to job duties covered under collective bargaining agreements.

(g) Recipients assigned to a work experience placement must participate and cooperate in the placement and meet all work readiness requirements. The county shall terminate assistance payments provided under this section as specified in Minnesota Statutes, section 256D.051, subdivision 1a, for a nonexempt recipient who refuses without good cause to participate in a work experience placement.

(h) The commissioner shall provide a report to the legislature on the operation of the pilot project by March 1, 1995.

Subd. 3. **EXPIRATION DATE.** The pilot projects established under this section terminate on June 30, 1995.

Sec. 56. **REPEALER.**

Minnesota Statutes 1992, section 256.985 is repealed.

Sec. 57. **EFFECTIVE DATES.**

Subdivision 1. Section 40, subdivisions 5 and 6, is effective the day following final enactment. All other subdivisions in section 40 are effective January 1, 1994.

Subd. 2. Sections 53 and 54 are effective for crimes committed on or after July 1, 1993.

Subd. 3. Sections 7 and 9 to 21 are effective October 1, 1993.

Subd. 4. Sections 1, 33 to 39, and 47 are effective January 1, 1994.

ARTICLE 7

REGIONAL TREATMENT CENTERS

AND MENTAL HEALTH ADMINISTRATION

Section 1. **[245.037] LEASES FOR REGIONAL TREATMENT CENTER AND STATE NURSING HOME PROPERTY.**

Notwithstanding any law to the contrary, money collected as rent under section 16B.24, subdivision 5, for state property at any of the regional treatment centers or state nursing home facilities administered by the commissioner of human services is dedicated to the regional treatment center or state nursing home from which it is generated. Any balance remaining at the end of the fiscal year shall not cancel and is available until expended.

Sec. 2. Minnesota Statutes 1992, section 245.462, subdivision 4, is amended to read:

Subd. 4. **CASE MANAGER.** "Case manager" means an individual employed by the county or other entity authorized by the county board to provide case management services specified in section 245.4711. A case manager must have a bachelor's degree in one of the behavioral sciences or related fields from an accredited college or university and have at least 2,000 hours of supervised experience in the delivery of services to adults with mental illness, must be skilled in the process of identifying and assessing a wide range of client needs, and must be knowledgeable about local community resources and how to use those resources for the benefit of the client. The case manager shall meet in person with a mental health professional at least once each month to obtain clinical supervision of the case manager's activities. Case managers with a bachelor's degree but without 2,000 hours of supervised experience in the delivery of services to adults with mental illness must complete 40 hours of training approved by the commissioner of human services in case management skills and in the characteristics and needs of adults with serious and persistent mental illness and must receive clinical supervision regarding individual service delivery from a mental health professional at least once each week until the requirement of 2,000 hours of supervised experience is met. Clinical supervision must be documented in the client record.

Until June 30, ~~1991~~ 1996, a refugee who does not have the qualifications specified in this subdivision may provide case management services to adult refugees with serious and persistent mental illness who are members of the same ethnic group as the case manager if the person: (1) is actively pursuing credits toward the completion of a bachelor's degree in one of the behavioral sciences or a related field from an accredited college or university; (2) completes 40 hours of training as specified in this subdivision; and (3) receives clinical supervision at least once a week until the requirements of obtaining a bachelor's degree and 2,000 hours of supervised experience are met.

Sec. 3. Minnesota Statutes 1992, section 245.462, subdivision 20, is amended to read:

Subd. 20. **MENTAL ILLNESS.** (a) "Mental illness" means an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is listed in the clinical manual of the International Classification of Diseases (ICD-9-CM), current edition, code range 290.0 to 302.99 or 306.0 to 316.0 or the corresponding code in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-MD), current edition, Axes I, II, or III, and that seriously limits a person's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, and recreation.

(b) An "adult with acute mental illness" means an adult who has a mental illness that is serious enough to require prompt intervention.

(c) For purposes of case management and community support services, a "person with serious and persistent mental illness" means an adult who has a mental illness and meets at least one of the following criteria:

(1) the adult has undergone two or more episodes of inpatient care for a mental illness within the preceding 24 months;

(2) the adult has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months' duration within the preceding 12 months;

(3) the adult:

(i) has a diagnosis of schizophrenia, bipolar disorder, major depression, or borderline personality disorder;

(ii) indicates a significant impairment in functioning; and

(iii) has a written opinion from a mental health professional, in the last three years, stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in clause (1) or (2), unless ~~an~~ ongoing case management or community support services ~~program is~~ are provided; ~~or~~

(4) the adult has, in the last three years, been committed by a court as a mentally ill person under chapter 253B, or the adult's commitment has been stayed or continued; or

(5) the adult (i) was eligible under clauses (1) to (4), but the specified time period has expired or the adult was eligible as a child under section 245.4871, subdivision 6; and (ii) has a written opinion from a mental health professional, in the last three years, stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in

clause (1) or (2), unless ongoing case management or community support services are provided.

Sec. 4. Minnesota Statutes 1992, section 245.464, subdivision 1, is amended to read:

Subdivision 1. **COORDINATION.** The commissioner shall supervise the development and coordination of locally available adult mental health services by the county boards in a manner consistent with sections 245.461 to 245.486. The commissioner shall coordinate locally available services with those services available from the regional treatment center serving the area including state-operated services offered at sites outside of the regional treatment centers. The commissioner shall review the adult mental health component of the community social services plan developed by county boards as specified in section 245.463 and provide technical assistance to county boards in developing and maintaining locally available mental health services. The commissioner shall monitor the county board's progress in developing its full system capacity and quality through ongoing review of the county board's adult mental health component of the community social services plan and other information as required by sections 245.461 to 245.486.

Sec. 5. Minnesota Statutes 1992, section 245.466, subdivision 1, is amended to read:

Subdivision 1. **DEVELOPMENT OF SERVICES.** The county board in each county is responsible for using all available resources to develop and coordinate a system of locally available and affordable adult mental health services. The county board may provide some or all of the mental health services and activities specified in subdivision 2 directly through a county agency or under contracts with other individuals or agencies. A county or counties may enter into an agreement with a regional treatment center under section 246.57 or with any state facility or program as defined in section 246.50, subdivision 3, to enable the county or counties to provide the treatment services in subdivision 2. Services provided through an agreement between a county and a regional treatment center must meet the same requirements as services from other service providers. County boards shall demonstrate their continuous progress toward full implementation of sections 245.461 to 245.486 during the period July 1, 1987, to January 1, 1990. County boards must develop fully each of the treatment services and management activities prescribed by sections 245.461 to 245.486 by January 1, 1990, according to the priorities established in section 245.464 and the adult mental health component of the community social services plan approved by the commissioner under section 245.478.

Sec. 6. Minnesota Statutes 1992, section 245.474, is amended to read:

245.474 **REGIONAL TREATMENT CENTER INPATIENT SERVICES.**

Subdivision 1. **AVAILABILITY OF REGIONAL TREATMENT CENTER**

INPATIENT SERVICES. By July 1, 1987, the commissioner shall make sufficient regional treatment center inpatient services available to adults with mental illness throughout the state who need this level of care. Inpatient services may be provided either on the regional treatment center campus or at any state facility or program as defined in section 246.50, subdivision 3. Services must be as close to the patient's county of residence as possible. Regional treatment centers are responsible to:

(1) provide acute care inpatient hospitalization;

(2) stabilize the medical and mental health condition of the adult requiring the admission;

(3) improve functioning to the point where discharge to community-based mental health services is possible;

(4) strengthen family and community support; and

(5) facilitate appropriate discharge and referrals for follow-up mental health care in the community.

Subd. 2. **QUALITY OF SERVICE.** The commissioner shall biennially determine the needs of all adults with mental illness who are served by regional treatment centers or at any state facility or program as defined in section 246.50, subdivision 3, by administering a client-based evaluation system. The client-based evaluation system must include at least the following independent measurements: behavioral development assessment; habilitation program assessment; medical needs assessment; maladaptive behavioral assessment; and vocational behavior assessment. The commissioner shall propose staff ratios to the legislature for the mental health and support units in regional treatment centers as indicated by the results of the client-based evaluation system and the types of state-operated services needed. The proposed staffing ratios shall include professional, nursing, direct care, medical, clerical, and support staff based on the client-based evaluation system. The commissioner shall recompute staffing ratios and recommendations on a biennial basis.

Subd. 3. **TRANSITION TO COMMUNITY.** Regional treatment centers must plan for and assist clients in making a transition from regional treatment centers and other inpatient facilities or programs, as defined in section 246.50, subdivision 3, to other community-based services. In coordination with the client's case manager, if any, regional treatment centers must also arrange for appropriate follow-up care in the community during the transition period. Before a client is discharged, the regional treatment center must notify the client's case manager, so that the case manager can monitor and coordinate the transition and arrangements for the client's appropriate follow-up care in the community.

Sec. 7. Minnesota Statutes 1992, section 245.484, is amended to read:

245.484 **RULES.**

The commissioner shall adopt emergency rules to govern implementation of case management services for eligible children in section 245.4881 and professional home-based family treatment services for medical assistance eligible children, in section 245.4884, subdivision 3, by January 1, 1992, and must adopt permanent rules by January 1, 1993.

The commissioner shall adopt permanent rules as necessary to carry out sections 245.461 to 245.486 and 245.487 to 245.4888. The commissioner shall reassign agency staff as necessary to meet this deadline.

By January 1, ~~1993~~ 1994, the commissioner shall adopt permanent rules specifying program requirements for family community support services.

Sec. 8. Minnesota Statutes 1992, section 245.4871, subdivision 4, is amended to read:

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

(b) A case manager must:

(1) have at least a bachelor's degree in one of the behavioral sciences or a related field from an accredited college or university;

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

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

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

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

(d) The case manager must meet in person with a mental health professional at least once each month to obtain clinical supervision.

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

(1) begin 40 hours of training approved by the commissioner of human services in case management skills and in the characteristics and needs of children

with severe emotional disturbance before beginning to provide case management services; and

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

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

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

(h) Until June 30, ~~1991~~ 1996, a refugee who does not have the qualifications specified in this subdivision may provide case management services to child refugees with severe emotional disturbance of the same ethnic group as the refugee if the person:

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

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

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

Sec. 9. Minnesota Statutes 1992, section 245.4873, subdivision 2, is amended to read:

Subd. 2. **STATE LEVEL; COORDINATION.** The state coordinating council consists of the commissioners or designees of commissioners of the departments of human services, health, education, ~~state planning,~~ and corrections, and a representative of the Minnesota district judges association juvenile committee, in conjunction with the commissioner of commerce or a designee of the commissioner, and the director or designee of the director of the office of strategic and long-range planning. The members of the council shall annually alternate chairing the council beginning with the commissioner of human services and proceeding in the order as listed in this subdivision. The council shall meet at least quarterly to:

(1) educate each agency about the policies, procedures, funding, and services for children with emotional disturbances of all agencies represented;

(2) develop mechanisms for interagency coordination on behalf of children with emotional disturbances;

(3) identify barriers including policies and procedures within all agencies represented that interfere with delivery of mental health services for children;

(4) recommend policy and procedural changes needed to improve development and delivery of mental health services for children in the agency or agencies they represent;

(5) identify mechanisms for better use of federal and state funding in the delivery of mental health services for children; and

(6) ~~until February 15, 1992, prepare an annual report on the policy and procedural changes needed to implement a coordinated, effective, and cost-efficient children's mental health delivery system.~~

~~This report shall be submitted to the legislature and the state mental health advisory council annually as part of the report required under section 245.487, subdivision 4. The report shall include information from each department represented on:~~

~~(1) the number of children in each department's system who require mental health services;~~

~~(2) the number of children in each system who receive mental health services;~~

~~(3) how mental health services for children are funded within each system;~~

~~(4) how mental health services for children could be coordinated to provide more effectively appropriate mental health services for children; and~~

~~(5) recommendations for the provision of early screening and identification of mental illness in each system~~ perform the duties required under sections 245.494 to 245.496.

Sec. 10. Minnesota Statutes 1992, section 245.4882, subdivision 5, is amended to read:

Subd. 5. **SPECIALIZED RESIDENTIAL TREATMENT SERVICES.** The commissioner of human services shall ~~establish or contract for~~ continue efforts to further interagency collaboration to develop a comprehensive system of services, including family community support and specialized residential treatment services for children. The services shall be designed for children with emotional disturbance who exhibit violent or destructive behavior and for whom local treatment services are not feasible due to the small number of children statewide who need the services and the specialized nature of the services required. The services shall be located in community settings. If no appropriate services are available in Minnesota or within the geographical area in which the residents of the county normally do business, the commissioner is responsible, effective July 1, 1995, for 50 percent of the nonfederal costs of out-of-state treatment of chil-

dren for whom no appropriate resources are available in Minnesota. Counties are eligible to receive enhanced state funding under this section only if they have established juvenile screening teams under section 260.151, subdivision 3, and if the out-of-state treatment has been approved by the commissioner. By January 1, 1995, the commissioners of human services and corrections shall jointly develop a plan, including a financing strategy, for increasing the in-state availability of treatment within a secure setting. By July 1, 1994, the commissioner of human services shall also:

(1) conduct a study and develop a plan to meet the needs of children with both a developmental disability and severe emotional disturbance; and

(2) study the feasibility of expanding medical assistance coverage to include specialized residential treatment for the children described in this subdivision.

Sec. 11. **[245.491] CITATION; DECLARATION OF PURPOSE.**

Subdivision 1. **CITATION.** Sections 245.491 to 245.496 may be cited as "the children's mental health integrated fund."

Subd. 2. **PURPOSE.** The legislature finds that children with emotional or behavioral disturbances or who are at risk of suffering such disturbances often require services from multiple service systems including mental health, social services, education, corrections, juvenile court, health, and jobs and training. In order to better meet the needs of these children, it is the intent of the legislature to establish an integrated children's mental health service system that:

(1) allows local service decision makers to draw funding from a single local source so that funds follow clients and eliminates the need to match clients, funds, services, and provider eligibilities;

(2) creates a local pool of state, local, and private funds to procure a greater medical assistance federal financial participation;

(3) improves the efficiency of use of existing resources;

(4) minimizes or eliminates the incentives for cost and risk shifting; and

(5) increases the incentives for earlier identification and intervention.

The children's mental health integrated fund established under sections 245.491 to 245.496 must be used to develop and support this integrated mental health service system. In developing this integrated service system, it is not the intent of the legislature to limit any rights available to children and their families through existing federal and state laws.

Sec. 12. **[245.492] DEFINITIONS.**

Subdivision 1. **DEFINITIONS.** The definitions in this section apply to sections 245.491 to 245.496.

Subd. 2. **BASE LEVEL FUNDING.** "Base level funding" means funding received from state, federal, or local sources and expended across the local system of care in fiscal year 1993 for children's mental health services or for special education services for children with emotional or behavioral disturbances.

In subsequent years, base level funding may be adjusted to reflect decreases in the numbers of children in the target population.

Subd. 3. **CHILDREN WITH EMOTIONAL OR BEHAVIORAL DISTURBANCES.** "Children with emotional or behavioral disturbances" includes children with emotional disturbances as defined in section 245.4871, subdivision 15, and children with emotional or behavioral disorders as defined in Minnesota Rules, part 3525.1329, subpart 1.

Subd. 4. **FAMILY.** "Family" has the definition provided in section 245.4871, subdivision 16.

Subd. 5. **FAMILY COMMUNITY SUPPORT SERVICES.** "Family community support services" has the definition provided in section 245.4871, subdivision 17.

Subd. 6. **INITIAL TARGET POPULATION.** "Initial target population" means a population of children that the local children's mental health collaborative agrees to serve in the start-up phase and who meet the criteria for the target population. The initial target population may be less than the target population.

Subd. 7. **INTEGRATED FUND.** "Integrated fund" is a pool of both public and private local, state, and federal resources, consolidated at the local level, to accomplish locally agreed upon service goals for the target population. The fund is used to help the local children's mental health collaborative to serve the mental health needs of children in the target population by allowing the local children's mental health collaboratives to develop and implement an integrated service system.

Subd. 8. **INTEGRATED FUND TASK FORCE.** "The integrated fund task force" means the statewide task force established in Laws 1991, chapter 292, article 6, section 57.

Subd. 9. **INTEGRATED SERVICE SYSTEM.** "Integrated service system" means a coordinated set of procedures established by the local children's mental health collaborative for coordinating services and actions across categorical systems and agencies that results in:

(1) integrated funding;

(2) improved outreach, early identification, and intervention across systems;

(3) strong collaboration between parents and professionals in identifying children in the target population facilitating access to the integrated system, and coordinating care and services for these children;

(4) a coordinated assessment process across systems that determines which children need multiagency care coordination and wraparound services;

(5) multiagency plan of care; and

(6) wraparound services.

Services provided by the integrated service system must meet the requirements set out in sections 245.487 to 245.4887. Children served by the integrated service system must be economically and culturally representative of children in the service delivery area.

Subd. 10. **INTERAGENCY EARLY INTERVENTION COMMITTEE.** "Interagency early intervention committee" refers to the committee established under section 120.17, subdivision 12.

Subd. 11. **LOCAL CHILDREN'S ADVISORY COUNCIL.** "Local children's advisory council" refers to the council established under section 245.4875, subdivision 5.

Subd. 12. **LOCAL CHILDREN'S MENTAL HEALTH COLLABORATIVE.** "Local children's mental health collaborative" or "collaborative" means an entity formed by the agreement of representatives of the local system of care including mental health services, social services, correctional services, education services, health services, and vocational services for the purpose of developing and governing an integrated service system. A local coordinating council, a community transition interagency committee as defined in section 120.17, subdivision 16, or an interagency early intervention committee may serve as a local children's mental health collaborative if its representatives are capable of carrying out the duties of the local children's mental health collaborative set out in sections 245.491 to 245.496. Where a local coordinating council is not the local children's mental health collaborative, the local children's mental health collaborative must work closely with the local coordinating council in designing the integrated service system.

Subd. 13. **LOCAL COORDINATING COUNCIL.** "Local coordinating council" refers to the council established under section 245.4875, subdivision 6.

Subd. 14. **LOCAL SYSTEM OF CARE.** "Local system of care" has the definition provided in section 245.4871, subdivision 24.

Subd. 15. **MENTAL HEALTH SERVICES.** "Mental health services" has the definition provided in section 245.4871, subdivision 28.

Subd. 16. **MULTIAGENCY PLAN OF CARE.** "Multiagency plan of care" means a written plan of intervention and integrated services developed by a multiagency team in conjunction with the child and family based on their unique strengths and needs as determined by a multiagency assessment. The plan must outline measurable client outcomes and specific services needed to

attain these outcomes, the agencies responsible for providing the specified services, funding responsibilities, timelines, the judicial or administrative procedures needed to implement the plan of care, the agencies responsible for initiating these procedures and designate one person with lead responsibility for overseeing implementation of the plan.

Subd. 17. **RESPITE CARE.** "Respite care" is planned routine care to support the continued residence of a child with emotional or behavioral disturbance with the child's family or long-term primary caretaker.

Subd. 18. **SERVICE DELIVERY AREA.** "Service delivery area" means the geographic area to be served by the local children's mental health collaborative and must include at a minimum a part of a county and school district or a special education cooperative.

Subd. 19. **START-UP FUNDS.** "Start-up funds" means the funds available to assist a local children's mental health collaborative in planning and implementing the integrated service system for children in the target population, in setting up a local integrated fund, and in developing procedures for enhancing federal financial participation.

Subd. 20. **STATE COORDINATING COUNCIL.** "State coordinating council" means the council established under section 245.4873, subdivision 2.

Subd. 21. **TARGET POPULATION.** "Target population" means children up to age 18 with an emotional or behavioral disturbance or who are at risk of suffering an emotional or behavioral disturbance as evidenced by a behavior or condition that affects the child's ability to function in a primary aspect of daily living including personal relations, living arrangements, work, school, and recreation, and a child who can benefit from:

(1) multiagency service coordination and wraparound services; or

(2) informal coordination of traditional mental health services provided on a temporary basis.

Children between the ages of 18 and 21 who meet these criteria may be included in the target population at the option of the local children's mental health collaborative.

Subd. 22. **THERAPEUTIC SUPPORT OF FOSTER CARE.** "Therapeutic support of foster care" has the definition provided in section 245.4871, subdivision 34.

Subd. 23. **WRAPAROUND SERVICES.** "Wraparound services" are alternative, flexible, coordinated, and highly individualized services that are based on a multiagency plan of care. These services are designed to build on the strengths and respond to the needs identified in the child's multiagency assessment and to improve the child's ability to function in the home, school, and

community. Wraparound services may include, but are not limited to, residential services, respite services, services that assist the child or family in enrolling in or participating in recreational activities, assistance in purchasing otherwise unavailable items or services important to maintain a specific child in the family, and services that assist the child to participate in more traditional services and programs.

Sec. 13. **[245.493] LOCAL LEVEL COORDINATION.**

Subdivision 1. **REQUIREMENTS TO QUALIFY AS A LOCAL CHILDREN'S MENTAL HEALTH COLLABORATIVE.** In order to qualify as a local children's mental health collaborative and be eligible to receive start-up funds, the representatives of the local system of care, or at a minimum one county, one school district or special education cooperative, and one mental health entity must agree to the following:

(1) to establish a local children's mental health collaborative and develop an integrated service system; and

(2) to commit resources to providing services through the local children's mental health collaborative.

Subd. 2. **GENERAL DUTIES OF THE LOCAL CHILDREN'S MENTAL HEALTH COLLABORATIVES.** Each local children's mental health collaborative must:

(1) identify a service delivery area and an initial target population within that service delivery area. The initial target population must be economically and culturally representative of children in the service delivery area to be served by the local children's mental health collaborative. The size of the initial target population must also be economically viable for the service delivery area;

(2) seek to maximize federal revenues available to serve children in the target population by designating local expenditures for mental health services that can be matched with federal dollars;

(3) in consultation with the local children's advisory council and the local coordinating council, if it is not the local children's mental health collaborative, design, develop, and ensure implementation of an integrated service system and develop interagency agreements necessary to implement the system;

(4) expand membership to include representatives of other services in the local system of care including prepaid health plans under contract with the commissioner of human services to serve the mental health needs of children and families;

(5) create or designate a management structure for fiscal and clinical responsibility and outcome evaluation;

(6) spend funds generated by the local children's mental health collaborative as required in sections 245.491 to 245.496; and

(7) explore methods and recommend changes needed at the state level to reduce duplication and promote coordination of services including the use of uniform forms for reporting, billing, and planning of services.

Sec. 14. **[245.4931] INTEGRATED LOCAL SERVICE SYSTEM.**

The integrated service system established by the local children's mental health collaborative must:

(1) include a process for communicating to agencies in the local system of care eligibility criteria for services received through the local children's mental health collaborative and a process for determining eligibility. The process shall place strong emphasis on outreach to families, respecting the family role in identifying children in need, and valuing families as partners;

(2) include measurable outcomes, timelines for evaluating progress, and mechanisms for quality assurance and appeals;

(3) involve the family, and where appropriate the individual child, in developing multiagency service plans to the extent required in sections 120.17, subdivision 3a; 245.4871, subdivision 21; 245.4881, subdivision 4; 253B.03, subdivision 7; 257.071, subdivision 1; and 260.191, subdivision 1e;

(4) meet all standards and provide all mental health services as required in sections 245.487 to 245.4888, and ensure that the services provided are culturally appropriate;

(5) spend funds generated by the local children's mental health collaborative as required in sections 245.491 to 245.496;

(6) encourage public-private partnerships to increase efficiency, reduce redundancy, and promote quality of care; and

(7) ensure that, if the county participant of the local children's mental health collaborative is also a provider of child welfare targeted case management as authorized by the 1993 legislature, then federal reimbursement received by the county for child welfare targeted case management provided to children served by the local children's mental health collaborative must be directed to the integrated fund.

Sec. 15. **[245.4932] REVENUE ENHANCEMENT; AUTHORITY AND RESPONSIBILITIES.**

Subdivision 1. **PROVIDER RESPONSIBILITIES.** The children's mental health collaborative shall have the following authority and responsibilities regarding federal revenue enhancement:

(1) the collaborative shall designate a lead county or other qualified entity as the fiscal agency for reporting, claiming, and receiving payments;

(2) the collaborative or lead county may enter into subcontracts with other counties, school districts, special education cooperatives, municipalities, and other public and nonprofit entities for purposes of identifying and claiming eligible expenditures to enhance federal reimbursement;

(3) the collaborative must continue the base level of expenditures for services for children with emotional or behavioral disturbances and their families from any state, county, federal, or other public or private funding source which, in the absence of the new federal reimbursement earned under sections 245.491 to 245.496, would have been available for those services. The base year for purposes of this subdivision shall be the accounting period closest to state fiscal year 1993;

(4) the collaborative or lead county must develop and maintain an accounting and financial management system adequate to support all claims for federal reimbursement, including a clear audit trail and any provisions specified in the contract;

(5) the collaborative shall pay the nonfederal share of the medical assistance costs for services designated by the collaborative;

(6) the lead county or other qualified entity may not use federal funds or local funds designated as matching for other federal funds to provide the nonfederal share of medical assistance.

Subd. 2. **COMMISSIONER'S RESPONSIBILITIES.** (1) Notwithstanding sections 256B.19, subdivision 1, and 256B.0625, the commissioner shall be required to amend the state medical assistance plan to include as covered services eligible for medical assistance reimbursement, those services eligible for reimbursement under federal law or waiver, which a collaborative elects to provide and for which the collaborative elects to pay the nonfederal share of the medical assistance costs.

(2) The commissioner may suspend, reduce, or terminate the federal reimbursement to a provider that does not meet the requirements of sections 245.493 to 245.496.

(3) The commissioner shall recover from the collaborative any federal fiscal disallowances or sanctions for audit exceptions directly attributable to the collaborative's actions or the proportional share if federal fiscal disallowances or sanctions are based on a statewide random sample.

Subd. 3. **PAYMENTS.** Notwithstanding section 256.025, subdivision 2, payments under sections 245.493 to 245.496 to providers for wraparound service expenditures and expenditures for other services for which the collaborative elects to pay the nonfederal share of medical assistance shall only be made of federal earnings from services provided under sections 245.493 to 245.496.

Subd. 4. **CENTRALIZED DISBURSEMENT OF MEDICAL ASSISTANCE PAYMENTS.** Notwithstanding section 256B.041, and except for family community support services and therapeutic support of foster care, county payments for the cost of wraparound services and other services for which the collaborative elects to pay the nonfederal share, for reimbursement under medical assistance, shall not be made to the state treasurer. For purposes of wraparound services under sections 245.493 to 245.496, the centralized disbursement of payments to providers under section 256B.041 consists only of federal earnings from services provided under sections 245.493 to 245.496.

Sec. 16. **[245.494] STATE LEVEL COORDINATION.**

Subdivision 1. **STATE COORDINATING COUNCIL.** The state coordinating council, in consultation with the integrated fund task force, shall:

(1) assist local children's mental health collaboratives in meeting the requirements of sections 245.491 to 245.496, by seeking consultation and technical assistance from national experts and coordinating presentations and assistance from these experts to local children's mental health collaboratives;

(2) assist local children's mental health collaboratives in identifying an economically viable initial target population;

(3) develop methods to reduce duplication and promote coordinated services including uniform forms for reporting, billing, and planning of services;

(4) by September 1, 1994, develop a model multiagency plan of care that can be used by local children's mental health collaboratives in place of an individual education plan, individual family community support plan, individual family support plan, and an individual treatment plan;

(5) assist in the implementation and operation of local children's mental health collaboratives by facilitating the integration of funds, coordination of services, and measurement of results, and by providing other assistance as needed;

(6) by July 1, 1993, develop a procedure for awarding start-up funds. Development of this procedure shall be exempt from chapter 14;

(7) develop procedures and provide technical assistance to allow local children's mental health collaboratives to integrate resources for children's mental health services with other resources available to serve children in the target population in order to maximize federal participation and improve efficiency of funding;

(8) ensure that local children's mental health collaboratives and the services received through these collaboratives meet the requirements set out in sections 245.491 to 245.496;

(9) identify base level funding from state and federal sources across systems;

(10) explore ways to access additional federal funds and enhance revenues available to address the needs of the target population;

(11) develop a mechanism for identifying the state share of funding for services to children in the target population and for making these funds available on a per capita basis for services provided through the local children's mental health collaborative to children in the target population. Each year beginning January 1, 1994, forecast the growth in the state share and increase funding for local children's mental health collaboratives accordingly;

(12) identify barriers to integrated service systems that arise from data practices and make recommendations including legislative changes needed in the data practices act to address these barriers; and

(13) annually review the expenditures of local children's mental health collaboratives to ensure that funding for services provided to the target population continues from sources other than the federal funds earned under sections 245.491 to 245.496 and that federal funds earned are spent consistent with sections 245.491 to 245.496.

Subd. 2. **STATE COORDINATING COUNCIL REPORT.** Each year, beginning February 1, 1995, the state coordinating council must submit a report to the legislature on the status of the local children's mental health collaboratives. The report must include the number of local children's mental health collaboratives, the amount and type of resources committed to local children's mental health collaboratives, the additional federal revenue received as a result of local children's mental health collaboratives, the services provided, the number of children served, outcome indicators, the identification of barriers to additional collaboratives and funding integration, and recommendations for further improving service coordination and funding integration.

Subd. 3. **DUTIES OF THE COMMISSIONER OF HUMAN SERVICES.**

The commissioner of human services, in consultation with the integrated fund task force, shall:

(1) beginning January 1, 1994, in areas where a local children's mental health collaborative has been established, based on an independent actuarial analysis, separate all medical assistance, general assistance medical care, and MinnesotaCare resources devoted to mental health services for children and their families including inpatient, outpatient, medication management, services under the rehabilitation option, and related physician services from the total health capitation from prepaid plans, including plans established under section 256B.69, for the target population as identified in section 245.492, subdivision 21, and develop guidelines for managing these mental health benefits that will require all contractors to:

(i) provide mental health services eligible for medical assistance reimbursement;

(ii) meet performance standards established by the commissioner of human services including providing services consistent with the requirements and standards set out in sections 245.487 to 245.4888 and 245.491 to 245.496;

(iii) provide the commissioner of human services with data consistent with that collected under sections 245.487 to 245.4888; and

(iv) in service delivery areas where there is a local children's mental health collaborative for the target population defined by local children's mental health collaborative:

(A) participate in the local children's mental health collaborative;

(B) commit resources to the integrated fund that are actuarially equivalent to resources received for the target population being served by local children's mental health collaboratives; and

(C) meet the requirements and the performance standards developed for local children's mental health collaboratives;

(2) ensure that any prepaid health plan that is operating within the jurisdiction of a local children's mental health collaborative and that is able to meet all the requirements under section 245.494, subdivision 3, paragraph (1), items (i) to (iv), shall have 60 days from the date of receipt of written notice of the establishment of the collaborative to decide whether it will participate in the local children's mental health collaborative; the prepaid health plan shall notify the collaborative and the commissioner of its decision to participate;

(3) develop a mechanism for integrating medical assistance resources for mental health service with resources for general assistance medical care, MinnesotaCare, and any other state and local resources available for services for children and develop a procedure for making these resources available for use by a local children's mental health collaborative;

(4) gather data needed to manage mental health care including evaluation data and data necessary to establish a separate capitation rate for children's mental health services if that option is selected;

(5) by January 1, 1994, develop a model contract for providers of mental health managed care that meets the requirements set out in sections 245.491 to 245.496 and 256B.69, and utilize this contract for all subsequent awards, and before January 1, 1995, the commissioner of human services shall not enter into or extend any contract for any prepaid plan that would impede the implementation of sections 245.491 to 245.496;

(6) develop revenue enhancement or rebate mechanisms and procedures to certify expenditures made through local children's mental health collaboratives for services including administration and outreach that may be eligible for federal financial participation under medical assistance, including expenses for administration, and other federal programs;

(7) ensure that new contracts and extensions or modifications to existing contracts under section 256B.69 do not impede implementation of sections 245.491 to 245.496;

(8) provide technical assistance to help local children's mental health collaboratives certify local expenditures for federal financial participation, using due diligence in order to meet implementation timelines for sections 245.491 to 245.496 and recommend necessary legislation to enhance federal revenue, provide clinical and management flexibility, and otherwise meet the goals of local children's mental health collaboratives and request necessary state plan amendments to maximize the availability of medical assistance for activities undertaken by the local children's mental health collaborative;

(9) take all steps necessary to secure medical assistance reimbursement under the rehabilitation option for family community support services and therapeutic support of foster care, and for residential treatment and wraparound services when these services are provided through a local children's mental health collaborative;

(10) provide a mechanism to identify separately the reimbursement to a county for child welfare targeted case management provided to children served by the local collaborative for purposes of subsequent transfer by the county to the integrated fund; and

(11) where interested and qualified contractors are available, finalize contracts within 180 days of receipt of written notification of the establishment of a local children's mental health collaborative.

Subd. 4. **RULEMAKING.** The commissioners of human services, health, and corrections, and the state board of education shall adopt or amend rules as necessary to implement sections 245.491 to 245.496.

Subd. 5. **RULE MODIFICATION.** By January 15, 1994, the commissioner shall report to the legislature the extent to which claims for federal reimbursement for case management as set out in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, as they pertain to mental health case management are consistent with the number of children eligible to receive this service. The report shall also identify how the commissioner intends to increase the numbers of eligible children receiving this service, including recommendations for modifying rules or statutes to improve access to this service and to reduce barriers to its provision.

In developing these recommendations, the commissioner shall:

(1) review experience and consider alternatives to the reporting and claiming requirements, such as the rate of reimbursement, the claiming unit of time, and documenting and reporting procedures set out in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, as they pertain to mental health case management;

(2) consider experience gained from implementation of child welfare targeted case management;

(3) determine how to adjust the reimbursement rate to reflect reductions in caseload size;

(4) determine how to ensure that provision of targeted child welfare case management does not preclude an eligible child's right, or limit access, to case management services for children with severe emotional disturbance as set out in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, as they pertain to mental health case management;

(5) determine how to include cost and time data collection for contracted providers for rate setting, claims, and reimbursement purposes;

(6) evaluate the need for cost control measures where there is no county share; and

(7) determine how multiagency teams may share the reimbursement.

The commissioner shall conduct a study of the cost of county staff providing case management services under Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, as they pertain to mental health case management. If the average cost of providing case management services to children with severe emotional disturbance is determined by the commissioner to be greater than the average cost of providing child welfare targeted case management, the commissioner shall ensure that a higher reimbursement rate is provided for case management services under Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, to children with severe emotional disturbance. The total medical assistance funds expended for this service in the biennium ending in state fiscal year 1995 shall not exceed the amount projected in the state Medicaid forecast for case management for children with serious emotional disturbances.

Sec. 17. **[245.495] ADDITIONAL FEDERAL REVENUES.**

(a) Each local children's mental health collaborative shall report expenditures eligible for federal reimbursement in a manner prescribed by the commissioner of human services under section 256.01, subdivision 2, clause (17). The commissioner of human services shall pay all funds earned by each local children's mental health collaborative to the collaborative. Each local children's mental health collaborative must use these funds to expand the initial target population or to develop or provide mental health services through the local integrated service system to children in the target population. Funds may not be used to supplant funding for services to children in the target population.

For purposes of this section, "mental health services" are community-based, nonresidential services, which may include respite care, that are identified in the child's multiagency plan of care.

(b) The commissioner may 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 set-aside must not exceed five percent of the federal reimbursement earned by collaboratives and repayment is limited to:

(1) the costs of developing and implementing sections 245.491 to 245.496, including the costs of technical assistance from the departments of human services, education, health, and corrections to implement the children's mental health integrated fund;

(2) programming the information systems; and

(3) any lost federal revenue for the central office claim directly caused by the implementation of these sections.

(c) Any unexpended funds from the set-aside described in paragraph (b) shall be distributed to counties according to section 245.496, subdivision 2.

Sec. 18. **[245.496] IMPLEMENTATION.**

Subdivision 1. **APPLICATIONS FOR START-UP FUNDS FOR LOCAL CHILDREN'S MENTAL HEALTH COLLABORATIVES.** By July 1, 1993, the commissioner of human services shall publish the procedures for awarding start-up funds. Applications for local children's mental health collaboratives shall be obtained through the commissioner of human services and submitted to the state coordinating council. The application must state the amount of start-up funds requested by the local children's mental health collaborative and how the local children's mental health collaborative intends on using these funds.

Subd. 2. **DISTRIBUTION OF START-UP FUNDS.** By October 1, 1993, the state coordinating council must ensure distribution of start-up funds to local children's mental health collaboratives that meet the requirements established in section 245.493 and whose applications have been approved by the council. The remaining appropriation for start-up funds shall be distributed by February 1, 1994. If the number of applications received exceed the number of local children's mental health collaboratives that can be funded, the funds must be geographically distributed across the state and balanced between the seven county metro area and the rest of the state. Preference must be given to collaboratives that include the juvenile court and correctional systems, multiple school districts, or other multiple government entities from the local system of care. In rural areas, preference must also be given to local children's mental health collaboratives that include multiple counties.

Subd. 3. **SUBMISSION AND APPROVAL OF LOCAL COLLABORATIVE PROPOSALS FOR INTEGRATED SYSTEMS.** By December 31, 1994, a local children's mental health collaborative that received start-up funds must submit to the state coordinating council its proposal for creating and funding an integrated service system for children in the target population. Within 60 days

of receiving the local collaborative proposal the state coordinating council must review the proposal and notify the local children's mental health collaborative as to whether or not the proposal has been approved. If the proposal is not approved, the state coordinating council must indicate changes needed to receive approval.

Sec. 19. Minnesota Statutes 1992, section 245.652, subdivision 1, is amended to read:

Subdivision 1. **PURPOSE.** The regional treatment centers shall provide services designed to end a person's reliance on chemical use or a person's chemical abuse and increase effective and chemical-free functioning. Clinically effective programs must be provided in accordance with section 246.64. Services may be offered on the regional center campus or at sites elsewhere in the catchment area served by the regional treatment center.

Sec. 20. Minnesota Statutes 1992, section 245.652, subdivision 4, is amended to read:

Subd. 4. **SYSTEM LOCATIONS.** Programs shall be located in Anoka, Brainerd, Fergus Falls, ~~Moose Lake,~~ St. Peter, and Willmar and may be offered at other selected sites.

Sec. 21. Minnesota Statutes 1992, section 245.73, subdivision 2, is amended to read:

Subd. 2. **APPLICATION; CRITERIA.** County boards may submit an application and budget for use of the money in the form specified by the commissioner. The commissioner shall make grants only to counties whose applications and budgets are approved by the commissioner for residential programs for adults with mental illness to meet licensing requirements pursuant to sections 245A.01 to 245A.16. ~~State funds received by a county pursuant to this section shall be used only for direct service costs. Both direct service and other costs, including but not limited to renovation, construction or rent of buildings, purchase or lease of vehicles or equipment as required for licensure as a residential program for adults with mental illness under sections 245A.01 to 245A.16, may be paid out of the matching funds required under subdivision 3. Neither the state funds nor the matching funds~~ These grants shall not be used for room and board costs. For calendar year 1994 and subsequent years, the commissioner shall allocate the money appropriated under this section on a calendar year basis.

Sec. 22. Minnesota Statutes 1992, section 245.73, subdivision 3, is amended to read:

Subd. 3. **FORMULA.** Grants made pursuant to this section shall finance 75 to 100 percent of the county's costs of expanding or providing services for adult mentally ill persons in residential facilities as provided in subdivision 2.

Sec. 23. Minnesota Statutes 1992, section 245.73, is amended by adding a subdivision to read:

Subd. 5. **TRANSFER OF FUNDS.** The commissioner may transfer money from adult mental health residential program grants to community support program grants under section 256E.12 if the county requests such a transfer and if the commissioner determines the transfer will help adults with mental illness to remain and function in their own communities. The commissioner shall consider past utilization of the residential program in determining which counties to include in the transferred fund.

Sec. 24. Minnesota Statutes 1992, section 246.0135, is amended to read:

246.0135 **OPERATION OF REGIONAL TREATMENT CENTERS.**

(a) The commissioner of human services is prohibited from closing any regional treatment center or state-operated nursing home or any program at any of the regional treatment centers or state-operated nursing homes, without specific legislative authorization. For persons with mental retardation or related conditions who move from one regional treatment center to another regional treatment center, the provisions of section 256B.092, subdivision 10, must be followed for both the discharge from one regional treatment center and admission to another regional treatment center, except that the move is not subject to the consensus requirement of section 256B.092, subdivision 10, paragraph (b).

(b) Prior to closing or downsizing a regional treatment center, the commissioner of human services shall be responsible for assuring that community-based alternatives developed in response are adequate to meet the program needs identified by each county within the catchment area and do not require additional local county property tax expenditures.

(c) The nonfederal share of the cost of alternative treatment or care developed as the result of the closure of a regional treatment center, including costs associated with fulfillment of responsibilities under chapter 253B shall be paid from state funds appropriated for purposes specified in section 246.013.

(d) Counties in the catchment area of a regional treatment center which has been closed or downsized may not at any time be required to pay a greater cost of care for alternative care and treatment than the county share set by the commissioner for the cost of care provided by regional treatment centers.

(e) The commissioner may not divert state funds used for providing for care or treatment of persons residing in a regional treatment center for purposes unrelated to the care and treatment of such persons.

Sec. 25. Minnesota Statutes 1992, section 246.02, subdivision 2, is amended to read:

Subd. 2. The commissioner of human services shall act with the advice of

the medical policy directional committee on mental health in the appointment and removal of the chief executive officers of the following institutions: Anoka-Metro Regional Treatment Center, Ah-Gwah-Ching Center, Fergus Falls Regional Treatment Center, ~~Moose Lake Regional Treatment Center, Oak Terrace Nursing Home, Rochester State Hospital,~~ St. Peter Regional Treatment Center and Minnesota Security Hospital, Willmar Regional Treatment Center, Faribault Regional Center, Cambridge Regional Human Services Center, ~~and~~ Brainerd Regional Human Services Center, and until June 30, 1995, Moose Lake Regional Treatment Center, and after June 30, 1995, Minnesota Psychopathic Personality Treatment Center.

Sec. 26. Minnesota Statutes 1992, section 246.151, subdivision 1, is amended to read:

Subdivision 1. **COMPENSATION.** Notwithstanding any law to the contrary, the commissioners of human services and veterans affairs are authorized to provide for the payment to patients or residents of state institutions under their management and control of such pecuniary compensation as ~~they may deem proper,~~ required by the United States Department of Labor. Payment of subminimum wages shall meet all requirements of United States Department of Labor Regulations, Code of Federal Regulations, title 29, part 525. The amount of compensation ~~to depend~~ depends upon the quality and character of the work performed as determined by the commissioner and the chief executive officer~~, but in no case less than 25 percent of the minimum wage established~~ pursuant to section 177.24.

Sec. 27. **[246B.01] MINNESOTA PSYCHOPATHIC PERSONALITY TREATMENT CENTER; DEFINITIONS.**

Subdivision 1. **APPLICABILITY.** The definitions in this section apply to this chapter.

Subd. 2. **COMMISSIONER.** "Commissioner" means the commissioner of human services or the commissioner's designee.

Subd. 3. **PSYCHOPATHIC PERSONALITY.** "Psychopathic personality" has the meaning given in section 526.09.

Sec. 28. **[246B.02] ESTABLISHMENT OF MINNESOTA PSYCHOPATHIC PERSONALITY TREATMENT CENTER.**

The commissioner of human services shall establish and maintain a secure facility located in Moose Lake. The facility shall be known as the Minnesota Psychopathic Personality Treatment Center. The facility shall provide care and treatment to 100 persons committed by the courts as psychopathic personalities, or persons admitted there with the consent of the commissioner of human services.

Sec. 29. **[246B.03] LICENSURE.**

The commissioner of human services shall apply to the commissioner of health to license the Minnesota Psychopathic Personality Treatment Center as a supervised living facility with applicable program licensing standards.

Sec. 30. **[246B.04] RULES; EVALUATION.**

The commissioner of human services shall adopt rules to govern the operation, maintenance, and licensure of the program established at the Minnesota Psychopathic Personality Treatment Center for persons committed as a psychopathic personality. The commissioner shall establish an evaluation process to measure outcomes and behavioral changes as a result of treatment compared with incarceration without treatment, to determine the value, if any, of treatment in protecting the public.

Sec. 31. Minnesota Statutes 1992, section 252.025, subdivision 4, is amended to read:

Subd. 4. **STATE-PROVIDED SERVICES.** (a) It is the policy of the state to capitalize and recapitalize the regional treatment centers as necessary to prevent depreciation and obsolescence of physical facilities and to ensure they retain the physical capability to provide residential programs. Consistent with that policy and with section 252.50, and within the limits of appropriations made available for this purpose, the commissioner may establish, by June 30, 1991, the following state-operated, community-based programs for the least vulnerable regional treatment center residents: at Brainerd regional services center, two residential programs and two day programs; at Cambridge regional treatment center, four residential programs and two day programs; at Faribault regional treatment center, ten residential programs and six day programs; at Fergus Falls regional treatment center, two residential programs and one day program; at Moose Lake regional treatment center, four residential programs and two day programs; and at Willmar regional treatment center, two residential programs and one day program.

(b) By January 15, 1991, the commissioner shall report to the legislature a plan to provide continued regional treatment center capacity and state-operated, community-based residential and day programs for persons with developmental disabilities at Brainerd, Cambridge, Faribault, Fergus Falls, ~~Moose Lake,~~ St. Peter, and Willmar, as follows:

(1) by July 1, 1998, continued regional treatment center capacity to serve 350 persons with developmental disabilities as follows: at Brainerd, 80 persons; at Cambridge, 12 persons; at Faribault, 110 persons; at Fergus Falls, 60 persons; ~~at Moose Lake, 12 persons;~~ at St. Peter, 35 persons; at Willmar, 25 persons; and up to 16 crisis beds in the Twin Cities metropolitan area; and

(2) by July 1, 1999, continued regional treatment center capacity to serve

254 persons with developmental disabilities as follows: at Brainerd, 57 persons; at Cambridge, 12 persons; at Faribault, 80 persons; at Fergus Falls, 35 persons; ~~at Moose Lake, 12 persons;~~ at St. Peter, 30 persons; at Willmar, 12 persons, and up to 16 crisis beds in the Twin Cities metropolitan area. In addition, the plan shall provide for the capacity to provide residential services to 570 persons with developmental disabilities in 95 state-operated, community-based residential programs.

The commissioner is subject to a mandamus action under chapter 586 for any failure to comply with the provisions of this subdivision.

Sec. 32. Minnesota Statutes 1992, section 252.025, is amended by adding a subdivision to read:

Subd. 5. **SERVICES FOR DEVELOPMENTALLY DISABLED PERSONS: MOOSE LAKE REGIONAL TREATMENT CENTER CATCHMENT AREA.** Notwithstanding subdivision 4, the commissioner shall develop in the Moose Lake regional treatment center catchment area for persons with developmental disabilities at least 12 beds in state-operated waivered homes, eight state-operated crisis beds, one state-operated day training and habilitation facility, and 21 beds in other community settings. These services must be established by October 1, 1993, to serve persons relocated from the Moose Lake regional treatment center.

These services shall be in addition to any state-operated, community services and day treatment centers in operation in the Moose Lake catchment area during state fiscal year 1993.

Sec. 33. Minnesota Statutes 1992, section 252.025, is amended by adding a subdivision to read:

Subd. 6. **DEVELOPMENT OF STATE-OPERATED SERVICES.** Notwithstanding subdivision 4, during the biennium ending June 30, 1995, the commissioner shall establish the following services for persons with developmental disabilities:

(1) by June 30, 1994, eight state-operated, community-based waivered homes located anywhere in the state for 32 persons and two state-operated day training and habilitation facilities for persons leaving regional treatment centers as a result of downsizing;

(2) by June 30, 1994, 16 state-operated, community-based waivered homes at Faribault for 64 persons, four state-operated day training and habilitation facilities, and 38 beds in community settings for persons leaving the Faribault regional treatment center;

(3) by June 30, 1995, 78 beds in private community settings for persons leaving the Faribault regional treatment center;

(4) by June 30, 1995, eight state-operated crisis beds in the Faribault regional treatment center catchment area;

(5) by June 30, 1994, private community-based beds located anywhere in the state to achieve a net reduction of 93 persons leaving regional treatment centers as a result of downsizing; and

(6) by June 30, 1995, nine state-operated waivered homes for 36 persons and two state-operated day training and habilitation facilities for persons leaving regional treatment centers as a result of downsizing, and sufficient beds in private community settings to achieve a net reduction of 84 beds in regional treatment centers.

Sec. 34. Minnesota Statutes 1992, section 252.50, is amended by adding a subdivision to read:

Subd. 2a. **USE OF ENHANCED WAIVERED SERVICES FUNDS.** The commissioner may, within the limits of appropriations made available for this purpose, use enhanced waivered services funds under the home- and community-based waiver for persons with mental retardation or related conditions to move to state-operated community programs and to private facilities.

Sec. 35. Minnesota Statutes 1992, section 253.015, subdivision 1, is amended to read:

Subdivision 1. **STATE HOSPITALS FOR PERSONS WITH MENTAL ILLNESS.** The state hospitals located at Anoka, Brainerd, Fergus Falls, ~~Moose Lake,~~ St. Peter, ~~and~~ Willmar, and Moose Lake until June 30, 1995, shall constitute the state hospitals for persons with mental illness, and shall be maintained under the general management of the commissioner of human services. The commissioner of human services shall determine to what state hospital persons with mental illness shall be committed from each county and notify the probate judge thereof, and of changes made from time to time. The chief executive officer of each hospital for persons with mental illness shall be known as the chief executive officer.

Sec. 36. Minnesota Statutes 1992, section 253.015, is amended by adding a subdivision to read:

Subd. 3. **SERVICES FOR PERSONS WITH MENTAL ILLNESS FROM MOOSE LAKE REGIONAL TREATMENT CENTER.** (a) The commissioner shall develop the following services in the Moose Lake catchment area for patients with mental illness relocated from the Moose Lake regional treatment center and must promote a mix of state-operated and private services to include the following:

(1) by September 1, 1994, services in community nursing facilities for 45 patients with mental illness;

(2) by December 1, 1994, 24 state-operated community service slots, which may be a combination of residential and crisis services, designed to serve persons with mental illness and at least 75 percent of these state-operated community service slots shall be residential services;

(3) by December 1, 1994, 16 service slots in other community settings; and

(4) by December 1, 1994, 25 inpatient psychiatric beds in community hospitals for adult patients who are acutely ill, particularly those under judicial commitment.

(b) By October 1, 1994, 15 inpatient acute care state-operated psychiatric beds in the Moose Lake catchment area;

(c) By July 1, 1995, the commissioner shall establish 60 beds at Brainerd regional human services center to serve persons with mental illness being relocated from the Moose Lake regional treatment center.

Sec. 37. Minnesota Statutes 1992, section 253.015, is amended by adding a subdivision to read:

Subd. 4. **SERVICES FOR PERSONS WITH TRAUMATIC BRAIN INJURY.** By June 30, 1994, the commissioner shall develop 15 beds at Brainerd regional human services center for persons with traumatic brain injury, including patients relocated from the Moose Lake regional treatment center.

Sec. 38. Minnesota Statutes 1992, section 253.202, is amended to read:

253.202 **MANAGEMENT.**

Notwithstanding the provisions of section 253.201, or any other law to the contrary, the Minnesota Security Hospital shall be under the administrative management of a hospital administrator, to be appointed by the commissioner of human services, who shall be a graduate of an accredited college giving a course leading to a degree in hospital administration, and the commissioner of human services, by rule, shall designate such colleges which in the commissioner's opinion give an accredited course in hospital administration. ~~The administrative management of the Minnesota Security Hospital shall not continue under the management of the superintendent of the St. Peter regional treatment center.~~ In addition to a hospital administrator, the commissioner of human services may appoint a licensed doctor of medicine as chief of the medical staff and the doctor shall be in charge of all medical care, treatment, rehabilitation, and research. This section is effective on July 1, 1963.

Sec. 39. Minnesota Statutes 1992, section 254.04, is amended to read:

254.04 **TREATMENT OF ~~INEBRIATES~~ CHEMICALLY DEPENDENT PERSONS.**

The commissioner of human services is hereby authorized to continue the treatment of ~~inebriates~~ chemically dependent persons at ~~the state hospital farm for inebriates~~ Ah-Gwah-Ching and at the regional treatment centers located at Anoka, Brainerd, Fergus Falls, Moose Lake, St. Peter, and Willmar ~~as now provided by law, and in addition thereto the commissioner is authorized to provide for the treatment of inebriates at the Moose Lake regional treatment center, but no inebriate shall be committed for treatment to either facility except as may be authorized and permitted by the commissioner of human services~~. During the year ending June 30, 1994, the commissioner shall relocate, in the catchment area served by the Moose Lake regional treatment center, two state-operated off-campus programs designed to serve patients who are relocated from the Moose Lake regional treatment center. One program shall be a 35-bed program for women who are chemically dependent; the other shall be a 25-bed program for men who are chemically dependent. The facility space housing the Liberalis chemical dependency program (building C-35) and the men's chemical dependency program (4th floor main) may not be vacated until suitable off-campus space for the women's chemical dependency program of 35 beds and the men's chemical dependency program of 25 beds is located and clients and staff are relocated.

Sec. 40. Minnesota Statutes 1992, section 254.05, is amended to read:

254.05 **DESIGNATION OF STATE HOSPITALS.**

The state hospital ~~for the insane~~ located at Anoka shall hereafter be known and designated as the Anoka-metro regional treatment center; ~~the state hospital for the insane located at Hastings shall hereafter be known and designated as the Hastings state hospital;~~ the state hospital ~~for the insane and the hospital farm for inebriates~~ located at Willmar shall hereafter be known and designated as the Willmar regional treatment center; until June 30, 1995, the state hospital ~~for the insane~~ located at Moose Lake shall ~~hereafter~~ be known and designated as the Moose Lake regional treatment center; after June 30, 1995, the newly established state facility at Moose Lake shall be known and designated as the Minnesota psychopathic personality treatment center; the state hospital ~~for the insane~~ located at Fergus Falls shall hereafter be known and designated as the Fergus Falls regional treatment center; ~~the state hospital for the insane located at Rochester shall hereafter be known and designated as the Rochester state hospital;~~ and the state hospital ~~for the insane~~ located at St. Peter shall hereafter be known and designated as the St. Peter regional treatment center. Each of the foregoing state hospitals shall also be known by the name of regional center at the discretion of the commissioner of human services. The terms "human services" or "treatment" may be included in the designation.

Sec. 41. Minnesota Statutes 1992, section 256B.0625, subdivision 20, is amended to read:

Subd. 20. **MENTAL ILLNESS 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 or subject to federal approval, children with severe emotional disturbance. 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 subpart 6.

(b) In counties where fewer than 50 percent of children estimated to be eligible under medical assistance to receive case management services for children with severe emotional disturbance actually receive these services in state fiscal year 1995, community mental health centers serving those counties, entities meeting program standards in Minnesota Rules, parts 9520.0570 to 9520.0870, and other entities authorized by the commissioner 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 subpart 6.

Sec. 42. Minnesota Statutes 1992, section 256B.0625, is amended by adding a subdivision to read:

Subd. 36. **FAMILY COMMUNITY SUPPORT SERVICES.** Medical assistance covers family community support services as defined in section 245.4871, subdivision 17.

Sec. 43. Minnesota Statutes 1992, section 256B.0625, is amended by adding a subdivision to read:

Subd. 37. **THERAPEUTIC SUPPORT OF FOSTER CARE.** Medical assistance covers therapeutic support of foster care as defined in section 245.4871, subdivision 34.

Sec. 44. Minnesota Statutes 1992, section 256B.0625, is amended by adding a subdivision to read:

Subd. 38. **WRAPAROUND SERVICES.** Medical assistance covers wraparound services as defined in section 245.492, subdivision 20, that are provided through a local children's mental health collaborative, as that entity is defined in section 245.492, subdivision 11.

Sec. 45. Laws 1991, chapter 292, article 6, section 54, is amended to read:

Sec. 54. **RULE REVISION.**

The commissioner must revise Minnesota Rules, parts 9545.0900 to 9545.1090, which govern facilities that provide residential services for children with emotional handicaps. The rule revisions must be adopted ~~within 12 months of the effective date of this section~~ by January 1, 1994.

Sec. 46. Laws 1991, chapter 292, article 6, section 57, subdivision 1, is amended to read:

Subdivision 1. **STATEWIDE TASK FORCE.** The commissioner of human services shall convene a task force to study the feasibility of establishing an integrated children's mental health fund. The task force shall consist of mental health professionals, county social services personnel, service providers, advocates, and parents of children who have experienced episodes of emotional disturbance. The task force shall also include representatives of the children's mental health subcommittee of the state advisory council and local coordinating councils established under Minnesota Statutes, sections 245.487 to 245.4887. The task force shall include the commissioners of education, health, and human services; two members of the senate; and two members of the house of representatives. The task force shall examine all possible county, state, and federal sources of funds for children's mental health with a view to designing an integrated children's mental health fund, improving methods of coordinating and maximizing all funding sources, and increasing federal funding. Programs to be examined shall include, but not be limited to, the following: medical assistance, title IV-E of the social security act, title XX social service programs, chemical dependency programs, education and special education programs, and, for children with a dual diagnosis, programs for the developmentally disabled. The task force may consult with experts in the field, as necessary. ~~The task force shall make a preliminary report and recommendations on local coordination of funding sources by January 1, 1992, to facilitate the development of local protocols and procedures under subdivision 2. The task force shall submit a final report to the legislature by January 1, 1993, with its findings and recommendations.~~ By January 1, 1994, the task force shall provide a report to the legislature with recommendations of the task force for promoting integrated funding and services for children's mental health. The report must include the following recommendations: (1) how to phase in all delivery systems, including the juvenile court and correctional systems; (2) how to expand the initial target population so that the state eventually has a statewide integrated children's mental health service system that integrates funding regardless of source for children with emotional or behavioral disturbances or those at risk of suffering such disturbances; (3) proposed outcome measures for local children's mental health collaboratives; and (4) any necessary legislative changes in the data practices act.

The task force shall continue through June 30, 1995, and shall advise and assist the state coordinating council and local children's mental health collaboratives as required in Minnesota Statutes, sections 245.491 to 245.496.

Sec. 47. Laws 1991, chapter 292, article 6, section 57, subdivision 3, is amended to read:

Subd. 3. ~~FINAL~~ **REPORT.** By February 15, 1993, the commissioner of human services shall provide a report to the legislature that describes the reports and recommendations of the statewide task force under subdivision 1 and of the

local coordinating councils under subdivision 2, and provides the commissioner's recommendations for legislation or other needed changes.

Sec. 48. **ADULT MENTAL HEALTH SERVICES AND FUNDING.**

Subdivision 1. **STATEWIDE TASK FORCE.** The commissioner of human services shall convene a task force to study and make recommendations concerning adult mental health services and funding. The task force shall consist of the commissioners of health, jobs and training, corrections, and commerce, the director of the housing finance agency, two members of the house of representatives, and two members of the senate. The task force shall also include persons diagnosed with mental illness, family members of persons diagnosed with mental illness, mental health professionals, county social services personnel, public and private service providers, advocates for persons with mental illness, and representatives of the state advisory council established under Minnesota Statutes, section 245.697, and of the local advisory council established under Minnesota Statutes, section 245.466, subdivision 5. The task force must also include public employee representatives from each of the state regional treatment centers that treat adults with mental illness, the division of rehabilitative services, and county public employee bargaining units whose members serve adults with mental illness. Public employee representatives must be selected by their exclusive representatives. The commissioner of human services shall contract with a facilitator-mediator chosen by agreement of the members of the task force. The task force shall examine all possible county, state, and federal sources of funds for adult mental health with a view to improving methods of coordinating services and maximizing all funding sources and community support services, and increasing federal funding. Programs to be examined shall include, but not be limited to, the following: medical assistance, title XX social services programs, jobs and training programs, corrections programs, and housing programs. The task force may consult with experts in the field, as necessary. The task force shall make a preliminary report and recommendations on coordination of services and funding sources by January 1, 1994, to facilitate the development of local protocols and procedures under subdivision 2. The task force shall submit a final report to the legislature by January 1, 1995, with its findings and recommendations. Once this report has been submitted, the task force will expire.

Subd. 2. **DEVELOPMENT OF LOCAL PROTOCOLS AND PROCEDURES.** (a) By January 1, 1994, each local adult mental health advisory council established under Minnesota Statutes, section 245.466, subdivision 5, may establish a task force to develop recommended protocols and procedures that will ensure that the planning, case management, and delivery of services for adults with severe mental illness are coordinated and make the most efficient and effective use of available funding. The task force must include, at a minimum, representatives of county medical assistance and mental health staff and representatives of state and county public employee bargaining units. The protocols and procedures must be designed to:

(1) ensure that services to adults are adequately funded to meet the adult's needs;

(2) ensure that planning for services, case management, service delivery, and payment for services involves coordination of all affected agencies, providers, and funding sources; and

(3) maximize available funding by making full use of all available funding, including medical assistance.

(b) By June 1, 1994, each council may make recommendations to the statewide task force established under subdivision 1 regarding the feasibility and desirability of existing or proposed methods of service delivery and funding sources to ensure that services are tailored to the specific needs of each adult and to allow where feasible greater flexibility in paying for services.

(c) By June 1, 1994, each local advisory council may report to the commissioner of human services the council's findings and the recommended protocols and procedures. The council may also recommend legislative changes or rule changes that will improve local coordination and further maximize available funding.

Subd. 3. **FINAL REPORT.** By February 15, 1995, the commissioner of human services shall provide a report to the legislature that describes the reports and recommendations of the statewide task force under subdivision 1 and of the local advisory councils under subdivision 2, and provides the commissioner's recommendations for legislation or other needed changes.

Sec. 49. **MENTAL HEALTH SERVICES DELIVERY SYSTEM PILOT PROJECT IN DAKOTA COUNTY.**

Subdivision 1. **AUTHORIZATION FOR CONTINUATION OF PILOT PROJECT.** (a) The previously authorized mental health services delivery system pilot project in Dakota county shall be continued for a two-year period commencing on July 1, 1993, and ending on June 30, 1995.

(b) Dakota county shall receive a grant from the department of human services in the amount of $50,000 per year to pay related expenses associated with the pilot project during fiscal years 1994 and 1995.

Subd. 2. **AUTHORIZATION FOR INTEGRATED FUNDING OF STATE-SUPPORTED MENTAL HEALTH SERVICES.** (a) The commissioner of human services shall establish an adult mental health services integrated fund for Dakota county to permit flexibility in expenditures based on local needs with local control.

(b) The revenues and expenditures included in the integrated fund shall be as follows:

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

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

(3) Anoka alternatives grant funds;

(4) housing support services grant funds;

(5) OBRA grant funds; and

(6) crisis foster homes grant funds.

(c) As part of the pilot project, Dakota county may study the feasibility of adding medical assistance, general assistance, general assistance medical care, and Minnesota supplemental aid to the integrated fund. The commissioner of human services, with the express consent of the Dakota county board of commissioners, may add medical assistance, general assistance, general assistance medical care, and Minnesota supplemental aid to the integrated fund.

(d) Dakota county must provide the commissioner of human services with timely and pertinent information about the county's adult mental health service delivery system through the following methods:

(1) submission of community social services act plans and plan amendments;

(2) submission of social service expenditure and grant reconciliation reports, based on a coding format to be determined by mutual agreement between the county and the commissioner;

(3) compliance with the community mental health reporting system and with other state reporting systems necessary for the production of comprehensive statewide information;

(4) submission of the data on clients, services, costs, providers, human resources, and outcomes that the state needs in order to compile information on a statewide basis; and

(5) participation in semiannual meetings convened by the commissioner for the purpose of reviewing Dakota county's adult mental health program and assessing the impact of integrated funding.

(e) The commissioner of human services shall waive or modify any administrative rules, regulations, or guidelines which are incompatible with the implementation of the integrated fund.

(f) The integrated fund may be subject to the following conditions and understandings.

(1) Dakota county may apply for any new or expanded mental health service funds which may become available in the future, on an equal basis with other counties.

(2) The integrated fund may be adjusted at least biennially to reflect any increase in the population of Dakota county, using a method to be determined by mutual agreement between the county and the commissioner of human services.

(3) If the level of state funding for mental health services in other counties is adjusted upward or downward, an adjustment at the equivalent rate shall be made to Dakota county's integrated fund, to the extent that the adjustment made elsewhere applies to the revenue and expenditure categories included in the integrated fund.

(4) Payments to Dakota county for the integrated fund shall be made in 12 equal installments per year at the beginning of each month, or by another method to be determined by mutual agreement between the county and the commissioner of human services.

(5) The commissioner of human services shall exempt Dakota county from fiscal and other sanctions for noncompliance with any requirements in state rules, regulations, or guidelines which are incompatible with the implementation of the integrated fund.

(6) The integrated fund may be discontinued for any reason by the Dakota county board of commissioners or the commissioner of human services, after 90 days' written notice to the other party.

(7) If the integrated fund is discontinued, any expenses incurred by Dakota county in order to resume full compliance with state rules, regulations, and guidelines, shall be covered by the state, to the extent allowed by rules and appropriation funding.

(8) The integrated fund shall be established on July 1, 1993, or later by mutual agreement between the county and the commissioner of human services.

(9) If any of the revenues included in the integrated fund are federal in origin, any federal requirements for the use and reporting of those funds shall remain in force, unless such requirements are waived or modified by the appropriate federal agency.

Sec. 50. **REPEALER, COUNTY GRANTS, FEDERAL BLOCK GRANTS.**

Minnesota Statutes 1992, sections 245.711 and 245.712, are repealed.

Sec. 51. **EFFECTIVE DATES.**

Subdivision 1. Section 49 is effective July 1, 1993.

Subd. 2. Section 10 is effective July 1, 1993.

Subd. 3. Sections 16, subdivision 1, clause (6), and 18, subdivision 1, are effective the day following final enactment.

Subd. 4. Section 41, paragraph (b), is effective October 1, 1995.

Subd. 5. Sections 42 and 43 are effective October 1, 1994.

Subd. 6. Section 44 is effective January 1, 1994.

ARTICLE 8

GROUP RESIDENTIAL HOUSING

Section 1. Minnesota Statutes 1992, section 256.025, subdivision 1, is amended to read:

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

(b) "Base amount" means the calendar year 1990 county share of county agency expenditures for all of the programs specified in subdivision 2, except for the programs in subdivision 2, clauses (4), (7), and (13). The 1990 base amount for subdivision 2, clause (4), shall be reduced by one-seventh for each county, and the 1990 base amount for subdivision 2, clause (7) shall be reduced by seven-tenths for each county, and those amounts in total shall be the 1990 base amount for group residential housing in subdivision 2, clause (13).

(c) "County agency expenditure" means the total expenditure or cost incurred by the county of financial responsibility for the benefits and services for each of the programs specified in subdivision 2. The term includes the federal, state, and county share of costs for programs in which there is federal financial participation. For programs in which there is no federal financial participation, the term includes the state and county share of costs. The term excludes county administrative costs, unless otherwise specified.

(d) "Nonfederal share" means the sum of state and county shares of costs of the programs specified in subdivision 2.

(e) The "county share of county agency expenditures growth amount" is the amount by which the county share of county agency expenditures in calendar years 1991 to 2000 has increased over the base amount.

Sec. 2. Minnesota Statutes 1992, section 256.025, subdivision 2, is amended to read:

Subd. 2. **COVERED PROGRAMS AND SERVICES.** The procedures in this section govern payment of county agency expenditures for benefits and services distributed under the following programs:

(1) aid to families with dependent children under sections 256.82, subdivision 1, and 256.935, subdivision 1;

(2) medical assistance under sections 256B.041, subdivision 5, and 256B.19, subdivision 1;

(3) general assistance medical care under section 256D.03, subdivision 6;

(4) general assistance under section 256D.03, subdivision 2;

(5) work readiness under section 256D.03, subdivision 2;

(6) emergency assistance under section 256.871, subdivision 6;

(7) Minnesota supplemental aid under section 256D.36, subdivision 1;

(8) preadmission screening and alternative care grants;

(9) work readiness services under section 256D.051;

(10) case management services under section 256.736, subdivision 13;

(11) general assistance claims processing, medical transportation and related costs; ~~and~~

(12) medical assistance, medical transportation and related costs; and

(13) group residential housing under section 256I.05, subdivision 8, transferred from programs in clauses (4) and (7).

Sec. 3. Minnesota Statutes 1992, 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 spend-down of excess income according to section 256B.056, subdivision 5, and:

(1) who is receiving assistance under section 256D.05 or 256D.051, or who is having a payment made on the person's behalf under sections 256I.01 to 256I.06; 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 pursuant to section 256B.056, subdivision 5, using a six-month budget period, except that a one-month budget period must be used for recipients residing in a long-term care facility. The method for calculating earned income disregards and deductions for a person who resides with a dependent child under age 21 shall be as specified in section 256.74, subdivision 1. However, if a disregard of $30 and one-third of the remainder described in section 256.74, subdivision 1, clause (4), 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 aid to families with dependent children 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; or

(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.

(b) Eligibility is available for the month of application, and for three months prior to application if the person was eligible in those prior months. A redetermination of eligibility must occur every 12 months.

(c) 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.

(d) 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.

(e) 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 30 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.

Sec. 4. Minnesota Statutes 1992, section 256D.35, subdivision 3a, is amended to read:

Subd. 3a. **ASSISTANCE UNIT.** "Assistance unit" means the individual applicant or recipient or an eligible applicant married couple or recipient married couple who live together.

Sec. 5. Minnesota Statutes 1992, section 256D.44, subdivision 2, is amended to read:

Subd. 2. **STANDARD OF ASSISTANCE FOR SHELTER.** The state standard of assistance for shelter provides for the recipient's shelter costs. The monthly state standard of assistance for shelter must be determined according to paragraphs (a) to ~~(e)~~ (f).

(a) If ~~the~~ an applicant or recipient does not reside with another person or persons, the state standard of assistance is the actual cost for shelter items or $124, whichever is less.

(b) ~~If the recipient resides with another person, the state standard of assistance is the actual costs for shelter items or $93, whichever is less.~~ If an applicant married couple or recipient married couple, who live together, does not reside with others, the state standard of assistance is the actual cost for shelter items or $186, whichever is less.

(c) ~~Actual shelter costs for applicants or recipients are determined by dividing the total monthly shelter costs by the number of persons who share the residence.~~ If an applicant or recipient resides with another person or persons, the

state standard of assistance is the actual cost for shelter items or $93, whichever is less.

(d) If an applicant married couple or recipient married couple, who live together, resides with others, the state standard of assistance is the actual cost for shelter items or $124, whichever is less.

(e) Actual shelter costs for applicants or recipients, who reside with others, are determined by dividing the total monthly shelter costs by the number of persons who share the residence.

(f) Married couples, living together and receiving MSA on January 1, 1994, and whose eligibility has not been terminated for a full calendar month, are exempt from the standards in paragraphs (b) and (d).

Sec. 6. Minnesota Statutes 1992, section 256D.44, subdivision 3, is amended to read:

Subd. 3. **STANDARD OF ASSISTANCE FOR BASIC NEEDS.** The state standard of assistance for basic needs provides for the applicant's or recipient's maintenance needs, other than actual shelter costs. Except as provided in subdivision 4, the monthly state standard of assistance for basic needs is as follows:

(a) ~~For~~ If an applicant or recipient who does not reside with another person or persons, the state standard of assistance is ~~$305~~ $371.

(b) ~~For an individual who resides with another person or persons, the state standard of assistance is $242.~~ If an applicant married couple or recipient married couple who live together, does not reside with others, the state standard of assistance is $557.

(c) If an applicant or recipient resides with another person or persons, the state standard of assistance is $286.

(d) If an applicant married couple or recipient married couple who live together, resides with others, the state standard of assistance is $371.

(e) Married couples, living together and receiving MSA on January 1, 1994, and whose eligibility has not been terminated a full calendar month, are exempt from the standards in paragraphs (b) and (d).

Sec. 7. Minnesota Statutes 1992, section 256I.01, is amended to read:

256I.01 **CITATION.**

Sections 256I.01 to 256I.06 shall be cited as the "group residential housing ~~rate~~ act."

Sec. 8. Minnesota Statutes 1992, section 256I.02, is amended to read:

256I.02 **PURPOSE.**

The group residential housing ~~rate~~ act establishes a comprehensive system of rates and payments for persons who reside in a group residence and who meet the eligibility criteria ~~of the general assistance program under sections 256D.01 to 256D.21, or the Minnesota supplemental aid program under sections 256D.33 to 256D.54~~ under section 256I.04, subdivision 1.

Sec. 9. Minnesota Statutes 1992, section 256I.03, subdivision 2, is amended to read:

Subd. 2. **GROUP RESIDENTIAL HOUSING RATE.** "Group residential housing rate" means a monthly rate set for shelter, fuel, food, utilities, household supplies, and other costs necessary to provide room and board for eligible individuals ~~eligible for general assistance under sections 256D.01 to 256D.21 or supplemental aid under sections 256D.33 to 256D.54~~. Group residential housing rate does not include payments for foster care for children who are not blind, child welfare services, medical care, dental care, hospitalization, nursing care, drugs or medical supplies, program costs, or other social services. ~~However, the group residential housing rate for recipients living in residences in section 256I.05, subdivision 2, paragraph (c), clause (2), includes all items covered by that residence's medical assistance per diem rate.~~ The rate is negotiated by the county agency ~~or the state~~ according to the provisions of sections 256I.01 to 256I.06.

Sec. 10. Minnesota Statutes 1992, section 256I.03, subdivision 3, is amended to read:

Subd. 3. **GROUP RESIDENTIAL HOUSING.** "Group residential housing" means a group living situation that provides at a minimum room and board to unrelated persons who meet the eligibility requirements of section 256I.04. This definition includes foster care settings for a single adult. To receive payment for a group residence rate, the residence must ~~be licensed by either the department of health or human services and must comply with applicable laws and rules establishing standards for health, safety, and licensure. Secure crisis shelters for battered women and their children designated by the department of corrections are not group residences under this chapter~~ meet the requirements under section 256I.04, subdivision 2a.

Sec. 11. Minnesota Statutes 1992, section 256I.03, is amended by adding a subdivision to read:

Subd. 5. **MSA EQUIVALENT RATE.** "MSA equivalent rate" means an amount equal to the total of:

(1) the combined maximum shelter and basic needs standards for MSA recipients living alone specified in section 256D.44, subdivisions 2, paragraph (a); and 3, paragraph (a); plus

(2) for persons who are not eligible to receive food stamps due to living arrangement, the maximum allotment authorized by the federal Food Stamp Program for a single individual which is in effect on the first day of July each year; less

(3) the personal needs allowance authorized for medical assistance recipients under section 256B.35.

The MSA equivalent rate is to be adjusted on the first day of July each year to reflect changes in any of the component rates under clauses (1) to (3).

Sec. 12. Minnesota Statutes 1992, section 256I.03, is amended by adding a subdivision to read:

Subd. 6. **MEDICAL ASSISTANCE ROOM AND BOARD RATE.** "Medical assistance room and board rate" means an amount equal to the medical assistance income standard for a single individual living alone in the community less the medical assistance personal needs allowance under section 256B.35. For the purposes of this section, the amount of the group residential housing rate that exceeds the medical assistance room and board rate is considered a remedial care cost. A remedial care cost may be used to meet a spend down obligation under section 256B.056, subdivision 5. The medical assistance room and board rate is to be adjusted on the first day of January of each year.

Sec. 13. Minnesota Statutes 1992, section 256I.04, subdivision 1, is amended to read:

Subdivision 1. **INDIVIDUAL ELIGIBILITY REQUIREMENTS.** ~~To be eligible for a group residential housing payment, the individual must be eligible for general assistance under sections 256D.01 to 256D.21, or supplemental aid under sections 256D.33 to 256D.54. If the individual is in the group residence due to illness or incapacity, the individual must be in the residence under a plan developed or approved by the county agency. Residence in other group residences must be approved by the county agency.~~ An individual is eligible for and entitled to a group residential housing payment to be made on the individual's behalf if the county agency has approved the individual's residence in a group residential housing setting and the individual meets the requirements in paragraph (a) or (b).

(a) The individual is aged, blind, or is over 18 years of age and disabled as determined under the criteria used by the title II program of the Social Security Act, and meets the resource restrictions and standards of the supplemental security income program, and the individual's countable income after deducting the exclusions and disregards of the SSI program and the medical assistance personal needs allowance under section 256B.35 is less than the monthly rate specified in the county agency's agreement with the provider of group residential housing in which the individual resides.

(b) The individual's resources are less than the standards specified by section 256D.08, and the individual's countable income as determined under sections 256D.01 to 256D.21, less the medical assistance personal needs allowance under section 256B.35 is less than the monthly rate specified in the county agency's agreement with the provider of group residential housing in which the individual resides.

Sec. 14. Minnesota Statutes 1992, section 256I.04, is amended by adding a subdivision to read:

Subd. 1a. **COUNTY APPROVAL.** A county agency may not approve a group residential housing payment for an individual in any setting with a rate in excess of the MSA equivalent rate for more than 30 days in a calendar year unless the county agency has developed or approved a plan for the individual which specifies that:

(1) the individual has an illness or incapacity which prevents the person from living independently in the community; and

(2) the individual's illness or incapacity requires the services which are available in the group residence.

Sec. 15. Minnesota Statutes 1992, section 256I.04, is amended by adding a subdivision to read:

Subd. 1b. **OPTIONAL STATE SUPPLEMENTS TO SSI.** Group residential housing payments made on behalf of persons eligible under subdivision 1, paragraph (a), are optional state supplements to the SSI program.

Sec. 16. Minnesota Statutes 1992, section 256I.04, is amended by adding a subdivision to read:

Subd. 1c. **INTERIM ASSISTANCE.** Group residential housing payments made on behalf of persons eligible under subdivision 1, paragraph (b), are considered interim assistance payments to applicants for the federal SSI program.

Sec. 17. Minnesota Statutes 1992, section 256I.04, subdivision 2, is amended to read:

Subd. 2. **DATE OF ELIGIBILITY.** ~~For a person living in a group residence who is eligible for general assistance under sections 256D.01 to 256D.21, payment shall be made from the date a signed application form is received by the county agency or the date the applicant meets all eligibility factors, whichever is later. For a person living in a group residence who is eligible for supplemental aid under sections 256D.33 to 256D.54, payment shall be made from the first of the month in which an approved application is received by a county agency.~~ An individual who has met the eligibility requirements of subdivision 1, shall have a group residential housing payment made on the individual's behalf from the first day of the month in which a signed application form is received by

a county agency, or the first day of the month in which all eligibility factors have been met, whichever is later.

Sec. 18. Minnesota Statutes 1992, section 256I.04, is amended by adding a subdivision to read:

Subd. 2a. **LICENSE REQUIRED.** A county agency may not enter into an agreement with an establishment to provide group residential housing unless:

(1) the establishment is licensed by the department of health as a hotel and restaurant; a board and lodging establishment; a residential care home; a boarding care home before March 1, 1985; or a supervised living facility, and the service provider for residents of the facility is licensed under chapter 245A; or

(2) the residence is licensed by the commissioner of human services under Minnesota Rules, parts 9555.5050 to 9555.6265, or certified by a county human services agency prior to July 1, 1992, using the standards under Minnesota Rules, parts 9555.5050 to 9555.6265.

The requirements under clauses (1) and (2) do not apply to establishments exempt from state licensure because they are located on Indian reservations and subject to tribal health and safety requirements.

Sec. 19. Minnesota Statutes 1992, section 256I.04, is amended by adding a subdivision to read:

Subd. 2b. **GROUP RESIDENTIAL HOUSING AGREEMENTS.** Agreements between county agencies and providers of group residential housing must be in writing and must specify the name and address under which the establishment subject to the agreement does business and under which the establishment, or service provider, if different from the group residential housing establishment, is licensed by the department of health or the department of human services; the address of the location or locations at which group residential housing is provided under this agreement; the per diem and monthly rates that are to be paid from group residential housing funds for each eligible resident at each location; the number of beds at each location which are subject to the group residential housing agreement; and a statement that the agreement is subject to the provisions of sections 256I.01 to 256I.06 and subject to any changes to those sections.

Sec. 20. Minnesota Statutes 1992, section 256I.04, is amended by adding a subdivision to read:

Subd. 2c. **CRISIS SHELTERS.** Secure crisis shelters for battered women and their children designated by the Minnesota department of corrections are not group residences under this chapter.

Sec. 21. Minnesota Statutes 1992, section 256I.04, subdivision 3, is amended to read:

Subd. 3. **MORATORIUM ON THE DEVELOPMENT OF GROUP RESIDENTIAL HOUSING BEDS.** (a) County agencies shall not enter into agreements for new ~~general assistance or Minnesota supplemental aid~~ group ~~residence~~ residential housing beds except: (1) ~~for adult foster homes licensed by the commissioner of human services under Minnesota Rules, parts 9555.5105 to 9555.6265~~ for group residential housing establishments meeting the requirements of subdivision 2a, clause (2); (2) for ~~facilities~~ group residential housing establishments licensed under Minnesota Rules, parts 9525.0215 to 9525.0355, provided the facility is needed to meet the census reduction targets for persons with mental retardation or related conditions at regional treatment centers; (3) to ensure compliance with the federal Omnibus Budget Reconciliation Act alternative disposition plan requirements for inappropriately placed persons with mental retardation or related conditions or mental illness; or (4) up to 80 beds in a single, specialized facility located in Hennepin county that will provide housing for chronic inebriates who are repetitive users of detoxification centers and are refused placement in emergency shelters because of their state of intoxication. Planning for the specialized facility must have been initiated before July 1, 1991, in anticipation of receiving a grant from the housing finance agency under section 462A.05, subdivision 20a, paragraph (b).

(b) A county agency may enter into a group residential housing agreement for beds in addition to those currently covered under a group residential housing agreement if the additional beds are only a replacement of beds which have been made available due to closure of a setting, a change of licensure or certification which removes the beds from group residential housing payment, or as a result of the downsizing of a group residential housing setting. The transfer of available beds from one county to another can only occur by the agreement of both counties.

(c) Group residential housing beds which become available as a result of downsizing settings which have a license issued under Minnesota Rules, parts 9520.0500 to 9520.0690, must be permanently removed from the group residential housing census and not replaced.

Sec. 22. Minnesota Statutes 1992, section 256I.05, subdivision 1, is amended to read:

Subdivision 1. ~~**MONTHLY**~~ **MAXIMUM RATES.** (a) Monthly ~~payments for~~ room and board rates negotiated by a county agency~~, or set by the department under rules developed pursuant to subdivision 6, on behalf of~~ for a recipient living in ~~a~~ group ~~residence~~ residential housing must ~~be paid at the rates in effect on June 30, 1991,~~ not ~~to~~ exceed ~~$966.37 for a group residence that entered into an initial group residential housing agreement with a county agency before June 1, 1989~~ the MSA equivalent rate specified under section 256I.03, subdivision 5, with the exception that a county agency may negotiate a room and board rate that exceeds the MSA equivalent rate by up to $426.37 for recipients of waiver services under title XIX of the Social Security Act. This exception is subject to the following conditions:

(1) that the secretary of health and human services has not approved a state request to include room and board costs which exceed the MSA equivalent rate in an individual's set of waiver services under title XIX of the Social Security Act; or

(2) that the secretary of health and human services has approved the inclusion of room and board costs which exceed the MSA equivalent rate, but in an amount that is insufficient to cover costs which are included in a group residential housing agreement in effect on June 30, 1994, and the amount of the rate that is above the MSA equivalent rate has been approved by the commissioner. The county agency may at any time negotiate a lower ~~payment~~ room and board rate than the rate that would otherwise be paid under this subdivision.

(b) The maximum monthly rate for an establishment that enters into an initial group residential housing agreement with a county agency on or after June 1, 1989, may not exceed 90 percent of the maximum rate established under subdivision 1. This is effective until June 30, 1994.

Sec. 23. Minnesota Statutes 1992, section 256I.05, subdivision 1a, is amended to read:

Subd. 1a. ~~LOWER MAXIMUM~~ SUPPLEMENTARY RATES. ~~(a) The maximum monthly rate for a general assistance or Minnesota supplemental aid group residence that enters into an initial group residential housing agreement with a county agency on or after June 1, 1989, may not exceed 90 percent of the maximum rate established under subdivision 1. This is effective until June 30, 1993, or until the statewide system authorized under subdivision 6 is established, whichever occurs first.~~

~~(b) The maximum monthly rate for a general assistance or Minnesota supplemental aid group residence that is neither licensed by nor registered with the Minnesota department of health, or licensed by the department of human services, to provide programs or services in addition to room and board is an amount equal to the total of:~~

~~(1) the combined maximum shelter and basic needs standards for Minnesota supplemental aid recipients living alone specified in section 256D.44, subdivisions 2, paragraph (a), and 3, paragraph (a); plus~~

~~(2) for persons who are not eligible to receive food stamps due to living arrangements, the maximum allotment authorized by the federal food stamp program for a single individual which is in effect on the first day of July each year; less~~

~~(3) the personal needs allowance authorized for medical assistance recipients under section 256B.35.~~ In addition to the room and board rate specified in subdivision 1, the county agency may negotiate a payment not to exceed $426.37 for other services necessary to provide room and board provided by the

group residence if the residence is licensed by or registered by the department of health, or licensed by the department of human services to provide services in addition to room and board, and if the recipient of services is not also concurrently receiving services under a home and community-based waiver under title XIX of the Social Security Act or residing in a setting which receives funding under Minnesota Rules, parts 9535.2000 to 9535.3000. The registration and licensure requirement does not apply to establishments which are exempt from state licensure because they are located on Indian reservations and for which the tribe has prescribed health and safety requirements. Service payments under this section may be prohibited under rules to prevent the supplanting of federal funds with state funds. The commissioner shall pursue the feasibility of obtaining the approval of the secretary of health and human services to provide home and community-based waiver services under title XIX of the Social Security Act for residents who are not eligible for an existing home and community-based waiver due to a primary diagnosis of mental illness or chemical dependency, and shall apply for a waiver if it is determined to be cost effective.

Sec. 24. Minnesota Statutes 1992, section 256I.05, is amended by adding a subdivision to read:

Subd. 1c. **RATE INCREASES.** A county agency may not increase the rates negotiated for group residential housing above those in effect on June 30, 1993, except:

(a) A county may increase the rates for group residential housing settings to the MSA equivalent rate for those settings whose current rate is below the MSA equivalent rate.

(b) A county agency may increase the rates for residents in adult foster care whose difficulty of care has increased. The total group residential housing rate for these residents must not exceed the maximum rate specified in subdivisions 1 and 1a. County agencies must not include nor increase group residential housing difficulty of care rates for adults in foster care whose difficulty of care is eligible for funding by home and community-based waiver programs under title XIX of the Social Security Act.

(c) The room and board rates will be increased each year when the MSA equivalent rate is adjusted for SSI cost-of-living increases by the amount of the annual SSI increase, less the amount of the increase in the medical assistance personal needs allowance under section 256B.35.

(d) When a group residential housing rate is used to pay for an individual's room and board, or other costs necessary to provide room and board, the rate payable to the residence must continue for up to 18 calendar days per incident that the person is temporarily absent from the residence, not to exceed 60 days in a calendar year, if the absence or absences have received the prior approval of the county agency's social service staff. Prior approval is not required for emergency absences due to crisis, illness or injury.

(e) For facilities meeting substantial change criteria within the prior year. Substantial change criteria exists if the group residential housing establishment experiences a 25 percent increase or decrease in the total number of its beds, if the net cost of capital additions or improvements is in excess of 15 percent of the current market value of the residence, or if the residence physically moves, or changes its licensure, and incurs a resulting increase in operation and property costs.

(f) Until June 30, 1994, a county agency may increase by up to five percent the total rate paid for recipients of assistance under sections 256D.01 to 256D.21 or 256D.33 to 256D.54 who reside in residences that are licensed by the commissioner of health as a boarding care home, but are not certified for the purposes of the medical assistance program. However, an increase under this clause must not exceed an amount equivalent to 65 percent of the 1991 medical assistance reimbursement rate for nursing home resident class A, in the geographic grouping in which the facility is located, as established under Minnesota Rules, parts 9549.0050 to 9549.0058.

Sec. 25. Minnesota Statutes 1992, section 256I.05, subdivision 2, is amended to read:

Subd. 2. **MONTHLY RATES; EXEMPTIONS.** ~~(a)~~ The maximum group residential housing rate does not apply to a residence that on August 1, 1984, was licensed by the commissioner of health only as a boarding care home, certified by the commissioner of health as an intermediate care facility, and licensed by the commissioner of human services under Minnesota Rules, parts 9520.0500 to 9520.0690.

~~(b) The maximum group residential housing rate does not apply to a residence that on August 1, 1984, was licensed by the commissioner of human services under Minnesota Rules, parts 9525.0520 to 9525.0660, but funded as a group residence under general assistance or Minnesota supplemental aid.~~

Sec. 26. Minnesota Statutes 1992, section 256I.05, subdivision 8, is amended to read:

Subd. 8. **STATE PARTICIPATION.** For a resident of a group residence who is eligible ~~for general assistance~~ under ~~sections 256D.01 to 256D.21~~ section 256I.04, subdivision 1, paragraph (b), state participation in the group residential housing ~~rate~~ payment is determined according to section 256D.03, subdivision 2. For a resident of a group residence who is eligible under ~~sections 256D.33 to 256D.54~~ section 256I.04, subdivision 1, paragraph (a), state participation in the group residential housing rate is determined according to section 256D.36.

Sec. 27. Minnesota Statutes 1992, section 256I.06, is amended to read:

256I.06 **PAYMENT METHODS.**

~~When a group residential housing rate is used to pay the room and board costs of a person eligible under sections 256D.01 to 256D.21, the Monthly payment may~~ Subdivision 1. **MONTHLY PAYMENTS.** Monthly payments made on an individual's behalf for group residential housing must be issued as a voucher or vendor payment. ~~When a group residential housing rate is used to pay the room and board costs of a person eligible under sections 256D.33 to 256D.54, payments must be made to the recipient. If a recipient is not able to manage the recipient's finances, a representative payee must be appointed.~~

Subd. 2. **TIME OF PAYMENT.** A county agency may make payments to a group residence in advance for an individual whose stay in the group residence is expected to last beyond the calendar month for which the payment is made and who does not expect to receive countable earned income during the month for which the payment is made. Group residential housing payments made by a county agency on behalf of an individual who is not expected to remain in the group residence beyond the month for which payment is made must be made subsequent to the individual's departure from the group residence. Group residential housing payments made by a county agency on behalf of an individual with earned income must be made subsequent to receipt of a monthly household report form.

Subd. 3. **FILING OF APPLICATION.** The county agency must immediately provide an application form to any person requesting group residential housing. Application for group residential housing must be in writing on a form prescribed by the commissioner. The county agency must determine an applicant's eligibility for group residential housing as soon as the required verifications are received by the county agency and within 30 days after a signed application is received by the county agency for the aged or blind or within 60 days for the disabled.

Subd. 4. **VERIFICATION.** The county agency must request, and applicants and recipients must provide and verify, all information necessary to determine initial and continuing eligibility and group residential housing payment amounts. If necessary, the county agency shall assist the applicant or recipient in obtaining verifications. If the applicant or recipient refuses or fails without good cause to provide the information or verification, the county agency shall deny or terminate eligibility for group residential housing payments.

Subd. 5. **REDETERMINATION OF ELIGIBILITY.** The eligibility of each recipient must be redetermined at least once every 12 months.

Subd. 6. **REPORTS.** Recipients must report changes in circumstances that affect eligibility or group residential housing payment amounts within ten days of the change. Recipients with earned income must complete a monthly household report form. If the report form is not received before the end of the month in which it is due, the county agency must terminate eligibility for group residential housing payments. The termination shall be effective on the first day of

the month following the month in which the report was due. If a complete report is received within the month eligibility was terminated, the individual is considered to have continued an application for group residential housing payment effective the first day of the month the eligibility was terminated.

Subd. 7. **DETERMINATION OF RATES.** The county in which a group residence is located will determine the amount of group residential housing rate to be paid on behalf of an individual in the group residence regardless of the individual's county of financial responsibility.

Subd. 8. **AMOUNT OF GROUP RESIDENTIAL HOUSING PAYMENT.** The amount of a group residential housing payment to be made on behalf of an eligible individual is determined by subtracting the individual's countable income under section 256I.04, subdivision 1, for a whole calendar month from the group residential housing charge for that same month. The group residential housing charge is determined by multiplying the group residential housing rate times the period of time the individual was a resident or temporarily absent under section 256I.05, subdivision 1c, paragraph (d).

Sec. 28. **TRANSFER OF GROUP RESIDENTIAL HOUSING FUNDS.**

Upon federal approval of payment under the home and community-based waiver provisions for room and board costs in addition to the MSA equivalent rate defined in Minnesota Statutes, section 256I.03, the commissioner of human services shall transfer anticipated group residential housing expenditures to the medical assistance account to meet the nonfederal share requirement of funding these additional costs as home and community-based services. Any transfer of group residential housing funds to the medical assistance account shall correspond to the increase in the waiver rates resulting from medical assistance payment for unusual room and board costs in excess of the MSA equivalent rate.

Sec. 29. **REPEALER.**

Minnesota Statutes 1992, sections 256I.03, subdivision 4; 256I.05, subdivisions 4, 9, and 10; and 256I.051, are repealed.

Sec. 30. **EFFECTIVE DATES.**

Subdivision 1. Section 25 is effective July 1, 1994.

Subd. 2. Sections 1 to 3, 8, 9, 13 to 17, 22, 23, and 26 to 29 are effective July 1, 1994, contingent upon federal recognition that group residential housing payments qualify as optional state supplement payments to the supplemental security income program under title XVI of the Social Security Act and confer categorical eligibility for medical assistance under the state plan for medical assistance.

Subd. 3. Sections 4 to 6 are effective January 1, 1994.

Subd. 4. Implementation of section 12 is contingent upon approval by the Secretary of Health and Human Services of the definition and procedure contained in that section.

ARTICLE 9

HEALTH DEPARTMENT

Section 1. **[115C.082] LEAD FUND.**

Subdivision 1. **FUND ESTABLISHED.** A lead fund is created in the state treasury. The fund consists of all revenue deposited in the fund under sections 115C.081 and 297E.01, subdivision 11, and all other money and interest made available to the fund by law.

Subd. 2. **USES OF FUND.** (a) Money in the lead fund may be appropriated for:

(1) all lead programs administered by the commissioner of jobs and training;

(2) all lead activities and programs administered by the commissioner of health; and

(3) all lead programs administered by the commissioner of the housing finance agency.

(b) Money in the lead fund must be annually distributed for lead abatement as follows:

(1) 25 percent to the commissioner of health for lead activities and programs including contracting with community health boards;

(2) ten percent to the housing development fund for lead programs; and

(3) the remainder to the commissioner of jobs and training for lead abatement programs.

(c) In expending funds under this program, the commissioner of health shall abide by the following requirements:

(1) no funds shall be spent for lead screening unless the board of health or grantee meets the center for disease control proficiency requirements and the analytical requirements specified in section 144.873, subdivision 3. The commissioner may make grants that include providing the appropriate analytical equipment in order to meet this condition;

(2) no money shall be provided to boards of health who issue abatement orders inconsistent with the rules promulgated under section 144.878; and

(3) before issuing a contract to boards of health, outside a city of the first class, the commissioner of health shall evaluate the need and cost effectiveness of contracting for sanitarian and public health nurse services to determine whether the contract grant should be with an individual board of health, or a group of boards of health, or whether services should be delivered by the commissioner. Nothing in this provision is designed to restrict grants for lead education or lead screening.

Sec. 2. Minnesota Statutes 1992, section 116.76, subdivision 14, is amended to read:

Subd. 14. **PATHOLOGICAL WASTE.** "Pathological waste" means human tissues and body parts removed accidentally or during surgery or autopsy intended for disposal. ~~Pathological waste does not include teeth.~~

Sec. 3. Minnesota Statutes 1992, section 116.78, subdivision 4, is amended to read:

Subd. 4. **SHARPS.** Sharps, except those generated from a household or from a farm operation or agricultural business:

(1) must be placed in puncture-resistant containers;

(2) may not be compacted or mixed with other waste material whether or not the sharps are decontaminated unless it is part of an infectious waste decontamination process approved by the ~~commissioner of health or the~~ commissioner of the pollution control agency that will prevent exposure during transportation and disposal; and

(3) may not be disposed of at refuse-derived fuel facilities or at other facilities where waste is hand sorted.

Sec. 4. Minnesota Statutes 1992, section 116.78, subdivision 7, is amended to read:

Subd. 7. **COMPACTION AND MIXTURE WITH OTHER WASTES.** Infectious waste may not be compacted or mixed with other waste materials prior to incineration or disposal. Compaction is acceptable if it is part of an infectious waste system, approved by the ~~commissioner of health or the~~ commissioner of the pollution control agency, that is designed to prevent exposure during storage, transportation, and disposal.

Sec. 5. Minnesota Statutes 1992, section 116.79, subdivision 1, is amended to read:

Subdivision 1. **PREPARATION OF MANAGEMENT PLANS.** (a) To the

extent applicable to the facility, a person in charge of a facility that generates, stores, decontaminates, incinerates, or disposes of infectious or pathological waste must prepare a management plan for the infectious or pathological waste handled by the facility. A person may prepare a common management plan for all generating facilities owned and operated by the person. If a single plan is prepared to cover multiple facilities, the plan must identify common policy and procedures for the facilities and any management procedures that are facility specific. The plan must identify each generating facility covered by the plan. A management plan must list all physicians, dentists, chiropractors, podiatrists, veterinarians, certified nurse practitioners, certified nurse midwives, or physician assistants, employed by, under contract to, or working at the generating facilities, except hospitals or laboratories. A management plan from a hospital must list the number of licensed beds and from a laboratory must list the number of generating employees.

(b) The management plan must describe, to the extent the information is applicable to the facility:

(1) the type of infectious waste and pathological waste that the person generates or handles;

(2) the segregation, packaging, labeling, collection, storage, and transportation procedures for the infectious waste or pathological waste that will be followed;

(3) the decontamination or disposal methods for the infectious or pathological waste that will be used;

(4) the transporters and disposal facilities that will be used for the infectious waste;

(5) the steps that will be taken to minimize the exposure of employees to infectious agents throughout the process of disposing of infectious or pathological wastes; and

(6) the name of the individual responsible for the management of the infectious waste or pathological waste.

(c) The management plan must be kept at the facility.

(d) To the extent applicable to the facility, management plans must be accompanied by a statement of the quantity of infectious and pathological waste generated, decontaminated, stored, incinerated, or disposed of at the facility during the previous two-year period. Quantities shall be reported in ~~gallons or~~ pounds. ~~The commissioner of health shall prepare a summary of the quantities of infectious and pathological waste generated, by facility type.~~

(e) A management plan must be updated ~~and resubmitted~~ at least once every two years.

New language is indicated by underline, deletions by ~~strikeout~~.

Sec. 6. Minnesota Statutes 1992, section 116.79, subdivision 4, is amended to read:

Subd. 4. **PLANS FOR STORAGE, DECONTAMINATION, INCINERATION, AND DISPOSAL FACILITIES.** (a) A person who stores, incinerates, or decontaminates infectious or pathological waste, other than at the facility where the waste was generated, or a person who incinerates ~~or disposes of~~ infectious or pathological waste on site, must submit a copy of the management plan to the commissioner of the pollution control agency with a fee of $225. The fee must be deposited in the state treasury and credited to the general fund. ~~A person who incinerates on site must submit an attachment to the generator's management plan detailing the incineration operation.~~

(b) The commissioner shall review the plans and may require a plan to be modified within 180 days after the plan is submitted if the commissioner determines that the plan is not consistent with state or federal law or that the plan is not adequate to minimize exposure of persons to the waste.

Sec. 7. Minnesota Statutes 1992, section 116.80, subdivision 1, is amended to read:

Subdivision 1. **TRANSFER OF INFECTIOUS WASTE.** (a) A generator may not transfer infectious waste to a commercial transporter unless the transporter is registered with the commissioner.

(b) A transporter may not deliver infectious waste to a facility prohibited to accept the waste.

(c) A person who is registered to transport infectious waste may not refuse waste generated from a facility that is properly packaged and labeled ~~as "infectious waste."~~.

Sec. 8. Minnesota Statutes 1992, section 116.80, subdivision 2, is amended to read:

Subd. 2. **PREPARATION OF MANAGEMENT PLANS.** (a) A commercial transporter in charge of a business that transports infectious waste must prepare a management plan for the infectious waste handled by the commercial transporter.

(b) The management plan must describe, to the extent the information is applicable to the commercial transporter:

(1) the type of infectious waste that the commercial transporter handles;

(2) the transportation procedures for the infectious waste that will be followed;

(3) the disposal facilities that will be used for the infectious waste;

(4) the steps that will be taken to minimize the exposure of employees to infectious agents throughout the process of transporting and disposing of infectious waste; and

(5) the name of the individual responsible for the transportation and management of the infectious waste.

(c) The management plan must be kept at the commercial transporter's principal place of business.

(d) Management plans must be accompanied by a statement of the quantity of infectious waste transported during the previous two-year period. Quantities shall be reported in ~~gallons or~~ pounds.

(e) A management plan must be updated and resubmitted at least once every two years.

(f) The commissioner shall review the plans and may require a plan to be modified within 180 days after the plan is submitted if the commissioner determines that the plan is not consistent with state or federal law or that the plan is not adequate to minimize exposure of persons to the waste.

Sec. 9. Minnesota Statutes 1992, section 116.81, subdivision 1, is amended to read:

Subdivision 1. **AGENCY RULES.** The agency, in consultation with the commissioner of health, may adopt rules to implement sections 116.76 to 116.82. ~~The agency has primary responsibility for rules relating to transportation of infectious waste and facilities storing, transporting, decontaminating, incinerating, and disposing of infectious waste.~~ The agency, before adopting rules affecting animals or research animal waste, must consult the commissioner of agriculture and the board of animal health.

Sec. 10. Minnesota Statutes 1992, section 116.82, subdivision 3, is amended to read:

Subd. 3. **LOCAL ENFORCEMENT.** Sections 116.76 to 116.81 may be enforced by a county by delegation of enforcement authority granted to the ~~commissioner of health and the~~ agency in section 116.83. Separate enforcement actions may not be brought by a state agency and a county for the same violations. The state or county may not bring an action that is being enforced by the federal Office of Safety and Health Administration.

Sec. 11. Minnesota Statutes 1992, section 116.83, subdivision 1, is amended to read:

Subdivision 1. ~~STATE RESPONSIBILITIES~~ ENFORCEMENT AUTHORITY. The agency ~~or the commissioner of health~~ may enforce sections 116.76 to 116.81. ~~The commissioner of health is primarily responsible for enforcement involving generators. The agency is primarily responsible for enforcement involving other persons subject to sections 116.76 to 116.81.~~

New language is indicated by underline, deletions by ~~strikeout~~.

Sec. 12. Minnesota Statutes 1992, section 116.83, subdivision 3, is amended to read:

Subd. 3. **ACCESS TO INFORMATION AND PROPERTY.** Subject to section 144.651, the commissioner of the pollution control agency ~~or the commissioner of health~~ may on presentation of credentials, during regular business hours:

(1) examine and copy any books, records, memoranda, or data that is related to compliance with sections 116.76 to 116.81; and

(2) enter public or private property regulated by sections 116.76 to 116.81 for the purpose of taking an action authorized by this section including obtaining information and conducting investigations.

Sec. 13. **[116.87] DEFINITIONS.**

Subdivision 1. **RESIDENTIAL LEAD PAINT WASTE.** "Residential lead paint waste" means waste produced by removing lead paint from the interior or exterior structure or the ground surface of a residence. Residential lead paint waste does not include:

(1) lead paint waste removed with the aid of any chemical paint stripper; or

(2) lead paint waste that is mixed with water and that contains any free liquid.

Subd. 2. **RESIDENCE.** The term "residence" has the meaning given in rules adopted under sections 144.871 to 144.879.

Sec. 14. **[116.875] AUTHORIZED MANAGEMENT METHODS.**

Subdivision 1. **DISPOSAL.** Notwithstanding any other law, a person who disposes of residential lead paint waste in the state may dispose of the waste at:

(1) a land disposal facility that meets the requirements of Minnesota Rules, chapter 7045;

(2) a facility that meets the requirements for a new mixed municipal solid waste land disposal facility under Minnesota Rules, chapter 7035 that began operation after January 1, 1989;

(3) a demolition debris land disposal facility equipped with a clay or artificial liner and leachate collection system; or

(4) a solid waste incinerator ash landfill if disposal is approved by the commissioner in accordance with agency rules.

Subd. 2. **MANAGEMENT RESPONSIBILITY; NOT TRANSFERABLE TO OCCUPANT.** (a) A person whose activities produce residential lead paint waste is responsible for the management and proper disposal of the waste.

(b) When residential lead paint waste is produced by activities of a person other than the occupant of the residence from which the waste is removed, the person shall not leave the residential lead paint waste at that residence and shall not transfer responsibility for managing or disposing of the waste to the occupant.

Subd. 3. **WASTE PRODUCED BY OCCUPANT.** Residential lead paint waste produced by activities of the occupant of the residence from which the waste is removed must be managed as provided by law for household hazardous waste.

Subd. 4. **DEMOLITION DEBRIS.** Residential lead paint waste attached to woodwork, walls, or other elements removed from the structure of a residence that constitute demolition debris may be disposed of at any permitted demolition debris land disposal facility.

Sec. 15. **[116.88] PROHIBITED METHODS OF MANAGEMENT.**

Subdivision 1. **UNLINED LANDFILLS.** Except as provided in section 116.875, subdivision 4, no person shall dispose of residential lead paint waste at an unlined land disposal facility.

Subd. 2. **INCINERATION.** No person shall send or accept residential lead paint waste for incineration by a mixed municipal solid waste incinerator.

Sec. 16. **[116.885] RECYCLING AND TREATMENT.**

Nothing in sections 116.87 to 116.89 is intended to prevent or discourage treatment or recycling of residential lead paint waste. The commissioner shall encourage treatment and recycling of residential lead paint waste.

Sec. 17. **[116.89] ENFORCEMENT.**

Subdivision 1. **RULES.** The Minnesota pollution control agency may adopt rules necessary to implement and enforce the provisions of sections 116.87 to 116.885, including rules to regulate the transportation, storage, disposal, and other management of residential lead paint waste after the waste leaves the site where it was produced.

Subd. 2. **LICENSE REVOCATION.** In addition to enforcement by the Minnesota pollution control agency, the commissioner of health may revoke the license of an abatement contractor that violates any provision of sections 116.87 to 116.885 or the rules adopted under subdivision 1.

Sec. 18. Minnesota Statutes 1992, section 144.122, is amended to read:

144.122 **LICENSE AND PERMIT FEES.**

(a) The state commissioner of health, by rule, may prescribe reasonable pro-

cedures 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 ~~general~~ 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 1993 and beyond, shall set license fees for hospitals and nursing homes that are not boarding care homes at a level sufficient to recover, over a two-year period, the deficit associated with the collection of license fees from these facilities. The license fees for these facilities shall be set at the following levels:

Joint Commission on Accreditation of Healthcare Organizations (JCAHO hospitals)	$2,142
Non-JCAHO hospitals	$2,228 plus $138 per bed
Nursing home	$324 plus $76 per bed

For fiscal years 1993 and beyond, the commissioner shall set license fees for outpatient surgical centers, boarding care homes, and supervised living facilities at a level sufficient to recover, over a four-year period, the deficit associated with the collection of license fees from these facilities. The license fees for these facilities shall be set at the following levels:

Outpatient surgical centers	$1,645
Boarding care homes	$249 plus $58 per bed
Supervised living facilities	$249 plus $58 per bed.

Sec. 19. Minnesota Statutes 1992, section 144.123, subdivision 1, is amended to read:

Subdivision 1. **WHO MUST PAY.** Except for the limitation contained in this section, the commissioner of health shall charge a handling fee for each specimen submitted to the department of health for analysis for diagnostic purposes by any hospital, private laboratory, private clinic, or physician. No fee shall be charged to any entity which receives direct or indirect financial assistance from state or federal funds administered by the department of health, including any public health department, nonprofit community clinic, venereal disease clinic, family planning clinic, or similar entity. The commissioner of health may establish by rule other exceptions to the handling fee as may be necessary to gather information for epidemiologic purposes. All fees collected pursuant to this section shall be deposited in the state treasury and credited to the ~~general~~ state government special revenue fund.

Sec. 20. Minnesota Statutes 1992, section 144.226, subdivision 2, is amended to read:

Subd. 2. **FEES TO ~~GENERAL~~ STATE GOVERNMENT SPECIAL REVENUE FUND.** Fees collected under this section by the state registrar shall be deposited to the ~~general~~ state government special revenue fund.

Sec. 21. Minnesota Statutes 1992, section 144.3831, subdivision 2, is amended to read:

Subd. 2. **COLLECTION AND PAYMENT OF FEE.** The public water supply described in subdivision 1 shall:

(1) collect the fees assessed on its service connections;

(2) pay the department of revenue an amount equivalent to the fees based on the total number of service connections. The service connections for each public water supply described in subdivision 1 shall be verified every four years by the department of health; and

(3) pay one-fourth of the total yearly fee to the department of revenue each calendar quarter. The first quarterly payment is due on or before September 30, 1992. In lieu of quarterly payments, a public water supply described in subdivision 1 with fewer than 50 service connections may make a single annual payment by June 30 each year, starting in 1993. The fees payable to the department of revenue shall be deposited in the state treasury as nondedicated ~~general~~ state government special revenue fund revenues.

Sec. 22. Minnesota Statutes 1992, section 144.802, subdivision 1, is amended to read:

Subdivision 1. **LICENSES; CONTENTS, CHANGES, AND TRANSFERS.** No natural person, partnership, association, corporation or unit of government may operate an ambulance service within this state unless it possesses a valid license to do so issued by the commissioner. The license shall specify the base of operations, primary service area, and the type or types of ambulance service for which the licensee is licensed. The licensee shall obtain a new license if it wishes to establish a new base of operation, or to expand its primary service area, or to provide a new type or types of service. A license, or the ownership of a licensed ambulance service, may be transferred only after the approval of the commissioner, based upon a finding that the proposed licensee or proposed new owner of a licensed ambulance service meets or will meet the requirements of section 144.804. If the proposed transfer would result in a change in or addition of a new base of operations, expansion of the service's primary service area, or provision of a new type or types of ambulance service, the commissioner shall require the prospective licensee or owner to comply with subdivision 3. The commissioner may approve the license or ownership transfer prior to completion of the application process described in subdivision 3 upon obtaining written assurances from the proposed licensee or proposed new owner that no change in the service's base of operations, expansion of the service's primary service area, or provision of a new type or types of ambulance service will occur during the processing of the application. The cost of licenses shall be in an amount prescribed by the commissioner pursuant to section 144.122. Licenses shall expire and be renewed as prescribed by the commissioner pursuant to section 144.122. Fees collected shall be deposited to the trunk highway fund.

Sec. 23. Minnesota Statutes 1992, section 144.8091, subdivision 1, is amended to read:

Subdivision 1. **REPAYMENT FOR VOLUNTEER TRAINING.** Any political subdivision, or nonprofit hospital or nonprofit corporation operating a licensed ambulance service shall be reimbursed by the commissioner for the necessary expense of the initial training of a volunteer ambulance attendant upon successful completion by the attendant of a basic emergency care course, or a continuing education course for basic emergency care, or both, which has been approved by the commissioner, pursuant to section 144.804. Reimbursement may include tuition, transportation, food, lodging, hourly payment for the time spent in the training course, and other necessary expenditures, except that in no instance shall a volunteer ambulance attendant be reimbursed more than ~~$350~~ $450 for successful completion of a basic course, and ~~$140~~ $225 for successful completion of a continuing education course.

Sec. 24. Minnesota Statutes 1992, section 144.871, subdivision 2, is amended to read:

Subd. 2. **ABATEMENT.** "Abatement" means removal of, replacement of, or encapsulation of deteriorated paint, bare soil, dust, drinking water, or other lead-containing materials that are or may become readily accessible during the lead abatement process and pose an immediate threat of actual lead exposure to people.

Sec. 25. Minnesota Statutes 1992, section 144.871, subdivision 6, is amended to read:

Subd. 6. **ELEVATED BLOOD LEAD LEVEL.** "Elevated blood lead level" in a child ~~no more than six years old~~ before the sixth birthday or in a pregnant woman means a blood lead level that exceeds the federal Centers for Disease Control guidelines for preventing lead poisoning in young children, unless the commissioner finds that a lower concentration is necessary to protect public health.

Sec. 26. Minnesota Statutes 1992, section 144.871, subdivision 7a, is amended to read:

Subd. 7a. **HIGH RISK FOR TOXIC LEAD EXPOSURE.** "High risk for toxic lead exposure" means ~~either~~ a census tract that meets one or more of the following criteria:

(1) ~~that~~ a census tract where elevated blood lead levels have been diagnosed in a population of children or pregnant women;

(2) ~~without blood lead data, that a population of children or pregnant women resides in:~~

~~(i)~~ a census tract with many residential structures known to have or suspected of having deteriorated lead-based paint; or

~~(ii)~~ (3) a census tract with a median soil lead concentration greater than 100 parts per million for any sample collected according to Minnesota Rules, part 4761.0400, subpart 8, and rules adopted under section 144.878~~; or~~

~~(3) the priorities adopted by the commissioner under section 144.878, subdivision 2, shall apply to this subdivision.~~

Sec. 27. Minnesota Statutes 1992, section 144.871, subdivision 7b, is amended to read:

Subd. 7b. **PRIMARY PREVENTION FOR TOXIC LEAD EXPOSURE.** "Primary prevention for toxic lead exposure" ~~means performance of swab team services, encapsulation, and removal and replacement abatement, including lead cleanup and health education, before children develop elevated blood lead levels.~~ includes any or all of the following:

(1) education of the general public in populations where children under six years of age and pregnant women have been identified with blood lead levels greater than nine micrograms per deciliter;

(2) education for property owners and renters concerning in-place management of potential lead hazards to create lead-safe housing;

(3) in-place management of potential lead hazards using swab team services or property owner or renter lead abatement activities; and

(4) encapsulation, and removal and replacement abatement where necessary to make the residence lead safe.

Sec. 28. Minnesota Statutes 1992, section 144.871, is amended by adding a subdivision to read:

Subd. 7c. **LEAD INSPECTOR.** "Lead inspector" means a person who has successfully completed a training course in investigation of residences for possible sources of lead exposure and who is licensed by the commissioner under section 144.877 to perform this activity.

Sec. 29. Minnesota Statutes 1992, section 144.871, is amended by adding a subdivision to read:

Subd. 7d. **PERSON.** "Person" has the meaning given in section 103I.005, subdivision 16.

Sec. 30. Minnesota Statutes 1992, section 144.871, subdivision 9, is amended to read:

Subd. 9. **SWAB TEAM.** "Swab team" means a person or persons who implement in-place management of lead exposure sources~~, which includes~~. Swab team services include any or all of the following:

(1) ~~covering or replacing bare soil that has a lead concentration of 100 parts per million, and establishing safe exterior play and garden areas;~~ removing lead dust by washing, vacuuming, and cleaning the interior of residential property;

(2) other means that immediately protect children who engage in mouthing or pica behavior from lead sources, including cleanup and health education, advice and assistance to help a family locate and move to a temporary lead-safe residence while abatement is being completed, or to help a family locate and move to alternate lead-safe housing when abatement is not completed by the property owner, and any other assistance necessary to meet the family's immediate needs as a result of the relocation;

(3) removing loose paint and paint chips and installing guards to protect intact paint; and

~~(3) removing lead dust by washing, vacuuming, and cleaning the interior of residential property including carpets; and~~

(4) ~~other means, including cleanup and health education, that immediately~~

~~protect children who engage in mouthing or pica behavior from lead sources~~ covering or replacing bare soil that has a lead concentration of 100 parts per million, and establishing safe exterior play and garden areas.

Sec. 31. Minnesota Statutes 1992, section 144.871, is amended by adding a subdivision to read:

Subd. 10. **VENOUS BLOOD SAMPLE.** "Venous blood sample" means a quantity of blood drawn from a vein.

Sec. 32. Minnesota Statutes 1992, section 144.872, subdivision 2, is amended to read:

Subd. 2. **HOME ASSESSMENTS.** (a) The commissioner shall, within available federal or state appropriations, contract with boards of health, who may determine priority for responding to cases of elevated blood lead levels, to conduct assessments to determine sources of lead contamination in the residences of pregnant women whose blood lead levels are at least ten micrograms per deciliter and of children whose blood lead levels are at least 20 micrograms per deciliter or whose blood lead levels persist in the range of 15 to 19 micrograms per deciliter for 90 days after initial identification to the board of health or the commissioner. Assessments must be conducted within five working days of the board of health receiving notice that the criteria in this subdivision have been met. The commissioner or boards of health must be notified of all violations of standards under section 144.878, subdivision 2, that are identified during a home assessment.

(b) The commissioner or boards of health must identify the known addresses for the previous 12 months of the child or pregnant woman with elevated blood lead levels and notify the property owners at those addresses. The commissioner may also collect information on the race, sex, and family income of children and pregnant women with elevated blood lead levels.

(c) Within the limits of appropriations, a board of health shall conduct home assessments for children and pregnant women whose confirmed blood lead levels are in the range of ten to 19 micrograms per deciliter.

(d) The commissioner shall also provide educational materials on all sources of lead to boards of health to provide education on ways of reducing the danger of lead contamination. The commissioner may provide laboratory or field lead testing equipment to a board of health or may reimburse a board of health for direct costs associated with assessments.

Sec. 33. Minnesota Statutes 1992, section 144.872, subdivision 3, is amended to read:

Subd. 3. **SAFE HOUSING.** The commissioner shall, within the limits of available appropriations, contract with boards of health for safe housing to be

used in meeting relocation requirements in section 144.874, subdivision 4. The commissioner shall, within available federal or state appropriations, award grants to boards of health for the purposes of paying housing and relocation costs under section 144.874, subdivision 4.

Sec. 34. Minnesota Statutes 1992, section 144.872, subdivision 4, is amended to read:

Subd. 4. **LEAD CLEANUP EQUIPMENT AND MATERIAL GRANTS.** (a) Within the limits of available state or federal appropriations, funds shall be made available under a grant program to nonprofit community-based organizations in areas at high risk for toxic lead exposure. Grantees shall use the money to purchase lead cleanup equipment ~~and educational materials,~~ and to pay for training for staff and volunteers for lead abatement certification. Grantees may work with licensed lead abatement contractors and certified trainers in order to ~~meet the requirements of this program~~ receive training necessary for certification under section 144.876, subdivision 1. Lead cleanup equipment shall include: high efficiency particle accumulator and wet vacuum cleaners, drop cloths, secure containers, respirators, scrapers, dust and particle containment material, and other cleanup and containment materials to remove loose paint and plaster, patch ~~loose paint and~~ plaster, control household dust, wax floors, clean carpets and sidewalks, and cover bare soil.

(b) Upon certification, the ~~grantees~~ grantee's staff and volunteers may make equipment and educational materials available to residents and property owners and instruct them on the proper use. Equipment shall be made available to low-income households on a priority basis at no fee, and other households on a sliding fee scale. Equipment shall not be made available to any person, licensed lead abatement contractor, or certified trainer who charges or intends to charge a fee for services performed using equipment or materials purchased by a nonprofit community-based organization through a grant obtained under this subdivision.

Sec. 35. Minnesota Statutes 1992, section 144.872, is amended by adding a subdivision to read:

Subd. 5. **SWAB TEAMS.** Boards of health may determine priority for responding to cases of elevated blood lead levels.

Sec. 36. Minnesota Statutes 1992, section 144.873, is amended to read:

144.873 **REPORTING OF MEDICAL AND ENVIRONMENTAL SAMPLE ANALYSES.**

Subdivision 1. **REPORT REQUIRED.** Medical laboratories performing blood lead analyses must report to the commissioner finger stick and venipuncture blood lead results and the method used to obtain these results. Boards of health must report to the commissioner the results of analyses from residential samples of paint, soil, dust, and drinking water. The commissioner shall require

the date of the test, and the current address and birthdate of the patient, and other related information from medical laboratories and boards of health as may be needed to monitor and evaluate blood lead levels in the public. If a clinic or physician sends a blood lead test to a medical laboratory outside of Minnesota, that clinic or physician must meet the reporting requirements under this subdivision.

Subd. 2. **TEST OF CHILDREN IN HIGH RISK AREAS.** Within limits of available state and federal appropriations, the commissioner shall promote and subsidize a blood lead test of all children ~~under six years of age~~ before the sixth birthday who live in all areas of high risk for toxic lead exposure that are currently known or subsequently identified. Within the limits of available appropriations, the commissioner shall conduct surveys~~, especially soil assessments larger than a residence, as defined by the commissioner,~~ to determine probable sources of lead exposure in greater Minnesota communities where a case of elevated blood lead levels has been reported.

Surveys conducted under this subdivision must consist of evaluating census tracts to determine whether or not they are at high risk for toxic lead exposure. The evaluation shall consist of a priority response determination under section 144.878, subdivision 2a. In making this evaluation, the commissioner shall:

(1) conduct a soil survey in the manner provided for under Minnesota Rules, part 4761.0400, subpart 8; and

(2) evaluate housing quality, if data is available.

The commissioner may also conduct a blood lead screening of children under six years of age within the census tract.

Subd. 3. **STATEWIDE LEAD SCREENING.** Statewide lead screening by blood lead assays in conjunction with routine blood tests analyzed by laboratories that meet the center for disease control laboratory proficiency standards, by atomic absorption equipment, or other equipment with equivalent or better accuracy shall be ~~advocated~~ used by boards of health.

Sec. 37. Minnesota Statutes 1992, section 144.874, subdivision 1, is amended to read:

Subdivision 1. **RESIDENCE ASSESSMENT.** (a) A board of health must conduct a timely assessment of a residence and all common areas, if the residence is located in a building with two or more residential units, within five working days of receiving notification that the criteria in this subdivision have been met, as confirmed by lead analysis of a venous blood sample, to determine sources of lead exposure if:

(1) a pregnant woman in the residence is identified as having a blood lead level of at least ten micrograms of lead per deciliter of whole blood;

(2) a child in the residence is identified as having a blood lead level at or above 20 micrograms per deciliter; or

(3) a child in the residence is identified as having a blood lead level that persists in the range of 15 to 19 micrograms per deciliter for 90 days after initial identification.

(b) Within the limits of available state and federal appropriations, a board of health shall also conduct home assessments for children whose confirmed blood lead levels are in the range of ten to 19 micrograms per deciliter. A board of health may assess a residence even if none of the three criteria in this subdivision are met.

(c) If a child regularly spends several hours ~~per day~~ at one or more other sites such as another residence, ~~such as~~ or a residential or commercial child care facility, the board of health must also assess the other ~~residence~~ sites. The board of health shall have one additional day to complete the assessment for each additional site.

~~(b)~~ (d) The board of health must conduct the residential assessment according to rules adopted by the commissioner ~~according to~~ under section 144.878. A board of health must have residence assessments performed by lead inspectors licensed by the commissioner according to rules adopted under section 144.878. A board of health may observe the performance of lead abatement in progress and may enforce the provisions of sections 144.871 to 144.879 under section 144.8781. The staff complement of the department of health shall be increased by two full-time equivalent positions who shall be lead inspectors.

Sec. 38. Minnesota Statutes 1992, section 144.874, subdivision 2, is amended to read:

Subd. 2. **RESIDENTIAL LEAD ASSESSMENT GUIDE.** (a) The commissioner of health shall develop or purchase a residential lead assessment guide that enables parents and other caregivers to assess the possible lead sources present and that suggests lead abatement actions. The guide must provide information on safe abatement and disposal methods, sources of equipment, and telephone numbers for additional information to enable the persons to either perform the abatement or to intelligently select an abatement contractor. In addition, the guide must:

(1) meet the requirements of Minnesota laws and rules;

(2) be understandable at not more than an eighth grade reading level;

(3) include information on all necessary safety precautions for all lead source cleanup; and

(4) be the best available educational material.

(b) A board of health must provide the residential lead assessment guide at no cost to:

(1) parents and other caregivers of children who are identified as having blood lead levels of at least ten micrograms per deciliter; and

(2) all property owners ~~and occupants~~ who are issued housing code orders requiring ~~disruption~~ abatement of lead sources, and all occupants of those residences.

(c) A board of health must provide the residential lead assessment guide on request to owners or ~~tenants~~ occupants of residential property within the jurisdiction of the board of health.

Sec. 39. Minnesota Statutes 1992, section 144.874, subdivision 3, is amended to read:

Subd. 3. **SWAB TEAMS; LEAD ASSESSMENT; LEAD ABATEMENT ORDERS.** A board of health must order a property owner to perform abatement on a lead source that exceeds a standard adopted according to section 144.878 at the residence of a child with an elevated blood lead level or a pregnant woman with a blood lead level of at least ten micrograms per deciliter. Lead abatement orders must require that any source of damage, such as leaking roofs, plumbing, and windows, must be repaired or replaced, as needed, to prevent damage to lead-containing interior surfaces. The board of health is not required to pay for lead abatement. With each lead abatement order, the board of health must coordinate with swab team abatement and provide a residential lead abatement guide.

Sec. 40. Minnesota Statutes 1992, section 144.874, is amended by adding a subdivision to read:

Subd. 3a. **SWAB TEAM SERVICES.** After issuing abatement orders for a residence of a child or pregnant women with elevated blood lead levels, the commissioner or a board of health must send a swab team within five working days to the residence to perform swab team services as defined in section 144.871, subdivision 9. If the commissioner or board of health provides swab team services after an assessment, but before the issuance of an abatement order, swab team services do not need to be repeated after the issuance of an abatement order. Swab team services are not considered completed until the reassessment required under subdivision 6 shows no violation of one or more of the standards under section 144.878, subdivision 2. If assessments and abatement orders are conducted at times when weather or soil conditions do not permit the assessment or abatement of lead in soil, the residences shall have their soil assessed and abated, if necessary, at the first opportunity that weather and soil conditions allow.

Sec. 41. Minnesota Statutes 1992, section 144.874, subdivision 4, is amended to read:

Subd. 4. **RELOCATION OF RESIDENTS.** (a) A board of health must ensure that residents are relocated from rooms or dwellings during abatement that generates leaded dust, such as removal or disruption of lead-based paint or plaster that contains lead. Residents must be allowed to return to the residence or dwelling after completion of abatement. A board of health shall use grant funds under section 144.872, subdivision 3, in cooperation with local housing agencies, to pay for moving costs and rent for a temporary residence for any low-income resident temporarily relocated during lead abatement~~, not to exceed $250 per household~~. For purposes of this section, "low-income resident" means any resident whose gross household income is at or below 185 percent of the federal poverty level.

(b) Any resident of rental property who is notified by the board of health to vacate the premises during lead abatement notwithstanding any rental agreement or lease provisions:

(1) shall not be required to pay rent due the landlord for the period of time the tenant must vacate the premises; and

(2) may elect to immediately terminate the tenancy effective on the date the tenant vacates the premises for lead abatement, and shall not be liable for any further rent or other charges due under the terms of the tenancy.

(c) A landlord of rental property in which tenants must vacate the premises during lead abatement must:

(1) allow a tenant to return to the dwelling after lead abatement and retesting, as required under subdivision 6, is completed unless the tenant has elected to terminate the tenancy under paragraph (b); and

(2) return any security deposit due under section 504.20 to any tenant who terminates tenancy under paragraph (b) within five days of the date the tenant vacates the unit.

Sec. 42. Minnesota Statutes 1992, section 144.874, subdivision 5, is amended to read:

Subd. 5. **WARNING NOTICE; FINE.** A warning notice must be posted on all entrances to properties for which an order to abate a lead source has been issued by a board of health. ~~This~~ A person who unlawfully removes a warning notice posted under this section may be subject to a fine up to $250. The warning notice must be at least 8-1/2 by 11 inches in size and must include the following language, or substantially similar language:

(a) "This property contains dangerous amounts of lead to which children under age six and pregnant women should not be exposed."

(b) "It is unlawful to remove or deface this warning. ~~This warning may be removed only upon the direction of the board of health.~~"

(c) "Persons who remove or deface this warning are subject to a $250 fine. This warning may be removed only upon the direction of the board of health."

Sec. 43. Minnesota Statutes 1992, section 144.874, subdivision 6, is amended to read:

Subd. 6. **SERVICES AND RETESTING REQUIRED.** After completion of swab team services and the abatement as ordered, including any repairs ordered by a local housing or building inspector, the board of health must retest the residence to assure the violations no longer exist. The board of health is not required to test a residence after lead abatement that was not ordered by the board of health.

Sec. 44. Minnesota Statutes 1992, section 144.874, subdivision 9, is amended to read:

Subd. 9. **PRIMARY PREVENTION.** Although children who are found to already have elevated blood lead levels must have the highest priority for intervention, the commissioner shall pursue primary prevention ~~of lead poisoning~~ for toxic lead exposure within the limits of appropriations.

Sec. 45. Minnesota Statutes 1992, section 144.874, is amended by adding a subdivision to read:

Subd. 11a. **LEAD ABATEMENT DIRECTIVES.** In order to achieve statewide consistency in the application of lead abatement standards, the commissioner shall issue program directives that interpret the application of rules under section 144.878 in ambiguous or unusual lead abatement situations. These directives are guidelines to local boards of health. The commissioner shall periodically review the evaluation of lead abatement orders and the program directives to determine if the rules under section 144.878 need to be amended to reflect new understanding of lead abatement practices and methods.

Sec. 46. Minnesota Statutes 1992, section 144.876, is amended by adding a subdivision to read:

Subd. 4. **NOTICE OF ABATEMENT.** At least five days before starting work at each lead abatement worksite, a lead abatement contractor shall give written notice to the commissioner and the board of health.

Sec. 47. **[144.877] LEAD INSPECTORS; LICENSING.**

Subdivision 1. **LICENSE REQUIRED.** A lead inspector must obtain a license within 180 days of the effective date of this section and must renew it annually. The license must be readily available at assessment sites for inspection by the commissioner or by staff of a board of health with jurisdiction over a work site. A license cannot be transferred.

Subd. 2. **LICENSE APPLICATION.** An application for license or license renewal must be on a form provided by the commissioner and must include:

(1) a $50 nonrefundable fee, in the form of a check;

(2) evidence that the applicant has successfully completed a lead inspector training course approved in subdivision 6, or has, within the previous 180 days, successfully completed an initial lead inspection training course.

The fee required in this subdivision is waived for an employee of a board of health.

Subd. 3. **LICENSE RENEWAL.** A license is valid for one year from the issuance date unless the commissioner revokes it. An applicant must successfully complete either an initial lead inspection training course or an annual refresher lead inspection training course to apply for license renewal.

Subd. 4. **LICENSE REPLACEMENT.** A licensed lead inspector may obtain a replacement license by reapplying for a license. A replacement expires on the same date as the original license. A nonrefundable $25 fee is required with each replacement application.

Subd. 5. **DENIAL OF LICENSE APPLICATION.** The commissioner may deny an application, revoke, or impose limitations or conditions on a license, if the applicant or licensed lead inspector:

(1) violates rules adopted under sections 144.871 to 144.879;

(2) submits an application that is incomplete, inaccurate, or lacks the required fee, or submits an invalid check;

(3) obtains a license, certificate, or approval through error, fraud, or cheating;

(4) provides false or fraudulent information on forms;

(5) aids or allows an unlicensed or uncertified person to engage in activities for which a license or certificate is required;

(6) endangers public health or safety;

(7) has been convicted during the previous five years of a felony or gross misdemeanor related to residential lead assessment or residential lead abatement; or

(8) has been convicted during the previous five years of a violation of section 270.72, 325F.69, or 325F.71.

An application for licensure that has been denied may be resubmitted when the reasons for denial have been corrected. A person whose license is revoked may not apply for a license within one year of the date of revocation. After one year, the application requirements must be followed by an applicant for a license, certificate, or course approval. An applicant who submits an approvable application within 60 days of initial denial is not required to pay a second fee.

Subd. 6. **APPROVAL OF LEAD INSPECTION COURSE.** A lead inspection course sponsored by the United States Environmental Protection Agency is an approved course for the purpose of this section.

Subd. 7. **LEAD INSPECTION; RULES.** The commissioner may adopt rules to implement this section. The commissioner may also approve lead inspector courses offered by groups other than those approved by the United States Environmental Protection Agency and shall charge a fee to cover the costs of approving courses.

Sec. 48. Minnesota Statutes 1992, section 144.878, subdivision 2, is amended to read:

Subd. 2. **LEAD STANDARDS AND ABATEMENT METHODS.** (a) The commissioner shall adopt rules establishing standards and abatement methods for lead in paint, dust, and drinking water in a manner that protects public health and the environment for all residences, including residences also used for a commercial purpose. ~~The commissioner shall adopt priorities for providing abatement services to areas defined to be at high risk for toxic lead exposure. In adopting priorities, the commission shall consider the number of children and pregnant women diagnosed with elevated blood lead levels and the median concentration of lead in the soil. The commissioner shall give priority to areas having the largest population of children and pregnant women having elevated blood lead levels, areas with the highest median soil lead concentration, and areas where it has been determined that there are large numbers of residences that have deteriorating paint.~~ The commissioner shall differentiate between intact paint and deteriorating paint. The commissioner and political subdivisions shall require abatement of intact paint only if the commissioner or political subdivision finds that the intact paint is on a chewable or lead-dust producing surface that is a known source or reasonably expected to be a source of actual lead exposure to a specific person. In adopting rules under this subdivision, the commissioner shall require the best available technology for lead abatement methods, paint stabilization, and repainting.

(b) The commissioner of health shall adopt standards and abatement methods for lead in bare soil on playgrounds and residential property in a manner to protect public health and the environment. The commissioner shall adopt a maximum standard of 100 parts of lead per million in bare soil, unless it is proven that a different standard provides greater protection of public health.

(c) The commissioner of the pollution control agency shall adopt rules to ensure that removal of exterior lead-based coatings from residential property by abrasive blasting methods ~~and disposal of any hazardous waste are~~ is conducted in a manner that protects public health and the environment.

(d) All standards adopted under this subdivision must provide ~~adequate~~ reasonable margins of safety that are consistent with a detailed review of scientific evidence and an emphasis on overprotection rather than underprotection when

the scientific evidence is ambiguous. The rules must apply to any individual performing or ordering the performance of lead abatement.

(e) No unit of local government may have an ordinance or regulation governing lead abatement methods for lead in paint, dust, or soil for residences and residential land that require a different lead abatement method than the lead abatement standards established under sections 144.871 to 144.879.

Sec. 49. Minnesota Statutes 1992, section 144.878, subdivision 2a, is amended to read:

Subd. 2a. **PRIORITIES FOR RESPONSE ACTION.** ~~By January 1, 1988,~~ The commissioner of health must adopt new rules establishing ~~the~~ a priority list of census tracts at high risk for toxic lead exposure for primary prevention response actions. ~~The rules must consider the potential for children's contact with the soil and the existing level of lead in the soil and may consider the relative risk to the public health, the size of the population at risk, and blood lead levels of resident populations.~~ In establishing the list, the commissioner shall award points under this subdivision to each census tract on which information is available. The priority for primary prevention response actions in census tracts at high risk for toxic lead exposure shall be based on the cumulative points awarded to each census tract. A greater number of points means a higher priority. If a tie occurs in the number of points, priority shall be given to the census tract with the higher percentage of population with blood lead levels greater than ten micrograms of lead per deciliter. All local governmental units and boards of health shall follow the priorities under this subdivision. The commissioner shall revise and update the priority list at least every five years. Points shall be awarded to each census tract for each criteria, considered independently, defined in section 144.871, subdivision 7a. Points shall be awarded as follows:

(a) In a census tract where at least 20 children have been screened in the last five years, one point shall be awarded for each five percent of children who were under six years old at the time they were screened for lead in blood and whose blood lead level exceeds ten micrograms of lead per deciliter. An additional point shall be awarded if one percent of the children had blood levels greater than 20 micrograms per deciliter of blood. Two points shall be awarded to a census tract, where the blood lead screening has been inadequate, that is contiguous with a census tract where more than ten percent of the children under six years of age have blood lead levels exceeding ten micrograms per deciliter.

(b) One point shall be awarded for every five percent of housing that is defined as dilapidated or deteriorated by the planning department or similar agency of the city in which the housing is located. Where data is available by neighborhood or section within a city, the percent of dilapidated or deteriorated housing shall apply equally to each census tract within the neighborhood or section.

(c) One point shall be awarded for every 100 parts per million of lead soil, based on the median soil lead values of foundation soil samples, calculated on

100 parts per million intervals, or fraction thereof. For the cities of St. Paul and Minneapolis, the commissioner shall use the June 1988 census tract version of the houseside map entitled "Distribution of Household Lead Content of Soil Dust in the Twin Cities," prepared by the center for urban and regional affairs. Where the map displays a census tract that is crossed by two or more intervals, the commissioner shall make a reasoned determination of the median foundation soil lead value for that tract. Values for census tracts may be updated by surveying the tract according to the procedures under Minnesota Rules, part 4761.0400, subpart 8.

Sec. 50. Minnesota Statutes 1992, section 144.878, subdivision 5, is amended to read:

Subd. 5. **LEAD ABATEMENT CONTRACTORS AND EMPLOYEES.** The commissioner shall adopt rules to license lead abatement contractors, to certify employees of lead abatement contractors who perform abatement, and to certify lead abatement trainers who provide lead abatement training for contractors, employees, or other lead abatement trainers. ~~The rules must include standards and procedures for on-the-job training for swab teams.~~ A person who performs painting, renovation, rehabilitation, remodeling, or other residential work that is not lead abatement need not be a licensed lead abatement contractor. By July 1, 1994, a person who performs work that removes intact paint on residences built before February 27, 1978, must determine whether lead sources are present and whether the planned work would be lead abatement as defined in section 144.871, subdivision 2. This determination may be made by quantitative chemical analysis, X-ray fluorescence analyzer, or chemical spot test using sodium rhodizonate. If lead sources are identified, the work must be performed by a licensed lead abatement contractor. An owner of an owner-occupied residence with one or two units is not subject to the requirements under this subdivision. All lead abatement training must include a hands-on component and instruction on the health effects of lead exposure, the use of personal protective equipment, workplace hazards and safety problems, abatement methods and work practices, decontamination procedures, cleanup and waste disposal procedures, lead monitoring and testing methods, and legal rights and responsibilities. The commissioner shall adopt rules to approve lead abatement training courses and to charge a fee for approval. At least 30 days before publishing initial notice of proposed rules under this subdivision on the licensing of lead abatement contractors, the commissioner shall submit the rules to the chairs of the health and human services committees in the house of representatives and the senate, and to any legislative committee on licensing created by the legislature.

Sec. 51. **[144.8781] ENFORCEMENT.**

Subdivision 1. **CEASE AND DESIST ORDER.** (a) The commissioner may issue an order requiring a person to cease lead abatement if the commissioner determines that a condition exists that poses an immediate danger to the public health. For purposes of this subdivision, an immediate danger to the public health exists if the commissioner determines that:

(1) lead abatement is being performed in a manner that violates applicable state or federal law or related rules;

(2) the person performing lead abatement is not currently licensed or certified as required by rules adopted under sections 144.871 to 144.879; or

(3) the lead abatement contractor has not given prior written notice required by section 144.876 to the commissioner and board of health.

(b) An order to cease lead abatement is effective for a maximum of 60 days. Following issuance of the order, the commissioner shall provide the contractor or individual with an opportunity for a hearing under the contested case provisions of chapter 14. Within ten days of the hearing, the commissioner shall decide whether to rescind, modify, or reissue the previous order. A modified or reissued order is effective for a maximum of 60 days from the date of modification or reissuance.

Subd. 2. **ORDER FOR CORRECTIVE ACTION.** (a) The commissioner may issue an order requiring a person violating sections 144.871 to 144.879 or a rule adopted under sections 144.871 to 144.879 to take the corrective action the commissioner determines will accomplish the purpose of the project and prevent future violation. The order for corrective action shall state the conditions that constitute the violation, the specific statute or rule violated, and the time by which the violation must be corrected.

(b) If the person believes that the information contained in the commissioner's order for corrective action is in error, the person may ask the commissioner to reconsider the parts of the order that are alleged to be in error. The request must be in writing, delivered to the commissioner by certified mail within five working days of receipt of the order, and:

(1) specify which parts of the order for corrective action are alleged to be in error;

(2) explain why they are in error; and

(3) provide documentation to support the allegation of error.

The commissioner shall respond to a request made under this subdivision within 15 working days after receipt of the request. A request for reconsideration does not stay the order for corrective action but the commissioner may provide additional time to comply with the order after reviewing the request. The commissioner's disposition of a request for reconsideration is final.

Subd. 3. **INJUNCTIVE RELIEF.** In addition to any other remedy provided by law, the commissioner may bring an action for injunctive relief in the district court in Ramsey county or, at the commissioner's discretion, in the district court in the county in which the lead abatement is being undertaken, to halt the work or an activity connected with it. A temporary restraining order or other

injunctive relief may be granted by the court if continuation of the lead abatement or an activity connected with it would result in an imminent risk of harm to any person.

Subd. 4. **PENALTIES.** (a) A person who violates any of the requirements of sections 144.871 to 144.879 or any requirement, rule, or order issued under this section is subject to a civil penalty of not more than $5,000 per day of violation. Penalties may be recovered in a civil action in the name of the state brought by the attorney general.

(b) The commissioner may issue an order assessing a penalty of not more than $5,000 per violation to any person who violates any of the requirements of sections 144.871 to 144.879 or any requirement, rule, or order issued under this section. A person subject to an administrative penalty order may request a contested case hearing under chapter 14 within 20 days from date of receipt of the penalty order. If the penalty order is not contested within 20 days of receipt, it becomes final and may not be contested.

(c) The amount of penalty shall be based on the past history of violations, the severity of violation, the culpability of the person, and other relevant factors.

(d) Penalties assessed under sections 144.871 to 144.879 shall be paid to the commissioner for deposit in the general fund. Unpaid penalties shall be increased to 125 percent of the original assessed amount if not paid within 60 days after the penalty order becomes final. After 60 days, interest shall accrue on the unpaid penalty balance at the rate established in section 549.09.

Subd. 5. **MISDEMEANOR PENALTY.** A person is guilty of a misdemeanor and may be sentenced to payment of a fine of not more than $700, imprisonment for not more than 30 days, or both, for each violation if that person:

(1) hinders or delays the commissioner or the commissioner's authorized representative in the performance of the duty to enforce sections 144.871 to 144.879;

(2) undertakes lead abatement without a current, valid license;

(3) refuses to make a license or certificate accessible to either the commissioner or the commissioner's authorized representative;

(4) employs a person to do lead abatement who does not have a valid certificate;

(5) fails to report lead abatement as required by section 144.876; or

(6) makes a false material statement related to a license, certificate, report, or other documents required under sections 144.871 to 144.879.

Subd. 6. **DISCRIMINATION.** A person who discriminates against or oth-

erwise sanctions an employee who complains to or cooperates with the commissioner in administering sections 144.871 to 144.879 is guilty of a misdemeanor.

Sec. 52. Minnesota Statutes 1992, section 144.98, subdivision 5, is amended to read:

Subd. 5. ~~LABORATORY CERTIFICATION ACCOUNT~~ STATE GOVERNMENT SPECIAL REVENUE FUND. ~~There is an account in the special revenue fund called the laboratory certification account.~~ Fees collected under this section ~~and appropriations for the purposes of this section~~ must be deposited in the ~~laboratory certification account. Money in the laboratory certification account is annually appropriated to the commissioner of health to administer this section~~ state government special revenue fund.

Sec. 53. Minnesota Statutes 1992, section 144A.04, subdivision 7, is amended to read:

Subd. 7. **MINIMUM NURSING STAFF REQUIREMENT.** Notwithstanding the provisions of Minnesota Rules, part 4655.5600, the minimum staffing standard for nursing personnel in certified nursing homes is as follows:

(a) The minimum number of hours of nursing personnel to be provided in a nursing home is the greater of two hours per resident per 24 hours or 0.95 hours per standardized resident day.

(b) For purposes of this subdivision, "hours of nursing personnel" means the paid, on-duty, productive nursing hours of all nurses and nursing assistants, calculated on the basis of any given 24-hour period. "Productive nursing hours" means all on-duty hours during which nurses and nursing assistants are engaged in nursing duties. Examples of nursing duties may be found in Minnesota Rules, parts 4655.5900, 4655.6100, and 4655.6400. Not included are vacations, holidays, sick leave, in-service classroom training, or lunches. Also not included are the nonproductive nursing hours of the in-service training director. In homes with more than 60 licensed beds, the hours of the director of nursing are excluded. "Standardized resident day" means the sum of the number of residents in each case mix class multiplied by the case mix weight for that resident class, as found in Minnesota Rules, part 9549.0059, subpart 2, calculated on the basis of a facility's census for any given day. For the purpose of determining a facility's census, the commissioner of health shall exclude the resident days claimed by the facility for resident therapeutic leave or bed hold days.

(c) Calculation of nursing hours per standardized resident day is performed by dividing total hours of nursing personnel for a given period by the total of standardized resident days for that same period.

(d) A nursing home that is issued a notice of noncompliance under section 144A.10, subdivision 5, for a violation of this subdivision, shall be assessed a civil fine of $300 for each day of noncompliance, subject to section 144A.10, subdivisions 7 and 8.

Sec. 54. **[144C.01] AMBULANCE SERVICE PERSONNEL LONGEVITY AWARD AND INCENTIVE PROGRAM.**

Subdivision 1. **ESTABLISHMENT.** An ambulance service personnel longevity award and incentive program is established. The program is intended to recognize the service rendered to state and local government and the citizens of Minnesota by qualified ambulance service personnel, and to reward qualified ambulance service personnel for significant contributions to state and local government and to the public. The purpose of the ambulance service personnel longevity award and incentive trust is to accumulate resources to allow for the payment of longevity awards to qualified ambulance service personnel upon the completion of a substantial ambulance service career.

Subd. 2. **ADMINISTRATION.** (a) Unless paragraph (c) applies, consistent with the responsibilities of the state board of investment and the various ambulance services, the ambulance service personnel longevity award and incentive program must be administered by the commissioner of health. The administrative responsibilities of the commissioner of health for the program relate solely to the record keeping, award application, and award payment functions. The state board of investment is responsible for the investment of the ambulance service personnel longevity award and incentive trust. The applicable ambulance service is responsible for determining, consistent with this chapter, who is a qualified ambulance service person, what constitutes a year of credited ambulance service, what constitutes sufficient documentation of a year of prior service, and for submission of all necessary data to the commissioner of health in a manner consistent with this chapter. Determinations of an ambulance service are final.

(b) The commissioner of health may administer the commissioner's assigned responsibilities regarding the program directly or may retain a qualified governmental or nongovernmental plan administrator under contract to administer those responsibilities regarding the program. A contract with a qualified plan administrator must be the result of an open competitive bidding process and must be reopened for competitive bidding at least once during every five-year period after the effective date of this section.

(c) The commissioner of employee relations shall review the options within state government for the most appropriate administration of pension plans or similar arrangements for emergency service personnel and recommend to the governor the most appropriate future pension plan or nonpension plan administrative arrangement for this chapter. If the governor concurs in the recommendation, the governor shall transfer the future administrative responsibilities relating to this chapter to that administrative agency.

Sec. 55. **[144C.02] PROGRAM ELIGIBILITY; QUALIFIED AMBULANCE SERVICE PERSONNEL.**

(a) Persons eligible to participate in the ambulance service personnel longevity award and incentive program are qualified ambulance service personnel.

(b) Qualified ambulance service personnel are ambulance attendants, ambulance drivers, and ambulance service medical directors or medical advisors who meet the following requirements:

(1) employment of the person by or provision by the person of service to an ambulance service that is licensed as such by the state of Minnesota and that provides ambulance services that are generally available to the public and are free of unfair discriminatory practices under chapter 363;

(2) performance by the person during the 12 months ending as of the immediately previous June 30 of all or a predominant portion of the person's services in the state of Minnesota or on behalf of Minnesota residents, as verified by August 1 annually in an affidavit from the chief administrative officer of the ambulance service;

(3) current certification of the person during the 12 months ending as of the immediately previous June 30 by the Minnesota department of health as an ambulance attendant, ambulance driver, or ambulance service medical director or medical advisor under section 144.804, and supporting rules, and current active ambulance service employment or service provision status of the person, as verified by August 1 annually in an affidavit from the chief administrative officer of the ambulance service; and

(4) conformance by the person with the definition of the phrase "volunteer ambulance attendant" under section 144.8091, subdivision 2, except that for the salary limit specified in that provision there must be substituted, for purposes of this section only, a limit of $3,000 for calendar year 1993, and $3,000 multiplied by the cumulative percentage increase in the national Consumer Price Index, all items, for urban wage earners and clerical workers, as published by the federal Department of Labor, Bureau of Labor Statistics, since December 31, 1993, and for an ambulance service medical director, conformance based solely on the person's hourly stipends or salary for service as a medical director.

(c) The term "active ambulance service employment or service provision status" means being in good standing with and on the active roster of the ambulance service making the certification.

(d) The maximum period of ambulance service employment or service provision for which a person may receive credit towards an award under this chapter, including prior service credit under section 144C.07, subdivision 2, paragraph (c), is 20 years.

(e) For a person who is employed by or provides service to more than one ambulance service concurrently during any period during the 12-month period, credit towards an award under this chapter is limited to one ambulance service during any period. The creditable period is with the ambulance service for which the person undertakes the greatest portion of employment or service hours.

Sec. 56. **[144C.03] AMBULANCE SERVICE PERSONNEL LONGEVITY AWARD AND INCENTIVE TRUST; TRUST ACCOUNT.**

Subdivision 1. **TRUST.** There is established an ambulance service personnel longevity award and incentive trust.

Subd. 2. **TRUST ACCOUNT.** There is established in the general fund an ambulance service personnel longevity award and incentive trust account. The trust account must be credited with appropriations for that purpose, and investment earnings on those accumulated proceeds. The assets and income of the trust account must be held and managed by the commissioner of finance and the state board of investment for the benefit of the state of Minnesota and its general creditors.

Subd. 3. **PRIORITY OF CLAIMS.** The state of Minnesota intends that this program, trust, and trust account not constitute a separate fund for any legal purpose, including the federal Internal Revenue Code, as amended, and the federal Employee Retirement Income Security Act of 1974, as amended. Qualified ambulance service personnel have only an unsecured promise of the state of Minnesota to pay a longevity award upon meeting entitlement requirements set forth in section 144C.08, and qualified ambulance service personnel meeting those entitlement requirements have the status of general unsecured creditors with respect to an ambulance service personnel longevity award, if and when awarded.

Sec. 57. **[144C.05] DISTRIBUTIONS FROM ACCOUNT.**

Subdivision 1. **AWARD PAYMENTS.** (a) The commissioner of health or the commissioner's designee under section 144C.01, subdivision 2, shall pay ambulance service personnel longevity awards to qualified ambulance service personnel determined to be entitled to an award under section 144C.08 by the commissioner based on the submissions by the various ambulance services. Amounts necessary to pay the ambulance service personnel longevity award are appropriated from the ambulance service personnel longevity award and incentive trust account to the commissioner of health.

(b) If the state of Minnesota is unable to meet its financial obligations as they become due, the commissioner of health shall undertake all necessary steps to discontinue paying ambulance service personnel longevity awards until the state of Minnesota is again able to meet its financial obligations as they become due.

Subd. 2. **GENERAL CREDITORS OF THE STATE.** The trust account is at all times subject to a levy under an execution of any general creditor of the state of Minnesota, and if no other funds are available to satisfy that levy, the levy has priority for payment from the trust account before any ambulance service personnel longevity award.

Sec. 58. **[144C.06] TRUST ACCOUNT INVESTMENT.**

The trust account must be invested by the state board of investment, as provided in section 11A.20.

Sec. 59. **[144C.07] CREDITING QUALIFIED AMBULANCE PERSONNEL SERVICE.**

Subdivision 1. **SEPARATE RECORD KEEPING.** The commissioner of health or the commissioner's designee under section 144C.01, subdivision 2, shall maintain a separate record of potential award accumulations for each qualified ambulance service person under subdivision 2.

Subd. 2. **POTENTIAL ALLOCATIONS.** (a) On September 1, annually, the commissioner of health or the commissioner's designee under section 144C.01, subdivision 2, shall determine the amount of the allocation of the prior year's accumulation to each qualified ambulance service person. The prior year's net investment gain or loss under paragraph (b) must be allocated and that year's appropriation, after deduction of administrative expenses, also must be allocated.

(b) The difference in the market value of the assets of the ambulance service personnel longevity award and incentive trust account as of the immediately previous June 30 and the June 30 occurring 12 months earlier must be reported on or before August 15 by the state board of investment. The market value gain or loss must be expressed as a percentage of the total potential award accumulations as of the immediately previous June 30, and that positive or negative percentage must be applied to increase or decrease the recorded potential award accumulation of each qualified ambulance service person.

(c) The appropriation for this purpose, after deduction of administrative expenses, must be divided by the total number of additional ambulance service personnel years of service recognized since the last allocation or 1,000 years of service, whichever is greater. A qualified ambulance service person must be credited with a year of service if the person is certified by the chief administrative officer of the ambulance service as having rendered active ambulance service during the 12 months ending as of the immediately previous June 30. If the person has rendered prior active ambulance service, the person must be additionally credited with one-fifth of a year of service for each year of active ambulance service rendered before June 30, 1993, but not to exceed in any year one additional year of service or to exceed in total five years of prior service. Prior active ambulance service means employment by or the provision of service to a licensed ambulance service before June 30, 1993, as determined by the person's current ambulance service based on records provided by the person that were contemporaneous to the service. The prior ambulance service must be reported on or before August 15 to the commissioner of health in an affidavit from the chief administrative officer of the ambulance service.

Sec. 60. **[144C.08] AMBULANCE SERVICE PERSONNEL LONGEVITY AWARD.**

(a) A qualified ambulance service person who has terminated active ambulance service, who has at least five years of credited ambulance service, who is at least 50 years old, and who is among the 400 persons with the greatest amount of credited ambulance service applying for a longevity award during that year, is entitled, upon application, to an ambulance service personnel longevity award. An applicant whose application is not approved because of the limit on the number of annual awards may apply in a subsequent year.

(b) If a qualified ambulance service person who meets the age and service requirements specified in paragraph (a) dies before applying for a longevity award, the estate of the decedent is entitled, upon application, to the decedent's ambulance service personnel longevity award, without reference to the limit on the number of annual awards.

(c) An ambulance service personnel longevity award is the total amount of the person's accumulations indicated in the person's separate record under section 144C.07 as of the August 15 preceding the application. The amount is payable only in a lump sum.

(d) Applications for an ambulance service personnel longevity award must be received by the commissioner of health or the commissioner's designee under section 144C.01, subdivision 2, by August 15, annually. Ambulance service personnel longevity awards are payable only as of the last business day in October annually.

Sec. 61. **[144C.09] EFFECT OF CHANGES.**

Subdivision 1. **MODIFICATIONS.** The ambulance service personnel longevity award and incentive program is a gratuity established by the state of Minnesota and may be modified by subsequent legislative enactment at any time without creating any cause of action for any ambulance service personnel related to the program as a result. No provision of this act and no subsequent amendment may be interpreted as causing or resulting in the program to be funded for federal Internal Revenue Code or federal Employee Retirement Income Security Act of 1974 purposes, or as causing or resulting in any contributions to or investment income earned by the ambulance service personnel longevity award and incentive trust account to be subject to federal income tax to ambulance service personnel or their beneficiaries before actual receipt of a longevity award under section 144C.08.

Subd. 2. **NONASSIGNABILITY.** No entitlement or claim of a qualified ambulance service person or the person's beneficiary to an ambulance service personnel longevity award is assignable, or subject to garnishment, attachment, execution, levy, or legal process of any kind, except as provided in section 518.58, 518.581, or 518.611. The commissioner of health may not recognize any attempted transfer, assignment, or pledge of an ambulance service personnel longevity award.

Subd. 3. **PUBLIC EMPLOYEE STATUS.** Recognizing the important public function performed by ambulance service personnel, only for purposes of this act and the receipt of a state sponsored gratuity in the form of an ambulance service personnel longevity award, all qualified ambulance service personnel are considered to be public employees.

Sec. 62. **[144C.10] SCOPE OF ADMINISTRATIVE DUTIES.**

For purposes of administering the award and incentive program, the commissioner of health cannot hear appeals, direct ambulance services to take any specific actions, investigate or take action on individual complaints, or otherwise act on information beyond that submitted by the licensed ambulance services.

Sec. 63. Minnesota Statutes 1992, section 149.04, is amended to read:

149.04 **RENEWAL OF LICENSE.**

Any license may be renewed from time to time and shall be in force after such renewal for a period specified by the state commissioner of health upon the payment of a renewal fee in an amount prescribed by the commissioner pursuant to section 144.122.

All fees received under this chapter shall be paid by the state commissioner of health to the credit of the ~~general~~ state government special revenue fund in the state treasury. The salaries of the necessary employees of the commissioner, the per diem of the inspectors and examiners, their expenses, and all incidental expenses of the commissioner in carrying out the provisions of this chapter shall be paid from the appropriations made to the state commissioner of health, but no expense or claim shall be incurred or paid in excess of the amount received from the fees herein provided.

Sec. 64. Minnesota Statutes 1992, section 157.045, is amended to read:

157.045 **INCREASE IN FEES.**

For licenses issued for 1989 and succeeding years, the commissioner of health shall increase license fees for facilities licensed under this chapter and chapter 327 to a level sufficient to recover all expenses related to the licensing, inspection, and enforcement activities prescribed in those chapters. In calculating the fee increase, the commissioner shall include the salaries and expenses of 5.5 new positions required to meet the inspection frequency prescribed in section 157.04. Fees collected must be deposited in the ~~special revenue account~~ state government special revenue fund.

Sec. 65. Minnesota Statutes 1992, section 198.34, is amended to read:

198.34 **DEPOSIT OF RECEIPTS.**

Federal money received by the board for the care of veterans in a veterans home~~, after being credited to a federal receipt account, must be transferred to~~

~~the general revenue fund in the state treasury~~ must be deposited into a dedicated account in the state treasury and is appropriated to the veterans homes board of directors for the operational needs of the veterans homes and the board of directors. Money paid to the board by a veteran or by another person on behalf of a veteran for care in a veterans home must be deposited in the state treasury ~~and credited to the general fund~~ in a dedicated account and is appropriated to the veterans homes board of directors for the operational needs of the veterans homes and the board of directors.

Sec. 66. **[198.36] VETERANS HOME; FERGUS FALLS.**

Subdivision 1. **ESTABLISHMENT.** The board shall establish a veterans home in Fergus Falls to provide at least 60 beds for skilled nursing care in conformance with licensing rules of the department of health.

Subd. 2. **FUNDING.** The home must be purchased or built with funds, 65 percent of which must be provided by the federal government, and 35 percent by other nonstate sources, including local units of government, veterans' organizations, and corporations or other business entities.

Subd. 3. **SUPPORT SERVICES.** Upon request, the department of human services shall arrange for the extension of support services to the veterans home in Fergus Falls including, but not limited to, the provision of utilities, and kitchen and laundry services.

Sec. 67. Minnesota Statutes 1992, section 214.04, subdivision 1, is amended to read:

Subdivision 1. **SERVICES PROVIDED.** The commissioner of administration with respect to the board of electricity, the commissioner of education with respect to the board of teaching, the commissioner of public safety with respect to the board of private detective and protective agent services, and the board of peace officer standards and training, and the commissioner of revenue with respect to the board of assessors, shall provide suitable offices and other space, joint conference and hearing facilities, examination rooms, and the following administrative support services: purchasing service, accounting service, advisory personnel services, consulting services relating to evaluation procedures and techniques, data processing, duplicating, mailing services, automated printing of license renewals, and such other similar services of a housekeeping nature as are generally available to other agencies of state government. Investigative services shall be provided the boards by employees of the office of attorney general. The commissioner of health with respect to the health-related licensing boards ~~and~~ shall provide mailing and office supply services and may provide other facilities and services listed in this subdivision at a central location upon request of the health-related licensing boards. The ~~chair of the department~~ commissioner of commerce with respect to the remaining non-health-related licensing boards shall provide the above facilities and services at a central location for the ~~health-related and~~ remaining non-health-related licensing boards. The legal and investi-

gative services for the boards shall be provided by employees of the attorney general assigned to the departments servicing the boards. Notwithstanding the foregoing, the attorney general shall not be precluded by this section from assigning other attorneys to service a board if necessary in order to insure competent and consistent legal representation. Persons providing legal and investigative services shall to the extent practicable provide the services on a regular basis to the same board or boards.

Sec. 68. Minnesota Statutes 1992, section 214.06, subdivision 1, is amended to read:

Subdivision 1. **FEE ADJUSTMENT.** Notwithstanding any law to the contrary, the commissioner of health as authorized by section 214.13, all health-related licensing boards and all non-health-related licensing boards shall by rule, with the approval of the commissioner of finance, adjust any fee which the commissioner of health or the board is empowered to assess a sufficient amount so that the total fees collected by each board will as closely as possible equal anticipated expenditures during the fiscal biennium, as provided in section 16A.128. For members of an occupation registered after July 1, 1984, by the commissioner of health under the provisions of section 214,13, the fee established must include an amount necessary to recover, over a five-year period, the commissioner's direct expenditures for adoption of the rules providing for registration of members of the occupation. All fees received shall be deposited in the state treasury. Fees received by the commissioner of health or health-related licensing boards must be credited to the health occupations licensing account in the state government special revenue fund.

Sec. 69. Minnesota Statutes 1992, section 214.06, is amended by adding a subdivision to read:

Subd. 3. **HEALTH-RELATED LICENSING BOARDS.** Notwithstanding section 14.22, subdivision 1, clause (3), a public hearing is not required to be held when the health-related licensing boards need to raise fees to cover anticipated expenditures in a biennium. The notice of intention to adopt the rules, as required under section 14.22, must state that no hearing will be held.

Sec. 70. **[214.103] HEALTH-RELATED LICENSING BOARDS; COMPLAINTS; INVESTIGATION AND HEARING.**

Subdivision 1. **APPLICATION.** For purposes of this section, "board" means "health-related licensing board" and does not include non-health-related licensing boards. Nothing in this section supersedes section 214.10, subdivisions 2a, 3, 8, and 9, as they apply to the health-related licensing boards.

Subd. 2. **RECEIPT OF COMPLAINT.** The boards shall receive and resolve complaints or other communications, whether oral or written, against regulated persons. Before resolving an oral complaint, the executive director or a board member designated by the board to review complaints may require the

complainant to state the complaint in writing. The executive director or the designated board member shall determine whether the complaint alleges or implies a violation of a statute or rule which the board is empowered to enforce. The executive director or the designated board member may consult with the designee of the attorney general as to a board's jurisdiction over a complaint. If the executive director or the designated board member determines that it is necessary, the executive director may seek additional information to determine whether the complaint is jurisdictional or to clarify the nature of the allegations by obtaining records or other written material, obtaining a handwriting sample from the regulated person, clarifying the alleged facts with the complainant, and requesting a written response from the subject of the complaint.

Subd. 3. **REFERRAL TO OTHER AGENCIES.** The executive director shall forward to another governmental agency any complaints received by the board which do not relate to the board's jurisdiction but which relate to matters within the jurisdiction of another governmental agency. The agency shall advise the executive director of the disposition of the complaint. A complaint or other information received by another governmental agency relating to a statute or rule which a board is empowered to enforce must be forwarded to the executive director of the board to be processed in accordance with this section.

Subd. 4. **ROLE OF THE ATTORNEY GENERAL.** The executive director or the designated board member shall forward a complaint and any additional information to the designee of the attorney general when the executive director or the designated board member determines that a complaint is jurisdictional and (1) requires investigation before the executive director or the designated board member may resolve the complaint; (2) that attempts at resolution for disciplinary action or the initiation of a contested case hearing is appropriate; (3) that an agreement for corrective action is warranted; or (4) that the complaint should be dismissed, consistent with subdivision 8.

Subd. 5. **INVESTIGATION BY ATTORNEY GENERAL.** If the executive director or the designated board member determines that investigation is necessary before resolving the complaint, the executive director shall forward the complaint and any additional information to the designee of the attorney general. The designee of the attorney general shall evaluate the communications forwarded and investigate as appropriate. The designee of the attorney general may also investigate any other complaint forwarded under subdivision 3 when the designee of the attorney general determines that investigation is necessary. In the process of evaluation and investigation, the designee shall consult with or seek the assistance of the executive director or the designated board member. The designee may also consult with or seek the assistance of other qualified persons who are not members of the board who the designee believes will materially aid in the process of evaluation or investigation. Upon completion of the investigation, the designee shall forward the investigative report to the executive director.

Subd. 6. **ATTEMPTS AT RESOLUTION.** (a) At any time after receipt of a complaint, the executive director or the designated board member may attempt to resolve the complaint with the regulated person. The available means for resolution include a conference or any other written or oral communication with the regulated person. A conference may be held for the purposes of investigation, negotiation, education, or conciliation. The results of attempts at resolution with the regulated person may include a recommendation to the board for disciplinary action, an agreement between the executive director or the designated board member and the regulated person for corrective action, or the dismissal of a complaint. If attempts at resolution are not in the public interest or are not satisfactory to the executive director or the designated board member, then the executive director or the designated board member may initiate a contested case hearing.

(1) The designee of the attorney general shall represent the board in all attempts at resolution which the executive director or the designated board member anticipate may result in disciplinary action. The available remedies for disciplinary action by consent with the regulated person are those listed in section 214.108, subdivision 4. A stipulation between the executive director or the designated board member and the regulated person shall be presented to the board for the board's consideration. An approved stipulation and resulting order shall become public data.

(2) The designee of the attorney general shall represent the board upon the request of the executive director or the designated board member in all attempts at resolution which the executive director or the designated board member anticipate may result in corrective action. Any agreement between the executive director or the designated board member and the regulated person for corrective action shall be in writing and shall be reviewed by the designee of the attorney general prior to its execution. The agreement for corrective action shall provide for dismissal of the complaint upon successful completion by the regulated person of the corrective action.

(b) Upon receipt of a complaint alleging sexual contact or sexual conduct with a client, the board must forward the complaint to the designee of the attorney general for an investigation. If, after it is investigated, the complaint appears to provide a basis for disciplinary action, the board shall resolve the complaint by disciplinary action or initiate a contested case hearing. Notwithstanding paragraph (a), clause (2), a board may not take corrective action or dismiss a complaint alleging sexual contact or sexual conduct with a client unless, in the opinion of the executive director, the designated board member, and the designee of the attorney general, there is insufficient evidence to justify disciplinary action.

Subd. 7. **CONTESTED CASE HEARING.** If the executive director or the designated board member determines that attempts at resolution of a complaint are not in the public interest or are not satisfactory to the executive director or the designated board member, the executive director or the designated board

member, after consultation with the designee of the attorney general, may initiate a contested case hearing under chapter 14. The designated board member or any board member who was consulted during the course of an investigation may participate at the contested case hearing. A designated or consulted board member may not deliberate or vote in any proceeding before the board pertaining to the case.

Subd. 8. **DISMISSAL OF A COMPLAINT.** A complaint may not be dismissed without the concurrence of two board members. The designee of the attorney general must review before dismissal any complaints which allege any violation of chapter 609, any conduct which would be required to be reported under section 626.556 or 626.557, any sexual contact or sexual conduct with a client, any violation of a federal law, any actual or potential inability to practice the regulated profession or occupation by reason of illness, use of alcohol, drugs, chemicals, or any other materials, or as a result of any mental or physical condition, any violation of state medical assistance laws, or any disciplinary action related to credentialing in another jurisdiction or country which was based on the same or related conduct specified in this subdivision.

Subd. 9. **INFORMATION TO COMPLAINANT.** A board shall furnish to a person who made a complaint a description of the actions of the board relating to the complaint.

Subd. 10. **PROHIBITED PARTICIPATION BY BOARD MEMBER.** A board member who has actual bias or a current or former direct financial or professional connection with a regulated person may not vote in board actions relating to the regulated person.

Sec. 71. Minnesota Statutes 1992, section 256B.0625, subdivision 14, is amended to read:

Subd. 14. **DIAGNOSTIC, SCREENING, AND PREVENTIVE SERVICES.** (a) Medical assistance covers diagnostic, screening, and preventive services.

(b) "Preventive services" include services related to pregnancy, including services for those conditions which may complicate a pregnancy and which may be available to a pregnant woman determined to be at risk of poor pregnancy outcome. Preventive services available to a woman at risk of poor pregnancy outcome may differ in an amount, duration, or scope from those available to other individuals eligible for medical assistance.

(c) "Screening services" include, but are not limited to, blood lead tests.

Sec. 72. Minnesota Statutes 1992, section 326.44, is amended to read:

326.44 **FEES PAID TO ~~GENERAL~~ STATE GOVERNMENT SPECIAL REVENUE FUND.**

All fees received under sections 326.37 to 326.45 shall be deposited by the state commissioner of health to the credit of the ~~general~~ state government special revenue fund in the state treasury. The salaries of the necessary employees of the commissioner and the per diem of the inspectors and examiners hereinbefore provided, their expenses and all incidental expenses of the commissioner in carrying out the provisions of sections 326.37 to 326.45, shall be paid, from the appropriations made to the state commissioner of health, but no expense or claim shall be incurred or paid in excess of the amount received from the fees herein provided.

Sec. 73. Minnesota Statutes 1992, section 326.75, subdivision 4, is amended to read:

Subd. 4. **DEPOSIT OF FEES.** Fees collected under this section shall be deposited in the ~~general~~ state government special revenue fund.

Sec. 74. Minnesota Statutes 1992, section 462A.03, subdivision 15, is amended to read:

Subd. 15. **REHABILITATION.** "Rehabilitation" means the repair, reconstruction, or improvement of existing residential housing with the object of making such residential housing decent, safe, sanitary and more desirable to live in, of greater market value or in conformance with state, county, or city health, housing, building, fire prevention, and housing maintenance codes, and lead and other public standards applicable to housing, as determined by the agency.

Sec. 75. **REPEALER.**

Subdivision 1. **LEAD ABATEMENT.** Minnesota Statutes 1992, sections 144.8721; 144.874, subdivision 10; and 144.878, subdivision 2a, are repealed.

Subd. 2. **INFECTIOUS WASTE.** Minnesota Statutes 1992, sections 116.76, subdivision 7; 116.79, subdivision 3; 116.81, subdivision 2; and 116.83, subdivision 2, are repealed.

Minnesota Rules, parts 4622.0100; 4622.0300; 4622.0400; 4622.0600; 4622.0700; 4622.0900; 4622.1000; 4622.1050; 4622.1100; 4622.1150; and 4622.1200, are repealed.

Subd. 3. **MENTAL HEALTH PRACTICE EXPENSES.** Minnesota Statutes 1992, section 148B.72, is repealed effective June 30, 1993.

Subd. 4. **ADVISORY COUNCIL.** Minnesota Statutes 1992, section 214.141, is repealed.

Sec. 76. **EFFECTIVE DATE.**

Sections 1, 13 to 17, 24 to 51, 71, 74, and 75, subdivision 1, are effective the day following final enactment. Section 60 is effective July 1, 1995.

Presented to the governor May 27, 1993

Signed by the governor May 27, 1993, 4:22 p.m.

CHAPTER 2—S.F.No. 2

An act relating to education; appropriating money for education and related purposes to the higher education coordinating board, state board of technical colleges, state board for community colleges, state university board, University of Minnesota, higher education board, and the Mayo medical foundation, with certain conditions; prescribing changes in eligibility and in duties and responsibilities for certain financial assistance programs; prescribing fees; adjusting certain duties and powers of the higher education coordinating board; prescribing certain changes for post-secondary systems; establishing an instructional telecommunications council; providing for grants from the higher education coordinating board for regional linkages and coordination; authorizing the state board of community colleges to use higher education facilities authority revenue bonds to construct student residences; creating three accounts in the permanent university fund and making allocations from the accounts; providing tuition exemptions at technical colleges for Southwest Asia veterans; establishing grant programs to promote recruitment and retention initiatives by nurses training programs directed toward persons of color; establishing grant programs for nursing students who are persons of color; amending Minnesota Statutes 1992, sections 3.9741; 16A.127, subdivision 8; 126.56, subdivision 5; 135A.03, subdivision 7; 135A.06, subdivision 1; 135A.061; 136A.02, subdivisions 5, 6, and 7; 136A.0411; 136A.08, subdivisions 2 and 6; 136A.101, subdivisions 1 and 7; 136A.121, subdivisions 6 and 9; 136A.1353, subdivision 4; 136A.1354, subdivision 4; 136A.1701, subdivision 4, and by adding a subdivision; 136A.233; 136A.653, subdivision 1; 136A.69; 136A.87; 136C.13, subdivision 4; 136C.15; 136C.61, subdivision 7; 136E.03; 136E.04, subdivision 1; 137.022, subdivision 3, and by adding a subdivision; 141.25, subdivision 8; 141.26, subdivisions 1 and 5; and 583.24, subdivision 4; Laws 1986, chapter 398, article 1, section 18, as amended; Laws 1990, chapter 591, article 3, section 10, as amended; Laws 1991, chapter 356, articles 6, section 4, as amended; and 9, sections 8 and 10; proposing coding for new law in Minnesota Statutes, chapters 136A; and 137; repealing Minnesota Statutes 1992, sections 136A.121, subdivision 10; 136A.134; 136A.234; and 136A.70; Laws 1991, chapter 356, article 8, section 23.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA: