CHAPTER 207—S.F.No. 1110

An act relating to human services; including provisions for human services administration; life skills and self-sufficiency; childrens' programs; economic self-sufficiency; medical assistance and general assistance medicare; long-term care; community mental health and regional treatment centers; health department; child support enforcement; department of human services flexibility reforms; appropriating money; amending Minnesota Statutes 1994, sections 14.03, subdivision 3; 16B.08, subdivision 5; 62A.045; 62A.046; 62A.048; 62A.27; 62N.381, subdivisions 2, 3, and 4; 144.0721, by adding subdivisions; 144.0723, subdivisions 1, 2, 3, 4, and 6; 144.122; 144.226, subdivision 1; 144.56, by adding a subdivision; 144.562, subdivision 2; 144.702, subdivision 2; 144.801, subdivisions 3 and 5; 144.802; 144.803; 144.804; 144.806; 144.807; 144.808; 144.809; 144.8091; 144.8093; 144.8095; 144A.071, subdivisions 2, 3, 4a, and by adding a subdivision; 144A.073, subdivisions 1, 2, 3, 4, 5, 8, and by adding a subdivision; 144A.31, subdivision 2a; 144A.33, subdivision 3; 144A.43, subdivision 3; 144A.47; 144B.01, subdivision 5; 144C.01, subdivision 2; 144C.05, subdivision 1; 144C.07; 144C.08; 144C.09, subdivision 2; 144C.10; 145A.15; 147.01, subdivision 6; 148.921, subdivision 2; 157.03; 171.07, by adding a subdivision; 198.003, subdivisions 3 and 4; 245.041; 245.4871, subdivisions 12, 33a, and by adding a subdivision; 245.4873, subdivisions 2 and 6; 245.4874; 245.4875, subdivision 2, and by adding a subdivision; 245.4878; 245.4882, subdivision 5; 245.4885, subdivision 2; 245.4886, by adding a subdivision; 245.492, subdivisions 2, 6, 9, and 23; 245.493, subdivision 2; 245.4932, subdivisions 1, 2, 3, and 4; 245.494, subdivisions 1, 2, and 3; 245.495; 245.496, subdivision 3, and by adding a subdivision; 245.825; 245A.02, by adding a subdivision; 245A.03, subdivision 2a; 245A.04, subdivisions 3, 3b, 7, and 9; 245A.06, subdivisions 2, 4, and by adding a subdivision; 245A.07, subdivision 3; 245A.09, by adding subdivisions; 245A.14, subdivisions 6 and 7; 246.18, subdivision 4, and by adding a subdivision; 246.23, subdivision 2; 246.56, by adding a subdivision; 252.27, subdivisions 1, 1a, 2a, and by adding subdivisions; 252.275, subdivisions 3, 4, and 8; 252.292, subdivision 4; 252.46, subdivisions 1, 3, 6, 17, and by adding subdivisions; 253B.091; 254A.17, subdivision 3; 254B.02, subdivision 1; 254B.05, subdivisions 1 and 4; 256.014, subdivision 1; 256.015, subdivisions 1, 2, and 7; 256.025, subdivisions 1, 2, and 3; 256.026; 256.034, subdivision 1; 256.045, subdivisions 3, 4, 4a, and 5; 256.12, subdivision 14; 256.73, subdivisions 2 and 3a; 256.736, subdivisions 3 and 13; 256.74, subdivision 1, and by adding a subdivision; 256.76, subdivision 1; 256.8711; 256.9353, subdivision 8; 256.9365; 256.9657, subdivisions 3 and 4; 256.9685, subdivision 1b, and by adding subdivisions; 256.969, subdivisions 1, 2b, 9, 10, 16, and by adding subdivisions; 256.975, by adding a subdivision; 256.98, subdivisions 1 and 8; 256.983, subdivision 4; 256B.042, subdivision 2; 256B.055, subdivision 12; 256B.056, subdivision 4, and by adding a subdivision; 256B.0575; 256B.059, subdivisions 1, 3, and 5; 256B.0595, subdivisions 1, 2, 3, and 4; 256B.06, subdivision 4; 256B.0625, subdivisions 5, 8, 8a, 13, 13a, 17, 18, 19a, 37, and by adding subdivisions; 256B.0627, subdivisions 1, 2, 4, and 5; 256B.0628, subdivision 2, and by adding a subdivision; 256B.0641, subdivision 1; 256B.0911, subdivisions 2, 2a, 3, 4, and 7; 256B.0913, subdi-

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

visions 4, 5, 8, 12, 14, and by adding subdivisions; 256B.0915, subdivisions 2, 3, 5, and by adding subdivisions; 256B.092, subdivision 4, and by adding a subdivision; 256B.093, subdivisions 1, 2, 3, and by adding a subdivision; 256B.15, subdivisions 1a, 2, and by adding a subdivision; 256B.19, subdivisions 1b, 1c, and 1d; 256B.27, subdivision 2a; 256B.431, subdivisions 2b, 2j, 15, 17, 23, and by adding a subdivision; 256B.432, subdivisions 1, 2, 3, 5, and 6; 256B.49, subdivision 1, and by adding subdivisions; 256B.501, subdivisions 1, 3, 3c, 3g, 8, and by adding subdivisions; 256B.69, subdivisions 4, 5, 6, 9, and by adding subdivisions; 256D.02, subdivision 5; 256D.03, subdivisions 3, 3b, and 4; 256D.05, subdivision 7; 256D.36, subdivision 1; 256D.385; 256D.405, subdivision 3; 256D.425, subdivision 1, and by adding a subdivision; 256D.435, subdivisions 1, 3, 4, 5, 6, and by adding a subdivision; 256D.44, subdivisions 1, 2, 3, 4, 5, and 6; 256D.45, subdivision 1; 256D.46, subdivisions 1 and 2; 256D.48, subdivision 1; 256E.08, subdivision 6; 256E.115; 256F.01; 256F.02; 256F.03, subdivision 5, and by adding a subdivision; 256F.04, subdivisions 1 and 2; 256F.05, subdivisions 2, 3, 4, 5, 7, 8, and by adding a subdivision; 256F.06, subdivisions 1, 2, and 4; 256F.09; 256H.01, subdivisions 9 and 12; 256H.02; 256H.03, subdivisions 1, 2a, 4, 6, and by adding a subdivision; 256H.05, subdivision 6; 256H.08; 256H.11, subdivision 1; 256H.12, subdivisions 1, 3, and by adding a subdivision; 256H.15, subdivision 1; 256H.18; 256H.20, subdivision 3a; 256I.03, subdivision 5, and by adding a subdivision; 256I.04, subdivisions 2b and 3; 256I.05, subdivisions 1, 1a, and 5; 256I.06, subdivisions 2 and 6; 257.3571, subdivision 1; 257.3572; 257.3577, subdivision 1; 257.55, subdivision 1; 257.57, subdivision 2; 257.62, subdivisions 1, 5, and 6; 257.64, subdivision 3; 257.69, subdivisions 1 and 2; 393.07, subdivisions 5 and 10; 393.12; 447.32, subdivision 5; 501B.89, subdivision 1, and by adding a subdivision; 518.171, subdivisions 1, 3, 4, 5, 7, and 8; 518.611, subdivisions 2 and 4; 518.613, subdivision 7; 518.615, subdivision 3; 524.6-207; 550.37, subdivision 14; and Laws 1993, First Special Session chapter 1, article 7, section 51, subdivision 5; and article 8, section 30, subdivision 2; proposing coding for new law in Minnesota Statutes, chapters 144; 145; 157; 214; 245; 245A; 256; and 256B; proposing coding for new law as Minnesota Statutes, chapters 144D; and 144E; repealing Minnesota Statutes 1994, sections 38.161; 38.162; 62C.141; 62C.143; 62D.106; 62E.04, subdivisions 9 and 10; 144.8097; 144A.31, subdivisions 2b, 4, 5, 6, and 7; 157.01; 157.02; 157.031; 157.04; 157.045; 157.05; 157.08; 157.12; 157.13; 157.14; 245.492, subdivision 20; 245.825, subdivision 2; 245.98, subdivision 3; 252.275, subdivisions 4a and 10; 256.851; 256D.35, subdivisions 14 and 19; 256D.36, subdivision 1a; 256D.37; 256D.425, subdivision 3; 256D.435, subdivisions 2, 7, 8, 9, and 10; 256D.44, subdivision 7; 256E.06, subdivisions 12 and 13; 256F.05, subdivisions 2a and 4a; 256F.06, subdivision 3; 256F.09, subdivision 4; and 256H.03, subdivisions 2 and 5.

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

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ARTICLE 1

APPROPRIATIONS

Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "APPROPRIATIONS" are appropriated from the general fund, or any other 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 "1996" and "1997" where used in this article, mean that the appropriation or appropriations listed under them are available for the fiscal year ending June 30, 1996, or June 30, 1997, respectively. Where a dollar amount appears in parentheses, it means a reduction of an appropriation.

SUMMARY BY FUND

APPROPRIATIONS	1996	1997	BIENNIAL TOTAL
General	$2,402,943,000	$2,598,629,000	$5,001,572,000
Local Government Trust Fund	50,499,000	-0-	50,499,000
State Government Special Revenue	24,853,000	24,830,000	49,683,000
Metropolitan Landfill Contingency Action Fund	193,000	193,000	386,000
Trunk Highway	1,513,000	1,513,000	3,026,000
Special Revenue	8,000	8,000	16,000
TOTAL	2,480,009,000	2,625,173,000	5,105,182,000

	APPROPRIATIONS Available for the Year Ending June 30	
	1996	1997
Sec. 2. COMMISSIONER OF HUMAN SERVICES		
Subdivision 1. Total Appropriation	2,395,537,000	2,540,250,000
Summary by Fund		
General	2,345,038,000	2,540,250,000
Local Government Trust Fund	50,499,000	-0-
Subd. 2. Finance and Management		
General	20,126,000	21,396,000

RECEIPTS FOR SYSTEMS PROJECTS. Appropriations and federal receipts for information system projects

for MAXIS, electronic benefit system, social services information system, child support enforcement, and Minnesota medicaid information system (MMIS II) must be deposited in the state system 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.

COMMUNICATION COSTS. The commissioner shall continue to operate the department of human services communication systems account established in Laws 1993, First Special Session chapter 1, article 1, section 2, subdivision 2, to manage shared communication costs necessary for the operation of the programs the commissioner supervises. 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 may accept on behalf of the state any gift, bequest, devise, or personal property of any kind or money tendered to the state for any lawful purpose pertaining to the communication activities of the department. Any money so received must be deposited in the department of human services 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.

ISSUANCE OPERATIONS CENTER. Payments to the commissioner from other governmental units and private enterprises for (1) services performed by the issuance operations center or (2) reports generated by the payment and eligibility systems must be deposited in the state systems account authorized in Minnesota Statutes, section 256.014. These payments are appropriated to the commissioner for the operation of the issuance center or system, in accordance with Minnesota Statutes, section 256.014.

SOCIAL SERVICES INFORMATION PROJECT. If the commissioner proceeds with the development and implementation of the social services information system (SSIS), the commissioner shall report annually by February 1 on the status of the project to the chairs of the house health and human services committee and of the senate health care and family services committees. This report must include an explanation of the linkages between the SSIS and the MAXIS and MMIS computer systems. The SSIS project must not result in an increase in the permanent staff of the department of human services.

PRINTING COSTS. In order to reduce printing costs, the commissioner shall solicit bids for printing from inmate work programs operated by the department of corrections.

Subd. 3. Life Skills Self-Sufficiency

114,755,000	120,918,000

	Summary by Fund	
General	64,256,000	120,918,000
Local Government Trust	50,499,000	-0-

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) Semi-Independent Living Services (SILS) Grants

4,766,000	4,819,000

(b) Chemical Dependency Consolidated Treatment

41,230,000	5,080,000

(c) Deaf and Hard of Hearing Services Grants

501,000	501,000

(d) Community Social Services Grants

51,476,000	52,902,000

	Summary by Fund	
General	977,000	52,902,000
Local Government Trust	50,499,000	-0-

CSSA APPROPRIATION. The increased appropriation available in fiscal year 1996 and thereafter must be used to increase each county's aid proportionately over the aid received in calendar year 1994.

(e) Consumer Support

125,000	1,832,000

(f) Developmental Disabilities Family Support Grants

1,599,000	1,074,000

(g) Aging Ombudsman

166,000	166,000

(h) Aging Grants

4,103,000	4,103,000

(i) American Indian Chemical Dependency Grants and Chemical Dependency Special Grants

2,265,000	2,265,000

(j) Chemical Dependency Consolidated Treatment - Nonentitled

2,100,000 2,100,000

(k) Administration and Other Grants

6,424,000 6,076,000

CROSS-CULTURAL TRAINING. Of this appropriation, $50,000 each year is for cross-cultural training for deaf and hard of hearing children and their families and is available only upon the receipt of $25,000 each year in nonstate matching funds.

INDIAN ELDERS. The Minnesota board on aging shall provide staff out of the available appropriation to support the Indian elders coordinator position.

USE OF MENTAL HEALTH COLLABORATIVE FUNDS. Once a children's mental health collaborative has been formed, the commissioner may provide and a collaborative may receive funding for two years for planning and implementation purposes. This does not preclude existing collaboratives from getting additional start-up funds.

CHEMICAL DEPENDENCY RATE FREEZE. Beginning January 1, 1996, rates for chemical dependency treatment services provided according to Minnesota Statutes, chapter 254B, shall be the same as those rates negotiated according to Minnesota Statutes, section 254B.03, subdivision 1, paragraph (b), and effective January 1, 1995. Rates for vendors under Minnesota Statutes, chapter 254B, who are enrolled after January 1, 1995, shall not be higher than the statewide average rate for vendors licensed at the same level of care. Counties and providers shall not negotiate an increase in rates between January 1, 1995, and December 31, 1997.

SILS TRANSFER. (a) For the purpose

of transferring certain persons from the semi-independent living services (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 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 Statutes, 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 9525.2140, if the services remain nonresidential as defined in Minnesota Statutes, section 245A.02, subdivision 10. For the purposes 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.

(b) Contingent upon continuing 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 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.

NEW ICF/MR. For the fiscal year ending June 30, 1996, a newly constructed or newly established intermediate care facility for persons with mental retardation 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 to 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.

ICF/MR RECEIVERSHIP. For the fiscal year ending June 30, 1996, if a facility which is in receivership under Minnesota Statutes, section 245A.12 or 245A.13, is sold to an unrelated organization: (a) the facility shall be considered a newly established facility for rate setting purposes, notwithstanding any provisions to the contrary in Minnesota Statutes, section 256B.501, subdivision 11; 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.

GRH TO CSSA TRANSFER. For the fiscal year ending June 30, 1995, the commissioner may transfer funds from the group residential housing (GRH) account to county community social services act (CSSA) grants to provide continuous funding for persons no longer eligible for GRH payments for the following reasons: they reside in a setting with only a semi-independent living services license; or they reside in family foster care settings and have become ineligible for GRH difficulty of care payments due to receipt of mental retardation/related conditions waivered services. The amount to be transferred must not exceed the amount of GRH payments for actual residents in the affected GRH settings during the fiscal year 1995. The amount transferred is to be added to the affected county's CSSA base. This paragraph is effective the day following final enactment.

COUNTY MAINTENANCE-MEALS-AGING. 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 1995.

Subd. 4. Children's Program	19,860,000	21,453,000

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) Children's Trust Fund Grants	247,000	247,000
(b) Families With Children Services Grants and Administration	1,718,000	1,710,000

(c) Family Service Collaborative Grants

1,000,000	1,500,000

(d) Family Preservation, Family Support, and Child Protection Grants

8,573,000	8,573,000

(e) Subsidized Adoption Grants

5,587,000	6,688,000

(f) Other Families with Children Services Grants

2,735,000	2,735,000

FAMILY SERVICES COLLABORATIVE. Plans for the expenditure of funds for family services collaboratives must be approved by the children's cabinet according to criteria in Minnesota Statutes, section 121.8355. Money appropriated for these purposes may be expended in either year of the biennium. Money appropriated for family services collaboratives is also available for start-up funds under Minnesota Statutes, section 245.492, subdivision 19, for children's mental health collaboratives.

HOME CHOICE PROGRAM. Of this appropriation, $75,000 each year must be used as a grant to the metropolitan council to support the housing and related counseling component of the home choice program.

FOSTER CARE. Foster care, as defined in Minnesota Statutes, section 260.015, subdivision 7, is not a community social service as defined in Minnesota Statutes, section 256E.03, subdivision 2, paragraph (a). This paragraph is effective the day following final enactment.

NEW CHANCE. 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.

HIPPY CARRY FORWARD. $50,000 in unexpended money appropriated in fiscal year 1995 for the Home Instruction Program for Preschool Youngsters (HIPPY) in Laws 1994, chapter 636, article 1, section 11, does not cancel but is available for the same purposes for fiscal year 1996.

COMMUNITY COLLABORATIVE MATCHING GRANT. Of the funds appropriated for family services collaboratives, $75,000 in fiscal year 1996 shall be used for the commissioner of human services to provide a matching grant for community collaborative projects for children and youth developed by a regional organization established under Minnesota Statutes, section 116N.08, to receive rural development challenge grants. The regional organization must include a broad cross-section of public and private sector community representatives to develop programs, services or facilities to address specific community needs of children and youth. The regional organization must also provide a two-to-one match of non-state dollars for this grant.

INDIAN CHILD WELFARE GRANTS. $100,000 is appropriated from the general fund to the commissioner of human services for the purposes of providing compliance grants to

an Indian child welfare defense corporation, pursuant to Minnesota Statutes, section 257.3571, subdivision 2a, to be available until June 30, 1997.

Subd. 5. Economic Self-Sufficiency
General
317,950,000 321,696,000

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) STRIDE Grants
8,939,000 8,211,000

(b) AFDC Grants
143,568,000 146,772,000

(c) General Assistance Grants
45,707,000 45,009,000

(d) Work Readiness Grants
1,573,000 -0-

(e) Minnesota Supplemental Aid
22,493,000 25,757,000

(f) Minnesota Family Investment Plan (MFIP) Grants
21,307,000 15,150,000

(g) Child-Care Fund Entitlement Grants
17,208,000 19,780,000

(h) Child Support Enforcement Grants
9,785,000 9,785,000

(i) Child Care Fund - Nonentitled
15,526,000 19,751,000

(j) Administration and Other Grants
31,844,000 31,481,000

FOOD STAMP EMPLOYMENT AND TRAINING. Federal food stamp employment and training funds are appropriated to the commissioner to reimburse counties for food stamp employment and training expenditures.

STATE TAKEOVER ACCELERATION. Notwithstanding Minnesota

Statutes, section 256.025, $800,000 of the funds appropriated for fiscal year 1996 under Minnesota Statutes, section 256.026, shall be used to reimburse the county share of project STRIDE case management and work readiness employment and training services for the first six months of calendar year 1995.

CASH BENEFITS IN ADVANCE. The commissioner, with the advance approval of the commissioner of finance, is authorized to issue cash assistance benefits up to two days before the first day of each month, including two days before the start of each state fiscal year. Of the money appropriated for the aid to families with dependent children program for fiscal year 1996, $12,000,000 is available in fiscal year 1995. If that amount is insufficient for the costs incurred, an additional amount of the fiscal year 1996 appropriation as needed may be transferred with the advance approval of the commissioner of finance. This paragraph is effective the day following final enactment.

MFIP TRANSFER. Unexpended money appropriated for the Minnesota family investment plan in fiscal year 1996 does not cancel but is available for those purposes in fiscal year 1997.

PATERNITY ESTABLISHMENT. Federal matching funds from the hospital acknowledgment reimbursement program may be retained by the commissioner to establish paternity in child support cases. These federal matching funds are appropriated to the commissioner and must be used for education and public information concerning paternity establishment and the prevention of nonmarital births.

CHILD SUPPORT INCENTIVES. The commissioner may transfer money appropriated for child support enforcement county performance incentives for fiscal years 1996 and 1997 between county performance incentive accounts. Unexpended money in fiscal year 1996 does not cancel but is available for county performance incentives in fiscal year 1997.

MINNESOTA PARENTS' FAIR SHARE. Unexpended money appropriated for Minnesota parents' fair share in fiscal year 1996 does not cancel but is available to the commissioner for this program in fiscal year 1997.

GA/AFDC TO SSI CONVERSION. The commissioner may contract with a private entity to convert general assistance and AFDC recipients to the federal Supplemental Security Income program. The contract shall pay only for cases successfully converted, at a rate to be negotiated by the commissioner.

GA STANDARD. The commissioner shall set the monthly standard of assistance for general assistance units consisting of an adult recipient who is childless and unmarried or living apart from his or her parents or a legal guardian at $203.

AFDC SUPPLEMENTARY GRANTS. 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.

WORK READINESS ELIMINATION. Notwithstanding Minnesota Statutes, section 256.025, $1,573,000 of the funds appropriated for fiscal year 1996 under Minnesota Statutes, section 256.026, must be used to reimburse the county share of work readiness grants for the first six months of calendar year 1995.

FEDERAL WELFARE REFORM. Notwithstanding the provisions of Minnesota Statutes, section 256.011 or any other law to the contrary, the commissioner of human services may not implement changes in human services block grants and entitlement programs mandated by the 104th Congress, without authorization by the Minnesota Legislature.

Subd. 6. Health Care General

1,668,242,000	1,794,408,000

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) Group Residential Housing Grants

48,284,000	54,776,000

(b) MA Long-Term Care Facilities

540,531,000	556,857,000

(c) MA Long-Term Care Waivers and Home Care

202,821,000	217,781,000

(d) MA Managed Care and Fee-for-Service

581,671,000	659,554,000

(e) General Assistance Medical Care

224,007,000	230,400,000

(f) Alternative Care

37,251,000	41,053,000

(g) Medicaid Management Information System

10,657,000 10,657,000

(h) Administration and Other Grants

23,020,000 23,330,000

PREADMISSION SCREENING TRANSFER. Effective the day following final enactment, up to $40,000 of the appropriation for preadmission screening and alternative care for fiscal year 1995 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.

ICF/MR AND NURSING FACILITY INFLATION. 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, and shall grant inflation adjustments for intermediate care facilities for persons with mental retardation or related conditions with rate years beginning during the biennium according to Minnesota Statutes, section 256B.501.

ICF/MR RATE EXEMPTIONS. For the rate year beginning October 1, 1995, the commissioner shall exempt ICF/MR facilities from reductions to the payment rates under Minnesota Statutes, section 256B.501, subdivision 5b, if the facility: (1) has had a settle-up payment rate established in the reporting year preceding the rate year for a one-time rate adjustment; (2) is a newly established facility; (3) is an A to B licensure conversion project under the reimbursement rule; (4) has a payment rate subject to a community conversion project

under Minnesota Statutes, section 252.292; or (5) has a payment rate established under Minnesota Statutes, section 245A.12 or 245A.13. The commissioner shall consider these exceptions in the promulgation of permanent rules for payment rates to be effective on or after October 1, 1996.

MINNESOTACARE PHARMACY. Notwithstanding the amendments in this act to Minnesota Statutes, section 256B.0625, subdivision 13, the pharmacy dispensing fee in the MinnesotaCare program shall be $4.10.

ALTERNATIVE CARE TRANSFER. Any money allocated to the alternative care program that is not spent for the purposes indicated does not cancel but shall be transferred to the medical assistance account.

RATABLE REDUCTION. For services rendered on or after July 1, 1995, the commissioner shall ratably reduce general assistance medical care payments for all services except pharmacy services by 4.0 percent.

INFLATIONARY FORECAST ERRORS. The commissioner shall adjust the medical assistance hospital cost index under Minnesota Statutes, section 256.969, subdivision 1, for admissions occurring on or after July 1, 1995, to recover payments under both medical assistance and general assistance medical care made to hospitals in prior years in which projected inflation exceeded actual inflation. The adjustment shall be determined by the commissioner and established at a level sufficient to recover the difference between projected inflation and actual inflation for rate years 1990 to 1992 by June 30, 1997.

PREADMISSION SCREENING RATE. The preadmission screening payment to all counties shall continue at the payment amount in effect for fiscal year 1995.

PAS/AC APPROPRIATION. The commissioner may expend the money appropriated for preadmission screening and the alternative care program for these purposes in either year of the biennium.

SAIL TRANSFER. Appropriations for administrative costs associated with the senior's agenda for independent living (SAIL) program may be transferred to SAIL grants as the commissioner determines necessary to facilitate the delivery of the program.

STUDY OF OUTPATIENT RATES. The commissioner shall conduct a review of payment rates and methodologies for medical services that are provided on an outpatient basis. The commissioner may convene a review panel that is comprised of agency staff and staff from hospitals and physician clinics to assist in the review. The commissioner shall submit a report on the results of the review, along with any recommendations for changes to the payment system for outpatient services, to the governor and the legislature by January 15, 1996.

ADDITIONAL WAIVERED SERVICES. (a) The commissioner shall seek the necessary amendments to home and community-based waiver programs to provide services to persons who, due to the inability to direct their own care, are no longer eligible for personal care assistant services but are eligible for the community alternatives for disabled individuals (CADI), community alternative care (CAC), mental retardation or

related conditions (MR/RC), traumatic brain injury (TBI), or elderly waivers. These recipients who transfer from personal care services to home and community-based waiver programs shall not be denied personal care services until waivered services are available.

(b) Notwithstanding Minnesota Rules, parts 9525.1800 to 9525.1930 and Minnesota Statutes, section 256B.092, subdivision 4, resources for home and community-based services for persons with mental retardation or related conditions, made available for the purpose of providing alternative services for persons affected by the PCA restructuring, shall be allocated based on criteria that considers the assessed needs and home care authorization levels of persons affected by the restructuring and provides preference to these persons during the allocation process.

CHILDREN INELIGIBLE FOR TEFRA. When a child is determined ineligible for TEFRA or a child or adult for PCA services, the commissioner shall provide the adult or the child's parent or guardian with information on how to apply for alternative services from the county, the local mental health collaborative, the public health agency, the departments of health and human services, and the Minnesota comprehensive health association.

ALLOCATION OF WAIVERED SLOTS. 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. Any unexpended appropriations from the regional treatment center supplements for state enhanced waiver slots

shall be transferred into the regional treatment center salary account.

CONSUMER SATISFACTION SURVEY. Any federal matching money received through the medical assistance program for the consumer satisfaction survey is appropriated to the commissioner for this purpose. The commissioner may expend the federal money received for the consumer satisfaction survey in either year of the biennium.

NURSING HOME GEOGRAPHIC GROUPS. The commissioner shall report to the chairs of the senate health care and family services finance division and the house health and human services finance division by January 15, 1996, with recommendations for changes in the current geographic grouping of nursing homes. The recommendations shall take into account changes in the federal definition of standard metropolitan statistical areas and inequities that result from the current groupings.

LONG-TERM CARE OPTIONS PROJECT. Federal funds received by the commissioner of human services for the long-term care options project may be transferred among object of expenditure classifications as the commissioner determines necessary for the implementation of the project.

MORATORIUM EXCEPTIONS. Of this appropriation, $200,000 each year is for the medical assistance costs of moratorium exceptions approved by the commissioner of health under Minnesota Statutes, section 144A.073.

SURCHARGE COMPLIANCE. 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 shall appeal the determination to the fullest extent permitted by law and may ratably reduce all medical assistance and general assistance medical care payments to providers other than the state of Minnesota 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 ratable reductions taken.

MANAGED CARE. The nonfederal share of the Prepaid Medical Assistance Program funds, which have been appropriated to fund county managed care advocacy and enrollment operating costs, shall be disbursed as grants using either a reimbursement or block grant mechanism.

PMAP CARRYOVER. Unexpended money appropriated for fiscal year 1996 for the nonfederal share of the prepaid medical assistance program to fund county managed care advocacy and enrollment operating costs does not cancel but is available in fiscal year 1997.

PREPAID RATE DISCOUNTS. Notwithstanding section 12 of this article, rates for rate years through December 31, 1998, for the prepaid medical assistance and prepaid general assistance medical care programs shall, in the aggregate for each program in expansion counties after July 1, 1995, include an effective ten percent discount for individuals under 65, and an effective five percent discount for persons age 65 and older, compared with expected fee-for-service costs for the same population.

COMPULSIVE GAMBLING. (a) Of the 1995 appropriation for the compulsive gambling program under Laws 1994, chapter 633, article 8, section 8, subdivision 1, up to $175,000 does not cancel but shall remain available for the development and implementation of outcome evaluation, treatment effectiveness research in the biennium ending June 30, 1997.

(b) Only contributions to the compulsive gambling program may be carried forward between fiscal years or from biennium to biennium.

(c) Paragraphs (a) and (b) are effective the day following final enactment.

Subd. 7. Community Mental Health and State-Operated Services General

254,604,000 260,379,000

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) Mental Health Grants - Children

7,097,000 12,536,000

MENTAL HEALTH COLLABORATIVE. Mental health grants available for children formerly served under the TEFRA program shall be distributed and administered by a children's mental health collaborative where a collaborative exists.

(b) Mental Health Grants - Adults

38,222,000 40,918,000

(c) Residential Treatment Center Facilities

194,921,000 192,265,000

(d) Developmental Disability and Mentally Ill (DD and MI) State-Operated Community Services (SOCS)

13,001,000 13,297,000

(e) Administration and Other Grants

1,363,000 1,363,000

MENTAL HEALTH GRANTS. (a) Mental health grants appropriated for the biennium as part of the TEFRA and PCA restructuring proposal shall be distributed to children's mental health collaboratives, or where there is no collaborative, to counties. Grants shall be prorated by county based on the estimated dollar value of services for children and adults with a mental health diagnosis that will be lost due to the changes in Minnesota Statutes, sections 256B.055, subdivision 12, and 256B.0627.

(b) The commissioner shall form a work group to recommend a process for awarding grants that will maximize services purchased and minimize administrative overhead. The task force shall include representatives of the state advisory council on mental health and the children's subcommittee, parents, consumers, advocacy groups, providers, and local social service and public health staff. The work group shall consider whether the process for awarding consumer support grants under Minnesota Statutes, section 256.476, can be utilized for awarding these mental health grants. In addition, the work group shall recommend ways to minimize harm to children and families and to reduce barriers to accessing alternative services.

(c) For the first year of the biennium, funds must be distributed by January 1, 1996, and for the second year, by July 1, 1996. None of this appropriation shall be used for county administration, but must be used to fund direct services to persons found ineligible for TEFRA or PCA services.

MENTAL HEALTH CASE MANAGEMENT. Notwithstanding section 12 of this article, this paragraph does

not expire. The reimbursement rate for mental health case management services provided by counties under Minnesota Statutes, sections 245.4881 and 256B.0625, for children with severe emotional disturbance is $45.

CALCULATION OF FTE's. When calculating regional treatment center full-time equivalent employees, the commissioner of finance shall make a separate calculation for physicians and their salaries.

RELOCATIONS FROM FARIBAULT. Of this appropriation, $162,000 in fiscal year 1996 and $37,000 in fiscal year 1997 are for grants to counties for discharge planning related to persons with mental retardation or related conditions being relocated from the Faribault regional center to community services.

TRANSFERS TO MOOSE LAKE. Notwithstanding Minnesota Statutes, sections 253B.18, subdivisions 4 and 6, and 253B.185, subdivision 2, with the establishment of the Minnesota sexual psychopathic personality treatment center, the commissioner is authorized to transfer any person committed as a psychopathic personality, sexual psychopathic personality, or sexually dangerous person, between the Minnesota security hospital and the facility at Moose Lake.

RTC CHEMICAL DEPENDENCY PROGRAMS. 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 commis-

sioner of finance may transfer general fund cash reserves into this account as necessary to meet cash demands. The cash flow transfers must be returned to the general fund in the fiscal year that the transfer was made. Any interest earned on general fund cash flow transfers accrues to the general fund and not the regional treatment center chemical dependency fund.

RTC RESTRUCTURING. 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 1996 shall be carried forward into fiscal year 1997. 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.

RTC POPULATION. 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 1996-97 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.

INFRASTRUCTURE REINVESTMENT. $750,000 is available from the public facilities authority under Minnesota Statutes 446A.071 for grant funds to a local unit of government for the development of infrastructure and planning for redevelopment in response to the memorandum of understanding for the regional treatment centers. Eligible costs include sewer, water, and easements and engineering costs associated with the project proposal.

CAMP. Of this appropriation, $30,000 is 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.

IMD DOWNSIZING FLEXIBILITY. If a county presents a budget-neutral plan for a net reduction in the number of institution for mental disease (IMD) beds funded under group residential housing, the commissioner may transfer the net savings from group residential housing and general assistance medical care to medical assistance and mental health grants to provide appropriate services in non-IMD settings.

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

PROJECT LABOR. 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.

PLAN FOR ADOLESCENT TREATMENT EXPANSION. The commissioner shall report to the legislature by January 15, 1996, with a cost-neutral plan to add up to 20 beds to each of the two existing adolescent treatment facilities at the regional treatment centers in order to reduce or eliminate out-of-state placement of adolescents who have serious emotional disturbance and exhibit violent behavior, if they cannot be treated in their own communities. Cost neutrality shall be determined by comparing the costs of program expansion with the projected costs of out-of-state placements.

Sec. 3. COMMISSIONER OF HEALTH

Subdivision 1. Total Appropriation		55,639,000	55,886,000
Summary by Fund			
General	37,978,000	37,950,000	
Metropolitan Landfill Contingency Action Fund	193,000	193,000	
State Government Special Revenue	15,947,000	16,222,000	
Trunk Highway	1,513,000	1,513,000	
Special Revenue	8,000	8,000	

LANDFILL CONTINGENCY. The appropriation from the metropolitan landfill contingency action fund is for monitoring well water supplies and conducting health assessments in the metropolitan area.

TRUNK HIGHWAY FUND. The appropriation from the trunk highway

fund is for emergency medical services activities.

Subd. 2. Health Systems Development		27,928,000	27,784,000
Summary by Fund			
General	27,499,000	27,354,000	
State Government Special Revenue	429,000	430,000	

WIC TRANSFERS. 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.

NURSING HOME RESIDENTS EDUCATION. Any efforts undertaken by the Minnesota departments of health or human services to conduct periodic education 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.

HOSPITAL CONVERSION. Of the appropriation from the general fund, the commissioner of health shall provide $25,000 to a 28-bed hospital located in Chisago county, to enable that facility to plan for closure and conversion, in partnership with other entities, in order to offer outpatient and emergency services at the site.

CARRYOVER. General fund appropriations for treatment services in the services for children with special health care needs program are available for either year of the biennium.

Subd. 3. Health Quality Assurance		6,934,000	7,065,000
Summary by Fund			
General	1,135,000	1,135,000	
Trunk Highway	1,431,000	1,431,000	
State Government Special Revenue	4,368,000	4,499,000	

NONCERTIFIED NURSING HOME. Of the appropriation from the state government special revenue fund, up to $250,000 is available if the commissioner determines the need to place a noncertified nursing home into receivership under Minnesota Statutes, section 144A.14 or 144A.15. Any money expended from this account for this purpose shall only be used to cover the necessary costs for the receivership and for the operation of the facility during the time period necessary to relocate residents from the facility. The commissioner shall suspend admissions to the nursing home effective as of the date of the commencement of the receivership. Notwithstanding the provisions of Minnesota Statutes, section 144A.16, and Minnesota Rules, parts 4655.6810 to 4655.6830, the commissioner shall relocate residents within 45 days from the commencement of the receivership if the receivership costs are covered by this section. Once relocation of the residents is completed, the nursing home license shall expire. Notwithstanding the provisions of Minnesota Statutes, section 144A.071, subdivision 3, paragraph (c), the commissioner may issue a new license to operate the facility as a nursing home within 120 days from the commencement of the receivership provided that the licensed and certified capacity does not exceed the capacity of the former facility and all money expended from the state government special revenue account is repaid to the commissioner prior to the issuance of the license. Any unrecovered costs to

the fund shall be included as costs to the activity under Minnesota Statutes, section 16A.1285. The commissioner shall report any use of this authority to the commissioner of finance and the chair of the senate health care and family services finance division and the chair of the house human services finance division.

Subd. 4. Health Protection		16,765,000	16,861,000
Summary by Fund			
General	6,899,000	6,895,000	
State Government Special Revenue	9,687,000	9,787,000	
Metropolitan Landfill Contingency Action Fund	171,000	171,000	
Special Revenue	8,000	8,000	

LEAD ABATEMENT. $200,000 is appropriated from the general fund to the commissioner of health for the biennium ending June 30, 1997, for the purpose of administering lead abatement activities. Of this amount, $25,000 shall be used for the purposes of lead-safe housing, and $25,000 shall be used for the purposes of lead cleanup equipment.

Subd. 5. Management and Support Services		4,012,000	4,176,000
Summary by Fund			
General	2,445,000	2,566,000	
Metropolitan Landfill Contingency Action Fund	22,000	22,000	
Trunk Highway	82,000	82,000	
State Government Special Revenue	1,463,000	1,506,000	
Sec. 4. VETERANS NURSING HOMES BOARD		17,937,000	18,614,000

SPECIAL REVENUE ACCOUNT. The general fund appropriations made to the veterans homes board shall be transferred to a veterans homes special revenue account in the special revenue fund in the same manner as other receipts

are deposited in accordance with Minnesota Statutes, section 198.34, and are appropriated to the veterans homes board of directors for the operation of board facilities and programs.

SETTING THE COST OF CARE. The veterans homes board may set the cost of care at the Silver Bay and Luverne facilities based on the cost of average skilled nursing care provided to residents of the Minneapolis veterans home for fiscal year 1996.

ROOMS WITH MORE THAN FOUR BEDS. (a) Until June 30, 1996, 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.

(b) The veterans homes board may not admit residents into the domiciliary beds at the Minnesota veterans home at Hastings before October 1, 1995.

LICENSED CAPACITY. The department of health shall not reduce the licensed bed capacity for the Minneapolis veterans home pending completion of the project authorized by Laws 1990, chapter 610, article 1, section 9, subdivision 3, unless the federal grant for the project is not awarded.

ALLOWANCE FOR FOOD. 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 1996 and fiscal year 1997 must be based on the June 1994 and June 1995 producer price index respectively, but the adjustment must be prorated if it would require money in excess of the appropriation.

FERGUS FALLS. If a federal grant for the construction of the Fergus Falls veterans home is received before the start of the 1996 legislative session, the veterans homes board of directors may use up to $150,000 of this appropriation to fund positions and support services to coordinate and oversee the construction of the home and to begin planning for the opening of the facility.

Sec. 5. HEALTH-RELATED BOARDS

Subdivision 1. Total Appropriation	8,906,000	8,608,000

STATE GOVERNMENT SPECIAL REVENUE FUND. The appropriations in this section are from the state government special revenue fund.

NO SPENDING IN EXCESS OF REVENUES. The commissioner of finance shall not permit the allotment, encumbrance, or expenditure of money appropriated in this section in excess of the anticipated biennial revenues or accumulated surplus revenues from fees collected by the boards. Neither this provision nor Minnesota Statutes, section 214.06, applies to transfers from the general contingent account, 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	309,000	313,000
Subd. 3. Board of Dentistry	698,000	708,000
Subd. 4. Board of Dietetic and Nutrition Practice	63,000	64,000
Subd. 5. Board of Marriage and Family Therapy	95,000	96,000
Subd. 6. Board of Medical Practice	3,204,000	3,188,000
Subd. 7. Board of Nursing	2,258,000	2,009,000

DISCIPLINE AND LICENSING SYSTEMS PROJECT. Of this appropriation, $548,000 the first year and $295,000 the second year is to implement the discipline and licensing systems project as recommended by the information policy office. In accordance with Minnesota Statutes, section 214.06, subdivision 1, the board may raise fees to fund this activity.

Subd. 8. Board of Nursing Home Administrators	182,000	186,000
Subd. 9. Board of Optometry	78,000	79,000
Subd. 10. Board of Pharmacy	900,000	894,000
Subd. 11. Board of Podiatry	31,000	32,000
Subd. 12. Board of Psychology	393,000	396,000
Subd. 13. Board of Social Work	553,000	492,000
Subd. 14. Board of Veterinary Medicine	142,000	151,000
Sec. 6. COUNCIL ON DISABILITY	725,000	581,000

COUNCIL ON DISABILITY. Of this appropriation $150,000 is from the general fund to the council on disability for fiscal year 1996, for the purposes of a matching grant to the Fergus Falls Center for the Arts, Inc. to complete renovations of a local theater necessary to bring it into compliance with the federal Americans with Disabilities Act. This appropriation must be matched by $50,000 of nonstate local funds.

Sec. 7. OMBUDSMAN FOR MENTAL HEALTH AND MENTAL RETARDATION	1,132,000	1,097,000
Sec. 8. OMBUDSMAN FOR FAMILIES	133,000	137,000

Sec. 9. TRANSFERS.

Subdivision 1. Entitlement programs

(a) Transfers in fiscal year 1995

Effective the day following final enact-

ment, the commissioner of human services may transfer unencumbered appropriation balances for fiscal year 1995 among the aid to families with dependent children, aid to families with dependent children child care, Minnesota family investment plan, 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, with the approval of the commissioner of finance after notification of the chair of the senate health care and family services finance division and the chair of the house of representatives health and human services finance division.

(b) Transfers of unencumbered entitled grant and aid appropriations

The commissioner of human services, with the approval of the commissioner of finance, and after notification of the chair of the senate health care and family services finance division and the chair of the house of representatives health and human services finance division, may transfer unencumbered appropriation balances for the biennium ending June 30, 1997, within fiscal years among the aid to families with dependent children, aid to families with dependent children child care, Minnesota family investment plan, 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.

Subd. 2. Approval required

Positions, salary money, and nonsalary administrative money may be transferred within the departments of human services and health and within the programs operated by the veterans nursing homes board as the commissioners and the board consider necessary, with the advance approval of the commissioner of finance. The commissioners and the board shall inform the chairs of the health and human services finance division of the house of representatives and the health and family services finance division of the senate quarterly about transfers made under this provision.

Subd. 3. Transfer

Funding appropriated by the legislature may not be transferred to a different department than that specified by the legislature without legislative authority.

Sec. 10. PROVISIONS

(a) Money appropriated to the commissioner of human services 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 drugs and medical and hospital supplies and equipment with written approval of the governor after consultation with the legislative advisory commission.

(b) For fiscal year 1996 the allowance for food may be adjusted to the equivalent of the 75th percentile of the comparable raw food costs for community nursing homes as reported to the commissioner of human services. For fiscal

year 1997 an adjustment may be made to reflect the annual change in the United States Bureau of Labor Statistics producer price index as of June 1996 with the approval of the commissioner of finance. The adjustments for either year must be prorated if they would require money in excess of this appropriation.

Sec. 11. CARRYOVER LIMITATION

None of the appropriations in this act which are allowed to be carried forward from fiscal year 1996 to fiscal year 1997 shall become part of the base level funding for the 1997-1999 biennial budget, unless specifically directed by the legislature.

Sec. 12. SUNSET OF UNCODIFIED LANGUAGE

All uncodified language contained in this article expires on June 30, 1997, unless a different expiration is explicit.

ARTICLE 2

HUMAN SERVICES ADMINISTRATION

Section 1. Minnesota Statutes 1994, section 14.03, subdivision 3, is amended to read:

Subd. 3. **RULEMAKING PROCEDURES.** The definition of a rule in section 14.02, subdivision 4, does not include:

(1) rules concerning only the internal management of the agency or other agencies that do not directly affect the rights of or procedures available to the public;

(2) rules of the commissioner of corrections relating to the placement and supervision of inmates serving a supervised release term, the internal management of institutions under the commissioner's control, and rules adopted under section 609.105 governing the inmates of those institutions;

(3) rules relating to weight limitations on the use of highways when the substance of the rules is indicated to the public by means of signs;

(4) opinions of the attorney general;

(5) the systems architecture plan and long-range plan of the state education management information system provided by section 121.931;

(6) the data element dictionary and the annual data acquisition calendar of the department of education to the extent provided by section 121.932;

(7) the occupational safety and health standards provided in section 182.655;

(8) revenue notices and tax information bulletins of the commissioner of revenue; ~~or~~

(9) uniform conveyancing forms adopted by the commissioner of commerce under section 507.09; or

(10) the interpretive guidelines developed by the commissioner of human services to the extent provided in chapter 245A.

Sec. 2. Minnesota Statutes 1994, section 16B.08, subdivision 5, is amended to read:

Subd. 5. **FEDERAL ~~GENERAL SERVICES ADMINISTRATION~~ AGENCY PRICE SCHEDULES.** Notwithstanding anything in this chapter to the contrary, the commissioner may, instead of soliciting bids, contract for purchases with suppliers who have published schedules of prices effective for sales to ~~the General Services Administration~~ any federal agency of the United States. These contracts may be entered into, regardless of the amount of the purchase price, if the commissioner considers them advantageous and if the purchase price of all the commodities purchased under the contract do not exceed the price specified by the schedule.

Sec. 3. Minnesota Statutes 1994, section 171.07, is amended by adding a subdivision to read:

Subd. 10. **AGREEMENTS WITH OTHER AGENCIES.** The commissioner of public safety is authorized to enter into agreements with other agencies to issue cards to clients of those agencies for use in their programs. The cards may be issued to persons who do not qualify for a Minnesota driver's license or do not provide evidence of name and identity as required by rule for a Minnesota identification card. Persons issued cards under this subdivision will meet the identification verification requirements of the contracting agency.

The interagency agreement may include provisions for the payment of the county fee provided in section 171.06, subdivision 4, and the actual cost to manufacture the card.

Cards issued under this subdivision are not Minnesota identification cards for the purposes defined in sections 48.512, 201.061, 201.161, 332.50, and 340A.503.

Sec. 4. Minnesota Statutes 1994, section 245A.02, is amended by adding a subdivision to read:

Subd. 7b. **INTERPRETIVE GUIDELINES.** "Interpretive guidelines" means a policy statement that has been published pursuant to section 245A.09, subdivision 12, and which provides interpretation, details, or supplementary information concerning the application of laws or rules. Interpretive guidelines are published for the information and guidance of consumers, providers of service, county agencies, the department of human services, and others concerned.

Sec. 5. Minnesota Statutes 1994, section 245A.03, subdivision 2a, is amended to read:

Subd. 2a. ~~**LICENSING OF**~~ **FOSTER CARE BY AN INDIVIDUAL WHO IS RELATED TO A CHILD; LICENSE REQUIRED.** Notwithstanding subdivision 2, clause (1), ~~the commissioner must license or approve an individual who is related to a child~~ in order to provide foster care for ~~that~~ a child, an individual who is related to the child, other than a parent, or legal guardian, must be licensed by the commissioner except as provided by section 245A.035. ~~The commissioner may issue the license or approval retroactive to the date the child was placed in the applicant's home, so long as no more than 90 days have elapsed since the placement. If more than 90 days have elapsed since the placement, the commissioner may issue the license or approval retroactive 90 days. The granting of a license or approval to an individual who is related to a child shall be according to standards set forth by foster care rule. The commissioner shall consider the importance of maintaining the child's relationship to family as an additional significant factor in determining whether to set aside a licensing disqualifier under section 245A.04, subdivision 3b, or to grant a variance of licensing requirements under section 245A.04, subdivision 9, in licensing or approving an individual related to a child.~~

Sec. 6. **[245A.035] RELATIVE FOSTER CARE; EMERGENCY LICENSE.**

Subdivision 1. **GRANT OF EMERGENCY LICENSE.** Notwithstanding section 245A.03, subdivision 2a, a county agency may place a child for foster care with a relative who is not licensed to provide foster care, provided the requirements of subdivision 2 are met. As used in this section, the term "relative" has the meaning given it under section 260.181, subdivision 3.

Subd. 2. **COOPERATION WITH EMERGENCY LICENSING PROCESS.** (a) A county agency that places a child with a relative who is not licensed to provide foster care must begin the process of securing an emergency license for the relative as soon as possible and must conduct the initial inspection required by subdivision 3, clause (1), whenever possible, prior to placing the child in the relative's home, but no later than three working days after placing the child in the home. A child placed in the home of a relative who is not licensed to provide foster care must be removed from that home if the relative fails to cooperate with the county agency in securing an emergency foster care

license. The commissioner may only issue an emergency foster care license to a relative with whom the county agency wishes to place or has placed a child for foster care.

(b) If a child is to be placed in the home of a relative not licensed to provide foster care, either the placing agency or the county agency in the county in which the relative lives shall conduct the emergency licensing process as required in this section.

Subd. 3. **REQUIREMENTS FOR EMERGENCY LICENSE.** Before an emergency license may be issued, the following requirements must be met:

(1) the county agency must conduct an initial inspection of the premises where the foster care is to be provided to ensure the health and safety of any child placed in the home. The county agency shall conduct the inspection using a form developed by the commissioner;

(2) at the time of the inspection or placement, whichever is earlier, the relative being considered for an emergency license shall receive an application form for a child foster care license; and

(3) whenever possible, prior to placing the child in the relative's home, the relative being considered for an emergency license shall provide the information required by section 245A.04, subdivision 3, paragraph (b).

Subd. 4. **APPLICANT STUDY.** When the county agency has received the information required by section 245A.04, subdivision 3, paragraph (b), the county agency shall begin an applicant study according to the procedures in section 245A.04, subdivision 3. The commissioner may issue an emergency license upon recommendation of the county agency once the initial inspection has been successfully completed and the information necessary to begin the applicant background study has been provided. If the county agency does not recommend that the emergency license be granted, the agency shall notify the relative in writing that the agency is recommending denial to the commissioner; shall remove any child who has been placed in the home prior to licensure; and shall inform the relative in writing of the procedure to request review pursuant to subdivision 6. An emergency license shall be effective until a child foster care license is granted or denied, but shall in no case remain in effect more than 90 days from the date of placement.

Subd. 5. **CHILD FOSTER CARE LICENSE APPLICATION.** The emergency license holder shall complete the child foster care license application and necessary paperwork within ten days of the placement. The county agency shall assist the emergency license holder to complete the application. The granting of a child foster care license to a relative shall be under the procedures in this chapter and according to the standards set forth by foster care rule. In licensing a relative, the commissioner shall consider the importance of maintaining the child's relationship with relatives as an additional significant factor in determining whether to set aside a licensing disqualifier under section 245A.04, subdivision

3b, or to grant a variance of licensing requirements under section 245A.04, subdivision 9.

Subd. 6. **DENIAL OF EMERGENCY LICENSE.** If the commissioner denies an application for an emergency foster care license under this section, that denial must be in writing and must include reasons for the denial. Denial of an emergency license is not subject to appeal under chapter 14. The relative may request a review of the denial by submitting to the commissioner a written statement of the reasons an emergency license should be granted. The commissioner shall evaluate the request for review and determine whether to grant the emergency license. The commissioner's review shall be based on a review of the records submitted by the county agency and the relative. Within 15 working days of the receipt of the request for review, the commissioner shall notify the relative requesting review in written form whether the emergency license will be granted. The commissioner's review shall be based on a review of the records submitted by the county agency and the relative. A child shall not be placed or remain placed in the relative's home while the request for review is pending. Denial of an emergency license shall not preclude an individual from reapplying for an emergency license or from applying for a child foster care license. The decision of the commissioner is the final administrative agency action.

Sec. 7. Minnesota Statutes 1994, section 245A.04, subdivision 3, is amended to read:

Subd. 3. **STUDY OF THE APPLICANT.** (a) Before the commissioner issues a license, the commissioner shall conduct a study of the individuals specified in clauses (1) to (4) according to rules of the commissioner. The applicant, license holder, the bureau of criminal apprehension, and county agencies, after written notice to the individual who is the subject of the study, shall help with the study by giving the commissioner criminal conviction data and reports about abuse or neglect of adults in licensed programs substantiated under section 626.557 and the maltreatment of minors in licensed programs substantiated under section 626.556. The individuals to be studied shall include:

(1) the applicant;

(2) persons over the age of 13 living in the household where the licensed program will be provided;

(3) current employees or contractors of the applicant who will have direct contact with persons served by the program; and

(4) volunteers who have direct contact with persons served by the program to provide program services, if the contact is not directly supervised by the individuals listed in clause (1) or (3).

The juvenile courts shall also help with the study by giving the commissioner existing juvenile court records on individuals described in clause (2) relating to delinquency proceedings held within either the five years immediately

preceding the application or the five years immediately preceding the individual's 18th birthday, whichever time period is longer. The commissioner shall destroy juvenile records obtained pursuant to this subdivision when the subject of the records reaches age 23.

For purposes of this section and Minnesota Rules, part 9543.3070, a finding that a delinquency petition is proven in juvenile court shall be considered a conviction in state district court.

For purposes of this subdivision, "direct contact" means providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by a program. For purposes of this subdivision, "directly supervised" means an individual listed in clause (1) or (3) is within sight or hearing of a volunteer to the extent that the individual listed in clause (1) or (3) is capable at all times of intervening to protect the health and safety of the persons served by the program who have direct contact with the volunteer.

A study of an individual in clauses (1) to (4) shall be conducted at least upon application for initial license and reapplication for a license. No applicant, license holder, or individual who is the subject of the study shall pay any fees required to conduct the study.

(b) The individual who is the subject of the study must provide the applicant or license holder with sufficient information to ensure an accurate study including the individual's first, middle, and last name; home address, city, county, and state of residence; zip code; sex; date of birth; and driver's license number. The applicant or license holder shall provide this information about an individual in paragraph (a), clauses (1) to (4), on forms prescribed by the commissioner. The commissioner may request additional information of the individual, which shall be optional for the individual to provide, such as the individual's social security number or race.

(c) Except for child foster care, adult foster care, and family day care homes, a study must include information from the county agency's record of substantiated abuse or neglect of adults in licensed programs, and the maltreatment of minors in licensed programs, information from juvenile courts as required in paragraph (a) for persons listed in paragraph (a), clause (2), and information from the bureau of criminal apprehension. For child foster care, adult foster care, and family day care homes, the study must include information from the county agency's record of substantiated abuse or neglect of adults, and the maltreatment of minors, information from juvenile courts as required in paragraph (a) for persons listed in paragraph (a), clause (2), and information from the bureau of criminal apprehension. The commissioner may also review arrest and investigative information from the bureau of criminal apprehension, a county attorney, county sheriff, county agency, local chief of police, other states, the courts, or a national criminal record repository if the commissioner has reasonable cause to believe the information is pertinent to the disqualification of an individual listed in paragraph (a), clauses (1) to (4). The commissioner is not required to conduct more than one review of a subject's records from the national criminal record repository if a review of the subject's criminal history

with the national criminal record repository has already been completed by the commissioner and there has been no break in the subject's affiliation with the license holder who initiated the background studies.

(d) An applicant's or license holder's failure or refusal to cooperate with the commissioner is reasonable cause to deny an application or immediately suspend, suspend, or revoke a license. Failure or refusal of an individual to cooperate with the study is just cause for denying or terminating employment of the individual if the individual's failure or refusal to cooperate could cause the applicant's application to be denied or the license holder's license to be immediately suspended, suspended, or revoked.

(e) The commissioner shall not consider an application to be complete until all of the information required to be provided under this subdivision has been received.

(f) No person in paragraph (a), clause (1), (2), (3), or (4) who is disqualified as a result of this section may be retained by the agency in a position involving direct contact with persons served by the program.

(g) Termination of persons in paragraph (a), clause (1), (2), (3), or (4) made in good faith reliance on a notice of disqualification provided by the commissioner shall not subject the applicant or license holder to civil liability.

(h) The commissioner may establish records to fulfill the requirements of this section.

(i) The commissioner may not disqualify an individual subject to a study under this section because that person has, or has had, a mental illness as defined in section 245.462, subdivision 20.

(j) An individual who is subject to an applicant background study under this section and whose disqualification in connection with a license would be subject to the limitations on reconsideration set forth in subdivision 3b, paragraph (c), shall be disqualified for conviction of the crimes specified in the manner specified in subdivision 3b, paragraph (c). The commissioner of human services shall amend Minnesota Rules, part 9543.3070, to conform to this section.

Sec. 8. Minnesota Statutes 1994, section 245A.04, subdivision 3b, is amended to read:

Subd. 3b. **RECONSIDERATION OF DISQUALIFICATION.** (a) Within 30 days after receiving notice of disqualification under subdivision 3a, the individual who is the subject of the study may request reconsideration of the notice of disqualification. The individual must submit the request for reconsideration to the commissioner in writing. The individual must present information to show that:

(1) the information the commissioner relied upon is incorrect; or

(2) the subject of the study does not pose a risk of harm to any person served by the applicant or license holder.

(b) The commissioner may set aside the disqualification if the commissioner finds that the information the commissioner relied upon is incorrect or the individual does not pose a risk of harm to any person served by the applicant or license holder. The commissioner shall review the consequences of the event or events that could lead to disqualification, whether there is more than one disqualifying event, the vulnerability of the victim at the time of the event, the time elapsed without a repeat of the same or similar event, and documentation of successful completion by the individual studied of training or rehabilitation pertinent to the event. In reviewing a disqualification, the commissioner shall give preeminent weight to the safety of each person to be served by the license holder or applicant over the interests of the license holder or applicant.

(c) Unless the information the commissioner relied on in disqualifying an individual is incorrect, the commissioner may not set aside the disqualification of an individual in connection with a license to provide family day care for children, foster care for children in the provider's own home, or foster care or day care services for adults in the provider's own home if:

(1) less than ten years have passed since the discharge of the sentence imposed for the offense; and the individual has been convicted of a violation of any offense listed in section 609.20 (manslaughter in the first degree), 609.205 (manslaughter in the second degree), 609.21 (criminal vehicular homicide), 609.215 (aiding suicide or aiding attempted suicide), 609.221 to 609.2231 (felony violations of assault in the first, second, third, or fourth degree), 609.713 (terroristic threats), 609.235 (use of drugs to injure or to facilitate crime), 609.24 (simple robbery), 609.245 (aggravated robbery), 609.25 (kidnapping), 609.255 (false imprisonment), 609.561 or 609.562 (arson in the first or second degree), 609.71 (riot), 609.582 (burglary in the first or second degree), 609.66 (reckless use of a gun or dangerous weapon or intentionally pointing a gun at or towards a human being), 609.665 (setting a spring gun), 609.67 (unlawfully owning, possessing, or operating a machine gun), 609.749 (stalking), 152.021 or 152.022 (controlled substance crime in the first or second degree), 152.023, subdivision 1, clause (3) or (4), or subdivision 2, clause (4) (controlled substance crime in the third degree), 152.024, subdivision 1, clause (2), (3), or (4) (controlled substance crime in the fourth degree), 609.228 (great bodily harm caused by distribution of drugs), 609.23 (mistreatment of persons confined), 609.231 (mistreatment of residents or patients), 609.265 (abduction), 609.2664 to 609.2665 (manslaughter of an unborn child in the first or second degree), 609.267 to 609.2672 (assault of an unborn child in the first, second, or third degree), 609.268 (injury or death of an unborn child in the commission of a crime), 617.293 (disseminating or displaying harmful material to minors), 609.378 (neglect or endangerment of a child), 609.377 (a gross misdemeanor offense of malicious punishment of a child); or an attempt or conspiracy to commit any of these offenses, as each of these offenses is defined in Minnesota Statutes; or an offense in any other state, the elements of which are substantially similar to the elements of any of the foregoing offenses;

(2) regardless of how much time has passed since the discharge of the sentence imposed for the offense, the individual was convicted of a violation of any offense listed in sections 609.185 to 609.195 (murder in the first, second, or third degree), 609.2661 to 609.2663 (murder of an unborn child in the first, second, or third degree), 609.377 (a felony offense of malicious punishment of a child), 609.322 (soliciting, inducement, or promotion of prostitution), 609.323 (receiving profit derived from prostitution), 609.342 to 609.345 (criminal sexual conduct in the first, second, third, or fourth degree), 609.352 (solicitation of children to engage in sexual conduct), 617.246 (use of minors in a sexual performance), 617.247 (possession of pictorial representations of a minor), 609.365 (incest), or an attempt or conspiracy to commit any of these offenses as defined in Minnesota Statutes, or an offense in any other state, the elements of which are substantially similar to any of the foregoing offenses;

(3) within the seven years preceding the study, the individual committed an act that constitutes maltreatment of a child under section 626.556, subdivision 10e, and that resulted in substantial bodily harm as defined in section 609.02, subdivision 7a, or substantial mental or emotional harm as supported by competent psychological or psychiatric evidence; or

(4) within the seven years preceding the study, the individual was determined under section 626.557 to be the perpetrator of a substantiated incident of abuse of a vulnerable adult that resulted in substantial bodily harm as defined in section 609.02, subdivision 7a, or substantial mental or emotional harm as supported by competent psychological or psychiatric evidence.

In the case of any ground for disqualification under clauses (1) to (4), if the act was committed by an individual other than the applicant or license holder residing in the applicant's or license holder's home, the applicant or license holder may seek reconsideration when the individual who committed the act no longer resides in the home.

The disqualification periods provided under clauses (1), (3), and (4) are the minimum applicable disqualification periods. The commissioner may determine that an individual should continue to be disqualified from licensure because the license holder or applicant poses a risk of harm to a person served by that individual after the minimum disqualification period has passed.

(d) The commissioner shall respond in writing to all reconsideration requests within 15 working days after receiving the request for reconsideration. If the disqualification is set aside, the commissioner shall notify the applicant or license holder in writing of the decision.

(e) Except as provided in subdivision 3c, the commissioner's decision to disqualify an individual, including the decision to grant or deny a reconsideration of disqualification under this subdivision, or to set aside or uphold the results of the study under subdivision 3, is the final administrative agency action and shall not be subject to further review in a contested case under chapter 14 involving a negative licensing action taken in response to the disqualification.

Sec. 9. Minnesota Statutes 1994, section 245A.04, subdivision 7, is amended to read:

Subd. 7. **ISSUANCE OF A LICENSE; PROVISIONAL LICENSE.** (a) If the commissioner determines that the program complies with all applicable rules and laws, the commissioner shall issue a license. At minimum, the license shall state:

(1) the name of the license holder;

(2) the address of the program;

(3) the effective date and expiration date of the license;

(4) the type of license;

(5) the maximum number and ages of persons that may receive services from the program; and

(6) any special conditions of licensure.

(b) The commissioner may issue a provisional license for a period not to exceed one year if:

(1) the commissioner is unable to conduct the evaluation or observation required by subdivision 4, paragraph (a), clauses (3) and (4), because the program is not yet operational;

(2) certain records and documents are not available because persons are not yet receiving services from the program; and

(3) the applicant complies with applicable laws and rules in all other respects.

A provisional license must not be issued except at the time that a license is first issued to an applicant.

(c) A decision by the commissioner to issue a license does not guarantee that any person or persons will be placed or cared for in the licensed program. A license shall not be transferable to another individual, corporation, partnership, voluntary association, other organization, or controlling individual, or to another location. Unless otherwise specified by statute, all licenses expire at 12:01 a.m. on the day after the expiration date stated on the license. A license holder must apply for and be granted a new license to operate the program or the program must not be operated after the expiration date.

Sec. 10. Minnesota Statutes 1994, section 245A.04, subdivision 9, is amended to read:

Subd. 9. **VARIANCES.** The commissioner may grant variances to rules that do not affect the health or safety of persons in a licensed program if the following conditions are met:

(1) the variance must be requested by an applicant or license holder on a form and in a manner prescribed by the commissioner;

(2) the request for a variance must include the reasons that the applicant or license holder cannot comply with a requirement as stated in the rule and the alternative equivalent measures that the applicant or license holder will follow to comply with the intent of the rule; and

(3) the request must state the period of time for which the variance is requested.

The commissioner may grant a permanent variance when conditions under which the variance is requested do not affect the health or safety of persons being served by the licensed program, nor compromise the qualifications of staff to provide services. The permanent variance shall expire as soon as the conditions that warranted the variance are modified in any way. Any applicant or license holder must inform the commissioner of any changes or modifications that have occurred in the conditions that warranted the permanent variance. Failure to advise the commissioner shall result in revocation of the permanent variance and may be cause for other sanctions under sections 245A.06 and 245A.07.

The commissioner's decision to grant or deny a variance request is final and not subject to appeal under the provisions of chapter 14.

Sec. 11. Minnesota Statutes 1994, section 245A.06, subdivision 2, is amended to read:

Subd. 2. **RECONSIDERATION OF CORRECTION ORDERS.** If the applicant or license holder believes that the contents of the commissioner's correction order are in error, the applicant or license holder may ask the department of human services to reconsider the parts of the correction order that are alleged to be in error. The request for reconsideration must be in writing~~, delivered by certified mail~~ and received by the commissioner within 20 calendar days after receipt of the correction order by the applicant or license holder, and:

(1) specify the parts of the correction order that are alleged to be in error;

(2) explain why they are in error; and

(3) include documentation to support the allegation of error.

A request for reconsideration does not stay any provisions or requirements of the correction order. The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14.

Sec. 12. Minnesota Statutes 1994, section 245A.06, subdivision 4, is amended to read:

Subd. 4. **NOTICE OF FINE; APPEAL.** A license holder who is ordered to

pay a fine must be notified of the order by certified mail. The notice must be mailed to the address shown on the application or the last known address of the license holder. The notice must state the reasons the fine was ordered and must inform the license holder of the responsibility for payment of fines in subdivision 7 and the right to a contested case hearing under chapter 14. The license holder may appeal the order to forfeit a fine by notifying the commissioner by certified mail within 15 calendar days after receiving the order. A timely appeal shall stay forfeiture of the fine until the commissioner issues a final order under section 245A.08, subdivision 5.

Sec. 13. Minnesota Statutes 1994, section 245A.06, is amended by adding a subdivision to read:

Subd. 7. **RESPONSIBILITY FOR PAYMENT OF FINES.** When a fine has been assessed, the license holder may not avoid payment by closing, selling, or otherwise transferring the licensed program to a third party. In such an event, the license holder will be personally liable for payment. In the case of a corporation, each controlling individual is personally and jointly liable for payment.

Sec. 14. Minnesota Statutes 1994, section 245A.07, subdivision 3, is amended to read:

Subd. 3. **SUSPENSION, REVOCATION, PROBATION.** The commissioner may suspend, revoke, or make probationary a license if a license holder fails to comply fully with applicable laws or rules or knowingly gives false or misleading information to the commissioner in connection with an application for a license or during an investigation. A license holder who has had a license suspended, revoked, or made probationary must be given notice of the action by certified mail. The notice must be mailed to the address shown on the application or the last known address of the license holder. The notice must state the reasons the license was suspended, revoked, or made probationary.

(a) If the license was suspended or revoked, the notice must inform the license holder of the right to a contested case hearing under chapter 14. The license holder may appeal an order suspending or revoking a license. The appeal of an order suspending or revoking a license must be made in writing by certified mail and must be received by the commissioner within ten calendar days after the license holder receives notice that the license has been suspended or revoked.

(b) If the license was made probationary, the notice must inform the license holder of the right to request a reconsideration by the commissioner. The request for reconsideration must be made in writing by certified mail and must be received by the commissioner within ten calendar days after the license holder receives notice that the license has been made probationary. The license holder may submit with the request for reconsideration written argument or evidence in support of the request for reconsideration. The commissioner's disposition of a request for reconsideration is final and is not subject to appeal under chapter 14.

Sec. 15. Minnesota Statutes 1994, section 245A.09, is amended by adding a subdivision to read:

Subd. 8. **INTERPRETIVE GUIDELINES; AUTHORITY.** The commissioner of human services may develop and publish interpretive guidelines.

Sec. 16. Minnesota Statutes 1994, section 245A.09, is amended by adding a subdivision to read:

Subd. 9. **EFFECT OF INTERPRETIVE GUIDELINES.** Interpretive guidelines do not have the force and effect of law and have no precedential effect, but may be relied on by consumers, providers of service, county agencies, the department of human services, and others concerned until revoked or modified. A guideline may be expressly revoked or modified by the commissioner, by the issuance of another interpretive guideline, but may not be revoked or modified retroactively to the detriment of consumers, providers of service, county agencies, the department of human services, or others concerned. A change in the law or an interpretation of the law occurring after the interpretive guidelines are issued, whether in the form of a statute, court decision, administrative ruling, or subsequent interpretive guideline, results in the revocation or modification of the previously adopted guidelines to the extent that the change affects the guidelines.

Sec. 17. Minnesota Statutes 1994, section 245A.09, is amended by adding a subdivision to read:

Subd. 10. **RULEMAKING PROCESS; COMMISSIONER EXEMPTED.** When developing, making, adopting, and issuing interpretive guidelines under the authority granted under subdivision 8, the commissioner is exempt from the rulemaking provisions of chapter 14.

Sec. 18. Minnesota Statutes 1994, section 245A.09, is amended by adding a subdivision to read:

Subd. 11. **ISSUANCE; DISCRETION OF THE COMMISSIONER.** The issuance of interpretive guidelines is at the discretion of the commissioner of human services.

Sec. 19. Minnesota Statutes 1994, section 245A.09, is amended by adding a subdivision to read:

Subd. 12. **PUBLICATION OF GUIDELINES.** The commissioner shall publish notice of interpretive guidelines availability in the State Register. The commissioner may publish or make available the interpretive guidelines in any manner determined by the commissioner, provided they are accessible to the general public. The commissioner may charge a reasonable fee for copies of the guidelines requested by interested parties when they are provided by the commissioner.

Sec. 20. Minnesota Statutes 1994, section 245A.14, subdivision 6, is amended to read:

Subd. 6. **DROP-IN CHILD CARE PROGRAMS.** (a) Except as expressly set forth in this subdivision, drop-in child care programs must be licensed as a drop-in program under the rules governing child care programs operated in a center.

(b) Drop-in child care programs are exempt from the following Minnesota Rules:

(1) part 9503.0040;

(2) part 9503.0045, subpart 1, items F and G;

(3) part 9503.0050, subpart 6, except for children less than 2-1/2 years old;

(4) one-half the requirements of part 9503.0060, subpart 4, item A, subitems (2), (5), and (8), subpart 5, item A, subitems (2), (3), and (7), and subpart 6, item A, subitems (3) and (6);

(5) part 9503.0070; and

(6) part 9503.0090, subpart 2.

(c) A drop-in child care program must be operated under the supervision of a person qualified as a director and a teacher.

(d) A drop-in child care program must have at least two persons on staff whenever the program is operating, except that the commissioner may permit variances from this requirement under specified circumstances for parent cooperative programs, as long as all other staff-to-child ratios are met.

(e) Whenever the total number of children present to be cared for at a center is more than 20, children that are younger than age 2-1/2 must be in a separate group. This group may contain children up to 60 months old. This group must be cared for in an area that is physically separated from older children.

(f) A drop-in child care program must maintain a minimum staff ratio for children age 2-1/2 or greater of one staff person for each ten children.

(g) If the program has additional staff who are on call as a mandatory condition of their employment, the minimum child-to-staff ratio may be exceeded only for children age 2-1/2 or greater, by a maximum of four children, for no more than 20 minutes while additional staff are in transit.

(h) The minimum staff-to-child ratio for infants up to 16 months of age is one staff person for every four infants. The minimum staff-to-child ratio for children age 17 months to 30 months is one staff for every seven children.

(i) In drop-in care programs that serve both infants and older children, children up to age 2-1/2 may be supervised by assistant teachers, as long as other staff are present in appropriate ratios.

(j) The minimum staff distribution pattern for a drop-in child care program serving children age 2-1/2 or greater is: the first staff member must be a teacher; the second, third, and fourth staff members must have at least the qualifications of a child care aide; the fifth staff member must have at least the qualifications of an assistant teacher; the sixth, seventh, and eighth staff members must have at least the qualifications of a child care aide; and the ninth staff person must have at least the qualifications of an assistant teacher.

(k) A drop-in child care program may care for siblings 16 months or older together in any group. For purposes of this subdivision, sibling is defined as sister or brother, half-sister or half-brother, or stepsister or stepbrother.

(l) The commissioner may grant a variance to any of the requirements in paragraphs (a) to (k), as long as the health and safety of the persons served by the program are not affected. The request for a variance shall comply with the provisions in section 245A.04, subdivision 9.

Sec. 21. Minnesota Statutes 1994, section 256.014, subdivision 1, is amended to read:

Subdivision 1. **ESTABLISHMENT OF SYSTEMS.** The commissioner of human services shall establish and enhance computer systems necessary for the efficient operation of the programs the commissioner supervises, including:

(1) management and administration of the food stamp and income maintenance programs, including the electronic distribution of benefits;

(2) management and administration of the child support enforcement program; and

(3) administration of medical assistance and general assistance medical care.

The commissioner shall distribute the nonfederal share of the costs of operating and maintaining the systems to the commissioner and to the counties participating in the system in a manner that reflects actual system usage, except that the nonfederal share of the costs of the MAXIS computer system and child support enforcement systems shall be borne entirely by the commissioner. Development costs must not be assessed against county agencies.

Sec. 22. Minnesota Statutes 1994, 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, excluding county optional costs which are not reimbursable with state funds. 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~~ 2002 has increased over the base amount.

Sec. 23. Minnesota Statutes 1994, 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, for assistance costs incurred prior to July 1, 1995;

(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 for employment and training services costs incurred prior to July 1, 1995;

(10) case management services under section 256.736, subdivision 13, for case management service costs incurred prior to July 1, 1995;

(11) general assistance claims processing, medical transportation and related costs;

(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. 24. Minnesota Statutes 1994, 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. Reimbursement may take the form of offsets to billings of a county, if the county agrees to the offset process.

(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 or quarterly pay to the state, as required by the department of human services, the portion of program costs not met by federal and state funds. The payment 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 or quarterly pay 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 payments shall be made by the state agency in any succeeding month.

Sec. 25. Minnesota Statutes 1994, section 256.026, is amended to read:

256.026 **ANNUAL APPROPRIATION.**

(a) There shall be appropriated from the general fund to the commissioner of human services in fiscal year ~~1994~~ 1996 the amount of $136,154,768 and in fiscal year 1997 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~~ $133,781,768.

(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~~ $5,574,241.

(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~~ 1996 and thereafter.

Sec. 26. Minnesota Statutes 1994, section 256.034, subdivision 1, is amended to read:

Subdivision 1. **CONSOLIDATION OF TYPES OF ASSISTANCE.** Under the Minnesota family investment plan, assistance previously provided to families through the AFDC, food stamp, and general assistance programs must be combined into a single cash assistance program. As authorized by Congress, families receiving assistance through the Minnesota family investment plan are automatically eligible for and entitled to medical assistance under chapter 256B. Federal, state, and local funds that would otherwise be allocated for assistance to families under the AFDC, food stamp, and general assistance programs must be transferred to the Minnesota family investment plan. The provisions of the Minnesota family investment plan prevail over any provisions of sections 245.771, 256.72 to 256.87, 256D.01 to 256D.21, or 393.07, subdivisions 10 and 10a, and any rules implementing those sections with which they are irreconcilable. The food stamp, general assistance, and work readiness programs for single persons and couples who are not responsible for the care of children are not replaced by the Minnesota family investment plan. Unless stated otherwise in statutes or rules governing the Minnesota family investment plan, participants in the Minnesota family investment plan shall be considered to be recipients of aid under aid to families with dependent children, family general assistance, and food stamps for the purposes of statutes and rules affecting such recipients or allocations of funding based on the assistance status of the recipients, and to specifically be subject to the provisions of section 256.98.

Sec. 27. Minnesota Statutes 1994, section 256.045, subdivision 3, is amended to read:

Subd. 3. **STATE AGENCY HEARINGS.** (a) Any person applying for, receiving or having received public assistance or a program of social services granted by the state agency or a county agency under sections 252.32, 256.031 to 256.036, and 256.72 to 256.879, chapters 256B, 256D, 256E, 261, or the federal Food Stamp Act whose application for assistance is denied, not acted upon with reasonable promptness, or whose assistance is suspended, reduced, terminated, or claimed to have been incorrectly paid, or any patient or relative aggrieved by an order of the commissioner under section 252.27, or a party aggrieved by a ruling of a prepaid health plan, may contest that action or decision before the state agency by submitting a written request for a hearing to the state agency within 30 days after receiving written notice of the action or decision, or within

90 days of such written notice if the applicant, recipient, patient, or relative shows good cause why the request was not submitted within the 30-day time limit.

(b) Except for a prepaid health plan, a vendor of medical care as defined in section 256B.02, subdivision 7, or a vendor under contract with a county agency to provide social services under section 256E.08, subdivision 4, is not a party and may not request a hearing under this section, except if assisting a recipient as provided in subdivision 4.

(c) An applicant or recipient is not entitled to receive social services beyond the services included in the amended community social services plan developed under section 256E.081, subdivision 3, if the county agency has met the requirements in section 256E.081.

Sec. 28. Minnesota Statutes 1994, section 256.045, subdivision 4, is amended to read:

Subd. 4. **CONDUCT OF HEARINGS.** All hearings held pursuant to subdivision 3, 3a, or 4a shall be conducted according to the provisions of the federal Social Security Act and the regulations implemented in accordance with that act to enable this state to qualify for federal grants-in-aid, and according to the rules and written policies of the commissioner of human services. County agencies shall install equipment necessary to conduct telephone hearings. A state human services referee may schedule a telephone conference hearing when the distance or time required to travel to the county agency offices will cause a delay in the issuance of an order, or to promote efficiency, or at the mutual request of the parties. Hearings may be conducted by telephone conferences unless the applicant, recipient, or former recipient objects. The hearing shall not be held earlier than five days after filing of the required notice with the county or state agency. The state human services referee shall notify all interested persons of the time, date, and location of the hearing at least five days before the date of the hearing. Interested persons may be represented by legal counsel or other representative of their choice, including a provider of therapy services, at the hearing and may appear personally, testify and offer evidence, and examine and cross-examine witnesses. The applicant, recipient, or former recipient shall have the opportunity to examine the contents of the case file and all documents and records to be used by the county or state agency at the hearing at a reasonable time before the date of the hearing and during the hearing. Upon request, the county agency shall provide reimbursement for transportation, child care, photocopying, medical assessment, witness fee, and other necessary and reasonable costs incurred by the applicant, recipient, or former recipient in connection with the appeal. All evidence, except that privileged by law, commonly accepted by reasonable people in the conduct of their affairs as having probative value with respect to the issues shall be submitted at the hearing and such hearing shall not be "a contested case" within the meaning of section 14.02, subdivision 3. The agency must present its evidence prior to or at the hearing, and may not submit evidence after the hearing except by agreement of the parties at the hearing, provided the recipient has the opportunity to respond.

Sec. 29. Minnesota Statutes 1994, section 256.045, subdivision 5, is amended to read:

Subd. 5. **ORDERS OF THE COMMISSIONER OF HUMAN SERVICES.** A state human services referee shall conduct a hearing on the appeal and shall recommend an order to the commissioner of human services. The recommended order must be based on all relevant evidence and must not be limited to a review of the propriety of the state or county agency's action. A referee may take official notice of adjudicative facts. The commissioner of human services may accept the recommended order of a state human services referee and issue the order to the county agency and the applicant, recipient, former recipient, or prepaid health plan. The commissioner on refusing to accept the recommended order of the state human services referee, shall notify the county agency and the applicant, recipient, former recipient, or prepaid health plan of that fact and shall state reasons therefor and shall allow each party ten days' time to submit additional written argument on the matter. After the expiration of the ten-day period, the commissioner shall issue an order on the matter to the county agency and the applicant, recipient, former recipient, or prepaid health plan.

A party aggrieved by an order of the commissioner may appeal under subdivision 7, or request reconsideration by the commissioner within 30 days after the date the commissioner issues the order. The commissioner may reconsider an order upon request of any party or on the commissioner's own motion. A request for reconsideration does not stay implementation of the commissioner's order. Upon reconsideration, the commissioner may issue an amended order or an order affirming the original order.

Any order of the commissioner issued under this subdivision shall be conclusive upon the parties unless appeal is taken in the manner provided by subdivision 7. Any order of the commissioner is binding on the parties and must be implemented by the state agency or a county agency until the order is reversed by the district court, or unless the commissioner or a district court orders monthly assistance or aid or services paid or provided under subdivision 10.

Except for a prepaid health plan, a vendor of medical care as defined in section 256B.02, subdivision 7, or a vendor under contract with a county agency to provide social services under section 256E.08, subdivision 4, is not a party and may not request a hearing or seek judicial review of an order issued under this section, unless assisting a recipient as provided in subdivision 4.

Sec. 30. Minnesota Statutes 1994, section 256.98, subdivision 1, is amended to read:

Subdivision 1. **WRONGFULLY OBTAINING ASSISTANCE.** A person who obtains, or attempts to obtain, or aids or abets any person to obtain by means of a willfully false statement or representation, by intentional concealment of a material fact, or by impersonation or other fraudulent device, assistance to which the person is not entitled or assistance greater than that to which the person is entitled, or who knowingly aids or abets in buying or in any way

disposing of the property of a recipient or applicant of assistance without the consent of the county agency with intent to defeat the purposes of sections 256.12, 256.031 to 256.0361, 256.72 to 256.871, and chapter 256B, or all of these sections is guilty of theft and shall be sentenced pursuant to section 609.52, subdivision 3, clauses (2), (3)(a) and (c), (4), and (5).

Sec. 31. Minnesota Statutes 1994, section 256.98, subdivision 8, is amended to read:

Subd. 8. **DISQUALIFICATION FROM PROGRAM.** Any person found to be guilty of wrongfully obtaining assistance by a federal or state court or by an administrative hearing determination, or waiver thereof, through a disqualification consent agreement, or as part of any approved diversion plan under section 401.065 in ~~either~~ the aid to families with dependent children program ~~or~~, the food stamp program, the Minnesota family investment plan, the general assistance or family general assistance program, the Minnesota supplemental aid program, or the work readiness program shall be disqualified from that program. The needs of that individual shall not be taken into consideration in determining the grant level for that assistance unit:

(1) for six months after the first offense;

(2) for 12 months after the second offense; and

(3) permanently after the third or subsequent offense.

~~Any~~ The period ~~for which sanctions are imposed is effective,~~ of program disqualification shall begin on the date stipulated on the advance notice of disqualification without possibility of postponement for administrative stay~~,~~ or administrative hearing and shall continue through completion unless and until the findings upon which the sanctions were imposed are reversed by a court of competent jurisdiction. The period for which sanctions are imposed is not subject to review. The sanctions provided under this subdivision are in addition to, and not in substitution for, any other sanctions that may be provided for by law for the offense involved. A disqualification established through hearing or waiver shall result in the disqualification period beginning immediately unless the person has become otherwise ineligible for assistance. If the person is ineligible for assistance, the disqualification period begins when the person again meets the eligibility criteria of the program from which they were disqualified.

Sec. 32. Minnesota Statutes 1994, section 256.983, subdivision 4, is amended to read:

Subd. 4. **FUNDING.** (a) Every involved county agency shall either have in place or obtain an approved contract which meets all federal requirements necessary to obtain enhanced federal funding for its welfare fraud control and fraud prevention investigation programs. County agency reimbursement shall be made through the settlement provisions applicable to the aid to families with dependent children and food stamp programs.

(b) After allowing an opportunity to establish compliance, the commissioner will deny administrative reimbursement if for any three-month period during any grant year, a county agency fails to comply with fraud investigation guidelines, or fails to meet the cost-effectiveness standards developed by the commissioner. This result is contingent on the commissioner providing written notice, including an offer of technical assistance, within 30 days of the end of the third or subsequent month of noncompliance. The county agency shall be required to submit a corrective action plan to the commissioner within 30 days of receipt of a notice of noncompliance. Failure to submit a corrective action plan or, continued deviation from standards of more than ten percent after submission of a corrective action plan, will result in denial of funding for each subsequent month during the grant year or billing the county agency for fraud prevention investigation (FPI) service provided by the commissioner. The denial of funding shall apply to the general settlement received by the county agency on a quarterly basis and shall not reduce the grant amount applicable to the FPI project.

Sec. 33. **[256.9861] FRAUD CONTROL; PROGRAM INTEGRITY REINVESTMENT PROJECT.**

Subdivision 1. **PROGRAM ESTABLISHED.** Within the limits of available state and federal appropriations, and to the extent required or authorized by applicable federal regulations, the commissioner of human services shall make funding available to county agencies for the establishment of program integrity reinvestment initiatives. The project shall initially be limited to those county agencies participating in federally funded optional fraud control programs as of January 1, 1995.

Subd. 2. **COUNTY PROPOSALS.** Each included county shall develop and submit annual funding, staffing, and operating grant proposals to the commissioner no later than April 30 of each year. For the first operating year only, the proposal shall be submitted no later than October 30. Each proposal shall provide information on: (a) the staffing and funding of the fraud investigation and prosecution operations; (b) job descriptions for agency fraud control staff; (c) contracts covering outside investigative agencies; (d) operational methods to integrate the use of fraud prevention investigation techniques; and (e) administrative disqualification hearings and diversions into the existing county fraud control and prosecution procedures.

Subd. 3. **DEPARTMENT RESPONSIBILITIES.** The commissioner shall provide written instructions outlining the contents of the proposals to be submitted under this section. Instructions shall be made available 30 days prior to the date by which proposals under subdivision 2 must be submitted. The commissioner shall establish training programs which shall be attended by fraud control staff of all involved counties. The commissioner shall also develop the necessary operational guidelines, forms, and reporting mechanisms which shall be used by the involved counties.

Subd. 4. **STANDARDS.** The commissioner shall establish standards governing the performance levels of involved county investigative units based on grant agreements negotiated with the involved county agencies. The standards

shall take into consideration and may include investigative caseloads, grant savings levels, the comparison of fraud prevention and prosecution directed investigations, utilization levels of administrative disqualification hearings, the timely reporting and implementation of disqualifications, and the timeliness of reports received from prosecutors.

Subd. 5. **FUNDING.** (a) Grant funds are intended to help offset the reduction in federal financial participation to 50 percent and may be apportioned to the participating counties whenever feasible, and within the commissioner's discretion, to achieve this goal. State funding shall be made available contingent on counties submitting a plan that is approved by the department of human services. Failure or delay in obtaining that approval shall not, however, eliminate the obligation to maintain fraud control efforts at the January 1, 1995, level. Additional counties may be added to the project to the extent that funds are subsequently made available. Every involved county must meet all federal requirements necessary to obtain federal funding for its welfare fraud control and prevention programs. County agency reimbursement shall be made through the settlement provisions applicable to the AFDC and food stamp programs.

(b) Should a county agency fail to comply with the standards set, or fail to meet cost-effectiveness standards developed by the commissioner for three months during any grant year, the commissioner shall deny reimbursement or administrative costs, after allowing an opportunity to establish compliance.

(c) Any denial of reimbursement under clause (b) is contingent on the commissioner providing written notice, including an offer of technical assistance, within 30 days of the end of the third or subsequent months of noncompliance. The county agency shall be required to submit a corrective action plan to the commissioner within 30 days of receipt of a notice of noncompliance. Failure to submit a corrective action plan or continued deviation from standards of more than ten percent after submission of corrective action plan, will result in denial of funding for each such month during the grant year, or billing the county agency for program integrity reinvestment project services provided by the commissioner. The denial of funding shall apply to the general settlement received by the county agency on a quarterly basis and shall not reduce the grant amount applicable to the program integrity reinvestment project.

Sec. 34. **[256.9862] ASSISTANCE TRANSACTION CARD FEE.**

Subdivision 1. **REPLACEMENT CARD.** The commissioner of human services may charge a cardholder, defined as a person in whose name the transaction card was issued, a $2 fee to replace an assistance transaction card. The fees shall be appropriated to the commissioner and used for electronic benefit purposes.

Subd. 2. **TRANSACTION FEE.** The commissioner may charge transaction fees in accordance with this subdivision up to a maximum of $10 in transaction fees per cardholder per month. In a given month, the first four cash withdrawals made by an individual cardholder are free. For subsequent cash withdrawals, $1

may be charged. No transaction fee can be charged if the card is used to purchase goods or services on a point of sale basis. A transaction fee subsequently set by the federal government may supersede a fee established under this subdivision. The fees shall be appropriated to the commissioner and used for electronic benefit purposes.

Sec. 35. Minnesota Statutes 1994, section 524.6-207, is amended to read:

524.6-207 **RIGHTS OF CREDITORS.**

No multiple-party account will be effective against an estate of a deceased party to transfer to a survivor sums needed to pay debts, taxes, and expenses of administration, including statutory allowances to the surviving spouse, minor children and dependent children or against a county agency with a claim authorized by section 256B.15, if other assets of the estate are insufficient, to the extent the deceased party is the source of the funds or beneficial owner. A surviving party or P.O.D. payee who receives payment from a multiple-party account after the death of a deceased party shall be liable to account to the deceased party's personal representative or a county agency with a claim authorized by section 256B.15 for amounts the decedent owned beneficially immediately before death to the extent necessary to discharge any such claims and charges remaining unpaid after the application of the assets of the decedent's estate. No proceeding to assert this liability shall be commenced ~~unless~~ by the personal representative unless the personal representative has received a written demand by a surviving spouse, a creditor or one acting for a minor dependent child of the decedent, and no proceeding shall be commenced later than two years following the death of the decedent. Sums recovered by the personal representative shall be administered as part of the decedent's estate. This section shall not affect the right of a financial institution to make payment on multiple-party accounts according to the terms thereof, or make it liable to the estate of a deceased party unless, before payment, the institution has been served with process in a proceeding by the personal representative or a county agency with a claim authorized by section 256B.15.

Sec. 36. Minnesota Statutes 1994, section 550.37, subdivision 14, is amended to read:

Subd. 14. **PUBLIC ASSISTANCE.** All relief based on need, and the earnings or salary of a person who is a recipient of relief based on need, shall be exempt from all claims of creditors including any contractual setoff or security interest asserted by a financial institution. For the purposes of this chapter, relief based on need includes AFDC, general assistance medical care, supplemental security income, medical assistance, Minnesota supplemental assistance, and general assistance. The salary or earnings of any debtor who is or has been ~~a~~ an eligible recipient of relief based on need, or an inmate of a correctional institution shall, upon the debtor's return to private employment or farming after having been ~~a~~ an eligible recipient of relief based on need, or an inmate of a correctional institution, be exempt from attachment, garnishment, or levy of execution

for a period of six months after the debtor's return to employment or farming and after all public assistance for which eligibility existed has been terminated. The exemption provisions contained in this subdivision also apply for 60 days after deposit in any financial institution, whether in a single or joint account. In tracing the funds, the first-in first-out method of accounting shall be used. The burden of establishing that funds are exempt rests upon the debtor. Agencies distributing relief and the correctional institutions shall, at the request of creditors, inform them whether or not any debtor has been ~~a~~ an eligible recipient of relief based on need, or an inmate of a correctional institution, within the preceding six months.

Sec. 37. **MCLEOD COUNTY; COUNTY OFFICES OUTSIDE COUNTY SEAT.**

Notwithstanding Minnesota Statutes, section 382.04 to the contrary, the McLeod county auditor, treasurer, social service director, and recorder may temporarily office at a location in Glencoe township. The authority provided in this section expires six years after final enactment.

Sec. 38. **WAIVER REQUEST; GRANDPARENT EXCLUSION FROM LICENSURE.**

The commissioner of human services shall seek a federal waiver to allow the exclusion of grandparents from the foster care licensing requirements. If the waiver is granted, notwithstanding Minnesota Statutes, section 245A.03, the commissioner may exclude grandparents from foster care licensure. The commissioner shall recommend to the legislature in the legislative session following the approval of the waiver, related, necessary changes in the law.

Sec. 39. **REPEALER.**

Minnesota Statutes 1994, section 256E.06, subdivisions 12 and 13, are repealed.

Sec. 40. **EFFECTIVE DATES.**

Subdivision 1. Sections 5 (245A.03, subdivision 2a), 6 (245A.035, subdivisions 1 to 6), 7 to 10 (245A.04, subdivisions 3, 3b, 7, and 9), 11 to 13 (245A.06, subdivisions 2, 4, and 7), 14 (245A.07, subdivision 3), and 20 (245A.14, subdivision 6), are effective the day following final enactment.

Subd. 2. Under Minnesota Statutes, section 645.023, subdivision 1, clause (a), section 32, takes effect, without local approval, the day following final enactment.

ARTICLE 3

LIFE SKILLS; SELF-SUFFICIENCY

Section 1. Minnesota Statutes 1994, section 246.23, subdivision 2, is amended to read:

Subd. 2. **CHEMICAL DEPENDENCY TREATMENT.** The commissioner shall maintain a regionally based, state-administered system of chemical dependency programs. Counties may refer individuals who are eligible for services under chapter 254B to the chemical dependency units in the regional treatment centers. A 15 percent county share of the per diem cost of treatment is required for individuals served within the treatment capacity funded by direct legislative appropriation. By July 1, 1991, the commissioner shall establish criteria for admission to the chemical dependency units that will maximize federal and private funding sources, fully utilize the regional treatment center capacity, and make state-funded treatment capacity available to counties on an equitable basis. The admission criteria may be adopted without rulemaking. Existing rules governing placements under chapters 254A and 254B do not apply to admissions to the capacity funded by direct appropriation. Private and third-party collections and payments are appropriated to the commissioner for the operation of the chemical dependency units. In addition to the chemical dependency treatment capacity funded by direct legislative appropriation, the regional treatment centers may provide treatment to additional individuals whose treatment is paid for out of the chemical dependency consolidated treatment fund under chapter 254B, in which case placement rules adopted under chapter 254B apply~~;~~ to those individuals who are ineligible but committed for treatment under chapter 253B as provided in section 254B.05, subdivision 4; or to individuals covered through other nonstate payment sources.

Sec. 2. Minnesota Statutes 1994, section 252.275, subdivision 3, is amended to read:

Subd. 3. **REIMBURSEMENT.** Counties shall be reimbursed for all expenditures made pursuant to subdivision 1 at a rate of 70 percent, up to the allocation determined pursuant to subdivisions 4~~,~~ ~~4a,~~ and 4b. However, the commissioner shall not reimburse costs of services for any person if the costs exceed the state share of the average medical assistance costs for services provided by intermediate care facilities for a person with mental retardation or a related condition for the same fiscal year, and shall not reimburse costs of a one-time living allowance for any person if the costs exceed $1,500 in a state fiscal year. ~~For the biennium ending June 30, 1993, the commissioner shall not reimburse costs in excess of the 85th percentile of hourly service costs based upon the cost information supplied to the legislature in the proposed budget for the biennium.~~ The commissioner may make payments to each county in quarterly installments. The commissioner may certify an advance of up to 25 percent of the allocation. Subsequent payments shall be made on a reimbursement basis for reported expenditures and may be adjusted for anticipated spending patterns.

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

Sec. 3. Minnesota Statutes 1994, section 252.275, subdivision 4, is amended to read:

Subd. 4. **FORMULA.** ~~Effective January 1, 1992,~~ The commissioner shall allocate funds on a calendar year basis. ~~For calendar year 1992, funds shall be allocated based on each county's portion of the statewide reimbursement received under this section for state fiscal year 1991. For subsequent calendar years, funds shall be~~ Beginning with the calendar year in the 1996 grant period, funds shall be allocated first in amounts equal to each county's guaranteed floor according to subdivision 4b, with any remaining available funds allocated based on each county's portion of the statewide expenditures eligible for reimbursement under this section during the 12 months ending on June 30 of the preceding calendar year.

If the legislature appropriates funds for special purposes, the commissioner may allocate the funds based on proposals submitted by the counties to the commissioner in a format prescribed by the commissioner. Nothing in this section prevents a county from using other funds to pay for additional costs of semi-independent living services.

Sec. 4. Minnesota Statutes 1994, 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~~ December 31, 1995.

Sec. 5. Minnesota Statutes 1994, section 252.292, subdivision 4, is amended to read:

Subd. 4. **FACILITY RATES.** For purposes of this section, the commissioner shall establish payment rates under section 256B.501 and Minnesota Rules, parts 9553.0010 to 9553.0080, except that, in order to facilitate an orderly transition of residents from community intermediate care facilities for persons with mental retardation or related conditions to services provided under the home and community-based services program, the commissioner may, in a contract with the provider, modify the effect of provisions in Minnesota Rules, parts 9553.0010 to 9553.0080, as stated in clauses (a) to (i):

(a) extend the interim and settle-up rate provisions to include facilities covered by this section;

(b) extend the length of the interim period but not to exceed ~~24~~ 12 months. The commissioner may grant a variance to exceed the ~~24-month~~ 12-month interim period, as necessary, for facilities which are licensed and certified to serve more than 99 persons. In no case shall the commissioner approve an interim period which exceeds ~~36~~ 24 months;

(c) waive the investment per bed limitations for the interim period and the settle-up rate;

(d) limit the amount of reimbursable expenses related to the acquisition of new capital assets;

(e) prohibit the acquisition of additional capital debt or refinancing of existing capital debt unless prior approval is obtained from the commissioner;

(f) establish an administrative operating cost limitation for the interim period and the settle-up rate;

(g) require the retention of financial and statistical records until the commissioner has audited the interim period and the settle-up rate;

(h) require that the interim period be audited by a certified or licensed public accounting firm; or

(i) change any other provision to which all parties to the contract agree.

Sec. 6. Minnesota Statutes 1994, section 252.46, subdivision 1, is amended to read:

Subdivision 1. **RATES.** (a) 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 19. 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.

(b) The commissioner may also approve an hourly job-coach, follow-along rate for services provided by one employee at or en route to or from community locations to supervise, support, and assist one person receiving the vendor's services to learn job-related skills necessary to obtain or retain employment when and where no other persons receiving services are present and when all the following criteria are met:

(1) the vendor requests and the county recommends the optional rate;

(2) the service is prior authorized by the county on the medicaid management information system for no more than 414 hours in a 12-month period and the daily per person charge to medical assistance does not exceed the vendor's approved full day plus transportation rates;

(3) separate full day, partial day, and transportation rates are not billed for the same person on the same day;

(4) the approved hourly rate does not exceed the sum of the vendor's current average hourly direct service wage, including fringe benefits and taxes, plus a component equal to the vendor's average hourly nondirect service wage expenses; and

(5) the actual revenue received for provision of hourly job-coach, follow-along services is subtracted from the vendor's total expenses for the same time period and those adjusted expenses are used for determining recommended full day and transportation payment rates under subdivision 5 in accordance with the limitations in subdivision 3.

(c) 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.

Sec. 7. Minnesota Statutes 1994, section 252.46, subdivision 3, is amended to read:

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.~~

Sec. 8. Minnesota Statutes 1994, section 252.46, subdivision 6, is amended to read:

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. 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, transportation, and other program related costs when any of the criteria in clauses (1) to ~~(3)~~ (4) is also met:

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

(2) a licensed vendor currently serving fewer than 70 persons with payment rates of 80 percent or less of the statewide average rates and with clients meeting the behavioral or medical criteria under clause (3) approved by the commissioner as a significant program change under section 252.28;

(3) a significant change is approved by the commissioner under section 252.28 that is necessary to provide authorized services to a new client or 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 a new client or clients directly discharged to the vendor's program from a regional treatment center; or

~~(3) a significant increase in the average level of~~ (4) there is a need to maintain required staffing ~~is needed~~ levels in order to provide authorized services approved by the commissioner under section 252.28, that is necessitated by a significant and permanent decrease in licensed capacity or ~~loss of~~ clientele ~~when counties choose alternative services under Laws 1992, chapter 513, article 9, section 41~~.

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

The county shall review the adequacy of services provided by vendors whose payment rates are 80 percent or more of the statewide average rates and 50 percent or more of the vendor's clients meet the behavioral or medical criteria in clause (3).

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 and 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 vendor documents efforts to reallocate current staff and any additional 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.

(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.

(6) The county board's recommended payment rates do not exceed 95 percent of the greater of 125 percent of the current 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.

Sec. 9. Minnesota Statutes 1994, section 252.46, subdivision 17, is amended to read:

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. 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 this subdivision. If the rates meeting the criteria in subdivisions 1 to 16 are lower than the county's or vendor's current rate, the county or vendor must continue to receive the current rate.

Sec. 10. Minnesota Statutes 1994, section 252.46, is amended by adding a subdivision to read:

Subd. 19. **VENDOR APPEALS.** With the concurrence of the county board, a vendor may appeal the commissioner's rejection of a variance request which has been submitted by the county under subdivision 6 and may appeal the commissioner's denial under subdivision 9 of a rate which has been recommended by the county. To appeal, the vendor and county board must file a written notice of appeal with the commissioner. The notice of appeal must be filed or received

by the commissioner within 45 days of the postmark date on the commissioner's notification to the vendor and county agency that a variance request or county recommended rate has been denied. The notice of appeal must specify the reasons for the appeal, the dollar amount in dispute, and the basis in statute or rule for challenging the commissioner's decision.

Within 45 days of receipt of the notice of appeal, the commissioner must convene a reconciliation conference to attempt to resolve the rate dispute. If the dispute is not resolved to the satisfaction of the parties, the parties may initiate a contested case proceeding under sections 14.57 to 14.69. In a contested case hearing held under this section, the appealing party must demonstrate by a preponderance of the evidence that the commissioner incorrectly applied the governing law or regulations, or that the commissioner improperly exercised the commissioner's discretion, in refusing to grant a variance or in refusing to adopt a county recommended rate.

Until the appeal is fully resolved, payments must continue at the existing rate pending the appeal. Retroactive payments consistent with the final decision shall be made after the appeal is fully resolved.

Sec. 11. Minnesota Statutes 1994, section 252.46, is amended by adding a subdivision to read:

Subd. 20. **STUDY OF DAY TRAINING AND HABILITATION VENDORS.** The commissioner shall study the feasibility of grouping vendors of similar size, location, direct service staffing needs or performance outcomes to establish payment rate limits that define cost-effective service. Based on the conclusions of the feasibility study the department shall consider developing a method to redistribute dollars from less cost effective to more cost-effective services based on vendor achievement of performance outcomes. The department shall report to the legislature by January 15, 1996, with results of the study and recommendations for further action. The department shall consult with an advisory committee representing counties, service consumers, vendors, and the legislature.

Sec. 12. Minnesota Statutes 1994, 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, and 1996, 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. A county must make a good faith effort to provide the transportation service through the most cost-effective community-based agencies or organizations eligible to provide the service. 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. 13. Minnesota Statutes 1994, section 254B.02, subdivision 1, is amended to read:

Subdivision 1. **CHEMICAL DEPENDENCY TREATMENT ALLOCATION.** The chemical dependency funds appropriated for allocation shall be placed in a special revenue account. For the fiscal year beginning July 1, 1987, funds shall be transferred to operate the vendor payment, invoice processing, and collections system for one year. The commissioner shall annually transfer funds from the chemical dependency fund to pay for operation of the drug and alcohol abuse normative evaluation system and to pay for all costs incurred by adding two positions for licensing of chemical dependency treatment and rehabilitation programs located in hospitals for which funds are not otherwise appropriated. The commissioner shall annually divide the money available in the chemical dependency fund that is not held in reserve by counties from a previous allocation. Twelve percent of the remaining money must be reserved for treatment of American Indians by eligible vendors under section 254B.05. The remainder of the money must be allocated among the counties according to the following formula, using state demographer data and other data sources determined by the commissioner:

~~(a) The county non-Indian and over age 14 per capita months of eligibility for aid to families with dependent children, general assistance, and medical assistance is divided by the total state non-Indian and over age 14 per capita months of eligibility to determine the caseload factor for each county.~~

~~(b) The average median married couple income for the previous three years for the state is divided by the average median married couple income for the previous three years for each county to determine the income factor.~~

~~(c) The non-Indian and over age 14 population of the county is multiplied by the sum of the income factor and the caseload factor to determine the adjusted population.~~

(a) For purposes of this formula, American Indians and children under age

14 are subtracted from the population of each county to determine the restricted population.

(b) The amount of chemical dependency fund expenditures for entitled persons for services not covered by prepaid plans governed by section 256B.69 in the previous year is divided by the amount of chemical dependency fund expenditures for entitled persons for all services to determine the proportion of exempt service expenditures for each county.

(c) The prepaid plan months of eligibility is multiplied by the proportion of exempt service expenditures to determine the adjusted prepaid plan months of eligibility for each county.

(d) The adjusted prepaid plan months of eligibility is added to the number of restricted population fee for service months of eligibility for aid to families with dependent children, general assistance, and medical assistance and divided by the county restricted population to determine county per capita months of covered service eligibility.

(e) The number of adjusted prepaid plan months of eligibility for the state is added to the number of fee for service months of eligibility for aid to families with dependent children, general assistance, and medical assistance for the state restricted population and divided by the state restricted population to determine state per capita months of covered service eligibility.

(f) The county per capita months of covered service eligibility is divided by the state per capita months of covered service eligibility to determine the county welfare caseload factor.

(g) The median married couple income for the most recent three-year period available for the state is divided by the median married couple income for the same period for each county to determine the income factor for each county.

(h) The county restricted population is multiplied by the sum of the county welfare caseload factor and the county income factor to determine the adjusted population.

~~(d)~~ (i) $15,000 shall be allocated to each county.

~~(e)~~ (j) The remaining funds shall be allocated proportional to the county adjusted population.

Sec. 14. Minnesota Statutes 1994, section 254B.05, subdivision 1, is amended to read:

Subdivision 1. **LICENSURE REQUIRED.** Programs licensed by the commissioner are eligible vendors. Hospitals may apply for and receive licenses to be eligible vendors, notwithstanding the provisions of section 245A.03. American Indian programs located on federally recognized tribal lands that provide chemical dependency primary treatment, extended care, transitional residence,

or outpatient treatment services, and are licensed by tribal government are eligible vendors. Detoxification programs are not eligible vendors. Programs that are not licensed as a chemical dependency residential or nonresidential treatment program by the commissioner or by tribal government are not eligible vendors. To be eligible for payment under the Consolidated Chemical Dependency Treatment Fund, a vendor must participate in the Drug and Alcohol Abuse Normative Evaluation System and the treatment accountability plan.

Sec. 15. **[256.476] CONSUMER SUPPORT PROGRAM.**

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

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

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

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

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

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

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

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

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

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

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

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

(3) refuse any or all alternatives.

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

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

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

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

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

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

(1) the person is eligible for medical assistance as determined under sections 256B.055 and 256B.056 or the person is eligible for alternative care services as determined under section 256B.0913;

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

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

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

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

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

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

(c) A person or person's family receiving a consumer support grant shall not be charged a fee or premium by a local agency for participating in the program. A person or person's family is not eligible for a consumer support grant if their income is at a level where they are required to pay a parental fee under sections 252.27, 256B.055, subdivision 12, and 256B.14 and rules adopted under those sections for medical assistance services to a disabled child living with at least one parent.

Subd. 4. **SUPPORT GRANTS; CRITERIA AND LIMITATIONS.** (a) A county board may choose to participate in the consumer support grant program. If a county board chooses to participate in the program, the local agency shall establish written procedures and criteria to determine the amount and use of support grants. These procedures must include, at least, the availability of respite care, assistance with daily living, and adaptive aids. The local agency may establish monthly or annual maximum amounts for grants and procedures where exceptional resources may be required to meet the health and safety needs of the person on a time-limited basis.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) their eligibility for current program and services;

(3) the amount of nonfederal dollars expended on those individuals for those programs and services; and

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

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

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

Subd. 6. **RIGHT TO APPEAL.** Notice, appeal, and hearing procedures shall be conducted in accordance with section 256.045. The denial, suspension, or termination of services under this program may be appealed by a recipient or applicant under section 256.045, subdivision 3. It is an absolute defense to an appeal under this section, if the county board proves that it followed the established written procedures and criteria and determined that the grant could not be provided within the county board's allocation of money for consumer support grants.

Subd. 7. **FEDERAL FUNDS.** The commissioner and the counties shall make reasonable efforts to maximize the use of federal funds including funds available through grants and federal waivers. If federal funds are made available to the consumer support grant program, the money shall be allocated to the responsible county agency's consumer support grant fund.

Subd. 8. **COMMISSIONER RESPONSIBILITIES.** The commissioner shall:

(1) transfer and allocate funds pursuant to this section;

(2) determine allocations based on projected and actual local agency use;

(3) monitor and oversee overall program spending;

(4) evaluate the effectiveness of the program;

(5) provide training and technical assistance for local agencies and consumers to help identify potential applicants to the program; and

(6) develop guidelines for local agency program administration and consumer information.

Subd. 9. **COUNTY BOARD RESPONSIBILITIES.** County boards receiving funds under this section shall:

(1) determine the needs of persons and families for services and supports;

(2) determine the eligibility for persons proposed for program participation;

(3) approve items and services to be reimbursed and inform families of their determination;

(4) issue support grants directly to or on behalf of persons;

(5) submit quarterly financial reports and an annual program report to the commissioner;

(6) coordinate services and supports with other programs offered or made available to persons or their families; and

(7) provide assistance to persons or their families in securing or maintaining supports, as needed.

Subd. 10. **CONSUMER RESPONSIBILITIES.** Persons receiving grants under this section shall:

(1) spend the grant money in a manner consistent with their agreement with the local agency;

(2) notify the local agency of any necessary changes in the grant or the items on which it is spent;

(3) notify the local agency of any decision made by the person, the person's legal representative, or the person's family that would change their eligibility for consumer support grants;

(4) arrange and pay for supports; and

(5) inform the local agency of areas where they have experienced difficulty securing or maintaining supports.

Sec. 16. **[256.973] HOUSING FOR PERSONS WHO ARE ELDERLY, PERSONS WITH PHYSICAL OR DEVELOPMENTAL DISABILITIES, AND SINGLE-PARENT FAMILIES.**

Subdivision 1. **HOME SHARING.** The home-sharing grant program authorized by section 462A.05, subdivision 24, is transferred from the Minnesota housing finance agency to the department of human services. The housing finance agency shall administer the current grants that terminate on August 30, 1995. The department of human services shall administer grants funded after August 30, 1995. The department of human services may engage in housing programs, as defined by the agency, to provide grants to housing sponsors who will provide a home-sharing program for low- and moderate-income elderly, persons with physical or developmental disabilities, or single-parent families in urban and rural areas.

Subd. 2. **MATCHING OWNERS AND TENANTS.** Housing sponsors of home sharing programs, as defined by the agency, shall match existing homeowners with prospective tenants who will contribute either rent or services to the homeowner, where either the homeowner or the prospective tenant is elderly, a person with physical or developmental disabilities, or the head of a

single-parent family. Home-sharing projects will coordinate efforts with appropriate public and private agencies and organizations in their area.

Subd. 3. **INFORMATION FOR PARTICIPANTS.** Housing sponsors who receive funding through these programs shall provide homeowners and tenants participating in a home-sharing program with information regarding their rights and obligations as they relate to federal and state tax law including, but not limited to, taxable rental income, homestead credit under chapter 273, and the property tax refund act under chapter 290A.

Subd. 4. **TECHNICAL ASSISTANCE.** The department of human services may provide technical assistance to sponsors of home-sharing programs or may contract or delegate the provision of technical assistance.

Subd. 5. **USING OUTSIDE AGENCIES.** The department of human services may delegate, use, or employ any federal, state, regional, or local public or private agency or organization, including organizations of physically handicapped persons, upon terms it deems necessary or desirable, to assist in the exercise of any of the powers granted in this section.

Sec. 17. Minnesota Statutes 1994, section 256.975, is amended by adding a subdivision to read:

Subd. 6. **INDIAN ELDERS POSITION.** The Minnesota board on aging shall create an Indian elders coordinator position, and shall hire staff as appropriations permit for the purposes of coordinating efforts with the National Indian Council on Aging and developing a comprehensive statewide service system for Indian elders. An Indian elder is defined for purposes of this subdivision as an Indian enrolled in a band or tribe who is 55 years or older. The statewide service system must include the following components:

(1) an assessment of the program eligibility, examining the need to change the age-based eligibility criteria to need-based eligibility criteria;

(2) a planning system that would grant or make recommendations for granting federal and state funding for services;

(3) a plan for service focal points, senior centers, or community centers for socialization and service accessibility for Indian elders;

(4) a plan to develop and implement education and public awareness campaigns including awareness programs, sensitivity cultural training, and public education on Indian elder needs;

(5) a plan for information and referral services including trained advocates and an Indian elder newsletter;

(6) a plan for a coordinated health care system including health promotion/prevention, in-home service, long-term care service, and health care services;

(7) a plan for ongoing research involving Indian elders including needs assessment and needs analysis;

(8) information and referral services for legal advice or legal counsel; and

(9) a plan to coordinate services with existing organizations including the council of Indian affairs, the Minnesota Indian council of elders, the Minnesota board on aging, and tribal governments.

Sec. 18. Minnesota Statutes 1994, section 256B.0628, is amended by adding a subdivision to read:

Subd. 3. **ASSESSMENT AND PRIOR AUTHORIZATION PROCESS FOR RECIPIENTS OF BOTH HOME CARE AND HOME AND COMMUNITY-BASED WAIVERED SERVICES FOR PERSONS WITH MENTAL RETARDATION OR RELATED CONDITIONS.** Effective January 1, 1996, for purposes of providing informed choice, coordinating of local planning decisions, and streamlining administrative requirements, the assessment and prior authorization process for persons receiving both home care and home and community-based waivered services for persons with mental retardation or related conditions shall meet the requirements of this section and section 256B.0627 with the following exceptions:

(a) Upon request for home care services and subsequent assessment by the public health nurse under section 256B.0627, the public health nurse shall participate in the screening process, as appropriate, and, if home care services are determined to be necessary, participate in the development of a service plan coordinating the need for home care and home and community-based waivered services with the assigned county case manager, the recipient of services, and the recipient's legal representative, if any.

(b) The public health nurse shall give prior authorization for home care services to the extent that home care services are:

(1) medically necessary;

(2) chosen by the recipient and their legal representative, if any, from the array of home care and home and community-based waivered services available;

(3) coordinated with other services to be received by the recipient as described in the service plan; and

(4) provided within the county's reimbursement limits for home care and home and community-based waivered services for persons with mental retardation or related conditions.

(c) If the public health agency is or may be the provider of home care services to the recipient, the public health agency shall provide the commissioner of human services with a written plan that specifies how the assessment and prior authorization process will be held separate and distinct from the provision of services.

Sec. 19. Minnesota Statutes 1994, section 256B.092, is amended by adding a subdivision to read:

Subd. 4c. **LIVING ARRANGEMENTS BASED ON A 24-HOUR PLAN OF CARE.** (a) Notwithstanding the requirements for licensure under Minnesota Rules, part 9525.1860, subpart 6, item D, and upon federal approval of an amendment to the home and community-based services waiver for persons with mental retardation or related conditions, a person receiving home and community-based services may choose to live in their own home without requiring that the living arrangement be licensed under Minnesota Rules, parts 9555.5050 to 9555.6265, provided the following conditions are met:

(1) the person receiving home and community-based services has chosen to live in their own home;

(2) home and community-based services are provided by a qualified vendor who meets the provider standards as approved in the Minnesota home and community-based services waiver plan for persons with mental retardation or related conditions;

(3) the person, or their legal representative, individually or with others has purchased or rents the home and the person's service provider has no financial interest in the home; and

(4) the service planning team, as defined in Minnesota Rules, part 9525.0004, subpart 24, has determined that the planned services, the 24-hour plan of care, and the housing arrangement are appropriate to address the health, safety, and welfare of the person.

(b) The county agency may require safety inspections of the selected housing as part of their determination of the adequacy of the living arrangement.

Sec. 20. **AUTHORIZATION FOR DOWNSIZING.**

Subdivision 1. **DUTIES OF THE COMMISSIONER.** (a) The commissioner of human services in consultation with Brown county and advocates of persons with mental retardation, shall carry out a voluntary downsizing of MBW on Center, an intermediate care facility for persons with mental retardation, to assure that appropriate services are provided in the least restrictive setting as provided under Minnesota Statutes, section 252.291, subdivision 3.

(b) The commissioner shall present a proposal to address issues relating to:

(1) redistribution of costs;

(2) specific plans for the development and provision of alternative services for residents moved from the intermediate care facility for persons with mental retardation or related conditions;

(3) timelines and expected beginning dates for resident relocation and facility downsizing; and

(4) projected expenditures for services provided to persons with mental retardation or related conditions.

(c) The commissioner shall ensure that residents discharged from the facility are appropriately placed according to need in compliance with Minnesota Rules, parts 9525.0025 to 9525.0165.

(d) The commissioner shall ensure that the proposal complies with need determination procedures in Minnesota Statutes, sections 252.28 and 252.291; case management responsibilities in Minnesota Statutes, section 256B.092; rate requirements in Minnesota Statutes, section 256B.501; the requirements under United States Code, title 42, section 1396, and the rules and regulations adopted under these laws.

(e) The resulting downsizing must result in living units of no larger than four persons, having single bedrooms and a common living room, dining room/kitchen, and bathroom.

(f) The commissioner shall contract with Brown county where the facility is located and the facility. The contract will address and be consistent with the requirements of the proposal.

(g) Operating costs of the facility after downsizing may not exceed the total allowable operating costs of the original facility. For purposes of rate setting for the facility after downsizing, fixed costs may be redistributed but must be based on the actual costs reflected in existing rates.

Subd. 2. **IMPLEMENTATION OF THE PROPOSAL.** For the purposes of the proposal, the commissioner shall:

(1) fund the downsizing of the ICF/MR; and

(2) notify Brown county and the facility of the selections made and approved by the commissioner. The decision of the commissioner is final and may not be appealed.

Sec. 21. **FACILITY CERTIFICATION.**

Notwithstanding Minnesota Statutes, section 252.291, subdivisions 1 and 2, the commissioner of health shall inspect to certify a large community-based facility currently licensed under Minnesota Rules, parts 9525.0215 to 9525.0355, for more than 16 beds and located in Northfield. The facility may be certified for up to 44 beds. The commissioner of health must inspect to certify the facility as soon as possible after the effective date of this section. The commissioner of human services shall work with the facility and affected counties to relocate any current residents of the facility who do not meet the admission criteria for an ICF/MR. To fund the ICF/MR services and relocations of current residents authorized, the commissioner of human services may transfer on a quarterly basis to the medical assistance account from each affected county's community social service allocation, an amount equal to the state share of medical assistance reimbursement for the residential and day habilitation services funded by medical assistance and provided to clients for whom the county is

financially responsible. For nonresidents of Minnesota seeking admission to the facility, Rice county shall be notified in order to assure that appropriate funding is guaranteed from their state or country of residence.

Sec. 22. **CRISIS INTERVENTION PROJECTS.**

(a) The commissioner of human services may authorize up to five projects to provide crisis intervention through community-based services in the private or public sector to persons with developmental disabilities. The projects must be geographically distributed in rural and urban areas. The parameters of these projects may be consistent with the special needs crisis services outlined under Minnesota Statutes, section 256B.501, subdivision 8a.

(b) The commissioner shall request proposals from individual counties or groups of counties and establish criteria for approval of proposals. Criteria shall include:

(1) avoidance of duplication of service by agreements with hospitals and other public or private vendors as appropriate;

(2) reduction of inpatient psychiatric hospital expenses using a cost-effective alternative service;

(3) maintenance of clients in their current homes;

(4) promotion of service to clients under a capitation agreement with providers;

(5) coordination with other target populations and other counties;

(6) provision of a full complement of on-site and off-site behavioral support and crisis response services including: training and technical assistance to prevent out of home placements; crisis response, including in-home and short-term placements; and assessment of service outcomes;

(7) evaluation of service program efficacy and cost effectiveness.

(c) The commissioner shall review proposals in accordance with Minnesota Statutes, section 252.28, and shall report to the legislature on the cost effectiveness of the projects by January 15, 1997.

Sec. 23. **REPEALER.**

Minnesota Statutes 1994, section 252.275, subdivisions 4a and 10, are repealed.

Sec. 24. **EFFECTIVE DATES.**

Section 15 (256.476) is effective July 1, 1996.

ARTICLE 4

CHILDREN'S PROGRAMS

Section 1. Minnesota Statutes 1994, section 245A.14, subdivision 7, is amended to read:

Subd. 7. **CULTURAL DYNAMICS AND DISABILITIES TRAINING FOR CHILD CARE PROVIDERS.** (a) The ~~ongoing~~ training required of licensed child care ~~centers~~ center staff and ~~group~~ family and group family child care providers and staff shall include training in the cultural dynamics of early childhood development and child care ~~as an option~~.

(b) The cultural dynamics and disabilities training ~~must include, but not be limited to, the following: awareness of the value and dignity of different cultures and how different cultures complement each other; awareness of the emotional, physical, and mental needs of children and families of different cultures; knowledge of current and traditional roles of women and men in different cultures, communities, and family environments; and awareness of the diversity of child rearing practices and parenting traditions.~~ and skills development of child care providers shall be designed to achieve outcomes for providers of child care that include, but are not limited to:

(1) an understanding and support of the importance of culture and differences in ability in children's identity development;

(2) understanding the importance of awareness of cultural differences and similarities in working with children and their families;

(3) understanding and support of the needs of families and children with differences in ability;

(4) developing skills to help children develop unbiased attitudes about cultural differences and differences in ability;

(5) developing skills in culturally appropriate caregiving; and

(6) developing skills in appropriate caregiving for children of different abilities.

Curriculum for cultural dynamics and disability training shall be approved by the commissioner.

(c) The commissioner shall amend current rules relating to the ~~initial~~ training of the licensed child care center staff and licensed providers ~~included in paragraph (a)~~ of family and group family child care and staff to require cultural dynamics training ~~upon determining that sufficient curriculum is developed statewide~~. Timelines established in the rule amendments for complying with the cultural dynamics training requirements shall be based on the commissioner's determination that curriculum materials and trainers are available statewide.

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

Sec. 2. Minnesota Statutes 1994, section 256.8711, is amended to read:

256.8711 **EMERGENCY ASSISTANCE; INTENSIVE FAMILY ~~PRESERVATION~~ SERVICES.**

Subdivision 1. **SCOPE OF SERVICES.** (a) 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 include both intensive family preservation services and emergency assistance placement services.

(b) For purposes of this section, intensive family preservation services 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 or five emergency assistance placement 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).

(c) For purposes of this section, emergency assistance placement services include:

(1) emergency shelter services;

(2) foster care services;

(3) group home services;

(4) child residential treatment services; and

(5) correctional facility services.

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; or when the dependent children have been removed from the home by a peace officer, by order of the juvenile court, or pursuant to a voluntary placement agreement, to a publicly funded out-of-home placement.

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 deter-

mine 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~~ 12 months for eligible families under this section and under section 256.871, subdivisions 1 and 3. ~~Effective October 1, 1995,~~ Once authorized, intensive family services shall be used singly or in any combination or duration up to 12 months appropriate to the needs of the child, as determined by the county agency.

Subd. 3a. **LIMITATIONS ON FEDERAL FUNDING.** County agencies shall determine eligibility under Title IV-E of the Social Security Act for every child being considered for emergency assistance placement services. The commissioner and county agencies shall make every effort to use federal funding under Title IV-E of the Social Security Act instead of federal funding under this section, whenever possible. 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~~ if the federal revenue earned under this section is terminated. If the federal revenue earned under this section is terminated or inadequate, the state has no obligation to pay for these services. In the event that federal limitations or ceilings are imposed on federal emergency assistance funding, the commissioner shall use the funds according to these priorities:

(1) emergency assistance benefits under section 256.871;

(2) emergency assistance benefits under the reserve established in subdivision 5;

(3) intensive family preservation services under this section; and

(4) emergency assistance placement services 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. Emergency assistance placement services provided under this section shall not be dependent on the client's available income or assets. However, county agencies shall seek costs of care as required under section 260.251 for emergency assistance placement services.

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 man-

ner 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); or 6b, paragraph (a), depending on how the funds were earned.

Subd. 6. **DISTRIBUTION OF NEW FEDERAL REVENUE EARNED FOR INTENSIVE FAMILY PRESERVATION SERVICES.** (a) All federal funds not set aside under paragraph (b), and at least 50 percent of all federal funds earned for intensive family preservation services 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 core services as defined in section 256F.03, subdivision ~~5~~ 10, 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 for intensive family preservation services under this section and earned through assessment activity described under subdivision 3. The set aside funds shall be used to develop and expand intensive family preservation services statewide as provided in subdivisions 6a and 7 and establish an emergency assistance reserve as provided in subdivision 5.

Subd. 6a. **DEVELOPMENT GRANTS.** Except for the portion needed for the emergency assistance reserve provided in subdivision 5, the commissioner ~~may~~ shall distribute the funds set aside under subdivision 6, paragraph (b), through development grants to ~~a county or~~ counties to establish and maintain ~~approved intensive~~ family preservation core services as defined in section 256F.03, subdivision 10, 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 preservation 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 core services statewide. Each county's development grant shall be paid and used as provided in sections 256F.01 to 256F.06.

Subd. 6b. **DISTRIBUTION OF NEW FEDERAL REVENUE EARNED FOR EMERGENCY ASSISTANCE PLACEMENT SERVICES.** (a) All federal funds earned for emergency assistance placement services not set aside under paragraph (b), shall be paid to each county based on its earnings. These payments shall constitute the placement earnings grant of the family preservation fund under sections 256F.01 to 256F.06.

(b) The commissioner may set aside a portion, not to exceed 15 percent, of the federal funds earned for emergency assistance placement services under this section. The set aside funds shall be used for the emergency assistance reserve as provided in subdivision 5.

Subd. 7. **EXPANSION OF SERVICES AND BASE LEVEL OF EXPENDITURES.** (a) Counties must continue the base level of expenditures for family preservation core services as defined in section 256F.03, subdivision ~~5~~ 10, from any state, county, or federal funding source, which, in the absence of federal funds earned for intensive family preservation services 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 core services as defined in section 256F.03, subdivision ~~5~~ 10, 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~~ shall, at the request of a county, reduce, suspend, or eliminate either or both of a county's obligations to continue the base level of expenditures and to expand family preservation core services as defined in section 256F.03, subdivision ~~5~~ 10, if the commissioner determines that one or more of the following conditions apply to that county:

(1) imposition of levy limits or other levy restrictions 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 or reduction of the federal revenue earned under this section; or

(5) other changes in state law that significantly impact the receipt or distribution of state and federal funding.

(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 core services as defined in section 256F.03, subdivision ~~5~~ 10, 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. 3. Minnesota Statutes 1994, 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.

~~For the period July 1, 1993 to June 30, 1995,~~ 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. 4. Minnesota Statutes 1994, section 256E.115, is amended to read:

256E.115 **SAFE HOUSES AND TRANSITIONAL HOUSING FOR HOMELESS YOUTH.**

Subdivision 1. **COMMISSIONER DUTIES.** The commissioner shall ~~have authority to make grants for pilot programs when the legislature authorizes money to encourage innovation in the development of safe house programs to respond to the needs of homeless youth~~ issue a request for proposals from organizations that are knowledgeable about the needs of homeless youth for the purpose of providing safe housesand transitional housing for homeless youth. The commissioner shall appoint a review committee of up to eight members to evaluate the proposals. The review panel must include representation from communities of color, youth, and other community providers and agency representatives who understand the needs and problems of homeless youth. The commissioner shall also assist in coordinating funding from federal and state grant programs and funding available from a variety of sources for efforts to promote a continuum of services for youth through a consolidated grant application. The commissioner shall analyze the needs of homeless youth and gaps in services throughout the state and determine how to best serve those needs within the available funding.

Subd. 2. **SAFE HOUSES AND TRANSITIONAL HOUSING.** A safe house provides emergency housing for homeless youth ranging in age from 13 to

22 with the goal of reuniting the family, if appropriate, whenever possible. Transitional housing provides housing for homeless youth ages 16 to 22 who are transitioning into independent living.

In developing both types of housing, the commissioner and the review committee shall try to create a family atmosphere in a neighborhood or community and, if possible, provide separate but cooperative homes for males and females. It may be necessary, due to licensing restrictions, to provide separate housing for different age groups. The following services, or adequate access to referrals for the following services, must be made available to the homeless youth:

(1) counseling services for the youth, and their families, if appropriate, on site, to help with problems that resulted in the homelessness;

(2) job services to help youth find employment in addition to creating jobs on site, including food service, maintenance, child care, and tutoring;

(3) health services that are confidential and provide preventive care services, crisis referrals, and other necessary health care services;

(4) living skills training to help youth learn how to care for themselves; and

(5) education services that help youth enroll in academic programs, if they are currently not in a program. Enrollment in an academic program is required for residency in transitional housing.

Sec. 5. Minnesota Statutes 1994, section 256F.01, is amended to read:

256F.01 **PUBLIC POLICY.**

The public policy of this state is to assure that all children~~, regardless of minority racial or ethnic heritage,~~ live in families that offer a safe, permanent relationship with nurturing parents or caretakers. To help assure children the opportunity to establish lifetime relationships, public social services must strive to provide culturally competent services and be directed toward:

(1) preventing the unnecessary separation of children from their families by identifying family problems, assisting families in resolving their problems, and preventing breakup of the family if it is desirable and possible;

(2) restoring to their families children who have been removed, by continuing to provide services to the reunited child and the families;

(3) placing children in suitable adoptive homes, in cases where restoration to the biological family is not possible or appropriate; and

(4) assuring adequate care of children away from their homes, in cases where the child cannot be returned home or cannot be placed for adoption.

Sec. 6. Minnesota Statutes 1994, section 256F.02, is amended to read:

256F.02 **CITATION.**

Sections 256F.01 to 256F.07 and 256F.10 may be cited as the "Minnesota family preservation act."

Sec. 7. Minnesota Statutes 1994, section 256F.03, subdivision 5, is amended to read:

Subd. 5. **FAMILY-BASED SERVICES.** "Family-based services" means one or more of the services described in paragraphs (a) to (f) provided to families primarily in their own home for a limited time. ~~Family-based services eligible for funding under the family preservation act are the services described in paragraphs (a) to (f).~~

(a) **CRISIS SERVICES.** "Crisis services" means professional services provided within 24 hours of referral to alleviate a family crisis and to offer an alternative to placing a child outside the family home. The services are intensive and time limited. The service may offer transition to other appropriate community-based services.

(b) **COUNSELING SERVICES.** "Counseling services" means professional family counseling provided to alleviate individual and family dysfunction; provide an alternative to placing a child outside the family home; or permit a child to return home. The duration, frequency, and intensity of the service is determined in the individual or family service plan.

(c) **LIFE MANAGEMENT SKILLS SERVICES.** "Life management skills services" means paraprofessional services that teach family members skills in such areas as parenting, budgeting, home management, and communication. The goal is to strengthen family skills as an alternative to placing a child outside the family home or to permit a child to return home. A social worker shall coordinate these services within the family case plan.

(d) **CASE COORDINATION SERVICES.** "Case coordination services" means professional services provided to an individual, family, or caretaker as an alternative to placing a child outside the family home, to permit a child to return home, or to stabilize the long-term or permanent placement of a child. Coordinated services are provided directly, are arranged, or are monitored to meet the needs of a child and family. The duration, frequency, and intensity of services is determined in the individual or family service plan.

(e) **MENTAL HEALTH SERVICES.** "Mental health services" means the professional services defined in section 245.4871, subdivision 31.

(f) **EARLY INTERVENTION SERVICES.** "Early intervention services" means family-based intervention services designed to help at-risk families avoid crisis situations.

Sec. 8. Minnesota Statutes 1994, section 256F.03, is amended by adding a subdivision to read:

Subd. 10. **FAMILY PRESERVATION CORE SERVICES.** "Family preservation core services" means adequate capacity of crisis services as defined in subdivision 5, paragraph (a), plus either or both counseling services as defined in subdivision 5, paragraph (b), and mental health services as defined in subdivision 5, paragraph (e), plus life management skills services as defined in subdivision 5, paragraph (c).

Sec. 9. Minnesota Statutes 1994, section 256F.04, subdivision 1, is amended to read:

Subdivision 1. **~~GRANT PROGRAM~~ FAMILY PRESERVATION FUND.** The commissioner shall establish a ~~statewide~~ family preservation ~~grant program~~ fund to assist counties in providing placement prevention and family reunification services. This fund shall include a basic grant for family preservation services, a placement earnings grant under section 256.8711, subdivision 6b, paragraph (a), and a development grant under section 256.8711, subdivision 6a, to assist counties in developing and expanding their family preservation core services as defined in section 256F.03, subdivision 10. Beginning with calendar year 1998, after each annual or quarterly calculation, these three component grants shall be added together and treated as a single family preservation grant.

Sec. 10. Minnesota Statutes 1994, section 256F.04, subdivision 2, is amended to read:

Subd. 2. **FORMS AND INSTRUCTIONS.** The commissioner shall provide necessary forms and instructions to the counties for their community social services plan, as required in section 256E.09, that incorporate the ~~permanency plan format and~~ information necessary to apply for a family preservation fund grant, and to exercise county options under section 256F.05, subdivision 7, paragraph (a), or subdivision 8, paragraph (c).

Sec. 11. Minnesota Statutes 1994, section 256F.05, is amended by adding a subdivision to read:

Subd. 1a. **DEVELOPMENT OF FAMILY PRESERVATION CORE SERVICES.** The commissioner shall annually determine whether a county's family preservation core services, as defined in section 256F.03, subdivision 10, are developed for that calendar year. In making this determination for any given calendar year, the commissioner shall consider factors for each county such as which family preservation core services are included in its community services plan under section 256E.09, the ratio of expenditures on family preservation core services to expenditures on out-of-home placements, the availability of crisis services as defined in section 256F.03, subdivision 5, paragraph (a), and recent trends in out-of-home placements both within that county and statewide.

Sec. 12. Minnesota Statutes 1994, section 256F.05, subdivision 2, is amended to read:

Subd. 2. **MONEY AVAILABLE FOR THE BASIC GRANT.** Money appropriated for family preservation ~~grants to counties~~ under sections 256F.04

to 256F.07, together with an amount as determined by the commissioner of title IV-B funds distributed to Minnesota according to the Social Security Act, United States Code, title 42, section 621, must be distributed to counties on a calendar year basis according to the formula in subdivision 3.

Sec. 13. Minnesota Statutes 1994, section 256F.05, subdivision 3, is amended to read:

Subd. 3. **BASIC GRANT FORMULA.** (a) The amount of money allocated to counties under subdivision 2 ~~must be based on the following two factors~~ shall first be allocated in amounts equal to each county's guaranteed floor according to paragraph (b), and second, any remaining available funds allocated as follows:

(1) 90 percent of the funds shall be allocated based on the population of the county under age 19 years as compared to the state as a whole as determined by the most recent data from the state demographer's office; and

(2) ten percent of the funds shall be allocated based on the county's percentage share of the number of minority children ~~in substitute care~~ receiving children's case management services as defined by the commissioner based on the most recent data as determined by the ~~most recent department of human services annual report on children in foster care~~ commissioner.

~~The amount of money allocated according to formula factor (1) must not be less than 90 percent of the total allocated under subdivision 2.~~

(b) Each county's basic grant guaranteed floor shall be calculated as follows:

(1) 90 percent of the county's allocation received in the preceding calendar year. For calendar year 1996 only, the allocation received in the preceding calendar year shall be determined by the commissioner based on the funding previously distributed as separate grants under sections 256F.04 to 256F.07; and

(2) when the amounts of funds available for allocation is less than the amount available in the previous year, each county's previous year allocation shall be reduced in proportion to the reduction in the statewide funding, for the purpose of establishing the guaranteed floor.

(c) The commissioner shall regularly review the use of family preservation fund allocations by county. The commissioner may reallocate unexpended or unencumbered money at any time among those counties that have expended or are projected to expend their full allocation.

Sec. 14. Minnesota Statutes 1994, section 256F.05, subdivision 4, is amended to read:

Subd. 4. **PAYMENTS.** The commissioner shall make grant payments to each county whose biennial community social services plan ~~includes a permaneney plan~~ has been approved under section 256F.04, subdivision 2. The ~~payment must be made~~ basic grant under subdivisions 2 and 3 and the development

grant under section 256.8711, subdivision 6a, shall be paid to counties in four installments per year. The commissioner may certify the payments for the first three months of a calendar year. Subsequent payments ~~must be made on May 15, August 15, and November 15, of each calendar year. When an amount of title IV-B funds as determined by the commissioner is made available, it shall be reimbursed to counties on November 15.~~ shall be based on reported expenditures and may be adjusted for anticipated spending patterns. The placement earnings grant under section 256.8711, subdivision 6b, paragraph (a), shall be based on earnings and coordinated with the other payments. In calendar years 1996 and 1997, the placement earnings grant and the development grant shall be distributed separately from the basic grant, except as provided in subdivision 7, paragraph (a). Beginning with calendar year 1998, after each annual or quarterly calculation, these three component grants shall be added together into a single family preservation fund grant and treated as a single grant.

Sec. 15. Minnesota Statutes 1994, section 256F.05, subdivision 5, is amended to read:

Subd. 5. **INAPPROPRIATE EXPENDITURES.** Family preservation fund basic, placement earnings, and development grant money must not be used for:

(1) child day care necessary solely because of the employment or training to prepare for employment, of a parent or other relative with whom the child is living;

(2) residential facility payments;

(3) adoption assistance payments;

(4) public assistance payments for aid to families with dependent children, supplemental aid, medical assistance, general assistance, general assistance medical care, or community health services authorized by sections 145A.09 to 145A.13; or

(5) administrative costs for local social services agency public assistance staff.

Sec. 16. Minnesota Statutes 1994, section 256F.05, subdivision 7, is amended to read:

Subd. 7. ~~**TRANSFER OF FUNDS**~~ **USES OF PLACEMENT EARNINGS AND DEVELOPMENT GRANTS.** ~~Notwithstanding subdivision 1, the commissioner may transfer money from the appropriation for family preservation grants to counties into the subsidized adoption account when a deficit in the subsidized adoption program occurs. The amount of the transfer must not exceed five percent of the appropriation for family preservation grants to counties.~~ (a) For calendar years 1996 and 1997, each county must use its placement earnings and development grants to develop and expand its family preservation core services as defined in section 256F.03, subdivision 10. If a county demonstrates that its family preservation core services are developed as provided in

subdivision 1a, then at the county's written request, the commissioner shall add its placement earnings and development grant to its basic grant, to be used as a single family preservation fund grant.

(b) Beginning with calendar year 1998, each county which has demonstrated that year that its family preservation core services are developed as provided in subdivision 1a, shall have its placement earnings and development grant added to its basic grant, to be used as a single family preservation fund grant. The development grant for any county which has not so demonstrated shall be redistributed to all counties which have, in proportion to their calculated development grants.

Sec. 17. Minnesota Statutes 1994, section 256F.05, subdivision 8, is amended to read:

Subd. 8. **USES OF FAMILY PRESERVATION FUND GRANTS ~~FOR FAMILY-BASED CRISIS SERVICES~~.** ~~Within the limits of appropriations made for this purpose, the commissioner may award grants for the families first program, including section 256F.08, to be distributed on a calendar year basis to counties to provide programs for family-based crisis services defined in section 256F.03, subdivision 5. The commissioner shall ask counties to present proposals for the funding and shall award grants for the funding on a competitive basis. Beginning January 1, 1993, the state share of the costs of the programs shall be 75 percent and the county share, 25 percent.~~ For both basic grants and single family preservation fund grants:

(a) A county which has not demonstrated that year that its family preservation core services are developed as provided in subdivision 1a, must use its family preservation fund grant exclusively for family preservation services defined in section 256F.03, subdivision 5, paragraphs (a), (b), (c), and (e).

(b) A county which has demonstrated that year that its family preservation core services are developed becomes eligible either to continue using its family preservation fund grant as provided in paragraph (a), or to exercise the expanded service option under paragraph (c).

(c) The expanded service option permits an eligible county to use its family preservation fund grant for child welfare preventative services as defined in section 256F.10, subdivision 7, paragraph (d). To exercise this option, an eligible county must notify the commissioner in writing of its intention to do so no later than 30 days into the quarter during which it intends to begin or in its county plan, as provided in section 256F.04, subdivision 2. Effective with the first day of that quarter, the county must maintain its base level of expenditures for child welfare preventative services and use the family preservation fund to expand them. The base level of expenditures for a county shall be that established under section 256F.10, subdivision 7. For counties which have no such base established, a comparable base shall be established with the base year being the calendar year ending at least two calendar quarters before the first calendar quarter in which the county exercises its expanded service option. The commissioner shall,

at the request of the counties, reduce, suspend, or eliminate either or both of a county's obligations to continue the base level of expenditures and to expand child welfare preventative services based on conditions described in section 256F.10, subdivision 7, paragraph (b) or (c).

(d) Each county's placement earnings and development grant shall be determined under section 256.8711, but after each annual or quarterly calculation, if added to that county's basic grant, the three component grants shall be treated as a single family preservation fund grant.

Sec. 18. Minnesota Statutes 1994, section 256F.06, subdivision 1, is amended to read:

Subdivision 1. **RESPONSIBILITIES.** A county board may, alone or in combination with other county boards, apply for a family preservation fund grant as provided in section 256F.04, subdivision 2. Upon approval of the ~~family preservation~~ grant, the county board may contract for or directly provide family-based and other eligible services.

Sec. 19. Minnesota Statutes 1994, section 256F.06, subdivision 2, is amended to read:

Subd. 2. ~~USES OF GRANTS~~ **DEVELOPING FAMILY PRESERVATION CORE SERVICES.** ~~The grant must be used exclusively for family-based services.~~ A county board shall endeavor to develop and expand its family preservation core services. When a county can demonstrate that its family preservation core services are developed as provided in section 256F.05, subdivision 1a, a county board becomes eligible to exercise the expanded service option under section 256F.05, subdivision 8, paragraph (c). For calendar years 1996 and 1997, the county board also becomes eligible to request that its basic, placement earnings, and development grants be added into a single grant under section 256F.05, subdivision 7, paragraph (a).

Sec. 20. Minnesota Statutes 1994, section 256F.06, subdivision 4, is amended to read:

Subd. 4. **REPORTING.** The commissioner shall specify requirements for reports, including quarterly fiscal reports, according to section 256.01, subdivision 2, paragraph (17). ~~The reports must include:~~

~~(1) a detailed statement of expenses attributable to the grant during the preceding quarter; and~~

~~(2) a statement of the expenditure of money for family-based services by the county during the preceding quarter, including the number of clients served and the expenditures, by client, for each service provided.~~

Sec. 21. Minnesota Statutes 1994, section 256F.09, is amended to read:

256F.09 **GRANTS FOR ~~CHILDREN'S SAFETY~~ FAMILY VISITATION CENTERS.**

Subdivision 1. **PURPOSE.** The commissioner shall issue a request for proposals from existing local nonprofit, nongovernmental, or governmental organizations, to use existing local facilities as ~~pilot children's safety~~ family visitation centers which may also be used for visitation exchanges. The commissioner shall award grants in amounts up to $50,000 for the purpose of creating ~~children's safety~~ or maintaining family visitation centers in an effort to reduce children's vulnerability to violence and trauma related to family visitation, where there has been a history of domestic violence or abuse within the family. ~~At least one of the pilot projects shall be located in the seven-county metropolitan area and at least one of the projects shall be located outside the seven-county metropolitan area, and~~ The commissioner shall award the grants to provide the greatest possible number of ~~safety~~ family visitation centers and to locate them to provide for the broadest possible geographic distribution of the centers throughout the state.

Each children's ~~safety~~ family visitation center must use existing local facilities to provide a healthy interactive environment for parents who are separated or divorced and for parents with children in foster homes to visit with their children. The centers must be available for use by district courts who may order visitation to occur at a ~~safety~~ family visitation center. The centers may also be used as drop-off sites, so that parents who are under court order to have no contact with each other can exchange children for visitation at a neutral site. Each center must provide sufficient security to ensure a safe visitation environment for children and their parents. A grantee must demonstrate the ability to provide a 25 percent local match, which may include in-kind contributions.

Subd. 1a. **COUNTY INVOLVEMENT.** Each county or group of counties is encouraged to provide supervised visitation services in an effort to fill the gap in the court system that orders supervised visitation, but does not provide a center to accomplish the supervised visitation as ordered. Each county or group of counties is encouraged to either financially contribute to an existing family visitation center in the area, or establish a new center if there is not one in the area, possibly through county social services. In creating a new center, the county may collaborate with other counties, other family visitation centers, family services collaboratives, court services, and any other entity or organization. The goal is to provide family visitation centers statewide. The county shall apply for funding that may be available through the federal government, specifically for family preservation or family reunification purposes, or any other source of funding that will aid in developing and maintaining this vital service.

Subd. 2. ~~**PRIORITIES**~~ **FUNDING.** The commissioner may award grants to create or maintain family visitation centers.

In awarding grants to maintain a family visitation center, the commissioner may award a grant to a center that can demonstrate a 35 percent local match, provided the center is diligently exploring and pursuing all available funding options in an effort to become self-sustaining, and those efforts are reported to the commissioner.

In awarding grants ~~under the program~~ to create a family visitation center, the commissioner shall give priority to:

(1) areas of the state where no ~~children's safety~~ other family visitation center or similar facility exists;

(2) applicants who demonstrate that private funding for the center is available and will continue; and

(3) facilities that are adapted for use to care for children, such as day care centers, religious institutions, community centers, schools, technical colleges, parenting resource centers, and child care referral services.

Subd. 3. **ADDITIONAL SERVICES.** Each family visitation center may provide parenting and child development classes, and offer support groups to participating custodial parents and hold regular classes designed to assist children who have experienced domestic violence and abuse.

Subd. 4. **REPORT.** The commissioner shall evaluate the operation of the ~~pilot children's safety~~ family visitation centers and report to the legislature by February 1, 1994, with recommendations.

Subd. 5. **ADMINISTRATION.** In administering the grants authorized by this section, the commissioner shall ensure that the term "family visitation center" is used in all future applications, publicity releases, requests for proposals, and other materials of like nature. Materials published prior to the enactment of this legislation which use different terms may be distributed by the commissioner until supplies are gone.

Sec. 22. Minnesota Statutes 1994, section 256H.01, subdivision 9, is amended to read:

Subd. 9. **FAMILY.** "Family" means parents, stepparents, guardians and their spouses, or other eligible relative caretakers and their spouses, and their blood related dependent children and adoptive siblings under the age of 18 years living in the same home including children temporarily absent from the household in settings such as schools, foster care, and residential treatment facilities. When a minor parent or parents and his, her, or their child or children are living with other relatives, and the minor parent or parents apply for a child care subsidy, "family" means only the minor parent or parents and the child or children. An adult may be considered a dependent member of the family unit if 50 percent of the adult's support is being provided by the parents, stepparents, guardians and their spouses, or eligible relative caretakers and their spouses, residing in the same household. An adult age 18 who is a full-time high school student and can reasonably be expected to graduate before age 19 may be considered a dependent member of the family unit.

Sec. 23. Minnesota Statutes 1994, section 256H.01, subdivision 12, is amended to read:

Subd. 12. **PROVIDER.** "Provider" means a child care license holder who operates a family day care home, a group family day care home, a day care center, a nursery school, a day nursery, an extended day school age child care program; a ~~person exempt from licensure who meets child care standards established~~ legal nonlicensed extended day school age child care program which operates under the auspices of a local school board that has adopted school age child care standards which meet or exceed standards recommended by the state ~~board~~ department of education; or a legal nonlicensed caregiver who is at least 18 years of age, and who is not a member of the AFDC assistance unit.

Sec. 24. Minnesota Statutes 1994, section 256H.02, is amended to read:

256H.02 **DUTIES OF COMMISSIONER.**

The commissioner shall develop standards for county and human services boards to provide child care services to enable eligible families to participate in employment, training, or education programs. Within the limits of available appropriations, the commissioner shall distribute money to counties to reduce the costs of child care for eligible families. The commissioner shall adopt rules to govern the program in accordance with this section. The rules must establish a sliding schedule of fees for parents receiving child care services. In the rules adopted under this section, county and human services boards shall be authorized to establish policies for payment of child care spaces for absent children, when the payment is required by the child's regular provider. The rules shall not set a maximum number of days for which absence payments can be made, but instead shall direct the county agency to set limits and pay for absences according to the prevailing market practice in the county. County policies for payment of absences shall be subject to the approval of the commissioner. The commissioner shall maximize the use of federal money ~~under the AFDC employment special needs program~~ in section 256.736~~, subdivision 8,~~ and other programs that provide federal reimbursement for child care services for recipients of aid to families with dependent children who are in education, training, job search, or other activities allowed under those programs. Money appropriated under this section must be coordinated with the ~~AFDC employment special needs program and other~~ programs that provide federal reimbursement for child care services to accomplish this purpose. Federal reimbursement obtained must be allocated to the county that spent money for child care that is federally reimbursable under programs that provide federal reimbursement for child care services. The counties shall use the federal money to expand child care services. The commissioner may adopt rules under chapter 14 to implement and coordinate federal program requirements.

Sec. 25. Minnesota Statutes 1994, section 256H.03, subdivision 1, is amended to read:

Subdivision 1. **ALLOCATION PERIOD; NOTICE OF ALLOCATION.** When the commissioner notifies county and human service boards of the forms and instructions they are to follow in the development of their biennial commu-

nity social services plans required under section 256E.08, the commissioner shall also notify county and human services boards of their estimated child care fund program allocation for the two years covered by the plan. By ~~June~~ October 1 of each year, the commissioner shall notify all counties of their final child care fund program allocation.

Sec. 26. Minnesota Statutes 1994, section 256H.03, subdivision 2a, is amended to read:

Subd. 2a. **ELIGIBLE RECIPIENTS.** Families that meet the eligibility requirements under sections 256H.10, except AFDC recipients, MFIP recipients, and transition year families, and 256H.11 are eligible for child care assistance under the basic sliding fee program. ~~From July 1, 1990, to June 30, 1991, a county may not accept new applications for the basic sliding fee program unless the county can demonstrate that its state money expenditures for the basic sliding fee program for this period will not exceed 95 percent of the county's allocation of state money for the fiscal year ending June 30, 1990. As basic sliding fee program money becomes available to serve new families, eligible families whose benefits were terminated during the fiscal year ending June 30, 1990, for reasons other than loss of eligibility shall be reinstated.~~ Families enrolled in the basic sliding fee program as of July 1, 1990, shall be continued until they are no longer eligible. Counties shall make vendor payments to the child care provider or pay the parent directly for eligible child care expenses on a reimbursement basis. Child care assistance provided through the child care fund is considered assistance to the parent.

Sec. 27. Minnesota Statutes 1994, section 256H.03, subdivision 4, is amended to read:

Subd. 4. **ALLOCATION FORMULA.** Beginning ~~July 1, 1992~~ January 1, 1996, the basic sliding fee state and federal funds shall be allocated on a calendar year basis. Funds shall be allocated first in amounts equal to each county's guaranteed floor according to subdivision 6, with any remaining available funds allocated according to the following formula:

(a) ~~One-half~~ One-third of the funds shall be allocated in proportion to each county's total expenditures for the basic sliding fee child care program reported during the ~~12-month period ending on December 31 of the preceding state fiscal year~~ most recent calendar year completed at the time of the notice of allocation.

(b) ~~One-fourth~~ One-third of the funds shall be allocated based on the number of children under age 13 in each county who are enrolled in general assistance medical care, medical assistance, and ~~the children's health plan on July 1, of each year~~ MinnesotaCare on December 31 of the most recent calendar year completed at the time of the notice of allocation.

(c) ~~One-fourth~~ One-third of the funds shall be allocated based on the number of children under age 13 who reside in each county, from the most recent estimates of the state demographer.

Sec. 28. Minnesota Statutes 1994, section 256H.03, is amended by adding a subdivision to read:

Subd. 4a. **SIX-MONTH ALLOCATION.** For the period from July 1, 1995, to December 31, 1995, every county shall receive an allocation at least equal and proportionate to one-half of its original allocation in state fiscal year 1995. This six-month allocation shall be combined with the calendar year 1996 allocation and be administered as one 18-month allocation.

Sec. 29. Minnesota Statutes 1994, section 256H.03, subdivision 6, is amended to read:

Subd. 6. **GUARANTEED FLOOR.** (a) ~~Each county's guaranteed floor shall equal the lesser of:~~

~~(1) the county's original allocation in the preceding state fiscal year; or~~

~~(2) 110 percent of the county's basic sliding fee child care program state and federal earnings for the 12-month period ending on December 31 of the preceding state fiscal year. For purposes of this clause, "state and federal earnings" means the reported direct child care expenditures adjusted for the administrative allowance and 15 percent required county match.~~ Beginning January 1, 1996, each county's guaranteed floor shall equal 90 percent of the allocation received in the preceding calendar year. For the calendar year 1996 allocation, the preceding calendar year shall be considered to be double the six-month allocation as provided for in subdivision 4a.

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

Sec. 30. Minnesota Statutes 1994, section 256H.05, subdivision 6, is amended to read:

Subd. 6. ~~**NON-STRIDE AFDC CHILD CARE PROGRAM**~~ **ACCESS CHILD CARE PROGRAM.** (a) Starting one month after April 30, 1992, the ~~department of human services~~ commissioner shall reimburse eligible expenditures for 2,000 family slots for AFDC caretakers not eligible for services under section 256.736, who are engaged in an authorized educational or job search program. Each county will receive a number of family slots based on the county's proportion of the AFDC caseload. A county must receive at least two family slots. Eligibility and reimbursement are limited to the number of family slots allocated to each county. County agencies shall authorize an educational plan for each student and may prioritize families eligible for this program in their child care fund plan upon approval of the commissioner ~~of human services~~. (b) Persons eligible for but unable to participate in the JOBS (STRIDE) program because of a waiting list may be accepted as a new participant, or continue to participate in the ACCESS child care program if a slot is available as long as all other eligibility factors are met. Child care assistance must continue under the ACCESS child care program until the participant loses eligibility or is enrolled in project STRIDE.

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

(c)(1) Effective July 1, 1995, the commissioner shall reclaim 90 percent of the vacant slots in each county and distribute those slots to counties with waiting lists of persons eligible for the ACCESS child care program. The slots must be distributed to eligible families based on the July 1, 1995, waiting list placement date, first come, first served basis.

(2) ACCESS child care slots remaining after the waiting list under clause (1) has been eliminated must be distributed to eligible families on a first come, first served basis, based on the client's date of request.

(3) The county must notify the commissioner when an ACCESS slot in the county becomes available. Notification by the county must be within five calendar days of the effective date of the termination of the ACCESS child care services. The resulting vacant slot must be returned to the department of human services. The slot must then be redistributed under clause (2).

(4) The commissioner shall consult with the task force on child care and make recommendations to the 1996 legislature for future distribution of the ACCESS slots under this paragraph.

Sec. 31. Minnesota Statutes 1994, section 256H.08, is amended to read:

256H.08 **USE OF MONEY.**

Money for persons listed in sections 256H.03, subdivision 2a, and 256H.05, subdivision 1b, shall be used to reduce the costs of child care for students, including the costs of child care for students while employed if enrolled in an eligible education program at the same time and making satisfactory progress towards completion of the program. Counties may not limit the duration of child care subsidies for a person in an employment or educational program, except when the person is found to be ineligible under the child care fund eligibility standards. Any limitation must be based on a person's employability plan in the case of an AFDC recipient, and county policies included in the child care allocation plan. Time limitations for child care assistance, as specified in Minnesota Rules, parts 9565.5000 to 9565.5200, do not apply to basic or remedial educational programs needed to prepare for post-secondary education or employment. These programs include: high school, general equivalency diploma, and English as a second language. Programs exempt from this time limit must not run concurrently with a post-secondary program. High school students who are participating in a post-secondary options program and who receive a high school diploma issued by the school district are exempt from the time limitations while pursuing a high school diploma. Financially eligible students who have received child care assistance for one academic year shall be provided child care assistance in the following academic year if funds allocated under sections 256H.03 and 256H.05 are available. If an AFDC recipient who is receiving AFDC child care assistance under this chapter moves to another county, continues to participate in educational or training programs authorized in their employability development plans, and continues to be eligible for AFDC child care assistance under this chapter, the AFDC caretaker must receive continued

child care assistance from the county responsible for their current employability development plan, without interruption.

Sec. 32. Minnesota Statutes 1994, section 256H.11, subdivision 1, is amended to read:

Subdivision 1. **ASSISTANCE FOR PERSONS SEEKING AND RETAINING EMPLOYMENT.** Persons who are seeking employment and who are eligible for assistance under this section are eligible to receive ~~the equivalent of up to one month of child care~~ up to 240 hours of child care assistance per calendar year. Employed persons who work at least an average of ten hours a week and receive at least a minimum wage for all hours worked are eligible for continued child care assistance.

Sec. 33. Minnesota Statutes 1994, section 256H.12, subdivision 1, is amended to read:

Subdivision 1. **COUNTY CONTRIBUTIONS REQUIRED.** Beginning July 1, 1995, in addition to payments from ~~parents~~ basic sliding fee child care program participants, counties shall contribute from county tax or other sources ~~a minimum of 15 percent of the cost of the basic sliding fee program~~ at the local match percentage calculated according to subdivision 1a. The commissioner shall recover funds from the county as necessary to bring county expenditures into compliance with this subdivision.

Sec. 34. Minnesota Statutes 1994, section 256H.12, is amended by adding a subdivision to read:

Subd. 1a. **LOCAL MATCH PERCENTAGE.** The local match percentage shall equal the lesser of either (i) 15 percent of the cost of the basic sliding fee program or (ii) the statewide required local match in state fiscal year 1995, divided by the sum of the current year's basic sliding fee allocation plus the statewide required local match in state fiscal year 1995. The resulting local match percentage shall be adjusted to reflect a statewide local match of five percent on any state and federal funding for the basic sliding fee program above the initial state fiscal year 1995 statewide allocation. For purposes of this computation, the statewide required local match in state fiscal year 1995 shall be equal to the initial state fiscal year 1995 basic sliding fee allocation, divided by 85 percent, and then multiplied by 15 percent. The calendar year 1996 local match percentage shall be in effect for the six-month allocation period defined in section 256H.03.

Sec. 35. Minnesota Statutes 1994, section 256H.12, subdivision 3, as amended by Laws 1995, chapter 139, section 1, is amended to read:

Subd. 3. **MAINTENANCE OF FUNDING EFFORT.** To receive money through this program, each county shall certify, in its annual plan to the commissioner, that the county has not reduced allocations from other federal and state sources, which, in the absence of the child care fund, would have been

available for child care assistance. However, the county must continue contributions, as necessary, to maintain on the basic sliding fee program ~~for,~~ families who are receiving assistance on July 1, 1995, until the family loses eligibility for the program or until a family voluntarily withdraws from the program. This subdivision does not affect the local match required for this program under other sections of the law.

Sec. 36. Minnesota Statutes 1994, section 256H.15, subdivision 1, is amended to read:

Subdivision 1. **SUBSIDY RESTRICTIONS.** ~~(a) Until June 30, 1991, the maximum child care rate is determined under this paragraph. The county board may limit the subsidy allowed by setting a maximum on the provider child care rate that the county shall subsidize. The maximum rate set by any county shall not be lower than 110 percent or higher than 125 percent of the median rate in that county for like care arrangements for all types of care, including special needs and handicapped care, as determined by the commissioner. If the county sets a maximum rate, it must pay the provider's rate for each child receiving a subsidy, up to the maximum rate set by the county. If a county does not set a maximum provider rate, it shall pay the provider's rate for every child in care. The maximum state payment is 125 percent of the median provider rate. If the county has not set a maximum provider rate and the provider rate is greater than 125 percent of the median provider rate in the county, the county shall pay the amount in excess of 125 percent of the median provider rate from county funding sources. The county shall pay the provider's full charges for every child in care up to the maximum established. The commissioner shall determine the maximum rate for each type of care, including special needs and handicapped care.~~

~~(b)~~ Effective July 1, 1991, the maximum rate paid for child care assistance under the child care fund is the maximum rate eligible for federal reimbursement ~~except that a provider receiving reimbursement under paragraph (a) as of January 1, 1991, shall be paid at a rate no less than the rate of reimbursement received under that paragraph~~. A rate which includes a provider bonus paid under subdivision 2 or a special needs rate paid under subdivision 3 may be in excess of the maximum rate allowed under this subdivision. The department of human services shall monitor the effect of this paragraph on provider rates. The county shall pay the provider's full charges for every child in care up to the maximum established. The commissioner shall determine the maximum rate for each type of care, including special needs and handicapped care.

(c) When the provider charge is greater than the maximum provider rate allowed, the parent is responsible for payment of the difference in the rates in addition to any family copayment fee.

Sec. 37. Minnesota Statutes 1994, section 256H.18, is amended to read:

256H.18 **ADMINISTRATIVE EXPENSES.**

The commissioner shall use up to ~~seven percent~~ one-eleventh of the state and federal funds ~~appropriated~~ available for the basic sliding fee program for payments to counties for administrative expenses. ~~The commissioner shall use up to ten percent of federal funds for payments to counties for administrative expenses.~~

Sec. 38. Minnesota Statutes 1994, section 256H.20, subdivision 3a, is amended to read:

Subd. 3a. **GRANT REQUIREMENTS AND PRIORITY.** Priority for awarding resource and referral grants shall be given in the following order:

(1) start up resource and referral programs in areas of the state where they do not exist; and

(2) improve resource and referral programs.

Resource and referral programs shall meet the following requirements:

(a) Each program shall identify all existing child care services through information provided by all relevant public and private agencies in the areas of service, and shall develop a resource file of the services which shall be maintained and updated at least quarterly. These services must include family day care homes; public and private day care programs; full-time and part-time programs; infant, preschool, and extended care programs; and programs for school age children.

The resource file must include: the type of program, hours of program service, ages of children served, fees, location of the program, eligibility requirements for enrollment, special needs services, and transportation available to the program. The file may also include program information and special program features.

(b) Each resource and referral program shall establish a referral process which responds to parental need for information and which fully recognizes confidentiality rights of parents. The referral process must afford parents maximum access to all referral information. This access must include telephone referral available for no less than 20 hours per week.

Each child care resource and referral agency shall publicize its services through popular media sources, agencies, employers, and other appropriate methods.

(c) Each resource and referral program shall maintain ongoing documentation of requests for service. All child care resource and referral agencies must maintain documentation of the number of calls and contacts to the child care information and referral agency or component. A resource and referral program shall collect and maintain the following information:

(1) ages of children served;

(2) time category of child care request for each child;

(3) special time category, such as nights, weekends, and swing shift; and

(4) reason that the child care is needed.

(d) Each resource and referral program shall make available the following information as an educational aid to parents:

(1) information on aspects of evaluating the quality and suitability of child care services, including licensing regulation, financial assistance available, child abuse reporting procedures, appropriate child development information;

(2) information on available parent, early childhood, and family education programs in the community.

(e) On or after one year of operation a resource and referral program shall provide technical assistance to employers and existing and potential providers of all types of child care services. This assistance shall include:

(1) information on all aspects of initiating new child care services including licensing, zoning, program and budget development, and assistance in finding information from other sources;

(2) information and resources which help existing child care providers to maximize their ability to serve the children and parents of their community;

(3) dissemination of information on current public issues affecting the local and state delivery of child care services;

(4) facilitation of communication between existing child care providers and child-related services in the community served;

(5) recruitment of licensed providers; and

(6) options, and the benefits available to employers utilizing the various options, to expand child care services to employees.

Services prescribed by this section must be designed to maximize parental choice in the selection of child care and to facilitate the maintenance and development of child care services and resources.

(f) Child care resource and referral information must be provided to all persons requesting services and to all types of child care providers and employers.

(g) Each resource and referral program shall coordinate early childhood training for child care providers in that program's service delivery area. The resource and referral program shall convene an early childhood care and education training advisory committee to assist in the following activities:

(1) assess the early childhood care and education training needs of child care center staff and family and group family child care providers;

(2) coordinate existing early childhood care and education training;

(3) develop new early childhood care and education training opportunities; and

(4) publicize all early childhood training classes and workshops to child care center staff and family and group family child care providers in the service delivery area.

(h) Public or private entities may apply to the commissioner for funding. A local match of up to 25 percent is required.

Sec. 39. Minnesota Statutes 1994, section 257.3571, subdivision 1, is amended to read:

Subdivision 1. **PRIMARY SUPPORT GRANTS.** The commissioner shall establish direct grants to Indian tribes ~~and~~, Indian organizations, and tribal social service agency programs located off-reservation that serve Indian children and their families to provide primary support for Indian child welfare programs to implement the Indian family preservation act.

Sec. 40. Minnesota Statutes 1994, section 257.3572, is amended to read:

257.3572 **GRANT APPLICATIONS.**

A tribe ~~or~~, Indian organization, or tribal social service agency program located off-reservation may apply for primary support grants under section 257.3571, subdivision 1. A local social service agency, tribe, Indian organization, or other social service organization may apply for special focus grants under section 257.3571, subdivision 2. Civil legal service organizations eligible for grants under section 257.3571, subdivision 2a, may apply for grants under that section. Application may be made alone or in combination with other tribes or Indian organizations.

Sec. 41. Minnesota Statutes 1994, section 257.3577, subdivision 1, is amended to read:

Subdivision 1. **PRIMARY SUPPORT GRANTS.** (a) The amount available for grants established under section 257.3571, subdivision 1, to tribes ~~and~~, Indian ~~organization grants~~ organizations, and tribal social service agency programs located off-reservation is four-fifths of the total annual appropriation for Indian child welfare grants.

(b) The commissioner shall award tribes at least 70 percent of the amount set in paragraph (a) for primary support grants. Each tribe shall be awarded a base amount of five percent of the total amount set in this paragraph. In addition, each tribe shall be allocated a proportion of the balance of the amount set in this paragraph, less the total base amounts for all reservations. This proportion must equal the ratio of the tribe's on-reservation population to the state's total on-reservation population. Population data must be based on the most recent federal census data according to the state demographer's office.

(c) The commissioner shall award Indian organizations and tribal social service agency programs located off-reservation that serve Indian children and families up to 30 percent of the amount set in paragraph (a) for primary support grants. A maximum of four multiservice Indian organizations and tribal social service agency programs located off-reservation may be awarded grants under this paragraph. "Multiservice Indian organizations" means Indian organizations recognized by the Indian community as providing a broad continuum of social, educational, or cultural services, including Indian child welfare services designed to meet the unique needs of the Indian communities in Minneapolis, St. Paul, and Duluth. Grants may be awarded to programs that submit acceptable proposals, comply with the goals and the application process of the program, and have budgets that reflect appropriate and efficient use of funds. To maintain continuity of service in Indian communities, primary support grants awarded under this paragraph which meet the grant criteria and have demonstrated satisfactory performance as established by the commissioner may be awarded on a noncompetitive basis. The commissioner may revoke or deny funding for Indian organizations or tribal social service agencies failing to meet the grant criteria established by the commissioner, and the commissioner may request new proposals from Indian organizations or tribal social service agencies to the extent that funding is available.

Sec. 42. **KINSHIP CAREGIVER INFORMATION.**

The commissioner of human services shall develop an informational brochure which describes the laws and services that may be applicable to and available to grandparents and other kinship caregivers to assist them in caring for the minor kinship children who are in their care. The brochure must also indicate how a kinship caregiver can receive further information. The brochure must be distributed to county social service agencies, area agencies on aging, the ombudsperson for families, and other known community organizations that may have contact with kinship caregivers. For purposes of this section, "kinship caregiver" means any of the following persons related to the child by marriage, blood, or adoption: grandparent, great grandparent, brother, sister, stepparent, stepsister, stepbrother, niece, nephew, uncle, great uncle, aunt, or great aunt.

Sec. 43. **DIFFICULTY OF CARE STUDY.**

The commissioner of human services shall study and report to the house health and human services finance division, and to the senate health care and family services finance division, on the advisability of continuing to reimburse for foster care services on the basis of difficulty of care factors. The report shall be submitted no later than January 1, 1996, and shall include specific recommendations as to whether the difficulty of care reimbursement system should be retained, modified, or abandoned. In preparing this report, the commissioner shall consult with public and private foster care agencies and with foster care providers, and shall consider the differential impact, if any, on the child from receiving foster care reimbursement through the difficulty of care reimbursement system versus through an alternative reimbursement mechanism. The report

must also identify the legal and institutional barriers, if any, to changing from a difficulty of care reimbursement system to another type of reimbursement system.

Sec. 44. **REPEALER.**

Minnesota Statutes 1994, sections 256F.05, subdivisions 2a and 4a; 256F.06, subdivision 3; 256F.09, subdivision 4; and 256H.03, subdivisions 2 and 5, are repealed.

Sec. 45. **EFFECTIVE DATE.**

Section 2 (256.8711, subdivisions 1 to 10) is effective October 1, 1995.

Sections 5 (256F.01), 6 (256F.02), 7 and 8 (256F.03, subdivisions 5 and 10), 9 and 10 (256F.04, subdivisions 1 and 2), 11 to 17 (256F.05, subdivisions 1a, 2, 3, 4, 5, 7, and 8), and 18 and 19 (256F.06, subdivisions 1 and 2) are effective January 1, 1996.

ARTICLE 5

ECONOMIC SELF-SUFFICIENCY

Section 1. Minnesota Statutes 1994, section 256.12, subdivision 14, is amended to read:

Subd. 14. **DEPENDENT CHILD.** (a) "Dependent child," as used in sections 256.72 to 256.87, means a child under the age of 18 years, or a child under the age of 19 years who is regularly attending as a full-time student, and is expected to complete before reaching age 19, a high school or a secondary level course of vocational or technical training designed to fit students for gainful employment, who is found to be deprived of parental support or care by reason of the death, continued absence from the home, physical or mental incapacity of a parent, or who is a child of an unemployed parent as that term is defined by the commissioner of human services, such definition to be consistent with and not to exceed minimum standards established by the Congress of the United States and the Secretary of Health and Human Services. When defining "unemployed parent," the commissioner shall count up to four calendar quarters of full-time attendance in any of the following toward the requirement that a principal earner have six or more quarters of work in any 13 calendar quarter period ending within one year before application for aid to families with dependent children:

(1) an elementary or secondary school;

(2) a federally approved vocational or technical training course designed to prepare the parent for gainful employment; or

(3) full-time participation in an education or training program established under the job training partnership act.

(b) Dependent child also means a child:

(1) whose relatives are liable under the law for the child's support and are not able to provide adequate care and support of the child; and

(2) who is living with ~~father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece~~ a parent or a person in one of the groups listed under Code of Federal Regulations, title 45, section 233.90(c)(1)(v)(A) in a place of residence maintained by one or more of these relatives as a home.

(c) Dependent child also means a child who has been removed from the home of a relative after a judicial determination that continuance in the home would be contrary to the welfare and best interests of the child and whose care and placement in a foster home, a different relative's home, or a private licensed child care institution is, in accordance with the rules of the commissioner, the responsibility of the state or county agency under sections 256.72 to 256.87. ~~This child is eligible for benefits only through the foster care and adoption assistance program contained in Title IV-E of the Social Security Act, United States Code, title 42, sections 670 to 676, and is not entitled to benefits under sections 256.72 to 256.87.~~

Sec. 2. Minnesota Statutes 1994, 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. The assistance unit must sign an agreement to dispose of the property and to ~~repay assistance received during the nine months 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 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 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.~~ give the local agency a lien to secure repayment of benefits received by the assistance unit during the nine-month period covered by the agreement. The provisions of section 514.981, subdivision 2, clauses (a)(1), (a)(3), (a)(4), (a)(5), and (e); subdivisions 4 and 5, clauses (a)(2), (b)(3) (b)(4), and (d); and subdivision 6; section 514.982, subdivision 1, clauses (1), (2), and (4);

and subdivision 2; and sections 514.983 and 514.984, regarding medical assistance liens, shall apply to AFDC liens under this section, except that the filing fees paid by the county agency under this section shall be deducted from recoveries made under this lien provision. For purposes of this paragraph, all references in sections 514.981 to 514.984, to medical assistance liens and to medical assistance benefits shall be construed to be references to AFDC liens and to AFDC benefits, respectively. 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. 3. Minnesota Statutes 1994, 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 months per calendar year and the earnings of a dependent child that are derived from the jobs training and partnership act (JTPA) may be disregarded for six 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~~;~~. If a stepparent's needs are included in the assistance unit as specified in section 256.74, subdivision 1, the disregards specified in section 256.74, subdivision 1, shall be applied.

(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. 4. Minnesota Statutes 1994, section 256.736, subdivision 3, is amended to read:

Subd. 3. **REGISTRATION.** (a) To the extent permissible under federal law, every caretaker or child is required to register for employment and training services, as a condition of receiving AFDC, unless the caretaker or child is:

(1) a child who is under age 16, a child age 16 or 17 who is attending elementary or secondary school or a secondary level vocational or technical school full time;

(2) ill, incapacitated, or age 60 or older;

(3) a person for whom participation in an employment and training service would require a round trip commuting time by available transportation of more than two hours;

(4) a person whose presence in the home is required because of illness or incapacity of another member of the household;

(5) a caretaker or other caretaker relative of a child under the age of three who personally provides full-time care for the child. In AFDC-UP cases, only one parent or other relative may qualify for this exemption;

(6) a caretaker or other caretaker relative personally providing care for a child under six years of age, except that when child care is arranged for or pro-

vided, the caretaker or caretaker relative may be required to register and participate in employment and training services up to a maximum of 20 hours per week. In AFDC-UP cases, only one parent or other relative may qualify for this exemption;

(7) a pregnant woman, if it has been medically verified that the child is expected to be born within the next six months; ~~or~~

(8) employed at least 30 hours per week; or

(9) an individual added to an assistance unit as an essential person under section 256.74, subdivision 1, who does not meet the definition of a "caretaker" as defined in subdivision 1a, paragraph (c).

(b) To the extent permissible by federal law, applicants for benefits under the AFDC program are registered for employment and training services by signing the application form. Applicants must be informed that they are registering for employment and training services by signing the form. Persons receiving benefits on or after July 1, 1987, shall register for employment and training services to the extent permissible by federal law. The caretaker has a right to a fair hearing under section 256.045 with respect to the appropriateness of the registration.

Sec. 5. Minnesota Statutes 1994, section 256.736, subdivision 13, is amended to read:

Subd. 13. **STATE SHARE.** The state must pay 75 percent of the nonfederal share of costs incurred by counties under subdivision 11.

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 county agency expenditures made under subdivision 11 from January 1, 1991, ~~on~~ to June 30, 1995. Payment to counties under this subdivision is subject to the provisions of section 256.017.

Beginning July 1, 1995, the state must pay 100 percent of the nonfederal share incurred by counties under subdivision 11, up to the limit of state appropriations. If the state appropriation is not sufficient to fund the cost of case management services for all caretakers identified in subdivision 2a, the commissioner must define a statewide subgroup of caretakers which includes all caretakers in subdivision 2a, clause (1), and as many caretakers as possible from subdivision 2a, clauses (2) and (3).

Sec. 6. Minnesota Statutes 1994, 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~~ parent 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 suffi-

cient, 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. To the extent permissible under federal law, an eligible relative caretaker or parent shall have the option to include in the assistance unit the needs, income, and resources of the following essential persons who are not otherwise eligible for AFDC because they do not qualify as a caretaker or as a dependent child:

(1) a parent or relative caretaker's spouse and stepchildren; or

(2) blood or legally adopted relatives who are under the age of 18 or under the age of 19 years who are regularly attending as a full-time student, and are expected to complete before or during the month of their 19th birthday, a high school or secondary level course of vocational or technical training designed to prepare students for gainful employment. 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 AFDC family must be budgeted in the normal retrospective cycle. When the family's income, after application of the applicable disregards, exceeds the need standard for the 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. Any income remaining from this calculation is income in the first month following the period of ineligibility. 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 AFDC who is a full-time student or is a part-time student 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 and includes a participant in the Job Corps program under the Job Training Partnership Act (JTPA). The county agency shall also disregard all income of each dependent child 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 months per calendar year;

(2) all educational ~~grants and loans~~ assistance, except the county agency shall count graduate student teaching assistantships, fellowships, and other similar paid work as earned income and, after allowing deductions for any unmet and necessary educational expenses, shall count scholarships or grants awarded to graduate students that do not require teaching or research as unearned income;

(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. 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. 7. Minnesota Statutes 1994, section 256D.05, subdivision 7, is amended to read:

Subd. 7. **INELIGIBILITY FOR GENERAL ASSISTANCE.** No person ~~disqualified from any federally aided assistance program~~ shall be eligible for general assistance during ~~the~~ a period ~~covered by the disqualification sanction~~ of disqualification because of sanctions, from any federally aided assistance program; or if the person could be considered an essential person under section 256.74, subdivision 1.

Sec. 8. Minnesota Statutes 1994, section 256D.36, subdivision 1, is amended to read:

Subdivision 1. **STATE PARTICIPATION.** ~~(a) ELIGIBILITY. Commencing January 1, 1974, the commissioner shall certify to each county agency the names of all county residents who were eligible for and did receive aid during December, 1973, pursuant to a categorical aid program of old age assistance, aid to the blind, or aid to the disabled. The amount of supplemental aid for each~~

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

~~individual eligible under this section shall be calculated according to the formula in title II, section 212(a) (3) of Public Law Number 93-66, as amended.~~

~~(b) DIVISION COSTS. From and after January 1, 1980, until January 1, 1981, the state shall pay 70 percent and the county shall pay 30 percent of the supplemental aid calculated for each county resident certified under this section who is an applicant for or recipient of supplemental security income. After December 31, 1980,~~ The state share of aid paid shall be 85 percent and the county share shall be 15 percent. Benefits shall be issued to recipients by the state or county and funded according to section 256.025, subdivision 3, subject to provisions of section 256.017.

Beginning July 1, 1991, the state will reimburse counties according to the payment schedule in section 256.025 for the county share of county agency expenditures for financial benefits to individuals under this subdivision from January 1, 1991, on. Payment to counties under this subdivision is subject to the provisions of section 256.017.

Sec. 9. Minnesota Statutes 1994, section 256D.385, is amended to read:

256D.385 **RESIDENCE.**

To be eligible for Minnesota supplemental aid, a person must be a resident of Minnesota and (1) a citizen of the United States, or (2) ~~an alien lawfully admitted to the United States for permanent residence, or (3) otherwise permanently residing in the United States under color of law as defined by~~ an alien eligible to receive benefits from the supplemental security income program.

Sec. 10. Minnesota Statutes 1994, section 256D.405, subdivision 3, is amended to read:

Subd. 3. **REPORTS.** Recipients must report changes in circumstances that affect eligibility or assistance payment amounts within ten days of the change. Recipients ~~with earned income, and recipients~~ who do not receive SSI because of excess income must complete a monthly report form if they have earned income, if they have income ~~allocated~~ deemed to them from a financially responsible relative with whom the recipient resides, ~~must complete a monthly household report form~~ or if they have income deemed to them by a sponsor. If the report form is not received before the end of the month in which it is due, the county agency must terminate assistance. 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 the assistance was terminated, the assistance unit is considered to have continued its application for assistance, effective the first day of the month the assistance was terminated.

Sec. 11. Minnesota Statutes 1994, section 256D.425, subdivision 1, is amended to read:

Subdivision 1. **PERSONS ENTITLED TO RECEIVE AID.** ~~A person who is aged, blind, or 18 years of age or older and disabled, whose income is less~~

~~than the standards of assistance in section 256D.44 and whose resources are less than the limits in subdivision 2 is eligible for and entitled to Minnesota supplemental aid. A person found eligible by the Social Security Administration for supplemental security income under Title XVI on the basis of age, blindness, or disability meets these requirements. A person who would be eligible for the supplemental security income program except for income that exceeds the limit of that program but that~~ A person receiving supplemental security benefits under Title XVI on the basis of age, blindness, or disability (or would be eligible for such benefits except for excess income) is eligible for a payment under the Minnesota supplemental aid program, if the person's net income is less than the standards in section 256D.44. Persons who are not receiving supplemental security income benefits under Title XVI of the Social Security Act or disability insurance benefits under Title II of the Social Security Act due to exhausting time limited benefits are not eligible to receive benefits under the MSA program. Persons who are not receiving social security or other maintenance benefits for failure to meet or comply with the social security or other maintenance program requirements are not eligible to receive benefits under the MSA program. Persons who are found ineligible for supplemental security income because of excess income, but whose income is within the limits of the Minnesota supplemental aid program, must have blindness or disability determined by the state medical review team.

Sec. 12. Minnesota Statutes 1994, section 256D.435, subdivision 1, is amended to read:

Subdivision 1. ~~EXCLUSIONS~~ INCOME. ~~The following is excluded from income in determining eligibility for Minnesota supplemental aid:~~

~~(1) the value of food stamps;~~

~~(2) home-produced food used by the household;~~

~~(3) Indian claim payments made by the United States Congress to compensate members of Indian tribes for the taking of tribal lands by the federal government;~~

~~(4) cash payments to displaced persons who face relocation as a result of the Housing Act of 1965, the Housing and Urban Development Act of 1965, or the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;~~

~~(5) one-third of child support payments received by an eligible child from an absent parent;~~

~~(6) displaced homemaker payments;~~

~~(7) reimbursement received for maintenance costs of providing foster care to adults or children;~~

~~(8) benefits received under Title IV and Title VII of the Older Americans Act of 1965;~~

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

~~(9) Minnesota renter or homeowner property tax refunds;~~

~~(10) infrequent, irregular income that does not total more than $20 per person in a month;~~

~~(11) reimbursement payments received from the VISTA program;~~

~~(12) in-kind income;~~

~~(13) payments received for providing volunteer services under Title I, Title II, and Title III of the Domestic Volunteer Service Act of 1973;~~

~~(14) loans that have to be repaid;~~

~~(15) federal low-income heating assistance program payments;~~

~~(16) any other type of funds excluded as income by state law;~~

~~(17) student financial aid, as allowed for the supplemental security income program; and~~

~~(18) other income excluded by the supplemental security income program.~~ For persons receiving supplemental security income benefits, the countable income used to determine eligibility and benefits for Minnesota supplemental aid is the gross amount of the Federal Benefit Rate (FBR) after allowing for the general income disregard in subdivision 5. For persons who have been denied a supplemental security income benefit due to excess income, and have had their blindness or disability determined through the state medical review team, the countable income is the gross amount of earned and unearned income, minus the exclusions and disregards listed in subdivisions 4a, 5, and 6.

Sec. 13. Minnesota Statutes 1994, section 256D.435, subdivision 3, is amended to read:

Subd. 3. **APPLICATION FOR FEDERALLY FUNDED BENEFITS.** ~~Persons for whom the applicant or recipient has financial responsibility and who have unmet needs~~ Persons who live with the applicant or recipient, who have unmet needs and for whom the applicant or recipient has financial responsibility, must apply for and, if eligible, accept AFDC and other federally funded benefits. ~~If the persons are determined potentially eligible for AFDC by the county agency, the applicant or recipient may not allocate earned or unearned income to those persons while an AFDC application is pending, or after the persons are determined eligible for AFDC. If the persons are determined potentially eligible for other federal benefits, the applicant or recipient may only allocate income to those persons until they are determined eligible for those other benefits unless the amount of those benefits is less than the amount in subdivision 4.~~

Sec. 14. Minnesota Statutes 1994, section 256D.435, subdivision 4, is amended to read:

Subd. 4. **ALLOCATION AND DEEMING OF INCOME.** ~~The rate of allocation to relatives for whom the applicant or recipient is financially responsible is one-half the individual supplemental security income standard of assistance, except as restricted in subdivision 3.~~

~~If the applicant or recipient shares a residence with another person who has financial responsibility for the applicant or recipient, the income of that person is considered available to the applicant or recipient after allowing: (1) the deductions in subdivisions 7 and 8; and (2) a deduction for the needs of the financially responsible relative and others in the household for whom that relative is financially responsible. The rate allowed to meet the needs of each of these people is one-half the individual supplemental security income standard.~~ The county agency shall apply the supplemental security income rules regarding financial responsibility when determining the amount of income to allocate or deem.

Sec. 15. Minnesota Statutes 1994, section 256D.435, is amended by adding a subdivision to read:

Subd. 4a. **EXCLUSIONS.** The income exclusions used to determine eligibility for Minnesota supplemental aid are those used to determine benefits for supplemental security income.

Sec. 16. Minnesota Statutes 1994, section 256D.435, subdivision 5, is amended to read:

Subd. 5. **GENERAL INCOME DISREGARD.** The county agency shall disregard the first $20 of the assistance unit's unearned or earned income ~~from the assistance unit's gross earned income~~.

Sec. 17. Minnesota Statutes 1994, section 256D.435, subdivision 6, is amended to read:

Subd. 6. **EARNED INCOME DISREGARDS.** ~~From the assistance unit's gross earned income, the county agency shall disregard $65 plus one-half of the remaining income.~~ The earned income disregards used to determine eligibility for Minnesota supplemental aid are those used to determine benefits for supplemental security income.

Sec. 18. Minnesota Statutes 1994, section 256D.44, subdivision 1, is amended to read:

Subdivision 1. **USE OF STANDARDS; INCREASES.** The state standards of assistance for ~~shelter,~~ basic needs, ~~and~~ plus special need items ~~that~~ establish the total amount of ~~maintenance~~ need for an applicant for or recipient of Minnesota supplemental aid, ~~are~~ used to determine the assistance unit's eligibility for Minnesota supplemental aid. The state standards of assistance for basic needs must increase by an amount equal to the dollar value, rounded up to the nearest dollar, of any cost of living increases in the supplemental security income program.

Sec. 19. Minnesota Statutes 1994, section 256D.44, subdivision 2, is amended to read:

Subd. 2. **STANDARD OF ASSISTANCE FOR ~~SHELTER~~ PERSONS ELIGIBLE FOR MEDICAL ASSISTANCE WAIVERS OR AT RISK OF PLACEMENT IN A GROUP RESIDENTIAL HOUSING FACILITY.** ~~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 (f).~~

~~(a) If 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 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) If an applicant or recipient resides with another person or persons, the state standard of assistanee 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).~~ The state standard of assistance for a person who is eligible for a medical assistance home and community-based services waiver or a person who has been determined by the local agency to meet the plan requirements for placement in a group residential housing facility under section 256I.04, subdivision 1a, is the standard established in subdivision 3, paragraph (a) or (b).

Sec. 20. Minnesota Statutes 1994, 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) If an applicant or recipient does not reside with another person or persons, the state standard of assistance is ~~$371~~ $519.

(b) If an applicant married couple or recipient married couple who live together, does not reside with others, the state standard of assistance is ~~$557~~ $778.

(c) If an applicant or recipient resides with another person or persons, the state standard of assistance is ~~$286~~ $395.

(d) If an applicant married couple or recipient married couple who live together, resides with others, the state standard of assistance is ~~$371~~ $519.

(e) Married couples, living together who do not reside with others and were receiving MSA ~~on~~ prior to January 1, 1994, and whose eligibility has not been terminated a full calendar month, ~~are exempt from the standards in paragraphs (b) and (d)~~ the state standard of assistance is $793.

(f) Married couples living together who reside with others and were receiving MSA prior to January 1, 1994, and whose eligibility has not been terminated a full calendar month, the state standard of assistance is $682.

(g) For an individual who is a resident of a nursing home, a regional treatment center or a group residential housing facility, the state standard of assistance is the personal needs allowance for medical assistance recipients under section 256B.35.

Sec. 21. Minnesota Statutes 1994, section 256D.44, subdivision 4, is amended to read:

Subd. 4. **TEMPORARY ABSENCE DUE TO ILLNESS.** For the purposes of this subdivision, "home" means a residence owned or rented by a recipient or the recipient's spouse. Home does not include a ~~negotiated rate~~ group residential housing facility. Assistance payments for recipients who are temporarily absent from their home due to hospitalization for illness must continue at the same level of payment during their absence if the following criteria are met:

(1) a physician certifies that the absence is not expected to continue for more than three months;

(2) a physician certifies that the recipient will be able to return to independent living; and

(3) the recipient has expenses associated with maintaining a residence in the community.

Sec. 22. Minnesota Statutes 1994, section 256D.44, subdivision 5, is amended to read:

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

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

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

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

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

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

Sec. 23. Minnesota Statutes 1994, section 256D.44, subdivision 6, is amended to read:

Subd. 6. **COUNTY AGENCY STANDARDS OF ASSISTANCE.** The county agency may establish standards of assistance for ~~shelter,~~ basic needs, special needs, and clothing and personal needs~~, and negotiated rates~~ that exceed the corresponding state standards of assistance. State aid is not available for costs above state standards.

Sec. 24. Minnesota Statutes 1994, section 256D.45, subdivision 1, is amended to read:

Subdivision 1. ~~**PROSPECTIVE**~~ **BUDGETING.** ~~A calendar month is~~ The payment period and budgeting cycle for Minnesota supplemental aid~~. The monthly payment to a recipient must be determined prospectively~~ are those of the supplemental security income program.

Sec. 25. Minnesota Statutes 1994, section 256D.46, subdivision 1, is amended to read:

Subdivision 1. **ELIGIBILITY.** Emergency Minnesota supplemental aid

must be granted if the recipient is without adequate resources to resolve an emergency that, if unresolved, will threaten the health or safety of the recipient. For the purposes of this section, the term "recipient" includes persons for whom a group residential housing benefit is being paid under sections 256I.01 to 256I.06.

Sec. 26. Minnesota Statutes 1994, section 256D.46, subdivision 2, is amended to read:

Subd. 2. **INCOME AND RESOURCE TEST.** All income and resources available to the recipient ~~during the month in which the need for emergency Minnesota supplemental aid arises~~ must be considered in determining the recipient's ability to meet the emergency need. Property that can be liquidated in time to resolve the emergency and income (excluding Minnesota supplemental aid issued for current month's need) that is normally disregarded or excluded under the Minnesota supplemental aid program must be considered available to meet the emergency need.

Sec. 27. Minnesota Statutes 1994, section 256D.48, subdivision 1, is amended to read:

Subdivision 1. **NEED FOR PROTECTIVE PAYEE.** The county agency shall determine whether a recipient needs a protective payee when a physical or mental condition renders the recipient unable to manage funds and when payments to the recipient would be contrary to the recipient's welfare. Protective payments must be issued when there is evidence of: (1) repeated inability to plan the use of income to meet necessary expenditures; (2) repeated observation that the recipient is not properly fed or clothed; (3) repeated failure to meet obligations for rent, utilities, food, and other essentials; (4) evictions or a repeated incurrence of debts; ~~or~~ (5) lost or stolen checks; or (6) use of emergency Minnesota supplemental aid more than twice in a calendar year. The determination of representative payment by the Social Security Administration for the recipient is sufficient reason for protective payment of Minnesota supplemental aid payments.

Sec. 28. Minnesota Statutes 1994, section 256I.03, subdivision 5, is amended 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. 29. Minnesota Statutes 1994, section 256I.03, is amended by adding a subdivision to read:

Subd. 7. **COUNTABLE INCOME.** "Countable income" means all income received by an applicant or recipient less any applicable exclusions or disregards. For a recipient of any cash benefit from the SSI program, countable income means the SSI benefit limit in effect at the time the person is in a GRH setting less $20, less the medical assistance personal needs allowance. If the SSI limit has been reduced for a person due to events occurring prior to the persons entering the GRH setting, countable income means actual income less any applicable exclusions and disregards.

Sec. 30. Minnesota Statutes 1994, section 256I.04, subdivision 2b, is amended 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 specific license or registration from the department of health or the department of human services held by the provider and the number of beds subject to that license; 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; whether the license holder is a not-for-profit corporation under section 501(c)(3) of the Internal Revenue Code; 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. 31. Minnesota Statutes 1994, 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 group residential housing beds with total rates in excess of the MSA equivalent rate except: (1) for group residential housing establishments meeting the requirements of subdivision 2a, clause (2) with department approval; (2) for 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)~~.~~; or (5) notwithstanding the provisions of subdivision 2a, for up to 180 supportive housing units in Anoka, Dakota, Hennepin, or Ramsey county for homeless adults with a mental illness, a history of substance abuse, or human immunodeficiency virus or acquired immunodeficiency syndrome. For purposes of this section, "homeless adult" means a person who is living on the street or in a shelter or is evicted from a dwelling unit or discharged from a regional treatment center, community hospital, or residential treatment program and has no appropriate housing available and lacks the resources and support necessary to access appropriate housing. At least 70 percent of the supportive housing units must serve homeless adults with mental illness, substance abuse problems, or human immunodeficiency virus or acquired immunodeficiency syndrome who are about to be discharged from a regional treatment center, or a state-contracted psychiatric bed in a community hospital, or a residential mental health or chemical dependency treatment program. If a person meets the requirements of subdivision 1, paragraph (a), the group residential housing rate for that person is limited to the supplementary rate under section 256I.05, subdivision 1a, and is determined by subtracting the amount of the person's countable income that exceeds the MSA equivalent rate from the group residential housing supplementary rate. Service funding under section 256I.05, subdivision 1a, must end June 30, 1997. Effective July 1, 1997, services to persons in these settings must be provided through a managed care entity. This provision is subject to the availability of matching federal funds.

(b) A county agency may enter into a group residential housing agreement for beds with rates in excess of the MSA equivalent rate in addition to those currently covered under a group residential housing agreement if the additional beds are only a replacement of beds with rates in excess of the MSA equivalent rate 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. 32. Minnesota Statutes 1994, section 256I.05, subdivision 1, is amended to read:

Subdivision 1. **MAXIMUM RATES.** ~~(a)~~ Monthly room and board rates negotiated by a county agency for a recipient living in group residential housing must not exceed 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

(3) 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 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 this subdivision. This is effective until June 30, 1994.~~

Sec. 33. Minnesota Statutes 1994, section 256I.05, subdivision 1a, is amended to read:

Subd. 1a. **SUPPLEMENTARY RATES.** 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~~ provider of services is not also concurrently receiving funding for services for a recipient 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. If funding is available for other necessary services through a home and community-based waiver, then the GRH rate is limited to the rate set in subdivision 1. 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. 34. Minnesota Statutes 1994, section 256I.05, subdivision 5, is amended to read:

Subd. 5. **ADULT FOSTER CARE RATES.** The commissioner shall annually establish statewide maintenance and difficulty of care ~~rates~~ limits for adults in foster care. ~~The commissioner shall adopt rules to implement statewide rates. In adopting rules, the commissioner shall consider existing maintenance and difficulty of care rates so that, to the extent possible, an adult for whom a maintenance or difficulty of care rate is established will not be adversely affected.~~

Sec. 35. Minnesota Statutes 1994, section 256I.06, subdivision 2, is amended to read:

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 countable earned income must be made subsequent to receipt of a monthly household report form.

Sec. 36. Minnesota Statutes 1994, section 256I.06, subdivision 6, is amended to read:

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 countable 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.

Sec. 37. Minnesota Statutes 1994, section 393.07, subdivision 10, is amended to read:

Subd. 10. **FEDERAL FOOD STAMP PROGRAM.** (a) The local social

services agency 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 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;

(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.

(e) Food stamp overpayment claims which are due in whole or in part to client error shall be established by the county agency for a period of six years from the date of any resultant overpayment.

(f) With regard to the federal tax revenue offset program only, recovery incentives authorized by the federal food and consumer service shall be retained at the rate of 50 percent by the state agency and 50 percent by the certifying county agency.

Sec. 38. **RAMSEY COUNTY ELECTRONIC BENEFIT SERVICE.**

Notwithstanding the requirements for state contracts contained in Minnesota Statutes, chapter 16B, or Laws 1993, First Special Session chapter 1, article 1, section 2, subdivision 5, or any other law to the contrary, the commissioner, under terms and conditions approved by the attorney general, may accept assignment from Ramsey county of any existing contract, license agreement, or similar transactional document related to the Ramsey county electronic benefit system. The term of any contract, agreement, or other document assigned to the state, including the agreement arising from the Ramsey county electronic benefit services pilot project, may not extend beyond June 30, 1997, and the commissioner must publish a request for proposals for succeeding electronic benefits services, including services required for statewide expansion in the State Register before January 1, 1996.

Sec. 39. Laws 1993, First Special Session chapter 1, article 8, section 30, subdivision 2, is amended to read:

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.~~ The amendments and repeals by Laws 1993, First Special Session chapter 1, article 8, sections 1 to 3, 8, 9, 13 to 17, 22, 23, 26, and 29, are effective July 1, 1994.

Sec. 40. **REPEALER.**

Minnesota Statutes 1994, sections 256.851; 256D.35, subdivisions 14 and 19; 256D.36, subdivision 1a; 256D.37; 256D.425, subdivision 3; 256D.435, subdivisions 2, 7, 8, 9, and 10; and 256D.44, subdivision 7, are repealed.

Sec. 41. **EFFECTIVE DATES.**

Section 31 (256I.04, subdivision 3) is effective July 1, 1996.

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

ARTICLE 6

MA AND GAMC

Section 1. Minnesota Statutes 1994, section 144.0721, is amended by adding a subdivision to read:

Subd. 3. **LEVEL OF CARE CRITERIA; MODIFICATIONS.** The commissioner shall seek appropriate federal waivers to implement this subdivision. Notwithstanding any laws or rules to the contrary, effective July 1, 1996, Minnesota's level of care criteria for admission of any person to a nursing facility licensed under chapter 144A, or a boarding care home licensed under sections 144.50 to 144.56, are modified as follows:

(1) the resident reimbursement classifications and terminology established by rule under sections 256B.41 to 256B.48 are the basis for applying the level of care criteria changes;

(2) an applicant to a certified nursing facility or certified boarding care home who is dependent in one or two case mix activities of daily living, is classified as a case mix A, and is independent in orientation and self-preservation, is reclassified as a high function class A person and is not eligible for admission to Minnesota certified nursing facilities or certified boarding care homes;

(3) applicants in clause (2) who are eligible for assistance as determined under sections 256B.055 and 256B.056 or meet eligibility criteria for section 256B.0913 are eligible for a service allowance under section 256B.0913, subdivision 15, and are not eligible for services under sections 256B.0913, subdivisions 1 to 14, and 256B.0915. Applicants in clause (2) shall have the option of receiving personal care assistant and home health aide services under section 256B.0625, if otherwise eligible, or of receiving the service allowance option, but not both. Applicants in clause (2) shall have the option of residing in community settings under sections 256I.01 to 256I.06, if otherwise eligible, or receiving the services allowance option under section 256B.0913, subdivision 15, but not both;

(4) residents of a certified nursing facility or certified boarding care home who were admitted before July 1, 1996, or individuals receiving services under section 256B.0913, subdivisions 1 to 14, or 256B.0915, before July 1, 1996, are not subject to the new level of care criteria unless the resident is discharged home or to another service setting other than a certified nursing facility or certified boarding care home and applies for admission to a certified nursing facility or certified boarding care home after June 30, 1996;

(5) the local screening teams under section 256B.0911 shall make preliminary determinations concerning the existence of extraordinary circumstances and may authorize an admission for a short-term stay at a certified nursing facility or certified boarding care home in accordance with a treatment and discharge plan for up to 30 days per year; and

(6) an individual deemed ineligible for admission to Minnesota certified nursing facilities is entitled to an appeal under section 256.045.

If the commissioner determines upon appeal that an applicant in clause (2) presents extraordinary circumstances including but not limited to the absence or inaccessibility of suitable alternatives, contravening family circumstances, and protective service issues, the applicant may be eligible for admission to Minnesota certified nursing facilities or certified boarding care homes.

Sec. 2. Minnesota Statutes 1994, section 144.0721, is amended by adding a subdivision to read:

Subd. 3a. **EXCEPTION.** Subdivision 3 does not apply to a facility whose rates are subject to section 256I.05, subdivision 2.

Sec. 3. Minnesota Statutes 1994, section 144.702, subdivision 2, is amended to read:

Subd. 2. **APPROVAL OF ORGANIZATION'S REPORTING PROCEDURES.** The commissioner of health may approve voluntary reporting procedures consistent with written operating requirements for the voluntary, nonprofit reporting organization which shall be established annually by the commissioner. These written operating requirements shall specify reports, analyses, and other deliverables to be produced by the voluntary, nonprofit reporting organization, and the dates on which those deliverables must be submitted to the commissioner. These written operating requirements shall specify deliverable dates sufficient to enable the commissioner of health to process and report health care cost information system data to the commissioner of human services by August 15 of each year. The commissioner of health shall, by rule, prescribe standards for submission of data by hospitals and outpatient surgical centers to the voluntary, nonprofit reporting organization or to the commissioner. These standards shall provide for:

(a) The filing of appropriate financial information with the reporting organization;

(b) Adequate analysis and verification of that financial information; and

(c) Timely publication of the costs, revenues, and rates of individual hospitals and outpatient surgical centers prior to the effective date of any proposed rate increase. The commissioner of health shall annually review the procedures approved pursuant to this subdivision.

Sec. 4. Minnesota Statutes 1994, section 252.27, subdivision 1, is amended to read:

Subdivision 1. **COUNTY OF FINANCIAL RESPONSIBILITY.** Whenever any child who has mental retardation or a related condition, or a physical disability or emotional disturbance is in 24-hour care outside the home including respite care, in a facility licensed by the commissioner of human services, the

cost of services shall be paid by the county of financial responsibility determined pursuant to chapter 256G. If the child's parents or guardians do not reside in this state, the cost shall be paid by the responsible governmental agency in the state from which the child came, by the parents or guardians of the child if they are financially able, or, if no other payment source is available, by the commissioner of human services.

Sec. 5. Minnesota Statutes 1994, section 252.27, subdivision 1a, is amended to read:

Subd. 1a. **DEFINITIONS.** A ~~person has a~~ "related condition" ~~if that person has~~ is a condition that is found to be closely related to mental retardation, including, but not limited to, cerebral palsy, epilepsy, autism, and Prader-Willi syndrome and that meets all of the following criteria: (a) is severe~~,~~ and chronic ~~disability that meets all of the following conditions: (a) is attributable to cerebral palsy, epilepsy, autism, Prader-Willi syndrome, or any other condition, other than mental illness as defined under section 245.462, subdivision 20, or an emotional disturbance, as defined under section 245.4871, subdivision 15, found to be closely related to mental retardation because the condition~~; (b) results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with mental retardation ~~and~~; (c) requires treatment or services similar to those required for persons with mental retardation; ~~(b)~~ (d) is manifested before the person reaches 22 years of age; ~~(c)~~ (e) is likely to continue indefinitely; ~~and (d)~~ (f) results in substantial functional limitations in three or more of the following areas of major life activity: (1) self-care, (2) understanding and use of language, (3) learning, (4) mobility, (5) self-direction, (6) capacity for independent living; and (g) is not attributable to mental illness as defined in section 245.462, subdivision 20, or an emotional disturbance as defined in section 245.4871, subdivision 15. For purposes of clause (g), notwithstanding section 245.462, subdivision 20, or 245.4871, subdivision 15, "mental illness" does not include autism or other pervasive developmental disorders.

Sec. 6. Minnesota Statutes 1994, section 252.27, subdivision 2a, is amended to read:

Subd. 2a. **CONTRIBUTION AMOUNT.** (a) The natural or adoptive parents of a minor child, including a child determined eligible for medical assistance without consideration of parental income, must contribute monthly to the cost of services, unless the child is married or has been married, parental rights have been terminated, or the child's adoption is subsidized according to section 259.67 or through title IV-E of the Social Security Act.

(b) The parental contribution shall be the greater of a minimum monthly fee of $25 for households with adjusted gross income of $30,000 and over, or an amount to be computed by applying to the adjusted gross income of the natural or adoptive parents that exceeds ~~200~~ 150 percent of the federal poverty guidelines for the applicable household size, the following schedule of rates:

(1) on the amount of adjusted gross income over ~~200~~ 150 percent of poverty, but not over $50,000, ten percent;

(2) on the amount of adjusted gross income over ~~200~~ 150 percent of poverty and over $50,000 but not over $60,000, 12 percent;

(3) on the amount of adjusted gross income over ~~200~~ 150 percent of poverty, and over $60,000 but not over $75,000, 14 percent; and

(4) on all adjusted gross income amounts over ~~200~~ 150 percent of poverty, and over $75,000, 15 percent.

If the child lives with the parent, the parental contribution is reduced by $200, except that the parent must pay the minimum monthly $25 fee under this paragraph. If the child resides in an institution specified in section 256B.35, the parent is responsible for the personal needs allowance specified under that section in addition to the parental contribution determined under this section. The parental contribution is reduced by any amount required to be paid directly to the child pursuant to a court order, but only if actually paid.

(c) The household size to be used in determining the amount of contribution under paragraph (b) includes natural and adoptive parents and their dependents under age 21, including the child receiving services. Adjustments in the contribution amount due to annual changes in the federal poverty guidelines shall be implemented on the first day of July following publication of the changes.

(d) For purposes of paragraph (b), "income" means the adjusted gross income of the natural or adoptive parents determined according to the previous year's federal tax form.

(e) The contribution shall be explained in writing to the parents at the time eligibility for services is being determined. The contribution shall be made on a monthly basis effective with the first month in which the child receives services. Annually upon redetermination or at termination of eligibility, if the contribution exceeded the cost of services provided, the local agency or the state shall reimburse that excess amount to the parents, either by direct reimbursement if the parent is no longer required to pay a contribution, or by a reduction in or waiver of parental fees until the excess amount is exhausted.

(f) The monthly contribution amount must be reviewed at least every 12 months; when there is a change in household size; and when there is a loss of or gain in income from one month to another in excess of ten percent. The local agency shall mail a written notice 30 days in advance of the effective date of a change in the contribution amount. A decrease in the contribution amount is effective in the month that the parent verifies a reduction in income or change in household size.

(g) Parents of a minor child who do not live with each other shall each pay the contribution required under paragraph (a), except that a court-ordered child support payment actually paid on behalf of the child receiving services shall be deducted from the contribution of the parent making the payment.

(h) The contribution under paragraph (b) shall be increased by an additional five percent if the local agency determines that insurance coverage is available but not obtained for the child. For purposes of this section, "available" means the insurance is a benefit of employment for a family member at an annual cost of no more than five percent of the family's annual income. For purposes of this section, insurance means health and accident insurance coverage, enrollment in a nonprofit health service plan, health maintenance organization, self-insured plan, or preferred provider organization.

Parents who have more than one child receiving services shall not be required to pay more than the amount for the child with the highest expenditures. There shall be no resource contribution from the parents. The parent shall not be required to pay a contribution in excess of the cost of the services provided to the child, not counting payments made to school districts for education-related services. Notice of an increase in fee payment must be given at least 30 days before the increased fee is due.

Sec. 7. Minnesota Statutes 1994, section 252.27, is amended by adding a subdivision to read:

Subd. 5. **DETERMINATION; REDETERMINATION; NOTICE.** A determination order and notice of parental fee shall be mailed to the parent at least annually, or more frequently as provided in Minnesota Rules, parts 9550.6220 to 9550.6229. The determination order and notice shall contain the following information: (1) the amount the parent is required to contribute; (2) notice of the right to a redetermination and appeal; and (3) the telephone number of the division at the department of human services that is responsible for redeterminations.

Sec. 8. Minnesota Statutes 1994, section 252.27, is amended by adding a subdivision to read:

Subd. 6. **APPEALS.** A parent may appeal the determination or redetermination of an obligation to make a contribution under this section, according to section 256.045. The parent must make a request for a hearing in writing within 30 days of the date the determination or redetermination order is mailed, or within 90 days of such written notice if the parent shows good cause why the request was not submitted within the 30-day time limit. The commissioner must provide the parent with a written notice that acknowledges receipt of the request and notifies the parent of the date of the hearing. While the appeal is pending, the parent has the rights regarding making payment that are provided in Minnesota Rules, part 9550.6235. If the commissioner's determination or redetermination is affirmed, the parent shall, within 90 calendar days after the date an order is issued under section 256.045, subdivision 5, pay the total amount due from the effective date of the notice of determination or redetermination that was appealed by the parent. If the commissioner's order under this subdivision results in a decrease in the parental fee amount, any payments made by the parent that result in an overpayment shall be credited to the parent as provided in Minnesota Rules, part 9550.6235, subpart 3.

Sec. 9. Minnesota Statutes 1994, section 256.015, subdivision 1, is amended to read:

Subdivision 1. **STATE AGENCY HAS LIEN.** When the state agency provides, pays for, or becomes liable for medical care or furnishes subsistence or other payments to a person, the agency has a lien for the cost of the care and payments on all causes of action that accrue to the person to whom the care or payments were furnished, or to the person's legal representatives, as a result of the occurrence that necessitated the medical care, subsistence, or other payments. For purposes of this section, "state agency" includes authorized agents of the state agency.

Sec. 10. Minnesota Statutes 1994, section 256.015, subdivision 2, is amended to read:

Subd. 2. **PERFECTION; ENFORCEMENT.** The state agency may perfect and enforce its lien under sections 514.69, 514.70, and 514.71, and must file the verified lien statement with the appropriate court administrator in the county of financial responsibility. The verified lien statement must contain the following: the name and address of the person to whom medical care, subsistence, or other payment was furnished; the date of injury; the name and address of vendors furnishing medical care; the dates of the service or payment; the amount claimed to be due for the care or payment; and to the best of the state agency's knowledge, the names and addresses of all persons, firms, or corporations claimed to be liable for damages arising from the injuries.

This section does not affect the priority of any attorney's lien. The state agency is not subject to any limitations period referred to in section 514.69 or 514.71 and has one year from the date notice is first received by it under subdivision 4, paragraph (c), even if the notice is untimely, or one year from the date medical bills are first paid by the state agency, whichever is later, to file its verified lien statement. The state agency may commence an action to enforce the lien within one year of (1) the date the notice required by subdivision 4, paragraph (c), is received, or (2) the date the person's cause of action is concluded by judgment, award, settlement, or otherwise, whichever is later.

Sec. 11. Minnesota Statutes 1994, section 256.015, subdivision 7, is amended to read:

Subd. 7. **COOPERATION REQUIRED.** Upon the request of the department of human services, any state agency or third party payer shall cooperate with the department in furnishing information to help establish a third party liability. Upon the request of the department of human services or county child support or human service agencies, any employer or third party payer shall cooperate in furnishing information about group health insurance plans or medical benefit plans available to its employees. The department of human services and county agencies shall limit its use of information gained from agencies ~~and~~, third party payers, and employers to purposes directly connected with the administration of its public assistance and child support programs. The provi-

sion of information by agencies ~~and~~, third party payers, and employers to the department under this subdivision is not a violation of any right of confidentiality or data privacy.

Sec. 12. Minnesota Statutes 1994, section 256.9353, subdivision 8, is amended to read:

Subd. 8. **LIEN.** When the state agency provides, pays for, or becomes liable for covered health services, the agency shall have a lien for the cost of the covered health services upon any and all causes of action accruing to the enrollee, or to the enrollee's legal representatives, as a result of the occurrence that necessitated the payment for the covered health services. All liens under this section shall be subject to the provisions of section 256.015. For purposes of this subdivision, "state agency" includes authorized agents of the state agency.

Sec. 13. Minnesota Statutes 1994, section 256.9365, is amended to read:

256.9365 **PURCHASE OF CONTINUATION COVERAGE FOR AIDS PATIENTS.**

Subdivision 1. **PROGRAM ESTABLISHED.** The commissioner of human services shall establish a program to pay private health plan premiums for persons who have contracted human immunodeficiency virus (HIV) to enable them to continue coverage under a group or individual health plan. If a person is determined to be eligible under subdivision 2, the commissioner shall: ~~(1) pay the eligible person's group plan premium for the period of continuation coverage provided in the Consolidated Omnibus Budget Reconciliation Act of 1985; or (2) pay the eligible person's individual plan premium for 24 months~~ pay the portion of the group plan premium for which the individual is responsible, if the individual is responsible for at least 50 percent of the cost of the premium, or pay the individual plan premium. The commissioner shall not pay for that portion of a premium that is attributable to other family members or dependents.

Subd. 2. **ELIGIBILITY REQUIREMENTS.** To be eligible for the program, an applicant must satisfy the following requirements:

(1) the applicant must provide a physician's statement verifying that the applicant is infected with HIV and is, or within three months is likely to become, too ill to work in the applicant's current employment because of HIV-related disease;

(2) the applicant's monthly gross family income must not exceed 300 percent of the federal poverty guidelines, after deducting medical expenses and insurance premiums;

(3) the applicant must not own assets with a combined value of more than $25,000; and

(4) if applying for payment of group plan premiums, the applicant must be covered by an employer's or former employer's group insurance plan ~~and be eligible to purchase continuation coverage; and~~

~~(5) if applying for payment of individual plan premiums, the applicant must be covered by an individual health plan whose coverage and premium costs satisfy additional requirements established by the commissioner in rule.~~

Subd. 3. ~~RULES~~ COST-EFFECTIVE COVERAGE. ~~The commissioner shall establish rules as necessary to implement the program. Special~~ Requirements for the payment of individual plan premiums under subdivision 2, clause (5), must be designed to ensure that the state cost of paying an individual plan premium ~~over a two-year period~~ does not exceed the estimated state cost that would otherwise be incurred in the medical assistance or general assistance medical care program. The commissioner shall purchase the most cost-effective coverage available for eligible individuals.

Sec. 14. Minnesota Statutes 1994, section 256.9657, subdivision 3, is amended to read:

Subd. 3. **HEALTH MAINTENANCE ORGANIZATION; INTEGRATED SERVICE NETWORK SURCHARGE.** (a) Effective October 1, 1992, each health maintenance organization with a certificate of authority issued by the commissioner of health under chapter 62D and each integrated service network and community integrated service network licensed by the commissioner under chapter 62N 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, integrated service network, or community integrated service network 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, integrated service network, or community integrated service network 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, an integrated service network, or a community integrated service network 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, integrated service network, or community integrated service network 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, integrated service network, or community integrated service network for more than one reporting period, the portion of the payment that has not yet been earned must be treated as a liability.

(c) When a health maintenance organization or an integrated service network or community integrated service network merges or consolidates with or is acquired by another health maintenance organization, integrated service network, or community integrated service network, the surviving corporation or the new corporation shall be responsible for the annual surcharge originally imposed on each of the entities or corporations subject to the merger, consolidation, or acquisition, regardless of whether one of the entities or corporations does not retain a certificate of authority under chapter 62D or a license under chapter 62N.

(d) Effective July 1 of each year, the surviving corporation's or the new corporation's surcharge shall be based on the revenues earned in the second previous calendar year by all of the entities or corporations subject to the merger, consolidation, or acquisition regardless of whether one of the entities or corporations does not retain a certificate of authority under chapter 62D or a license under chapter 62N until the total premium revenues of the surviving corporation include the total premium revenues of all the merged entities as reported to the commissioner of health.

(e) When a health maintenance organization, integrated service network, or community integrated service network, which is subject to liability for the surcharge under this chapter, transfers, assigns, sells, leases, or disposes of all or substantially all of its property or assets, liability for the surcharge imposed by this chapter is imposed on the transferee, assignee, or buyer of the health maintenance organization, integrated service network, or community integrated service network.

(f) In the event a health maintenance organization, integrated service network, or community integrated service network converts its licensure to a different type of entity subject to liability for the surcharge under this chapter, but survives in the same or substantially similar form, the surviving entity remains liable for the surcharge regardless of whether one of the entities or corporations does not retain a certificate of authority under chapter 62D or a license under chapter 62N.

(g) The surcharge assessed to a health maintenance organization, integrated service network, or community integrated service network ends when the entity ceases providing services for premiums and the cessation is not connected with a merger, consolidation, acquisition, or conversion.

Sec. 15. Minnesota Statutes 1994, section 256.9657, subdivision 4, is amended to read:

Subd. 4. **PAYMENTS INTO THE ACCOUNT.** (a) Payments to the com-

missioner under subdivisions 1 to 3 must be paid in monthly installments due on the 15th of the month beginning October 15, 1992. The monthly payment must be equal to the annual surcharge divided by 12. Payments to the commissioner under subdivisions 2 and 3 for fiscal year 1993 must be based on calendar year 1990 revenues. Effective July 1 of each year, beginning in 1993, payments under subdivisions 2 and 3 must be based on revenues earned in the second previous calendar year.

(b) Effective October 1, 1995, and each October 1 thereafter, the payments in subdivisions 2 and 3 must be based on revenues earned in the previous calendar year.

(c) If the commissioner of health does not provide by August 15 of any year data needed to update the base year for the hospital and health maintenance organization surcharges, the commissioner of human services may estimate base year revenue and use that estimate for the purposes of this section until actual data is provided by the commissioner of health.

Sec. 16. Minnesota Statutes 1994, section 256.9685, subdivision 1b, is amended to read:

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 after the reconsideration 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. 17. Minnesota Statutes 1994, section 256.9685, is amended by adding a subdivision to read:

Subd. 1c. **JUDICIAL REVIEW.** A hospital or physician aggrieved by an order of the commissioner under subdivision 1b may appeal the order to the district court of the county in which the physician or hospital is located by:

(1) serving a written copy of a notice of appeal upon the commissioner within 30 days after the date the commissioner issued the order; and

(2) filing the original notice of appeal and proof of service with the court administrator of the district court. The appeal shall be treated as a dispositive motion under the Minnesota General Rules of Practice, rule 115. The district court scope of review shall be as set forth in section 14.69.

Sec. 18. Minnesota Statutes 1994, section 256.9685, is amended by adding a subdivision to read:

Subd. 1d. **TRANSMITTAL OF RECORD.** Within 30 days after being served with the notice of appeal, the commissioner shall transmit to the district court the original or certified copy of the entire record considered by the commissioner in making the final agency decision. The district court shall not consider evidence that was not included in the record before the commissioner.

Sec. 19. Minnesota Statutes 1994, 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 change in the Consumer Price Index-All Items (United States city average) (CPI-U) forecasted by Data Resources, Inc. The commissioner shall use the indices as forecasted in the third quarter of the calendar year prior to the rate year. 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, 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, nor under general assistance medical care, except that the inflation adjustments under paragraph (a) for medical assistance, excluding general assistance medical care, shall apply for the biennium ending June 30, 1997. 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. 20. Minnesota Statutes 1994, section 256.969, subdivision 2b, is amended to read:

Subd. 2b. **OPERATING PAYMENT RATES.** In determining operating payment rates for admissions occurring on or after the rate year beginning January 1, 1991, and every two years after, or more frequently as determined by the commissioner, the commissioner shall obtain operating data from an updated

base year and establish operating payment rates per admission for each hospital based on the cost-finding methods and allowable costs of the Medicare program in effect during the base year. Rates under the general assistance medical care program shall not be rebased to more current data on January 1, 1997. The base year operating payment rate per admission is standardized by the case mix index and adjusted by the hospital cost index, relative values, and disproportionate population adjustment. The cost and charge data used to establish operating rates shall only reflect inpatient services covered by medical assistance and shall not include property cost information and costs recognized in outlier payments.

Sec. 21. Minnesota Statutes 1994, section 256.969, is amended by adding a subdivision to read:

Subd. 8a. **UNUSUAL SHORT LENGTH OF STAY.** Except as provided in subdivision 13, for admissions occurring on or after July 1, 1995, payment shall be determined as follows and shall be included in the base year for rate setting purposes.

(1) For an admission that is categorized to a neonatal diagnostic related group in which the length of stay is less than 50 percent of the average length of stay for the category in the base year and the patient at admission is equal to or greater than the age of one, payments shall be established according to the methods of subdivision 14.

(2) For an admission that is categorized to a diagnostic category that includes neonatal respiratory distress syndrome, the hospital must have a level II or level III nursery and the patient must receive treatment in that unit or payment will be made without regard to the syndrome condition.

Sec. 22. Minnesota Statutes 1994, section 256.969, subdivision 9, 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 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)~~, a medical assistance disproportionate population adjustment shall be paid in addition to any other disproportionate payment due under this subdivision as follows: $1,515,000 due on the 15th of each month after noon, beginning July 15, 1995. For a hospital

that 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~~ $505,000 due on the 15th of each month after noon, beginning July 15, ~~1993~~ 1995.

(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. 23. Minnesota Statutes 1994, section 256.969, subdivision 10, is amended to read:

Subd. 10. **SEPARATE BILLING BY CERTIFIED REGISTERED NURSE ANESTHETISTS.** Hospitals may exclude certified registered nurse anesthetist costs from the operating payment rate as allowed by section 256B.0625, subdivision 11. To be eligible, a hospital must notify the commissioner in writing by October 1 of the year preceding the rate year of the request to exclude certified registered nurse anesthetist costs. The hospital must agree that all hospital claims for the cost and charges of certified registered nurse anesthetist services will not be included as part of the rates for inpatient services provided during the rate year. In this case, the operating payment rate shall be adjusted to exclude the cost of certified registered nurse anesthetist services. ~~Payments made through separate claims for certified registered nurse anesthetist services shall not be paid directly through the hospital provider number or indirectly by the certified registered nurse anesthetist to the hospital or related organizations.~~

For admissions occurring on or after July 1, 1991, and until the expiration date of section 256.9695, subdivision 3, services of certified registered nurse anesthetists provided on an inpatient basis may be paid as allowed by section 256B.0625, subdivision 11, when the hospital's base year did not include the cost of these services. To be eligible, a hospital must notify the commissioner in writing by July 1, 1991, of the request and must comply with all other requirements of this subdivision.

Sec. 24. Minnesota Statutes 1994, section 256.969, subdivision 16, is amended to read:

Subd. 16. **INDIAN HEALTH SERVICE FACILITIES.** Indian health service facilities are exempt from the rate establishment methods required by this section and shall be reimbursed at charges as limited to the amount allowed under federal law. ~~This exemption is not effective for payments under general assistance medical care.~~

Sec. 25. Minnesota Statutes 1994, section 256.969, is amended by adding a subdivision to read:

Subd. 25. **LONG-TERM HOSPITAL RATES.** For admissions occurring on or after April 1, 1995, a long-term hospital as designated by Medicare that does not have admissions in the base year shall have inpatient rates established at the average of other hospitals with the same designation. For subsequent rate-setting periods in which base years are updated, the hospital's base year shall be the first Medicare cost report filed with the long-term hospital designation and shall remain in effect until it falls within the same period as other hospitals.

Sec. 26. Minnesota Statutes 1994, section 256B.042, subdivision 2, is amended to read:

Subd. 2. **LIEN ENFORCEMENT.** The state agency may perfect and enforce its lien by following the procedures set forth in sections 514.69, 514.70 and 514.71, and its verified lien statement shall be filed with the appropriate court administrator in the county of financial responsibility. The verified lien statement shall contain the following: the name and address of the person to whom medical care was furnished, the date of injury, the name and address of the vendor or vendors furnishing medical care, the dates of the service, the amount claimed to be due for the care, and, to the best of the state agency's knowledge, the names and addresses of all persons, firms, or corporations claimed to be liable for damages arising from the injuries. This section shall not affect the priority of any attorney's lien. The state agency is not subject to any limitations period referred to in section 514.69 or 514.71 and has one year from the date notice is first received by it under subdivision 4, paragraph (c), even if the notice is untimely, or one year from the date medical bills are first paid by the state agency, whichever is later, to file its verified lien statement. The state agency may commence an action to enforce the lien within one year of (1) the date the notice required by subdivision 4, paragraph (c), is received or (2) the date the recipient's cause of action is concluded by judgment, award, settlement, or otherwise, whichever is later. For purposes of this section, "state agency" includes authorized agents of the state agency.

Sec. 27. Minnesota Statutes 1994, section 256B.055, subdivision 12, is amended to read:

Subd. 12. **DISABLED CHILDREN.** (a) A person is eligible for medical assistance if the person is under age 19 and qualifies as a disabled individual under United States Code, title 42, section 1382c(a), and would be eligible for medical assistance under the state plan if residing in a medical institution, and ~~who~~ the child requires a level of care provided in a hospital, ~~skilled~~ nursing

facility, ~~intermediate care facility,~~ or intermediate care facility for persons with mental retardation or related conditions, for whom home care is appropriate, provided that the cost to medical assistance ~~for home care services~~ under this section is not more than the amount that medical assistance would pay for ~~appropriate institutional care~~ if the child resides in an institution. Eligibility under this section must be determined annually.

(b) For purposes of this subdivision, "hospital" means an ~~acute care~~ institution as defined in section 144.696, subdivision 3, 144.55, subdivision 3, or Minnesota Rules, part 4640.3600, and licensed pursuant to sections 144.50 to 144.58~~, which is appropriate if a person is technology dependent or has a chronic health condition which requires frequent intervention by a health care professional to avoid death~~. For purposes of this subdivision, a child requires a level of care provided in a hospital if the child is determined by the commissioner to need an extensive array of health services, including mental health services, for an undetermined period of time, whose health condition requires frequent monitoring and treatment by a health care professional or by a person supervised by a health care professional, who would reside in a hospital or require frequent hospitalization if these services were not provided, and the daily care needs are more complex than a nursing facility level of care.

A child with serious emotional disturbance requires a level of care provided in a hospital if the commissioner determines that the individual requires 24-hour supervision because the person exhibits recurrent or frequent suicidal or homicidal ideation or behavior, recurrent or frequent psychosomatic disorders or somatopsychic disorders that may become life threatening, recurrent or frequent severe socially unacceptable behavior associated with psychiatric disorder, ongoing and chronic psychosis or severe, ongoing and chronic developmental problems requiring continuous skilled observation, or severe disabling symptoms for which office-centered outpatient treatment is not adequate, and which overall severely impact the individual's ability to function.

(c) For purposes of this subdivision, "~~skilled~~ nursing facility" ~~and "intermediate care facility"~~ means a facility which provides nursing care as defined in section 144A.01, subdivision 5, licensed pursuant to sections 144A.02 to 144A.10, which is appropriate if a person is in active restorative treatment; is in need of special treatments provided or supervised by a licensed nurse; or has unpredictable episodes of active disease processes requiring immediate judgment by a licensed nurse. For purposes of this subdivision, a child requires the level of care provided in a nursing facility if the child is determined by the commissioner to meet the requirements of the preadmission screening assessment document under section 256B.0911 and the home care independent rating document under section 256B.0627, subdivision 5, paragraph (f), item (iii), adjusted to address age-appropriate standards for children age 18 and under, pursuant to section 256B.0627, subdivision 5, paragraph (d), clause (2).

(d) For purposes of this subdivision, "intermediate care facility for ~~the mentally retarded~~ persons with mental retardation or related conditions" or "ICF/

MR" means a program licensed to provide services to persons with mental retardation under section 252.28, and chapter 245A, and a physical plant licensed as a supervised living facility under chapter 144, which together are certified by the Minnesota department of health as meeting the standards in Code of Federal Regulations, title 42, part 483, for an intermediate care facility which provides services for persons with mental retardation or persons with related conditions who require 24-hour supervision and active treatment for medical, behavioral, or habilitation needs. For purposes of this subdivision, a child requires a level of care provided in an ICF/MR if the commissioner finds that the child has mental retardation or a related condition in accordance with section 256B.092, is in need of a 24-hour plan of care and active treatment similar to persons with mental retardation, and there is a reasonable indication that the child will need ICF/MR services.

(e) ~~For purposes of this subdivision, a person "requires a level of care provided in a hospital, skilled nursing facility, intermediate care facility, or intermediate care facility for persons with mental retardation or related conditions" if the person requires 24-hour supervision because the person exhibits suicidal or homicidal ideation or behavior, psychosomatic disorders or somatopsychic disorders that may become life threatening, severe socially unacceptable behavior associated with psychiatric disorder, psychosis or severe developmental problems requiring continuous skilled observation, or disabling symptoms that do not respond to office-centered outpatient treatment.~~ The determination of the level of care needed by the child shall be made by the commissioner based on information supplied to the commissioner by ~~the case manager if the child has one,~~ the parent or guardian, the child's physician or physicians ~~or, if available, the screening information obtained under section 256B.092,~~ and other professionals as requested by the commissioner. The commissioner shall establish a screening team to conduct the level of care determinations according to this subdivision.

(f) If a child meets the conditions in paragraph (b), (c), or (d), the commissioner must assess the case to determine whether:

(1) the child qualifies as a disabled individual under United States Code, title 42, section 1382c(a) and would be eligible for medical assistance if residing in a medical institution; and

(2) the cost of medical assistance services for the child, if eligible under this subdivision, would not be more than the cost to medical assistance if the child resides in a medical institution to be determined as follows:

(i) for a child who requires a level of care provided in an ICF/MR, the cost of care for the child in an institution shall be determined using the average payment rate established for the regional treatment centers that are certified as ICFs/MR;

(ii) for a child who requires a level of care provided in an inpatient hospital setting according to paragraph (b), cost-effectiveness shall be determined according to Minnesota Rules, part 9505.3520, items F and G; and

(iii) for a child who requires a level of care provided in a nursing facility according to paragraph (c), cost-effectiveness shall be determined according to Minnesota Rules, part 9505.3040, except that the nursing facility average rate shall be adjusted to reflect rates which would be paid for children under age 16. The commissioner may authorize an amount up to the amount medical assistance would pay for a child referred to the commissioner by the preadmission screening team under section 256B.0911.

(g) Children eligible for medical assistance services under section 256B.055, subdivision 12, as of June 30, 1995, must be screened according to the criteria in this subdivision prior to January 1, 1996. Children found to be ineligible may not be removed from the program until January 1, 1996.

Sec. 28. Minnesota Statutes 1994, section 256B.056, is amended by adding a subdivision to read:

Subd. 3b. **TREATMENT OF TRUSTS.** (a) A "medical assistance qualifying trust" is a revocable or irrevocable trust, or similar legal device, established on or before August 10, 1993, by a person or the person's spouse under the terms of which the person receives or could receive payments from the trust principal or income and the trustee has discretion in making payments to the person from the trust principal or income. Notwithstanding that definition, a medical assistance qualifying trust does not include: (1) a trust set up by will; (2) a trust set up before April 7, 1986, solely to benefit a person with mental retardation living in an intermediate care facility for persons with mental retardation; or (3) a trust set up by a person with payments made by the Social Security Administration pursuant to the United States Supreme Court decision in Sullivan v. Zebley, 110 S. Ct. 885 (1990). The maximum amount of payments that a trustee of a medical assistance qualifying trust may make to a person under the terms of the trust is considered to be available assets to the person, without regard to whether the trustee actually makes the maximum payments to the person and without regard to the purpose for which the medical assistance qualifying trust was established.

(b) Trusts established after August 10, 1993, are treated according to section 13611(b) of the Omnibus Budget Reconciliation Act of 1993 (OBRA), Public Law Number 103-66.

Sec. 29. Minnesota Statutes 1994, section 256B.056, subdivision 4, is amended to read:

Subd. 4. **INCOME.** To be eligible for medical assistance, a person must not have, or anticipate receiving, semiannual income in excess of 120 percent of the income standards by family size used in the aid to families with dependent children program, except that families and children may have an income up to 133-1/3 percent of the AFDC income standard. In computing income to determine eligibility of persons who are not residents of long-term care facilities, the commissioner shall disregard increases in income as required by Public Law Numbers 94-566, section 503; 99-272; and 99-509. Veterans aid and attendance benefits are considered income to the recipient.

Sec. 30. Minnesota Statutes 1994, 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 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 reparations payments made by the Netherlands for victims of Nazi persecution between 1940 and 1945; 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. 31. Minnesota Statutes 1994, section 256B.059, subdivision 1, is amended to read:

Subdivision 1. **DEFINITIONS.** (a) For purposes of this section, the terms defined in this subdivision have the meanings given them.

(b) "Community spouse" means the spouse of an institutionalized ~~person~~ spouse.

(c) "Spousal share" means one-half of the total value of all assets, to the extent that either the institutionalized spouse or the community spouse had an ownership interest at the time of institutionalization.

(d) "Assets otherwise available to the community spouse" means assets individually or jointly owned by the community spouse, other than assets excluded by subdivision 5, paragraph (c).

(e) "Community spouse asset allowance" is the value of assets that can be transferred under subdivision 3.

(f) "Institutionalized spouse" means a person who is:

(1) in a hospital, nursing facility, or intermediate care facility for persons with mental retardation, or receiving home and community-based services under section 256B.0915 or 256B.49, and is expected to remain in the facility or insti-

tution or receive the home and community-based services for at least 30 consecutive days; and

(2) married to a person who is not in a hospital, nursing facility, or intermediate care facility for persons with mental retardation, and is not receiving home and community-based services under section 256B.0915 or 256B.49.

Sec. 32. Minnesota Statutes 1994, section 256B.059, subdivision 3, is amended to read:

Subd. 3. **COMMUNITY SPOUSE ASSET ALLOWANCE.** 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 as follows:

(1) prior to July 1, 1994, the greater of:

(i) $14,148;

(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; and

(2) for persons ~~who begin~~ whose date of initial determination of eligibility for medical assistance following their first continuous period of institutionalization occurs 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, 1994, and every January 1 thereafter, the 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 limits in subdivision 5.

Sec. 33. Minnesota Statutes 1994, section 256B.059, subdivision 5, is amended to read:

Subd. 5. **ASSET AVAILABILITY.** (a) At the time of ~~application~~ initial determination of eligibility for medical assistance benefits following the first continuous period of institutionalization, 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 following:

(1) prior to July 1, 1994, the greater of:

(i) $14,148;

(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;

(2) for persons ~~who begin~~ whose date of initial determination of eligibility for medical assistance following their first continuous period of institutionalization occurs 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 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~~ paragraph (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~~ the supplemental security income program.

Sec. 34. Minnesota Statutes 1994, section 256B.0595, subdivision 1, is amended to read:

Subdivision 1. **PROHIBITED TRANSFERS.** (a) For transfers of assets made on or before August 10, 1993, if a person or the person's spouse has given away, sold, or disposed of, for less than fair market value, any asset or interest therein, except assets other than the homestead that are excluded under ~~section 256B.056, subdivision 3~~ the supplemental security program, within 30 months before or any time after the date of institutionalization if the person has been determined eligible for medical assistance, or within 30 months before or any time after the date of the first approved application for medical assistance if the person has not yet been determined eligible for medical assistance, the person is ineligible for long-term care services for the period of time determined under subdivision 2.

(b) Effective for transfers made ~~on or~~ after ~~July 1, 1993, or upon federal approval, whichever is later~~ August 10, 1993, a person, a person's spouse, or ~~a person's authorized representative~~ any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the person or person's spouse, may not give away, sell, or dispose of, for less than fair market value, any asset or interest therein, except assets other than the homestead that are excluded under the supplemental security income program, for the purpose of establishing or maintaining medical assistance eligibility. For purposes of determining eligibility for ~~medical assistance~~ long-term care services, any transfer of ~~an asset~~ such assets within ~~60~~ 36 months ~~preceding application~~ before or any time after an institutionalized person applies for medical assistance ~~or during the period of medical assistance eligibility, including assets excluded under section 256B.056, subdivision 3~~, or 36 months before or any time after a medical assistance recipient becomes institutionalized, for less than fair market value may be considered. Any such transfer ~~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~~ long-term care services for the period of time determined under subdivision 2, unless the person furnishes convincing evidence to establish that the transaction was exclusively for another purpose, or unless the transfer is permitted under ~~subdivisions~~ subdivision 3 or 4. Notwithstanding the provisions of this paragraph, in the case of payments from a trust or portions of a trust that are considered transfers of assets under federal law, any transfers made within 60 months before or any time after an institutionalized person applies for medical assistance and within 60 months before or any time after a medical assistance recipient becomes institutionalized, may be considered.

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

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

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

(e) This section applies to the portion of any asset or interest that a person ~~or~~, a person's spouse ~~transfers~~, or any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the person or the person's spouse, to ~~an irrevocable~~ any 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.

(f) For purposes of this section, long-term care services include services in a nursing facility, services that are eligible for payment according to section 256B.0625, subdivision 2, because they are provided in a swing bed, intermediate care facility for persons with mental retardation, and home and community-based services provided pursuant to ~~section 256B.491~~ sections 256B.0915, 256B.092, and 256B.49. For purposes of this subdivision and subdivisions 2, 3, and 4, "institutionalized person" includes a person who is an inpatient in a nursing facility, or in a swing bed, or intermediate care facility for persons with mental retardation or who is receiving home and community-based services under ~~section 256B.491~~ sections 256B.0915, 256B.092, and 256B.49.

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

made for the purpose of establishing or maintaining medical assistance eligibility and the person is ineligible for long-term care services for the period of time determined under subdivision 2, unless the person furnishes convincing evidence to establish that the transaction was exclusively for another purpose, or unless the transfer is permitted under subdivision 3 or 4.

Sec. 35. Minnesota Statutes 1994, section 256B.0595, subdivision 2, is amended to read:

Subd. 2. **PERIOD OF INELIGIBILITY.** (a) For any uncompensated transfer occurring on or before August 10, 1993, the number of months of ineligibility for long-term care services shall be the lesser of 30 months, or the uncompensated transfer amount divided by the average medical assistance rate for nursing facility services in the state in effect on the date of application. The amount used to calculate the average medical assistance payment rate shall be adjusted each July 1 to reflect payment rates for the previous calendar year. The period of ineligibility begins with the month in which the assets were transferred. If the transfer was not reported to the local agency at the time of application, and the applicant received long-term care services during what would have been the period of ineligibility if the transfer had been reported, a cause of action exists against the transferee for the cost of long-term care services provided during the period of ineligibility, or for the uncompensated amount of the transfer, whichever is less. The action may be brought by the state or the local agency responsible for providing medical assistance under chapter 256G. The uncompensated transfer amount is the fair market value of the asset at the time it was given away, sold, or disposed of, less the amount of compensation received.

(b) For uncompensated transfers made ~~on or~~ after ~~July 1,~~ August 10, 1993, ~~or upon federal approval, whichever is later,~~ the number of months of ineligibility~~, including partial months,~~ for ~~medical assistance~~ long-term care services shall be the total uncompensated value of the resources transferred divided by the average medical assistance rate for nursing facility services in the state in effect on the date of application. ~~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.~~ If a calculation of a penalty period results in a partial month, payments for long-term care services shall be reduced in an amount equal to the fraction, except that in calculating the value of uncompensated transfers, if the total value of all uncompensated transfers made in a month does not exceed $1,000, then such transfers shall be disregarded for each month prior to the month of application for or during receipt of medical assistance.

Sec. 36. Minnesota Statutes 1994, section 256B.0595, subdivision 3, is amended to read:

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:

(1) 30 months of ~~the~~ a transfer made on or before August 10, 1993;

(2) 60 months if the homestead was transferred after August 10, 1993, to a trust or portion of a trust that is considered a transfer of assets under federal law; or

(3) 36 months if transferred in any other manner after August 10, 1993,

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.~~

Sec. 37. Minnesota Statutes 1994, section 256B.0595, subdivision 4, is amended to read:

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~~ individual's spouse~~, as defined in section 256B.059~~ or to another for the sole benefit of the spouse; 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 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:

(i) 30 months of ~~the~~ a transfer made on or before August 10, 1993;

(ii) 60 months of a transfer if the assets were transferred after August 30, 1993, to a trust or portion of a trust that is considered a transfer of assets under federal law; or

(iii) 36 months of a transfer if transferred in any other manner after August 10, 1993,

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~~.~~; or

(6) for transfers occurring after August 10, 1993, the assets were transferred

by the person or person's spouse: (i) into a trust established solely for the benefit of a son or daughter of any age who is blind or disabled as defined by the Supplemental Security Income program; or (ii) into a trust established solely for the benefit of an individual who is under 65 years of age who is disabled as defined by the Supplemental Security Income program.

~~(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.~~

Sec. 38. Minnesota Statutes 1994, section 256B.06, subdivision 4, is amended to read:

Subd. 4. **CITIZENSHIP REQUIREMENTS.** Eligibility for medical assistance is limited to citizens of the United States and aliens lawfully admitted for permanent residence or otherwise permanently residing in the United States under the color of law. Aliens who are seeking legalization under the Immigration Reform and Control Act of 1986, Public Law Number 99-603, who are under age 18, over age 65, blind, disabled, or Cuban or Haitian, and who meet the eligibility requirements of medical assistance under subdivision 1 and sections 256B.055 to 256B.062 are eligible to receive medical assistance. Pregnant women who are aliens seeking legalization under the Immigration Reform and Control Act of 1986, Public Law Number 99-603, and who meet the eligibility

requirements of medical assistance under subdivision 1 are eligible for payment of care and services through the period of pregnancy and six weeks postpartum. Payment shall also be made for care and services that are furnished to an alien, regardless of immigration status, who otherwise meets the eligibility requirements of this section if such care and services are necessary for the treatment of an emergency medical condition, except for organ transplants and related care and services. For purposes of this subdivision, the term "emergency medical condition" means a medical condition, including labor and delivery, that if not immediately treated could cause a person physical or mental disability, continuation of severe pain, or death.

Sec. 39. Minnesota Statutes 1994, section 256B.0625, subdivision 5, is amended to read:

Subd. 5. **COMMUNITY MENTAL HEALTH CENTER SERVICES.** Medical assistance covers community mental health center services~~, as defined in rules adopted by the commissioner pursuant to section 256B.04, subdivision 2, and~~ provided by a community mental health center ~~as defined in section 245.62, subdivision 2~~ that meets the requirements in paragraphs (a) to (j).

(a) The provider is licensed under Minnesota Rules, parts 9520.0750 to 9520.0870.

(b) The provider provides mental health services under the clinical supervision of a mental health professional who is licensed for independent practice at the doctoral level or by a board-certified psychiatrist or a psychiatrist who is eligible for board certification. Clinical supervision has the meaning given in Minnesota Rules, part 9505.0323, subpart 1, item F.

(c) The provider must be a private nonprofit corporation or a governmental agency and have a community board of directors as specified by section 245.66.

(d) The provider must have a sliding fee scale that meets the requirements in Minnesota Rules, part 9550.0060, and agree to serve within the limits of its capacity all individuals residing in its service delivery area.

(e) At a minimum, the provider must provide the following outpatient mental health services: diagnostic assessment; explanation of findings; family, group, and individual psychotherapy, including crisis intervention psychotherapy services, multiple family group psychotherapy, psychological testing, and medication management. In addition, the provider must provide or be capable of providing upon request of the local mental health authority day treatment services and professional home-based mental health services. The provider must have the capacity to provide such services to specialized populations such as the elderly, families with children, persons who are seriously and persistently mentally ill, and children who are seriously emotionally disturbed.

(f) The provider must be capable of providing the services specified in paragraph (e) to individuals who are diagnosed with both mental illness or emotional

disturbance, and chemical dependency, and to individuals dually diagnosed with a mental illness or emotional disturbance and mental retardation or a related condition.

(g) The provider must provide 24-hour emergency care services or demonstrate the capacity to assist recipients in need of such services to access such services on a 24-hour basis.

(h) The provider must have a contract with the local mental health authority to provide one or more of the services specified in paragraph (e).

(i) The provider must agree, upon request of the local mental health authority, to enter into a contract with the county to provide mental health services not reimbursable under the medical assistance program.

(j) The provider may not be enrolled with the medical assistance program as both a hospital and a community mental health center. The community mental health center's administrative, organizational, and financial structure must be separate and distinct from that of the hospital.

Sec. 40. Minnesota Statutes 1994, section 256B.0625, subdivision 8, is amended to read:

Subd. 8. **PHYSICAL THERAPY.** Medical assistance covers physical therapy and related services. 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.

Sec. 41. Minnesota Statutes 1994, section 256B.0625, subdivision 8a, is amended to read:

Subd. 8a. **OCCUPATIONAL THERAPY.** Medical assistance covers occupational therapy and related services. 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 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.

Sec. 42. Minnesota Statutes 1994, 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, or by a

physician or a nurse practitioner employed by or under contract with a community health board as defined in section 145A.02, subdivision 5, for the purposes of communicable disease control. The commissioner, after receiving recommendations from professional medical associations and professional pharmacist associations, shall designate a formulary committee to advise the commissioner on the names of drugs for which payment is made, recommend a system for reimbursing providers on a set fee or charge basis rather than the present system, and develop methods encouraging use of generic drugs when they are less expensive and equally effective as trademark drugs. The formulary committee shall consist of nine members, four of whom shall be physicians who are not employed by the department of human services, and a majority of whose practice is for persons paying privately or through health insurance, three of whom shall be pharmacists who are not employed by the department of human services, and a majority of whose practice is for persons paying privately or through health insurance, a consumer representative, and a nursing home representative. Committee members shall serve three-year terms and shall serve without compensation. Members may be reappointed once.

(b) The commissioner shall establish a drug formulary. Its establishment and publication shall not be subject to the requirements of the administrative procedure act, but the formulary committee shall review and comment on the formulary contents. The formulary committee shall review and recommend drugs which require prior authorization. The formulary committee may recommend drugs for prior authorization directly to the commissioner, as long as opportunity for public input is provided. Prior authorization may be requested by the commissioner based on medical and clinical criteria before certain drugs are eligible for payment. Before a drug may be considered for prior authorization at the request of the commissioner:

(1) the drug formulary committee must develop criteria to be used for identifying drugs; the development of these criteria is not subject to the requirements of chapter 14, but the formulary committee shall provide opportunity for public input in developing criteria;

(2) the drug formulary committee must hold a public forum and receive public comment for an additional 15 days; and

(3) the commissioner must provide information to the formulary committee on the impact that placing the drug on prior authorization will have on the quality of patient care and information regarding whether the drug is subject to clinical abuse or misuse. Prior authorization may be required by the commissioner before certain formulary drugs are eligible for payment. The formulary shall not include:

(i) drugs or products for which there is no federal funding;

(ii) over-the-counter drugs, except for antacids, acetaminophen, family planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults with documented vitamin deficiencies, and vitamins for children under the age of seven and pregnant or nursing women;

(iii) 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;

(iv) anorectics; and

(v) drugs for which medical value has not been established.

The commissioner shall publish conditions for prohibiting payment for specific drugs after considering the formulary committee's recommendations.

(c) The basis for determining the amount of payment shall be the lower of the actual acquisition costs of the drugs plus a fixed dispensing fee ~~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. The pharmacy dispensing fee shall be $3.85. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. The actual acquisition cost of a drug shall be estimated by the commissioner, at average wholesale price minus ~~7.6~~ nine percent effective January 1, 1994. 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.~~

~~(d) Until the date the on-line, real-time Medicaid Management Information~~

~~System (MMIS) upgrade is successfully implemented, as determined by the commissioner of administration, a pharmacy provider may require individuals who seek to become eligible for medical assistance under a one-month spenddown, as provided in section 256B.056, subdivision 5, to pay for services to the extent of the spenddown 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 spenddown of (1) their right to appeal the denial of services on the grounds that they have satisfied the spenddown requirement, and (2) their potential eligibility for the MinnesotaCare program or the children's health plan.~~

Sec. 43. Minnesota Statutes 1994, section 256B.0625, subdivision 13a, is amended to read:

Subd. 13a. **DRUG UTILIZATION REVIEW BOARD.** A ~~12-member~~ nine-member drug utilization review board is established. The board is comprised of ~~six~~ at least three but no more than four licensed physicians actively engaged in the practice of medicine in Minnesota; ~~five~~ at least three licensed pharmacists actively engaged in the practice of pharmacy in Minnesota; and one consumer representative; the remainder to be made up of health care professionals who are licensed in their field and have recognized knowledge in the clinically appropriate prescribing, dispensing, and monitoring of covered outpatient drugs. The board shall be staffed by an employee of the department who shall serve as an ex officio nonvoting member of the board. The members of the board shall be appointed by the commissioner and shall serve three-year terms. The ~~physician~~ members shall be selected from lists submitted by professional ~~medical~~ associations. ~~The pharmacist members shall be selected from lists submitted by professional pharmacist associations.~~ The commissioner shall appoint the initial members of the board for terms expiring as follows: ~~four~~ three members for terms expiring June 30, ~~1995~~ 1996; ~~four~~ three members for terms expiring June 30, ~~1994~~ 1997; and ~~four~~ three members for terms expiring June 30, ~~1993~~ 1998. Members may be reappointed once. The board shall annually elect a chair from among the members.

The commissioner shall, with the advice of the board:

(1) implement a medical assistance retrospective and prospective drug utilization review program as required by United States Code, title 42, section 1396r-8(g)(3);

(2) develop and implement the predetermined criteria and practice parameters for appropriate prescribing to be used in retrospective and prospective drug utilization review;

(3) develop, select, implement, and assess interventions for physicians, pharmacists, and patients that are educational and not punitive in nature;

(4) establish a grievance and appeals process for physicians and pharmacists under this section;

(5) publish and disseminate educational information to physicians and pharmacists regarding the board and the review program;

(6) adopt and implement procedures designed to ensure the confidentiality of any information collected, stored, retrieved, assessed, or analyzed by the board, staff to the board, or contractors to the review program that identifies individual physicians, pharmacists, or recipients;

(7) establish and implement an ongoing process to (i) receive public comment regarding drug utilization review criteria and standards, and (ii) consider the comments along with other scientific and clinical information in order to revise criteria and standards on a timely basis; and

(8) adopt any rules necessary to carry out this section.

The board may establish advisory committees. The commissioner may contract with appropriate organizations to assist the board in carrying out the board's duties. The commissioner may enter into contracts for services to develop and implement a retrospective and prospective review program.

The board shall report to the commissioner annually on ~~December 1~~ the date the Drug Utilization Review Annual Report is due to the Health Care Financing Administration. This report is to cover the preceding federal fiscal year. The commissioner shall make the report available to the public upon request. The report must include information on the activities of the board and the program; the effectiveness of implemented interventions; administrative costs; and any fiscal impact resulting from the program. An honorarium of $50 per meeting shall be paid to each board member in attendance.

Sec. 44. Minnesota Statutes 1994, section 256B.0625, is amended by adding a subdivision to read:

Subd. 13b. **PHARMACY COPAYMENT REQUIREMENTS.** A copayment of $1 per prescription shall be required under the medical assistance and general assistance medical care programs according to paragraphs (a) to (d):

(a) A copayment shall not be required of children, pregnant women through the postpartum period, recipients whose only available income is a personal needs allowance in the amount established under section 256B.35 or 256B.36, recipients residing in a setting which receives funding under sections 256I.01 to 256I.06, or institutionalized recipients or, under medical assistance only, from any other persons required to be exempted under federal law;

(b) A copayment shall not be required for family planning services or supplies, psychotropic drugs or emergency services;

(c) A provider may not deny a prescription to a recipient because the recipient is unable to pay the copayment;

(d) A lower copayment shall be collected, under medical assistance only, up to the maximum permitted by federal law, for prescriptions on which federal law prohibits a $1 copayment;

(e) The amount of the copayment under this subdivision shall be subtracted from the payment under subdivision 13; and

(f) This subdivision does not apply to services under the MinnesotaCare program.

Sec. 45. Minnesota Statutes 1994, section 256B.0625, subdivision 17, is amended to read:

Subd. 17. **TRANSPORTATION COSTS.** (a) Medical assistance covers transportation costs incurred solely for obtaining emergency medical care or transportation costs incurred by nonambulatory persons in obtaining emergency or nonemergency medical care when paid directly to an ambulance company, common carrier, or other recognized providers of transportation services. For the purpose of this subdivision, a person who is incapable of transport by taxicab or bus shall be considered to be nonambulatory.

(b) Medical assistance covers special transportation, as defined in Minnesota Rules, part 9505.0315, subpart 1, item F, if the provider receives and maintains a current physician's order by the recipient's attending physician certifying that the recipient is so mentally or physically impaired as to be unable to safely access and use a bus, taxi, other commercial transportation, or private automobile. 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 $14 for the base rate and $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. 46. Minnesota Statutes 1994, section 256B.0625, subdivision 18, is amended to read:

Subd. 18. **BUS OR TAXICAB TRANSPORTATION.** To the extent authorized by rule of the state agency, medical assistance covers costs of ~~bus or taxicab~~ the most appropriate and cost-effective form of transportation incurred by any ambulatory eligible person for obtaining nonemergency medical care.

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

Sec. 47. Minnesota Statutes 1994, section 256B.0625, is amended by adding a subdivision to read:

Subd. 18a. **PAYMENT FOR MEALS AND LODGING.** (a) Medical assistance reimbursement for meals for persons traveling to receive medical care may not exceed $5.50 for breakfast, $6.50 for lunch, or $8 for dinner.

(b) Medical assistance reimbursement for lodging for persons traveling to receive medical care may not exceed $50 per day unless prior authorized by the local agency.

(c) Medical assistance direct mileage reimbursement to the eligible person or the eligible person's driver may not exceed 20 cents per mile.

Sec. 48. Minnesota Statutes 1994, section 256B.0625, subdivision 19a, is amended to read:

Subd. 19a. **PERSONAL CARE SERVICES.** Medical assistance covers personal care services in a recipient's home. To qualify for personal care services recipients ~~who can direct their own care, or persons who cannot direct their own care when authorized by the responsible party, may use~~ must be able to identify their needs, direct and evaluate task accomplishment, and assure their health and safety. Approved hours may be used outside the home when normal life activities take them outside the home and when, without the provision of personal care, their health and safety would be jeopardized. Total hours for services, whether actually performed inside or outside the recipient's home, cannot exceed that which is otherwise allowed for personal care services in an in-home setting according to section 256B.0627. Medical assistance does not cover personal care services for residents of a hospital, nursing facility, intermediate care facility, health care facility licensed by the commissioner of health, or unless a resident who is otherwise eligible is on leave from the facility and the facility either pays for the personal care services or forgoes the facility per diem for the leave days that personal care services are used ~~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 or legal guardian 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 not the recipient's legal guardian and are granted a waiver under section 256B.0627.

Sec. 49. Minnesota Statutes 1994, section 256B.0625, is amended by adding a subdivision to read:

Subd. 38. **PAYMENTS FOR MENTAL HEALTH SERVICES.** Payments for mental health services covered under the medical assistance program that are provided by masters-prepared mental health professionals shall be 80 percent of the rate paid to doctoral-prepared professionals. Payments for mental health services covered under the medical assistance program that are provided by masters-prepared mental health professionals employed by community mental health centers shall be 100 percent of the rate paid to doctoral-prepared professionals.

Sec. 50. Minnesota Statutes 1994, section 256B.0625, is amended by adding a subdivision to read:

Subd. 39. **CHILDHOOD IMMUNIZATIONS.** Providers who administer pediatric vaccines within the scope of their licensure, and who are enrolled as a medical assistance provider, must enroll in the pediatric vaccine administration program established by section 13631 of the Omnibus Budget Reconciliation Act of 1993. Medical assistance shall pay an $8.50 fee per dose for administration of the vaccine to children eligible for medical assistance. Medical assistance does not pay for vaccines that are available at no cost from the pediatric vaccine administration program.

Sec. 51. Minnesota Statutes 1994, section 256B.0625, is amended by adding a subdivision to read:

Subd. 40. **TUBERCULOSIS RELATED SERVICES.** (a) For persons infected with tuberculosis, medical assistance covers case management services and direct observation of the intake of drugs prescribed to treat tuberculosis.

(b) "Case management services" means services furnished to assist persons infected with tuberculosis in gaining access to needed medical services. Case management services include at a minimum:

(1) assessing a person's need for medical services to treat tuberculosis;

(2) developing a care plan that addresses the needs identified in clause (1);

(3) assisting the person in accessing medical services identified in the care plan; and

(4) monitoring the person's compliance with the care plan to ensure completion of tuberculosis therapy. Medical assistance covers case management services under this subdivision only if the services are provided by a certified public health nurse who is employed by a community health board as defined in section 145A.02, subdivision 5.

(c) To be covered by medical assistance, direct observation of the intake of drugs prescribed to treat tuberculosis must be provided by a community outreach worker, licensed practical nurse, registered nurse who is trained and supervised by a public health nurse employed by a community health board as defined in section 145A.02, subdivision 5, or a public health nurse employed by a community health board.

Sec. 52. Minnesota Statutes 1994, 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) "Assessment" means a review and evaluation of a recipient's need for home care services conducted in person. Assessments for private duty nursing shall be conducted by a private duty nurse. Assessments for home health agency services shall be conducted by a home health agency nurse. Assessments for personal care services shall be conducted by the county public health nurse or a certified public health nurse under contract with the county. Assessments must be completed on forms provided by the commissioner within 30 days of a request for home care services by a recipient or responsible party.

~~(c) "Care plan"~~ (d) "Service plan" means a written description of the services needed ~~which is~~ based on the assessment developed by the ~~supervisory~~ nurse who conducts the assessment together with the recipient ~~or responsible party and includes a detailed.~~ The service plan shall include a description of the covered home care services, ~~who is providing the services,~~ frequency and duration of services, and expected outcomes and goals. The ~~provider must give the recipient or responsible party~~ recipient and the provider chosen by the recipient or responsible party must be given a copy of the completed ~~care~~ service plan within 30 calendar days ~~of beginning home care services.~~ of the request for home care services by the recipient or responsible party.

(e) "Care plan" means a written description of personal care assistant services developed by the agency nurse with the recipient or responsible party to be used by the personal care assistant with a copy provided to the recipient or responsible party.

~~(d) "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.~~

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

~~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.~~ (f) "Personal care assistant" means a person who: (1) is at least 18 years old; (2) is able to read, write, and speak English, or communicate with sign language, as well as communicate with the recipient; (3) effective July 1, 1996, has completed one of the training requirements as specified in Minnesota Rules, part 9505.0335, subpart 3, items A to D; (4) has the ability to, and provides covered personal care services according to the recipient's care plan; (5) is not a consumer of personal care services; and (6) is subject to criminal background checks. An individual who has ever been convicted of a crime specified in Minnesota Rules, part 4668.0020, subpart 14, or a comparable crime in another jurisdiction is disqualified from being a personal care assistant.

(g) "Personal care provider organization" means an organization enrolled to provide personal care services under the medical assistance program that complies with the following: (1) owners who have a five percent interest or more are subject to a criminal history check as provided in section 245A.04 at the time of application. An organization will be barred from enrollment if an owner or managerial official of the organization has ever been convicted of a crime specified in Minnesota Rules, part 4668.0020, subpart 14, or a comparable crime in another jurisdiction; (2) the organization must maintain a surety bond and liability insurance throughout the duration of enrollment and provides proof thereof. The insurer must notify the department of human services of the cancellation or lapse of policy; and (3) the organization must maintain documentation of services as specified in Minnesota Rules, part 9505.2175, subpart 7, as well as evidence of compliance with personal care assistant training requirements.

Sec. 53. Minnesota Statutes 1994, section 256B.0627, subdivision 2, is amended to read:

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

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

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

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

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

(5) nursing supervision of personal care services under section 256B.0625, subdivision 19a; and

(6) assessments by county public health nurses for services under section 256B.0625, subdivision 19a.

Sec. 54. Minnesota Statutes 1994, 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~~ repetitive maintenance range of motion and muscle strengthening exercises specific to maintaining a recipient's optimal level of function;

(4) respiratory assistance;

(5) transfers and ambulation:

(6) bathing, grooming, and hairwashing necessary for personal hygiene;

(7) turning and positioning;

(8) assistance with furnishing medication that is ~~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~~ eating and meal preparation and necessary grocery shopping;

(13) accompanying a recipient to obtain medical diagnosis or treatment; and

(14) ~~assisting, monitoring, or prompting the recipient to complete the services in clauses (1) to (13);~~

~~(15) redirection, monitoring, and observation that are medically necessary and an integral part of completing the personal 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~~

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

~~(18)~~ incidental household services that are an integral part of a personal care service described in clauses (1) to ~~(17)~~ (13).

~~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~~ ordered by the physician;

(2) assessments by personal care provider organizations or by independently enrolled registered nurses;

(3) services that are not ~~supervised by the registered nurse~~ in the service plan;

~~(3)~~ (4) services provided by the recipient's spouse, legal guardian for an adult or child recipient, or parent of a ~~minor child~~ recipient under age 18;

~~(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;

(7) sterile procedures;

(8) injections of fluids into veins, muscles, or skin;

(9) services provided by parents of adult recipients, adult children~~,~~ or adult siblings of the recipient, unless these relatives meet one of the following hardship criteria and the commissioner waives this requirement:

(i) the relative resigns from a part-time or full-time job to provide personal care for the recipient;

(ii) the relative goes from a full-time to a part-time job with less compensation to provide personal care for the recipient;

(iii) the relative takes a leave of absence without pay to provide personal care for the recipient;

(iv) the relative incurs substantial expenses by providing personal care for the recipient; or

(v) because of labor conditions, the relative is needed in order to provide an adequate number of qualified personal care assistants to meet the medical needs of the recipient;

(10) homemaker services that are not an integral part of a personal care services; ~~and~~

(11) home maintenance, or chore services;

(12) services not specified under paragraph (a); and

(13) services not authorized by the commissioner or the commissioner's designee.

Sec. 55. Minnesota Statutes 1994, 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) ~~up to two assessments by a supervising registered nurse~~ assessments and reassessments done 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)~~ (b) **PRIOR AUTHORIZATION; EXCEPTIONS.** All home care services above the limits in paragraph ~~(b)~~ (a) must receive the commissioner's prior authorization, except when:

(1) the home care services were required to treat an emergency medical condition that if not immediately treated could cause a recipient serious physical or mental disability, continuation of severe pain, or death. The provider must request retroactive authorization no later than five working days after giving the

initial service. The provider must be able to substantiate the emergency by documentation such as reports, notes, and admission or discharge histories;

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

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

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

~~(d)~~ (c) **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.~~

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

(1) The amount and type of service authorized based upon the assessment and service plan will follow the recipient if the recipient chooses to change providers.

(2) If the recipient's medical need changes, the recipient's provider may assess the need for a change in service authorization and request the change from the county public health nurse. Within 30 days of the request, the public health nurse will determine whether to request the change in services based upon the provider assessment, or conduct a home visit to assess the need and determine whether the change is appropriate.

(3) To continue to receive ~~home~~ personal care services when the recipient displays no significant change, the ~~supervising nurse~~ county public health nurse has the option to review with the commissioner, or the commissioner's designee, the ~~care~~ service plan on record and receive authorization for up to an additional 12 months.

~~(f)~~ (e) **PRIOR AUTHORIZATION.** The commissioner, or the commissioner's designee, shall review the assessment, the ~~care~~ service plan, and any additional information that is submitted. The commissioner shall, within 30 days after receiving a complete request, assessment, and ~~care~~ service 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)~~ (a) must be prior authorized by the commissioner or the commissioner's designee. Prior authorization must be based on medical necessity and cost-effectiveness when compared with other care options. When home health services are used in combination with personal care and private duty nursing, the cost of all home care services shall be considered for cost-effectiveness. The commissioner shall limit nurse and home health aide visits to no more than one visit each per day.

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

(A) up to ~~two~~ 1.75 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~~ 2.625 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 but in no case shall the dollar amount authorized exceed the statewide weighted average nursing facility payment rate for fiscal year 1995; 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 Level I behavior; or~~

~~(D)~~ up to the amount the commissioner would pay, as of July 1, 1991, plus any inflation adjustment provided for home care services, for care provided in a

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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)~~ (D) 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)~~ (E) 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 report submitted to the department by nursing facilities. The average number of direct care hours, ~~as established by May 1, 1992~~ for the report year 1993, as established by July 11, 1994, shall be calculated and incorporated into the home care limits on July 1, ~~1992~~ 1996. These limits shall be calculated to the nearest quarter hour.

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

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

(A) daily tube feedings;

(B) daily parenteral therapy;

(C) wound or decubiti care;

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

(E) catheterization;

(F) ostomy care;

(G) quadriplegia; or

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

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

~~(A) injury to his or her own body;~~

~~(B) physical injury to other people; or~~

~~(C) destruction of property.~~

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

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

~~(A) unusual or repetitive habits;~~

~~(B) withdrawn behavior; or~~

~~(C) offensive behavior.~~

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

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

(i) the recipient requires more individual and continuous care than can be provided during a nurse visit; or

(ii) the cares are outside of the scope of services that can be provided by a home health aide or personal care assistant.

The commissioner may authorize:

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

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

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

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

(4) **VENTILATOR-DEPENDENT RECIPIENTS.** If the recipient is ventilator-dependent, the monthly medical assistance authorization for home care services shall not exceed what the commissioner would pay for care at the highest cost hospital designated as a long-term hospital under the Medicare program. For purposes of this clause, home care services means all services provided in the home that would be included in the payment for care at the long-term hospital. "Ventilator-dependent" means an individual who receives mechanical ventilation for life support at least six hours per day and is expected to be or has been dependent for at least 30 consecutive days.

~~(g)~~ (f) **PRIOR AUTHORIZATION; TIME LIMITS.** The commissioner or the commissioner's designee shall determine the time period for which a prior authorization shall be effective. If the recipient continues to require home care services beyond the duration of the prior authorization, the home care provider must request a new prior authorization ~~through the process described above~~. Under no circumstances, other than the exceptions in ~~subdivision 5,~~ paragraph ~~(e)~~ (b), shall a prior authorization be valid prior to the date the commissioner receives the request or for more than 12 months. A recipient who appeals a reduction in previously authorized home care services may continue previously authorized services, other than temporary services under paragraph ~~(i)~~ (h), pending an appeal under section 256.045. The commissioner must provide a detailed

explanation of why the authorized services are reduced in amount from those requested by the home care provider.

~~(h)~~ (g) **APPROVAL OF HOME CARE SERVICES.** The commissioner or the commissioner's designee shall determine the medical necessity of home care services, the level of caregiver according to subdivision 2, and the institutional comparison according to this subdivision, the cost-effectiveness of services, and the amount, scope, and duration of home care services reimbursable by medical assistance, based on the assessment, 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)~~ (h) **PRIOR AUTHORIZATION REQUESTS; TEMPORARY SERVICES.** ~~Providers~~ The agency nurse, the independently enrolled private duty nurse, or county public health nurse may request a temporary authorization for home care services by telephone. The commissioner may approve a temporary level of home care services based on the assessment and service or care plan information ~~provided by an appropriately licensed nurse~~. Authorization for a temporary level of home care services including nurse supervision is limited to the time specified by the commissioner, but shall not exceed 45 days, unless extended because the county public health nurse has not completed the required assessment and service plan, or the commissioner's determination has not been made. The level of services authorized under this provision shall have no bearing on a future prior authorization.

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

The commissioner may not authorize:

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

(2) ~~personal care services when the foster care license holder is also the personal care provider or personal care assistant unless the recipient can direct the recipient's own care, or case management is provided as required in section 256B.0625, subdivision 19a;~~

~~(3) personal care services when the responsible party is an employee of, or under contract with, or has any direct or indirect financial relationship with the personal care provider or personal care assistant, unless case management is provided as required in section 256B.0625, subdivision 19a;~~

~~(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 pro-~~

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

~~vided, and case management is provided as required in section 256B.0625, subdivision 19a~~; or

~~(5)~~ (3) 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. 56. Minnesota Statutes 1994, section 256B.0628, subdivision 2, is amended to read:

Subd. 2. **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 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~~ service 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 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 commissioner or the commissioner's designee may:

(1) review ~~care~~ service 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 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. 57. Minnesota Statutes 1994, 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 located within the state of Minnesota;

(3) individuals who have a contractual right to have their nursing facility care paid for indefinitely by the veteran's administration; ~~or~~

(4) individuals who are enrolled in the Ebenezer/Group Health social health maintenance organization project, or enrolled in a demonstration project under section 256B.69, subdivision 18, at the time of application to a nursing home; or

(5) individuals previously screened and currently being served under the alternative care program or under a home and community-based services waiver authorized under section 1915(c) of the Social Security Act.

Regardless of the exemptions in clauses (2) to (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.

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. 58. Minnesota Statutes 1994, section 256B.0911, subdivision 2a, is amended 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. The screener shall confer with the screening team to ensure that the health and social needs of the individual are assessed. 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. 59. Minnesota Statutes 1994, 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 board of commissioners. Each local screening team shall 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. The screening team members must confer regarding the most appropriate care for each individual screened. Two or more counties may collaborate to establish a joint local screening team or teams.

(b) In assessing a person's needs, screeners shall have a physician available for consultation and shall consider the assessment of the individual's attending physician, if any. The individual's physician shall be included if the physician chooses to participate. Other personnel may be included on the team as deemed appropriate by the county agencies.

Sec. 60. Minnesota Statutes 1994, section 256B.0911, subdivision 4, is amended to read:

Subd. 4. **RESPONSIBILITIES OF THE COUNTY AND THE SCREENING TEAM.** (a) The county 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 specialized service needs 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.

(b) The 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.

(c) Screeners shall adhere to the level of care criteria for admission to a certified nursing facility established under section 144.0721.

(d) 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 a screener or the case manager in the discharge planning process for those individuals who the team has

determined have discharge potential. The screener or the case manager must ensure a smooth transition and follow-up for the individual's return to the community.

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 screeners shall encourage the use of volunteers from families, religious organizations, social clubs, and similar civic and service organizations to provide services.

Sec. 61. Minnesota Statutes 1994, section 256B.0911, subdivision 7, is amended to read:

Subd. 7. **REIMBURSEMENT FOR CERTIFIED NURSING FACILITIES.** (a) Medical assistance reimbursement for nursing facilities shall be authorized for a medical assistance recipient only if a preadmission screening has been conducted prior to admission or the local county agency has authorized an exemption. Medical assistance reimbursement for nursing facilities shall not be provided for any recipient who the local screener has determined does not meet the level of care criteria for nursing facility placement or, if indicated, has not had a level II PASARR 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 county preadmission screening team may deny certified nursing facility admission using the level of care criteria established under section 144.0721 and deny medical assistance reimbursement for certified nursing facility care. Persons receiving care in a certified nursing facility or certified boarding care home who are reassessed and no longer meet the level of care criteria for a certified nursing facility or certified boarding care home may no longer remain a resident in the certified nursing facility or certified boarding care home and must be relocated to the community if the persons were admitted on or after July 1, 1996. Persons receiving services under section 256B.0913, subdivisions 1 to 14, or 256B.0915 who are reassessed and found to not meet the level of care criteria for admission to a certified nursing facility or certified boarding care home may no longer receive these services after July 1, 1996. 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).

(b) The local county mental health authority or the state mental retardation authority under Public Law Numbers 100-203 and 101-508 may prohibit admission to a nursing facility, if the individual does not meet the nursing facility level of care criteria or needs specialized services as defined in Public Law Numbers 100-203 and 101-508. For purposes of this section, "specialized services" for a person with mental retardation or a related condition means "active treat-

ment" 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. **[256B.0912] ALTERNATIVE CARE AND WAIVERED SERVICE PROGRAMS.**

Subdivision 1. **RESTRUCTURING PLAN.** By January 1, 1996, the commissioner shall present a plan to the legislature to restructure administration of the alternative care, elderly waiver, and disabled waiver programs. The plan must demonstrate cost neutrality and provide counties with the flexibility, authority, and accountability to administer home and community-based service programs within predetermined fixed budgets. To support this local program administration, the commissioner shall explore options with the health care financing administration to assure flexibility to expand core services within the elderly and disabled waivers as long as cost neutrality is maintained.

Subd. 2. **WAIVER PROGRAM MODIFICATIONS.** The commissioner of human services shall make the following modifications in medical assistance waiver programs, effective for services rendered after June 30, 1995, or, if necessary, after federal approval is granted:

(a) The community alternatives for disabled individuals waiver shall:

(1) if medical supplies and equipment or adaptations are or will be purchased for a waiver services recipient, allow the prorating of costs on a monthly basis throughout the year in which they are purchased. If the monthly cost of a recipient's other waivered services exceeds the monthly limit established in this paragraph, the annual cost of the waivered services shall be determined. In this event, the annual cost of waivered services shall not exceed 12 times the monthly limit calculated in this paragraph;

(2) require client reassessments once every 12 months;

(3) permit the purchase of supplies and equipment costing $150 or less without prior approval of the commissioner of human services. A county is not required to contract with a provider of supplies and equipment if the monthly cost of supplies and equipment is less than $250; and

(4) allow the implementation of care plans without the approval of the county of financial responsibility when the client receives services from another county.

(b) The traumatic brain injury waiver shall:

(1) require client reassessments once every 12 months;

(2) permit the purchase of supplies and equipment costing $250 or less without having a contract with the supplier; and

(3) allow the implementation of care plans without the approval of the county of financial responsibility when the client receives services from another county.

Sec. 63. Minnesota Statutes 1994, section 256B.0913, subdivision 4, is amended to read:

Subd. 4. **ELIGIBILITY FOR FUNDING FOR SERVICES FOR NONMEDICAL ASSISTANCE RECIPIENTS.** (a) Funding for services under the alternative care program is available to persons who meet the following criteria:

(1) the person has been screened by the county screening team or, if previously screened and served under the alternative care program, assessed by the local county social worker or public health nurse;

(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;

(6) the person needs services that are not available at that time in the county through other county, state, or federal funding sources; and

(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. If medical supplies and equipment or adaptations are or will be purchased for an alternative care services recipient, the costs may

be prorated on a monthly basis throughout the year in which they are purchased. If the monthly cost of a recipient's other alternative care services exceeds the monthly limit established in this paragraph, the annual cost of the alternative care services shall be determined. In this event, the annual cost of alternative care services shall not exceed 12 times the monthly limit calculated in this paragraph.

(b) Individuals who meet the criteria in paragraph (a) and who have been approved for alternative care funding are called 180-day eligible clients.

(c) The statewide average payment for nursing facility care is the statewide average monthly nursing facility rate in effect on July 1 of the fiscal year in which the cost is incurred, less the statewide average monthly income of nursing facility residents who are age 65 or older and who are medical assistance recipients in the month of March of the previous fiscal year. This monthly limit does not prohibit the 180-day eligible client from paying for additional services needed or desired.

(d) In determining the total costs of alternative care services for one month, the costs of all services funded by the alternative care program, including supplies and equipment, must be included.

(e) Alternative care funding under this subdivision is not available for a person who is a medical assistance recipient or who would be eligible for medical assistance without a spenddown ~~if the person applied~~, unless authorized by the commissioner. 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 from the date 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. 64. Minnesota Statutes 1994, section 256B.0913, subdivision 5, is amended to read:

Subd. 5. **SERVICES COVERED UNDER ALTERNATIVE CARE.** (a) Alternative care funding may be used for payment of costs of:

(1) adult foster care;

(2) adult day care;

(3) home health aide;

(4) homemaker services;

(5) personal care;

(6) case management;

(7) respite care;

(8) assisted living;

(9) residential care services;

(10) care-related supplies and equipment;

(11) meals delivered to the home;

(12) transportation;

(13) skilled nursing;

(14) chore services;

(15) companion services;

(16) nutrition services; and

(17) training for direct informal caregivers.

(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.

(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 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.

(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.

(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.

(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. A county is not required to contract with a provider of supplies and equipment if the monthly cost of the supplies and equipment is less than $250.

(g) For purposes of this section, residential care services are services which are provided to individuals living in residential care homes. Residential care homes are currently licensed as board and lodging establishments and are registered with the department of health as providing special services. 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 clients who reside in the same apartment building of three or more units. 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.

(i) For the purposes of this section, 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~~ and authorized by 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 Laws 1988, chapter 689, article 2, section 256, ~~whose~~ monthly rates may not exceed 65 percent of ~~either~~ the greater of either 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)~~ (j) 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)~~ (k) 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. 65. Minnesota Statutes 1994, section 256B.0913, subdivision 8, is amended to read:

Subd. 8. **REQUIREMENTS FOR INDIVIDUAL CARE PLAN.** (a) The case manager shall implement the plan of care for each 180-day eligible client and ensure that a client's service needs and eligibility are reassessed at least every ~~six~~ 12 months. The plan shall include any services prescribed by the individual's attending physician as necessary to allow the individual to remain in a community setting. In developing the individual's care plan, the case manager should include the use of volunteers from families and neighbors, religious organizations, social clubs, and civic and service organizations to support the formal home care services. The county shall be held harmless for damages or injuries sustained through the use of volunteers under this subdivision including workers' compensation liability. The lead agency shall provide documentation to the commissioner verifying that the individual's alternative care is not available at that time through any other public assistance or service program. The lead agency shall provide documentation in each individual's plan of care and to the commissioner that the most cost-effective alternatives available have been offered to the individual and that the individual was free to choose among available qualified providers, both public and private. The case manager must give the individual a ten-day written notice of any decrease in or termination of alternative care services.

(b) If the county administering alternative care services is different than the

county of financial responsibility, the care plan may be implemented without the approval of the county of financial responsibility.

Sec. 66. Minnesota Statutes 1994, 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 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 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 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~~ based on the cost of the first full month ~~in which the~~ of 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~~ until the next reassessment is completed or at the end of 12 months, whichever comes first. Premiums are due and payable each month alternative care services are received unless the actual cost of the services is less than the premium.

(b) The fee shall be waived by the commissioner when:

(1) a person who is residing in a nursing facility is receiving case management only;

(2) a person is applying for medical assistance;

(3) a married couple is requesting an asset assessment under the spousal impoverishment provisions;

(4) a person is a medical assistance recipient, but has been approved for alternative care-funded assisted living services;

(5) a person is found eligible for alternative care, but is not yet receiving alternative care services; or

(6) ~~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 spenddown, 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 program. The client must supply the county with the client's social security number at the time of application. If a client fails or refuses to pay the premium due, the county shall supply the commissioner with the client's social security number and other information the commissioner requires to collect the premium from the client. The commissioner shall collect unpaid premiums using the revenue recapture act in chapter 270A and other methods available to the commissioner. The commissioner may require counties to inform clients of the collection procedures that may be used by the state if a premium is not paid.

(d) The commissioner shall begin to adopt emergency or permanent rules governing client premiums within 30 days after July 1, 1991, including criteria for determining when services to a client must be terminated due to failure to pay a premium.

Sec. 67. Minnesota Statutes 1994, section 256B.0913, subdivision 14, is amended to read:

Subd. 14. **REIMBURSEMENT AND RATE ADJUSTMENTS.** (a) Reimbursement for expenditures for the alternative care services as approved by the client's case manager shall be through the invoice processing procedures of the department's Medicaid Management Information System (MMIS)~~, only with the approval of the client's case manager~~. To receive reimbursement, the county or vendor must submit invoices within ~~120 days~~ 12 months following the ~~month~~ date of service. The county agency and its vendors under contract shall not be reimbursed for services which exceed the county allocation.

(b) If a county collects less than 50 percent of the client premiums due under subdivision 12, the commissioner may withhold up to three percent of the county's final alternative care program allocation determined under subdivisions 10 and 11.

(c) 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 1994, section 256B.0913, is amended by adding a subdivision to read:

Subd. 15. **SERVICE ALLOWANCE FUND AVAILABILITY.** (a) Effective July 1, 1996, the commissioner may use alternative care funds for services to high function class A persons as defined in section 144.0721, subdivision 3, clause (2). The county alternative care grant allocation will be supplemented with a special allocation amount based on the projected number of eligible high function class A's and computed on the basis of $240 per month per projected eligible person. Individual monthly expenditures under the service allowance option are permitted to be either greater or less than the amount of $240 per month based on individual need. County allocations shall be adjusted periodically based on the actual provision of services to high function class A persons.

(b) Counties shall have the option of providing services, cash service allowances, vouchers, or a combination of these options to high function class A persons defined in section 144.0721, subdivision 3, clause (2). High function class A persons may choose services from among the categories of services listed under section 256B.0913, subdivision 5, except for case management services.

(c) If the allocation to a county is not sufficient to serve all persons who qualify for alternative care services, the county is not required to provide any alternative care services to a high function class A person but shall establish a waiting list to provide services as funding becomes available.

Sec. 69. Minnesota Statutes 1994, section 256B.0913, is amended by adding a subdivision to read:

Subd. 15a. **REIMBURSEMENT RATE; ANOKA COUNTY.** Notwithstanding subdivision 14, paragraph (e), or any other law to the contrary, for services rendered on or after January 1, 1996, Anoka county may pay vendors, and the commissioner shall reimburse the county, for actual costs up to the rate in effect on December 31, 1995, plus half the difference between that rate and the maximum allowed state rate for home health aide and homemaker services.

Sec. 70. Minnesota Statutes 1994, section 256B.0915, subdivision 2, is amended to read:

Subd. 2. **SPOUSAL IMPOVERISHMENT POLICIES.** The commissioner shall seek to amend the federal waiver and the medical assistance state plan to allow spousal impoverishment criteria as authorized ~~in Code of Federal Regulations, title 42, section 435.726(1924)~~ under United States Code, title 42, section 1396r-5, and as implemented in sections 256B.0575, 256B.058, and 256B.059 ~~to be applied to persons who are screened and determined to need a nursing facility level of care~~, except that the amendment shall seek to add to the personal needs allowance permitted in section 256B.0575, an amount equivalent to the group residential housing rate as set by section 256I.03, subdivision 5.

Sec. 71. Minnesota Statutes 1994, 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 the medical assistance case mix reimbursement system. If medical supplies and equipment or adaptations are or will be purchased for an elderly waiver services recipient, the costs may be prorated on a monthly basis throughout the year in which they are purchased. If the monthly cost of a recipient's other waivered services exceeds the monthly limit established in this paragraph, the annual cost of the waivered services shall be determined. In this event, the annual cost of waivered services shall not exceed 12 times the monthly limit calculated in this paragraph. The statewide average payment rate is calculated by determining the statewide average monthly nursing home rate, effective July 1 of the fiscal year in which the cost is incurred, less the statewide average monthly income of nursing home residents who are age 65 or older, and who are medical assistance recipients in the month of March of the previous state fiscal year. The annual cost divided by 12 of elderly or disabled waivered services for a person who is a nursing facility resident at the time of requesting a determination of eligibility for elderly or disabled waivered services shall not exceed the monthly payment for the resident class assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, for that

resident in the nursing facility where the resident currently resides. 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. A county is not required to contract with a provider of supplies and equipment if the monthly cost of the supplies and equipment is less than $250.

(e) 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~~; the rate 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~~ community alternatives for disabled individuals (CADI) 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~~, except~~. For alternative care assisted living projects established under Laws 1988, chapter 689, article 2, section 256, ~~whose~~ monthly rates may not exceed 65 percent of the greater of either the statewide or any of the geographic groups' weighted average monthly medical assistance nursing facility payment rate for the case mix resident class to which the elderly or disabled client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059. The rate may not cover direct rent or food costs.

(h) 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.

(j) Reimbursement for the medical assistance recipients under the approved waiver shall be made from the medical assistance account through the invoice processing procedures of the department's Medicaid Management Information System (MMIS), only with the approval of the client's case manager. The budget for the state share of the Medicaid expenditures shall be forecasted with the medical assistance budget, and shall be consistent with the approved waiver.

(k) 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.

Sec. 72. Minnesota Statutes 1994, section 256B.0915, is amended by adding a subdivision to read:

Subd. 3a. **REIMBURSEMENT RATE; ANOKA COUNTY.** Notwithstanding subdivision 3, paragraph (h), or any other law to the contrary, for services rendered on or after January 1, 1996, Anoka county may pay vendors, and the commissioner shall reimburse the county, for actual costs up to the rate in effect on December 31, 1995, plus half the difference between that rate and the maximum allowed state rate for home health aide and homemaker services.

Sec. 73. Minnesota Statutes 1994, section 256B.0915, subdivision 5, is amended to read:

Subd. 5. **REASSESSMENTS FOR WAIVER CLIENTS.** A reassessment of a client served under the elderly or disabled waiver must be conducted at least every ~~six~~ 12 months and at other times when the case manager determines that there has been significant change in the client's functioning. This may include instances where the client is discharged from the hospital.

Sec. 74. Minnesota Statutes 1994, section 256B.0915, is amended by adding a subdivision to read:

Subd. 6. **IMPLEMENTATION OF CARE PLAN.** If the county administering waivered services is different than the county of financial responsibility, the care plan may be implemented without the approval of the county of financial responsibility.

Sec. 75. Minnesota Statutes 1994, section 256B.093, subdivision 1, is amended to read:

Subdivision 1. **STATE TRAUMATIC BRAIN INJURY PROGRAM.** The commissioner of human services shall:

(1) ~~establish and~~ maintain a statewide traumatic brain injury 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 consultation;

(4) ~~establish~~ maintain an advisory committee to provide recommendations in ~~a report~~ reports to the 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)~~ the traumatic brain injury home and community-based services waiver; and

~~(ii) traumatic brain injury services not covered by any other statute or rule~~ (6) investigate present and potential models of service coordination which can be delivered at the local level.

Sec. 76. Minnesota Statutes 1994, section 256B.093, subdivision 2, is amended to read:

Subd. 2. **ELIGIBILITY.** Persons eligible for traumatic brain injury administrative case management and consultation must be eligible medical assistance recipients who have traumatic or certain acquired brain injury and~~:~~

~~(1)~~ are at risk of institutionalization~~;~~ ~~or~~

~~(2) exceed limits established by the commissioner in section 256B.0627, subdivision 5, paragraph (b)~~.

Sec. 77. Minnesota Statutes 1994, section 256B.093, subdivision 3, is amended to read:

Subd. 3. **TRAUMATIC BRAIN INJURY PROGRAM DUTIES.** The

department shall fund administrative case management under this subdivision using medical assistance administrative funds. The traumatic brain injury program duties include:

~~(1) 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;~~

~~(10)~~ (1) 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)~~ (2) coordinating the traumatic brain injury home and community-based waiver; ~~and~~

~~(12)~~ (3) approving traumatic brain injury waiver eligibility or care plans or both;

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

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

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

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

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

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

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

Sec. 78. Minnesota Statutes 1994, section 256B.093, is amended by adding a subdivision to read:

Subd. 3a. **TRAUMATIC BRAIN INJURY CASE MANAGEMENT SERVICES.** The annual appropriation established under section 171.29, subdivision 2, paragraph (b), clause (5), shall be used for traumatic brain injury program services that include, but are not limited to:

(1) collaborating with counties, providers, and other public and private organizations to expand and strengthen local capacity for delivering needed services and supports, including efforts to increase access to supportive residential housing options;

(2) participating in planning and accessing services not otherwise covered in subdivision 3 to allow individuals to attain and maintain community-based services;

(3) providing information, referral, and case consultation to access health and human services for persons with traumatic brain injury not eligible for medical assistance, though direct access to this assistance may be limited due to the structure of the program; and

(4) collaborating on injury prevention efforts.

Sec. 79. Minnesota Statutes 1994, section 256B.15, subdivision 1a, is amended to read:

Subd. 1a. **ESTATES SUBJECT TO CLAIMS.** If a person receives any

medical assistance hereunder, on the person's death, if single, or on the death of the survivor of a married couple, either or both of whom received medical assistance, the total amount paid for medical assistance rendered for the person and spouse shall be filed as a claim against the estate of the person or the estate of the surviving spouse in the court having jurisdiction to probate the estate.

A claim shall be filed if medical assistance was rendered for either or both persons under one of the following circumstances:

(a) the person was over ~~65~~ 55 years of age, and received services under this chapter, excluding alternative care;

(b) the person resided in a medical institution for six months or longer, received services under this chapter excluding alternative care, and, at the time of institutionalization or application for medical assistance, whichever is later, the person could not have reasonably been expected to be discharged and returned home, as certified in writing by the person's treating physician. For purposes of this section only, a "medical institution" means a skilled nursing facility, intermediate care facility, intermediate care facility for persons with mental retardation, nursing facility, or inpatient hospital; or

(c) the person received general assistance medical care services under chapter 256D.

The claim shall be considered an expense of the last illness of the decedent for the purpose of section 524.3-805. Any statute of limitations that purports to limit any county agency or the state agency, or both, to recover for medical assistance granted hereunder shall not apply to any claim made hereunder for reimbursement for any medical assistance granted hereunder. Notice of the claim shall be given to all heirs and devisees of the decedent whose identity can be ascertained with reasonable diligence. The notice must include procedures and instructions for making an application for a hardship waiver under subdivision 5; time frames for submitting an application and determination; and information regarding appeal rights and procedures. Counties are entitled to one-half of the nonfederal share of medical assistance collections from estates that are directly attributable to county effort.

Sec. 80. Minnesota Statutes 1994, 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~~ 55 or during a period of institutionalization described in subdivision 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. 81. Minnesota Statutes 1994, section 256B.15, is amended by adding a subdivision to read:

Subd. 5. **UNDUE HARDSHIP.** Any person entitled to notice in subdivision 1a has a right to apply for waiver of the claim based upon undue hardship. Any claim pursuant to this section may be fully or partially waived because of undue hardship. Undue hardship does not include action taken by the decedent which divested or diverted assets in order to avoid estate recovery. Any waiver of a claim must benefit the person claiming undue hardship.

Sec. 82. Minnesota Statutes 1994, 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 University of Minnesota. For purposes of this subdivision, "public hospital" means the Hennepin County Medical Center and the University of Minnesota hospital.

(b) From July 1, 1993 through June 30, 1994, Hennepin county 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.

(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. The base year for determining this transfer amount shall be established according to section 256.9657, subdivision 4.

(d) 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. 83. Minnesota Statutes 1994, section 256B.19, subdivision 1c, is amended 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~~ $1,500,000, due before noon on the 15th of each month and the University of Minnesota shall be responsible for a monthly transfer payment of $500,000 due before noon on the 15th of each month, beginning July 15, ~~1993~~ 1995. 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. 84. Minnesota Statutes 1994, section 256B.19, subdivision 1d, is amended 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 and operated by the county, with the county named as licensee, multiplied by $5,723. If two or more counties own and operate 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. 85. Minnesota Statutes 1994, 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 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.

(i) For the cost report year ending September 30, 1996, and for all subsequent reporting years, certified nursing facilities must identify, differentiate, and record resident day statistics for residents in case mix classification A who, on or after July 1, 1996, meet the modified level of care criteria in section 144.0721. The resident day statistics shall be separated into case mix classification A-1 for any resident day meeting the high-function class A level of care criteria and case mix classification A-2 for other case mix class A resident days.

Sec. 86. Minnesota Statutes 1994, section 256B.431, subdivision 23, is amended 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 operated, with the county named as licensee by the commissioner of health, 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. 87. Minnesota Statutes 1994, section 256B.49, subdivision 1, is amended to read:

Subdivision 1. **STUDY; WAIVER APPLICATION.** The commissioner shall authorize a study to assess the need for home and community-based waivers for chronically ill children who have been and will continue to be hospitalized without a waiver, and for disabled individuals under the age of 65 who are likely to reside in an acute care or nursing home facility in the absence of a waiver. If a need for these waivers can be demonstrated, the commissioner shall apply for federal waivers necessary to secure, to the extent allowed by law, federal participation under United States Code, title 42, sections 1396-1396p, as amended through December 31, 1982, for the provision of home and community-based services to chronically ill children who, in the absence of such a waiver, would remain in an acute care setting, and to disabled individuals under the age of 65 who, in the absence of a waiver, would reside in an acute care or nursing home setting. If the need is demonstrated, the commissioner shall request a waiver under United States Code, title 42, sections 1396-1396p, to allow medicaid eligibility for blind or disabled children with ineligible parents where income deemed from the parents would cause the applicant to be ineligible for supple-

mental security income if the family shared a household and to furnish necessary services in the home or community to disabled individuals under the age of 65 who would be eligible for medicaid if institutionalized in an acute care or nursing home setting. These waivers are requested to furnish necessary services in the home and community setting to children or disabled adults under age 65 who are medicaid eligible when institutionalized in an acute care or nursing home setting. The commissioner shall assure that the cost of home and community-based care will not be more than the cost of care if the eligible child or disabled adult under age 65 were to remain institutionalized. The commissioner shall seek to amend the federal waivers obtained under this section to apply criteria to protect against spousal impoverishment as authorized under United States Code, title 42, section 1396r-5, and as implemented in sections 256B.0575, 256B.058, and 256B.059, except that the amendment shall seek to add to the personal needs allowance permitted in section 256B.0575, an amount equivalent to the group residential housing rate as set by section 256I.03, subdivision 5.

Sec. 88. Minnesota Statutes 1994, section 256B.49, is amended by adding a subdivision to read:

Subd. 6. **ADMISSION CERTIFICATION.** In determining an individual's eligibility for the community alternative care waiver program, and an individual's eligibility for medical assistance under section 256B.055, subdivision 12, paragraph (b), the commissioner may review or contract for review of the individual's medical condition to determine level of care using criteria in Minnesota Rules, parts 9505.0520 to 9505.0540.

For purposes of this subdivision, a person requires long-term care in an inpatient hospital setting if the person has an ongoing condition that is expected to last one year or longer, and would require continuous or frequent hospitalizations during that period, but for the provision of home care services under this section.

Sec. 89. Minnesota Statutes 1994, section 256B.49, is amended by adding a subdivision to read:

Subd. 7. **PERSONS WITH DEVELOPMENTAL DISABILITIES OR RELATED CONDITIONS.** Individuals who apply for services under the community alternatives for disabled individuals (CADI) waiver program who have developmental disabilities or related conditions must be screened for the appropriate institutional level of care in accordance with section 256B.092.

Sec. 90. Minnesota Statutes 1994, section 256B.69, is amended by adding a subdivision to read:

Subd. 3a. **COUNTY AUTHORITY.** The commissioner, when implementing the general assistance medical care or medical assistance prepayment program within a county, must include the county board in the process of development, approval, and issuance of the request for proposals to provide ser-

vices to eligible individuals within the proposed county. County boards must be given reasonable opportunity to make recommendations regarding the development, issuance, review of responses, and changes needed in the request for proposals. The commissioner must provide county boards the opportunity to review each proposal based on the identification of community needs under chapters 145A and 256E and county advocacy activities. If a county board finds that a proposal does not address certain community needs, the county board and commissioner shall continue efforts for improving the proposal and network prior to the approval of the contract. The county board shall make recommendations regarding the approval of local networks and their operations to ensure adequate availability and access to covered services. The provider or health plan must respond directly to county advocates and the state prepaid medical assistance ombudsperson regarding service delivery and must be accountable to the state regarding contracts with medical assistance and general assistance medical care funds. The county board may recommend a maximum number of participating health plans after considering the size of the enrolling population; ensuring adequate access and capacity; considering the client and county administrative complexity; and considering the need to promote the viability of locally developed health plans. Prior to the development of the request for proposal, there shall be established a mutually agreed upon timetable. This process shall in no way delay the department's ability to secure and finalize contracts for the medical assistance prepayment program.

Sec. 91. Minnesota Statutes 1994, section 256B.69, subdivision 4, is amended to read:

Subd. 4. **LIMITATION OF CHOICE.** The commissioner shall develop criteria to determine when limitation of choice may be implemented in the experimental counties. The criteria shall ensure that all eligible individuals in the county have continuing access to the full range of medical assistance services as specified in subdivision 6. The commissioner shall exempt the following persons from participation in the project, in addition to those who do not meet the criteria for limitation of choice: (1) persons eligible for medical assistance according to section 256B.055, subdivision 1; ~~and children under age 21 who are in foster placement~~; (2) persons eligible for medical assistance due to blindness or disability as determined by the social security administration or the state medical review team, unless: (i) they are 65 years of age or older, or (ii) they are eligible for medical assistance according to section 256B.055, subdivision 12; (3) recipients who currently have private coverage through a health maintenance organization; ~~and~~ (4) recipients who are eligible for medical assistance by spending down excess income for medical expenses other than the nursing facility per diem expense; and (5) recipients who receive benefits under the Refugee Assistance Program, established under United States Code, title 8, section 1522(e). Children under age 21 who are in foster placement may enroll in the project on an elective basis. The commissioner may allow persons with a one-month spenddown who are otherwise eligible to enroll to voluntarily enroll or remain enrolled, if they elect to prepay their monthly spenddown to the state. Before limitation of choice is implemented, eligible individuals shall be notified and

after notification, shall be allowed to choose only among demonstration providers. After initially choosing a provider, the recipient is allowed to change that choice only at specified times as allowed by the commissioner. If a demonstration provider ends participation in the project for any reason, a recipient enrolled with that provider must select a new provider but may change providers without cause once more within the first 60 days after enrollment with the second provider.

Sec. 92. Minnesota Statutes 1994, section 256B.69, is amended by adding a subdivision to read:

Subd. 4a. **REQUIREMENTS OF REQUEST FOR PROPOSAL.** In implementing the limitation of choice for persons eligible for medical assistance according to section 256B.055, subdivision 12, hereinafter referred to as TEFRA recipients, the commissioner shall comply with the request for proposal process applicable to the prepaid medical assistance program. Notwithstanding any provision to the contrary, the commissioner shall include the following in the request for proposal issued to health plans for purposes of covering TEFRA recipients:

(1) evidence that eligibility criteria for personal care assistant services have been developed and implemented with respect to TEFRA recipients;

(2) a complete and detailed description of the benefits the health plan is responsible for providing to the TEFRA recipients;

(3) identification of the circumstances under which and the point at which the health plan covering the TEFRA recipient pursuant to this section is responsible for the costs of and delivery of benefits to the TEFRA recipient. The purpose of this information is to facilitate coordination of benefits with private health plans, including self-insured employers who are covering the TEFRA recipients. The point at which and circumstances under which the health plan is responsible must be identified and developed so as to be applied consistently to all TEFRA recipients;

(4) statistical information including the following:

(i) how many TEFRA recipients will be enrolled;

(ii) historical cost and utilization information, by type of service and diagnosis or condition, and any other data or statistics used in developing the proposed rate of payment to the health plan;

(iii) average cost per TEFRA recipient to the state; and

(iv) outlier information, including diagnosis categories, cost, and the number of TEFRA recipients; and

(5) actuarially valid rates of payment proposed to be paid to the health plans.

Sec. 93. Minnesota Statutes 1994, section 256B.69, subdivision 5, is amended to read:

Subd. 5. **PROSPECTIVE PER CAPITA PAYMENT.** The commissioner shall establish the method and amount of payments for services. The commissioner shall annually contract with demonstration providers to provide services consistent with these established methods and amounts for payment. Notwithstanding section 62D.02, subdivision 1, payments for services rendered as part of the project may be made to providers that are not licensed health maintenance organizations on a risk-based, prepaid capitation basis.

If allowed by the commissioner, a demonstration provider may contract with an insurer, health care provider, nonprofit health service plan corporation, or the commissioner, to provide insurance or similar protection against the cost of care provided by the demonstration provider or to provide coverage against the risks incurred by demonstration providers under this section. The recipients enrolled with a demonstration provider are a permissible group under group insurance laws and chapter 62C, the Nonprofit Health Service Plan Corporations Act. Under this type of contract, the insurer or corporation may make benefit payments to a demonstration provider for services rendered or to be rendered to a recipient. Any insurer or nonprofit health service plan corporation licensed to do business in this state is authorized to provide this insurance or similar protection.

Payments to providers participating in the project are exempt from the requirements of sections 256.966 and 256B.03, subdivision 2. The commissioner shall complete development of capitation rates for payments before delivery of services under this section is begun. For payments made during calendar year 1990 and later years, the commissioner shall contract with an independent actuary to establish prepayment rates.

By January 15, 1996, the commissioner shall report to the legislature on the methodology used to allocate to participating counties available administrative reimbursement for advocacy and enrollment costs. The report shall reflect the commissioner's judgment as to the adequacy of the funds made available and of the methodology for equitable distribution of the funds. The commissioner must involve participating counties in the development of the report.

Sec. 94. Minnesota Statutes 1994, section 256B.69, is amended by adding a subdivision to read:

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

Sec. 95. Minnesota Statutes 1994, section 256B.69, is amended by adding a subdivision to read:

Subd. 5b. **PROSPECTIVE REIMBURSEMENT RATES.** For prepaid medical assistance and general assistance medical care program contract rates effective January 1, 1996, through December 31, 1996, capitation rates for nonmetropolitan counties shall on a weighted average be no less than 85 percent of the capitation rates for metropolitan counties, excluding Hennepin county.

Sec. 96. Minnesota Statutes 1994, section 256B.69, subdivision 6, is amended to read:

Subd. 6. **SERVICE DELIVERY.** (a) Each demonstration provider shall be responsible for the health care coordination for eligible individuals. Demonstration providers:

(1) shall authorize and arrange for the provision of all needed health services including but not limited to the full range of services listed in sections 256B.02, subdivision 8, and 256B.0625 and for children eligible for medical assistance under section 256B.055, subdivision 12, home care services and personal care assistant services in order to ensure appropriate health care is delivered to enrollees;

(2) shall accept the prospective, per capita payment from the commissioner in return for the provision of comprehensive and coordinated health care services for eligible individuals enrolled in the program;

(3) may contract with other health care and social service practitioners to provide services to enrollees; and

(4) shall institute recipient grievance procedures according to the method established by the project, utilizing applicable requirements of chapter 62D. Disputes not resolved through this process shall be appealable to the commissioner as provided in subdivision 11.

(b) Demonstration providers must comply with the standards for claims settlement under section 72A.201, subdivisions 4, 5, 7, and 8, when contracting with other health care and social service practitioners to provide services to enrollees. A demonstration provider must pay a clean claim, as defined in Code of Federal Regulations, title 42, section 447.45(b), within 30 business days of the date of acceptance of the claim.

Sec. 97. Minnesota Statutes 1994, section 256B.69, subdivision 9, is amended to read:

Subd. 9. **REPORTING.** Each demonstration provider shall submit information as required by the commissioner, including data required for assessing client satisfaction, quality of care, cost, and utilization of services for purposes of project evaluation. The commissioner shall also develop methods of data collection from county advocacy activities in order to provide aggregate enrollee information on encounters and outcomes to determine access and quality assurance. Required information shall be specified before the commissioner contracts with a demonstration provider.

Sec. 98. Minnesota Statutes 1994, section 256B.69, is amended by adding a subdivision to read:

Subd. 18. **SERVICES PENDING APPEAL.** If the recipient appeals in writing to the state agency on or before the tenth day after the decision of the prepaid health plan to reduce, suspend, or terminate services which the recipient had been receiving, and the treating physician or another plan physician orders the services to be continued at the previous level, the prepaid health plan must continue to provide services at a level equal to the level ordered by the plan's physician until the state agency renders its decision.

Sec. 99. Minnesota Statutes 1994, section 256B.69, is amended by adding a subdivision to read:

Subd. 19. **LIMITATION ON REIMBURSEMENT TO PROVIDERS NOT AFFILIATED WITH A PREPAID HEALTH PLAN.** A prepaid health plan may limit any reimbursement it may be required to pay to providers not employed by or under contract with the prepaid health plan to the medical assistance rates for medical assistance enrollees, and the general assistance medical care rates for general assistance medical care enrollees, paid by the commissioner of human services to providers for services to recipients not enrolled in a prepaid health plan.

Sec. 100. Minnesota Statutes 1994, section 256B.69, is amended by adding a subdivision to read:

Subd. 20. **OMBUDSPERSON.** The commissioner shall designate an ombudsperson to advocate for persons required to enroll in prepaid health plans under this section. The ombudsperson shall advocate for recipients enrolled in prepaid health plans through complaint and appeal procedures and ensure that necessary medical services are provided either by the prepaid health plan directly or by referral to appropriate social services. At the time of enrollment in a prepaid health plan, the local agency shall inform recipients about the ombudsperson program and their right to a resolution of a complaint by the prepaid health plan if they experience a problem with the plan or its providers.

Sec. 101. Minnesota Statutes 1994, section 256B.69, is amended by adding a subdivision to read:

Subd. 21. **PREPAYMENT COORDINATOR.** The local agency shall designate a prepayment coordinator to assist the state agency in implementing this section and section 256D.03, subdivision 4. Assistance must include educating recipients about available health care options, enrolling recipients under subdivision 5, providing necessary eligibility and enrollment information to health plans and the state agency, and coordinating complaints and appeals with the ombudsman established in subdivision 18.

Sec. 102. Minnesota Statutes 1994, section 256B.69, is amended by adding a subdivision to read:

Subd. 22. **IMPACT ON PUBLIC OR TEACHING HOSPITALS AND COMMUNITY CLINICS.** (a) 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, provided the terms of participation in the program are competitive with the terms of other participants.

(b) Prepaid health plans serving counties with a nonprofit community clinic or community health services agency must contract with the clinic or agency to provide services to clients who choose to receive services from the clinic or agency, if the clinic or agency agrees to payment rates that are competitive with rates paid to other health plan providers for the same or similar services.

Sec. 103. **[256B.691] RISK-BASED TRANSPORTATION PAYMENTS.**

Any contract with a prepaid health plan under the medical assistance, general assistance medical care, or MinnesotaCare program that requires the health plan to cover transportation services for obtaining medical care for eligible individuals who are ambulatory must provide for payment for those services on a risk basis.

Sec. 104. Minnesota Statutes 1994, section 256D.03, subdivision 3, is amended to read:

Subd. 3. **GENERAL ASSISTANCE MEDICAL CARE; ELIGIBILITY.** (a) General assistance medical care may be paid for any person who is not eligible for medical assistance under chapter 256B, including eligibility for medical assistance based on a spenddown of excess income according to section 256B.056, subdivision 5, 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. No asset test shall be applied to children and their parents living in the same household. 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~~ 60 months preceding application for general assistance medical care or during the period of eligibility. Any transfer described in this paragraph shall be presumed to have been for the purpose of establishing eligibility for general assistance medical care, unless the individual furnishes convincing evidence to establish that the transaction was exclusively for another purpose. For purposes of this paragraph, the value of the asset or interest shall be the fair market value at the time it was given away, sold, or disposed of, less the amount of compensation received. For any uncompensated transfer, the number of months of ineligibility, including partial months, shall be calculated by dividing the uncompensated transfer amount by the average monthly per person payment

made by the medical assistance program to skilled nursing facilities for the previous calendar year. The individual shall remain ineligible until this fixed period has expired. The period of ineligibility may exceed 30 months, and a reapplication for benefits after 30 months from the date of the transfer shall not result in eligibility unless and until the period of ineligibility has expired. The period of ineligibility begins in the month the transfer was reported to the county agency, or if the transfer was not reported, the month in which the county agency discovered the transfer, whichever comes first. For applicants, the period of ineligibility begins on the date of the first approved application.

(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), except that it also means services rendered because of suspected or actual pesticide poisoning.

Sec. 105. Minnesota Statutes 1994, section 256D.03, subdivision 3b, is amended to read:

Subd. 3b. **COOPERATION.** General assistance or general assistance medical care applicants and recipients must cooperate with the state and local agency to identify potentially liable third-party payors and assist the state in obtaining third-party payments. Cooperation includes identifying any third party who may be liable for care and services provided under this chapter to the applicant, recipient, or any other family member for whom application is made and providing relevant information to assist the state in pursuing a potentially liable third party. General assistance medical care applicants and recipients must cooperate by providing information about any group health plan in which they may be eligible to enroll. They must cooperate with the state and local agency in determining if the plan is cost-effective. If the plan is determined cost-effective and the premium will be paid by the state or local agency or is available at no cost to the person, they must enroll or remain enrolled in the group health plan. Cost-effective insurance premiums approved for payment by the state agency and paid by the local agency are eligible for reimbursement according to subdivision 6.

Sec. 106. Minnesota Statutes 1994, 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;

(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; and

(22) services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic that is a department of, or that operates under the direct authority of, a unit of government, if the service is within the scope of practice of the public health nurse's license as a registered nurse, as defined in section 148.171.

(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, and for contracts beginning on or after July 1, 1995, shall be discounted ten percent from comparable fee for service payments. For payments made during fiscal year 1990 and later years, the commissioner shall consult with an independent actuary in establishing prepayment rates, but shall retain final control over the rate methodology. Notwithstanding the provisions of subdivision 3, an individual who becomes ineligible for general assistance medical care because of failure to submit income reports or recertification forms in a timely manner, shall remain enrolled in the prepaid health plan and shall remain eligible for general assistance medical care coverage through the last day of the month in which the enrollee became ineligible for general assistance medical care.

(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. 107. Minnesota Statutes 1994, section 256D.425, is amended by adding a subdivision to read:

Subd. 4. **COOPERATION.** To be eligible for the Minnesota supplemental aid program, applicants and recipients must cooperate with the state and local agency to identify potentially liable third-party payors and assist the state in obtaining third-party payments. Cooperation includes identifying any third party who may be liable for benefits provided under this chapter to the applicant, recipient, or any other family member for whom application is made, and providing relevant information to assist the state in pursuing a potentially liable third party.

Sec. 108. Minnesota Statutes 1994, section 501B.89, subdivision 1, is amended to read:

Subdivision 1. **TRUSTS CONTAINING LIMITATIONS LINKED TO ELIGIBILITY FOR PUBLIC ASSISTANCE.** (a) Except as allowed by subdivision 2 or 3, a provision in a trust that provides for the suspension, termination, limitation, or diversion of the principal, income, or beneficial interest of a beneficiary if the beneficiary applies for, is determined eligible for, or receives public assistance or benefits under a public health care program is unenforceable as against the public policy of this state, without regard to the irrevocability of the trust or the purpose for which the trust was created.

(b) This subdivision applies to trust provisions created after July 1, 1992.

For purposes of this section, a trust provision is created on the date of execution of the first instrument that contains the provision, even though the trust provision is later amended or reformed or the trust is not funded until a later date.

Sec. 109. Minnesota Statutes 1994, section 501B.89, is amended by adding a subdivision to read:

Subd. 3. **SUPPLEMENTAL NEEDS TRUSTS UNDER FEDERAL LAW.** A trust created on or after August 11, 1993, which qualifies as a supplemental needs trust for a person with a disability under United States Code, title 42, section 1396p(c)(2)(B)(iv) or 1396p(d), as amended by section 13611(b) of the Omnibus Budget Reconciliation Act of 1993, Public Law Number 103-66, commonly known as OBRA 1993, is enforceable, and the courts of this state may authorize creation and funding of a trust which so qualifies.

Sec. 110. **TEFRA FEE STUDY.**

The commissioner of human services shall study and report to the legislature by January 15, 1996, recommendations to modify the fee structure for the parents of children eligible for medical assistance under Minnesota Statutes, section 256B.055, subdivision 12. The report shall include a comparison of the fee schedule for these parents with fee schedules in the social services, MinnesotaCare, and sliding fee child care programs. The commissioner shall appoint an advisory committee to assist with the study which must include parents, advocates, and other interested persons.

Sec. 111. **IMPLEMENTATION PLAN FOR HOME CARE SERVICES.**

The commissioner of human services, in conjunction with the commissioner of education, shall require the provision of the following types of home care services equivalent to personal care assistant services through waivered programs and managed care programs beginning July 1, 1996:

(1) school-based after school services; and

(2) vacation and summer-only services.

The commissioners shall define program participants, structure, and activities and shall recommend to the 1996 legislature any changes in licensing requirements or other law changes necessary to implement the program. The commissioner of human services shall require participants in waivered programs and managed care programs to receive services through these options unless the requirement would create an undue hardship for recipients.

Sec. 112. **WAIVER.**

The commissioner of human services shall seek a federal waiver to implement the 60-month period for transfers of assets under section 256B.0595, subdivision 1, paragraph (g).

Sec. 113. **ADVISORY TASK FORCE TO STANDARDIZE SUPPORTING DOCUMENTATION FOR PRIOR AUTHORIZATION.**

Subdivision 1. **COMPOSITION OF TASK FORCE.** A six-member advisory task force on prior authorization for physical therapy, occupational therapy, speech therapy, or related services supporting documentation shall be established. The task force shall be comprised of one licensed physiatrist, one licensed physical therapist, one licensed occupational therapist, one licensed speech therapist, one licensed rehabilitation nurse, and one consumer representative. All licensed task force members must be actively engaged in the practice of their profession in Minnesota. The members of the task force shall be appointed by the commissioner of human services. No more than three members may be of one gender. All licensed professional members shall be selected from lists submitted to the commissioner by the appropriate professional associations. Task force members who are licensed professionals shall not be compensated for their service. The consumer representative member must be compensated for time spent on task force activities as specified in Minnesota Statutes, section 15.059, subdivision 3. The task force shall expire on December 31, 1996.

Subd. 2. **DUTIES OF COMMISSIONER AND TASK FORCE.** The task force shall study the lists of items, specified in the issue of the medical assistance and general assistance medical care provider manual which is in effect as of the effective date of this act, that are required to be submitted by each category of provider along with the provider's request for prior authorization. The task force shall recommend to the commissioner any amendments or refinements needed to clarify the lists. The commissioner shall use the recommendations of the task force to develop standardized documentation which a provider must submit with a prior authorization request. If the commissioner intends to depart from the recommendations of the task force, the commissioner shall inform the task force of the intended departure, provide a written explanation of the reasons for the departure, and give the task force an opportunity to comment on the intended departure.

Sec. 114. **MEDICAL ASSISTANCE ASSET TRANSFER AND ELIGIBILITY REQUIREMENTS.**

The commissioner of human services shall investigate and pursue all viable options for tightening the medical assistance asset transfer and eligibility requirements to restore and preserve the function of the medical assistance program as a safety net program for low-income Minnesotans who cannot afford to meet their medical needs with their own resources. Among other actions, the commissioner shall aggressively pursue waivers of federal requirements to strengthen restrictions on transfers of assets for the purposes of gaining eligibility for medical assistance.

Sec. 115. **CONTINUATION OF PILOT PROJECTS.**

The alternative care pilot projects authorized in Laws 1993, First Special Session chapter 1, article 5, section 133, shall not expire on June 30, 1995, but shall continue until June 30, 1997, except that the three percent rate increases authorized in Laws 1993, First Special Session chapter 1, article 1, section 2, subdivision 4, shall be incorporated in average monthly cost effective July 1,

1995. The commissioner shall allow additional counties at their option to implement the alternative care program within the parameters established in Laws 1993, First Special Session chapter 1, article 5, section 133. If more than five counties exercise this option, the commissioner may require counties to make this change on a phased schedule if necessary in order to implement this provision within the limit of available resources. For newly participating counties, the previous fiscal year shall be the base year.

Sec. 116. **RATE CONSOLIDATION PLAN.**

The commissioner of human services, in cooperation with counties, shall prepare an implementation plan to consolidate payment rates for alternative care services, elderly waiver services, community alternatives for disabled individuals services, traumatic brain injury services, and comparable medical assistance services provided after June 30, 1996, that establishes a statewide rate cap for each individual service that is equal to the highest rate cap in any program for that service. The plan must be submitted to the legislature by October 1, 1995.

Sec. 117. **REIMBURSEMENT INCREASE.**

Notwithstanding statutory provisions to the contrary, the commissioner of human services shall increase reimbursement rates for the following by 1.5 percent on April 1, 1996:

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

(2) home and community-based services waiver for persons with mental retardation and related conditions under Minnesota Statutes, section 256B.501;

(3) adult residential program grants, under Minnesota Rules, parts 9535.2000 to 9535.3000;

(4) adult and family community support grants, under Minnesota Rules, parts 9535.1700 to 9535.1760;

(5) day training and habilitation services for adults with mental retardation and related conditions under Minnesota Statutes, sections 252.40 to 252.47; and

(6) semi-independent living services under Minnesota Statutes, section 252.275.

Sec. 118. **MANAGED CARE RATE SETTING METHODOLOGY.**

Subdivision 1. **DEVELOPMENT.** The commissioner of human services, in conjunction with the rate setting task force established in subdivision 2, shall develop a prospective rate setting methodology for implementation on January 1, 1998. The methodology must incorporate the public program risk adjustment mechanism and, at a minimum, take into account the following factors:

(1) costs of ensuring appropriate access to health care services in all counties;

(2) costs of medical education, disproportionate share payments, provisions for federally qualified health care centers, rural health clinics, and other adjustors historically provided for in the fee-for-service payments to specific providers;

(3) health status;

(4) statistically valid regional utilization patterns as well as population characteristics;

(5) the benefit set to be provided through the prepaid medical assistance program; and

(6) utilization demands resulting from program changes and newly created access to care.

Subd. 2. **RATE SETTING TASK FORCE.** The commissioner shall establish a task force consisting of representatives of health plans, public program providers, disproportionate share and teaching hospitals, independent actuaries, counties, and consumers, to develop recommendations for a prospective rate setting methodology with a risk adjustment mechanism to be implemented by January 1, 1998. The task force shall include at least one representative of each regional coordinating board established under section 62J.09. Fifty percent of the provider, county, and consumer members shall be from non-metro counties. The commissioner and task force shall jointly deliver a progress report to the legislature by January 15, 1996, and a final methodology proposal to the legislature by December 15, 1996.

Sec. 119. **JOINT PURCHASER DEMONSTRATION PROJECTS.**

Subdivision 1. **DEMONSTRATION PROJECTS.** A county or counties may apply or the commissioner may solicit a demonstration project or projects for a state-county partnership as joint purchasers for services provided to eligible individuals under medical assistance, general assistance medical care, state health and social service grants, and county funds for these or other participants. Individual county staff who are employed by a publicly owned health plan that intends to respond to the request for proposal are prohibited from reviewing, critiquing, or approving any proposals submitted in accordance with this section. As part of this project, the commissioner, in cooperation with the county boards, must explore options for various purchasing models including contracting directly with providers or provider networks. The commissioner retains total responsibility for the medical assistance and general assistance medical care contracts.

Subd. 2. **OBJECTIVES.** The objective of the demonstration project is to promote the development of local provider networks; further define the county

role and authorities in providing publicly reimbursed health services, including services reimbursed by the county; to provide better coordination of services; and to identify costs and methods to reduce cost-shifting.

Subd. 3. **PARTICIPATING COUNTIES.** Carlton, Cook, Koochiching, Lake, and Saint Louis counties shall be allowed to participate in joint purchasing demonstration projects at the option of their county boards. Any county may also participate in a joint purchasing demonstration project, which may include county employees, at the option of the county board.

Sec. 120. **DEMONSTRATION PROJECT TO TEST ALTERNATIVES TO DELIVERY OF SERVICES TO HIGH-RISK MEDICAL ASSISTANCE RECIPIENTS.**

Subdivision 1. **AUTHORIZATION FOR DEMONSTRATION PROJECTS.** Counties may propose demonstration projects to test alternatives to the delivery of health services to high risk populations. The commissioner of human services shall review and may approve demonstration project proposals and shall seek federal waivers as applicable for approved demonstration projects.

Subd. 2. **PROGRAM DESIGN AND IMPLEMENTATION.** (a) The demonstration projects shall be established jointly by the commissioners and participating county boards to design and plan an improved health services delivery system for high-risk medical assistance recipients who also receive services under other publicly funded health, human services, or corrections programs. In counties where prepaid medical assistance programs have been implemented, health plan companies participating in the prepaid program shall be included in the program design. In the proposal, the county must delineate exactly which populations would be served and what enrollment procedures would be used. The projects must address one or more of the following:

(1) provide an array of health and social services that are better coordinated for persons and families now served by multiple, uncoordinated programs;

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

(3) coordinate between provider networks or health plan companies and the community health and human services infrastructure through creative partnerships with local vendors; and

(4) utilize existing categorical funding streams and reimbursement sources in coordinated and creative ways.

(b) All projects must complete their planning phase and be operational by June 30, 1997.

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

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

Subd. 5. **PLANNING FOR DEMONSTRATION PROJECTS.** Each local plan for a demonstration project must be developed under the direction of the county board, or multiple county boards acting jointly, as the local health and human services authority. The planning process for each demonstration shall include, but not be limited to, advocates, providers, and the departments of health and human services.

Subd. 6. **DUTIES OF COMMISSIONER.** (a) For purposes of the demonstration projects, the commissioner of human services shall facilitate coordination of funds or other resources as needed and requested by each project. These resources may include: medical assistance, general assistance medical care, MinnesotaCare, and other categorical state and federal funds if requested by the county boards, and if the commissioner determines this would be consistent with the state's overall health care reform efforts.

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

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

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

(3) geographical distribution.

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

(d) The county board may seek a waiver of administrative procedural rules under Minnesota Statutes, section 465.797.

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

(f) The commissioner may award grants to a county board or group of county boards to pay for start-up, implementation, and evaluation costs of the demonstration project.

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

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

(2) ensure that no one is denied services for which they would otherwise be eligible; and

(3) provide the commissioner of human services with timely and pertinent information through the following methods:

(i) submission of community health services act, maternal and child health act, and community social services act plans and plan amendments;

(ii) submission of health and social services expenditure and grant reconciliation reports, based on a coding format to be determined by mutual agreement between the project's managing entity and the commissioner; and

(iii) submission of data and participation in an evaluation of the demonstration projects, to be designed cooperatively by the commissioner and the projects.

Sec. 121. **TASK FORCE FOR HOME CARE SERVICES.**

The commissioner shall appoint a home care services task force to recommend changes to medical assistance home care services as alternatives to the home care changes to take effect July 1, 1996, Minnesota Statutes, sections 256B.0625, subdivisions 6a, 7, and 19a; 256B.0627; and 256B.0628, which will reduce projected growth for the 1996-1997 biennium to no more than five percent over 1995 projected expenditures as described in the November 1994 medical assistance forecast, department of human services. The recommendations shall include: proposals for independent delivery models for personal care assistant services; county assessment, service plan, and care plan development; coordination, including coordination with mental health services; streamlining of assessment and reporting processes to achieve administrative cost efficiencies; and alternative ways to serve segments of this population with needed services. The task force shall be comprised of home care services recipients, providers, advocates, staff from counties, the departments of human services, health, finance, the attorney general's office, in addition to the chairs of the health and human services finance committees of both housesof the legislature or their representatives. The recommendations shall be completed by December 1, 1995, except that the recommendations relating to county assessment and streamlining of assessment and reporting processes shall be completed by October 1, 1995, and presented to the next session, including a special session, of the Minnesota legislature.

By January 15, 1996, the commissioner of human services, jointly with counties, shall develop a plan for presentation to the legislature at their next session, including any special session, to allow counties to assume the prior authorization for home care services at the option of the county. The plan must provide participating counties with the funding, flexibility, authority, and accountability to administer both the assessment and prior authorization functions for medical assistance reimbursement for services under section 256B.0627, subdivision 2.

The plan shall also make a recommendation for adequate reimbursement of county administrative responsibilities of assessment, case management and

appeals activities. In developing the plan and recommendations, the commissioner of human services shall involve the counties, consumers, and providers and include the development of standards, criteria and outcomes to foster local authority and flexibility, while defining quality expectations, budgetary incentives and sanctions, and promoting consistency.

Sec. 122. **INSURANCE STUDY.**

The Minnesota health care commission shall report to the legislature by January 15, 1996, recommendations to improve coverage through private health plans, the Minnesota comprehensive health association, and other public or private programs for children and adults with disabilities.

Sec. 123. **TEFRA MANAGED CARE ADVISORY COMMITTEE AND PROGRESS REPORT.**

Subdivision 1. **ADVISORY COMMITTEE.** The commissioner shall appoint an advisory committee to assist with the development of managed care for children eligible for medical assistance under Minnesota Statutes, section 256B.055, subdivision 12. The advisory committee shall include representatives of parents, advocates, health plan companies, health care providers serving the children, counties, and other other interested persons.

Subd. 2. **PROGRESS REPORT.** The commission shall report to the legislature by December 15, 1995, regarding progress toward implementing managed care. The report shall make recommendations regarding the following: any law changes needed for effective implementation; how to coordinate with other insurance coverage the families may have; how managed care plans would operate as to varying coverage; what services would be available, including any gaps under managed care plans; and whether going to managed care results in cost savings to the state. The report shall also provide information by county and major diagnoses of children found eligible and ineligible for TEFRA, the services and amounts paid by the medical assistance program, name of health insurance plan, family income, and total number of TEFRA eligible children in each county.

Sec. 124. **REPEALER.**

Minnesota Statutes 1994, sections 252.27, subdivision 2c; and 256.969, subdivision 24, are repealed.

Minnesota Rules, part 9500.1452, subpart 2, item B, is repealed.

Sec. 125. **EFFECTIVE DATE.**

Subdivision 1. Sections 79 and 80, the amendments to section 256B.15, subdivisions 1a and 2, relating only to the age of a medical assistance recipient for purposes of estate claims, are effective for persons who are between the ages of 55 and 64 on or after July 1, 1995, for the total amount of medical assistance rendered on or after July 1, 1995.

Subd. 2. Sections 34 to 37, section 256B.0595, subdivisions 1, 2, 3, and 4, are effective retroactive to August 11, 1993, except that portion amending subdivision 2, paragraph (c), is effective retroactive to transfers of income or assets made on or after September 1994.

Subd. 3. Sections 28, 108, and 109, sections 256B.056, subdivision 3b, and 501B.89, subdivisions 1 and 3, are effective retroactive to August 11, 1993.

Subd. 4. Sections 14, 49, 84, and 86, sections 256.9657, subdivision 3, 256B.0625, subdivision 38, 256B.19, subdivision 1d, and 256B.431, subdivision 23, are effective the day following final enactment.

Subd. 5. Section 30, the amendment to section 256B.0575, paragraph (a), clause (5), is effective retroactive to January 1, 1994.

Subd. 6. Section 91, the amendment to section 256B.69, subdivision 4, requiring children eligible for medical assistance under section 256B.055, subdivision 12, to participate in managed care, is effective July 1, 1996.

Subd. 7. Section 96, the amendment to section 256B.69, subdivision 6, expanding services under managed care to include home care services and personal care assistant services for certain recipients, is effective July 1, 1996.

Subd. 8. Section 48, section 256B.0625, subdivision 19a, is effective July 1, 1996.

Subd. 9. Section 52, section 256B.0627, subdivision 1, paragraph (c), is effective January 1, 1996; paragraph (d) is effective January 1, 1996, except the deletions relating to responsible party are effective July 1, 1996; and the stricken paragraph (d), the deletion of the definition of responsible party, is effective July 1, 1996.

Subd. 10. Section 53, section 256B.0627, subdivision 2, clause (6), is effective January 1, 1996.

Subd. 11. Section 54, section 256B.0627, subdivision 4, paragraph (a), is effective July 1, 1996; and paragraph (b), clauses (2) and (3), are effective January 1, 1996; and the stricken language in clause (1) and the stricken language in the stricken clause (4), are effective July 1, 1996.

Subd. 12. Section 55, section 256B.0627, subdivision 5, paragraph (a), clause (2), is effective January 1, 1996; paragraph (d) is effective January 1, 1996; paragraph (e), clause (2)(i), the new language relating to the registered nurse supervision is effective January 1, 1996; paragraph (e), clause (2)(i)A, B, C, D, and E, are effective July 1, 1996; paragraph (e), clause (2)(ii), is effective July 1, 1996; paragraph (e), clause (2)(iii), the new language relating to county public health nurse, is effective January 1, 1996, and the stricken language relating to the seizure activity provision, is effective July 1, 1996; paragraph (e), clause (2), the language striking items (v) to (viii), is effective July 1, 1996; paragraph (h), is effective January 1, 1996; and paragraph (i), clause (2), the stricken language

relating to the foster care license holder, and the language in the stricken clause (3) relating to the responsible party, is effective July 1, 1996.

ARTICLE 7

LONG-TERM CARE

Section 1. Minnesota Statutes 1994, section 144.0723, subdivision 1, is amended to read:

Subdivision 1. **CLIENT ~~REIMBURSEMENT~~ CLASSIFICATIONS.** The commissioner of health shall establish ~~reimbursement~~ classifications based upon the assessment of each client in intermediate care facilities for the mentally retarded conducted after December 31, ~~1988~~ 1992, under section 256B.501, subdivision 3g~~, or under rules established by the commissioner of human services under section 256B.501, subdivision 3j~~. The ~~reimbursement~~ classifications established by the commissioner must conform to ~~the~~ section 256B.501, subdivision 3g, and subsequent rules established by the commissioner of human services to set payment rates for intermediate care facilities for the mentally retarded ~~beginning on or after October 1, 1990~~.

Sec. 2. Minnesota Statutes 1994, section 144.0723, subdivision 2, is amended to read:

Subd. 2. **NOTICE OF CLIENT ~~REIMBURSEMENT~~ CLASSIFICATION.** The commissioner of health shall notify each ~~client and~~ intermediate care facility for the mentally retarded ~~in which the client resides~~ of the ~~reimbursement classification~~ classifications established under subdivision 1 for each client residing in the facility. The notice must inform the ~~client~~ intermediate care facility for the mentally retarded of the ~~classification~~ classifications that ~~was~~ are assigned~~, the opportunity to review the documentation supporting the classification, the opportunity to obtain clarification from the commissioner,~~ and the opportunity to request a reconsideration of ~~the classification~~ any classifications assigned. The notice of classification must be sent by first-class mail. ~~The individual client notices may be sent to the client's intermediate care facility for the mentally retarded for distribution to the client. The facility must distribute the notice to the client's case manager and to the client or to the client's representative. This notice must be distributed within three working days after the facility receives the notices from the department. For the purposes of this section, "representative" includes the client's legal representative as defined in Minnesota Rules, part 9525.0015, subpart 18, the person authorized to pay the client's facility expenses, or any other individual designated by the client.~~

Sec. 3. Minnesota Statutes 1994, section 144.0723, subdivision 3, is amended to read:

Subd. 3. **REQUEST FOR RECONSIDERATION.** The ~~client, client's rep-~~

~~resentative, or the~~ intermediate care facility for the mentally retarded may request that the commissioner reconsider the assigned classification. The request for reconsideration must be submitted in writing to the commissioner within 30 days after the receipt of the notice of client classification. The request for reconsideration must include the name of the client, the name and address of the facility in which the client resides, the reasons for the reconsideration, the requested classification changes, and documentation supporting the requested classification. The documentation accompanying the reconsideration request is limited to documentation establishing that the needs of the client and services provided to the client at the time of the assessment resulting in the disputed classification justify a change of classification.

Sec. 4. Minnesota Statutes 1994, section 144.0723, subdivision 4, is amended to read:

Subd. 4. **ACCESS TO INFORMATION.** Annually, at the interdisciplinary team meeting, the intermediate care facility for the mentally retarded shall inform the client or the client's representative and case manager of the client's most recent classification as determined by the department of health. Upon written request, the intermediate care facility for the mentally retarded must give the client's case manager, the client, or the client's representative a copy of the assessment form and the other documentation that was given to the department to support the assessment findings. ~~The facility shall also provide access to and a copy of other information from the client's record that has been requested by or on behalf of the client to support a client's reconsideration request. A copy of any requested material must be provided within three working days after the facility receives a written request for the information. If the facility fails to provide the material within this time, it is subject to the issuance of a correction order and penalty assessment. Notwithstanding this section, any order issued by the commissioner under this subdivision must require that the facility immediately comply with the request for information and that as of the date the order is issued, the facility shall forfeit to the state a $100 fine the first day of noncompliance, and an increase in the $100 fine by $50 increments for each day the noncompliance continues.~~

Sec. 5. Minnesota Statutes 1994, section 144.0723, subdivision 6, is amended to read:

Subd. 6. **RECONSIDERATION.** The commissioner's reconsideration must be made by individuals not involved in reviewing the assessment that established the disputed classification. The reconsideration must be based upon the initial assessment and upon the information provided to the commissioner under ~~subdivisions~~ subdivision 3 ~~and 5. If necessary for evaluating the reconsideration request, the commissioner may conduct on-site reviews. At the commissioner's discretion, the commissioner may review the reimbursement classifications assigned to all clients in the facility.~~ Within 15 working days after receiving the request for reconsideration, the commissioner shall affirm or modify the original client classification. The original classification must be modified

if the commissioner determines that the assessment resulting in the classification did not accurately reflect the status of the client at the time of the assessment. The ~~client and the~~ intermediate care facility for the mentally retarded shall be notified within five working days after the decision is made. The commissioner's decision under this subdivision is the final administrative decision of the agency.

Sec. 6. Minnesota Statutes 1994, section 144.56, is amended by adding a subdivision to read:

Subd. 2b. **BOARDING CARE HOMES.** The commissioner shall not adopt or enforce any rule that limits a certified boarding care home from providing nursing services in accordance with the home's medicaid certification.

Sec. 7. Minnesota Statutes 1994, section 144.562, subdivision 2, is amended to read:

Subd. 2. **ELIGIBILITY FOR LICENSE CONDITION.** A hospital is not eligible to receive a license condition for swing beds unless (1) it either has a licensed bed capacity of less than 50 beds defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 482.66, or it has a licensed bed capacity of 50 beds or more and has swing beds that were approved for Medicare reimbursement before May 1, 1985, or it has a licensed bed capacity of less than 65 beds and~~, as of the effective date,~~ the available nursing homes within 50 miles have had, in the aggregate, an average occupancy ~~rates~~ rate of 96 percent or higher in the ~~past~~ most recent two years as documented on the statistical reports to the department of health; and (2) it is located in a rural area as defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 482.66~~; and (3) it agrees to utilize no more than four hospital beds as swing beds at any one time, except that the commissioner may approve the utilization of up to three additional beds at the request of a hospital if~~. Eligible hospitals are allowed a total of 1,460 days of swing bed use per year, provided that no more than ten hospital beds are used as swing beds at any one time. The commissioner of health must approve swing bed use beyond 1,460 days as long as there are no Medicare certified skilled nursing facility beds ~~are~~ available within 25 miles of that hospital.

Sec. 8. **[144.6505] SUBACUTE CARE WAIVERS.**

Subdivision 1. **SUBACUTE CARE; WAIVER FROM STATE AND FEDERAL RULES AND REGULATIONS.** The commissioners of health and human services shall work with providers to examine state and federal rules and regulations governing the provision of care in nursing facilities and apply for federal waivers and pursue state law changes to any impediments to the provision of subacute care in skilled nursing facilities.

Subd. 2. **DEFINITION OF SUBACUTE CARE.** (a) For the purpose of this section, "subacute care" means comprehensive inpatient care, as further defined in this subdivision, designed for persons who:

(1) have or have had an acute illness or accident, or an acute exacerbation of a chronic illness, and who require a moderate level of service intensity;

(2) do not require, or no longer require, technologically intensive diagnosis or management;

(3) have concurrent medical, nursing, and discharge and/or nondischarge oriented rehabilitation objectives that are expected to be achieved within a specified time; and

(4) require interdisciplinary management.

(b) Subacute care includes goal-oriented treatment rendered immediately after, as an appropriate alternative to, acute hospitalization with the goal of transitioning patients towards increased independence or lower acuity level in a cost-effective environment, to treat one or more specific active complex medical conditions or to administer one or more technically complex treatments, in the context of a patient's underlying long-term conditions and overall situation.

(c) Subacute care does not generally depend heavily on high technology monitoring or complex diagnostic procedures.

(d) Subacute care requires the coordinated services of an interdisciplinary team including physicians, nurses, and other relevant professional disciplines, who are trained and knowledgeable to assess and manage these specific conditions and perform the necessary procedures.

(e) Subacute care is provided as part of a specifically defined program.

(f) Subacute care includes more intensive care than traditional nursing facility care and less intensive care than acute care and may be provided at a variety of sites, including hospitals and skilled nursing facilities.

(g) Subacute care requires recurrent patient assessment on a daily to weekly basis and review of the clinical course and treatment plan for a limited time period ranging from several days to several months, until the condition is stabilized or a predetermined treatment course is completed.

Sec. 9. Minnesota Statutes 1994, section 144A.071, subdivision 2, is amended to read:

Subd. 2. **MORATORIUM.** The commissioner of health, in coordination with the commissioner of human services, shall deny each request for new licensed or certified nursing home or certified boarding care beds except as provided in subdivision 3 or 4a, or section 144A.073. "Certified bed" means a nursing home bed or a boarding care bed certified by the commissioner of health for the purposes of the medical assistance program, under United States Code, title 42, sections 1396 et seq.

The commissioner of human services, in coordination with the commis-

sioner of health, shall deny any request to issue a license under section 252.28 and chapter 245A to a nursing home or boarding care home, if that license would result in an increase in the medical assistance reimbursement amount.

In addition, the commissioner of health must not approve any construction project whose cost exceeds $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~~ damaged by fire, lightning, groundshifts, or other such hazards, including environmental hazards, provided that the provisions of subdivision 4a, clause (a), are met;

(5) as of May 1, 1992, the facility has submitted to the commissioner of health written documentation evidencing that the facility meets the "commenced construction" definition as specified in subdivision 1a, clause (d), or that substantial steps have been taken prior to April 1, 1992, relating to the construction project. "Substantial steps" require that the facility has made arrangements with outside parties relating to the construction project and include the hiring of an architect or construction firm, submission of preliminary plans to the department of health or documentation from a financial institution that financing arrangements for the construction project have been made; or

(6) is being proposed by a licensed nursing facility that is not certified to participate in the medical assistance program and will not result in new licensed or certified beds.

Prior to the final plan approval of any construction project, the commissioner of health shall be provided with an itemized cost estimate for the project construction costs. If a construction project is anticipated to be completed in phases, the total estimated cost of all phases of the project shall be submitted to the commissioner and shall be considered as one construction project. Once the construction project is completed and prior to the final clearance by the commissioner, the total project construction costs for the construction project shall be submitted to the commissioner. If the final project construction cost exceeds the dollar threshold in this subdivision, the commissioner of human services shall

not recognize any of the project construction costs or the related financing costs in excess of this threshold in establishing the facility's property-related payment rate.

The dollar thresholds for construction projects are as follows: for construction projects other than those authorized in clauses (1) to (6), the dollar threshold is $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.

Sec. 10. Minnesota Statutes 1994, section 144A.071, subdivision 3, is amended to read:

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 license or certify a new bed in place of one decertified after 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. 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 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~~

(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; or

(d) to certify two existing beds in a facility with 66 licensed beds on January 1, 1994, that had an average occupancy rate of 98 percent or higher in both calendar years 1992 and 1993, and which began construction of four attached assisted living units in April 1993.

Sec. 11. Minnesota Statutes 1994, section 144A.071, subdivision 4a, is amended to read:

Subd. 4a. **EXCEPTIONS FOR REPLACEMENT BEDS.** It is in the best interest of the state to ensure that nursing homes and boarding care homes continue to meet the physical plant licensing and certification requirements by permitting certain construction projects. Facilities should be maintained in condition to satisfy the physical and emotional needs of residents while allowing the state to maintain control over nursing home expenditure growth.

The commissioner of health in coordination with the commissioner of human services, may approve the renovation, replacement, upgrading, or relocation of a nursing home or boarding care home, under the following conditions:

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

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

(ii) at the time the facility was destroyed or damaged the controlling persons of the facility maintained insurance coverage for the type of hazard that occurred in an amount that a reasonable person would conclude was adequate;

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

(iv) the new facility is constructed on the same site as the destroyed facility or on another site subject to the restrictions in section 144A.073, subdivision 5;

(v) the number of licensed and certified beds in the new facility does not exceed the number of licensed and certified beds in the destroyed facility; and

(vi) the commissioner determines that the replacement beds are needed to prevent an inadequate supply of beds.

Project construction costs incurred for repairs authorized under this clause shall not be considered in the dollar threshold amount defined in subdivision 2;

(b) to license or certify beds that are moved from one location to another within a nursing home facility, provided the total costs of remodeling performed in conjunction with the relocation of beds does not exceed 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~~ 1997;

(o) to allow a project which will be completed in conjunction with an

approved moratorium exception project for a nursing home in southern Cass county and which is directly related to that portion of the facility that must be repaired, renovated, or replaced, to correct an emergency plumbing problem for which a state correction order has been issued and which must be corrected by August 31, 1993;

(p) to allow a facility that on April 16, 1993, was a 368-bed licensed and certified nursing facility located in Minneapolis to layaway, upon 30 days prior written notice to the commissioner, up to 30 of the facility's licensed and certified beds by converting three-bed wards to single or double occupancy. Beds on layaway status shall have the same status as voluntarily delicensed and decertified beds except that beds on layaway status remain subject to the surcharge in section 256.9657, remain subject to the license application and renewal fees under section 144A.07 and shall be subject to a $100 per bed reactivation fee. In addition, at any time within three years of the effective date of the layaway, the beds on layaway status may be:

(1) relicensed and recertified upon relocation and reactivation of some or all of the beds to an existing licensed and certified facility or facilities located in Pine River, Brainerd, or International Falls; provided that the total project construction costs related to the relocation of beds from layaway status for any facility receiving relocated beds may not exceed the dollar threshold provided in subdivision 2 unless the construction project has been approved through the moratorium exception process under section 144A.073;

(2) relicensed and recertified, upon reactivation of some or all of the beds within the facility which placed the beds in layaway status, if the commissioner has determined a need for the reactivation of the beds on layaway status.

The property-related payment rate of a facility placing beds on layaway status must be adjusted by the incremental change in its rental per diem after recalculating the rental per diem as provided in section 256B.431, subdivision 3a, paragraph (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;

(q) to license and certify beds in a renovation and remodeling project to convert 13 three-bed wards into 13 two-bed rooms and 13 single-bed rooms, expand space, and add improvements in a nursing home that, as of January 1, 1994, met the following conditions: the nursing home was located in Ramsey county; was not owned by a hospital corporation; had a licensed capacity of 64 beds; and had been ranked among the top 15 applicants by the 1993 morato-

rium exceptions advisory review panel. The total project construction cost estimate for this project must not exceed the cost estimate submitted in connection with the 1993 moratorium exception process; ~~or~~

(r) to license and certify beds in a renovation and remodeling project to convert 12 four-bed wards into 24 two-bed rooms, expand space, and add improvements in a nursing home that, as of January 1, 1994, met the following conditions: the nursing home was located in Ramsey county; had a licensed capacity of 154 beds; and had been ranked among the top 15 applicants by the 1993 moratorium exceptions advisory review panel. The total project construction cost estimate for this project must not exceed the cost estimate submitted in connection with the 1993 moratorium exception process~~.~~;

(s) to license and certify up to 117 beds that are relocated from a licensed and certified 138-bed nursing facility located in St. Paul to a hospital with 130 licensed hospital beds located in South St. Paul, provided that the nursing facility and hospital are owned by the same or a related organization and that prior to the date the relocation is completed the hospital ceases operation of its inpatient hospital services at that hospital. After relocation, the nursing facility's status under section 256B.431, subdivision 2, shall be the same as it was prior to relocation. The nursing facility's property-related payment rate resulting from the project authorized in this paragraph shall become effective no earlier than April 1, 1996. For purposes of calculating the incremental change in the facility's rental per diem resulting from this project, the allowable appraised value of the nursing facility portion of the existing health care facility physical plant prior to the renovation and relocation may not exceed $2,490,000;

(t) to license and certify two beds in a facility to replace beds that were voluntarily delicensed and decertified on June 28, 1991;

(u) to allow 16 licensed and certified beds located on July 1, 1994, in a 142-bed nursing home and 21-bed boarding care home facility in Minneapolis, notwithstanding the licensure and certification after July 1, 1995, of the Minneapolis facility as a 147-bed nursing home facility after completion of a construction project approved in 1993 under section 144A.073, to be laid away upon 30 days' prior written notice to the commissioner. Beds on layaway status shall have the same status as voluntarily delicensed or decertified beds except that they shall remain subject to the surcharge in section 256.9657. The 16 beds on layaway status may be relicensed as nursing home beds and recertified at any time within five years of the effective date of the layaway upon relocation of some or all of the beds to a licensed and certified facility located in Watertown, provided that the total project construction costs related to the relocation of beds from layaway status for the Watertown facility may not exceed the dollar threshold provided in subdivision 2 unless the construction project has been approved through the moratorium exception process under section 144A.073.

The property-related payment rate of the facility placing beds on layaway status must be adjusted by the incremental change in its rental per diem after recalculating the rental per diem as provided in section 256B.431, subdivision

3a, paragraph (d). The property-related payment rate for the facility relicensing and recertifying beds from layaway status must be adjusted by the incremental change in its rental per diem after recalculating its rental per diem using the number of beds after the relicensing to establish the facility's capacity day divisor, which shall be effective the first day of the month following the month in which the relicensing and recertification became effective. Any beds remaining on layaway status more than five years after the date the layaway status became effective must be removed from layaway status and immediately delicensed and decertified; or

(v) to license and certify beds that are moved within an existing area of a facility or to a newly-constructed addition which is built for the purpose of eliminating three- and four-bed rooms and adding space for dining, lounge areas, bathing rooms, and ancillary service areas in a nursing home that, as of January 1, 1995, was located in Fridley and had a licensed capacity of 129 beds.

Sec. 12. Minnesota Statutes 1994, section 144A.071, is amended by adding a subdivision to read:

Subd. 5a. **COST ESTIMATE OF A MORATORIUM EXCEPTION PROJECT.** (a) For the purposes of this section and section 144A.073, the cost estimate of a moratorium exception project shall include the effects of the proposed project on the costs of the state subsidy for community-based services, nursing services, and housing in institutional and noninstitutional settings. The commissioner of health, in cooperation with the commissioner of human services, shall define the method for estimating these costs in the permanent rule implementing section 144A.073. The commissioner of human services shall prepare an estimate of the total state annual long-term costs of each moratorium exception proposal.

(b) The interest rate to be used for estimating the cost of each moratorium exception project proposal shall be the lesser of either the prime rate plus two percentage points, or the posted yield for standard conventional fixed rate mortgages of the Federal Home Loan Mortgage Corporation plus two percentage points as published in the Wall Street Journal and in effect 56 days prior to the application deadline. If the applicant's proposal uses this interest rate, the commissioner of human services, in determining the facility's actual property-related payment rate to be established upon completion of the project must use the actual interest rate obtained by the facility for the project's permanent financing up to the maximum permitted under subdivision 6.

The applicant may choose an alternate interest rate for estimating the project's cost. If the applicant makes this election, the commissioner of human services, in determining the facility's actual property-related payment rate to be established upon completion of the project, must use the lesser of the actual interest rate obtained for the project's permanent financing or the interest rate which was used to estimate the proposal's project cost. For succeeding rate years, the applicant is at risk for financing costs in excess of the interest rate selected.

Sec. 13. Minnesota Statutes 1994, section 144A.073, subdivision 1, is amended to read:

Subdivision 1. **DEFINITIONS.** For purposes of this section, the following terms have the meanings given them:

(a) "Conversion" means the relocation of a nursing home bed from a nursing home to an attached hospital.

(b) "Relocation" means the movement of licensed nursing home beds or certified boarding care beds as permitted under subdivision 4, clause (3), and subdivision 5.

(c) "Renovation" means extensive remodeling of, or construction of an addition to, a facility on an existing site with a total cost exceeding ten percent of the appraised value of the facility or $200,000, whichever is less.

~~(c)~~ (d) "Replacement" means the demolition ~~or~~, delicensure, reconstruction, or construction of an addition to all or part of an existing facility.

~~(d)~~ (e) "Upgrading" means a change in the level of licensure of a bed from a boarding care bed to a nursing home bed in a certified boarding care facility.

Sec. 14. Minnesota Statutes 1994, section 144A.073, subdivision 2, is amended to read:

Subd. 2. **REQUEST FOR PROPOSALS.** At the ~~intervals specified in rules~~ authorization by the legislature of additional medical assistance expenditures for exceptions to the moratorium on nursing homes, the interagency committee shall publish in the State Register a request for proposals for nursing home projects to be licensed or certified under section 144A.071, subdivision 4a, clause (c). The public notice of this funding and the request for proposals must specify how the approval criteria will be prioritized by the advisory review panel, the interagency long-term care planning committee, and the commissioner. The notice must describe the information that must accompany a request and state that proposals must be submitted to the interagency committee within 90 days of the date of publication. The notice must include the amount of the legislative appropriation available for the additional costs to the medical assistance program of projects approved under this section. If no money is appropriated for a year, ~~the notice for that year must state that proposals will not be requested because no appropriations were made~~ the interagency committee shall publish a notice to that effect, and no proposals shall be requested. If money is appropriated, the interagency committee shall initiate the application and review process described in this section at least twice each biennium and up to four times each biennium, according to dates established by rule. Authorized funds shall be allocated proportionally to the number of processes. Funds not encumbered by an earlier process within a biennium shall carry forward to subsequent iterations of the process. Authorization for expenditures does not carry forward into the following biennium. To be considered for approval, a proposal must include the following information:

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

(2) a description of the problem the project is designed to address;

(3) a description of the proposed project;

(4) an analysis of projected costs of the nursing facility proposal, including initial construction and remodeling costs~~,~~; site preparation costs~~,~~; financing costs, including the current estimated long-term financing costs of the proposal, which consists of estimates of the amount and sources of money, reserves if required under the proposed funding mechanism, annual payments schedule, interest rates, length of term, closing costs and fees, insurance costs, and any completed marketing study or underwriting review; and estimated operating costs during the first two years after completion of the project;

(5) for proposals involving replacement of all or part of a facility, the proposed location of the replacement facility and an estimate of the cost of addressing the problem through renovation;

(6) for proposals involving renovation, an estimate of the cost of addressing the problem through replacement;

(7) the proposed timetable for commencing construction and completing the project; ~~and~~

(8) a statement of any licensure or certification issues, such as certification survey deficiencies;

(9) the proposed relocation plan for current residents if beds are to be closed so that the department of human services can estimate the total costs of a proposal; and

(10) other information required by permanent rule of the commissioner of health in accordance with subdivisions 4 and 8.

Sec. 15. Minnesota Statutes 1994, 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 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 commis-

sioner 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 advisory review panel, the committee, and the commissioner of health shall base their recommendations, approvals, or disapprovals on a comparison and ranking of proposals using only the criteria in subdivision 4 and in emergency and permanent rules adopted by the commissioner. 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 1a, paragraph (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. 16. Minnesota Statutes 1994, section 144A.073, is amended by adding a subdivision to read:

Subd. 3c. **COST NEUTRAL RELOCATION PROJECTS.** (a) Notwithstanding subdivision 3, the interagency committee may at any time accept proposals, or amendments to proposals previously approved under this section, for relocations that are cost neutral with respect to state costs as defined in section 144A.071, subdivision 5a. The committee shall review these applications and make recommendations to the commissioner within 90 days. The committee must evaluate proposals according to subdivision 4, clauses (1), (2), and (3), and other criteria established in rule. The commissioner shall approve or disapprove a project within 30 days of receiving the committee's recommendation. Proposals and amendments approved under this subdivision are not subject to the six-mile limit in subdivision 5, paragraph (e).

(b) For the purposes of paragraph (a), cost neutrality shall be measured over the first three 12-month periods of operation after completion of the project.

Sec. 17. Minnesota Statutes 1994, section 144A.073, subdivision 4, is amended to read:

Subd. 4. **CRITERIA FOR REVIEW.** ~~(a)~~ The following criteria ~~must~~ shall be used in a consistent manner to compare ~~and~~, evaluate, and rank all proposals submitted. Except for the criteria specified in clause (3), the application of criteria listed under this subdivision shall not reflect any distinction based on the geographic location of the proposed project:

(1) ~~the extent to which the average occupancy rate of the facility supports the need for the proposed project;~~

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

~~(2) the extent to which the average occupancy rate of all facilities in the county in which the applicant is located, together with all contiguous Minnesota counties, supports the need for the proposed project;~~

~~(3)~~ the extent to which the proposal furthers state long-term care goals, including the goals stated in section 144A.31, and including the goal of enhancing the availability and use of alternative care services and the goal of reducing the number of long-term care resident rooms with more than two beds;

~~(4) the cost-effectiveness of the proposal, including~~ (2) the proposal's long-term effects on ~~the~~ state costs ~~of the medical assistance program, as determined by the commissioner of human services; and~~ including the cost estimate of the project according to section 144A.071, subdivision 5a;

~~(5) other factors developed in rule by the commissioner of health that evaluate and assess how the proposed project will further promote or protect the health, safety, comfort, treatment, or well-being of the facility's residents.~~

~~(b) In addition to the criteria in paragraph (a), the following criteria must be used to evaluate, compare, and rank proposals involving renovation or replacement:~~

(3) the extent to which the proposal promotes equitable access to long-term care services in nursing homes through redistribution of the nursing home bed supply, as measured by the number of beds relative to the population 85 or older, projected to the year 2000 by the state demographer, and according to items (i) to (iv):

(i) reduce beds in counties where the supply is high, relative to the statewide mean, and increase beds in counties where the supply is low, relative to the statewide mean;

(ii) adjust the bed supply so as to create the greatest benefits in improving the distribution of beds;

(iii) adjust the existing bed supply in counties so that the bed supply in a county moves toward the statewide mean; and

(iv) adjust the existing bed supply so that the distribution of beds as projected for the year 2020 would be consistent with projected need, based on the methodology outlined in the interagency long-term care committee's 1993 nursing home bed distribution study;

~~(1)~~ (4) the extent to which the project improves conditions that affect the health or safety of residents, such as narrow corridors, narrow door frames, unenclosed fire exits, and wood frame construction, and similar provisions contained in fire and life safety codes and licensure and certification rules;

~~(2)~~ (5) the extent to which the project improves conditions that affect the comfort or quality of life of residents in a facility or the ability of the facility to

provide efficient care, such as a relatively high number of residents in a room; inadequate lighting or ventilation; poor access to bathing or toilet facilities; a lack of available ancillary space for dining rooms, day rooms, or rooms used for other activities; problems relating to heating, cooling, or energy efficiency; inefficient location of nursing stations; narrow corridors; or other provisions contained in the licensure and certification rules;

(6) the extent to which the applicant demonstrates the delivery of quality care, as defined in state and federal statutes and rules, to residents as evidenced by the two most recent state agency certification surveys and the applicants' response to those surveys;

(7) the extent to which the project removes the need for waivers or variances previously granted by either the licensing agency, certifying agency, fire marshal, or local government entity; and

(8) other factors that may be developed in permanent rule by the commissioner of health that evaluate and assess how the proposed project will further promote or protect the health, safety, comfort, treatment, or well-being of the facility's residents.

Sec. 18. Minnesota Statutes 1994, section 144A.073, subdivision 5, is amended to read:

Subd. 5. **REPLACEMENT RESTRICTIONS.** (a) Proposals submitted or approved under this section involving replacement must provide for replacement of the facility on the existing site except as allowed in this subdivision.

(b) Facilities located in a metropolitan statistical area other than the Minneapolis-St. Paul seven-county metropolitan area may relocate to a site within the same census tract or a contiguous census tract.

(c) Facilities located in the Minneapolis-St. Paul seven-county metropolitan area may relocate to a site within the same or contiguous health planning area as adopted in March 1982 by the metropolitan council.

(d) Facilities located outside a metropolitan statistical area may relocate to a site within the same city or township, or within a contiguous township.

(e) A facility relocated to a different site under paragraph (b), (c), or (d) must not be relocated to a site more than six miles from the existing site.

(f) The relocation of part of an existing first facility to a second location, under paragraphs (d) and (e), may include the relocation to the second location of up to four beds from part of an existing third facility located in a township contiguous to the location of the first facility. The six-mile limit in paragraph (e) does not apply to this relocation from the third facility.

(g) For proposals approved on January 13, 1994, under this section involving the replacement of 102 licensed and certified beds, the relocation of the

existing first facility to the second and third locations under paragraphs (d) and (e) may include the relocation of up to 50 percent of the beds of the existing first facility to each of the locations. The six-mile limit in paragraph (e) does not apply to this relocation to the third location. Notwithstanding subdivision 3, construction of this project may be commenced any time prior to January 1, 1996.

Sec. 19. Minnesota Statutes 1994, section 144A.073, subdivision 8, is amended to read:

Subd. 8. **RULEMAKING.** The commissioner of health shall adopt ~~emergency or~~ permanent rules to implement this section. The permanent rules must be in accordance with and implement only the criteria listed in this section. The authority to adopt ~~emergency~~ permanent rules continues until ~~December 30, 1988~~ July 1, 1996.

Sec. 20. Minnesota Statutes 1994, section 198.003, subdivision 3, is amended to read:

Subd. 3. **USE OF ~~FACILITIES~~ CAMPUS.** The board may allow veterans organizations or public or private social service, educational, or rehabilitation agencies or organizations and their clients to use surplus ~~facilities~~ space on a home's campus, staff, and other resources of the board and may require the participating agencies or organizations to pay for that use.

Sec. 21. Minnesota Statutes 1994, section 198.003, subdivision 4, is amended to read:

Subd. 4. **VETERANS HOMES RESOURCES ACCOUNT.** Money received by the board under subdivision 3 must be deposited in the state treasury and credited to a veterans homes resources account in the special revenue fund. Money in the account is appropriated to the board to operate, maintain, and ~~repair facilities~~ make repairs at the campus used under subdivision 3, ~~and to pay~~ including payment of associated legal fees and expenses.

Sec. 22. Minnesota Statutes 1994, section 256B.0641, subdivision 1, is amended to read:

Subdivision 1. **RECOVERY PROCEDURES; SOURCES.** Notwithstanding section 256B.72 or any law or rule to the contrary, when the commissioner or the federal government determines that an overpayment has been made by the state to any medical assistance vendor, the commissioner shall recover the overpayment as follows:

(1) if the federal share of the overpayment amount is due and owing to the federal government under federal law and regulations, the commissioner shall recover from the medical assistance vendor the federal share of the determined overpayment amount paid to that provider using the schedule of payments required by the federal government; ~~and~~

(2) if the overpayment to a medical assistance vendor is due to a retroactive adjustment made because the medical assistance vendor's temporary payment rate was higher than the established desk audit payment rate or because of a department error in calculating a payment rate, the commissioner shall recover from the medical assistance vendor the total amount of the overpayment within 120 days after the date on which written notice of the adjustment is sent to the medical assistance vendor or according to a schedule of payments approved by the commissioner; and

(3) a medical assistance vendor is liable for the overpayment amount owed by a long-term care provider if the vendors or their owners are under common control or ownership.

Sec. 23. Minnesota Statutes 1994, section 256B.431, subdivision 2j, is amended to read:

Subd. 2j. **HOSPITAL-ATTACHED NURSING FACILITY STATUS.** (a) For the purpose of setting rates under Minnesota Rules, parts 9549.0010 to 9549.0080, for rate years beginning after June 30, 1989, a hospital-attached nursing facility means a nursing facility which meets the requirements of clauses (1) to (3):

(1) the nursing facility is recognized by the federal Medicare program to be a hospital-based nursing facility for purposes of being subject to higher cost limits accorded hospital-based nursing facilities under the Medicare program, or, prior to June 30, 1983, was classified as a hospital-attached nursing facility under Minnesota Rules, parts 9510.0010 to 9510.0480~~, provided that~~;

(2) the nursing facility's cost report filed under Minnesota Rules, parts 9549.0010 to 9549.0080, shall use the same cost allocation principles and methods used in the reports filed for the Medicare program except as provided in clause (3); and

(3) direct identification of costs to the nursing facility cost center will be permitted only when the comparable hospital costs have also been directly identified to a cost center which is not allocated to the nursing facility.

(b) For rate years beginning after June 30, 1989, a nursing facility and hospital, which have applied for hospital-based nursing facility status under the federal Medicare program during the reporting year or the nine-month period following the nursing facility's reporting year, shall be considered a hospital-attached nursing facility for purposes of setting payment rates under Minnesota Rules, parts 9549.0010 to 9549.0080, for the rate year following the reporting year or the nine-month period in which the facility made its Medicare application. The nursing facility must file its cost report or an amended cost report for that reporting year before the following rate year using Medicare principles and Medicare's recommended cost allocation methods had the Medicare program's hospital-based nursing facility status been granted to the nursing facility. For each subsequent rate year, the nursing facility must meet the definition require-

ments in paragraph (a). If the nursing facility is denied hospital-based nursing facility status under the Medicare program, the nursing facility's payment rates for the rate years the nursing facility was considered to be a hospital-attached nursing facility pursuant to this paragraph shall be recalculated treating the nursing facility as a non-hospital-attached nursing facility.

(c) For rate years beginning on or after July 1, 1995, a nursing facility shall be considered a hospital attached nursing facility for purposes of setting payment rates under Minnesota Rules, parts 9549.0010 to 9549.0080 and this section if it meets the requirements of paragraphs (a) and (b), and

(1) the hospital and nursing facility are physically attached or connected by a tunnel or skyway; or

(2) the nursing facility was recognized by the Medicare program as hospital attached as of January 1, 1995, and this status has been maintained continuously.

Sec. 24. Minnesota Statutes 1994, 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)~~ (e).

(a) Notwithstanding Minnesota Rules, part 9549.0060, subpart 12, the costs of ~~acquiring~~ any of the following items not included in the equity incentive computations under subdivision 16 or reported as a capital asset addition under subdivision 18, paragraph (b), including cash payment for equity investment and principal and interest expense for debt financing, ~~shall~~ must 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; and

(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) repair or replacement of capital assets not included in the equity incentive computations under subdivision 16.~~

(b) Notwithstanding Minnesota Rules, part 9549.0060, subpart 12, the repair or replacement of a capital asset not included in the equity incentive computations under subdivision 16 or reported as a capital asset addition under subdivision 18, paragraph (b), must be reported under this subdivision when the cost of the item exceeds $500, or in the plant operations and maintenance cost category when the cost of the item is equal to or less than $500.

(c) 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)~~ (d) 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)~~ (e) 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. 25. Minnesota Statutes 1994, section 256B.431, subdivision 17, is amended to read:

Subd. 17. **SPECIAL PROVISIONS FOR MORATORIUM EXCEPTIONS.** (a) Notwithstanding Minnesota Rules, part 9549.0060, subpart 3, for rate periods beginning on October 1, 1992, and for rate years beginning after June 30, 1993, a nursing facility that (1) has completed a construction project approved under section 144A.071, subdivision 4a, clause (m); (2) has completed a construction project approved under section 144A.071, subdivision 4a and

effective after June 30, 1995; or (3) has completed a renovation, replacement, or upgrading project approved under the moratorium exception process in section 144A.073 shall be reimbursed for costs directly identified to that project as provided in subdivision 16 and this subdivision.

(b) Notwithstanding Minnesota Rules, part 9549.0060, subparts 5, item A, subitems (1) and (3), and 7, item D, allowable interest expense on debt shall include:

(1) interest expense on debt related to the cost of purchasing or replacing depreciable equipment, excluding vehicles, not to exceed six percent of the total historical cost of the project; and

(2) interest expense on debt related to financing or refinancing costs, including costs related to points, loan origination fees, financing charges, legal fees, and title searches; and issuance costs including bond discounts, bond counsel, underwriter's counsel, corporate counsel, printing, and financial forecasts. Allowable debt related to items in this clause shall not exceed seven percent of the total historical cost of the project. To the extent these costs are financed, the straight-line amortization of the costs in this clause is not an allowable cost; and

(3) interest on debt incurred for the establishment of a debt reserve fund, net of the interest earned on the debt reserve fund.

(c) Debt incurred for costs under paragraph (b) is not subject to Minnesota Rules, part 9549.0060, subpart 5, item A, subitem (5) or (6).

(d) The incremental increase in a nursing facility's rental rate, determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section, resulting from the acquisition of allowable capital assets, and allowable debt and interest expense under this subdivision shall be added to its property-related payment rate and shall be effective on the first day of the month following the month in which the moratorium project was completed.

(e) Notwithstanding subdivision 3f, paragraph (a), for rate periods beginning on October 1, 1992, and for rate years beginning after June 30, 1993, the replacement-costs-new per bed limit to be used in Minnesota Rules, part 9549.0060, subpart 4, item B, for a nursing facility that has completed a renovation, replacement, or upgrading project that has been approved under the moratorium exception process in section 144A.073, or that has completed an addition to or replacement of buildings, attached fixtures, or land improvements for which the total historical cost exceeds the lesser of $150,000 or ten percent of the most recent appraised value, must be $47,500 per licensed bed in multiple-bed rooms and $71,250 per licensed bed in a single-bed room. These amounts must be adjusted annually as specified in subdivision 3f, paragraph (a), beginning January 1, 1993.

(f) A nursing facility that completes a project identified in this subdivision and, as of April 17, 1992, has not been mailed a rate notice with a special

appraisal for a completed project, or completes a project after April 17, 1992, but before September 1, 1992, may elect either to request a special reappraisal with the corresponding adjustment to the property-related payment rate under the laws in effect on June 30, 1992, or to submit their capital asset and debt information after that date and obtain the property-related payment rate adjustment under this section, but not both.

(g) For purposes of this paragraph, a total replacement means the complete replacement of the nursing facility's physical plant through the construction of a new physical plant or the transfer of the nursing facility's license from one physical plant location to another. For total replacement projects completed on or after July 1, 1992, the commissioner shall compute the incremental change in the nursing facility's rental per diem, for rate years beginning on or after July 1, 1995, by replacing its appraised value, including the historical capital asset costs, and the capital debt and interest costs with the new nursing facility's allowable capital asset costs and the related allowable capital debt and interest costs. If the new nursing facility has decreased its licensed capacity, the aggregate investment per bed limit in subdivision 3a, paragraph (d), shall apply. If the new nursing facility has retained a portion of the original physical plant for nursing facility usage, then a portion of the appraised value prior to the replacement must be retained and included in the calculation of the incremental change in the nursing facility's rental per diem. For purposes of this part, the original nursing facility means the nursing facility prior to the total replacement project. The portion of the appraised value to be retained shall be calculated according to clauses (1) to (3):

(1) The numerator of the allocation ratio shall be the square footage of the area in the original physical plant which is being retained for nursing facility usage.

(2) The denominator of the allocation ratio shall be the total square footage of the original nursing facility physical plant.

(3) Each component of the nursing facility's allowable appraised value prior to the total replacement project shall be multiplied by the allocation ratio developed by dividing clause (1) by clause (2).

In the case of either type of total replacement as authorized under section 144A.071 or 144A.073, the provisions of this subdivision shall also apply. For purposes of the moratorium exception authorized under section 144A.071, subdivision 4a, paragraph (s), if the total replacement involves the renovation and use of an existing health care facility physical plant, the new allowable capital asset costs and related debt and interest costs shall include first the allowable capital asset costs and related debt and interest costs of the renovation, to which shall be added the allowable capital asset costs of the existing physical plant prior to the renovation, and if reported by the facility, the related allowable capital debt and interest costs.

Sec. 26. Minnesota Statutes 1994, section 256B.431, is amended by adding a subdivision to read:

Subd. 25. **CHANGES TO NURSING FACILITY REIMBURSEMENT BEGINNING JULY 1, 1995.** The nursing facility reimbursement changes in paragraphs (a) to (g) shall apply in the sequence specified to Minnesota Rules, parts 9549.0010 to 9549.0080, and this section, beginning July 1, 1995.

(a) The eight-cent adjustment to care-related rates in subdivision 22, paragraph (e), shall no longer apply.

(b) For rate years beginning on or after July 1, 1995, the commissioner shall limit a nursing facility's allowable operating per diem for each case mix category for each rate year as in clauses (1) to (3).

(1) For the rate year beginning July 1, 1995, the commissioner shall group nursing facilities into two groups, freestanding and nonfreestanding, within each geographic group, using their operating cost per diem for the case mix A classification. A nonfreestanding nursing facility is a nursing facility whose other operating cost per diem is subject to the hospital attached, short length of stay, or the rule 80 limits. All other nursing facilities shall be considered freestanding nursing facilities. The commissioner shall then array all nursing facilities in each grouping by their allowable case mix A operating cost per diem. In calculating a nursing facility's operating cost per diem for this purpose, the commissioner shall exclude the raw food cost per diem related to providing special diets that are based on religious beliefs, as determined in subdivision 2b, paragraph (h). For those nursing facilities in each grouping whose case mix A operating cost per diem:

(i) is at or below the median minus 1.0 standard deviation of the array, the commissioner shall limit the nursing facility's allowable operating cost per diem for each case mix category to the lesser of the prior reporting year's allowable operating cost per diems plus the inflation factor as established in paragraph (f), clause (2), increased by six percentage points, or the current reporting year's corresponding allowable operating cost per diem;

(ii) is between minus .5 standard deviation and minus 1.0 standard deviation below the median of the array, the commissioner shall limit the nursing facility's allowable operating cost per diem for each case mix category to the lesser of the prior reporting year's allowable operating cost per diems plus the inflation factor as established in paragraph (f), clause (2), increased by four percentage points, or the current reporting year's corresponding allowable operating cost per diem; or

(iii) is equal to or above minus .5 standard deviation below the median of the array, the commissioner shall limit the nursing facility's allowable operating cost per diem for each case mix category to the lesser of the prior reporting year's allowable operating cost per diems plus the inflation factor as established in paragraph (f), clause (2), increased by three percentage points, or the current reporting year's corresponding allowable operating cost per diem.

(2) For the rate year beginning on July 1, 1996, the commissioner shall limit

the nursing facility's allowable operating cost per diem for each case mix category to the lesser of the prior reporting year's allowable operating cost per diems plus the inflation factor as established in paragraph (f), clause (2), increased by one percentage point or the current reporting year's corresponding allowable operating cost per diems; and

(3) For rate years beginning on or after July 1, 1997, the commissioner shall limit the nursing facility's allowable operating cost per diem for each case mix category to the lesser of the reporting year prior to the current reporting year's allowable operating cost per diems plus the inflation factor as established in paragraph (f), clause (2), or the current reporting year's corresponding allowable operating cost per diems.

(c) For rate years beginning on July 1, 1995, the commissioner shall limit the allowable operating cost per diems for high cost nursing facilities. After application of the limits in paragraph (b) to each nursing facility's operating cost per diems, the commissioner shall group nursing facilities into two groups, freestanding or nonfreestanding, within each geographic group. A nonfreestanding nursing facility is a nursing facility whose other operating cost per diems are subject to hospital attached, short length of stay, or rule 80 limits. All other nursing facilities shall be considered freestanding nursing facilities. The commissioner shall then array all nursing facilities within each grouping by their allowable case mix A operating cost per diems. In calculating a nursing facility's operating cost per diem for this purpose, the commissioner shall exclude the raw food cost per diem related to providing special diets that are based on religious beliefs, as determined in subdivision 2b, paragraph (h). For those nursing facilities in each grouping whose case mix A operating cost per diem exceeds 1.0 standard deviation above the median, the commissioner shall reduce their allowable operating cost per diems by two percent. For those nursing facilities in each grouping whose case mix A operating cost per diem exceeds 0.5 standard deviation above the median but is less than or equal to 1.0 standard deviation above the median, the commissioner shall reduce their allowable operating cost per diems by one percent.

(d) For rate years beginning on or after July 1, 1996, the commissioner shall limit the allowable operating cost per diems for high cost nursing facilities. After application of the limits in paragraph (b) to each nursing facility's operating cost per diems, the commissioner shall group nursing facilities into two groups, freestanding or nonfreestanding, within each geographic group. A nonfreestanding nursing facility is a nursing facility whose other operating cost per diems are subject to hospital attached, short length of stay, or rule 80 limits. All other nursing facilities shall be considered freestanding nursing facilities. The commissioner shall then array all nursing facilities within each grouping by their allowable case mix A operating cost per diems. In calculating a nursing facility's operating cost per diem for this purpose, the commissioner shall exclude the raw food cost per diem related to providing special diets that are based on religious beliefs, as determined in subdivision 2b, paragraph (h). In those nursing facilities in each grouping whose case mix A operating cost per diem exceeds 1.0 stan-

dard deviation above the median, the commissioner shall reduce their allowable operating cost per diems by three percent. For those nursing facilities in each grouping whose case mix A operating cost per diem exceeds 0.5 standard deviation above the median but is less than or equal to 1.0 standard deviation above the median, the commissioner shall reduce their allowable operating cost per diems by two percent.

(e) For rate years beginning on or after July 1, 1995, the commissioner shall determine a nursing facility's efficiency incentive by first computing the allowable difference, which is the lesser of $4.50 or 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 compute the efficiency incentive by:

(1) subtracting the allowable difference from $4.50 and dividing the result by $4.50;

(2) multiplying 0.20 by the ratio resulting from clause (1), and then;

(3) adding 0.50 to the result from clause (2); and

(4) multiplying the result from clause (3) times the allowable difference.

The nursing facility's efficiency incentive payment shall be the lesser of $2.25 or the product obtained in clause (4).

(f) For rate years beginning on or after July 1, 1995, the forecasted price index for a nursing facility's allowable operating cost per diems shall be determined under clause (1) to (3) using the change in the Consumer Price Index-All Items (United States city average) (CPI-U) or the change in the Nursing Home Market Basket, both as forecasted by Data Resources Inc. whichever is applicable. The commissioner shall use the indices as forecasted in the fourth quarter of the calendar year preceding the rate year, subject to subdivision 2l, paragraph (c). If, as a result of federal legislative or administrative action, the methodology used to calculate the Consumer Price Index-All Items (United States city average) (CPI-U) changes, the commissioner shall develop a conversion factor or other methodology to convert the CPI-U index factor that results from the new methodology to an index factor that approximates, as closely as possible, the index factor that would have resulted from application of the original CPI-U methodology prior to any changes in methodology. The commissioner shall use the conversion factor or other methodology to calculate an adjusted inflation index. The adjusted inflation index must be used to calculate payment rates under this section instead of the CPI-U index specified in paragraph (d). If the commissioner is required to develop an adjusted inflation index, the commissioner shall report to the legislature as part of the next budget submission the fiscal impact of applying this index.

(1) The CPI-U forecasted index for allowable operating cost per diems shall be based on the 21-month period from the midpoint of the nursing facility's reporting year to the midpoint of the rate year following the reporting year.

(2) The Nursing Home Market Basket forecasted index for allowable operating costs and per diem limits shall be based on the 12-month period between the midpoints of the two reporting years preceding the rate year.

(3) For rate years beginning on or after July 1, 1996, the forecasted index for operating cost limits referred to in subdivision 21, paragraph (b), shall be based on the CPI-U for the 12-month period between the midpoints of the two reporting years preceding the rate year.

(g) After applying these provisions for the respective rate years, the commissioner shall index these allowable operating costs per diems by the inflation factor provided for in paragraph (f), clause (1), and add the nursing facility's efficiency incentive as computed in paragraph (e).

Sec. 27. Minnesota Statutes 1994, section 256B.432, subdivision 1, is amended to read:

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

(a) "Management agreement" means an agreement in which one or more of the following criteria exist:

(1) the central, affiliated, or corporate office has or is authorized to assume day-to-day operational control of the ~~long-term care~~ nursing facility for any six-month period within a 24-month period. "Day-to-day operational control" means that the central, affiliated, or corporate office has the authority to require, mandate, direct, or compel the employees of the ~~long-term care~~ nursing facility to perform or refrain from performing certain acts, or to supplant or take the place of the top management of the ~~long-term care~~ nursing facility. "Day-to-day operational control" includes the authority to hire or terminate employees or to provide an employee of the central, affiliated, or corporate office to serve as administrator of the ~~long-term care~~ nursing facility;

(2) the central, affiliated, or corporate office performs or is authorized to perform two or more of the following: the execution of contracts; authorization of purchase orders; signature authority for checks, notes, or other financial instruments; requiring the ~~long-term care~~ nursing facility to use the group or volume purchasing services of the central, affiliated, or corporate office; or the authority to make annual capital expenditures for the ~~long-term care~~ nursing facility exceeding $50,000, or $500 per licensed bed, whichever is less, without first securing the approval of the ~~long-term care~~ nursing facility board of directors;

(3) the central, affiliated, or corporate office becomes or is required to become the licensee under applicable state law;

(4) the agreement provides that the compensation for services provided under the agreement is directly related to any profits made by the ~~long-term care~~ nursing facility; or

(5) the ~~long-term care~~ nursing facility entering into the agreement is governed by a governing body that meets fewer than four times a year, that does not publish notice of its meetings, or that does not keep formal records of its proceedings.

(b) "Consulting agreement" means any agreement the purpose of which is for a central, affiliated, or corporate office to advise, counsel, recommend, or suggest to the owner or operator of the nonrelated ~~long-term care~~ nursing facility measures and methods for improving the operations of the ~~long-term care~~ nursing facility.

(c) "~~Long-term care~~ Nursing facility" means a nursing facility whose medical assistance rates are determined according to section 256B.431 ~~or an intermediate care facility for persons with mental retardation and related conditions whose medical assistance rates are determined according to section 256B.501~~.

Sec. 28. Minnesota Statutes 1994, section 256B.432, subdivision 2, is amended to read:

Subd. 2. **EFFECTIVE DATE.** For rate years beginning on or after July 1, 1990, the central, affiliated, or corporate office cost allocations in subdivisions 3 to 6 must be used when determining medical assistance rates under sections 256B.431 and ~~256B.501~~ 256B.50.

Sec. 29. Minnesota Statutes 1994, section 256B.432, subdivision 3, is amended to read:

Subd. 3. **ALLOCATION; DIRECT IDENTIFICATION OF COSTS OF ~~LONG-TERM CARE~~ NURSING FACILITIES; MANAGEMENT AGREEMENT.** All costs that can be directly identified with a specific ~~long-term care~~ nursing facility that is a related organization to the central, affiliated, or corporate office, or that is controlled by the central, affiliated, or corporate office under a management agreement, must be allocated to that ~~long-term care~~ nursing facility.

Sec. 30. Minnesota Statutes 1994, 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~~ nursing facility operations and the other activities or facilities unrelated to the ~~long-term care~~ nursing facility operations based on the ratio of 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~~ nursing 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~~ nursing facility;

(2) for a central, affiliated, or corporate office providing goods or services to related organizations that are not ~~long-term care~~ nursing 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~~ nonnursing facility related organizations;

(3) for a central, affiliated, or corporate office providing goods or services to unrelated ~~long-term care~~ nursing 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~~ nursing 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. 31. Minnesota Statutes 1994, section 256B.432, subdivision 6, is amended to read:

Subd. 6. **COST ALLOCATION BETWEEN ~~LONG-TERM CARE~~ NURSING FACILITIES.** (a) Those ~~long-term care~~ nursing operations that have ~~long-term care~~ nursing facilities both in Minnesota and comparable facilities outside of Minnesota must allocate the ~~long-term care~~ nursing operation's central, affiliated, or corporate office costs identified in subdivision 5 to Minnesota based on the ratio of total resident days in Minnesota ~~long-term care~~ nursing facilities to the total resident days in all facilities.

(b) The Minnesota ~~long-term care~~ nursing operation's central, affiliated, or corporate office costs identified in paragraph (a) must be allocated to each Minnesota ~~long-term care~~ nursing facility on the basis of resident days.

Sec. 32. **[256B.434] CONTRACTUAL ALTERNATIVE PAYMENT DEMONSTRATION PROJECT FOR NURSING HOMES.**

Subdivision 1. **ALTERNATIVE PAYMENT DEMONSTRATION PROJECT ESTABLISHED.** The commissioner of human services shall establish a contractual alternative payment demonstration project for paying for nursing facility services under the medical assistance program. A nursing facility may apply to be paid under the contractual alternative payment demonstration project instead of the cost-based payment system established under section 256B.431. A nursing facility electing to use the alternative payment demonstration project must enter into a contract with the commissioner. Payment rates

and procedures for facilities electing to use the alternative payment demonstration project are determined and governed by this section and by the terms of the contract. The commissioner may negotiate different contract terms for different nursing facilities.

Subd. 2. **REQUESTS FOR PROPOSALS.** (a) No later than August 1, 1995, the commissioner shall publish in the State Register a request for proposals to provide nursing facility services according to this section. The commissioner shall issue two additional requests for proposals prior to July 1, 1997, based upon a timetable established by the commissioner. The commissioner must respond to all proposals in a timely manner.

(b) The commissioner may reject any proposal if, in the judgment of the commissioner, a contract with a particular facility is not in the best interests of the residents of the facility or the state of Minnesota. The commissioner may accept up to the number of proposals that can be adequately supported with available state resources, as determined by the commissioner, except that the commissioner shall not contract with more than 40 nursing facilities as part of any request for proposals. The commissioner may accept proposals from a single nursing facility or from a group of facilities through a managing entity. The commissioner shall seek to ensure that nursing facilities under contract are located in all geographic areas of the state. The commissioner shall present recommendations to the legislature by February 1, 1996, on the number of nursing facility contracts that may be entered into by the commissioner as a result of a request for proposals.

(c) In issuing the request for proposals, the commissioner may develop reasonable requirements which, in the judgment of the commissioner, are necessary to protect residents or ensure that the contractual alternative payment demonstration project furthers the interest of the state of Minnesota. The request for proposals may include, but need not be limited to, the following:

(1) a requirement that a nursing facility make reasonable efforts to maximize Medicare payments on behalf of eligible residents;

(2) requirements designed to prevent inappropriate or illegal discrimination against residents enrolled in the medical assistance program as compared to private paying residents;

(3) requirements designed to ensure that admissions to a nursing facility are appropriate and that reasonable efforts are made to place residents in home and community-based settings when appropriate;

(4) a requirement to agree to participate in a project to develop data collection systems and outcome-based standards for managed care contracting for long-term care services. Among other requirements specified by the commissioner, each facility entering into a contract may be required to pay an annual fee in an amount determined by the commissioner not to exceed $50 per bed. Revenue generated from the fees is appropriated to the commissioner and must

be used to contract with a qualified consultant or contractor to develop data collection systems and outcome-based contracting standards;

(5) a requirement that contractors agree to maintain Medicare cost reports and to submit them to the commissioner upon request or at times specified by the commissioner;

(6) a requirement for demonstrated willingness and ability to develop and maintain data collection and retrieval systems to be used in measuring outcomes; and

(7) a requirement to provide all information and assurances required by the terms and conditions of the federal waiver or federal approval.

(d) In addition to the information and assurances contained in the submitted proposals, the commissioner may consider the following in determining whether to accept or deny a proposal:

(1) the facility's history of compliance with federal and state laws and rules;

(2) whether the facility has a record of excessive licensure fines or sanctions or fraudulent cost reports;

(3) financial history and solvency; and

(4) other factors identified by the commissioner that the commissioner deems relevant to a determination that a contract with a particular facility is not in the best interests of the residents of the facility or the state of Minnesota.

(e) If the commissioner rejects the proposal of a nursing facility, the commissioner shall provide written notice to the facility of the reason for the rejection, including the factors and evidence upon which the rejection was based.

Subd. 3. **DURATION AND TERMINATION OF CONTRACTS.** (a) Subject to available resources, the commissioner may begin to execute contracts with nursing facilities November 1, 1995.

(b) All contracts entered into under this section are for a term of four years. Either party may terminate a contract effective July 1 of any year by providing written notice to the other party no later than April 1 of that year. If neither party provides written notice of termination by April 1, the contract is automatically renewed for the next rate year. The parties may voluntarily renegotiate the terms of the contract at any time by mutual agreement.

(c) If a nursing facility fails to comply with the terms of a contract, the commissioner shall provide reasonable notice regarding the breach of contract and a reasonable opportunity for the facility to come into compliance. If the facility fails to come into compliance or to remain in compliance, the commissioner may terminate the contract. If a contract is terminated, the contract payment remains in effect for the remainder of the rate year in which the contract was

terminated, but in all other respects the provisions of this section do not apply to that facility effective the date the contract is terminated. The contract shall contain a provision governing the transition back to the cost-based reimbursement system established under section 256B.431, subdivision 25, and Minnesota Rules, parts 9549.0010 to 9549.0080. A contract entered into under this section may be amended by mutual agreement of the parties.

Subd. 4. **ALTERNATE RATES FOR NURSING FACILITIES.** (a) For nursing facilities which have their payment rates determined under this section rather than section 256B.431, subdivision 25, the commissioner shall establish a rate under this subdivision. The nursing facility must enter into a written contract with the commissioner.

(b) A nursing facility's case mix payment rate for the first rate year of a facility's contract under this section is the payment rate the facility would have received under section 256B.431, subdivision 25.

(c) A nursing facility's case mix payment rates for the second and subsequent years of a facility's contract under this section are the previous rate year's contract payment rates plus an inflation adjustment. The index for the inflation adjustment must be based on the change in the Consumer Price Index-All Items (United States City average) (CPI-U) forecasted by Data Resources, Inc., as forecasted in the fourth quarter of the calendar year preceding the rate year. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined.

(d) The commissioner may develop additional incentive-based payments of up to five percent above the standard contract rate for achieving outcomes specified in each contract. The incentive system may be implemented for contract rate years beginning on or after July 1, 1996. The specified outcomes must be measurable and must be based on criteria to be developed by the commissioner. The commissioner may establish, for each contract, various levels of achievement within an outcome. After the outcomes have been specified the commissioner shall assign various levels of payment associated with achieving the outcome. Any incentive-based payment cancels if there is a termination of the contract. In establishing the specified outcomes and related criteria the commissioner shall consider the following state policy objectives:

(1) improved cost effectiveness and quality of life as measured by improved clinical outcomes;

(2) successful diversion or discharge to community alternatives;

(3) decreased acute care costs;

(4) improved consumer satisfaction;

(5) the achievement of quality; or

(6) any additional outcomes the commissioner finds desirable.

Subd. 5. **PRIVATE PAY RATES.** (a) Notwithstanding section 256B.48, subdivision 1, paragraph (a), the commissioner shall determine the maximum private pay case mix payment rates for nursing facilities that have entered into an alternative payment demonstration contract under this section as specified in this subdivision. Nothing in this section shall limit the exceptions for private pay rates authorized under section 256B.48, subdivision 1, paragraph (a).

(b) The maximum private pay rate for short-stay private paying residents who are discharged from the facility less than 101 days after admission is an amount equal to the greater of the Medicare payment rate for that facility or the resident's medical assistance case mix payment rate. For the first year of an alternative payment demonstration project contract the commissioner shall establish a maximum private paying rate for short-stay residents that is based on a nursing facility's estimated Medicare payment rate. When actual Medicare final rates are determined, the nursing facility shall retroactively adjust a private paying resident's rates and provide a refund or credit if the amount actually paid by the resident exceeds the amount that would have been paid using Medicare rates.

(c) When a private paying resident is admitted, a nursing facility shall determine, based on the resident's care plan, whether the resident is likely to be discharged less than 101 days after admission. If the resident is likely to be discharged less than 101 days after admission, the nursing facility may charge a short-stay private pay rate up to the maximum specified in paragraph (b). If the resident remains in the facility for longer than 100 days, the facility shall retroactively reduce the resident's payments to the maximum long-term rate specified in subdivision 4 effective from the date of admission and shall reimburse the resident for the overpayment. At the resident's option, the facility may reimburse residents for overpayments by providing a refund or a credit to be applied to future payments, or a combination of both, subject to the facility's right to offset for past-due payments. If the facility determines, based on the care plan, that the resident is likely to remain in the facility for longer than 100 days, the facility shall not charge a private pay rate greater than the maximum rate specified in subdivision 4.

(d) The provisions of paragraphs (b) and (c) do not apply to short-stay residents admitted prior to the effective date of a demonstration project contract.

Subd. 6. **CONTRACT PAYMENT RATES; APPEALS.** If an appeal is pending concerning the cost-based payment rates that are the basis for the calculation of the payment rate under the alternative payment demonstration project, the commissioner and the nursing facility may agree on an interim contract rate to be used until the appeal is resolved. When the appeal is resolved, the contract rate must be adjusted retroactively in accordance with the appeal decision.

Subd. 7. **CASE MIX ASSESSMENTS.** The commissioner may allow a contract facility to develop and implement a case mix assessment using the federal minimum data set resident assessment.

Subd. 8. **OPTIONAL HIGHER PAYMENTS FOR FIRST 100 DAYS.** The commissioner may include in the contract with a nursing facility under this section a higher rate for the first 100 days after admission than for subsequent days. The rate for the subsequent days must be reduced so that the estimated total cost to the medical assistance program will not exceed the estimated cost without the differential payment rates.

Subd. 9. **MANAGED CARE CONTRACTS FOR OTHER SERVICES.** Beginning July 1, 1995, the commissioner may contract with nursing facilities that have entered into alternative payment demonstration project contracts under this section to provide medical assistance services other than nursing facility care to residents of the facility under a prepaid, managed care payment system. For purposes of contracts entered into under this subdivision, the commissioner may waive one or more of the requirements for payment for ancillary services in section 256B.433. Managed care contracts for other services may be entered into at any time during the duration of a nursing facility's alternative payment demonstration project contract, and the terms of the managed care contracts need not coincide with the terms of the alternative payment demonstration project contract.

Subd. 10. **EXEMPTIONS.** (a) To the extent permitted by federal law, (1) a facility that has entered into a contract under this section is not required to file a cost report, as defined in Minnesota Rules, part 9549.0020, subpart 13, for any year after the base year that is the basis for the calculation of the contract payment rate for the first rate year of the alternative payment demonstration project contract; and (2) a facility under contract is not subject to audits of historical costs or revenues, or paybacks or retroactive adjustments based on these costs or revenues, except audits, paybacks, or adjustments relating to the cost report that is the basis for calculation of the first rate year under the contract.

(b) A facility that is under contract with the commissioner under this section is not subject to the moratorium on licensure or certification of new nursing home beds in section 144A.071, unless the project results in a net increase in bed capacity or involves relocation of beds from one site to another. Contract payment rates must not be adjusted to reflect any additional costs that a nursing facility incurs as a result of a construction project undertaken under this paragraph. In addition, as a condition of entering into a contract under this section, a nursing facility must agree that any future medical assistance payments for nursing facility services will not reflect any additional costs attributable to the sale of a nursing facility under this section and to construction undertaken under this paragraph that otherwise would not be authorized under the moratorium in sections 144A.071 and 144A.073. Nothing in this section prevents a nursing facility participating in the alternative payment demonstration project under this section from seeking approval of an exception to the moratorium through the process established in section 144A.071, and if approved the facility's rates shall be adjusted to reflect the cost of the project.

(c) Notwithstanding section 256B.48, subdivision 6, paragraphs (c), (d), and

(e), and pursuant to any terms and conditions contained in the facility's contract, a nursing facility that is under contract with the commissioner under this section is in compliance with section 256B.48, subdivision 6, paragraph (b), if the facility is Medicare certified.

(d) Notwithstanding paragraph (a), if by April 1, 1996, the health care financing administration has not approved a required waiver, or the health care financing administration otherwise requires cost reports to be filed prior to the waiver's approval, the commissioner shall require a cost report for the rate year.

Subd. 11. **CONSUMER PROTECTION.** As a condition of entering into a contract under this section, a nursing facility must agree to establish resident grievance procedures that are similar to those required under section 256.045, subdivision 3. The commissioner may also require nursing facilities to establish expedited grievance procedures to resolve complaints made by short-stay residents. The facility must notify its resident council of its intent to enter into a contract and must consult with the council regarding any changes in operation expected as a result of the contract.

Subd. 12. **CONTRACTS ARE VOLUNTARY.** Participation of nursing facilities in the alternative payment demonstration project is voluntary. The terms and procedures governing the alternative payment demonstration project are determined under this section and through negotiations between the commissioner and nursing facilities that have submitted a letter of intent to participate in the alternative demonstration project. For purposes of developing requests for proposals and contract requirements, and negotiating the terms, conditions, and requirements of contracts the commissioner is exempt from the rulemaking requirements in chapter 14.

Subd. 13. **PAYMENT SYSTEM REFORM ADVISORY COMMITTEE.** (a) The commissioner, in consultation with an advisory committee, shall study options for reforming the regulatory and reimbursement system for nursing facilities to reduce the level of regulation, reporting, and procedural requirements, and to provide greater flexibility and incentives to stimulate competition and innovation. The advisory committee shall include, at a minimum, representatives from the long-term care provider community, the department of health, and consumers of long-term care services. The advisory committee sunsets on June 30, 1997. Among other things, the commissioner shall consider the feasibility and desirability of changing from a certification requirement to an accreditation requirement for participation in the medical assistance program, options to encourage early discharge of short-term residents through the provision of intensive therapy, and further modifications needed in rate equalization. The commissioner shall also include detailed recommendations for a permanent managed care payment system to replace the contractual alternative payment demonstration project authorized under this section. The commissioner shall submit a report with findings and recommendations to the legislature by January 15, 1997.

(b) If a permanent managed care payment system has not been enacted into law by July 1, 1997, the commissioner shall develop and implement a transition plan to enable nursing facilities under contract with the commissioner under this section to revert to the cost-based payment system at the expiration of the alternative payment demonstration project. The commissioner shall include in the alternative payment demonstration project contracts entered into under this section a provision to permit an amendment to the contract to be made after July 1, 1997, governing the transition back to the cost-based payment system. The transition plan and contract amendments are not subject to rulemaking requirements.

Subd. 14. **FEDERAL REQUIREMENTS.** The commissioner shall implement the contractual alternative payment demonstration project subject to any required federal waivers or approval and in a manner that is consistent with federal requirements. If a provision of this section is inconsistent with a federal requirement the federal requirement supersedes the inconsistent provision. The commissioner shall seek federal approval and request waivers as necessary to implement this section.

Subd. 15. **EXTERNAL REVIEW PANEL.** The commissioner may establish an external review panel consisting of persons appointed by the commissioner for their expertise on issues relating to nursing facility services, quality, payment systems, and other matters, to advise the commissioner on the development and implementation of the contractual alternative payment demonstration project and to assist the commissioner in assessing the quality of care provided and evaluating a facility's compliance with performance standards specified in a contract. The external review panel must include, among other members, representatives of nursing facilities.

Subd. 16. **ALTERNATIVE CONTRACTS.** The commissioner may also contract with nursing facilities in other ways through requests for proposals, including contracts on a risk or nonrisk basis, with nursing facilities or consortia of nursing facilities, to provide comprehensive long-term care coverage on a premium or capitated basis.

Subd. 17. **REPORT.** The commissioner shall report to the legislature by January 15, 1997, regarding the impact of the alternative payment demonstration project. In assessing the impact, the commissioner may examine elements of the project including consumer satisfaction, quality of care, adequacy of services, timeliness in the delivery of services, and other elements determined appropriate by the commissioner. In developing this report, the commissioner may involve appropriate consumer advocate groups as needed to assist in monitoring and evaluating changes in a nursing facility's behavior, including the monitoring and evaluation of issues involving resident protection. The report must include recommendations for reimbursement of nursing homes after June 30, 1997, based on experience with the demonstration project.

Sec. 33. Minnesota Statutes 1994, section 256B.501, subdivision 1, is amended to read:

Subdivision 1. **DEFINITIONS.** For the purposes of this section, the following terms have the meaning given them.

(a) "Commissioner" means the commissioner of human services.

(b) "Facility" means a facility licensed as a mental retardation residential facility under section 252.28, licensed as a supervised living facility under chapter 144, and certified as an intermediate care facility for persons with mental retardation or related conditions. The term does not include a state regional treatment center.

(c) "Waivered service" means home or community-based service authorized under United States Code, title 42, section 1396n(c), as amended through December 31, 1987, and defined in the Minnesota state plan for the provision of medical assistance services. Waivered services include, at a minimum, case management, family training and support, developmental training homes, supervised living arrangements, semi-independent living services, respite care, and training and habilitation services.

Sec. 34. Minnesota Statutes 1994, section 256B.501, subdivision 3, is amended to read:

Subd. 3. **RATES FOR INTERMEDIATE CARE FACILITIES FOR PERSONS WITH MENTAL RETARDATION OR RELATED CONDITIONS.** The commissioner shall establish, by rule, procedures for determining rates for care of residents of intermediate care facilities for persons with mental retardation or related conditions. ~~The procedures shall 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 residents in efficiently and economically operated facilities.~~ In developing the procedures, the commissioner shall include:

(a) cost containment measures that assure efficient and prudent management of capital assets and operating cost increases which do not exceed increases in other sections of the economy;

(b) limits on the amounts of reimbursement for property~~, general and administration,~~ and new facilities;

(c) requirements to ensure that the accounting practices of the facilities conform to generally accepted accounting principles;

(d) incentives to reward accumulation of equity;

(e) ~~a revaluation on sale between unrelated organizations for a facility that, for at least three years before its use as an intermediate care facility, has been used by the seller as a single family home and been claimed by the seller as a homestead, and was not revalued immediately prior to or upon entering the medical assistance program, provided that the facility revaluation not exceed the amount permitted by the Social Security Act, section 1902(a)(13), and~~ rule revisions which:

(1) combine the program, maintenance, and administrative operating cost categories, and professional liability and real estate insurance expenses into one general operating cost category;

(2) eliminate the maintenance and administrative operating cost category limits and account for disallowances under the rule existing on the effective date of this section in the revised rule. If this provision is later invalidated, the total administrative cost disallowance shall be deducted from economical facility payments in clause (3);

(3) establish an economical facility incentive that rewards facilities that provide all appropriate services in a cost-effective manner and penalizes reductions of either direct service wages or standardized hours of care per resident;

(4) establish a best practices award system that is based on outcome measures and that rewards quality, innovation, cost effectiveness, and staff retention;

(5) establish compensation limits for employees on the basis of full-time employment and the developmentally disabled client base of a provider group or facility. The commissioner may consider the inclusion of hold harmless provisions;

(6) establish overall limits on a high cost facility's general operating costs. The commissioner shall consider groupings of facilities that account for a significant variation in cost. The commissioner may differentiate in the application of these limits between high and very high cost facilities. The limits, once established, shall be indexed for inflation and may be rebased by the commissioner;

(7) utilize the client assessment information obtained from the application of the provisions in subdivision 3g for the revisions in clauses (3), (4), and (6); and

(8) develop cost allocation principles which are based on facility expenses; and

(f) appeals procedures that satisfy the requirements of section 256B.50 ~~for appeals of decisions arising from the application of standards or methods pursuant to Minnesota Rules, parts 9510.0500 to 9510.0890, 9553.0010 to 9553.0080, and 12 MCAR 2.05301 to 2.05315 (temporary)~~.

~~In establishing rules and procedures for setting rates for care of residents in intermediate care facilities for persons with mental retardation or related conditions, the commissioner shall consider the recommendations contained in the February 11, 1983, Report of the Legislative Auditor on Community Residential Programs for the Mentally Retarded and the recommendations contained in the 1982 Report of the Department of Public Welfare Rule 52 Task Force. Rates paid to supervised living facilities for rate years beginning during the fiscal biennium ending June 30, 1985, shall not exceed the final rate allowed the facility for the previous rate year by more than five percent.~~

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

Sec. 35. Minnesota Statutes 1994, section 256B.501, subdivision 3c, is amended to read:

Subd. 3c. ~~COMPOSITE~~ **FORECASTED INDEX.** ~~For rate years beginning on or after October 1, 1988, the commissioner shall establish a statewide composite forecasted index to take into account economic trends and conditions between the midpoint of the facility's reporting year and the midpoint of the rate year following the reporting year. The statewide composite index must incorporate the forecast by Data Resources, Inc. of increases in the average hourly earnings of nursing and personal care workers indexed in Standard Industrial Code 805 in "Employment and Earnings," published by the Bureau of Labor Statistics, United States Department of Labor. This portion of the index must be weighted annually by the proportion of total allowable salaries and wages to the total allowable operating costs in the program, maintenance, and administrative operating cost categories for all facilities.~~

~~For adjustments to the other operating costs in the program, maintenance, and administrative operating cost categories, the statewide index must incorporate the Data Resources, Inc. forecast for increases in the national CPI-U. This portion of the index must be weighted annually by the proportion of total allowable other operating costs to the total allowable operating costs in the program, maintenance, and administrative operating cost categories for all facilities. The commissioner shall use the indices as forecasted by Data Resources, Inc., in the fourth quarter of the reporting year.~~

For rate years beginning on or after October 1, 1990, the commissioner shall index a facility's allowable operating costs in the program, maintenance, and administrative operating cost categories by using Data Resources, Inc., forecast for change in the Consumer Price Index-All Items (U.S. city average) (CPI-U). The commissioner shall use the indices as forecasted by Data Resources, Inc., in the first quarter of the calendar year in which the rate year begins. For fiscal years beginning after June 30, 1993, the commissioner shall not provide automatic inflation adjustments for intermediate care facilities for persons with mental retardation. The commissioner of finance shall include annual inflation adjustments in operating costs for intermediate care facilities for persons with mental retardation and related conditions as a budget change request in each biennial detailed expenditure budget submitted to the legislature under section 16A.11. The commissioner shall use the Consumer Price Index-All Items (United States city average) (CPI-U) as forecasted by Data Resources, Inc., to take into account economic trends and conditions for changes in facility allowable historical general operating costs and limits. The forecasted index shall be established for allowable historical general operating costs as follows:

(1) the CPI-U forecasted index for allowable historical general operating costs shall be determined in the first quarter of the calendar year in which the rate year begins, and shall be based on the 21-month period from the midpoint of the facility's reporting year to the midpoint of the rate year following the reporting year; and

(2) for rate years beginning on or after October 1, 1995, the CPI-U forecasted index for the overall operating cost limits and for the individual compensation limit shall be determined in the first quarter of the calendar year in which the rate year begins, and shall be based on the 12-month period between the midpoints of the two reporting years preceding the rate year.

Sec. 36. Minnesota Statutes 1994, section 256B.501, subdivision 3g, is amended to read:

Subd. 3g. **ASSESSMENT OF ~~RESIDENTS~~ CLIENTS.** (a) To establish the service characteristics of ~~residents~~ clients, the ~~quality assurance and review teams in the department of health~~ Minnesota department of health case mix review program shall assess all ~~residents~~ clients annually. ~~beginning January 1, 1989, using a uniform assessment instrument developed by the commissioner. This instrument shall include assessment of the 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. 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.~~ The facility's qualified mental retardation professional (QMRP) with primary responsibility for the client's individual program plan, in conjunction with the interdisciplinary team, shall assess each client who is newly admitted to a facility. This assessment must occur within 30 days from the date of admission during the interdisciplinary team meeting.

(b) All client assessments must be conducted as set forth in the manual, Minnesota ICF/MR Client Assessment Manual, February 1995, hereinafter referred to in this subdivision as the manual. Client assessments completed by the case mix review program and the facility QMRP must be recorded on assessment forms developed by the commissioner of health. The facility QMRP must complete the assessment form, submit it to the case mix review program, and mail a copy to the client's case manager within ten working days following the interdisciplinary team meeting.

(c) The case mix review program shall score assessments according to attachment E of the manual in the assessment domains of personal interaction, independence, and integration, challenging behaviors and preventive practice, activities of daily living, and special treatments. Scores must be based on information from the assessment form. A client's score from each assessment domain shall be used to determine that client's classification.

(d) The commissioner of health shall determine and assign classifications for each client using the procedures specified in attachment F of the manual. The commissioner of health shall assign the client classification within 15 working days after receiving the completed assessment form submitted by the case mix review program team or the facility QMRP. The classification for a newly admitted client is effective retroactive to the date of the client's admission. If a facility QMRP submits an incomplete assessment form, the case mix review program shall inform the facility QMRP of the need to submit additional information necessary for assigning a classification. The facility QMRP must mail the additional information to the case mix review program no later than five working days after receiving the request for the information. If a facility QMRP fails to submit a completed client assessment for a client who is newly admitted to the facility, that client's first assessment in the facility conducted by the case mix review program shall be used to establish a client classification retroactive to the date of the client's admission. Any change in classification due to annual assessment by the case mix review program will be effective on the first day of the month following completion of the case mix review program's annual assessment of all the facility's clients. A client who has resided in the facility less than 30 days must be assessed by the case mix review program during the annual assessment, but must not have a client classification assigned based on the case mix review program's assessment unless the facility QMRP fails to submit a completed client assessment and the client goes on to reside in the facility for more than 30 days.

(e) The facility QMRP may request a reclassification for a client by completing a new client assessment if the facility QMRP believes that the client's status has changed since the case mix review program's annual assessment and that these changes will result in a change in the client's classification. Client assessments for purposes of reclassification will be governed by the following:

(1) The facility QMRP that requests reclassification of a client must provide the case mix review program with evidence to determine a change in the client's classification. Evidence must include photocopies of documentation from the client's record, as specified in the documentation requirements sections of the manual.

(2) A reclassification assessment must occur between the third and the ninth month following the case mix review program's annual assessment of the client. The facility QMRP can request only one reclassification for each client annually.

(3) Any change in classification approved by the case mix review program shall be effective on the first day of the month following the date when the facility QMRP assessed the client for the reclassification.

(4) The case mix review program shall determine reclassification based on the documentation submitted by the facility QMRP. If there is not sufficient information submitted to justify a change to a higher classification, the case mix review program may request additional information necessary to complete a reclassification.

(5) If the facility QMRP does not provide sufficient documentation to support a change in classification, the classification shall remain at the level assessed by the case mix review program at the last inspection of care.

(f) The case mix review program shall conduct desk audits or on-site audits of assessments performed by facility QMRPs. Case mix review program staff shall conduct desk audits of any assessment believed to be inaccurate. The case mix review program may request the facility to submit additional information needed to conduct a desk audit. The facility shall mail the requested information within five working days after receiving the request.

(g) The case mix review program may conduct on-site audits of at least ten percent of the total assessments submitted by facility QMRPs in the previous year and may also conduct special audits if it determines that circumstances exist that could change or affect the validity of assigned classifications. The facility shall grant the case mix review program staff access to the client records during regular business hours for the purpose of conducting an audit. For assessments submitted for new clients, the case mix review program shall consider documentation in the client's record up to and including the date the client was assessed by the facility QMRP. For audits of reclassification assessments, the case mix review program shall consider documentation in the client's record from three months preceding the assessment up to and including the date the client was assessed by the facility QMRP. If the audit reveals that the facility's assessment does not accurately reflect the client's status for the time period and the appropriate supporting documentation cannot be produced by the facility, the case mix review program shall change the classification so that it is consistent with the results of the audit. Any change in client classification that results from an audit must be retroactive to the effective date of the client assessment that was audited. Case mix review program staff shall not discuss preliminary audit findings with the facility's staff. Within 15 working days after completing the audit, the case mix review program shall mail a notice of the results of the audit to the facility.

(h) Requests for reconsideration of client classifications shall be made under section 144.0723 and must be submitted according to section IV of the manual. A reconsideration must be reviewed by case mix review program staff not involved in completing the assessment that established the disputed classification. The reconsideration must be based upon the information provided to the case mix review program. Within 15 working days after receiving the request for reconsideration, the case mix review program shall affirm or modify the original classification. The original classification must be modified if the case mix review program determines that the assessment resulting in the classification did not accurately reflect the status of the client at the time of the assessment. The department of health's decision on reconsiderations is the final administrative decision of the department. The classification assigned by the department of health must be the classification that applies to the client while the request for reconsideration is pending. A change in a classification resulting from a reconsideration must be retroactive to the effective date of the client assessment for which a reconsideration was requested.

(i) The commissioner of human services shall assign weights to each client's classification according to the following table:

Classification	Classification Weight
1S	1.00
1I	1.04
2S	1.36
2I	1.52
3S	1.58
3I	1.68
4S	1.87
4I	2.02
5S	2.09
5I	2.26
6S	2.26
6I	2.52
7S	2.10
7I	2.37
8S	2.26
8I	2.52

Sec. 37. Minnesota Statutes 1994, section 256B.501, is amended by adding a subdivision to read:

Subd. 5b. **ICF/MR OPERATING COST LIMITATION AFTER SEPTEMBER 30, 1995.** (a) For rate years beginning on October 1, 1995, and October 1, 1996, the commissioner shall limit the allowable operating cost per diems, as determined under this subdivision and the reimbursement rules, for high cost ICF's/MR. Prior to indexing each facility's operating cost per diems for inflation, the commissioner shall group the facilities into eight groups. The commissioner shall then array all facilities within each grouping by their general operating cost per service unit per diems.

(b) The commissioner shall annually review and adjust the general operating costs incurred by the facility during the reporting year preceding the rate year to determine the facility's allowable historical general operating costs. For this purpose, the term general operating costs means the facility's allowable operating costs included in the program, maintenance, and administrative operating costs categories, as well as the facility's related payroll taxes and fringe benefits, real estate insurance, and professional liability insurance. A facility's total operating cost payment rate shall be limited according to paragraphs (c) and (d) as follows:

(c) A facility's total operating cost payment rate shall be equal to its allowable historical operating cost per diems for program, maintenance, and administrative cost categories multiplied by the forecasted inflation index in subdivision 3c, clause (1), subject to the limitations in paragraph (d).

(d) For the rate years beginning on or after October 1, 1995, the commissioner shall establish maximum overall general operating cost per service unit

limits for facilities according to clauses (1) to (8). Each facility's allowable historical general operating costs and client assessment information obtained from client assessments completed under subdivision 3g for the reporting year ending December 31, 1994 (the base year), shall be used for establishing the overall limits. If a facility's proportion of temporary care resident days to total resident days exceeds 80 percent, the commissioner must exempt that facility from the overall general operating cost per service unit limits in clauses (1) to (8). For this purpose, "temporary care" means care provided by a facility to a client for less than 30 consecutive resident days.

(1) The commissioner shall determine each facility's weighted service units for the reporting year by multiplying its resident days in each client classification level as established in subdivision 3g, paragraph (d), by the corresponding weights for that classification level, as established in subdivision 3g, paragraph (i), and summing the results. For the reporting year ending December 31, 1994, the commissioner shall use the service unit score computed from the client classifications determined by the Minnesota department of health's annual review, including those of clients admitted during that year.

(2) The facility's service unit score is equal to its weighted service units as computed in clause (1), divided by the facility's total resident days excluding temporary care resident days, for the reporting year.

(3) For each facility, the commissioner shall determine the facility's cost per service unit by dividing its allowable historical general operating costs for the reporting year by the facility's service unit score in clause (2) multiplied by its total resident days, or 85 percent of the facility's capacity days times its service unit score in clause (2), if the facility's occupancy is less than 85 percent of licensed capacity. If a facility reports temporary care resident days, the temporary care resident days shall be multiplied by the service unit score in clause (2), and the resulting weighted resident days shall be added to the facility's weighted service units in clause (1) prior to computing the facility's cost per service unit under this clause.

(4) The commissioner shall group facilities based on class A or class B licensure designation, number of licensed beds, and geographic location. For purposes of this grouping, facilities with six beds or less shall be designated as small facilities and facilities with more than six beds shall be designated as large facilities. If a facility has both class A and class B licensed beds, the facility shall be considered a class A facility for this purpose if the number of class A beds is more than half its total number of ICF/MR beds; otherwise the facility shall be considered a class B facility. The metropolitan geographic designation shall include Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington counties. All other Minnesota counties shall be designated as the nonmetropolitan geographic group. These characteristics result in the following eight groupings:

(i) small class A metropolitan;

(ii) large class A metropolitan;

(iii) small class B metropolitan;

(iv) large class B metropolitan;

(v) small class A nonmetropolitan;

(vi) large class A nonmetropolitan;

(vii) small class B nonmetropolitan; and

(viii) large class B nonmetropolitan.

(5) The commissioner shall array facilities within each grouping in clause (4) by each facility's cost per service unit as determined in clause (3).

(6) In each array established under clause (5), facilities with a cost per service unit at or above the median shall be limited to the lesser of: (i) the current reporting year's cost per service unit; or (ii) the prior reporting year's allowable historical general operating cost per service unit plus the inflation factor as established in subdivision 3c, clause (2), increased by three percentage points.

(7) The overall operating cost per service unit limit for each group shall be established as follows:

(i) each array established under clause (5) shall be arrayed again after the application of clause (6);

(ii) in each array established in clause (5), two general operating cost limits shall be determined. The first cost per service unit limit shall be established at 0.5 and less than or equal to 1.0 standard deviation above the median of that array. The second cost per service unit limit shall be established at 1.0 standard deviation above the median of the array; and

(iii) the overall operating cost per service unit limits shall be indexed for inflation annually beginning with the reporting year ending December 31, 1995, using the forecasted inflation index in subdivision 3c, clause (2).

(8) Annually, facilities shall be arrayed using the method described in clauses (5) and (7). Each facility with a cost per service unit at or above its group's first cost per service unit limit, but less than the second cost per service unit limit for that group, shall be limited to 98 percent of its total operating cost per diems then add the forecasted inflation index in subdivision 3c, clause (1). Each facility with a cost per service unit at or above the second cost per service unit limit will be limited to 97 percent of its total operating cost per diems, then add the forecasted inflation index in subdivision 3c, clause (1).

(9) The commissioner may rebase these overall limits, using the method described in this subdivision, but no more frequently than once every three years.

(e) For rate years beginning on or after October 1, 1995, the facility's efficiency incentive shall be determined as provided in the reimbursement rule.

(f) The total operating cost payment rate shall be the sum of paragraphs (c) and (e).

Sec. 38. Minnesota Statutes 1994, section 256B.501, is amended by adding a subdivision to read:

Subd. 5c. **OPERATING COSTS AFTER SEPTEMBER 30, 1997.** (a) In general, the commissioner shall establish maximum standard rates for the prospective reimbursement of facility costs. The maximum standard rates must take into account the level of reimbursement which is adequate to cover the base-level costs of economically operated facilities. In determining the base-level costs, the commissioner shall consider geographic location, types of facilities (class A or class B), minimum staffing standards, resident assessment under subdivision 3g, and other factors as determined by the commissioner.

(b) The commissioner shall also develop additional incentive-based payments which, if achieved for specified outcomes, will be added to the maximum standard rates. The specified outcomes must be measurable and shall be based on criteria to be developed by the commissioner during fiscal year 1996. The commissioner may establish various levels of achievement within an outcome. Once the outcomes are established, the commissioner shall assign various levels of payment associated with achieving the outcome. In establishing the specified outcomes and the related criteria, the commissioner shall consider the following state policy objectives: (1) resident transitioned into cost-effective community alternatives; (2) the results of a uniform consumer satisfaction survey; (3) the achievement of no major licensure or certification deficiencies; or (4) any other outcomes the commissioner finds desirable.

(c) In developing the maximum standard rates and the incentive-based payments, desirable outcomes, and related criteria, the commissioner, in collaboration with the commissioner of health, shall form an advisory committee. The membership of the advisory committee shall include representation from the consumers advocacy groups (3), the two facility trade associations (3 each), counties (3), commissioner of finance (1), the legislature (2 each from both the house and senate), and others the commissioners find appropriate.

(d) Beginning July 1, 1996, the commissioner shall collect the data from the facilities, the department of health, or others as necessary to determine the extent to which a facility has met any of the outcomes and related criteria. Payment rates under this subdivision shall be effective October 1, 1997.

(e) The commissioner shall report to the legislature on the progress of the advisory committee by January 31, 1996, any necessary changes to the reimbursement methodology proposed under this subdivision. By January 15, 1997, the commissioner shall recommend to the legislature legislation which will implement this reimbursement methodology for rate years beginning on or after the proposed effective date of October 1, 1997.

Sec. 39. Minnesota Statutes 1994, section 256B.501, subdivision 8, is amended to read:

Subd. 8. **PAYMENT FOR PERSONS WITH SPECIAL NEEDS.** The commissioner shall establish by December 31, 1983, procedures to be followed by the counties to seek authorization from the commissioner for medical assistance reimbursement for very dependent persons with special needs in an amount in excess of the rates allowed pursuant to subdivision 2, including rates established under section 252.46 when they apply to services provided to residents of intermediate care facilities for persons with mental retardation or related conditions, and procedures to be followed for rate limitation exemptions for intermediate care facilities for persons with mental retardation or related conditions. Rate payments under subdivision 8a are eligible for a rate exception under this subdivision. No excess payment approved by the commissioner after June 30, 1991, shall be authorized unless:

(1) the need for specific level of service is documented in the individual service plan of the person to be served;

(2) the level of service needed can be provided within the rates established under section 252.46 and Minnesota Rules, parts 9553.0010 to 9553.0080, without a rate exception within 12 months;

(3) staff hours beyond those available under the rates established under section 252.46 and Minnesota Rules, parts 9553.0010 to 9553.0080, necessary to deliver services do not exceed 1,440 hours within 12 months;

(4) there is a basis for the estimated cost of services;

(5) the provider requesting the exception documents that current per diem rates are insufficient to support needed services;

(6) estimated costs, when added to the costs of current medical assistance-funded residential and day training and habilitation services and calculated as a per diem, do not exceed the per diem established for the regional treatment centers for persons with mental retardation and related conditions on July 1, 1990, indexed annually by the urban consumer price index, all items, as forecasted by Data Resources Inc., for the next fiscal year over the current fiscal year;

(7) any contingencies for an approval as outlined in writing by the commissioner are met; and

(8) any commissioner orders for use of preferred providers are met.

The commissioner shall evaluate the services provided pursuant to this subdivision through program and fiscal audits.

The commissioner may terminate the rate exception at any time under any of the conditions outlined in Minnesota Rules, part 9510.1120, subpart 3, for county termination, or by reason of information obtained through program and

fiscal audits which indicate the criteria outlined in this subdivision have not been, or are no longer being, met.

The commissioner may approve no more than one rate exception, up to 12 months duration, for an eligible client.

Sec. 40. Minnesota Statutes 1994, section 256B.501, is amended by adding a subdivision to read:

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

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

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

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

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

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

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

(d) Payment rates are determined annually for each crisis services provider based on cost of care for each provider as defined in section 246.50. Interim payment rates are calculated on a per diem basis by dividing the projected cost

of providing care by the projected number of contact days for the fiscal year, as estimated by the commissioner. Final payment rates are calculated by dividing the actual cost of providing care by the actual number of contact days in the applicable fiscal year.

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

(f) Payment for residential crisis services is limited to 21 days, unless an additional period is authorized by the commissioner. The additional period may not exceed 21 days.

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

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

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

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

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

Sec. 41. Minnesota Statutes 1994, section 256B.69, is amended by adding a subdivision to read:

Subd. 23. **ALTERNATIVE INTEGRATED LONG-TERM CARE SERVICES; ELDERLY AND DISABLED PERSONS.** (a) The commissioner may implement demonstration projects to create alternative integrated delivery systems for acute and long-term care services to elderly and disabled persons that provide increased coordination, improve access to quality services, and mitigate future cost increases. The commissioner may seek federal authority to combine Medicare and Medicaid capitation payments for the purpose of such demonstrations. Medicare funds and services shall be administered according to the terms

and conditions of the federal waiver and demonstration provisions. For the purpose of administering medical assistance funds, demonstrations under this subdivision are subject to subdivisions 1 to 17. The provisions of Minnesota Rules, parts 9500.1450 to 9500.1464, apply to these demonstrations, with the exceptions of parts 9500.1452, subpart 2, item B; and 9500.1457, subpart 1, items B and C, which do not apply to elderly persons enrolling in demonstrations under this section. An initial open enrollment period may be provided. Persons who disenroll from demonstrations under this subdivision remain subject to Minnesota Rules, parts 9500.1450 to 9500.1464. When a person is enrolled in a health plan under these demonstrations and the health plan's participation is subsequently terminated for any reason, the person shall be provided an opportunity to select a new health plan and shall have the right to change health plans within the first 60 days of enrollment in the second health plan. Persons required to participate in health plans under this section who fail to make a choice of health plan shall not be randomly assigned to health plans under these demonstrations. Notwithstanding section 256.9363, subdivision 5, and Minnesota Rules, part 9505.5220, subpart 1, item A, if adopted, for the purpose of demonstrations under this subdivision, the commissioner may contract with managed care organizations to serve only elderly persons eligible for medical assistance, elderly and disabled persons, or disabled persons only.

Before implementation of a demonstration project for disabled persons, the commissioner must provide information to appropriate committees of the house of representatives and senate and must involve representatives of affected disability groups in the design of the demonstration projects.

(b) A nursing facility reimbursed under the alternative reimbursement methodology in section 256B.434 may, in collaboration with a hospital, clinic, or other health care entity provide services under paragraph (a). The commissioner shall amend the state plan and seek any federal waivers necessary to implement this paragraph.

Sec. 42. **ICF/MR RULE REVISION RECORDKEEPING.**

The commissioner shall consider various time record and time distribution recordkeeping requirements when developing rule revisions for cost allocation regarding intermediate care facilities for persons with mental retardation or related conditions. The commissioner shall consider information from the public, including providers, provider associations, advocates, and counties when developing rule amendments in the area of cost allocation.

From July 1, 1995, until June 30, 1996, all employees and consultants of ICFs/MR, including any individual for whom any portion of that individual's compensation is reported for reimbursement under Minnesota Rules, parts 9553.0010 to 9553.0080, shall document their service to all sites according to paragraphs (a) to (c). For this purpose, and for paragraphs (a) to (c), "employee" means an individual who is compensated by a facility or provider group for necessary services on any hourly or salaried basis. Employees and consultants for

whom no portion of that individual's total compensation is reported for reimbursement in Minnesota Rules, parts 9553.0010 to 9553.0080, are exempt from the recordkeeping requirements in paragraphs (a) to (c).

(a) Time and attendance records are required for all employees and consultants as set forth in Minnesota Statutes, section 256B.432, subdivision 8.

(b) Employees and consultants shall keep time records on a daily basis showing the actual time spent on various activities, as required by Minnesota Rules, part 9553.0030, except that employees with multiple duties must not use a sampling method.

(c) All employees and consultants who work for the benefit of more than one site shall keep a record of where work is performed. This record must specify the time in which work performed at a site solely benefits that site. The amount of time reported for work performed at a site for the sole benefit of that site does not need to be adjusted for brief, infrequent telephone interruptions, time spent away from the site when accompanying clients from that site, and time away from the site for shopping or errands if the shopping or errands benefit solely that site.

For recordkeeping purposes, "site" means a Minnesota ICF/MR, waivered services location, semi-independent living service arrangement, day training and habilitation operation, or similar out-of-state service operation for persons with developmental disabilities. Site also means any nondevelopmental disability service location or any business operation owned or operated by a provider group, either in or outside of Minnesota, whether or not that operation provides a service to persons with developmental disabilities.

Sec. 43. **REPEALER.**

Subdivision 1. Minnesota Statutes 1994, sections 144.0723, subdivision 5, 144A.073, subdivision 3a, 252.47, and 256B.501, subdivision 3f, are repealed.

Subd. 2. Minnesota Statutes 1994, section 256B.501, subdivisions 3d and 3e, is repealed for rate years beginning after September 30, 1996.

Sec. 44. **EFFECTIVE DATES.**

Subdivision 1. Sections 12 (144A.071, subdivision 5a), 13, 16, 17, and 18 (144A.073, subdivisions 1, 3c, 4, and 5), are effective the day following final enactment.

Subd. 2. Sections 39 and 40 (256B.501, subdivisions 8 and 8a) are effective upon publication in the State Register by the commissioner of human services that federal approval has been received.

Subd. 3. Sections 27 to 31 (256B.432, subdivisions 1, 2, 3, 5, and 6) are effective for ICF/MR rate years beginning after September 30, 1996.

ARTICLE 8

COMMUNITY MENTAL HEALTH AND REGIONAL TREATMENT CENTERS

Section 1. Minnesota Statutes 1994, section 245.041, is amended to read:

245.041 **PROVISION OF FIREARMS BACKGROUND CHECK INFORMATION.**

Notwithstanding section 253B.23, subdivision 9, the commissioner of human services shall provide commitment information to local law enforcement agencies on an individual request basis by means of electronic data transfer from the department of human services through the Minnesota crime information system for the sole purpose of facilitating a firearms background check under section 624.7131, 624.7132, or 624.714. The information to be provided is limited to whether the person has been committed under chapter 253B and, if so, the type of commitment.

Sec. 2. Minnesota Statutes 1994, section 245.4871, subdivision 12, is amended to read:

Subd. 12. ~~EARLY~~ MENTAL HEALTH **IDENTIFICATION AND INTERVENTION SERVICES.** "~~Early~~ Mental health identification and intervention services" means services that are designed to identify children who are at risk of needing or who need mental health services and that arrange for intervention and treatment.

Sec. 3. Minnesota Statutes 1994, section 245.4871, subdivision 33a, is amended to read:

Subd. 33a. ~~SPECIAL~~ CULTURALLY INFORMED **MENTAL HEALTH CONSULTANT.** "~~Special~~ Culturally informed mental health consultant" is a ~~mental health practitioner or professional with special expertise in treating children from a particular cultural or racial minority group~~ person who is recognized by the culture as one who has knowledge of a particular culture and its definition of health and mental health; and who is used as necessary to assist the county board and its mental health providers in assessing and providing appropriate mental health services for children from that particular cultural, linguistic, or racial heritage and their families.

Sec. 4. Minnesota Statutes 1994, section 245.4871, is amended by adding a subdivision to read:

Subd. 35. **TRANSITION SERVICES.** "Transition services" means mental health services, designed within an outcome oriented process that promotes movement from school to postschool activities, including post-secondary education, vocational training, integrated employment including supported employment, continuing and adult education, adult mental health and social services, other adult services, independent living, or community participation.

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

Sec. 5. Minnesota Statutes 1994, section 245.4873, subdivision 6, is amended to read:

Subd. 6. **PRIORITIES.** By January 1, 1992, the commissioner shall require that each of the treatment services and management activities described in sections 245.487 to 245.4888 be developed for children with emotional disturbances within available resources based on the following ranked priorities. The commissioner shall reassign agency staff and use consultants as necessary to meet this deadline:

(1) the provision of locally available mental health emergency services;

(2) the provision of locally available mental health services to all children with severe emotional disturbance;

(3) the provision of ~~early~~ mental health identification and intervention services to children who are at risk of needing or who need mental health services;

(4) the provision of specialized mental health services regionally available to meet the special needs of all children with severe emotional disturbance, and all children with emotional disturbances;

(5) the provision of locally available services to children with emotional disturbances; and

(6) the provision of education and preventive mental health services.

Sec. 6. Minnesota Statutes 1994, section 245.4874, is amended to read:

245.4874 **DUTIES OF COUNTY BOARD.**

The county board in each county shall use its share of mental health and community social services act funds allocated by the commissioner according to a biennial children's mental health component of the community social services plan required under section 245.4888, and approved by the commissioner. The county board must:

(1) develop a system of affordable and locally available children's mental health services according to sections 245.487 to 245.4888;

(2) establish a mechanism providing for interagency coordination as specified in section 245.4875, subdivision 6;

(3) develop a biennial children's mental health component of the community social services plan required under section 256E.09 which considers the assessment of unmet needs in the county as reported by the local children's mental health advisory council under section 245.4875, subdivision 5, paragraph (b), clause (3). The county shall provide, upon request of the local children's mental health advisory council, readily available data to assist in the determination of unmet needs;

(4) assure that parents and providers in the county receive information about how to gain access to services provided according to sections 245.487 to 245.4888;

(5) coordinate the delivery of children's mental health services with services provided by social services, education, corrections, health, and vocational agencies to improve the availability of mental health services to children and the cost-effectiveness of their delivery;

(6) assure that mental health services delivered according to sections 245.487 to 245.4888 are delivered expeditiously and are appropriate to the child's diagnostic assessment and individual treatment plan;

(7) provide the community with information about predictors and symptoms of emotional disturbances and how to access children's mental health services according to sections 245.4877 and 245.4878;

(8) provide for case management services to each child with severe emotional disturbance according to sections 245.486; 245.4871, subdivisions 3 and 4; and 245.4881, subdivisions 1, 3, and 5;

(9) provide for screening of each child under section 245.4885 upon admission to a residential treatment facility, acute care hospital inpatient treatment, or informal admission to a regional treatment center;

(10) prudently administer grants and purchase-of-service contracts that the county board determines are necessary to fulfill its responsibilities under sections 245.487 to 245.4888;

(11) assure that mental health professionals, mental health practitioners, and case managers employed by or under contract to the county to provide mental health services are qualified under section 245.4871;

(12) assure that children's mental health services are coordinated with adult mental health services specified in sections 245.461 to 245.486 so that a continuum of mental health services is available to serve persons with mental illness, regardless of the person's age; and

(13) assure that ~~special~~ culturally informed mental health consultants are used as necessary to assist the county board in assessing and providing appropriate treatment for children of cultural or racial minority heritage.

Sec. 7. Minnesota Statutes 1994, section 245.4875, subdivision 2, is amended to read:

Subd. 2. **CHILDREN'S MENTAL HEALTH SERVICES.** The children's mental health service system developed by each county board must include the following services:

(1) education and prevention services according to section 245.4877;

(2) ~~early~~ mental health identification and intervention services according to section 245.4878;

(3) emergency services according to section 245.4879;

(4) outpatient services according to section 245.488;

(5) family community support services according to section 245.4881;

(6) day treatment services according to section 245.4884, subdivision 2;

(7) residential treatment services according to section 245.4882;

(8) acute care hospital inpatient treatment services according to section 245.4883;

(9) screening according to section 245.4885;

(10) case management according to section 245.4881;

(11) therapeutic support of foster care according to section 245.4884, subdivision 4; and

(12) professional home-based family treatment according to section 245.4884, subdivision 4.

Sec. 8. Minnesota Statutes 1994, section 245.4875, is amended by adding a subdivision to read:

Subd. 8. **TRANSITION SERVICES.** The county board may continue to provide mental health services as defined in sections 245.487 to 245.4888 to persons over 18 years of age, but under 21 years of age, if the person was receiving case management or family community support services prior to age 18, and if one of the following conditions is met:

(1) the person is receiving special education services through the local school district; or

(2) it is in the best interest of the person to continue services defined in sections 245.487 to 245.4888.

Sec. 9. Minnesota Statutes 1994, section 245.4878, is amended to read:

245.4878 **~~EARLY~~ MENTAL HEALTH IDENTIFICATION AND INTERVENTION.**

By January 1, 1991, ~~early~~ mental health identification and intervention services must be available to meet the needs of all children and their families residing in the county, consistent with section 245.4873. ~~Early~~ Mental health identification and intervention services must be designed to identify children who are at risk of needing or who need mental health services. The county board

must provide intervention and offer treatment services to each child who is identified as needing mental health services. The county board must offer intervention services to each child who is identified as being at risk of needing mental health services.

Sec. 10. Minnesota Statutes 1994, section 245.4882, subdivision 5, is amended to read:

Subd. 5. **SPECIALIZED RESIDENTIAL TREATMENT SERVICES.** The commissioner of human services shall 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~~ 1997, for 50 percent of the nonfederal costs of out-of-state treatment of children 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. Minnesota Statutes 1994, section 245.4885, subdivision 2, is amended to read:

Subd. 2. **QUALIFICATIONS.** No later than July 1, 1991, screening of children for residential and inpatient services must be conducted by a mental health professional. Where appropriate and available, ~~special~~ culturally informed mental health consultants must participate in the screening. Mental health professionals providing screening for inpatient and residential services must not be financially affiliated with any acute care inpatient hospital, residential treatment facility, or regional treatment center. The commissioner may waive this requirement for mental health professional participation after July 1, 1991, if the county documents that:

(1) mental health professionals or mental health practitioners are unavailable to provide this service; and

(2) services are provided by a designated person with training in human services who receives clinical supervision from a mental health professional.

Sec. 12. Minnesota Statutes 1994, section 245.4886, is amended by adding a subdivision to read:

Subd. 3. **GRANTS FOR ADOLESCENT SERVICES.** The commissioner may make grants for community-based services for adolescents who have serious emotional disturbance and exhibit violent behavior. The commissioner may administer these grants as a supplement to the grants for children's community-based mental health services under subdivision 1. The same administrative requirements shall apply to these grants as the grants under subdivision 1, except that these grants:

(1) shall be primarily for areas with the greatest need for services;

(2) may be used for assessment, family community support services, specialized treatment approaches, specialized adolescent community-based residential treatment, and community transition services for adolescents and preadolescents who have serious emotional disturbance and exhibit violent behavior;

(3) shall emphasize intensive services as an alternative to placement;

(4) shall not be used to supplant existing funds;

(5) shall require grantees to continue base level funding as defined in section 245.492, subdivision 2;

(6) must, wherever possible, be administered under the auspices of a children's mental health collaborative established under section 245.491 if the collaborative chooses to serve the target population;

(7) must be used for mental health services that are integrated with other services whenever possible; and

(8) must be based on a proposal submitted to the commissioner by a children's mental health collaborative or a county board that is based on guidelines published by the commissioner. The guidelines must require that proposed services be based on treatment methods that have proven effective, or that show promise, in meeting the needs of this population. The guidelines may incorporate preferences for proposals that would convert existing residential treatment beds for children in the county or collaborative's service area to community-based mental health services, encourage the active participation of the children's families in the treatment plans of these children, or promote the integration of these children into school, home, and community. The commissioner shall consult with parents, educators, mental health professionals, county mental health staff, and representatives of the children's subcommittee of the state advisory board on mental health in developing the guidelines and evaluating proposals.

Sec. 13. Minnesota Statutes 1994, section 245.492, subdivision 2, is amended to read:

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~~ 1995 for children's mental health services ~~or~~, for special education services, and for other services for children with emotional or behavioral disturbances and their families.

In subsequent years, base level funding may be adjusted to reflect decreases in the numbers of children in the target population.

Sec. 14. Minnesota Statutes 1994, section 245.492, subdivision 6, is amended to read:

Subd. 6. ~~**INITIAL**~~ **OPERATIONAL TARGET POPULATION.** "~~Initial~~ Operational 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~~ fall within the criteria for the target population. The ~~initial~~ operational target population may be less than the target population.

Sec. 15. Minnesota Statutes 1994, section 245.492, subdivision 9, is amended to read:

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~~ individualized rehabilitation 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.

Sec. 16. Minnesota Statutes 1994, section 245.492, subdivision 23, is amended to read:

Subd. 23. ~~**WRAPAROUND**~~ **INDIVIDUALIZED REHABILITATION SERVICES.** "~~Wraparound~~ Individualized rehabilitation services" are alterna-

tive, 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~~ Individualized rehabilitation 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. 17. Minnesota Statutes 1994, section 245.493, subdivision 2, is amended to read:

Subd. 2. **GENERAL DUTIES OF THE LOCAL CHILDREN'S MENTAL HEALTH COLLABORATIVES.** Each local children's mental health collaborative must:

(1) notify the commissioner of human services within ten days of formation by signing a collaborative agreement and providing the commissioner with a copy of the signed agreement;

(2) identify a service delivery area and an ~~initial~~ operational target population within that service delivery area. The ~~initial~~ operational 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~~ operational target population must also be economically viable for the service delivery area;

~~(2)~~ (3) seek to maximize federal revenues available to serve children in the target population by designating local expenditures for ~~mental health~~ services for these children and their families that can be matched with federal dollars;

~~(3)~~ (4) 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 that meets the requirements for state and federal reimbursement and develop interagency agreements necessary to implement the system;

~~(4)~~ (5) 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 in the target population and their families;

~~(5)~~ (6) create or designate a management structure for fiscal and clinical responsibility and outcome evaluation;

~~(6)~~ (7) spend funds generated by the local children's mental health collaborative as required in sections 245.491 to 245.496; ~~and~~

~~(7)~~ (8) 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~~.~~;

(9) submit its integrated service system design to the state coordinating council for approval within one year of notifying the commissioner of human services of its formation;

(10) provide an annual report that includes the elements listed in section 245.494, subdivision 2, and the collaborative's planned timeline to expand its operational target population to the state coordinating council; and

(11) expand its operational target population.

Each local children's mental health collaborative may contract with the commissioner of human services to become a medical assistance provider of mental health services according to section 245.4933.

Sec. 18. Minnesota Statutes 1994, section 245.4932, subdivision 1, is amended to read:

Subdivision 1. ~~**PROVIDER**~~ **COLLABORATIVE RESPONSIBILITIES.** The children's mental health collaborative shall have the following authority and responsibilities regarding federal revenue enhancement:

(1) the collaborative must establish an integrated fund;

(2) the collaborative shall designate a lead county or other qualified entity as the fiscal agency for reporting, claiming, and receiving payments;

~~(2)~~ (3) 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)~~ (4) the collaborative shall use any enhanced revenue attributable to the activities of the collaborative, including administrative and service revenue, solely to provide mental health services or to expand the operational target population. The lead county or other qualified entity may not use enhanced federal revenue for any other purpose;

(5) the members of the collaborative must continue the base level of expenditures, as defined in section 245.492, subdivision 2, 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)~~ (6) 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 with the commissioner of human services;

~~(5)~~ (7) the collaborative ~~shall~~ or its members may elect to pay the nonfederal share of the medical assistance costs for services designated by the collaborative; and

~~(6)~~ (8) 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.

Sec. 19. Minnesota Statutes 1994, section 245.4932, subdivision 2, is amended to read:

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~~ collaborative 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.

Sec. 20. Minnesota Statutes 1994, section 245.4932, subdivision 3, is amended to read:

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.

Sec. 21. Minnesota Statutes 1994, section 245.4932, subdivision 4, is amended to read:

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~~

individualized rehabilitation 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. 22. **[245.4933] MEDICAL ASSISTANCE PROVIDER STATUS.**

Subdivision 1. **REQUIREMENTS TO SERVE CHILDREN NOT ENROLLED IN A PREPAID MEDICAL ASSISTANCE OR MINNESOTACARE HEALTH PLAN.** (a) In order for a local children's mental health collaborative to become a prepaid provider of medical assistance services and be eligible to receive medical assistance reimbursement, the collaborative must:

(1) enter into a contract with the commissioner of human services to provide mental health services including inpatient, outpatient, medication management, services under the rehabilitation option, and related physician services;

(2) meet the applicable federal requirements;

(3) either carry stop-loss insurance or enter into a risk-sharing agreement with the commissioner of human services; and

(4) provide medically necessary medical assistance mental health services to children in the target population who enroll in the local children's mental health collaborative.

(b) Upon execution of the provider contract with the commissioner of human services the local children's mental health collaborative may:

(1) provide mental health services which are not medical assistance state plan services in addition to the state plan services described in the contract with the commissioner of human services; and

(2) enter into subcontracts which meet the requirements of Code of Federal Regulations, title 42, section 434.6, with other providers of mental health services including prepaid health plans established under section 256B.69.

Subd. 2. **REQUIREMENTS TO SERVE CHILDREN ENROLLED IN A PREPAID HEALTH PLAN.** A children's mental health collaborative may serve children in the collaborative's target population who are enrolled in a prepaid health plan under contract with the commissioner of human services by contracting with one or more such health plans to provide medical assistance or MinnesotaCare mental health services to children enrolled in the health plan. The collaborative and the health plan shall work cooperatively to ensure the integration of physical and mental health services.

Subd. 3. **REQUIREMENTS TO SERVE CHILDREN WHO BECOME ENROLLED IN A PREPAID HEALTH PLAN.** A children's mental health collaborative may provide prepaid medical assistance or MinnesotaCare mental health services to children who are not enrolled in prepaid health plans until those children are enrolled. Publication of a request for proposals in the State

Register shall serve as notice to the collaborative of the commissioner's intent to execute contracts for medical assistance and MinnesotaCare services. In order to become or continue to be a provider of medical assistance or MinnesotaCare services the collaborative may contract with one or more such prepaid health plans after the collaborative's target population is enrolled in a prepaid health plan. The collaborative and the health plan shall work cooperatively to ensure the integration of physical and mental health services.

Subd. 4. **COMMISSIONER'S DUTIES.** (a) The commissioner of human services shall provide to each children's mental health collaborative that is considering whether to become a prepaid provider of mental health services the commissioner's best estimate of a capitated payment rate prior to an actuarial study based upon the collaborative's operational target population. The capitated payment rate shall be adjusted annually, if necessary, for changes in the operational target population.

(b) The commissioner shall negotiate risk adjustment and reinsurance mechanisms with children's mental health collaboratives that become medical assistance providers including those that subcontract with prepaid health plans.

Subd. 5. **NONCONTRACTING COLLABORATIVES.** A local children's mental health collaborative that does not become a prepaid provider of medical assistance or MinnesotaCare services may provide services through individual members of a noncontracting collaborative who have a medical assistance provider agreement to eligible recipients who are not enrolled in the health plan.

Subd. 6. **INDIVIDUALIZED REHABILITATION SERVICES.** A children's mental health collaborative with an integrated service system approved by the state coordinating council may become a medical assistance provider for the purpose of obtaining prior authorization for and providing individualized rehabilitation services.

Sec. 23. Minnesota Statutes 1994, section 245.494, subdivision 1, is amended to read:

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~~ operational 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.

Sec. 24. Minnesota Statutes 1994, section 245.494, subdivision 3, is amended to read:

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,~~ in the first quarter of 1994, in areas where a local children's mental health collaborative has been established, based on an independent actuarial analysis, ~~separate~~ identify all medical assistance~~, general assistance medical care,~~ and MinnesotaCare resources devoted to mental health services for children ~~and their families~~ in the target population including inpatient, outpatient, medication management, services under the rehabilitation option, and related physician services ~~from~~ in the total health capitation ~~from~~ of prepaid plans~~, including plans established~~ under contract with the commissioner to provide medical assistance services 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)~~ (2) assist each children's mental health collaborative to determine an actuarially feasible operational target population;

(3) ensure that a prepaid health plan that contracts with the commissioner to provide medical assistance or MinnesotaCare services shall pass through the identified resources to a collaborative or collaboratives upon the collaboratives

meeting the requirements of section 245.4933 to serve the collaborative's operational target population. The commissioner shall, through an independent actuarial analysis, specify differential rates the prepaid health plan must pay the collaborative based upon severity, functioning, and other risk factors, taking into consideration the fee-for-service experience of children excluded from prepaid medical assistance participation;

(4) ensure that a children's mental health collaborative that enters into an agreement with a prepaid health plan under contract with the commissioner shall accept medical assistance recipients in the operational target population on a first-come, first-served basis up to the collaborative's operating capacity or as determined in the agreement between the collaborative and the commissioner;

(5) ensure that a children's mental health collaborative that receives resources passed through a prepaid health plan under contract with the commissioner shall be subject to the quality assurance standards, reporting of utilization information, standards set out in sections 245.487 to 245.4888, and other requirements established in Minnesota Rules, part 9500.1460;

(6) ensure that any prepaid health plan that contracts with the commissioner, including a plan that contracts under section 256B.69, must enter into an agreement with any collaborative operating in the same service delivery area that:

(i) meets the requirements of section 245.4933;

(ii) is willing to accept the rate determined by the commissioner to provide medical assistance services; and

(iii) requests to contract with the prepaid health plan;

(7) ensure that no agreement between a health plan and a collaborative shall terminate the legal responsibility of the health plan to assure that all activities under the contract are carried out. The agreement may require the collaborative to indemnify the health plan for activities that are not carried out;

(8) ensure that where a collaborative enters into an agreement with the commissioner to provide medical assistance and MinnesotaCare services a separate capitation rate will be determined through an independent actuarial analysis which is based upon the factors set forth in clause (3) to be paid to a collaborative for children in the operational target population who are eligible for medical assistance but not included in the prepaid health plan contract with the commissioner;

(9) ensure that in counties where no prepaid health plan contract to provide medical assistance or MinnesotaCare services exists, a children's mental health collaborative that meets the requirements of section 245.4933 shall:

(i) be paid a capitated rate, actuarially determined, that is based upon the collaborative's operational target population;

(ii) accept medical assistance or MinnesotaCare recipients in the operational target population on a first-come, first-served basis up to the collaborative's operating capacity or as determined in the contract between the collaborative and the commissioner; and

(iii) comply with quality assurance standards, reporting of utilization information, standards set out in sections 245.487 to 245.4888, and other requirements established in Minnesota Rules, part 9500.1460;

(10) subject to federal approval, in the development of rates for local children's mental health collaboratives, the commissioner shall consider, and may adjust, trend and utilization factors, to reflect changes in mental health service utilization and access;

(11) consider changes in mental health service utilization, access, and price, and determine the actuarial value of the services in the maintenance of rates for local children's mental health collaborative provided services, subject to federal approval;

(12) provide written notice to any prepaid health plan operating within the service delivery area of a children's mental health collaborative of the collaborative's existence within 30 days of the commissioner's receipt of notice of the collaborative's formation;

(13) ensure that in a geographic area where both a prepaid health plan including those established under either section 256.9363 or 256B.69 and a local children's mental health collaborative exist, medical assistance and MinnesotaCare recipients in the operational target population who are enrolled in prepaid health plans will have the choice to receive mental health services through either the prepaid health plan or the collaborative that has a contract with the prepaid health plan, according to the terms of the contract;

(14) 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 in the operational target population, and develop a procedure for making these resources available for use by a local children's mental health collaborative;

~~(4)~~ (15) 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)~~ (16) 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)~~ (17) 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)~~ (18) 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)~~ (19) 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)~~ (20) 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~~ individualized rehabilitation services;

~~(10)~~ (21) 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.~~

(22) ensure that family members who are enrolled in a prepaid health plan and whose children are receiving mental health services through a local children's mental health collaborative file complaints about mental health services needed by the family members, the commissioner shall comply with section 256B.031, subdivision 6. A collaborative may assist a family to make a complaint; and

(23) facilitate a smooth transition for children receiving prepaid medical assistance or MinnesotaCare services through a children's mental health collaborative who become enrolled in a prepaid health plan.

Sec. 25. Minnesota Statutes 1994, section 245.495, is amended to read:

245.495 **ADDITIONAL FEDERAL REVENUES.**

(a) Each local children's mental health collaborative shall report expendi-

tures 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~~ operational 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. 26. Minnesota Statutes 1994, section 245.496, subdivision 3, is amended to read:

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. A local children's mental health collaborative which forms without receiving start-up funds must submit its proposal for creating and funding an integrated service system within one year of notifying the commissioner of human services of its existence. 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. 27. Minnesota Statutes 1994, section 245.496, is amended by adding a subdivision to read:

Subd. 4. **APPROVAL OF A COLLABORATIVE'S INTEGRATED SERVICE SYSTEM.** A collaborative may not become a medical assistance provider unless the state coordinating council approves a collaborative's proposed integrated service system design. The state coordinating council shall approve the integrated service system proposal only when the following elements are present:

(1) interagency agreements signed by the head of each member agency who has the authority to obligate the agency and which set forth the specific financial commitments of each member agency;

(2) an adequate management structure for fiscal and clinical responsibility including appropriate allocation of risk and liability;

(3) a process of utilization review; and

(4) compliance with sections 245.491 to 245.496.

Sec. 28. Minnesota Statutes 1994, section 246.18, subdivision 4, is amended to read:

Subd. 4. **COLLECTIONS DEPOSITED IN THE GENERAL FUND.** Except as provided in subdivisions 2 ~~and~~, 5, and 6, 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 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. 29. Minnesota Statutes 1994, section 246.18, is amended by adding a subdivision to read:

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

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

(2) community health clinic services;

(3) accredited hospital outpatient department services;

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

(5) community-based transitional support services for adults with serious and persistent mental illness.

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

Sec. 30. Minnesota Statutes 1994, section 246.56, is amended by adding a subdivision to read:

Subd. 3. The commissioner of human services is not required to include indirect costs as defined in section 16A.127 in work activity contracts for patients of the regional treatment centers, and is not required to reimburse the general fund for indirect costs related to work activity programs.

Sec. 31. Minnesota Statutes 1994, section 253B.091, is amended to read:

253B.091 **REPORTING JUDICIAL COMMITMENTS INVOLVING PRIVATE TREATMENT PROGRAMS OR FACILITIES.**

Notwithstanding section 253B.23, subdivision 9, when a committing court judicially commits a proposed patient to a treatment program or facility other than a state-operated program or facility, the court shall report the commitment to the commissioner of human services through the supreme court information system for purposes of providing commitment information for firearm background checks under section 245.041.

Sec. 32. Minnesota Statutes 1994, section 254B.05, subdivision 4, is amended to read:

Subd. 4. **REGIONAL TREATMENT CENTERS.** Regional treatment center chemical dependency treatment units are eligible vendors. The commissioner may expand the capacity of chemical dependency treatment units beyond the capacity funded by direct legislative appropriation to serve individuals who are referred for treatment by counties and whose treatment will be paid for with a county's allocation under section 254B.02 or other funding sources. Notwithstanding the provisions of sections 254B.03 to 254B.041, payment for any person committed at county request to a regional treatment center under chapter 253B for chemical dependency treatment and determined to be ineligible under the chemical dependency consolidated treatment fund, shall become the responsibility of the county.

Sec. 33. Minnesota Statutes 1994, section 256B.0625, subdivision 37, is amended to read:

Subd. 37. ~~**WRAPAROUND**~~ **INDIVIDUALIZED REHABILITATION SERVICES.** Medical assistance covers ~~wraparound~~ individualized rehabilitation 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~~ 23, that are provided by a collaborative, county, or an entity under contract with a county through an integrated service system, as

described in section 245.4931, that is approved by the state coordinating council, subject to federal approval.

Sec. 34. Minnesota Statutes 1994, section 256B.092, subdivision 4, is amended to read:

Subd. 4. **HOME AND COMMUNITY-BASED SERVICES FOR PERSONS WITH MENTAL RETARDATION OR RELATED CONDITIONS.** (a) The commissioner shall make payments to approved vendors participating in the medical assistance program to pay costs of providing home and community-based services, including case management service activities provided as an approved home and community-based service, to medical assistance eligible persons with mental retardation or related conditions who have been screened under subdivision 7 and according to federal requirements. Federal requirements include those services and limitations included in the federally approved application for home and community-based services for persons with mental retardation or related conditions and subsequent amendments.

(b) Effective July 1, 1995, and contingent upon federal approval and state appropriations made available for this purpose, and in conjunction with section 40, the commissioner of human services shall allocate resources to county agencies for home and community-based waivered services for persons with mental retardation or related conditions authorized but not receiving those services as of June 30, 1995, based upon the average resource need of persons with similar functional characteristics. To ensure service continuity for service recipients receiving home and community-based waivered services for persons with mental retardation or related conditions prior to July 1, 1995, the commissioner shall make available to the county of financial responsibility home and community-based waivered services resources based upon fiscal year 1995 authorized levels.

(c) Home and community-based resources for all recipients shall be managed by the county of financial responsibility within an allowable reimbursement average established for each county. Payments for home and community-based services provided to individual recipients shall not exceed amounts authorized by the county of financial responsibility. For specifically identified former residents of ~~regional treatment centers and~~ nursing facilities, the commissioner shall be responsible for authorizing payments and payment limits under the appropriate home and community-based service program. Payment is available under this subdivision only for persons who, if not provided these services, would require the level of care provided in an intermediate care facility for persons with mental retardation or related conditions.

Sec. 35. Laws 1993, First Special Session chapter 1, article 7, section 51, subdivision 5, is amended to read:

Subd. 5. Sections 42 and 43 are effective ~~October 1, 1994~~ July 1, 1996.

Sec. 36. **SERVICES FOR DEVELOPMENTALLY DISABLED PERSONS; FARIBAULT REGIONAL CENTER CATCHMENT AREA.**

(a) This section governs the downsizing of the Faribault regional center (FRC). As residents are discharged from the Faribault regional center, the buildings will be transferred to the department of corrections, and the department of human services will develop a system of state-operated services that: (1) meets the needs of clients discharged from the Faribault regional center; (2) is fiscally sound; and (3) accommodates the evolving nature of the health care system.

(b) The Minnesota correctional facility at Faribault (MCF-FRB) shall expand its existing capacity by 300 beds. The department of human services shall transfer buildings related to this expansion according to agreements between the department of corrections and the Faribault community task force, established pursuant to Minnesota Statutes, section 252.51, no sooner than July 1, 1995.

After the city of Faribault has held a public hearing, the Minnesota correctional facility at Faribault may subsequently proceed with expansion of its capacity by an additional 300 beds, on or after a date when the commissioner of human services certifies that the Faribault regional center campus will be vacated because alternative community-based services, including those developed by the department of human services in accordance with section 12, will be available for the remaining residents of the Faribault regional center. The actual date on which the remainder of the Faribault regional center campus will be transferred to the commissioner of corrections shall be determined by mutual agreement between the commissioners of human services and corrections, after consultation with the exclusive representatives and the Faribault community task force. In no event shall the total capacity of the Minnesota correctional facility at Faribault exceed 1,200 beds, and the Minnesota correctional facility at Faribault shall not include any maximum security beds. The transfer of the Faribault regional center campus to the commissioner of corrections shall occur no sooner than July 1, 1998, unless negotiated with the exclusive representatives and community task force.

(c) The department of corrections shall provide necessary and appropriate modifications to road access on the Faribault regional center campus within the available appropriation. The city of Faribault shall not bear any cost of such modifications.

The department of corrections shall request necessary appropriations in future legislative sessions to provide necessary and appropriate modifications to the water-sewage system used by the Faribault regional center, the Minnesota correctional facility at Faribault, and the city of Faribault. The city of Faribault shall not bear any cost of such modifications.

(d) No sooner than July 1, 1995, the Faribault regional center shall transfer the operation of its power plant to the Minnesota correctional facility at Faribault contingent upon the Minnesota correctional facility at Faribault receiving a state appropriation for the full cost of necessary positions. The Faribault regional center employees in positions assigned to the power plant as of the

transfer date shall be allowed to transfer to the Minnesota correctional facility at Faribault or exercise their memorandum of understanding options. All employees who transfer shall retain their current classification, employment condition, and salary upon such transfer.

(e) Prior to the transfer of the Faribault regional center laundry to the Minnesota correctional facility at Faribault, the Faribault regional center shall decrease laundry positions as the Faribault regional center resident population declines. However, the department of human services and the Faribault regional center laundry management shall actively pursue additional shared service contracts to offset any involuntary position reductions in the laundry. The additional laundry work done as a result of the initial 300-bed corrections expansion will also be used to offset any involuntary position reductions. Further expansion of corrections beds and the resultant increased laundry will also be used to offset any involuntary reductions. If, after the above, position reductions are necessary, they shall occur pursuant to the memorandum of understanding between the state, the department of human services, and the exclusive representatives.

Upon the transfer of the Faribault regional center campus to the commissioner of corrections, the Faribault regional center may transfer the laundry to the Minnesota correctional facility at Faribault. If the transfer occurs, the Minnesota correctional facility at Faribault shall operate the laundry as a prison industry. The Minnesota correctional facility at Faribault shall maintain existing shared service contracts. The shared service positions shall be maintained by the Minnesota correctional facility at Faribault unless shared service income does not support these positions. If such positions are to be eliminated, such elimination shall be pursuant to the memorandum of understanding. However, other than specified above, the Minnesota correctional facility at Faribault shall only eliminate positions through attrition.

All Faribault regional center employees assigned to the laundry as of the transfer date shall be allowed to transfer to the Minnesota correctional facility at Faribault or exercise their memorandum of understanding options. All employees who transfer shall retain their current classification, employment condition, and salary upon such transfer.

(f) In consultation with the applicable exclusive representatives, the departments of corrections, human services, and employee relations shall establish training programs to enhance the opportunity of the Faribault regional center employees to obtain positions beyond entry level at the Minnesota correctional facility at Faribault. While participating in this training, individuals shall remain on the Faribault regional center payroll and the department of human services shall seek a legislative appropriation for this purpose. The department of corrections shall seek a legislative appropriation for retraining the Faribault regional center employees.

Sec. 37. **SOUTHERN CITIES COMMUNITY HEALTH CLINIC.**

The commissioner of human services shall consult with the Faribault community task force and the exclusive representatives before making any decisions about:

(1) the future of the Southern Cities Community Health Clinic;

(2) the services currently provided by that clinic to developmentally disabled clients in the Faribault regional center catchment area; and

(3) changes in the model for providing those services.

The department of human services shall guarantee the provision of medically necessary psychiatric and dental services to developmentally disabled clients in the Faribault service area until or unless other appropriate arrangements have been made to provide those clients with those services.

Sec. 38. **STATE-OPERATED SERVICES IN THE FARIBAULT CATCHMENT AREA.**

(a) Notwithstanding Minnesota Statutes, section 252.025, subdivision 4, and in addition to the programs already developed, the department of human services shall establish the following state-operated, community-based programs in the Faribault regional center catchment area:

(1) state-operated community residential services to serve as a primary provider for 40 current residents of the Faribault regional center whose clinical symptoms or behaviors make them difficult to serve. Those state-operated, community-based residential services shall be configured as ten four-bed waivered services homes. The program configuration may be modified in accordance with paragraph (c).

Beginning July 1, 1995, in addition to the residential services for those 40 clients, the department of human services agrees to seek legislation to develop and establish state-operated, community-based residential services for any other current residents of the Faribault regional center for whom the commissioner of human services finds that respective counties of financial responsibility are unable to find appropriate residential services operated by private providers. Counties shall give the strongest possible consideration to the placement preference of clients and families;

(2) a minimum of four state-operated day training and habilitation facilities for persons leaving the Faribault regional center as the result of downsizing and for other individuals referred by county agencies;

(3) crisis services for developmentally disabled persons in the Faribault regional center catchment area, including crisis beds and mobile intervention teams. These state-operated crisis services shall be configured as three four-bed programs. The program configuration may be modified in accordance with paragraph (c);

(4) area management services sufficient to manage state-operated, community-based programs within the existing Faribault regional center catchment area;

(5) area maintenance services sufficient to maintain the physical facilities housing state-operated services in the Faribault regional center catchment area; and

(6) technical assistance and training services for both public and private providers.

(b) All employees of the state-operated services established under this subdivision shall be state employees under Minnesota Statutes, chapters 43A and 179A, and shall consist of no fewer than 182 full-time employee equivalents, excluding additional personnel that may be necessary to staff additional state-operated, community-based residential services.

(c) Any changes in the configuration and design of programs described in this subdivision must be negotiated and agreed to by the affected exclusive representatives. The parties also must meet and discuss ways to provide the highest quality services, while maintaining or increasing cost effectiveness.

(d) The department of human services shall assist the counties with financial responsibility for those Faribault regional center residents who will be discharged into state-operated, community-based residential programs in developing service options located in and around the city of Faribault.

The department of human services shall seek funding, including the capital bonding necessary to establish the state-operated services authorized in this subdivision, including area management services to be located in or around the city of Faribault.

Sec. 39. **CAMBRIDGE REGIONAL HUMAN SERVICE CENTER COMMUNITY INTEGRATION PROGRAM.**

Subdivision 1. **COMMUNITY INTEGRATION PROGRAMS.** Notwithstanding the requirements of Minnesota Statutes, section 252.025 or 252.50, and sections 36 to 38, the commissioner of human services shall develop the following state-operated community services for persons with developmental disabilities in cooperation with the Cambridge regional human services center: residential services for 12 persons each year of the 1996-1997 biennium for a total of not fewer than 24 persons. The commissioner shall also develop residential services for 12 persons each year of the 1998-1999 biennium. In addition, the commissioner shall authorize the development of state-operated community services for other persons for whom the counties of financial responsibility are unable to find appropriate residential or day training and habilitation services. These services shall be developed in the catchment area currently served by the Cambridge regional human services center in accordance with the requirements of Minnesota Statutes, section 252.51, and shall be in addition to the services and programs currently authorized for the catchment area. The provisions in this

subdivision may be implemented when the request for developing the service is made by the county of financial responsibility, and is approved by the individual or the individual's legally authorized agent. During the biennium ending June 30, 1997, the commissioner shall allocate waiver slots for state-operated community services according to the authorization made by the legislature for the biennium. Within the available funding for waivered state-operated community services, the commissioner shall assure that the costs for state-operated community services are met on a cost-of-care basis. These services shall be in addition to the services and programs currently operated by the Cambridge regional human services center and the center shall provide administrative and support services for the programs developed under this section.

Subd. 2. **CAMPUS PROGRAMS.** (a) During the 1996-1997 biennium, the commissioner shall maintain capacity at Cambridge regional human services center and will continue to provide residential and crisis services at Cambridge for persons with complex behavioral and social problems committed by the courts from the Faribault regional center and Cambridge regional human services center catchment areas.

The commissioner shall develop a specialized service model at the Cambridge campus to serve citizens of Minnesota who have a developmental disability and exhibit severe behaviors which present a risk to public safety. This service will have the capacity to serve between 40 to 100 individuals and will maintain a staffing ratio of 1:1.938 plus six technical positions for outreach and follow-along care.

During fiscal year 1996, the commissioner shall initiate an implementation process which must include representatives selected by the employees' exclusive representatives. The implementation process will include assessing the actual need for service in this specialized model, defining the service capacity, program design, and establishment of the service model.

This implementation process will also include assessing the service capacity needed to allow Cambridge regional human services center to provide a safety net of residential and crisis services to persons with developmental disabilities and complex behavioral and social problems who are committed by the courts.

The commissioner shall also initiate architectural and engineering predesign required to develop a capital budget proposal for the 1996 legislative session. This proposal shall include any necessary campus infrastructure improvements, building modifications, and construction required to accommodate the above referenced services and related restructuring of the Cambridge campus.

During the fiscal year 1996-1997 biennium the commissioner shall make every reasonable effort, within the limits of available resources, to achieve a 1:1.938 staffing ratio for the 35 individuals residing at the Cambridge regional human service center who will be served in the future by the specialized service model. Any appropriations made specifically for this purpose shall be used to achieve a 1:1.938 staffing ratio at the earliest possible date within the biennium.

(b) The commissioner of human services shall provide a report for the 1996 legislature by January 15, 1996, regarding the number of children with developmental disabilities who are receiving residential services out of state. The report shall include the number of children involved, the location and type of services being received, and the cost of those services.

(c) The satellite office designated for local administration of MinnesotaCare including enrollment staff functions shall be located on the campus of the Cambridge regional human services center.

Sec. 40. **WAIVER ALLOCATION FOR STATE-OPERATED COMMUNITY SERVICES.**

In the administration of waivers for home and community-based services subject to Minnesota Statutes, section 256B.092, the commissioner of human services shall be solely responsible for the allocation of waiver resources to counties and such costs shall be based on average resource need of persons with similar functional characteristics. During the biennium ending June 30, 1997, the commissioner shall allocate waiver slots for state-operated community services according to the authorizations made by the legislature for the biennium, including requests by counties under sections 38 and 39. The commissioner of human services shall assure that the costs for state-operated community-based services are met on a cost-of-care basis. Within available appropriations for home and community-based waivers, the commissioner may establish state-operated, community-based residential services, in addition to those authorized, for residents of regional treatment centers for whom the commissioner finds that the respective counties of financial responsibility are unable to find appropriate residential services operated by private providers. Counties shall give the strongest possible consideration to the placement preferences of clients and families.

Sec. 41. **PILOT PROJECTS TO TEST ALTERNATIVES TO DELIVERY OF MENTAL HEALTH SERVICES.**

Subdivision 1. **AUTHORIZATION FOR PILOT PROJECTS.** The commissioner of human services may approve pilot projects to test alternatives to or the enhanced coordination of the delivery of mental health services required under the Minnesota comprehensive adult mental health act, Minnesota Statutes, sections 245.461 to 245.486.

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

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

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

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

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

(b) All projects must complete their planning phase and be operational by June 30, 1997.

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

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

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

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

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

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

(3) other mental health special project funds;

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

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

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

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

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

(3) geographical distribution.

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

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

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

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

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

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

(2) assure that no one is denied services for which they would otherwise be eligible; and

(3) provide the commissioner of human services with timely and pertinent information through the following methods:

(i) submission of community social services act plans and plan amendments;

(ii) submission of social services expenditure and grant reconciliation reports, based on a coding format to be determined by mutual agreement between the project's managing entity and the commissioner; and

(iii) submission of data and participation in an evaluation of the pilot projects, to be designed cooperatively by the commissioner and the projects.

Sec. 42. **LOCALLY MANAGED INTEGRATED FUND DEMONSTRATION PILOT PROJECT.**

Subdivision. 1. **DEFINITIONS.** (a) "Eligible persons" means individuals who reside within the geographic area designated under subdivision 2 and who are otherwise eligible as defined in Minnesota Statutes, section 256B.092. Other persons with a developmental disability as defined in United States Code, title 42, section 6001, may be determined eligible by the local managing entity to participate in these pilots.

(b) "Local managing entity" means the county agency or alliance of agencies approved by the county under contract with the Minnesota department of human services and participating in each local demonstration project that manages the resources and the delivery of services to eligible individuals.

Subd. 2. **GEOGRAPHIC AREA.** The commissioner shall designate the geographic areas in which eligible individuals and organizations will be included in the project.

Subd. 3. **PAYMENT.** The commissioner shall establish the method and amount of payments and prepayments for the management and delivery of services. The managing entity may integrate these funds with local resources appropriated for services to persons with mental retardation or related conditions and may require transfer of resources from other county agencies for eligible persons who reside within the geographic area and who are the financial responsibility of another county. The commissioner shall contract with the local managing entity and the contract shall be consistent with these established methods and amounts for payment.

Subd. 4. **SERVICE DELIVERY.** Each managing entity shall be responsible for management and delivery of services for eligible individuals within their geographic area. Managing entities:

(1) shall accept the prospective, per capita payment from the commissioner in return for the provision of comprehensive and coordinated services for eligible individuals enrolled in the project;

(2) may contract with health care, long-term care, and other providers to serve eligible persons enrolled in the project; and

(3) may integrate state, federal, and county resources into an account and draw funding from this single source to purchase or provide services for eligible persons.

Subd. 5. **REPORTING.** Each participating local managing entity shall submit information as required by the commissioner, including data required for assessing client satisfaction, quality of care, cost, and utilization of services for purposes of project evaluation.

Subd. 6. **ALTERNATIVE METHODS.** Upon federal waiver approval to

proceed with these pilots, the commissioner may approve alternative methods to meet the intent of existing rules and statutes relating to services for eligible persons. The commissioner shall ensure that in no case are the rights and protections afforded under these rules and statutes abridged. The commissioner shall not waive the 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.

Subd. 7. **COMMISSIONER DUTIES.** For purposes of this project, waiver of certain statutory provisions is necessary in accordance with this section, specifically subdivision 6. The commissioner shall seek all federal waivers as necessary to implement this section. In the biennium ending June 30, 1997, the commissioner may establish up to two pilot projects.

Sec. 43. **STATE-OPERATED, COMMUNITY-BASED SERVICES; REPORT ON COST-EFFECTIVE ALTERNATIVE.**

The commissioner shall develop a more cost-effective model than the four-bed, state-operated, or private community-based services model for purposes of serving high level care clients who are released from regional treatment centers. The commissioner must report recommendations to the legislature by January 15, 1996.

Sec. 44. **AH GWAH CHING NURSING HOME.**

Notwithstanding Minnesota Statutes, sections 429.061, subdivision 2, and 435.19, subdivision 2, the commissioner may, by contract with the city of Walker, agree to an assessment for sewer pond repairs which will constitute a valid lien on property now under the management and control of the commissioner of human services currently being used for the Ah Gwah Ching nursing home and the lien hereby authorized may, if not paid when due, be recovered in a civil action against the state or may be enforced as if the property described above were privately owned.

Sec. 45. **TRANSFER OF FUNDS.**

During the biennium ending June 30, 1997, state funds, which had been used during the 1994-95 biennium to supplement payments to state operated home- and community-based waiver services, shall be transferred to the medical assistance account in order to implement the requirements of Minnesota Statutes, section 256B.092, subdivision 4. Sufficient money shall be retained in the applicable accounts to fund cost-of-living adjustments in the state operated community waivered services programs.

Sec. 46. **EFFECTIVE DATES.**

Sections 28 and 29 (246.18, subdivisions 4 and 6) are effective the day following final enactment.

Section 42 is effective January 1, 1996.

ARTICLE 9

HEALTH DEPARTMENT

Section 1. Minnesota Statutes 1994, section 62N.381, subdivision 2, is amended to read:

Subd. 2. **RANGE OF RATES.** The reimbursement rate negotiated for a contract period must not be more than 20 percent above or below the individual ambulance service's current customary charges, plus the rate of growth allowed under section 62J.04, subdivision 1. If the network and ambulance service cannot agree on a reimbursement rate, each party shall submit their rate proposal along with supportive data to the ~~commissioner~~ emergency medical services regulatory board.

Sec. 2. Minnesota Statutes 1994, section 62N.381, subdivision 3, is amended to read:

Subd. 3. **DEVELOPMENT OF CRITERIA.** The ~~commissioner~~ emergency medical services regulatory board, in consultation with representatives of the Minnesota Ambulance Association, regional emergency medical services programs, community integrated service networks, and integrated service networks, shall develop guidelines to use in reviewing rate proposals and making a final reimbursement rate determination.

Sec. 3. Minnesota Statutes 1994, section 62N.381, subdivision 4, is amended to read:

Subd. 4. **REVIEW OF RATE PROPOSALS.** The ~~commissioner~~ emergency medical services regulatory board, using the guidelines developed under subdivision 3, shall review the rate proposals of the ambulance service and community integrated service network or integrated service network and shall adopt either the network's or the ambulance service's proposal. The ~~commissioner~~ board shall require the network and ambulance service to adhere to this reimbursement rate for the contract period.

Sec. 4. Minnesota Statutes 1994, section 144.122, is amended to read:

144.122 **LICENSE AND PERMIT FEES.**

(a) The state commissioner of health, by rule, may prescribe reasonable procedures and fees for filing with the commissioner as prescribed by statute and for the issuance of original and renewal permits, licenses, registrations, and certifications issued under authority of the commissioner. The expiration dates of the various licenses, permits, registrations, and certifications as prescribed by the

rules shall be plainly marked thereon. Fees may include application and examination fees and a penalty fee for renewal applications submitted after the expiration date of the previously issued permit, license, registration, and certification. The commissioner may also prescribe, by rule, reduced fees for permits, licenses, registrations, and certifications when the application therefor is submitted during the last three months of the permit, license, registration, or certification period. Fees proposed to be prescribed in the rules shall be first approved by the department of finance. All fees proposed to be prescribed in rules shall be reasonable. The fees shall be in an amount so that the total fees collected by the commissioner will, where practical, approximate the cost to the commissioner in administering the program. All fees collected shall be deposited in the state treasury and credited to the state government special revenue fund unless otherwise specifically appropriated by law for specific purposes.

(b) The commissioner may charge a fee for voluntary certification of medical laboratories and environmental laboratories, and for environmental and medical laboratory services provided by the department, without complying with paragraph (a) or chapter 14. Fees charged for environment and medical laboratory services provided by the department must be approximately equal to the costs of providing the services.

(c) The commissioner may develop a schedule of fees for diagnostic evaluations conducted at clinics held by the services for children with handicaps program. All receipts generated by the program are annually appropriated to the commissioner for use in the maternal and child health program.

(d) The commissioner, for fiscal years ~~1993~~ 1996 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~~ $1,017
Non-JCAHO hospitals	~~$2,228 plus $138 per bed~~ $762 plus $34 per bed
Nursing home	~~$324 plus $76 per bed~~ $78 plus $19 per bed

For fiscal years ~~1993~~ 1996 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~~ $517
Boarding care homes	~~$249 plus $58 per bed~~ $78 plus $19 per bed
Supervised living facilities	~~$249 plus $58 per bed~~ $78 plus $19 per bed.

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

Sec. 5. Minnesota Statutes 1994, section 144.226, subdivision 1, is amended to read:

Subdivision 1. **WHICH SERVICES ARE FOR FEE.** The fees for any of the following services shall be in an amount prescribed by rule of the commissioner:

(a) The issuance of a certified copy or certification of a vital record, or a certification that the record cannot be found~~, provided that a fee shall not be charged for any certified copy required for service in the armed forces or the Merchant Marine of the United States or required in the presentation of claims to the United States Veterans Administration of any state or territory of the United States, or for any copy requested by the commissioner of human services for the discharge of duties relating to state wards. No fee shall be charged for verification of information requested by official agencies of this state, local governments in this state, or the federal government~~;

(b) The replacement of a birth certificate;

(c) The filing of a delayed registration of birth or death;

(d) The alteration, correction, or completion of any vital record, provided that no fee shall be charged for an alteration, correction, or completion requested within one year after the filing of the certificate; and

(e) The verification of information from or noncertified copies of vital records. Fees charged shall approximate the costs incurred in searching and copying the records. The fee shall be payable at time of application.

Sec. 6. **[144.394] SMOKING PREVENTION.**

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.

Sec. 7. Minnesota Statutes 1994, section 144.801, subdivision 3, is amended to read:

Subd. 3. ~~**COMMISSIONER**~~ **BOARD.** ~~"Commissioner" means the commissioner of health of the state of Minnesota~~ "Board" means the emergency medical services regulatory board.

Sec. 8. Minnesota Statutes 1994, section 144.801, subdivision 5, is amended to read:

Subd. 5. **LICENSE.** "License" means authority granted by the ~~commissioner~~ board for the operation of an ambulance service in the state of Minnesota.

Sec. 9. Minnesota Statutes 1994, section 144.802, is amended to read:

144.802 **LICENSING.**

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~~ board. 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~~ board, 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~~ board shall require the prospective licensee or owner to comply with subdivision 3. The ~~commissioner~~ board 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~~ board pursuant to section 144.122. Licenses shall expire and be renewed as prescribed by the ~~commissioner~~ board pursuant to section 144.122. Fees collected shall be deposited to the trunk highway fund.

Subd. 2. **REQUIREMENTS FOR NEW LICENSES.** The ~~commissioner~~ board shall not issue a license authorizing the operation of a new ambulance service, provision of a new type or types of ambulance service by an existing service, or establishment of a new base of operation or an expanded primary service area for an existing service unless the requirements of sections 144.801 to 144.807 are met.

Subd. 3. **APPLICATIONS; NOTICE OF APPLICATION; RECOMMENDATIONS.** (a) Each prospective licensee and each present licensee wishing to offer a new type or types of ambulance service, to establish a new base of operation, or to expand a primary service area, shall make written application for a license to the ~~commissioner~~ board on a form provided by the ~~commissioner~~ board.

(b) The board shall review the application for completeness, clarity, and content.

(c) For applications for the provision of ambulance services in a service area located within a county, the ~~commissioner~~ board shall promptly send notice of the completed application to the county board and to each community health

board, governing body of a regional emergency medical services system designated under section 144.8093, ambulance service, and municipality in the area in which ambulance service would be provided by the applicant. The ~~commissioner~~ board shall publish the notice, at the applicant's expense, in the State Register and in a newspaper in the municipality in which the base of operation will be located, or if no newspaper is published in the municipality or if the service would be provided in more than one municipality, in a newspaper published at the county seat of the county in which the service would be provided.

~~(c)~~ (d) For applications for the provision of ambulance services in a service area larger than a county, the ~~commissioner~~ board shall promptly send notice of the completed application to the municipality in which the service's base of operation will be located and to each community health board, county board, governing body of a regional emergency medical services system designated under section 144.8093, and ambulance service located within the counties in which any part of the service area described by the applicant is located, and any contiguous counties. The ~~commissioner~~ board shall publish this notice, at the applicant's expense, in the State Register.

~~(d) The commissioner~~ (e) Within 30 days of receiving a completed application, the board shall forward the application, along with any recommendations regarding the application, and shall request that the chief administrative law judge appoint an administrative law judge to hold a public hearing in the municipality in which the service's base of operation will be located. The public hearing shall be conducted as contested case hearing under chapter 14.

~~(e)~~ (f) Each municipality, county, community health board, governing body of a regional emergency medical services system, ambulance service, and other person wishing to make recommendations concerning the disposition of the application shall make written recommendations to the administrative law judge within 30 days of the publication of notice of the application in the State Register.

~~(f)~~ (g) The administrative law judge shall:

(1) hold a public hearing in the municipality in which the service's base of operations is or will be located;

(2) provide notice of the public hearing in the newspaper or newspapers in which notice was published under paragraph (b) for two successive weeks at least ten days before the date of the hearing;

(3) allow any interested person the opportunity to be heard, to be represented by counsel, and to present oral and written evidence at the public hearing;

(4) provide a transcript of the hearing at the expense of any individual requesting it; and

(5) consider and make part of the public record the recommendations of the board.

~~(g)~~ (h) The administrative law judge shall review ~~and comment upon~~ the application and shall ~~make written recommendations~~ forward a decision and order as to its disposition to the ~~commissioner~~ board within 90 days of receiving notice of the application. In making the ~~recommendations~~ decision, the administrative law judge shall consider and make written comments as to whether the proposed service, change in base of operations, or expansion in primary service area is needed, based on consideration of the following factors:

(1) the relationship of the proposed service, change in base of operations or expansion in primary service area to the current community health plan as approved by the commissioner of health under section 145A.12, subdivision 4;

(2) the recommendations or comments of the governing bodies of the counties ~~and~~, municipalities, and regional emergency medical services system designated under section 144.8093 in which the service would be provided;

(3) the deleterious effects on the public health from duplication, if any, of ambulance services that would result from granting the license;

(4) the estimated effect of the proposed service, change in base of operation or expansion in primary service area on the public health;

(5) whether any benefit accruing to the public health would outweigh the costs associated with the proposed service, change in base of operations, or expansion in primary service area.

The administrative law judge shall ~~recommend that~~ order the ~~commissioner either~~ board to grant or deny a license or ~~recommend~~ order that a modified license be granted. The reasons for the ~~recommendation~~ order shall be set forth in detail. The administrative law judge shall make the ~~recommendations~~ order and reasons available to any individual requesting them.

Subd. 3a. **LICENSURE OF AIR AMBULANCE SERVICES.** Except for submission of a written application to the ~~commissioner~~ board on a form provided by the ~~commissioner~~ board, an application to provide air ambulance service shall be exempt from the provisions of subdivisions 3 and 4.

A license issued pursuant to this subdivision need not designate a primary service area.

No license shall be issued under this subdivision unless the ~~commissioner of health~~ board determines that the applicant complies with the requirements of applicable federal and state statutes and rules governing aviation operations within the state.

Subd. 3b. **SUMMARY APPROVAL OF PRIMARY SERVICE AREAS.** Except for submission of a written application to the ~~commissioner~~ board on a

form provided by the ~~commissioner~~ board, an application to provide changes in a primary service area shall be exempt from subdivisions 3, paragraphs (d) to (g); and 4, if:

(1) the application is for a change of primary service area to improve coverage, to improve coordination with 911 emergency dispatching, or to improve efficiency of operations;

(2) the application requests redefinition of contiguous or overlapping primary service areas;

(3) the application shows approval from the ambulance licensees whose primary service areas are directly affected by a change in the applicant's primary service area;

(4) the application shows that the applicant requested review and comment on the application, and has included those comments received from: all county boards in the areas of coverage included in the application; all community health boards in the areas of coverage included in the application; all directors of 911 public safety answering point areas in the areas of coverage included in the application; and all regional emergency medical systems areas designated under section 144.8093 in the areas of coverage included in the application; and

(5) the application shows consideration of the factors listed in subdivision 3, paragraph (g).

Subd. 4. ~~**COMMISSIONER'S DECISION**~~ **ISSUANCE OF LICENSE.** Within 30 days after receiving the administrative law judge's ~~report~~ order, the ~~commissioner~~ board shall grant or deny a license to the applicant. ~~In granting or denying a license, the commissioner shall consider the administrative law judge's report, the evidence contained in the application, and any hearing record and other applicable evidence. The commissioner's decision shall be based on a consideration of the factors contained in subdivision 3, clause (g). If the commissioner's decision is different from the administrative law judge's recommendations, the commissioner shall set forth in detail the reasons for differing from the recommendations.~~

Subd. 5. **CONTESTED CASES.** The ~~commissioner's~~ board's decision made under subdivision 3a or 4 the administrative law judge's decision under subdivision 3 shall be the final administrative decision. Any person aggrieved by the ~~commissioner's~~ board's decision or action shall be entitled to judicial review in the manner provided in sections 14.63 to 14.69.

Subd. 6. **TEMPORARY LICENSE.** Notwithstanding other provisions herein, the ~~commissioner~~ board may issue a temporary license for instances in which a primary service area would be deprived of ambulance service. The temporary license shall expire when an applicant has been issued a regular license under this section. The temporary license shall be valid no more than six months from date of issuance. A temporary licensee must provide evidence that

the licensee will meet the requirements of section 144.804 and the rules adopted under this section.

Sec. 10. Minnesota Statutes 1994, section 144.803, is amended to read:

144.803 **LICENSING; SUSPENSION AND REVOCATION.**

The ~~commissioner~~ board may~~,~~ ~~after~~ ~~conducting~~ initiate a contested case hearing upon reasonable notice~~,~~ to suspend ~~or~~, revoke, or refuse to renew the license of a licensee upon finding that the licensee has violated sections 144.801 to 144.808 or has ceased to provide the service for which it is licensed. The decision of the administrative law judge in the contested case hearing shall be the decision of the board.

Sec. 11. Minnesota Statutes 1994, section 144.804, is amended to read:

144.804 **STANDARDS.**

Subdivision 1. **DRIVERS AND ATTENDANTS.** No publicly or privately owned basic ambulance service shall be operated in the state unless its drivers and attendants possess a current emergency care course certificate authorized by rules adopted by the ~~commissioner of health~~ board according to chapter 14. Until August 1, 1994, a licensee may substitute a person currently certified by the American Red Cross in advanced first aid and emergency care or a person who has successfully completed the United States Department of Transportation first responder curriculum, and who has also been trained to use basic life support equipment as required by rules adopted by the ~~commissioner~~ board under section 144.804, subdivision 3, for one of the persons on a basic ambulance, provided that person will function as the driver while transporting a patient. The ~~commissioner~~ board may grant a variance to allow a licensed ambulance service to use attendants certified by the American Red Cross in advanced first aid and emergency care in order to ensure 24-hour emergency ambulance coverage. ~~The commissioner shall study the roles and responsibilities of first responder units and report the findings by January 1, 1991. This study shall address at a minimum:~~

~~(1) education and training;~~

~~(2) appropriate equipment and its use;~~

~~(3) medical direction and supervision; and~~

~~(4) supervisory and regulatory requirements.~~

Subd. 2. **EQUIPMENT AND STAFF.** (a) Every ambulance offering ambulance service shall be equipped as required by the ~~commissioner~~ board and carry at least the minimal equipment necessary for the type of service to be provided as determined by standards adopted by the ~~commissioner~~ board pursuant to subdivision 3.

(b) Each ambulance service shall offer service 24 hours per day every day of the year, unless otherwise authorized by the ~~commissioner~~ board.

(c) Each ambulance while transporting a patient shall be staffed by at least a driver and an attendant, according to subdivision 1. An ambulance service may substitute for the attendant a physician, osteopath, registered nurse, or physician's assistant who is qualified by training to use appropriate equipment in the ambulance. Advanced life support procedures including, but not limited to, intravenous fluid administration, drug administration, endotracheal intubation, cardioversion, defibrillation, and intravenous access may be performed by the physician, osteopath, registered nurse, or physician's assistant who has appropriate training and authorization, and who provides all of the equipment and supplies not normally carried on basic ambulances.

(d) An ambulance service shall not deny emergency ambulance service to any person needing emergency ambulance service because of inability to pay or due to source of payment for services if this need develops within the licensee's primary service area. Transport for such a patient may be limited to the closest appropriate emergency medical facility.

Subd. 3. **TYPES OF SERVICES TO BE REGULATED.** The ~~commissioner~~ board may adopt rules needed to carry out sections 144.801 to 144.8091, including the following types of ambulance service:

(a) basic ambulance service that has appropriate personnel, vehicles, and equipment, and is maintained according to rules adopted by the ~~commissioner~~ board according to chapter 14, and that provides a level of care so as to ensure that life-threatening situations and potentially serious injuries can be recognized, patients will be protected from additional hazards, basic treatment to reduce the seriousness of emergency situations will be administered and patients transported to an appropriate medical facility for treatment;

(b) intermediate ambulance service that has appropriate personnel, vehicles, and equipment, and is maintained according to standards the ~~commissioner~~ board adopts according to chapter 14, and that provides basic ambulance service and intravenous infusions or defibrillation or both. Standards adopted by the commissioner shall include, but not be limited to, equipment, training, procedures, and medical control;

(c) advanced ambulance service that has appropriate personnel, vehicles, and equipment, and is maintained according to standards the ~~commissioner~~ board adopts according to chapter 14, and that provides basic ambulance service, and in addition, advanced airway management, defibrillation, and administration of intravenous fluids and pharmaceuticals. Vehicles of advanced ambulance service licensees not equipped or staffed at the advanced ambulance service level shall not be identified to the public as capable of providing advanced ambulance service.

(d) specialized ambulance service that provides basic, intermediate, or

advanced service as designated by the ~~commissioner~~ board, and is restricted by the ~~commissioner~~ board to (1) less than 24 hours of every day, (2) designated segments of the population, or (3) certain types of medical conditions; and

(e) air ambulance service, that includes fixed-wing and helicopter, and is specialized ambulance service.

Until standards have been developed under clauses (b), (d), and (e), the current provisions of Minnesota Rules shall govern these services.

Subd. 5. **LOCAL GOVERNMENT'S POWERS.** Local units of government may, with the approval of the ~~commissioner~~ board, establish standards for ambulance services which impose additional requirements upon such services. Local units of government intending to impose additional requirements shall consider whether any benefit accruing to the public health would outweigh the costs associated with the additional requirements. Local units of government which desire to impose such additional requirements shall, prior to promulgation of relevant ordinances, rules or regulations, furnish the ~~commissioner~~ board with a copy of such proposed ordinances, rules or regulations, along with information which affirmatively substantiates that the proposed ordinances, rules or regulations: will in no way conflict with the relevant rules of the department of health; will establish additional requirements tending to protect the public health; will not diminish public access to ambulance services of acceptable quality; and will not interfere with the orderly development of regional systems of emergency medical care. The ~~commissioner~~ board shall base any decision to approve or disapprove such standards upon whether or not the local unit of government in question has affirmatively substantiated that the proposed ordinances, rules or regulations meet these criteria.

Subd. 6. **RULES ON PRIMARY SERVICE AREAS.** The ~~commissioner~~ board shall promulgate rules defining primary service areas under section 144.801, subdivision 8, under which the ~~commissioner~~ board shall designate each licensed ambulance service as serving a primary service area or areas.

Subd. 7. **DRIVERS OF AMBULANCES.** An ambulance service vehicle shall be staffed by a driver possessing a current Minnesota driver's license or equivalent and whose driving privileges are not under suspension or revocation by any state. If red lights and siren are used, the driver must also have completed training approved by the ~~commissioner~~ board in emergency driving techniques. An ambulance transporting patients must be staffed by at least two persons who are trained according to subdivision 1, or section 144.809, one of whom may be the driver. A third person serving as driver shall be trained according to this subdivision.

Sec. 12. Minnesota Statutes 1994, section 144.806, is amended to read:

144.806 **PENALTIES.**

Any person who violates a provision of sections 144.801 to 144.806 is guilty

of a misdemeanor. The ~~commissioner~~ board may issue fines to assure compliance with sections 144.801 to 144.806 and rules adopted under those sections. The ~~commissioner~~ board shall adopt rules to implement a schedule of fines by January 1, 1991.

Sec. 13. Minnesota Statutes 1994, section 144.807, is amended to read:

144.807 **REPORTS.**

Subdivision 1. **REPORTING OF INFORMATION.** Operators of ambulance services licensed pursuant to sections 144.801 to 144.806 shall report information about ambulance service to the ~~commissioner~~ board as the ~~commissioner~~ board may require. The reports shall be classified as "private data on individuals" under the Minnesota government data practices act, chapter 13.

Subd. 2. **FAILURE TO REPORT.** Failure to report all information required by the ~~commissioner~~ board shall constitute grounds for licensure revocation.

Sec. 14. Minnesota Statutes 1994, section 144.808, is amended to read:

144.808 **INSPECTIONS.**

The ~~commissioner~~ board may inspect ambulance services as frequently as deemed necessary. These inspections shall be for the purpose of determining whether the ambulance and equipment is clean and in proper working order and whether the operator is in compliance with sections 144.801 to 144.804 and any rules that the ~~commissioner~~ board adopts related to sections 144.801 to 144.804.

Sec. 15. Minnesota Statutes 1994, section 144.809, is amended to read:

144.809 **RENEWAL OF BASIC EMERGENCY CARE COURSE CERTIFICATE; FEE.**

Subdivision 1. **STANDARDS FOR RECERTIFICATION.** The ~~commissioner~~ board shall adopt rules establishing minimum standards for expiration and recertification of basic emergency care course certificates. These standards shall require:

(1) four years after initial certification, and every four years thereafter, formal classroom training and successful completion of a written test and practical examination, both of which must be approved by the ~~commissioner~~ board; and

(2) two years after initial certification, and every four years thereafter, in-service continuing education, including knowledge and skill proficiency testing, all of which must be conducted under the supervision of a medical director or medical advisor and approved by the ~~commissioner~~ board.

Course requirements under clause (1) shall not exceed 24 hours. Course requirements under clause (2) shall not exceed 36 hours, of which at least 12

hours may consist of course material developed by the medical director or medical advisor.

Individuals may choose to complete, two years after initial certification, and every two years thereafter, formal classroom training and successful completion of a written test and practical examination, both of which are approved by the ~~commissioner~~ board, in lieu of completing requirements in clauses (1) and (2).

Subd. 2. **UPGRADING TO BASIC EMERGENCY CARE COURSE CERTIFICATE.** ~~By August 1, 1994,~~ The ~~commissioner~~ board shall adopt rules authorizing the equivalence of the following as credit toward successful completion of the ~~commissioner's~~ board's basic emergency care course:

(1) successful completion of the United States Department of Transportation first responder curriculum;

(2) a minimum of two years of documented continuous service as an ambulance driver, as authorized in section 144.804, subdivision 7;

(3) documented clinical experience obtained through work or volunteer activity as a first responder; and

(4) documented continuing education in emergency care.

Subd. 3. **LIMITATION ON FEES.** No fee set by the ~~commissioner~~ board for biennial renewal of a basic emergency care course certificate by a volunteer member of an ambulance service, fire department, or police department shall exceed $2.

Sec. 16. Minnesota Statutes 1994, section 144.8091, is amended to read:

144.8091 **REIMBURSEMENT TO NONPROFIT AMBULANCE SERVICES.**

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~~ board 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~~ board, 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 $450 for successful completion of a basic course, and $225 for successful completion of a continuing education course.

Subd. 2. **VOLUNTEER ATTENDANT DEFINED.** For purposes of this section, "volunteer ambulance attendant" means a person who provides emergency medical services for a Minnesota licensed ambulance service without the

expectation of remuneration and who does not depend in any way upon the provision of these services for the person's livelihood. An individual may be considered a volunteer ambulance attendant even though that individual receives an hourly stipend for each hour of actual service provided, except for hours on standby alert, even though this hourly stipend is regarded as taxable income for purposes of state or federal law, provided that this hourly stipend does not exceed $3,000 within one year of the final certification examination. Reimbursement will be paid under provisions of this section when documentation is provided the ~~department of health~~ board that the individual has served for one year from the date of the final certification exam as an active member of a Minnesota licensed ambulance service.

Sec. 17. Minnesota Statutes 1994, section 144.8093, is amended to read:

144.8093 **EMERGENCY MEDICAL SERVICES FUND.**

Subdivision 1. **CITATION.** This section is the "Minnesota emergency medical services system support act."

Subd. 2. **ESTABLISHMENT AND PURPOSE.** In order to develop, maintain, and improve regional emergency medical services systems, the ~~department of health~~ emergency medical services regulatory board shall establish an emergency medical services system fund. The fund shall be used for the general purposes of promoting systematic, cost-effective delivery of emergency medical care throughout the state; identifying common local, regional, and state emergency medical system needs and providing assistance in addressing those needs; providing discretionary grants for emergency medical service projects with potential regionwide significance; providing for public education about emergency medical care; promoting the exchange of emergency medical care information; ensuring the ongoing coordination of regional emergency medical services systems; and establishing and maintaining training standards to ensure consistent quality of emergency medical services throughout the state.

Subd. 2a. **DEFINITION.** For purposes of this section, "board" means the emergency medical services regulatory board.

Subd. 3. **USE AND RESTRICTIONS.** Designated regional emergency medical services systems may use emergency medical services system funds to support local and regional emergency medical services as determined within the region, with particular emphasis given to supporting and improving emergency trauma and cardiac care and training. No part of a region's share of the fund may be used to directly subsidize any ambulance service operations or rescue service operations or to purchase any vehicles or parts of vehicles for an ambulance service or a rescue service.

Subd. 4. **DISTRIBUTION.** Money from the fund shall be distributed according to this subdivision. Ninety-three and one-third percent of the fund shall be distributed annually on a contract for services basis with each of the eight regional emergency medical services systems designated by the ~~commis-~~

~~sioner of health~~ board. The systems shall be governed by a body consisting of appointed representatives from each of the counties in that region and shall also include representatives from emergency medical services organizations. The ~~commissioner~~ board shall contract with a regional entity only if the contract proposal satisfactorily addresses proposed emergency medical services activities in the following areas: personnel training, transportation coordination, public safety agency cooperation, communications systems maintenance and development, public involvement, health care facilities involvement, and system management. If each of the regional emergency medical services systems submits a satisfactory contract proposal, then this part of the fund shall be distributed evenly among the regions. If one or more of the regions does not contract for the full amount of its even share or if its proposal is unsatisfactory, then the ~~commissioner~~ board may reallocate the unused funds to the remaining regions on a pro rata basis. Six and two-thirds percent of the fund shall be used by the commissioner to support regionwide reporting systems and to provide other regional administration and technical assistance.

Sec. 18. Minnesota Statutes 1994, section 144.8095, is amended to read:

144.8095 **FUNDING FOR THE EMERGENCY MEDICAL SERVICES REGIONS.**

The ~~commissioner of health~~ emergency medical services regulatory board shall distribute funds appropriated from the general fund equally among the emergency medical service regions. Each regional board may use this money to reimburse eligible emergency medical services personnel for continuing education costs related to emergency care that are personally incurred and are not reimbursed from other sources. Eligible emergency medical services personnel include, but are not limited to, dispatchers, emergency room physicians, emergency room nurses, first responders, emergency medical technicians, and paramedics.

Sec. 19. Minnesota Statutes 1994, section 144A.33, subdivision 3, is amended to read:

Subd. 3. **FUNDING OF ADVISORY COUNCIL EDUCATION.** A license application or renewal fee for nursing homes and boarding care homes under section 144.53 or 144A.07 must be increased by ~~$2.75~~ $5 per bed to fund the development and education of resident and family advisory councils.

Sec. 20. Minnesota Statutes 1994, section 144A.43, subdivision 3, is amended to read:

Subd. 3. **HOME CARE SERVICE.** "Home care service" means any of the following services when delivered in a place of residence to a person whose illness, disability, or physical condition creates a need for the service:

(1) nursing services, including the services of a home health aide;

(2) personal care services not included under sections 148.171 to 148.285;

(3) physical therapy;

(4) speech therapy;

(5) respiratory therapy;

(6) occupational therapy;

(7) nutritional services;

(8) home management services when provided to a person who is unable to perform these activities due to illness, disability, or physical condition. Home management services include at least two of the following services: housekeeping, meal preparation, and shopping;

(9) medical social services;

(10) the provision of medical supplies and equipment when accompanied by the provision of a home care service;

(11) the provision of a hospice program as specified in section 144A.48; and

(12) other similar medical services and health-related support services identified by the commissioner in rule.

"Home care service" does not include the following activities conducted by the commissioner of health or a board of health as defined in section 145A.02, subdivision 2: communicable disease investigations or testing; administering or monitoring a prescribed therapy necessary to control or prevent a communicable disease; or the monitoring of an individual's compliance with a health directive as defined in section 144.4172, subdivision 6.

Sec. 21. Minnesota Statutes 1994, section 144A.47, is amended to read:

144A.47 **INFORMATION AND REFERRAL SERVICES.**

The commissioner shall ensure that information and referral services relating to home care are available in all regions of the state. The commissioner shall collect and make available information about available home care services, sources of payment, providers, and the rights of consumers. The commissioner may require home care providers to provide information requested for the purposes of this section~~, including price information,~~ as a condition of registration or licensure. ~~Specific price information furnished by providers under this section is not public data and must not be released without the written permission of the agency.~~ The commissioner may publish and make available:

(1) general information ~~and a summary of the range of prices of~~ describing home care services in the state;

(2) limitations on hours, availability of services, and eligibility for third-party payments, applicable to individual providers; and

(3) other information the commissioner determines to be appropriate.

Sec. 22. Minnesota Statutes 1994, section 144B.01, subdivision 5, is amended to read:

Subd. 5. **RESIDENTIAL CARE HOME OR HOME.** "Residential care home" or "home" means an establishment with a minimum of five beds, where adult residents are provided sleeping accommodations and three or more meals per day and where at least two or more supportive services or at least one health-related service are provided or offered to all residents by the home. A residential care home is not required to offer every supportive or health-related service. A "residential care home" does not include:

(1) a board and lodging establishment licensed under chapter 157 and the provisions of Minnesota Rules, parts 9530.4100 to 9530.4450;

(2) a boarding care home or a supervised living facility licensed under chapter 144;

(3) a home care provider licensed under chapter 144A;

(4) any housing arrangement which consists of apartments containing a separate kitchen or kitchen equipment that will allow residents to prepare meals and where supportive services may be provided, on an individual basis, to residents in their living units either by the management of the residential care home or by home care providers under contract with the home's management; ~~and~~

(5) a board or lodging establishment which serves as a shelter for battered women or other similar purpose; and

(6) an elderly housing with services establishment registered under chapter 144D.

Sec. 23. Minnesota Statutes 1994, section 144C.01, subdivision 2, is amended to read:

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~~ emergency medical services regulatory board. The administrative responsibilities of the ~~commissioner of health~~ board 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~~ board in a manner consistent with this chapter. Determinations of an ambulance service are final.

(b) The ~~commissioner of health~~ board may administer ~~the commissioner's~~ its 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 July 1, 1993.

(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. 24. Minnesota Statutes 1994, section 144C.05, subdivision 1, is amended to read:

Subdivision 1. **AWARD PAYMENTS.** (a) The ~~commissioner of health~~ emergency medical services regulatory board or the ~~commissioner's~~ board'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~~ board 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~~ board.

(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.

Sec. 25. Minnesota Statutes 1994, section 144C.07, is amended to read:

144C.07 **CREDITING QUALIFIED AMBULANCE PERSONNEL SERVICE.**

Subdivision 1. **SEPARATE RECORD KEEPING.** The ~~commissioner of health~~ board or the ~~commissioner's~~ board'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~~ board or the ~~commissioner's~~ board'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 general fund appropriation, plus any transfer from the suspense account under section 144C.03, subdivision 2, and 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. If the allocation is based on the 1,000 years of service, any allocation not made for a qualified ambulance service person must be credited to the suspense account under section 144C.03, subdivision 2. 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~~ board in an affidavit from the chief administrative officer of the ambulance service.

Sec. 26. Minnesota Statutes 1994, section 144C.08, is amended to read:

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~~ board or the ~~commissioner's~~ board'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. 27. Minnesota Statutes 1994, section 144C.09, subdivision 2, is amended to read:

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~~ board may not recognize any attempted transfer, assignment, or pledge of an ambulance service personnel longevity award.

Sec. 28. Minnesota Statutes 1994, section 144C.10, is amended to read:

144C.10 **SCOPE OF ADMINISTRATIVE DUTIES.**

For purposes of administering the award and incentive program, the ~~commissioner of health~~ board 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. 29. **[144D.01] DEFINITIONS.**

Subdivision 1. **SCOPE.** As used in sections 144D.01 to 144D.06, the following terms have the meanings given them.

Subd. 2. **ADULT.** "Adult" means a natural person who has attained the age of 18 years.

Subd. 3. **COMMISSIONER.** "Commissioner" means the commissioner of health or the commissioner's designee.

Subd. 4. **ELDERLY HOUSING WITH SERVICES ESTABLISHMENT OR ESTABLISHMENT.** "Elderly housing with services establishment" or "establishment" means an establishment providing sleeping accommodations to one or more adult residents, at least 80 percent of which are 55 years of age or older, and offering or providing, for a fee, one or more health-related or supportive service, whether offered or provided directly by the establishment or by another entity arranged for by the establishment.

Elderly housing with services establishment does not include:

(1) a nursing home licensed under chapter 144A;

(2) a hospital, boarding care home, or supervised living facility licensed under sections 144.50 to 144.56;

(3) a board and lodging establishment licensed under chapter 157 and Minnesota Rules, parts 9520.0500 to 9520.0670, 9525.0215 to 9525.0355, 9525.0500 to 9525.0660, or 9530.4100 to 9530.4450;

(4) a board and lodging establishment which serves as a shelter for battered women or other similar purpose;

(5) a family adult foster care home licensed under Minnesota Rules, parts 9543.0010 to 9543.0150; or

(6) private homes in which the residents are related by kinship, law, or affinity with the providers of services.

Subd. 5. **SUPPORTIVE SERVICES.** "Supportive services" means arranging for medical services, health-related services, social services, transportation, help with personal laundry, or handling or assisting with personal funds of residents.

Subd. 6. **HEALTH-RELATED SERVICES.** "Health-related services" include professional nursing services, home health aide tasks, and home care aide tasks identified in Minnesota Rules, parts 4668.0100, subparts 1 and 2; and 4668.0110, subpart 1, or the central storage of medication for residents under section 144A.485, subdivision 2, clause (6).

Sec. 30. **[144D.02] REGISTRATION REQUIRED.**

No entity may establish, operate, conduct, or maintain an elderly housing with services establishment in this state without registering and operating as required in sections 144D.01 to 144D.06.

Sec. 31. **[144D.03] REGISTRATION.**

Subdivision 1. **REGISTRATION PROCEDURES.** The commissioner shall establish forms and procedures for annual registration of elderly housing with services establishments. The commissioner shall charge an annual registration

fee of $35. No fee shall be refunded. A registered establishment shall notify the commissioner within 30 days of any change in the business name or address of the establishment, the name or mailing address of the owner or owners, or the name or mailing address of the managing agent. There shall be no fee for submission of the notice.

Subd. 2. **REGISTRATION INFORMATION.** The establishment shall provide the following information to the commissioner in order to be registered:

(1) the business name, street address, and mailing address of the establishment;

(2) the name and mailing address of the owner or owners of the establishment and, if the owner or owners are not natural persons, identification of the type of business entity of the owner or owners, and the names and addresses of the officers and members of the governing body, or comparable persons for partnerships, limited liability corporations, or other types of business organizations of the owner or owners;

(3) the name and mailing address of the managing agent, whether through management agreement or lease agreement, of the establishment, if different from the owner or owners, and the name of the on-site manager, if any;

(4) verification that the establishment has entered into an elderly housing with services contract, as required in section 144D.04, with each resident or resident's representative;

(5) the name and address of at least one natural person who shall be responsible for dealing with the commissioner on all matters provided for in sections 144D.01 to 144D.06, and on whom personal service of all notices and orders shall be made, and who shall be authorized to accept service on behalf of the owner or owners and the managing agent, if any; and

(6) the signature of the authorized representative of the owner or owners or, if the owner or owners are not natural persons, signatures of at least two authorized representatives of each owner, one of which shall be an officer of the owner.

Personal service on the person identified under clause (5) by the owner or owners in the registration shall be considered service on the owner or owners, and it shall not be a defense to any action that personal service was not made on each individual or entity. The designation of one or more individuals under this subdivision shall not affect the legal responsibility of the owner or owners under sections 144D.01 to 144D.06.

Sec. 32. **[144D.04] ELDERLY HOUSING WITH SERVICES CONTRACTS.**

Subdivision 1. **CONTRACT REQUIRED.** No elderly housing with services establishment may operate in this state unless a written elderly housing with ser-

vices contract, as defined in subdivision 2, is executed between the establishment and each resident or resident's representative and unless the establishment operates in accordance with the terms of the contract. The resident or the resident's representative shall be given a complete copy of the contract and all supporting documents and attachments and any changes whenever changes are made.

Subd. 2. **CONTENTS OF CONTRACT.** An elderly housing with services contract, which need not be entitled as such to comply with this section, shall include at least the following elements in itself or through supporting documents or attachments:

(1) name, street address, and mailing address of the establishment;

(2) the name and mailing address of the owner or owners of the establishment and, if the owner or owners is not a natural person, identification of the type of business entity of the owner or owners;

(3) the name and mailing address of the managing agent, through management agreement or lease agreement, of the establishment, if different from the owner or owners;

(4) the name and address of at least one natural person who is authorized to accept service on behalf of the owner or owners and managing agent;

(5) statement describing the registration and licensure status of the establishment and any provider providing health-related or supportive services under an arrangement with the establishment;

(6) term of the contract;

(7) description of the services to be provided to the resident in the base rate to be paid by resident;

(8) description of any additional services available for an additional fee from the establishment directly or through arrangements with the establishment;

(9) fee schedules outlining the cost of any additional services;

(10) description of the process through which the contract may be modified, amended, or terminated;

(11) description of the establishment's complaint resolution process available to residents;

(12) the resident's designated representative, if any;

(13) the establishment's referral procedures if the contract is terminated;

(14) criteria used by the establishment to determine who may continue to reside in the elderly housing with services establishment;

(15) billing and payment procedures and requirements;

(16) statement regarding the ability of residents to receive services from service providers with whom the establishment does not have an arrangement; and

(17) statement regarding the availability of public funds for payment for residence or services in the establishment.

Subd. 3. **CONTRACTS IN PERMANENT FILES.** Elderly housing with services contracts and related documents executed by each resident or resident's representative shall be maintained by the establishment in files from the date of execution until three years after the contract is terminated. The contracts shall be made available for on-site inspection by the commissioner upon request at any time.

Sec. 33. **[144D.05] AUTHORITY OF COMMISSIONER.**

The commissioner shall, upon receipt of information which may indicate the failure of the elderly housing with services establishment, a resident, a resident's representative, or a service provider to comply with a legal requirement to which one or more of them may be subject, make appropriate referrals to other governmental agencies and entities having jurisdiction over the subject matter. The commissioner may also make referrals to any public or private agency the commissioner considers available for appropriate assistance to those involved.

The commissioner shall have standing to bring an action for injunctive relief in the district court in the district in which an establishment is located to compel the elderly housing with services establishment to meet the requirements of this chapter or other requirements of the state or of any county or local governmental unit to which the establishment is otherwise subject. Proceedings for securing an injunction may be brought by the commissioner through the attorney general or through the appropriate county attorney. The sanctions in this section do not restrict the availability of other sanctions.

Sec. 34. **[144D.06] OTHER LAWS.**

An elderly housing with services establishment shall obtain and maintain all other licenses, permits, registrations, or other governmental approvals required of it in addition to registration under this chapter, except that an establishment registered under this chapter is exempt, at its option, from the requirement of obtaining and maintaining an adult foster care license under Minnesota Rules, parts 9543.0010 to 9543.0150, or a lodging license under chapter 157. An elderly housing with services establishment is subject to the provisions of sections 504.01 to 504.28 and 566.01 to 566.175. An elderly housing with services establishment which is also described in section 157.031 is exempt from the requirements of that section while it is registered under this chapter.

Sec. 35. **[144E.01] EMERGENCY MEDICAL SERVICES REGULATORY BOARD.**

Subdivision 1. **MEMBERSHIP.** (a) The emergency medical services regulatory board consists of the following members, all of whom must work in Minnesota, except for the person listed in clause (14):

(1) an emergency physician certified by the American board of emergency physicians;

(2) a representative of Minnesota hospitals;

(3) a representative of fire chiefs;

(4) a full-time firefighter who serves as a first responder and who is a member of a professional firefighter's union;

(5) a volunteer firefighter who serves as a first responder;

(6) an attendant currently practicing on a licensed ambulance service who is a paramedic or an emergency medical technician;

(7) an ambulance director for a licensed ambulance service;

(8) a representative of sheriffs;

(9) a member of a local board of health to represent community health services;

(10) two representatives of regional emergency medical services programs, one of whom must be from the metropolitan regional emergency medical services program;

(11) a registered nurse currently practicing in a hospital emergency department;

(12) a pediatrician, certified by the American board of pediatrics, with experience in emergency medical services;

(13) a family practice physician who is currently involved in emergency medical services; and

(14) a public member who resides in Minnesota and is at least 65 years of age.

(b) The governor shall appoint members under paragraph (a). Appointments under clauses (1) to (9) and (11) to (13) are subject to the advice and consent of the senate. In making appointments under clauses (1) to (9) and (11) to (13), the governor shall consider recommendations of the American college of emergency physicians, the Minnesota hospital association, the Minnesota and state fire chief's association, the Minnesota ambulance association, the Minnesota emergency medical services association, the Minnesota state sheriff's association, the association of Minnesota counties, the Minnesota nurses association, and the Minnesota chapter of the academy of pediatrics.

(c) No member appointed under paragraph (a) may serve consecutive terms.

(d) At least seven members appointed under paragraph (a) must reside outside of the seven-county metropolitan area, as defined in section 473.121.

Subd. 2. **EX OFFICIO MEMBERS.** The speaker of the house of representatives and the committee on rules and administration of the senate shall appoint one representative and one senator to serve as ex officio, nonvoting members.

Subd. 3. **CHAIR.** The governor shall designate one of the members appointed under subdivision 1 as chair of the board.

Subd. 4. **COMPENSATION; TERMS.** Membership terms, compensation, and removal of members appointed under subdivision 1, are governed by section 15.0575.

Subd. 5. **STAFF.** The board shall appoint an executive director who shall serve in the unclassified service and may appoint other staff.

Subd. 6. **DUTIES OF THE BOARD.** (a) The emergency medical services regulatory board shall:

(1) administer and enforce the provisions of this chapter and other duties as assigned to the board;

(2) advise applicants for state or federal emergency medical services funds, review and comment on such applications, and approve the use of such funds unless otherwise required by federal law;

(3) make recommendations to the legislature on improving the access, delivery, and effectiveness of the state's emergency medical services delivery system; and

(4) establish procedures for investigating, hearing, and resolving complaints against emergency medical services providers.

(b) The emergency medical services board may prepare an initial work plan, which may be updated biennially. The work plan may include provisions to:

(1) prepare an emergency medical services assessment which addresses issues affecting the statewide delivery system;

(2) establish a statewide public information and education system regarding emergency medical services;

(3) create, in conjunction with the department of public safety, a statewide injury and trauma prevention program; and

(4) designate an annual emergency medical services personnel recognition day.

Subd. 7. **CONFLICT OF INTEREST.** No member of the emergency medical services board may participate or vote in board proceedings in which the member has a direct conflict of interest, financial or otherwise.

Sec. 36. **[145.890] CHILDREN WITH SPECIAL NEEDS.**

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

Sec. 37. Minnesota Statutes 1994, section 145A.15, is amended to read:

145A.15 **HOME VISITING PROGRAM.**

Subdivision 1. **ESTABLISHMENT.** The commissioner of health shall ~~establish a~~ expand the current grant program to fund additional projects designed to prevent child abuse and neglect and reduce juvenile delinquency by promoting positive parenting, resiliency in children, and a healthy beginning for children by providing early intervention services for families ~~at risk of child abuse and neglect~~ in need. Grant dollars shall be available to train paraprofessionals to provide in-home intervention services and to allow public health nurses to do case management of services. The grant program shall provide early intervention services for families in need and will include:

(1) expansion of current public health nurse and family aide home visiting programs and public health home visiting projects which prevent child abuse and neglect, prevent juvenile delinquency, and build resiliency in children;

(2) early intervention to promote a healthy and nurturing beginning;

(3) distribution of educational and public information programs and materials in hospital maternity divisions, well-baby clinics, obstetrical clinics, and community clinics; and

~~(3)~~ (4) training of home visitors in skills necessary for comprehensive home visiting which promotes a healthy and nurturing beginning for the child.

Subd. 2. **GRANT RECIPIENTS.** The commissioner is authorized to award grants to programs that meet the requirements of subdivision 3 and ~~that are targeted to at-risk~~ include a strong child abuse and neglect prevention focus for families~~. Families~~ in need of services. Priority will be given to families considered to be ~~at-risk for child abuse and neglect~~ in need of additional services. These families include, but are not limited to, families with:

(1) adolescent parents;

(2) a history of alcohol and other drug abuse;

(3) a history of child abuse, domestic abuse, or other ~~dysfunction~~ types of violence in the family of origin;

(4) a history of domestic abuse, rape, or other forms of victimization;

(5) reduced cognitive functioning;

(6) a lack of knowledge of child growth and development stages; ~~or~~

(7) ~~difficulty dealing with stress, including stress caused by discrimination, mental illness, a high incidence of crime or poverty in the neighborhood, unemployment, divorce, and lack of basic needs, often found in conjunction with a pattern of family isolation~~ low resiliency to adversities and environmental stresses; or

(8) lack of sufficient financial resources to meet their needs.

Subd. 3. **PROGRAM REQUIREMENTS.** (a) The commissioner shall award grants, using a request for proposal system, to programs designed to:

(1) ~~develop a risk assessment tool and offer direct~~ contact families at the birth of the child through a public health nurse or trained program representative who will meet the family, provide information, describe the benefits of the program, and offer a home visit to the family to occur during the first weeks of the newborn's life in the home setting;

(2) visit the family and newborn in the home setting at which time the public health nurse or trained individual will answer parents' questions, give information, including information on breast feeding, and make referrals to any other appropriate services;

(3) conduct a screening process to determine if families need additional support or are at risk for child abuse and neglect and provide additional home visiting services ~~to at-risk~~ needed by the families including, but not limited to, education on: parenting skills, child development and stages of growth, communication skills, stress management, problem-solving skills, positive child discipline practices, methods to improve parent-child interactions and enhance self-esteem, community support services and other resources, and how to enjoy and have fun with your children;

~~(2)~~ (4) establish clear objectives and protocols for the home visits;

~~(3)~~ (5) determine the frequency and duration of home visits based on a risk-need assessment of the client; except that home visits ~~shall~~ may begin ~~in the second~~ as early as the first trimester of pregnancy and continue based on the need of the client until the child reaches age six;

(6) refer and actively assist the family in accessing new parent and family education, self-help and support services available in the community;

~~(4)~~ (7) develop and distribute educational resource materials and offer presentations on the prevention of child abuse and neglect for use in hospital maternity divisions, well-baby clinics, obstetrical clinics, and community clinics; and

~~(5)~~ (8) coordinate with other local home visitation programs, particularly those offered by school boards under section 121.882, subdivision 2b, so as to avoid duplication.

(b) Programs must provide at least 40 hours of training for public health nurses, family aides, and other home visitors. Training must include information on the following:

(1) the dynamics of child abuse and neglect, domestic and nondomestic violence, and victimization within family systems;

(2) signs of abuse or other indications that a child may be at risk of abuse or neglect;

(3) what is child abuse and neglect;

(4) how to properly report cases of child abuse and neglect;

(5) sensitivity and respect for diverse cultural ~~preferences~~ practices in child rearing and family systems, including but not limited to complex family relationships, safety, appropriate services, family preservation, family finances for self-sufficiency, and other special needs or circumstances;

(6) community resources, social service agencies, and family support activities or programs;

(7) healthy child development and growth;

(8) parenting skills;

(9) positive child discipline practices;

(10) identification of stress factors and stress reduction techniques;

(11) home visiting techniques; ~~and~~

(12) ~~risk~~ needs assessment measures; and

(13) caring for the special needs of newborns and mothers before and after the birth of the infant.

Program services must be community-based, accessible, and culturally relevant and must be designed to foster collaboration among existing agencies and community-based organizations.

Subd. 4. **EVALUATION.** Each program that receives a grant under this section must include a plan for program evaluation designed to measure the effectiveness of the program in preventing child abuse and neglect. On January 1, 1994, and annually thereafter, the commissioner of health shall submit a report to the legislature on all activities initiated in the prior biennium under this section. The report shall include information on the outcomes reported by all programs that received grant funds under this section in that biennium.

Sec. 38. Minnesota Statutes 1994, 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 residing in Minnesota and the states contiguous to Minnesota. The surcharge applies to a physician who is licensed as of or after October 1, 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. 39. Minnesota Statutes 1994, section 148.921, subdivision 2, is amended to read:

Subd. 2. **PERSONS PREVIOUSLY QUALIFIED.** (a) The board shall grant a license for a licensed psychologist to a person who:

(1) before November 1, 1991, entered a graduate program granting a master's degree with a major in psychology at an educational institution meeting the standards the board has established by rule and earned a master's degree or a master's equivalent in a doctoral program;

~~(2) before December 31, 1993, filed with the board a written declaration of intent to seek licensure under this subdivision;~~

~~(3)~~ (2) complied with all requirements of section 148.91, subdivisions 2 to 4, before December 31, 1997; and

~~(4)~~ (3) completed at least two full years or their equivalent of post-master's supervised psychological employment, including predoctoral internship, before December 31, 1998.

(b) Notwithstanding paragraph (a), the board shall not grant a license for a licensed psychologist under this subdivision ~~to a person who files a written declaration of licensure after October 31, 1992,~~ unless the applicant demonstrates that the applicant was a resident of Minnesota on October 31, 1992, and meets all ~~other~~ the requirements for licensure under this subdivision.

Sec. 40. Minnesota Statutes 1994, section 157.03, is amended to read:

157.03 **LICENSES REQUIRED; FEES.**

~~Each year~~ (a) A license is required annually for every person, firm, or corporation engaged in the business of conducting ~~an~~ a hotel, motel, restaurant, alcoholic beverage establishment, lodging ~~house, boarding house, or resort, or place of refreshment,~~ establishment, boarding establishment, resort, mobile food unit, seasonal food stand, food cart, or special event food stand or who ~~shall hereafter engage~~ thereafter engages in conducting ~~any~~ such a business~~, except vending machine operators licensed under the license provisions of sections 28A.01 to 28A.16, must procure a license for each hotel, motel, restaurant, lodging house, boarding house, or resort, or place of refreshment so conducted. For any hotel, motel, resort, campground, or manufactured home park as defined in section 327.15, in which food, fountain, or bar service is furnished, one license, in addition to the hotel, resort, manufactured home park, or campground license, shall be sufficient for all restaurants and places of refreshment conducted on the same premises and under the same management with the hotel, motel, resort, manufactured home park, or campground. Each license shall expire and be renewed as prescribed by the commissioner pursuant to section 144.122~~. Any person wishing to operate a place of business as licensed under this section shall first make application, pay the required fee, and receive approval for operation, including plan review approval. Application shall be made on forms provided by the commissioner and shall require the applicant to state the full name and address of the owner of the building, structure, or enclosure, and the lessee and manager of the hotel, motel, restaurant, alcoholic beverage establishment, boarding establishment, lodging establishment, resort, mobile food unit, seasonal food stand, food cart, or special event food stand. Initial and renewal licenses for all hotels, motels, restaurants, alcoholic beverage establishments, lodging establishments, boarding establishments, resorts, mobile food units, seasonal food stands, food carts, or special event food stands shall be issued for the calendar year for which application is made and shall expire on December 31 of that year. Any ~~proprietor~~ person who operates a place of business after the expiration date ~~without first having made application for~~ of a license ~~and~~ or without having ~~made payment of~~ paid the fee ~~thereof~~ shall be deemed to have violated the provisions of this chapter and be subject to ~~prosecution,~~ enforcement action as provided in ~~this chapter~~ the Health Enforcement Consolidation Act, sections 144.989 to 144.993. In addition ~~thereto~~, a penalty ~~in an amount prescribed by the commissioner pursuant to section 144.122~~ of $25 shall be added to the ~~amount~~ total of the license fee ~~and paid by the proprietor, as provided herein, if the application has not reached the office of the state commissioner of health within 30 days following the expiration of license; or, in the case of a new business, 30 days after the opening date of the business. Any person, firm, or corporation desiring to~~

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

~~conduct a hotel, motel, restaurant, lodging house, boarding house, or resort, or place of refreshment shall make application on forms provided by the department for a license therefor, which shall require the applicant to state the full name and address of the owner of the building, structure, or enclosure, the lessee and manager of the hotel, motel, restaurant, lodging house, boarding house, or resort, or place of refreshment, the location of the same, the name under which the business is to be conducted, and any other information as may be required therein by the state commissioner of health to complete the application for license. The application shall be accompanied by a license fee as hereinafter provided~~ for any mobile food unit, seasonal food stand, and food cart operating without a license, and a penalty of $50 shall be added to the total of the license fee for hotels, motels, restaurants, alcoholic beverage establishments, lodging establishments, boarding establishments, and resorts.

~~For hotels, motels, lodging houses,and resorts, the license fee may be graduated according to the number of sleeping rooms and the amount of the fees shall be prescribed by the state commissioner of health pursuant to section 144.122.~~

~~For restaurants, places of refreshment, and boarding houses,the license fee may be based on the average number of employees. The number of employees counted for each establishment shall be based upon the total number of employees employed full time and employed part time when added together to total the hours of full-time employment. Employees shall include all persons, except children of the licensee under the age of 18, at work in any capacity, either voluntary or paid, and whether or not reported under the labor laws of this state.~~

~~If the license fee is based upon the average number of employees, every licensee shall, at the time of application, certify as to the number of employees on forms provided by the state commissioner of health and the state commissioner of health shall have access, on demand, to any and all employment records for purposes of substantiating or correcting numbers of declared employees.~~

~~License fees for restaurants, places of refreshment, and boarding housesshall be in an amount prescribed by the state commissioner of health pursuant to section 144.122.~~

No school, as defined in sections 120.05 and 120.101, may be required to pay a license fee.

(b) Establishments licensed under chapter 157 shall pay the following fees:

(1) all establishments except special event food stands shall pay an annual base fee of $100;

(2) in addition to the base fee in clause (1) each establishment shall pay annually a fee for each fee category as specified in this clause:

(i) limited food menu selection, $30;

(ii) small menu selection with limited equipment, $55;

(iii) small establishment with full menu selection, $150;

(iv) large establishment with full menu selection, $250;

(v) temporary food service, $30;

(vi) alcohol service from bar, $75;

(vii) beer or wine table service, $30;

(viii) lodging per unit, $4, a maximum of $400;

(ix) first swimming pool, $100;

(x) additional swimming pool, $50;

(xi) first spa, $50;

(xii) additional spa, $25;

(xiii) private water or sewer, $30;

(3) a special event food stand shall pay a fee of $60 per event; and

(4) an initial license application for food, beverage, or lodging establishments must be accompanied by a fee of $150 for review of the construction or remodeling plans.

When hotels, motels, restaurants, alcoholic beverage establishments, lodging establishments, boarding establishments, resorts, and mobile food units are extensively remodeled, a fee of $150 must accompany the remodeling plans. Neither an initial license plan review fee nor a remodeling plan review fee shall be required for seasonal food stands, food carts, and special event food stands.

Sec. 41. **[157.15] DEFINITIONS.**

Subdivision 1. **APPLICATION.** The definitions in this section apply to sections 157.03 and 157.15 to 157.22.

Subd. 2. **ALCOHOLIC BEVERAGE ESTABLISHMENT.** "Alcoholic beverage establishment" means a building, structure, enclosure, or any part thereof used as, maintained as, advertised as, or held out to be a place where alcoholic beverages are served.

Subd. 3. **COMMISSIONER.** "Commissioner" means the commissioner of health.

Subd. 4. **BOARDING ESTABLISHMENT.** "Boarding establishment" means a building, structure, enclosure, or any part thereof used as, maintained as, advertised as, or held out to be a place where food or nonalcoholic beverages are furnished to five or more regular boarders, whether with or without sleeping accommodations, for periods of one week or more.

Subd. 5. **FOOD AND BEVERAGE ESTABLISHMENT.** "Food and beverage establishment" means a restaurant, alcoholic beverage establishment, boarding establishment, mobile food unit, seasonal food stand, food cart, or special event food stand.

Subd. 6. **FOOD CART.** "Food cart" means a nonmotorized vehicle limited to serving food that is not defined by rule as potentially hazardous food, except precooked frankfurters and other ready-to-eat link sausages.

Subd. 7. **HOTEL OR MOTEL.** "Hotel or motel" means a building, structure, enclosure, or any part thereof used as, maintained as, advertised as, or held out to be a place where sleeping accommodations are furnished to the public and furnishing accommodations for periods of less than one week.

Subd. 8. **LODGING ESTABLISHMENT.** "Lodging establishment" means a building, structure, enclosure, or any part thereof used as, maintained as, advertised as, or held out to be a place where sleeping accommodations are furnished to the public as regular roomers, for periods of one week or more, and having five or more beds to let to the public.

Subd. 9. **MOBILE FOOD UNIT.** "Mobile food unit" means a food service establishment that is a vehicle mounted unit, either motorized or trailered, and readily movable without disassembling, for transport to another location and remaining for no more than 14 days, annually, at any one place.

Subd. 10. **PERSON.** "Person" has the meaning given in section 103I.005, subdivision 16.

Subd. 11. **RESORT.** "Resort" means a building, structure, enclosure, or any part thereof located on, or on property neighboring, any lake, stream, skiing or hunting area, or any recreational area for purposes of providing convenient access thereto, kept, used, maintained, or advertised as, or held out to the public to be a place where sleeping accommodations are furnished to the public, and primarily to those seeking recreation for periods of one day, one week, or longer, and having for rent five or more cottages, rooms, or enclosures.

Subd. 12. **RESTAURANT.** "Restaurant" means a building, structure, enclosure, or any part thereof used as, maintained as, advertised as, or held out to be a place where food or nonalcoholic beverages are served or prepared for service to the public.

Subd. 13. **SEASONAL FOOD STAND.** "Seasonal food stand" means a food stand that is disassembled and moved from location to location, remaining no more than 14 days, annually, at any one place; or a permanent food service stand or building that operates no more than 14 days annually.

Subd. 14. **SPECIAL EVENT FOOD STAND.** "Special event food stand" means a food service used in conjunction with celebrations and special events, used not more than twice annually, and remaining no more than three consecutive days at any one location.

Sec. 42. **[157.16] LICENSES REQUIRED; FEES.**

Subdivision 1. **LICENSE REQUIRED ANNUALLY.** A license is required annually for every person engaged in the business of conducting a hotel, motel, restaurant, alcoholic beverage establishment, boarding establishment, lodging establishment, resort, mobile food unit, seasonal food stand, food cart, or special event food stand or who thereafter engages in conducting any such business. Any person wishing to operate a place of business licensed in this section shall first make application, pay the required fee, and receive approval for operation, including plan review approval. Application shall be made on forms provided by the commissioner and shall require the applicant to state the full name and address of the owner of the building, structure, or enclosure, the lessee and manager of the hotel, motel, restaurant, alcoholic beverage establishment, boarding establishment, lodging establishment, resort, mobile food unit, seasonal food stand, food cart, or special event food stand; the name under which the business is to be conducted; and any other information as may be required by the commissioner to complete the application for license.

Subd. 2. **LICENSE RENEWAL.** Initial and renewal licenses for all hotels, motels, restaurants, alcoholic beverage establishments, lodging establishments, boarding establishments, resorts, mobile food units, seasonal food stands, and food carts shall be issued for the calendar year for which application is made and shall expire on December 31 of such year. Any person who operates a place of business after the expiration date of a license or without having paid the fee shall be deemed to have violated the provisions of this chapter and shall be subject to enforcement action, as provided in the Health Enforcement Consolidation Act, sections 144.989 to 144.993. In addition, a penalty of $25 shall be added to the total of the license fee for any mobile food unit, seasonal food stand, and food cart operating without a license, and a penalty of $50 shall be added to the total of the license fee for all other food, beverage, and lodging establishments.

Subd. 3. **ESTABLISHMENT FEES; DEFINITIONS.** For the purposes of establishing food, beverage, and lodging establishment fees, the following definitions have the meanings given them.

(a) "Limited food menu selection" means a fee category that provides one or more of the following:

(1) prepackaged food that receives heat treatment and is served in the package;

(2) frozen pizza that is heated and served;

(3) a continental breakfast such as rolls, coffee, juice, milk, and cold cereal;

(4) soft drinks, coffee, or nonalcoholic beverages; or

(5) does not prepare food on site, however serves food that was prepared elsewhere and provides cleaning of eating, drinking, or cooking utensils.

(b) "Small menu selection with limited equipment" means a fee category that has no salad bar and provides one or more of the following:

(1) food service equipment that is limited to a deep fat fryer, a grill, two hot holding containers, and one or more microwave ovens;

(2) service of dipped ice cream or soft serve frozen desserts;

(3) service of breakfast in an owner-occupied bed and breakfast establishment; or

(4) is a boarding establishment.

(c) "Small establishment with full menu selection" means a fee category that provides one or more of the following:

(1) food service equipment that includes a range, oven, steam table, salad bar, or salad preparation area;

(2) food service equipment that includes more than one deep fat fryer, one grill, or two hot holding containers; or

(3) an establishment where food is prepared at one location and served at one or more separate locations.

(d) "Large establishment with full menu selection" means either a fee category that meets the criteria in paragraph (c), clause (1) or (2), for a small establishment with full menu selection and:

(1) seats more than 175 people;

(2) offers the full menu selection an average of five or more days a week during the weeks of operation; or means a service category that meets the criteria in paragraph (c), clause (3), for a small establishment with full menu selection; and

(3) prepares and serves 500 meals per day.

(e) "Temporary food service" means a fee category where food is prepared and served from a mobile food unit, seasonal food stand, or food cart.

(f) "Alcohol service from bar" means a fee category where alcoholic mixed drinks are served, or where beer or wine are served from a bar.

(g) "Beer or wine table service" means a fee category where the only alcoholic beverage service is beer or wine, served to customers seated at tables.

(h) "Individual water" means a fee category with a water supply other than a community public water supply as defined in Minnesota Rules, chapter 4720.

(i) "Individual sewer" means a fee category with an individual sewage treatment system which uses subsurface treatment and disposal.

(j) "Lodging per unit" means a fee category including the number of guest rooms, cottages, or other rental units of a hotel, motel, lodging establishment, or resort; or the number of beds in a dormitory.

(k) "Public pool" means a fee category that has the meaning given in Minnesota Rules, part 4717.0250, subpart 8.

(l) "Spa pool" means a fee category that has the meaning given in Minnesota Rules, part 4717.0250, subpart 9.

(m) "Special event food stand" means a fee category where food is prepared and served in conjunction with celebrations or special events, but not more than twice annually, and where the facility is used no more than three consecutive days per event.

Sec. 43. **[157.17] ADDITIONAL REGISTRATION REQUIRED FOR BOARDING AND LODGING ESTABLISHMENTS OR LODGING ESTABLISHMENTS; SPECIAL SERVICES.**

Subdivision 1. **DEFINITIONS.** (a) "Supportive services" means the provision of supervision and minimal assistance with independent living skills such as social and recreational opportunities, assistance with transportation, arranging for meetings and appointments, and arranging for medical and social services. Supportive services also include providing reminders to residents to take medications that are self-administered or providing storage for medications if requested.

(b) "Health supervision services" means the provision of assistance in the preparation and administration of medications other than injectables, the provision of therapeutic diets, taking vital signs, or providing assistance in dressing, grooming, bathing, or with walking devices.

Subd. 2. **REGISTRATION.** A board and lodging establishment or a lodging establishment that provides supportive services or health supervision services must register with the commissioner annually. The registration must include the name, address, and telephone number of the establishment, the types of services that are being provided, a description of the residents being served, the type and qualifications of staff in the facility, and other information that is necessary to identify the needs of the residents and the types of services that are being provided. The commissioner shall develop and furnish to the boarding and lodging establishment or lodging establishment the necessary form for submitting the registration. The requirement for registration is effective until the rules required by sections 144B.01 to 144B.17 are effective.

Subd. 3. **RESTRICTION ON THE PROVISION OF SERVICES.** Effective July 1, 1995, and until one year after the rules required under sections 144B.01 to 144B.17 are adopted, a boarding and lodging establishment or lodging establishment registered under subdivision 2 may provide health supervision services only if a licensed nurse is on site in the establishment for at least four

hours a week to provide monitoring of health supervision services for the residents. A boarding and lodging establishment or lodging establishment that admits or retains residents using wheelchairs or walkers must have the necessary clearances from the office of the state fire marshal.

Subd. 4. **RESIDENTIAL CARE HOME LICENSE REQUIRED.** Upon adoption of the rules required by sections 144B.01 to 144B.17, a boarding and lodging establishment or lodging establishment registered under subdivision 2, that provides either supportive care or health supervision services, must obtain a residential care home license from the commissioner within one year from the adoption of those rules.

Subd. 5. **SERVICES THAT MAY NOT BE PROVIDED IN A BOARDING AND LODGING ESTABLISHMENT OR LODGING ESTABLISHMENT.** A boarding and lodging establishment or lodging establishment may not admit or retain individuals who:

(1) would require assistance from establishment staff because of the following needs: bowel incontinence, catheter care, use of injectable or parenteral medications, wound care, or dressing changes or irrigations of any kind; or

(2) require a level of care and supervision beyond supportive services or health supervision services.

Subd. 6. **CERTAIN INDIVIDUALS MAY PROVIDE SERVICES.** This section does not prohibit the provision of health care services to residents of a boarding and lodging establishment or lodging establishment by family members of the resident or by a registered or licensed home care agency employed by the resident.

Subd. 7. **EXEMPTION FOR ESTABLISHMENTS WITH A HUMAN SERVICES LICENSE.** This section does not apply to a boarding and lodging establishment or lodging establishment that is licensed by the commissioner of human services under chapter 245A.

Subd. 8. **VIOLATIONS.** The commissioner may revoke the establishment license if the establishment is found to be in violation of this section. Violation of this section is a gross misdemeanor.

Sec. 44. **[157.18] POSTING REQUIREMENTS.**

Every hotel, motel, restaurant, alcoholic beverage establishment, boarding establishment, lodging establishment, resort, mobile food unit, seasonal food stand, food cart, or special event food stand securing a license or license fee receipt under the provisions of this chapter shall post in a conspicuous place a copy of the license or receipt.

Sec. 45. **[157.19] LEVELS OF RISK; DEFINITIONS.**

Subdivision 1. **HIGH-RISK ESTABLISHMENT.** "High-risk establishment" means any hotel, motel, restaurant, alcoholic beverage establishment, boarding establishment, lodging establishment, or resort that:

(1) serves potentially hazardous foods that require extensive processing on the premises, including manual handling, cooling, reheating, or holding for service;

(2) prepares foods several hours or days before service;

(3) serves menu items that epidemiologic experience has demonstrated to be common vehicles of food-borne illness;

(4) has a public swimming pool; or

(5) draws its drinking water from a surface water supply.

Subd. 2. **MEDIUM-RISK ESTABLISHMENT.** "Medium-risk establishment" means a hotel, motel, restaurant, alcoholic beverage establishment, boarding establishment, lodging establishment, or resort that:

(1) serves potentially hazardous foods but with minimal holding between preparation and service; or

(2) serves medium-risk foods, such as pizza, that require extensive handling, followed by heat treatment.

Subd. 3. **LOW-RISK ESTABLISHMENT.** "Low-risk establishment" means a hotel, motel, restaurant, alcoholic beverage establishment, boarding establishment, lodging establishment, or resort that is not a high-risk or medium-risk establishment.

Subd. 4. **TEMPORARY FOOD SERVICE AND SPECIAL EVENT FOOD STANDS.** Mobile food units, seasonal food stands, food carts, and special event food stands are not defined as high-, medium-, or low-risk establishments.

Sec. 46. **[157.20] INSPECTION; FREQUENCY; ORDERS.**

Subdivision 1. **INSPECTIONS.** It shall be the duty of the commissioner to inspect, or cause to be inspected, every hotel, motel, restaurant, alcoholic beverage establishment, boarding establishment, lodging establishment, resort, mobile food unit, seasonal food stand, food cart, and special event food stand in this state. For the purpose of conducting inspections, the commissioner shall have the right to enter and have access thereto at any time during the conduct of business.

Subd. 2. **INSPECTION FREQUENCY.** The frequency of inspections of the establishments shall be based on the degree of health risk.

(a) High-risk establishments must be inspected at least once a year.

(b) Medium-risk establishments must be inspected at least once every 18 months.

(c) Low-risk establishments must be inspected at least once every two years.

Subd. 3. **ORDERS.** When, upon inspection, it is found that the business and property so inspected is not being conducted, or is not equipped, in the manner required by the provisions of this chapter or the rules of the commissioner, or is being conducted in violation of any of the laws of this state pertaining to the business, it is the duty of the commissioner to notify the person in charge of the business, or the owner or agent of the buildings so occupied, of the condition found and issue an order for correction of the violations. Each person shall comply with the provisions of this chapter or the rules of the commissioner. A reasonable time may be granted by the commissioner for compliance with the provisions of this chapter.

Sec. 47. **[157.21] INSPECTION RECORDS.**

The commissioner shall keep inspection records for all hotels, motels, restaurants, alcoholic beverage establishments, boarding establishments, lodging establishments, resorts, mobile food units, seasonal food stands, food carts, and special event food stands, together with the name of the owner and operator.

Sec. 48. **[157.22] EXEMPTIONS.**

This chapter shall not be construed to apply to:

(1) interstate carriers under the supervision of the United States Department of Health and Human Services;

(2) any building constructed and primarily used for religious worship;

(3) any building owned, operated, and used by a college or university in accordance with health regulations promulgated by the college or university under chapter 14;

(4) any person, firm, or corporation whose principal mode of business is licensed under sections 28A.04 and 28A.05, is exempt at that premises from licensure as a food or beverage establishment; provided that the holding of any license pursuant to sections 28A.04 and 28A.05 shall not exempt any person, firm, or corporation from the applicable provisions of this chapter or the rules of the state commissioner of health relating to food and beverage service establishments;

(5) family day care homes and group family day care homes governed by sections 245A.01 to 245A.16;

(6) nonprofit senior citizen centers for the sale of home-baked goods; and

(7) food not prepared at an establishment and brought in by members of an organization for consumption by members at a potluck event.

Sec. 49. **[214.055] FEES TO RECOVER EXPENDITURES.**

A health-related licensing board that is created on or after September 1, 1995, must establish a fee structure which fully recovers its expenditures during a five-year period.

Sec. 50. Minnesota Statutes 1994, section 447.32, subdivision 5, is amended to read:

Subd. 5. **BOARD MEETINGS.** Regular meetings of the hospital board must be held at least once a month, at a time and place the board sets by resolution. A hospital board which no longer operates a district hospital shall meet annually, or more frequently as determined by the board. Special meetings may be held:

(1) at any time upon the call of the chair or of any two other members;

(2) upon written notice mailed to each member three days before the meeting;

(3) upon other notice as the board by resolution may provide; or

(4) without notice if each member is present or files with the clerk a written consent to holding the meeting. The consent may be filed before or after the meeting. Any action within the authority of the board may be taken by the vote of a majority of the members present at a regular or adjourned regular meeting or at a duly called special meeting, if a quorum is present. A majority of all the members of the board constitutes a quorum, but a lesser number may meet and adjourn from time to time and compel the attendance of absent members.

Sec. 51. **REPORT ON UNITED STATES ARMY SPRAYING OF ZINC CADMIUM SULFIDE AND OTHER CHEMICALS.**

The commissioner of health, in collaboration with the pollution control agency, the department of natural resources, the Leech Lake Reservation Tribal Council, Hennepin county, and the school of public health at the University of Minnesota shall review the National Academy of Science's report on the past and future adverse effects, if any, on public health and the environment, from the spraying of zinc cadmium sulfide and other chemicals in Minnesota in the 1950s and 1960s by the United States Army. The commissioner of health's report shall be submitted to the legislature within six months of completion of the National Academy of Science's report and shall contain recommendations for additional initiatives, if any, in Minnesota.

Sec. 52. **REVIEW BY ATTORNEY GENERAL.**

The attorney general shall determine:

(1) whether the spraying by the United States Army of zinc cadmium sulfide and other chemicals in Minnesota in the 1950s and 1960s, or any associated actions or failure to act, violated any provisions of state or federal law or the state or federal constitutions; and

(2) what legal actions might be available to prevent similar problems in the future and to recover damages and costs resulting from the spraying.

The attorney general's findings must be included in the report required in section 48.

Sec. 53. **OSTEOPOROSIS PREVENTION AND TREATMENT REPORT.**

The commissioner of health shall provide a report to the chairs of the house health and human services committee and the senate health care committee by January 15, 1996, providing information relating to the need for an osteoporosis prevention and treatment program to promote the awareness of and knowledge about the causes of osteoporosis and other related issues. The commissioner may conduct an assessment of the problem of osteoporosis, and provide the information in the report, to identify:

(1) the number of persons in the state afflicted with osteoporosis and the groups which appear to be most at risk for this disease;

(2) the level of public and professional awareness about osteoporosis;

(3) the needs of osteoporosis patients, their families, and caregivers;

(4) the needs of health care providers, including physicians, nurses, managed care organizations, and other health care providers, in treating and preventing osteoporosis;

(5) the services available to osteoporosis patients, including the existence of treatment programs, support groups, and rehabilitation services;

(6) the number and location of bone density testing equipment in the state; and

(7) available technical assistance, educational materials, and programs nationwide.

In addition, the commissioner is authorized to establish an osteoporosis prevention and treatment program, and may apply for and receive grants and gifts from any governmental agency, private entity, or other person to fund the program.

Sec. 54. **PESTICIDE REPORT AND PILOT PROJECT.**

The commissioner of health shall study and determine the extent of pesticide poisoning in Minnesota and recommend remedies to address this problem and report back to the legislature by January 15, 1997.

Sec. 55. **EMERGENCY MEDICAL SERVICES; TRANSITION PLAN.**

The commissioner of administration through the management analysis division, in consultation with the commissioners of health and public safety, the

emergency medical services regions, the Minnesota Ambulance Association, the Minnesota Hospital Association, third-party payors, the Minnesota Association of Emergency Medical Services Physicians, and the Minnesota Fire Chiefs Association shall develop a transition plan to transfer the appropriate emergency medical services-related authority from the commissioner of health to the board, created pursuant to sections 35, 56, and 59. The transition plan shall include any necessary legislative language to transfer authority and corresponding funding to the board. The transition plan must be presented to the legislature by February 15, 1996.

Sec. 56. **LEGISLATIVE FINDING; INTENT.**

The legislature finds that the emergency medical services (EMS) system and the critical public health needs it addresses would be greatly enhanced by establishing an independent governing body that has the responsibility and authority to ensure the efficient and effective operation of the system. The legislature further finds that the creation of an independent governing body can better coordinate all aspects of the EMS response system with various prevention efforts. This cooperation between prevention and response will positively affect the state's efforts to decrease death and disability due to trauma.

The legislature intends that the transfer required by section 58 not increase the level of funding for the functions transferred.

Sec. 57. **REPORT.**

The commissioner of health shall submit a report to the legislature by March 1, 1996, regarding the registration program for elderly housing with services establishments and recommendations for appropriate level of home care licensure for housing with services establishments. The commissioner shall also include in the report recommendations as to whether home sharing arrangements should be excluded from the registration program.

The report shall also address whether there is a need to include in the registration requirement condominiums organized under Minnesota Statutes, chapter 515A, cooperatives organized under Minnesota Statutes, chapter 308A, common interest communities organized under Minnesota Statutes, chapter 515B, or owners associations of any of the foregoing organized under Minnesota Statutes, chapter 317, where the units which comprise such condominiums, cooperatives, or common interest communities are occupied by the persons who are owners, members, or shareholders.

Sec. 58. **TRANSFER.**

The powers and duties of the commissioner of health under Minnesota Statutes, sections 62N.381, 144.801 to 144.8095, and chapter 144C are transferred to the emergency medical services regulatory board under Minnesota Statutes, section 15.039.

Sec. 59. **INITIAL BOARD.**

Subdivision 1. **MEMBERSHIP TERMS.** Notwithstanding section 35, subdivision 4 (144E.01, subdivision 4), for the initial emergency medical services board, five members shall have an initial term of two years, five members shall have an initial term of three years, and five members shall serve four years. Notwithstanding section 35, subdivision 1, paragraph (c), a member of the initial board appointed to a term of less than four years may serve a successive term.

Subd. 2. **COMPENSATION.** Notwithstanding section 35, subdivision 4 (144E.01, subdivision 4), for the biennium ending June 30, 1997, members of the emergency medical services board shall not be compensated except for expenses.

Sec. 60. **REVISOR'S INSTRUCTION; FOOD SERVICE STANDARDS.**

The revisor of statutes, in coordination with the health department, shall determine and implement appropriate cross-reference changes required as a result of sections 5, 40 to 48, and the repealer section (sections 144.226, 157.03, and 157.15 to 157.22).

Sec. 61. **REPEALER.**

Subdivision 1. **FOOD SERVICE STANDARDS.** Minnesota Statutes 1994, sections 38.161; 38.162; 157.01; 157.02; 157.031; 157.04; 157.045; 157.05; 157.08; 157.12; 157.13; and 157.14, are repealed.

Subd. 2. **EMERGENCY MEDICAL SERVICES REGULATORY BOARD.** Minnesota Statutes 1994, section 144.8097, is repealed effective July 1, 1996.

Sec. 62. **EFFECTIVE DATES.**

Subdivision 1. **EMERGENCY MEDICAL SERVICES REGULATORY BOARD.** Sections 1 to 3 (62N.381, subdivisions 2 to 4); 7 to 18 (144.801 to 144.8095); and 23 to 28 (144C.01 to 144C.10) are effective July 1, 1996. Sections 35, 56, and 59 (144E.01, subdivisions 1 to 7, legislative finding, initial board) are effective July 1, 1996. Section 58 (transfer) is effective July 1, 1996.

Subd. 2. **SPRAYING.** Sections 51 and 52 (spraying) are effective the day following final enactment.

Subd. 3. **HOME VISITING PROGRAM.** The amendments to Minnesota Statutes, section 145A.15, subdivisions 1 and 3, do not become effective until July 1, 1996, for home health visiting programs that received a grant under Minnesota Statutes, section 145A.14, and that were in existence on December 31, 1994.

Subd. 4. **ELDERLY HOUSING.** Sections 22 (144B.01, subdivision 5); and 29 to 34 (144D.01 to 144D.06), are effective August 1, 1996. Section 57 (elderly housing report) is effective the day following final enactment.

ARTICLE 10

CHILD SUPPORT ENFORCEMENT

Section 1. Minnesota Statutes 1994, section 62A.045, is amended to read:

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

(a) 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~~ health plan issued or renewed to provide coverage to a Minnesota resident 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 title XIX of the Social Security Act (Medicaid) in this or any other state; 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~~ health carrier providing benefits under ~~policies~~ plans 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.

(b) If payment for covered expenses has been made under state medical programs for health care items or services provided to an individual, and a third party has a legal liability to make payments, the rights of payment and appeal of an adverse coverage decision for the individual, or in the case of a child their responsible relative or caretaker, will be subrogated to the state and/or its authorized agent.

(c) Notwithstanding any law to the contrary, when a person covered ~~under~~ by a ~~policy of accident and sickness insurance, risk management plan, nonprofit health service plan, health maintenance organization, or self-insured~~ health 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~~ health carrier for those services. If the commissioner of human services notifies the ~~insurer~~ health carrier that the commissioner has made payments to the provider, payment for benefits or notices of denials issued by the ~~insurer~~ health carrier must be issued directly to the commissioner. Submission by the department to the ~~insurer~~ health carrier 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~~ health carrier 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~~ health carrier to the provider or the commissioner as required by this section.

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

(d) When a state agency has acquired the rights of an individual eligible for medical programs named in this section and has health benefits coverage through a health carrier, the health carrier shall not impose requirements that are different from requirements applicable to an agent or assignee of any other individual covered.

(e) For the purpose of this section, health plan includes coverage offered by integrated service networks, community integrated service networks, any plan governed under the federal Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, sections 1001 to 1461, and coverage offered under the exclusions listed in section 62A.011, subdivision 3, clauses (2), (6), (9), (10), and (12).

Sec. 2. Minnesota Statutes 1994, section 62A.046, is amended to read:

62A.046 **COORDINATION OF BENEFITS.**

~~(1)~~ Subdivision 1. **LIMITATION ON DENIAL OF COVERAGE; PAYMENT.** No group contract providing coverage for hospital and medical treatment or expenses issued or renewed after August 1, 1984, which is responsible for secondary coverage for services provided, may deny coverage or payment of the amount it owes as a secondary payor solely on the basis of the failure of another group contract, which is responsible for primary coverage, to pay for those services.

~~(2)~~ Subd. 2. **DEPENDENT COVERAGE.** A group contract which provides coverage of a claimant as a dependent of a parent who has legal responsibility for the dependent's medical care pursuant to a court order under section 518.171 must make payments directly to the provider of care, the custodial parent, or the department of human services pursuant to section 62A.045. In such cases, liability to the insured is satisfied to the extent of benefit payments made ~~to the provider~~ under this section.

~~(3)~~ Subd. 3. **APPLICATION.** This section applies to an insurer, a vendor of risk management services regulated under section 60A.23, a nonprofit health service plan corporation regulated under chapter 62C and a health maintenance organization regulated under chapter 62D. Nothing in this section shall require a secondary payor to pay the obligations of the primary payor nor shall it prevent the secondary payor from recovering from the primary payor the amount of any obligation of the primary payor that the secondary payor elects to pay.

~~(4)~~ Subd. 4. **DEDUCTIBLE PROVISION.** Payments made by an enrollee or by the commissioner on behalf of an enrollee in the children's health plan under sections 256.9351 to 256.9361, or a person receiving benefits under chapter 256B or 256D, for services that are covered by the policy or plan of health insurance shall, for purposes of the deductible, be treated as if made by the insured.

~~(5)~~ Subd. 5. **PAYMENT RECOVERY.** The commissioner of human ser-

vices shall recover payments made by the children's health plan from the responsible insurer, for services provided by the children's health plan and covered by the policy or plan of health insurance.

~~(6)~~ Subd. 6. **COORDINATION OF BENEFITS.** Insurers, vendors of risk management services, nonprofit health service plan corporations, fraternals, and health maintenance organizations may coordinate benefits to prohibit greater than 100 percent coverage when an insured, subscriber, or enrollee is covered by both an individual and a group contract providing coverage for hospital and medical treatment or expenses. Benefits coordinated under this paragraph must provide for 100 percent coverage of an insured, subscriber, or enrollee. To the extent appropriate, all coordination of benefits provisions currently applicable by law or rule to insurers, vendors of risk management services, nonprofit health service plan corporations, fraternals, and health maintenance organizations, shall apply to coordination of benefits between individual and group contracts, except that the group contract shall always be the primary plan. This paragraph does not apply to specified accident, hospital indemnity, specified disease, or other limited benefit insurance policies.

Sec. 3. Minnesota Statutes 1994, section 62A.048, is amended to read:

62A.048 **DEPENDENT COVERAGE.**

(a) A ~~policy of accident and sickness insurance~~ health plan that covers ~~an employee who is~~ a Minnesota resident must, if it provides dependent coverage, allow dependent children who do not reside with the ~~covered employee~~ participant to be covered on the same basis as if they reside with the ~~covered employee~~ participant. ~~Neither the amount of support provided by the employee to the dependent child nor the residency of the child may be used as an excluding or limiting factor for coverage or payment for health care.~~ Every health plan must provide coverage in accordance with section 518.171 to dependents covered by a qualified court or administrative order meeting the requirements of section 518.171, and enrollment of a child cannot be denied on the basis that the child was born out of wedlock, the child is not claimed as a dependent on a parent's federal income tax return, or the child does not reside with the parent or in the health carrier's service area.

(b) For the purpose of this section, health plan includes coverage offered by integrated service networks, community integrated service networks coverage designed solely to provide dental or vision care, and any plan governed under the federal Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, sections 1001 to 1461.

Sec. 4. Minnesota Statutes 1994, section 62A.27, is amended to read:

62A.27 **COVERAGE FOR ADOPTED CHILDREN.**

~~An individual or group policy or plan of health and accident insurance regulated under this chapter or chapter 64B, subscriber contract regulated under~~

~~chapter 62C, or health maintenance contract regulated under chapter 62D,~~ (a) A health plan that provides coverage to a Minnesota resident must cover adopted children of the insured, subscriber, participant, or enrollee on the same basis as other dependents. Consequently, the ~~policy or~~ plan shall not contain any provision concerning preexisting condition limitations, insurability, eligibility, or health underwriting approval concerning ~~adopted~~ children placed for adoption with the participant.

(b) The coverage required by this section is effective from the date of placement for ~~the purpose of~~ adoption ~~and continues unless the placement is disrupted prior to legal adoption and the child is removed from placement~~. For purposes of this section, placement for adoption means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The child's placement with a person terminates upon the termination of the legal obligation for total or partial support.

(c) For the purpose of this section, health plan includes coverage offered by integrated service networks, community integrated service networks coverage that is designed solely to provide dental or vision care, and any plan under the federal Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, sections 1001 to 1461.

Sec. 5. Minnesota Statutes 1994, section 256.74, is amended by adding a subdivision to read:

Subd. 7. **GOOD CAUSE CLAIMS.** All applications for good cause exemption from cooperation with child support enforcement shall be reviewed by designees of the county human services board to ensure the validity of good cause determinations.

Sec. 6. Minnesota Statutes 1994, section 256.76, subdivision 1, is amended to read:

Subdivision 1. Upon the completion of the investigation the county agency shall decide whether the child is eligible for assistance under the provisions of sections 256.72 to 256.87 and determine the amount of the assistance and the date on which the assistance begins. A decision on an application for assistance must be made as promptly as possible and no more than 30 days from the date of application. Notwithstanding section 393.07, the county agency shall not delay approval or issuance of assistance pending formal action of the county board of commissioners. The first month's grant shall be based upon that portion of the month from the date of application, or from the date that the applicant meets all eligibility factors, whichever occurs later, provided that on the date that assistance is first requested, the county agency shall inquire and determine whether the person requesting assistance is in immediate need of food, shelter, clothing, or other emergency assistance. If an emergency need is found to exist, the applicant shall be granted assistance pursuant to section 256.871 within a reasonable period of time. It shall make a grant of assistance which shall be binding upon the county and be complied with by the county until the

grant is modified or vacated. The county agency shall notify the applicant of its decision in writing. The assistance shall be paid monthly to the applicant or to the vendor of medical care upon order of the county agency from funds appropriated to the county agency for this purpose. ~~The county agency shall, upon the granting of assistance under these sections, file an order on the form to be approved by the state agency with the auditor of the county. After the order is filed, warrants shall be drawn and payments made only in accordance with this order to or for recipients of this assistance or in accordance with any subsequent order.~~

Sec. 7. Minnesota Statutes 1994, 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;

(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 paragraph 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 or genetic testing establishes the likelihood that 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. 8. Minnesota Statutes 1994, 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, paragraph (d), (e), (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, paragraph (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 or genetic test results.

Sec. 9. Minnesota Statutes 1994, section 257.62, subdivision 1, is amended to read:

Subdivision 1. **BLOOD OR GENETIC TESTS REQUIRED.** The court may, and upon request of a party shall, require the child, mother, or alleged father to submit to blood or genetic tests. A copy of the test results must be

served on the parties as provided in section 543.20. Any objection to the results of blood or genetic tests must be made in writing no later than 15 days prior to a hearing at which time those test results may be introduced into evidence. Test results served upon a party must include notice of this right to object. If the alleged father is dead, the court may, and upon request of a party shall, require the decedent's parents or brothers and sisters or both to submit to blood or genetic tests. However, in a case involving these relatives of an alleged father, who is deceased, the court may refuse to order blood or genetic tests if the court makes an express finding that submitting to the tests presents a danger to the health of one or more of these relatives that outweighs the child's interest in having the tests performed. Unless the person gives consent to the use, the results of any blood or genetic tests of the decedent's parents, brothers, or sisters may be used only to establish the right of the child to public assistance including but not limited to social security and veterans' benefits. The tests shall be performed by a qualified expert appointed by the court.

Sec. 10. Minnesota Statutes 1994, section 257.62, subdivision 5, is amended to read:

Subd. 5. **POSITIVE TEST RESULTS.** (a) If the results of blood or genetic tests completed in a laboratory accredited by the American Association of Blood Banks indicate that the likelihood of the alleged father's paternity, calculated with a prior probability of no more than 0.5 (50 percent), is 92 percent or greater, upon motion the court shall order the alleged father to pay temporary child support determined according to chapter 518. The alleged father shall pay the support money into court pursuant to the rules of civil procedure to await the results of the paternity proceedings.

(b) If the results of blood or genetic tests completed in a laboratory accredited by the American Association of Blood Banks indicate that likelihood of the alleged father's paternity, calculated with a prior probability of no more than 0.5 (50 percent), is 99 percent or greater, the alleged father is presumed to be the parent and the party opposing the establishment of the alleged father's paternity has the burden of proving by clear and convincing evidence that the alleged father is not the father of the child.

Sec. 11. Minnesota Statutes 1994, section 257.62, subdivision 6, is amended to read:

Subd. 6. **TESTS, EVIDENCE ADMISSIBLE.** In any hearing brought under subdivision 5, a certified report of the facts and results of a laboratory analysis or examination of blood or genetic tests, that is performed in a laboratory accredited to meet the Standards for Parentage Testing of the American Association of Blood Banks and is prepared and attested by a qualified expert appointed by the court, shall be admissible in evidence without proof of the seal, signature, or official character of the person whose name is signed to it~~, unless a demand is made by a party in a motion or responsive motion made within the time limit for making and filing a responsive motion that the matter be heard on~~

~~oral testimony before the court.~~ If no objection is made, the blood or genetic test results are admissible as evidence without the need for foundation testimony or other proof of authenticity or accuracy.

Sec. 12. Minnesota Statutes 1994, section 257.64, subdivision 3, is amended to read:

Subd. 3. If a party refuses to accept a recommendation made under subdivision 1 and blood or genetic tests have not been taken, the court shall require the parties to submit to blood or genetic tests~~, if practicable~~. Any objection to blood or genetic testing results must be made in writing no later than 15 days before any hearing at which time the results may be introduced into evidence. Test results served upon a party must include a notice of this right to object. Thereafter the court shall make an appropriate final recommendation. If a party refuses to accept the final recommendation the action shall be set for trial.

Sec. 13. Minnesota Statutes 1994, section 257.69, subdivision 1, is amended to read:

Subdivision 1. **REPRESENTATION BY COUNSEL.** In all proceedings under sections 257.51 to 257.74, any party may be represented by counsel. ~~If the public authority charged by law with support of a child is a party,~~ The county attorney shall represent the public authority. ~~If the child receives public assistance and no conflict of interest exists, the county attorney shall also represent the custodial parent. If a conflict of interest exists, the court shall appoint counsel for the custodial parent at no cost to the parent. If the child does not receive public assistance, the county attorney may represent the custodial parent at the parent's request.~~ The court shall appoint counsel for a party who is unable to pay timely for counsel in proceedings under sections 257.51 to 257.74.

Sec. 14. Minnesota Statutes 1994, section 257.69, subdivision 2, is amended to read:

Subd. 2. **GUARDIAN; LEGAL FEES.** The court may order expert witness and guardian ad litem fees and other costs of the trial and pretrial proceedings, including appropriate tests, to be paid by the parties in proportions and at times determined by the court. The court shall require a party to pay part of the fees of court-appointed counsel according to the party's ability to pay, but if counsel has been appointed the appropriate agency shall pay the party's proportion of all other fees and costs. The agency responsible for child support enforcement shall pay the fees and costs for blood or genetic tests in a proceeding in which it is a party, is the real party in interest, or is acting on behalf of the child. However, at the close of a proceeding in which paternity has been established under sections 257.51 to 257.74, the court shall order the adjudicated father to reimburse the public agency, if the court finds he has sufficient resources to pay the costs of the blood or genetic tests. When a party bringing an action is represented by the county attorney, no filing fee shall be paid to the court administrator.

Sec. 15. Minnesota Statutes 1994, section 518.171, subdivision 1, is amended to read:

Subdivision 1. **ORDER.** Compliance with this section constitutes compliance with a qualified medical child support order as described in the federal Employee Retirement Income Security Act of 1974 (ERISA) as amended by the federal Omnibus Budget Reconciliation Act of 1993 (OBRA).

(a) Every child support order must:

(1) expressly assign or reserve the responsibility for maintaining medical insurance for the minor children and the division of uninsured medical and dental costs; and

(2) contain the names and last known addresses, if any, of the dependents unless the court prohibits the inclusion of an address and orders the custodial parent to provide the address to the administrator of the health plan. The court shall order the party with the better group dependent health and dental insurance coverage or health insurance plan to name the minor child as beneficiary on any health and dental insurance plan that is available to the party on:

(i) a group basis;

(ii) through an employer or union; or

(iii) through a group health plan governed under the ERISA and included within the definitions relating to health plans found in section 62A.011, 62A.048, or 62E.06, subdivision 2.

"Health insurance" or "health insurance coverage" as used in this section means coverage that is comparable to or better than a number two qualified plan as defined in section 62E.06, subdivision 2. "Health insurance" or "health insurance coverage" as used in this section does not include medical assistance provided under chapter 256, 256B, or 256D.

(b) If the court finds that dependent health or dental insurance is not available to the obligor or obligee on a group basis or through an employer or union, or that group insurance is not accessible to the obligee, the court may require the obligor (1) to obtain other dependent health or dental insurance, (2) to be liable for reasonable and necessary medical or dental expenses of the child, or (3) to pay no less than $50 per month to be applied to the medical and dental expenses of the children or to the cost of health insurance dependent coverage.

(c) If the court finds that the available dependent health or dental insurance does not pay all the reasonable and necessary medical or dental expenses of the child, including any existing or anticipated extraordinary medical expenses, and the court finds that the obligor has the financial ability to contribute to the payment of these medical or dental expenses, the court shall require the obligor to be liable for all or a portion of the medical or dental expenses of the child not covered by the required health or dental plan. Medical and dental expenses include, but are not limited to, necessary orthodontia and eye care, including prescription lenses.

(d) Unless otherwise agreed by the parties and approved by the court, if the court finds that the obligee is not receiving public assistance for the child and has the financial ability to contribute to the cost of medical and dental expenses for the child, including the cost of insurance, the court shall order the obligee and obligor to each assume a portion of these expenses based on their proportionate share of their total net income as defined in section 518.54, subdivision 6.

(e) Payments ordered under this section are subject to section 518.611. An obligee who fails to apply payments received to the medical expenses of the dependents may be found in contempt of this order.

Sec. 16. Minnesota Statutes 1994, section 518.171, subdivision 3, is amended to read:

Subd. 3. **IMPLEMENTATION.** A copy of the court order for insurance coverage shall be forwarded to the obligor's employer or union and to the health or dental insurance carrier or employer by the obligee or the public authority responsible for support enforcement only when ordered by the court or when the following conditions are met:

(1) the obligor fails to provide written proof to the obligee or the public authority, within 30 days of the effective date of the court order, that the insurance has been obtained ~~or that application for insurability has been made~~;

(2) the obligee or the public authority serves written notice of its intent to enforce medical support on the obligor by mail at the obligor's last known post office address; and

(3) the obligor fails within 15 days after the mailing of the notice to provide written proof to the obligee or the public authority that the insurance coverage existed as of the date of mailing.

The employer or union shall forward a copy of the order to the health and dental insurance plan offered by the employer.

Sec. 17. Minnesota Statutes 1994, section 518.171, subdivision 4, is amended to read:

Subd. 4. **EFFECT OF ORDER.** (a) The order is binding on the employer or union and the health and dental insurance plan when service under subdivision 3 has been made. An employer or union that is included under ERISA may not deny enrollment based on exclusionary clauses described in section 62A.048. Upon receipt of the order, or upon application of the obligor pursuant to the order, the employer or union and its health and dental insurance plan shall enroll the minor child as a beneficiary in the group insurance plan and withhold any required premium from the obligor's income or wages. If more than one plan is offered by the employer or union, the child shall be enrolled in ~~the insurance plan in which the obligor is enrolled or~~ the least costly health insurance

plan otherwise available to the obligor that is comparable to a number two qualified plan. If the obligor is not enrolled in a health insurance plan, the employer or union shall also enroll the obligor in the chosen plan if enrollment of the obligor is necessary in order to obtain dependent coverage under the plan. Enrollment of dependents and the obligor shall be immediate and not dependent upon open enrollment periods. Enrollment is not subject to the underwriting policies described in section 62A.048.

(b) An employer or union that willfully fails to comply with the order is liable for any health or dental expenses incurred by the dependents during the period of time the dependents were eligible to be enrolled in the insurance program, and for any other premium costs incurred because the employer or union willfully failed to comply with the order. An employer or union that fails to comply with the order is subject to contempt under section 518.615 and is also subject to a fine of $500 to be paid to the obligee or public authority. Fines paid to the public authority are designated for child support enforcement services.

(c) Failure of the obligor to execute any documents necessary to enroll the dependent in the group health and dental insurance plan will not affect the obligation of the employer or union and group health and dental insurance plan to enroll the dependent in a plan ~~for which other eligibility requirements are met~~. Information and authorization provided by the public authority responsible for child support enforcement, or by the custodial parent or guardian, is valid for the purposes of meeting enrollment requirements of the health plan. The insurance coverage for a child eligible under subdivision 5 shall not be terminated except as authorized in subdivision 5.

Sec. 18. Minnesota Statutes 1994, section 518.171, subdivision 5, is amended to read:

Subd. 5. **ELIGIBLE CHILD.** A minor child that an obligor is required to cover as a beneficiary pursuant to this section is eligible for insurance coverage as a dependent of the obligor until the child is emancipated or until further order of the court. The health or dental insurance carrier or employer may not disenroll or eliminate coverage of the child unless the health or dental insurance carrier or employer is provided satisfactory written evidence that the court order is no longer in effect, or the child is or will be enrolled in comparable health coverage through another health or dental insurance plan that will take effect no later than the effective date of the disenrollment, or the employer has eliminated family health and dental coverage for all of its employees, or that the required premium has not been paid by or on behalf of the child. If disenrollment or elimination of coverage of a child under this subdivision is based upon nonpayment of premium, the health or dental insurance plan must provide 30 days written notice to the child's nonobligor parent prior to the disenrollment or elimination of coverage.

Sec. 19. Minnesota Statutes 1994, section 518.171, subdivision 7, is amended to read:

Subd. 7. **RELEASE OF INFORMATION.** When an order for dependent insurance coverage is in effect, the obligor's employer, union, or insurance agent shall release to the obligee or the public authority, upon request, information on the dependent coverage, including the name of the ~~insurer~~ health or dental insurance carrier or employer. The employer, union, or health or dental insurance plan shall provide the obligee with insurance identification cards and all necessary written information to enable the obligee to utilize the insurance benefits for the covered dependents. Notwithstanding any other law, information reported pursuant to section 268.121 shall be released to the public agency responsible for support enforcement that is enforcing an order for ~~medical~~ health or dental insurance coverage under this section. The public agency responsible for support enforcement is authorized to release to the obligor's ~~insurer~~ health or dental insurance carrier or employer or employer information necessary to obtain or enforce medical support.

Sec. 20. Minnesota Statutes 1994, section 518.171, subdivision 8, is amended to read:

Subd. 8. **OBLIGOR LIABILITY.** (a) An obligor who fails to maintain medical or dental insurance for the benefit of the children as ordered or fails to provide other medical support as ordered is liable to the obligee for any medical or dental expenses incurred from the effective date of the court order, including health and dental insurance premiums paid by the obligee because of the obligor's failure to obtain coverage as ordered. Proof of failure to maintain insurance or noncompliance with an order to provide other medical support constitutes a showing of increased need by the obligee pursuant to section 518.64 and provides a basis for a modification of the obligor's child support order.

(b) Payments for services rendered to the dependents that are directed to the obligor, in the form of reimbursement by the ~~insurer~~ health or dental insurance carrier or employer, must be endorsed over to and forwarded to the vendor or custodial parent or public authority when the reimbursement is not owed to the obligor. An obligor retaining insurance reimbursement not owed to the obligor may be found in contempt of this order and held liable for the amount of the reimbursement. Upon written verification by the ~~insurer~~ health or dental insurance carrier or employer of the amounts paid to the obligor, the reimbursement amount is subject to all enforcement remedies available under subdivision 10, including income withholding pursuant to section 518.611. The monthly amount to be withheld until the obligation is satisfied is 20 percent of the original debt or $50, whichever is greater.

Sec. 21. Minnesota Statutes 1994, section 518.611, subdivision 2, is amended to read:

Subd. 2. **CONDITIONS OF INCOME WITHHOLDING.** (a) Withholding shall result 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 and the court finds that previous support has not been paid on a timely or consistent basis or that the obligor has threatened expressly or otherwise to stop or reduce payments; or

(3) the obligor fails to make the maintenance or support payments, and the following conditions are met:

(i) the obligor is at least 30 days in arrears;

(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;

(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;

(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

(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.

(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 move the court, under section 518.64, to modify the order respecting the amount of maintenance or support.

(d) Every order for support or maintenance shall provide for a conspicuous notice of the provisions of this subdivision that complies with section 518.68, subdivision 2. An order without this notice remains subject to this subdivision.

(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. 22. Minnesota Statutes 1994, section 518.611, subdivision 4, is amended to read:

Subd. 4. **EFFECT OF ORDER.** (a) Notwithstanding any law to the contrary, the order is binding on the employer, trustee, payor of the funds, or financial institution when service under subdivision 2 has been made. Withholding must begin no later than the first pay period that occurs after 14 days following the date of the notice. In the case of a financial institution, preauthorized transfers must occur in accordance with a court-ordered payment schedule. An employer, payor of funds, or financial institution in this state is required to withhold income according to court orders for withholding issued by other states or territories. The payor shall withhold from the income payable to the obligor the amount specified in the order and amounts required under subdivision 2 and section 518.613 and shall remit, within ten days of the date the obligor is paid the remainder of the income, the amounts withheld to the public authority. The payor shall identify on the remittance information the date the obligor is paid the remainder of the income. The obligor is considered to have paid the amount withheld as of the date the obligor received the remainder of the income. The financial institution shall execute preauthorized transfers from the deposit accounts of the obligor in the amount specified in the order and amounts required under subdivision 2 as directed by the public authority responsible for child support enforcement.

(b) Employers may combine all amounts withheld from one pay period into one payment to each public authority, but shall separately identify each obligor making payment. Amounts received by the public authority which are in excess of public assistance expended for the party or for a child shall be remitted to the party.

(c) An employer shall not discharge, or refuse to hire, or otherwise discipline an employee as a result of a wage or salary withholding authorized by this section. The employer or other payor of funds shall be liable to the obligee for any amounts required to be withheld. A financial institution is liable to the obligee if funds in any of the obligor's deposit accounts identified in the court order equal the amount stated in the preauthorization agreement but are not transferred by the financial institution in accordance with the agreement. An employer or other payor of funds that fails to withhold or transfer funds in accordance with this section is also liable to the obligee for interest on the funds at the rate applicable to judgments under section 549.09, computed from the date the funds were required to be withheld or transferred. An employer or other payor of funds is liable for reasonable attorney fees of the obligee or public authority incurred in enforcing the liability under this paragraph. An employer or other payor of funds that has failed to comply with the requirements of this section is subject

to contempt sanctions under section 518.615. If an employer violates this subdivision, a court may award the employee twice the wages lost as a result of this violation. If a court finds the employer violates this subdivision, the court shall impose a civil fine of not less than $500.

Sec. 23. Minnesota Statutes 1994, section 518.613, subdivision 7, is amended to read:

Subd. 7. **WAIVER.** (a) The court may waive the requirements of this section if the court finds that there is no arrearage in child support or maintenance as of the date of the hearing~~, that it would not be contrary to the best interests of the child,~~ and: (1) one party demonstrates and the court finds that there is good cause to waive the requirements of this section or to terminate automatic income withholding on an order previously entered under this section; or (2) all parties reach a written agreement that provides for an alternative payment arrangement and the agreement is approved by the court after a finding that the agreement is likely to result in regular and timely payments. The court's findings waiving the requirements of this section must include a written explanation of the reasons why automatic withholding would not be in the best interests of the child and, in a case that involves modification of support, that past support has been timely made. If the court waives the requirements of this section:

(1) in all cases where the obligor is at least 30 days in arrears, withholding must be carried out pursuant to section 518.611;

(2) the obligee may at any time and without cause request the court to issue an order for automatic income withholding under this section; and

(3) the obligor may at any time request the public authority to begin withholding pursuant to this section, by serving upon the public authority the request and a copy of the order for child support or maintenance. Upon receipt of the request, the public authority shall serve a copy of the court's order and the provisions of section 518.611 and this section on the obligor's employer or other payor of funds. The public authority shall notify the court that withholding has begun at the request of the obligor pursuant to this clause.

(b) For purposes of this subdivision, "parties" includes the public authority in cases when it is a party pursuant to section 518.551, subdivision 9.

Sec. 24. Minnesota Statutes 1994, section 518.615, subdivision 3, is amended to read:

Subd. 3. **LIABILITY.** The employer, trustee, or payor of funds is liable to the obligee or the agency responsible for child support enforcement for any amounts required to be withheld that were not paid. The court may enter judgment against the employer, trustee, or payor of funds for support not withheld or remitted. An employer, trustee, or payor of funds found guilty of contempt shall be punished by a fine of not more than $250 as provided in chapter 588. The court may also impose other contempt sanctions authorized under chapter 588.

Sec. 25. **REPEALER.**

Minnesota Statutes 1994, sections 62C.141; 62C.143; 62D.106; and 62E.04, subdivisions 9 and 10, are repealed.

Sec. 26. **EFFECTIVE DATE.**

Sections 1 to 6 and 14 to 19 (62A.045; 62A.046; 62A.048; 62A.27; 256.74, subdivision 7; 256.76, subdivision 1; 257.69, subdivision 2; 518.171, subdivisions 1, 3, 4, 5, and 7) are effective retroactive to August 10, 1993.

ARTICLE 11

DHS FLEXIBILITY REFORMS

Section 1. Minnesota Statutes 1994, section 144A.31, subdivision 2a, is amended to read:

Subd. 2a. **DUTIES.** The interagency committee shall ~~identify long-term care issues requiring coordinated interagency policies and shall conduct analyses, coordinate policy development, and make recommendations to the commissioners for effective implementation of these policies. The committee shall refine state long-term goals, establish performance indicators, and develop other methods or measures to evaluate program performance, including client outcomes. The committee shall review the effectiveness of programs in meeting their objectives.~~

~~The committee shall also:~~

~~(1) facilitate the development of regional and local bodies to plan and coordinate regional and local services;~~

~~(2) recommend a single regional or local point of access for persons seeking information on long-term care services;~~

~~(3) recommend changes in state funding and administrative policies that are necessary to maximize the use of home and community-based care and that promote the use of the least costly alternative without sacrificing quality of care;~~

~~(4) develop methods of identifying and serving seniors who need minimal services to remain independent but who are likely to develop a need for more extensive services in the absence of these minimal services; and~~

~~(5) develop and implement strategies for advocating, promoting, and developing long-term care insurance and encourage insurance companies to offer long-term care insurance policies that are affordable and offer a wide range of benefits~~ manage and implement the moratorium exception process in accordance with sections 144A.071 and 144A.073.

Sec. 2. Minnesota Statutes 1994, 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, 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~~ The children's cabinet, under section 4.045, in consultation with a representative of the Minnesota district judges association juvenile committee, shall:

(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) perform the duties required under sections 245.494 to 245.496.

Sec. 3. Minnesota Statutes 1994, section 245.494, subdivision 2, is amended to read:

Subd. 2. **~~STATE COORDINATING COUNCIL~~ CHILDREN'S CABINET REPORT.** ~~Each year, beginning~~ By February 1, ~~1995~~ 1996, the ~~state coordinating council~~ children's cabinet, under section 4.045, in consultation with a representative of the Minnesota district judges association juvenile committee, 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.

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

Sec. 4. Minnesota Statutes 1994, section 245.825, is amended to read:

245.825 **USE OF AVERSIVE OR DEPRIVATION PROCEDURES IN FACILITIES SERVING PERSONS WITH MENTAL RETARDATION OR RELATED CONDITIONS.**

Subdivision 1. **RULES GOVERNING USE OF AVERSIVE AND DEPRIVATION PROCEDURES.** The commissioner of human services shall by October, 1983, promulgate rules governing the use of aversive and deprivation procedures in all licensed facilities and licensed services serving persons with mental retardation or related conditions, as defined in section 252.27, subdivision 1a. No provision of these rules shall encourage or require the use of aversive and deprivation procedures. The rules shall prohibit: (a) the application of certain aversive or deprivation procedures in facilities except as authorized and monitored by the ~~designated regional review committees~~ commissioner; (b) the use of aversive or deprivation procedures that restrict the consumers' normal access to nutritious diet, drinking water, adequate ventilation, necessary medical care, ordinary hygiene facilities, normal sleeping conditions, and necessary clothing; and (c) the use of faradic shock without a court order. The rule shall further specify that consumers may not be denied ordinary access to legal counsel and next of kin. In addition, the rule may specify other prohibited practices and the specific conditions under which permitted practices are to be carried out. For any persons receiving faradic shock, a plan to reduce and eliminate the use of faradic shock shall be in effect upon implementation of the procedure.

Subd. 1a. **ADVISORY COMMITTEE.** Notwithstanding the provisions of Minnesota Rules, parts 9525.2700 to 9525.2810, the commissioner shall establish an advisory committee on the use of aversive and deprivation procedures.

Subd. 1b. **REVIEW AND APPROVAL.** Notwithstanding the provisions of Minnesota Rules, parts 9525.2700 to 9525.2810, the commissioner may designate the county case manager to authorize the use of controlled procedures as defined in Minnesota Rules, parts 9525.2710, subpart 9 and 9525.2740, subparts 1 and 2, after review and approval by the interdisciplinary team and the internal review committee as required in Minnesota Rules, part 9525.2750, subparts 1a and 2. Use of controlled procedures must be reported to the commissioner in accordance with the requirements of Minnesota Rules, part 9525.2750, subpart 2a. The commissioner must provide all reports to the advisory committee at least quarterly.

~~Subd. 2. **REGIONAL REVIEW COMMITTEE.** After the rules have been promulgated the commissioner shall appoint regional review committees to monitor the rules.~~

Sec. 5. Minnesota Statutes 1994, section 256.045, subdivision 4a, is amended to read:

Subd. 4a. **CASE MANAGEMENT APPEALS.** Any recipient of case management services pursuant to section 256B.092, who contests the county agen-

cy's action or failure to act in the provision of those services, other than a failure to act with reasonable promptness or a suspension, reduction, denial, or termination of services, must submit a written request for a conciliation conference to the county agency. The county agency shall inform the commissioner of the receipt of a request when it is submitted and shall schedule a conciliation conference. The county agency shall notify the recipient, the commissioner, and all interested persons of the time, date, and location of the conciliation conference. ~~The commissioner shall designate a representative to be present at the conciliation conference to assist in the resolution of the dispute without the need for a hearing.~~ The commissioner may assist the county by providing mediation services or by identifying other resources that may assist in the mediation between the parties. Within 30 days, the county agency shall conduct the conciliation conference and inform the recipient in writing of the action the county agency is going to take and when that action will be taken and notify the recipient of the right to a hearing under this subdivision. The conciliation conference shall be conducted in a manner consistent with the commissioner's instructions. If the county fails to conduct the conciliation conference and issue its report within 30 days, or, at any time up to 90 days after the conciliation conference is held, a recipient may submit to the commissioner a written request for a hearing before a state human services referee to determine whether case management services have been provided in accordance with applicable laws and rules or whether the county agency has assured that the services identified in the recipient's individual service plan have been delivered in accordance with the laws and rules governing the provision of those services. The state human services referee shall recommend an order to the commissioner, who shall, in accordance with the procedure in subdivision 5, issue a final order within 60 days of the receipt of the request for a hearing, unless the commissioner refuses to accept the recommended order, in which event a final order shall issue within 90 days of the receipt of that request. The order may direct the county agency to take those actions necessary to comply with applicable laws or rules. The commissioner may issue a temporary order prohibiting the demission of a recipient of case management services from a residential or day habilitation program licensed under chapter 245A, while a county agency review process or an appeal brought by a recipient under this subdivision is pending, or for the period of time necessary for the county agency to implement the commissioner's order. The commissioner shall not issue a final order staying the demission of a recipient of case management services from a residential or day habilitation program licensed under chapter 245A.

Sec. 6. Minnesota Statutes 1994, section 256B.27, subdivision 2a, is amended to read:

Subd. 2a. Each year the commissioner shall provide for the on-site audit of the cost reports of nursing homes participating as vendors of medical assistance. The commissioner shall select for audit at least ~~five~~ 15 percent of these nursing homes at random ~~and at least 20 percent from the remaining nursing homes,~~ or using factors including, but not limited to: change in ownership; frequent changes in administration in excess of normal turnover rates; complaints to the

commissioner of health about care, safety, or rights; where previous inspections or reinspections under section 144A.10 have resulted in correction orders related to care, safety, or rights; or where persons involved in ownership or administration of the facility have been indicted for alleged criminal activity.

Sec. 7. Minnesota Statutes 1994, section 256E.08, subdivision 6, is amended to read:

Subd. 6. **FEES FOR SERVICES.** The county board may~~, subject to approval of the commissioner,~~ establish a schedule of fees based upon clients' ability to pay to be charged to recipients of community social services. Payment, in whole or in part, for services may be accepted from any person except that no fee may be charged to persons or families whose adjusted gross household income is below the federal poverty level. When services are provided to any person, including a recipient of aids administered by the federal, state or county government, payment of any charges due may be billed to and accepted from a public assistance agency or from any public or private corporation.

Sec. 8. Minnesota Statutes 1994, section 393.07, subdivision 5, is amended to read:

Subd. 5. **COMPLIANCE WITH FEDERAL SOCIAL SECURITY ACT; MERIT SYSTEM.** The commissioner of human services shall have authority to require such methods of administration as are necessary for compliance with requirements of the federal Social Security Act, as amended, and for the proper and efficient operation of all welfare programs. This authority to require methods of administration includes methods relating to the establishment and maintenance of personnel standards on a merit basis as concerns all employees of local social services agencies except those employed in an institution, sanitarium, or hospital. The commissioner of human services shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods. The adoption of methods relating to the establishment and maintenance of personnel standards on a merit basis of all such employees of the local social services agencies and the examination thereof, and the administration thereof shall be directed and controlled exclusively by the commissioner of human services.

Notwithstanding the provisions of any other law to the contrary, every employee of every local social services agency who occupies a position which requires as prerequisite to eligibility therefor graduation from an accredited four year college or a certificate of registration as a registered nurse under section 148.231, must be employed in such position under the merit system established under authority of this subdivision. Every such employee now employed by a local social services agency and who is not under said merit system is transferred, as of January 1, 1962, to a position of comparable classification in the merit system with the same status therein as the employee had in the county of employment prior thereto and every such employee shall be subject to and have the benefit of the merit system, including seniority within the local social ser-

vices agency, as though the employee had served thereunder from the date of entry into the service of the local social services agency.

By March 1, 1996, the commissioner of human services shall report to the chair of the senate health care and family services finance division and the chair of the house health and human services finance division on options for the delivery of merit-based employment services by entities other than the department of human services in order to reduce the administrative costs to the state while maintaining compliance with applicable federal regulations.

Sec. 9. Minnesota Statutes 1994, section 393.12, is amended to read:

393.12 **FEES FOR SOCIAL SERVICES.**

A local social services agency may charge fees for social services furnished to a family or individual not on public assistance. The local social services agency shall establish fee schedules based on the recipient's ability to pay and for day care services on the recommendations of the appropriate advisory council. ~~The schedules shall be subject to the approval of the commissioner of human services.~~

Sec. 10. **DEAF AND HARD OF HEARING CONSOLIDATION.**

The regional service center for the deaf and hard of hearing located on the St. Peter regional treatment center campus may be consolidated with the St. Peter regional treatment center deaf services program. The regional treatment center deaf program will continue to provide mental health support services to the regional treatment center patients. The St. Peter regional treatment center deaf program will also act as the area regional services center under the management oversight of the commissioner. Community-based services will be provided by the St. Peter regional treatment center deaf services program in accordance with Minnesota Statutes, sections 256C.22 to 256C.27.

Sec. 11. **INSTRUCTION TO REVISOR.**

The revisor of statutes is instructed to substitute the term "children's cabinet" in place of "state coordinating council" wherever the term appears in Minnesota Statutes, chapter 245.

Sec. 12. **REPEALER.**

Minnesota Statutes 1994, sections 144A.31, subdivisions 2b, 4, 5, 6, and 7; 245.492, subdivision 20; 245.825, subdivision 2; and 245.98, subdivision 3, are repealed.

Presented to the governor May 22, 1995

Signed by the governor May 25, 1995, 1:47 p.m.

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