

tree management research and development of an implementation plan for establishing hybrid tree plantations in the state. This appropriation is available to the extent matched by \$2 of nonstate ~~money~~ contributions, either cash or in-kind, for each \$1 of state money.

Sec. 3. EFFECTIVE DATE.

Sections 1 and 2 are effective the day following final enactment.

Presented to the governor April 4, 1996

Signed by the governor April 11, 1996, 11:37 a.m.

CHAPTER 451—H.F.No. 1584

An act relating to human services; changing provisions to health and continuing care related to MA and GAMC; changing provisions to long term care; changing provisions to health plan regulations; making technical and policy changes for the department of human services; requiring the commissioner of human services to study and make recommendations on the administration of the community alternative care program, and to study and report on the effect on medical assistance waiver programs of medically fragile children in foster care; appropriating money; amending Minnesota Statutes 1994, sections 62D.04, subdivision 5; 62N.10, subdivision 4; 62Q.075, subdivision 2; 144.0722, by adding a subdivision; 144.572; 144.71, subdivisions 1 and 2; 144.72, subdivisions 1 and 2; 144.73, subdivision 1; 144.74; 144A.04, by adding a subdivision; 144A.09, subdivision 1; 144A.20, subdivision 2; 145.61, subdivision 5; 148.235, by adding a subdivision; 148C.01, by adding a subdivision; 148C.09, by adding a subdivision; 245.462, subdivision 4; 245.4871, subdivision 4; 245.94, subdivisions 2a and 3; 245.95, subdivision 2; 245.97, subdivision 6; 246.57, by adding a subdivision; 253B.11, subdivision 2; 256.482, by adding a subdivision; 256.73, subdivision 1, and by adding a subdivision; 256.9355, subdivision 3; 256B.03, by adding a subdivision; 256B.056, subdivisions 1 and 1a; 256B.0595, by adding subdivisions; 256B.0627, subdivisions 1, as amended, 4, as amended, 5, as amended, and by adding a subdivision; 256B.0913, subdivision 7, and by adding subdivisions; 256B.0915, subdivision 1b, and by adding subdivisions; 256B.15, by adding subdivisions; 256B.35, subdivision 1; 256B.37, subdivision 5; 256B.49, by adding a subdivision; 256B.501, by adding subdivisions; 256B.69, by adding a subdivision; 256G.01, subdivision 3, and by adding subdivisions; 256G.02, subdivisions 4 and 6; 256G.03; 256G.06; 256G.07, subdivisions 1 and 2; 256G.08, subdivision 1; 256G.09, subdivision 2; 256G.10; 256I.04, subdivision 1; 256I.05, subdivision 1c, and by adding a subdivision; 325F.71, subdivision 2; 327.14, subdivision 8; 524.2-403; and 524.3-801; Minnesota Statutes 1995 Supplement, sections 62Q.03, subdivision 8; 62Q.19, subdivisions 1 and 5; 62R.17; 144.122; 144.9503, subdivisions 6, 8, and 9; 144.9504, subdivisions 2, 7, and 8; 144.9505, subdivision 4; 144A.071, subdivisions 3 and 4a; 148C.01, subdivisions 12 and 13; 148C.02, subdivisions 1 and 2; 148C.03, subdivision 1; 148C.04, subdivisions 3, 4, and by adding a subdivision; 148C.05, subdivision 1; 148C.06; 148C.11, subdivisions 1 and 3; 157.011, subdivision 1; 157.15, subdivisions 4, 5, 6, 9, 12, 13, 14, and by adding subdivisions; 157.16; 157.17, subdivision 2; 157.20, subdivision 1, and by adding a subdivision; 157.21; 252.27, subdivision 2a; 256.045, subdivision 3; 256.969, subdivisions 1, 2b, 9, and 10; 256B.055, subdivi-

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

sion 12; 256B.0575; 256B.0595, subdivisions 1, 2, 3, and 4; 256B.0625, subdivisions 17, 19a, and 30; 256B.0628, subdivision 2; 256B.0913, subdivisions 5 and 15a; 256B.0915, subdivisions 3 and 3a; 256B.093, subdivision 3; 256B.15, subdivision 5; 256B.431, subdivision 25; 256B.432, subdivision 2; 256B.434, subdivision 10; 256B.49, subdivisions 6 and 7; 256B.501, subdivisions 5b and 5c; 256B.69, subdivisions 3a, 4, 5b, 6, and 21; 256D.02, subdivision 12a; 256D.03, subdivision 4; 256D.045; and 256L.04, subdivisions 2b and 3; Laws 1995, chapter 207, article 1, section 2, subdivision 4; proposing coding for new law in Minnesota Statutes, chapters 62J; 144; 145; 252; 256; 256B; and 299A; proposing coding for new law as Minnesota Statutes, chapter 252B; repealing Minnesota Statutes 1994, sections 144.691, subdivision 4; 146.14; and 146.20; Minnesota Statutes 1995 Supplement, sections 157.03; 157.15, subdivision 2; 157.18; 157.19; 256B.15, subdivision 5; 256B.69, subdivision 4a; 256G.05, subdivision 1; and 256G.07, subdivision 3a; Minnesota Rules, part 9505.5230.

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

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

	1996	1997	BIENNIAL TOTAL
General	\$ (118,284,000)	\$ (57,253,000)	\$ (175,537,000)
State Government			
Special Revenue	50,000	300,000	350,000
TOTAL	\$ (118,234,000)	\$ (56,953,000)	\$ (175,187,000)

APPROPRIATIONS
Available for the Year
Ending June 30
1996 1997

Sec. 2. COMMISSIONER OF
HUMAN SERVICES

Subdivision 1. Total

Appropriation	(118,284,000)	(59,533,000)
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This reduction is taken from the appropriation in Laws 1995, chapter 207, article 1, section 2.

The amounts that are added to or reduced from the appropriation for each program are specified in the following subdivisions.

DHS SPENDING CAP. The 1998–1999 general fund spending in the department of human services is limited to \$2,602,561,000 in fiscal year 1998 and \$2,823,204,000 in fiscal year 1999. Policy changes made to meet this spending cap will include the effects on both revenues and expenditures. Changes from end of session revenue estimates shall be counted against this expenditures limit. Expenditures in the department may exceed these estimates only if forecast caseloads increase. After consultation with the legislature, the commissioner of finance may also adjust these limits to recognize any errors or omissions in the workpapers used to generate the figure.

Subd. 2. Life Skills

Self-Sufficiency

(3,462,000)	90,000
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The amounts that may be spent from this appropriation for each purpose are as follows:

(a) Chemical Dependency

Consolidated Treatment

(3,462,000)	(1,346,000)
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(b) Deaf and Hard-of-Hearing

Services Grants

-0-	100,000
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(c) Community Social Services Grants	
-0-	36,000
(d) Aging Grants	
-0-	1,050,000
(e) Administration and Other Grants	
-0-	250,000

DEAF AND HARD-OF-HEARING PROGRAMS.

Of this appropriation, \$100,000 in fiscal year 1997 is for a grant to a nonprofit agency that is currently serving deaf and hard-of-hearing adults with mental illness through residential programs and supported housing outreach activities. The grant must be used to expand the services provided by the nonprofit agency to include community support services for deaf and hard-of-hearing adults with mental illness. This appropriation shall not become part of the base for the 1998-1999 biennial budget.

ADULT DAY CARE. Of this appropriation, \$250,000 in fiscal year 1997 is for grants to counties to expand or upgrade adult day care services and adult day care facilities. This appropriation is available until expended but shall not become part of the base appropriation for the biennium beginning July 1, 1997. The commissioner shall distribute grants to counties outside the metropolitan area where there is a need for expanded or improved services, facilities, or other capital assets, including vans for transporting clients, and the commissioner shall require a ten percent local match from the adult day care agency. The county shall award grants to nonprofit or loans to for-profit adult day care agencies in order for the agency to physically upgrade the facility, which will result in the expansion of the number of clients served in adult day care, expand the type of services offered, or enable programs to service persons with greater needs. For-profit adult day care agencies eligible for funds under this section receive funds as a loan. If a county elects to provide a loan to a for-profit agency, the county shall make provisions for the repayment of the loan within five years, and redistribute the funds for

additional expansion or upgrading. A grant or loan to an adult day care nonprofit or for-profit agency, respectively, may not exceed \$10,000. These funds shall not be used to pay for service costs.

SENIOR PROGRAMS. For fiscal year 1997, of this appropriation, \$150,000 is for volunteer programs for retired senior citizens established under Minnesota Statutes, section 256.9753, \$150,000 is for the foster grandparent program established under Minnesota Statutes, section 256.976, and \$150,000 is for the senior companion program established under Minnesota Statutes, section 256.977.

SENIOR NUTRITION PROGRAM. Of this appropriation, \$600,000 in fiscal year 1997 is for senior nutrition programs under Minnesota Statutes, section 256.9752. Not less than \$400,000 of this appropriation shall be used for congregate dining sites and home-delivered meals, and not more than \$200,000 shall be used for nutritional support services.

Subd. 3. Children's Program	-0-	2,400,000
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The amounts that may be spent from this appropriation for each purpose are as follows:

- (a) Subsidized Adoption Grants

-0-	1,500,000
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- (b) Other Families With Children Services Administration

-0-	900,000
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SOCIAL SERVICES INFORMATION SYSTEM. Of this appropriation, \$850,000 in fiscal year 1997 is for the social services information system. This appropriation shall not become part of the base for the 1998-1999 biennial budget.

CHILD WELFARE TECHNOLOGY GRANT. Of this appropriation, \$50,000 is for purposes of developing an integrated child welfare computer system to connect tribal social services, counties, nonprofit organizations, and state agencies that are in-

volved with child welfare issues, including adoption, foster care, and out-of-home placement issues. The appropriation will be provided to the commissioner when the commissioner applies for and receives a technology grant through the United States Department of Commerce, Division of National Technology Information Administration, to develop and implement the child welfare network. This \$50,000 in state funding is part of the 50 percent match that is necessary in order to be eligible for the federal technology grant.

Subd. 4. Economic Self-Sufficiency
General

(13,668,000)	(14,350,000)
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The amounts that may be spent from this appropriation for each purpose are as follows:

(a) AFDC Grants	(13,196,000)	(16,000,000)
(b) General Assistance Grants	878,000	2,593,000
(c) Minnesota Supplemental Aid	(262,000)	(328,000)
(d) Minnesota Family Investment Plan (MFIP) Grants	-0-	64,000
(e) Child Care Fund Entitlement Grants	(1,258,000)	(1,321,000)
(f) Administration and Other Grants	170,000	642,000

RESIDENCY REQUIREMENT ADMINISTRATIVE COSTS. (a) Of this appropriation, \$225,000 in fiscal year 1997 is to reimburse the counties for the verified administrative costs of implementing the 30-day residency requirement in the general assistance and general assistance medical care programs.

(b) The commissioner of finance shall include in the department of human services biennial budget recommendation for the 1998-1999 biennium an appropriation suffi-

cient to reimburse the counties for the verified administrative costs of implementing the 30-day residency requirement in the medical assistance, aid to families with dependent children, general assistance, and general assistance medical care programs.

COMBINED MANUAL PRODUCTION COSTS. For the biennium ending June 30, 1997, the commissioner may increase the fee charged to, and may retain money received from, individuals and private entities in order to recover the difference between the costs of producing the department of human services combined manual and the subsidized price charged to individuals and private entities on January 1, 1996. This provision does not apply to government agencies and nonprofit agencies serving the legal or social service needs of clients.

Subd. 5. Health Care
General

(100,714,000)	(47,590,000)
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The amounts that may be spent from this appropriation for each purpose are as follows:

(a) Group Residential Housing Grants	(4,562,000)	(3,874,000)
(b) MA Long-Term Care Facilities	(24,640,000)	3,231,000
(c) MA Long-Term Care Waivers and Home Care	(5,945,000)	2,422,000
(d) MA Managed Care and Fee-for-Service	(2,164,000)	(2,733,000)
(e) General Assistance Medical Care	(63,873,000)	(47,276,000)
(f) Administration and Other Grants	470,000	640,000

NEW ICF/MR. A newly constructed or newly established intermediate care facility for persons with mental retardation that is developed and financed during fiscal year 1997 shall not be subject to the equity requirements in Minnesota Statutes, section

256B.501, subdivision 11, paragraph (d), or 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. If a facility which is in receivership under Minnesota Statutes, section 245A.12 or 245A.13, is sold during fiscal year 1997 to an unrelated organization: (1) 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 (2) 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.

ICF/MR RATE EXEMPTION. If the commissioner of human services is unable to complete the rulemaking revisions to the ICF/MR reimbursement rule by September 30, 1996, for the rate year beginning October 1, 1996, the commissioner shall exempt ICF/MR facilities from reductions to the payment rates under Minnesota Statutes, section 256B.501, subdivision 5b, paragraph (d), clause (6), if the facility: (1) has had a settle-up payment rate established in the reporting year preceding the rate year for the one-time rate adjustment; (2) is a newly established facility; (3) is an A to B conversion under the reimbursement rule; (4) has a payment rate subject to a community conversion project under Minnesota Statutes, section 252.292; (5) has a payment rate established under Minnesota Statutes, section 245A.12 or 245A.13; or (6) is a facility created by the relocation of more than 25 percent of the capacity of a related facility during the reporting year.

COUNTY WAIVERED SERVICES RESERVE. Notwithstanding the provisions of Minnesota Statutes, section 256B.092, subdivision 4, and Minnesota Rules, part 9525.1830, subpart 2, the commissioner may approve written procedures and criteria for the allocation of home- and community-based waived services funding for persons with mental retardation or related conditions which enables a county to maintain a reserve resource account. The reserve resource account may not exceed five percent of the county agency's total annual allocation of home- and community-based waived services funds. The reserve may be utilized to ensure the county's ability to meet the changing needs of current recipients, to ensure the health and safety needs of current recipients, or to provide short-term emergency intervention care to eligible waiver recipients.

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 1996 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.

SERVICE ALLOWANCE TRANSFER. For the fiscal year ending June 30, 1997, the commissioner may transfer \$848,000 from the medical assistance grants account to the alternative care grants account for allocation as service allowances to counties under Minnesota Statutes 1995 Supplement, section 256B.0913, subdivision 15.

HIV/AIDS DRUG REIMBURSEMENT PROGRAM. Of this appropriation, \$150,000 in fiscal year 1997 is for the HIV/AIDS drug reimbursement program and shall be added to federal funds available for that program.

ICF/MR ALTERNATIVE RATE STRUCTURE. The commissioner, in con-

junction with ICF/MR service providers, shall present to the legislature by January 31, 1997, recommendations for an alternative rate structure that recognizes the small size and individual needs of ICFs/MR. The system proposed must recognize costs incurred, must not penalize facilities converted since 1990 as part of the A to B conversion project, and must reimburse the costs associated with federal active treatment standards. As part of developing these recommendations the commissioner shall also examine issues related to the relative size and cost of these facilities and shall develop recommendations regarding whether allowing the development of larger facilities can be a high-quality, cost-efficient service option.

TEFRA CRITERIA MODIFICATIONS.

The commissioner shall report to the legislature by February 1, 1997, on the number of children found eligible for medical assistance under the TEFRA option as a result of the modifications in Minnesota Statutes, section 256B.055, subdivision 12, paragraph (e), adopted in this chapter. The report must include information on the medical condition of the children found eligible and on the services provided to them. The report must include recommendations on any changes in these criteria developed in consultation with interested family, client, provider, and county representatives.

TEFRA DENIALS. Effective the day following final enactment, for children found ineligible for medical assistance under the TEFRA option under criteria in Minnesota Statutes, section 256B.055, subdivision 12, established in Laws 1995, chapter 207, article 6, if the reason for denial is lack of information on the child's condition, the commissioner shall notify the family of the lack of documentation at least 60 days prior to termination of eligibility for notices sent between April 1 and July 1, 1996. All TEFRA ineligibility notices sent between April 1 and July 1, 1996, must contain the telephone number of a department of human services

staff person whom the family can contact about alternative sources of health coverage, including MinnesotaCare, the Minnesota comprehensive health association, services for children with special health care needs, and other types of assistance for children with disabilities or chronic illnesses.

PUBLIC HEALTH NURSE ASSESSMENT. Effective for public health nurse visits on or after July 1, 1996, the reimbursement for public health nurse visits relating to the provision of personal care assistant services under Minnesota Statutes, sections 256B.0625, subdivision 19a, and 256B.0627, is \$204.36 for the initial assessment visit and \$102.18 for each reassessment visit.

NF PAYMENT INCREASE. For the rate year beginning July 1, 1996, the commissioner shall increase each nursing facility's payment rate for those facilities whose rates are determined under Minnesota Statutes, section 256B.431, subdivision 25, by \$0.06 per resident per day.

Subd. 6. Community Mental Health
and State-Operated Services
General

(440,000)	(83,000)
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The amounts that are reduced from this appropriation for each purpose are as follows:

(a) Mental Health Grants - Children	
(400,000)	277,000
(b) Mental Health Grants - Adults	
(40,000)	(360,000)

CRISIS SERVICES. Crisis services for developmentally disabled persons in each regional center catchment area, including crisis beds and mobile intervention teams, shall be at Brainerd, Cambridge, Fergus Falls, St. Peter, and Willmar regional centers in accordance with the agreement reached in 1989, and codified in Minnesota Statutes, section 252.025. The program design 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.

COMPULSIVE GAMBLING. For the fiscal year beginning July 1, 1996, the state lottery board shall deposit \$800,000 in the general fund for use by the commissioner of human services to pay for compulsive gambling services as follows: \$500,000 is allocated for treatment of compulsive gamblers; \$150,000 is allocated for the compulsive gambling treatment pilot project for treating individual compulsive gamblers; and \$150,000 is allocated for education and prevention efforts, of which \$50,000 is for a grant to a compulsive gambling council located in St. Louis county for the extension of the information gathering and dissemination network and the establishment of training scholarships. The amount deposited by the board shall be deducted from the lottery prize fund established under Minnesota Statutes, section 349A.10, subdivision 2. The amount deposited is appropriated to the commissioner of human services for this purpose. None of the amount appropriated for compulsive gambling services under this section may be used to pay administrative costs of the department of human services.

COMPULSIVE GAMBLING GRANT FOR ADOLESCENT PROGRAMS. Of this appropriation, \$40,000 in fiscal year 1997 is for a grant to a compulsive gambling council located in St. Louis county for a compulsive gambling prevention and education project for adolescents. This appropriation shall not become part of the base level funding for the 1998-1999 biennial budget. The appropriation in Laws 1995, chapter 207, article 1, section 2, subdivision 7, for compulsive gambling programs for fiscal year 1996 is reduced by \$40,000.

RTC DENTAL SERVICES REPORT. The commissioner shall report to the chairs of the house health and human services committee and the senate health care committee

by November 1, 1996, on the implementation of Minnesota Statutes, section 246,57, subdivision 6.

Sec. 3. COMMISSIONER OF HEALTH

Subdivision 1. Total			
Appropriation		-0-	2,280,000
	Summary by Fund		
General	-0-	2,080,000	
State Government			
Special Revenue	-0-	200,000	

This appropriation is added to the appropriation in Laws 1995, chapter 207, article 1, section 3.

The amounts that may be spent from this appropriation for each program are specified in the following subdivisions.

Subd. 2. Health Systems and			
Special Populations		-0-	1,985,000
	Summary by Fund		
General	-0-	1,785,000	
State Government			
Special Revenue	-0-	200,000	

CORE PUBLIC HEALTH FUNCTIONS.

Of this appropriation, \$1,500,000 in fiscal year 1997 is for core public health functions. Of this amount, up to five percent is available to the commissioner for administrative and technical support of community health boards. Funds distributed shall not be used to displace current appropriations or to provide individual personal health care services which compete with or duplicate services otherwise available through the prepaid medical assistance program. These funds shall be distributed on a pro rata basis according to the existing community health services subsidy formula to those community health service areas which are participating in the state's prepaid medical assistance program. This appropriation shall not become part of the base for the 1998-1999 biennial budget.

DIRECT CONTRACTING REPORT.

The commissioners of health and commerce

shall jointly study and report to the legislative oversight commission on health care access by December 15, 1996, on the feasibility of allowing direct provider contracting of health care services. Included in this report shall be recommendations on the consumer protections, reserve requirements, and protections for consumers who will not have direct contracting available to them that the legislature should consider to ensure protection of persons receiving health coverage through networks allowed to conduct direct provider contracting.

HOSPITAL CONVERSION; SUPPLEMENTAL ALLOCATION. Of the appropriation from the general fund, for the fiscal year ending June 30, 1997, 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. This allocation is in addition to funds authorized by Laws 1995, article 1, section 3, subdivision 2.

MEDICARE INITIAL SURVEYS. (a) \$200,000 is appropriated to the commissioner from the general fund for the fiscal year ending June 30, 1997, to support initial surveys of Medicare providers. This appropriation shall be available until the federal law prohibiting the collection of fees for Medicare initial surveys is repealed.

(b) \$200,000 is appropriated to the commissioner from the state government special revenue fund for the fiscal year ending June 30, 1997, to support initial surveys of Medicare providers once the federal law prohibiting the collection of fees for this activity is repealed. Upon repeal of the federal law, the commissioner shall charge fees as provided under Minnesota Statutes, section 144.122, paragraph (e).

PROJECT REVIEW BEFORE CONSTRUCTION. Before construction may commence on the project authorized in

Minnesota Statutes, section 144A.071, subdivision 4a, paragraph (w), the interagency long-term care planning committee must review the project to ascertain the extent to which the project meets the objectives of Minnesota Statutes, section 144A.073, subdivision 4, and approve the project if it meets the objectives.

SHARED ADMINISTRATOR. Notwithstanding the provisions of Minnesota Statutes, section 144A.04, subdivision 5, the administrator of a county owned nursing home may serve, until September 30, 1996, as the administrator of a nursing home located in a county owned hospital provided that the total number of nursing home beds in both facilities does not exceed 153 beds. This provision is effective the day following final enactment.

Subd. 3. Health Protection

-0-

295,000

BIRTH DEFECTS REGISTRY. Of this appropriation, \$195,000 in fiscal year 1997 is for the birth defects registry system under Minnesota Statutes, section 144.2215. The startup costs shall not become part of the base for the 1998-1999 biennial budget.

LEAD HAZARD REDUCTION. Of this appropriation, \$100,000 in fiscal year 1997 is for lead hazard reduction under Minnesota Statutes, section 144.9504, subdivisions 1 and 7, and section 144.9503, subdivision 9.

REPORT ON INSPECTION FEES. The commissioner may spend up to \$20,000 of the money appropriated for the fiscal year ending June 30, 1997, to develop recommendations for options to reduce inspection fees for establishments licensed under Minnesota Statutes, chapter 157, which are operating in the category of small establishment with full menu selection, and which have ten or fewer employees. The recommendations must not include the option of a general fund appropriation as a way to reduce inspection fees. The commissioner must report the rec-

ommendations to the legislature by October 1, 1996.

Sec. 4. VETERANS NURSING

HOMES BOARD	-0-	125,000
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This appropriation is added to the appropriation in Laws 1995, chapter 207, article 1, section 4.

VETERANS NURSING HOMES BOARD. \$125,000 is appropriated from the general fund to the veterans nursing homes board for the fiscal year ending June 30, 1997, for the nursing home in Fergus Falls. This appropriation is to fund positions and support services, to coordinate and oversee the construction of the facility, and to begin planning for the opening of the facility.

Sec. 5. HEALTH-RELATED BOARDS

Subdivision 1. Total

Appropriation		50,000	175,000
	Summary by Fund		
General	-0-	75,000	
State Government			
Special Revenue	50,000	100,000	

This appropriation is added to the appropriation in Laws 1995, chapter 207, article 1, section 5.

Subd. 2. Emergency Medical Services Regulatory Board

General Fund	-0-	75,000
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EMS TRANSFER EXPENSES. \$75,000 is appropriated to the emergency medical services regulatory board from the general fund for the fiscal year ending June 30, 1997, for expenses incurred in transferring regulatory authority from the commissioner of health to the board under Laws 1995, chapter 207, article 9. This appropriation shall not become part of the base for the 1998-1999 biennial budget.

Subd. 3. Board of Medical Practice

State Government Special

Fund

50,000

100,000

MEDICAL PRACTICE BOARD.

\$50,000 in fiscal year 1996 and \$100,000 in fiscal year 1997 is appropriated from the state government special revenue fund to the board of medical practice for the health professionals services program, and is added to the appropriation in Laws 1995, chapter 207, article 1, section 5, subdivision 6.

STATE GOVERNMENT SPECIAL REVENUE FUND. The appropriations in this subdivision 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 subdivision 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.

Sec. 6. CARRYOVER LIMITATION.

None of the appropriations in this article 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 1998-1999 biennial budget, unless specifically directed by the legislature.

Sec. 7. SUNSET OF UNCODIFIED LANGUAGE.

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

ARTICLE 2

HEALTH AND CONTINUING CARE RELATED TO MEDICAL ASSISTANCE AND GENERAL ASSISTANCE MEDICAL CARE

Section 1. Minnesota Statutes 1995 Supplement, section 62Q.19, subdivision 1, is amended to read:

Subdivision 1. **DESIGNATION.** The commissioner shall designate essential community providers. The criteria for essential community provider designation shall be the following:

(1) a demonstrated ability to integrate applicable supportive and stabilizing services with medical care for uninsured persons and high-risk and special needs populations as defined in section 62Q.07, subdivision 2, paragraph (e), underserved, and other special needs populations; and

(2) a commitment to serve low-income and underserved populations by meeting the following requirements:

(i) has nonprofit status in accordance with chapter 317A;

(ii) has tax exempt status in accordance with the Internal Revenue Service Code, section 501(c)(3);

(iii) charges for services on a sliding fee schedule based on current poverty income guidelines; and

(iv) does not restrict access or services because of a client's financial limitation; or

(3) status as a local government unit as defined in section 62D.02, subdivision 11, an Indian tribal government, an Indian health service unit, or community health board as defined in chapter 145A; or

(4) a former state hospital that specializes in the treatment of cerebral palsy, spina bifida, epilepsy, closed head injuries, specialized orthopedic problems, and other disabling conditions.

Prior to designation, the commissioner shall publish the names of all applicants in the State Register. The public shall have 30 days from the date of publication to submit written comments to the commissioner on the application. No designation shall be made by the commissioner until the 30-day period has expired.

The commissioner may designate an eligible provider as an essential community provider for all the services offered by that provider or for specific services designated by the commissioner.

For the purpose of this subdivision, supportive and stabilizing services include at a minimum, transportation, child care, cultural, and linguistic services where appropriate.

Sec. 2. Minnesota Statutes 1995 Supplement, section 62Q.19, subdivision 5, is amended to read:

Subd. 5. **CONTRACT PAYMENT RATES.** An essential community provider and a health plan company may negotiate the payment rate for covered services provided by

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

the essential community provider. This rate must be at least the same rate per unit of service as is paid to other health plan providers for the same or similar services.

Sec. 3. Minnesota Statutes 1995 Supplement, 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 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 150 percent of poverty, but not over \$50,000, ten percent;

(2) on the amount of adjusted gross income over 150 percent of poverty and over \$50,000 but not over \$60,000, 12 percent;

(3) on the amount of adjusted gross income over 150 percent of poverty, and over \$60,000 but not over \$75,000, 14 percent; and

(4) on all adjusted gross income amounts over 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.

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(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.

(i) The contribution under paragraph (b) shall be reduced by \$300 per fiscal year if, in the 12 months prior to July 1;

(1) the parent applied for insurance for the child,

(2) the insurer denied insurance,

(3) the parents submitted a complaint or appeal, in writing to the insurer, submitted a complaint or appeal, in writing, to the commissioner of health or the commissioner of commerce, or litigated the complaint or appeal, and

(4) as a result of the dispute, the insurer reversed its decision and granted insurance.

For purposes of this section, insurance has the meaning given in paragraph (h).

A parent who has requested a reduction in the contribution amount under this paragraph shall submit proof in the form and manner prescribed by the commissioner or county agency, including, but not limited to, the insurer's denial of insurance, the written letter or complaint of the parents, court documents, and the written response of the insurer approving insurance. The determinations of the commissioner or county agency under this paragraph are not rules subject to chapter 14.

Sec. 4. [252.53] DAY TRAINING AND HABILITATION SERVICES.

Day training and habilitation license holders are exempt from the requirements of Minnesota Rules, part 9525.1630, subparts 3 (review of progress toward individual habilitation plan goals), 4 (initial assessment), and 5 (reassessment), for persons for whom

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progress reviews, initial assessments, and reassessments are completed by the license holder according to requirements established in the person's individual service plan developed by the county case manager under Minnesota Statutes, section 256B.092, subdivision 1b.

Sec. 5. Minnesota Statutes 1995 Supplement, 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

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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 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, 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 was the primary hospital 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: \$505,000 due on the 15th of each month after noon, beginning July 15, 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. 6. [256.9692] EFFECT OF INTEGRATION AGREEMENT ON DIVISION OF COST.

Beginning in the first calendar month after there is a definitive integration agreement affecting the University of Minnesota hospital and clinics and Fairview hospital and health care services, Fairview hospital and health care services shall pay the University of Minnesota \$505,000 on the 15th of each month, after receiving the state payment, provided that the University of Minnesota has fulfilled the requirements of section 256B.19, subdivision 1c.

Sec. 7. Minnesota Statutes 1995 Supplement, 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 the child requires a level of care provided in a hospital, nursing facility, or intermediate care facility for persons with mental retardation or related conditions, for whom home care is appropriate, provided that the

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cost to medical assistance under this section is not more than the amount that medical assistance would pay for if the child resides in an institution. ~~Eligibility under this section must be determined annually. After the child is determined to be eligible under this section, the commissioner shall review the child's disability under United States Code, title 42, section 1382c(a) and level of care defined under this section no more often than annually and may elect, based on the recommendation of health care professionals under contract with the state medical review team, to extend the review of disability and level of care up to a maximum of four years. The commissioner's decision on the frequency of continuing review of disability and level of care is not subject to administrative appeal under section 256.045. Nothing in this subdivision shall be construed as affecting other redeterminations of medical assistance eligibility under chapter 256B and annual cost effective reviews under this section.~~

(b) For purposes of this subdivision, "hospital" means an 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. 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, "nursing 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 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,

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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 the level of care provided in a nursing facility if the person requires 24-hour monitoring or supervision and a plan of mental health treatment because of specific symptoms or functional impairments associated with a serious mental illness or disorder diagnosis, which meet severity criteria for mental health established by the commissioner based on standards developed for the Wisconsin Katie Beckett program published in July 1994.

(f) 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 parent or guardian, the child's physician or physicians, 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)~~ (g) If a child meets the conditions in paragraph (b), (c), ~~or~~ (d), or (e), 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) or (e), 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.

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Sec. 8. Minnesota Statutes 1994, section 256B.056, subdivision 1, is amended to read:

Subdivision 1. **RESIDENCY.** To be eligible for medical assistance, a person must reside have resided in Minnesota for at least 30 days, or, if absent from the state, be deemed to be a resident of Minnesota in accordance with the rules of the state agency.

A person who has resided in the state for less than 30 days is considered to be a Minnesota resident if the person:

- (1) was born in the state;
- (2) has in the past resided in the state for at least 365 consecutive days;
- (3) has come to the state to join a close relative, which, for purposes of this subdivision means a parent, grandparent, brother, sister, spouse, or child; or
- (4) has come to this state to accept a bona fide offer of employment for which the person is eligible.

A county agency shall waive the 30-day residency requirement in cases of medical emergency or where unusual hardship would result from denial of assistance. The county agency must report to the commissioner within 30 days on any waiver granted under this section. The county shall not deny an application solely because the applicant does not meet at least one of the criteria in this subdivision, but shall continue to process the application and leave the application pending until the residency requirement is met or until eligibility or ineligibility is established.

Sec. 9. Minnesota Statutes 1994, section 256B.056, subdivision 1a, is amended to read:

Subd. 1a. **INCOME AND ASSETS GENERALLY.** Unless specifically required by state law or rule or federal law or regulation, the methodologies used in counting income and assets to determine eligibility for medical assistance for persons whose eligibility category is based on blindness, disability, or age of 65 or more years, the methodologies for the supplemental security income program shall be used, except that payments made pursuant to a court order for the support of children shall be excluded from income in an amount not to exceed the difference between the applicable income standard used in the state's medical assistance program for aged, blind, and disabled persons and the applicable income standard used in the state's medical assistance program for families with children. Exclusion of court-ordered child support payments is subject to the condition that if there has been a change in the financial circumstances of the person with the legal obligation to pay support since the support order was entered, the person with the legal obligation to pay support has petitioned for modification of the support order. For families and children, which includes all other eligibility categories, the methodologies for the aid to families with dependent children program under section 256.73 shall be used. Effective upon federal approval, in-kind contributions to, and payments made on behalf of, a recipient, by an obligor, in satisfaction of or in addition to a temporary or permanent order for child support or maintenance, shall be considered income to the recipient. For these purposes, a "methodology" does not include an asset or income standard, or accounting method, or method of determining effective dates.

Sec. 10. Minnesota Statutes 1995 Supplement, section 256B.0575, is amended to read:

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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 to the extent that the deduction is not included in the personal needs allowance under section 256B.35, subdivision 1, as child support garnished under a court order;

(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:

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(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. 11. Minnesota Statutes 1995 Supplement, section 256B.0595, subdivision 1, is amended to read:

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

(b) Effective for transfers made after August 10, 1993, a person, a person's spouse, or any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the person or person's spouse, may not give away, sell, or dispose of, for less than fair market value, any asset or interest therein, except assets other than the homestead that are excluded under the supplemental security income program, for the purpose of establishing or maintaining medical assistance eligibility. For purposes of determining eligibility for long-term care services, any transfer of such assets within 36 months before or any time after an institutionalized person applies for medical assistance, or 36 months before or any time after a medical assistance recipient becomes institutionalized, for less than fair market value may be considered. Any such transfer is presumed to have been made for the purpose of establishing or maintaining medical assistance eligibility and the person is ineligible for long-term care services for the period of time determined under subdivision 2, unless the person furnishes convincing evidence to establish that the transaction was exclusively for another purpose, or unless the transfer is permitted under subdivision 3 or 4. Notwithstanding the provisions of this paragraph, in the case of payments from a trust or portions of a trust that are considered transfers of assets under federal law, any transfers made within 60 months before or any time after an institutionalized person applies for medical assistance and within 60 months before or any time after a medical assistance recipient becomes institutionalized, may be considered.

(c) This section applies to transfers, for less than fair market value, of income or assets, including assets that are considered income in the month received, such as inheri-

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tances, court settlements, and retroactive benefit payments or income to which the person or the person's spouse is entitled but does not receive due to action by the person, the person's spouse, or any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the person or the person's spouse.

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

(e) This section applies to the portion of any asset or interest that a person, a person's spouse, or any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the person or the person's spouse, transfers to any 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 sections 256B.0915, 256B.092, and 256B.49. For purposes of this subdivision and subdivisions 2, 3, and 4, "institutionalized person" includes a person who is an inpatient in a nursing facility or in a swing bed, or intermediate care facility for persons with mental retardation or who is receiving home and community-based services under sections 256B.0915, 256B.092, and 256B.49.

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

Sec. 12. Minnesota Statutes 1994, section 256B.0595, is amended by adding a subdivision to read:

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Subd. 1a. **PROHIBITED TRANSFERS.** (a) Notwithstanding any contrary provisions of this section, this subdivision applies to transfers involving recipients of medical assistance that are made on or after its effective date and to all transfers involving persons who apply for medical assistance on or after its effective date if the transfer occurred within 72 months before the person applies for medical assistance, except that this subdivision does not apply to transfers made prior to March 1, 1996. A person, a person's spouse, or any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the person or the person's spouse, may not give away, sell, dispose of, or reduce ownership or control of any income, asset, or interest therein for less than fair market value for the purpose of establishing or maintaining medical assistance eligibility for the person. For purposes of determining eligibility for medical assistance services, any transfer of such income or assets for less than fair market value within 72 months before or any time after a person applies for medical assistance 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 medical assistance services for the period of time determined under subdivision 2a, unless the person furnishes convincing evidence to establish that the transaction was exclusively for another purpose, or unless the transfer is permitted under subdivision 3a or 4a.

(b) This section applies to transfers of income or assets for less than fair market value, 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.

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

(d) This section applies to the portion of any income, asset, or interest therein that a person, a person's spouse, or any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the person or the person's spouse, transfers to any annuity that exceeds the value of the benefit likely to be returned to the person or spouse while alive, based on estimated life expectancy of adults entering long-term care. The commissioner shall adopt rules establishing life expectancies of adults entering long-term care.

Sec. 13. Minnesota Statutes 1995 Supplement, 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 assis-

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tance payment rate shall be adjusted each July 1 to reflect payment rates for the previous calendar year. The period of ineligibility begins with the month in which the assets were transferred. If the transfer was not reported to the local agency at the time of application, and the applicant received long-term care services during what would have been the period of ineligibility if the transfer had been reported, a cause of action exists against the transferee for the cost of long-term care services provided during the period of ineligibility, or for the uncompensated amount of the transfer, whichever is less. The action may be brought by the state or the local agency responsible for providing medical assistance under chapter 256G. The uncompensated transfer amount is the fair market value of the asset at the time it was given away, sold, or disposed of, less the amount of compensation received.

(b) For uncompensated transfers made after August 10, 1993, the number of months of ineligibility for long-term care services shall be the total uncompensated value of the resources transferred divided by the average medical assistance rate for nursing facility services in the state in effect on the date of application. The amount used to calculate the average medical assistance payment rate shall be adjusted each July 1 to reflect payment rates for the previous calendar year. The period of ineligibility begins with the month in which the assets were transferred except that if one or more uncompensated transfers are made during a period of ineligibility, the total assets transferred during the ineligibility period shall be combined and a penalty period calculated to begin in the month the first uncompensated transfer was made. If the transfer was not reported to the local agency at the time of application, and the applicant received medical assistance services during what would have been the period of ineligibility if the transfer had been reported, a cause of action exists against the transferee for the cost of medical assistance services provided during the period of ineligibility, or for the uncompensated amount of the transfer, whichever is less. The action may be brought by the state or the local agency responsible for providing medical assistance under chapter 256G. The uncompensated transfer amount is the fair market value of the asset at the time it was given away, sold, or disposed of, less the amount of compensation received.

(c) If a calculation of a penalty period results in a partial month, payments for long-term care services shall be reduced in an amount equal to the fraction, except that in calculating the value of uncompensated transfers, if the total value of all uncompensated transfers made in a month not included in an existing penalty period does not exceed \$1,000 \$500, then such transfers shall be disregarded for each month prior to the month of application for or during receipt of medical assistance.

Sec. 14. Minnesota Statutes 1994, section 256B.0595, is amended by adding a subdivision to read:

Subd. 2a. PERIOD OF INELIGIBILITY. (a) Notwithstanding any contrary provisions of this section, this subdivision applies to transfers involving recipients of medical assistance that are made on or after its effective date and to all transfers involving persons who apply for medical assistance on or after its effective date, regardless of when the transfer occurred, except that this subdivision does not apply to transfers made prior to March 1, 1996. For any uncompensated transfer occurring within 72 months prior to the date of application, at any time after application, or while eligible, the number of months of cumulative ineligibility for medical assistance services shall be the total uncompensated value of the assets and income transferred divided by the statewide average per per-

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son nursing facility payment made by the state in effect on the date of application. The amount used to calculate the average per person payment shall be adjusted each July 1 to reflect average payments for the previous calendar year. For applicants, the period of ineligibility begins with the month in which the person applied for medical assistance and satisfied all other requirements for eligibility, or the month the local agency becomes aware of the transfer, if later. For recipients, the period of ineligibility begins in the month the agency becomes aware of the transfer, except that penalty periods for transfers made during a period of ineligibility as determined under this section shall begin in the month following the existing period of ineligibility. 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 that was not recovered from the transferor through the implementation of a penalty period under this subdivision, whichever is less. The action may be brought by the state or the local agency responsible for providing medical assistance under chapter 256G. The total uncompensated value is the fair market value of the income or asset at the time it was given away, sold, or disposed of, less the amount of compensation received. No cause of action exists for a transfer, unless: (1) the transferee knew or should have known that the transfer was being made by a person who was a resident of a long-term care facility or was receiving that level of care in the community at the time of the transfer; (2) the transferee knew or should have known that the transfer was being made to assist the person to qualify for or retain medical assistance eligibility; or (3) the transferee actively solicited the transfer with intent to assist the person to qualify for or retain eligibility for medical assistance.

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

Sec. 15. Minnesota Statutes 1995 Supplement, 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

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(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, as certified by the individual's attending physician, 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 a penalty resulting from a transfer for less than fair market value because denial of eligibility would cause undue hardship for the individual, based on imminent threat to the individual's health and well-being. Whenever an applicant or recipient is denied eligibility because of a transfer for less than fair market value, the local agency shall notify the applicant or recipient that they may request a waiver of the penalty if the denial of eligibility will cause undue hardship. In evaluating a waiver, the local agency shall take into account whether the individual was the victim of financial exploitation, whether the individual has made reasonable efforts to recover the transferred property or resource, and other factors relevant to a determination of hardship. If the local agency does not approve a hardship waiver, the local agency shall issue a written notice to the individual stating the reasons for the denial and the process for appealing the local agency's decision.

(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 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 shall be brought by the state or unless the state delegates this responsibility to the local agency responsible for providing medical assistance under chapter 256G.

Sec. 16. Minnesota Statutes 1994, section 256B.0595, is amended by adding a subdivision to read:

Subd. 3a. HOMESTEAD EXCEPTION TO TRANSFER PROHIBITION. (a) This subdivision applies to transfers involving recipients of medical assistance that are made on or after its effective date and to all transfers involving persons who apply for medical assistance on or after its effective date, regardless of when the transfer occurred, except that this subdivision does not apply to transfers made prior to March 1, 1996. A person is not ineligible for medical assistance services due to a transfer of assets for less than fair market value as described in subdivision 1a if the asset transferred was a homestead and:

(1) title to the homestead was transferred to the individual's relatives who are residing in the homestead and are the individual's

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(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, as certified by the individual's attending physician, 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 a penalty resulting from a transfer for less than fair market value because denial of eligibility would cause undue hardship for the individual and there exists an imminent threat to the individual's health and well-being. Whenever an applicant or recipient is denied eligibility because of a transfer for less than fair market value, the local agency shall notify the applicant or recipient that they may request a waiver of the penalty if the denial of eligibility will cause undue hardship. In evaluating a waiver, the local agency shall take into account whether the individual was the victim of financial exploitation, whether the individual has made reasonable efforts to recover the transferred property or resource, and other factors relevant to a determination of hardship. If the local agency does not approve a hardship waiver, the local agency shall issue a written notice to the individual stating the reasons for the denial and the process for appealing the local agency's decision.

(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 medical assistance services granted within 72 months of the date the transferor applied for medical assistance and satisfied all other requirements for eligibility, or the amount of the uncompensated transfer, whichever is less, together with the costs incurred due to the action. The action shall be brought by the state unless the state delegates this responsibility to the local agency responsible for providing medical assistance under chapter 256G.

Sec. 17. Minnesota Statutes 1995 Supplement, section 256B.0595, subdivision 4, is amended to read:

Subd. 4. **OTHER EXCEPTIONS TO TRANSFER PROHIBITION.** 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 individual's spouse 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

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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~~ a penalty resulting from a transfer for less than fair market value based on an imminent threat to the individual's health and well-being. Whenever an applicant or recipient is denied eligibility because of a transfer for less than fair market value, the local agency shall notify the applicant or recipient that they may request a waiver of the penalty if the denial of eligibility will cause undue hardship. In evaluating a waiver, the local agency shall take into account whether the individual was the victim of financial exploitation, whether the individual has made reasonable efforts to recover the transferred property or resource, and other factors relevant to a determination of hardship. If the local agency does not approve a hardship waiver, the local agency shall issue a written notice to the individual stating the reasons for the denial and the process for appealing the local agency's decision. 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 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~~ shall be brought by the state ~~or unless the state delegates this responsibility to~~ 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.

Sec. 18. Minnesota Statutes 1994, section 256B.0595, is amended by adding a subdivision to read:

Subd. 4a. OTHER EXCEPTIONS TO TRANSFER PROHIBITION. This subdivision applies to transfers involving recipients of medical assistance that are made on or after its effective date and to all transfers involving persons who apply for medical assistance on or after its effective date, regardless of when the transfer occurred, except that this subdivision does not apply to transfers made prior to March 1, 1996. A person or a person's spouse who has made a transfer prohibited by subdivision 1a is not ineligible for medical assistance services if one of the following conditions applies:

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(1) the assets or income were transferred to the individual's spouse or to another for the sole benefit of the spouse, except that after eligibility is established, transfers to a spouse are permitted only to comply with the provisions of section 256B.059; or

(2) the institutionalized spouse, prior to being institutionalized, transferred assets or income to a spouse, provided that the spouse to whom the assets or income were transferred does not then transfer those assets or income 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 or income were transferred to a trust for the sole benefit of the individual's child who is blind or permanently and totally disabled as determined in the supplemental security income program and the trust reverts to the state upon the disabled child's death to the extent medical assistance has paid for services for the child. This paragraph applies to a trust established after the commissioner publishes a notice in the State Register that the commissioner has been authorized to implement this paragraph due to a change in federal law or the approval of a federal waiver; or

(4) a satisfactory showing is made that the individual intended to dispose of the assets or income 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 a penalty resulting from a transfer for less than fair market value because there exists an imminent threat to the individual's health and well-being. Whenever an applicant or recipient is denied eligibility because of a transfer for less than fair market value, the local agency shall notify the applicant or recipient that they may request a waiver of the penalty if the denial of eligibility will cause undue hardship. In evaluating a waiver, the local agency shall take into account whether the individual was the victim of financial exploitation, whether the individual has made reasonable efforts to recover the transferred property or resource, and other factors relevant to a determination of hardship. If the local agency does not approve a hardship waiver, the local agency shall issue a written notice to the individual stating the reasons for the denial and the process for appealing the local agency's decision. 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 within 72 months of the date the transferor applied for medical assistance and satisfied all other requirements for eligibility,

or the amount of the uncompensated transfer, whichever is less, together with the costs incurred due to the action. The action shall be brought by the state unless the state delegates this responsibility to the local agency responsible for providing medical assistance under this chapter.

Sec. 19. Minnesota Statutes 1994, section 256B.0595, is amended by adding a subdivision to read:

Subd. 7. NOTICE OF RIGHTS. If a period of ineligibility is imposed under subdivision 2 or 2a, the local agency shall inform the applicant or recipient subject to the penalty of the person's rights under section 325F.71, subdivision 2.

Sec. 20. Minnesota Statutes 1995 Supplement, section 256B.0625, subdivision 19a, is amended to read:

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Subd. 19a. **PERSONAL CARE SERVICES.** Medical assistance covers personal care services in a recipient's home. To qualify for personal care services, recipients or responsible parties must be able to identify ~~their~~ the recipient's needs, direct and evaluate task accomplishment, and assure ~~their~~ provide for health and safety. Approved hours may be used outside the home when normal life activities take them outside the home and when, without the provision of personal care, their health and safety would be jeopardized. Total hours for services, whether actually performed inside or outside the recipient's home, cannot exceed that which is otherwise allowed for personal care services in an in-home setting according to section 256B.0627. Medical assistance does not cover personal care services for residents of a hospital, nursing facility, intermediate care facility, health care facility licensed by the commissioner of health, or unless a resident who is otherwise eligible is on leave from the facility and the facility either pays for the personal care services or forgoes the facility per diem for the leave days that personal care services are used. All personal care services must be provided according to section 256B.0627. Personal care services may not be reimbursed if the personal care assistant is the spouse or legal guardian of the recipient or the parent of a recipient under age 18, or the responsible party or the foster care provider of a recipient who cannot direct the recipient's own care unless, in the case of a foster care provider, a county or state case manager visits the recipient as needed, but not less than every six months, to monitor the health and safety of the recipient and to ensure the goals of the care plan are met. Parents of adult recipients, adult children of the recipient or adult siblings of the recipient may be reimbursed for personal care services if they are not the recipient's legal guardian and are granted a waiver under section 256B.0627.

Sec. 21. Minnesota Statutes 1995 Supplement, 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 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;
- (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.

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(c) In addition, the commissioner or the commissioner's designee may:

(1) review 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; and

(6) assure that all liable third-party payers including Medicare have been used prior to medical assistance for home care services, including but not limited to, home health agency, elected hospice benefit, waivered services, alternative care program services, and personal 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. 22. [256B.071] MEDICARE MAXIMIZATION PROGRAM.

Subdivision 1. **DEFINITION.** (a) "Dual entitlees" means recipients eligible for either the medical assistance program or the alternative care program who are also eligible for the federal Medicare program.

(b) For purposes of this section "home care services" means home health agency services, private duty nursing services, personal care assistant services, waivered services, alternative care program services, hospice services, rehabilitation therapy services, and medical supplies and equipment.

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

(b) Any provider of home care services enrolled in the medical assistance program, or county public health nursing agency responsible for personal care assessments, or county case managers for alternative care or medical assistance waiver programs, is required to use the method developed and supplied by the department of human services for determining Medicare coverage for home care equipment and services provided to dual entitlees to ensure appropriate billing of Medicare. The method will be developed in two phases; the first phase is a manual system effective July 1, 1996, and the second phase

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will automate the manual procedure by expanding the current Medicaid Management Information System (MMIS) effective January 1, 1997. Both methods will determine Medicare coverage for the dates of service, Medicare coverage for home care services, and create an audit trail including reports. Both methods will be linked to prior authorization, therefore, either method must be used before home care services are authorized and when there is a change of condition affecting medical assistance authorization. The department will conduct periodic reviews of participant performance with the method and upon demonstrating appropriate referral and billing of Medicare, participants may be determined exempt from regular performance audits.

Subd. 3. REFERRALS TO MEDICARE CERTIFIED PROVIDERS REQUIRED. Non-Medicare certified and nonparticipating Medicare certified home care service providers must refer dual eligible recipients to Medicare certified providers when Medicare is determined to be the appropriate payer for supplies and equipment or services. Non-Medicare certified and nonparticipating Medicare certified home care service providers will be terminated from participation in the medical assistance program for failure to make such referrals.

Subd. 4. MEDICARE CERTIFICATION REQUIREMENT. Medicare certification is required of all medical assistance enrolled home care service providers as defined in subdivision 1 within one year of the date the Minnesota department of health gives notice to the department that initial Medicare surveys will resume.

Subd. 5. ADVISORY COMMITTEE. The commissioner shall establish an advisory committee comprised of home care services recipients, providers, county public health nurses, home care and county nursing associations, and department of human services staff to make recommendations to the Medicare maximization program. The recommendations shall include: nursing practice issues as they relate to home care services funded by Medicare and medical assistance; and streamlining assessment, prior authorization, and up-front payer determination processes to achieve administrative efficiencies.

Sec. 23. Minnesota Statutes 1995 Supplement, section 256B.0913, subdivision 15a, is amended 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 effective January 1, 1996, Anoka county may pay vendors, and the commissioner shall reimburse the county, for actual costs up to a limit which is the maximum rate in effect on December 31, 1995, plus half the difference between that rate and the maximum allowed state county's maximum allowed rate for home health aide services per 15-minute unit is \$4.39, and its maximum allowed rate for homemaker services per 15-minute unit is \$2.90. Any adjustments in fiscal year 1997 to the maximum allowed rates for home health aide or homemaker services for Anoka county shall be calculated from the maximum rate in effect on January 1, 1996.

Sec. 24. Minnesota Statutes 1994, section 256B.0913, is amended by adding a subdivision to read:

Subd. 15b. REIMBURSEMENT RATE; AITKIN COUNTY. Notwithstanding subdivision 14, paragraph (e), effective April 1, 1996, Aitkin county's maximum allowed rate for in-home respite care services is \$6.62 per 30-minute unit. Any adjustments in

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fiscal year 1997 to the maximum allowed rate for in-home respite care services for Aitkin county shall be calculated from the maximum rate in effect on April 1, 1996.

Sec. 25. Minnesota Statutes 1994, section 256B.0913, is amended by adding a subdivision to read:

Subd. 15c. REIMBURSEMENT RATE; POLK AND PENNINGTON COUNTIES. Notwithstanding subdivision 14, paragraph (e), effective July 1, 1996, Polk and Pennington counties' maximum allowed rate for homemaker services is \$6.18 per 30-minute unit. Any adjustments in fiscal year 1997 to the maximum allowed rate for homemaker services for Polk and Pennington counties shall be calculated from the maximum rate in effect on July 1, 1996.

Sec. 26. Minnesota Statutes 1995 Supplement, section 256B.0915, subdivision 3a, is amended 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 effective January 1, 1996, Anoka county may pay vendors, and the commissioner shall reimburse the county, for actual costs up to a limit which is the maximum rate in effect on December 31, 1995, plus half the difference between that rate and the maximum allowed state county's maximum allowed rate for home health aide services per 15-minute unit is \$4.43, and its maximum allowed rate for homemaker services per 15-minute unit is \$2.93. Any adjustments in fiscal year 1997 to the maximum allowed rates for home health aide or homemaker services for Anoka county shall be calculated from the maximum rate in effect on January 1, 1996.

Sec. 27. Minnesota Statutes 1994, section 256B.0915, is amended by adding a subdivision to read:

Subd. 3b. REIMBURSEMENT RATE; AITKIN COUNTY. Notwithstanding subdivision 3, paragraph (h), effective April 1, 1996, Aitkin county's maximum allowed rate for in-home respite care services is \$6.67 per 30-minute unit. Any adjustments in fiscal year 1997 to the maximum allowed rate for in-home respite care services for Aitkin county shall be calculated from the maximum rate in effect on April 1, 1996.

Sec. 28. Minnesota Statutes 1994, section 256B.0915, is amended by adding a subdivision to read:

Subd. 3c. REIMBURSEMENT RATE; POLK AND PENNINGTON COUNTIES. Notwithstanding subdivision 3, paragraph (h), effective July 1, 1996, Polk and Pennington counties' maximum allowed rate for homemaker services is \$6.25 per 30-minute unit. Any adjustments in fiscal year 1997 to the maximum allowed rate for homemaker services for Polk and Pennington counties shall be calculated from the maximum rate in effect on July 1, 1996.

Sec. 29. Minnesota Statutes 1994, section 256B.15, is amended by adding a subdivision to read:

Subd. 1b. CLAIMS ON THE ESTATE OF A PREDECEASED SPOUSE. Upon the death of a spouse who did not receive medical assistance and who predeceases a spouse who did or does receive medical assistance, a claim for the total amount paid for medical assistance rendered for the surviving spouse through the date the deceased

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spouse died shall be filed against the deceased spouse's estate in the court having jurisdiction to probate the estate. The claim shall be filed if medical assistance was rendered for the surviving spouse under any one of the circumstances in subdivision 1a, paragraphs (a), (b), or (c). Claims under this subdivision shall have the same priority for purposes of section 524.3-805, and the same exceptions with respect to statutes of limitations as claims under subdivision 1a.

Sec. 30. Minnesota Statutes 1994, section 256B.15, is amended by adding a subdivision to read:

Subd. 2a. **LIMITATIONS ON CLAIMS ON THE ESTATE OF A PREDECEASED SPOUSE.** A claim under subdivision 1b shall include only the total amount of medical assistance rendered after age 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 spouse who did not receive medical assistance who predeceases the spouse who did receive medical assistance, for medical assistance rendered for the 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. 31. Minnesota Statutes 1994, section 256B.35, subdivision 1, is amended to read:

Subdivision 1. **PERSONAL NEEDS ALLOWANCE.** (a) Notwithstanding any law to the contrary, welfare allowances for clothing and personal needs for individuals receiving medical assistance while residing in any skilled nursing home, intermediate care facility, or medical institution including recipients of supplemental security income, in this state shall not be less than \$45 per month from all sources. When benefit amounts for social security or supplemental security income recipients are increased pursuant to United States Code, title 42, sections 415(i) and 1382f, the commissioner shall, effective in the month in which the increase takes effect, increase by the same percentage to the nearest whole dollar the clothing and personal needs allowance for individuals receiving medical assistance while residing in any skilled nursing home, medical institution, or intermediate care facility. The commissioner shall provide timely notice to local agencies, providers, and recipients of increases under this provision.

(b) The personal needs allowance may be paid as part of the Minnesota supplemental aid program, notwithstanding the provisions of section 256D.37, subdivision 2, and payments to recipients of Minnesota supplemental aid may be made once each three months covering liabilities that accrued during the preceding three months.

(c) The personal needs allowance shall be increased to include income garnished for child support under a court order, up to a maximum of \$250 per month but only to the extent that the amount garnished is not deducted as a monthly allowance for children under section 256B.0575, paragraph (a), clause (5).

Sec. 32. Minnesota Statutes 1994, section 256B.37, subdivision 5, is amended to read:

Subd. 5. **PRIVATE BENEFITS TO BE USED FIRST.** Private accident and health care coverage including Medicare for medical services is primary coverage and must be

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exhausted before medical assistance is paid for medical services including home health care, personal care assistant services, hospice, or services covered under a Health Care Financing Administration (HCFA) waiver. When a person who is otherwise eligible for medical assistance has private accident or health care coverage, including Medicare or a prepaid health plan, the private health care benefits available to the person must be used first and to the fullest extent.

Sec. 33. Minnesota Statutes 1995 Supplement, section 256B.69, subdivision 3a, is amended to read:

Subd. 3a. **COUNTY AUTHORITY.** (a) The commissioner, when implementing the general assistance medical care, or medical assistance prepayment program within a county, must include the county board in the process of development, approval, and issuance of the request for proposals to provide services to eligible individuals within the proposed county. County boards must be given reasonable opportunity to make recommendations regarding the development, issuance, review of responses, and changes needed in the request for proposals. The commissioner must provide county boards the opportunity to review each proposal based on the identification of community needs under chapters 145A and 256E and county advocacy activities. If a county board finds that a proposal does not address certain community needs, the county board and commissioner shall continue efforts for improving the proposal and network prior to the approval of the contract. The county board shall make recommendations regarding the approval of local networks and their operations to ensure adequate availability and access to covered services. The provider or health plan must respond directly to county advocates and the state prepaid medical assistance ombudsperson regarding service delivery and must be accountable to the state regarding contracts with medical assistance and general assistance medical care funds. The county board may recommend a maximum number of participating health plans after considering the size of the enrolling population; ensuring adequate access and capacity; considering the client and county administrative complexity; and considering the need to promote the viability of locally developed health plans. The commissioner in conjunction with the county board, shall actively seek to develop a mutually agreeable timetable prior to the development of the request for proposal, 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. At least 90 days before enrollment in the medical assistance and general assistance medical care prepaid programs begins in a county in which the prepaid programs have not been established, the commissioner shall provide a report to the chairs of senate and house committees having jurisdiction over state health care programs which verifies that the commissioner complied with the requirements for county involvement that are specified in this subdivision.

(b) The commissioner shall seek a federal waiver to allow a fee-for-service plan option to MinnesotaCare enrollees. The commissioner shall develop an increase of the premium fees required under section 256.9356 up to 20 percent of the premium fees for the enrollees who elect the fee-for-service option. Prior to implementation, the commissioner shall submit this fee schedule to the chair and ranking minority member of the senate health care committee, the senate health care and family services funding division, the house of representatives health and human services committee, and the house of representatives health and human services finance division.

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Sec. 34. Minnesota Statutes 1995 Supplement, section 256B.69, subdivision 4, is amended to read:

Subd. 4. **LIMITATION OF CHOICE.** The commissioner shall develop criteria to determine when limitation of choice may be implemented in the experimental counties. The criteria shall ensure that all eligible individuals in the county have continuing access to the full range of medical assistance services as specified in subdivision 6. The commissioner shall exempt the following persons from participation in the project, in addition to those who do not meet the criteria for limitation of choice: (1) persons eligible for medical assistance according to section 256B.055, subdivision 1; (2) persons eligible for medical assistance due to blindness or disability as determined by the social security administration or the state medical review team, unless: (i) they are 65 years of age or older, or (ii) they are eligible for medical assistance according to section 256B.055, subdivision 12, or (iii) unless they reside in Itasca county or they reside in a county in which the commissioner conducts a pilot project under a waiver granted pursuant to section 1115 of the Social Security Act; (3) recipients who currently have private coverage through a health maintenance organization; (4) recipients who are eligible for medical assistance by spending down excess income for medical expenses other than the nursing facility per diem expense; and (5) recipients who receive benefits under the Refugee Assistance Program, established under United States Code, title 8, section 1522(e); (6) children who are both determined to be severely emotionally disturbed and receiving case management services according to section 256B.0625, subdivision 20; and (7) adults who are both determined to be seriously and persistently mentally ill and received case management services according to section 256B.0625, subdivision 20. Children under age 21 who are in foster placement may enroll in the project on an elective basis. Individuals excluded under clauses (6) and (7) may choose to enroll on an elective basis. The commissioner may allow persons with a one-month spenddown who are otherwise eligible to enroll to voluntarily enroll or remain enrolled, if they elect to prepay their monthly spenddown to the state. Beginning on or after July 1, 1997, the commissioner may require those individuals to enroll in the prepaid medical assistance program who otherwise would have been excluded under clauses (1) and (3) and under Minnesota Rules, part 9500.1452, subpart 2, items H, K, and L. Before limitation of choice is implemented, eligible individuals shall be notified and after notification, shall be allowed to choose only among demonstration providers. The commissioner may assign an individual with private coverage through a health maintenance organization, to the same health maintenance organization for medical assistance coverage, if the health maintenance organization is under contract for medical assistance in the individual's county of residence. After initially choosing a provider, the recipient is allowed to change that choice only at specified times as allowed by the commissioner. If a demonstration provider ends participation in the project for any reason, a recipient enrolled with that provider must select a new provider but may change providers without cause once more within the first 60 days after enrollment with the second provider.

Sec. 35. Minnesota Statutes 1995 Supplement, section 256B.69, subdivision 5b, is amended to read:

Subd. 5b. **PROSPECTIVE REIMBURSEMENT RATES.** For prepaid medical assistance and general assistance medical care program contract rates set by the commissioner under subdivision 5 and effective on or after January 1, 1996 1997, through December 31, 1996 1998, capitation rates for nonmetropolitan counties shall on a weighted

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average be no less than 85 percent of the capitation rates for metropolitan counties, excluding Hennepin county.

Sec. 36. Minnesota Statutes 1995 Supplement, section 256B.69, subdivision 21, is amended to read:

Subd. 21. **PREPAYMENT COORDINATOR.** The local agency county board 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. 37. Minnesota Statutes 1994, section 256B.69, is amended by adding a subdivision to read:

Subd. 24. **SOCIAL SERVICE AND PUBLIC HEALTH COSTS.** The commissioner shall report on recommendations to the legislature by January 15, 1997, identifying county social services and public health administrative costs for each target population that should be excluded from the overall capitation rate.

Sec. 38. Minnesota Statutes 1995 Supplement, section 256D.02, subdivision 12a, is amended to read:

Subd. 12a. **RESIDENT.** (a) For purposes of eligibility for general assistance under section 256D.05, and ~~payments under section 256D.051 and general assistance medical care,~~ a "resident" is a person living in the state for at least 30 days with the intention of making the person's home here and not for any temporary purpose. All applicants for these programs are required to demonstrate the requisite intent and can do so in any of the following ways:

(1) by showing that the applicant maintains a residence at a verified address, other than a place of public accommodation. An applicant may verify a residence address by presenting a valid state driver's license, a state identification card, a voter registration card, a rent receipt, a statement by the landlord, apartment manager, or homeowner verifying that the individual is residing at the address, or other form of verification approved by the commissioner; or

(2) by providing written documentation verifying residence in accordance with Minnesota Rules, part 9500.1219, subpart 3, item (c).

(b) An applicant who has been in the state for less than 30 days shall be considered a resident if the applicant can provide documentation:

(1) that the applicant came to was born in the state in response to an offer of employment;

(3) by providing verification (2) that the applicant has been a long-time resident of the state or was formerly a resident of the state for at least 365 days and is returning to the state from a temporary absence, as those terms are defined in rules to be adopted by the commissioner;

(3) that the applicant has come to the state to join a close relative which, for purposes of this subdivision, means a parent, grandparent, brother, sister, spouse, or child; or

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(4) by providing other persuasive evidence to show that the applicant is a resident of the state, according to rules adopted by the commissioner that the applicant has come to this state to accept a bona fide offer of employment for which the applicant is eligible.

A county agency shall waive the 30-day residency requirement in cases of emergencies, including medical emergencies, or where unusual hardship would result from denial of general assistance medical care. A county may waive the 30-day residency requirement in cases of emergencies, including medical emergencies, or where unusual hardship would result from denial of general assistance. The county agency must report to the commissioner within 30 days on any waiver granted under this section. The county shall not deny an application solely because the applicant does not meet at least one of the criteria in this subdivision, but shall continue to process the application and leave the application pending until the residency requirement is met or until eligibility or ineligibility is established.

Sec. 39. Minnesota Statutes 1995 Supplement, section 256D.045, is amended to read:

256D.045 SOCIAL SECURITY NUMBER REQUIRED.

To be eligible for general assistance under sections 256D.01 to 256D.21, an individual must provide the individual's social security number to the county agency or submit proof that an application has been made. The provisions of this section do not apply to the determination of eligibility for emergency general assistance under section 256D.06, subdivision 2. This provision applies to eligible children under the age of 18 effective July 1, 1997.

Sec. 40. Minnesota Statutes 1994, section 256G.01, subdivision 3, is amended to read:

Subd. 3. PROGRAM COVERAGE. This chapter applies to all social service programs administered by the commissioner in which residence is the determining factor in establishing financial responsibility. These include, but are not limited to: aid to families with dependent children; medical assistance; general assistance; work readiness; general assistance medical care; Minnesota supplemental aid; commitment proceedings, including voluntary admissions; emergency holds; poor relief funded wholly through local agencies; and social services, including title XX, IV-E and other components of the community social services act, sections 256E.01 to 256E.12; social services programs funded wholly through the resources of county agencies; social services provided under the Minnesota Indian family preservation act, sections 257.35 to 257.356; costs for delinquency confinement under section 393.07, subdivision 2; service responsibility for these programs; and group residential housing.

Sec. 41. Minnesota Statutes 1994, section 256G.01, is amended by adding a subdivision to read:

Subd. 4. ADDITIONAL COVERAGE. The provisions in sections 256G.02, subdivision 4, paragraphs (a) to (d); 256G.02, subdivisions 5 to 8; 256G.03; 256G.04; 256G.05; and 256G.07, subdivisions 1 to 3, apply to the following programs: aid to families with dependent children; medical assistance; general assistance; family general assistance; general assistance medical care; and Minnesota supplemental aid.

Sec. 42. Minnesota Statutes 1994, section 256G.01, is amended by adding a subdivision to read:

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Subd. 5. SCOPE AND EFFECT. Unless stated otherwise, the provisions of this chapter also apply to disputes involving financial responsibility for social services when another definition of the county of financial responsibility has been created in Minnesota Statutes.

Sec. 43. Minnesota Statutes 1994, section 256G.02, subdivision 4, is amended to read:

Subd. 4. **COUNTY OF FINANCIAL RESPONSIBILITY.** (a) "County of financial responsibility" has the meanings in paragraphs (b) to (h).

(b) For an applicant who resides in the state and is not in a facility described in subdivision 6, it means the county in which the applicant resides at the time of application.

(c) For an applicant who resides in a facility described in subdivision 6, it means the county in which the applicant last resided in nonexcluded status immediately before entering the facility.

(d) For an applicant who has not resided in this state for any time other than the excluded time, and subject to the limitations in section 256G.03, subdivision 2, it means the county in which the applicant resides at the time of making application.

(e) ~~For medical assistance purposes only, and for an infant who has resided only in an excluded time facility, it means the county that would have been responsible for the infant if eligibility had been established, based on that of the birth mother, at the time of application.~~

(f) ~~Notwithstanding paragraphs (b) to (d), the county of financial responsibility for medical assistance recipients is the county from which a recipient is receiving a maintenance grant or money payment under the program of aid to families with dependent children or Minnesota supplemental aid.~~

(g) ~~Notwithstanding paragraphs (b) to (f), the county of financial responsibility for social services for a person receiving aid to families with dependent children, general assistance, general assistance medical care, medical assistance, or Minnesota supplemental aid is the county from which that person is receiving the aid or assistance. If more than one named program is open concurrently For an individual already having a social service case open in one county, financial responsibility for any additional social services attaches to the program case that has the earliest date of application and has been open without interruption.~~

(h) ~~(f)~~ Notwithstanding paragraphs (b) to ~~(g)~~ (e), the county of financial responsibility for semi-independent living services provided under section 252.275, and Minnesota Rules, parts 9525.0500 to 9525.0660, is the county of residence in nonexcluded status immediately before the placement into or request for those services.

Sec. 44. Minnesota Statutes 1994, section 256G.02, subdivision 6, is amended to read:

Subd. 6. **EXCLUDED TIME.** "Excluded time" means:

(a) any period an applicant spends in a hospital, sanitarium, nursing home, shelter other than an emergency shelter, halfway house, foster home, semi-independent living domicile or services program, residential facility offering care, board and lodging facility

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or other institution for the hospitalization or care of human beings, as defined in section 144.50, 144A.01, or 245A.02, subdivision 14; or in a maternity home, battered women's shelter, or correctional facility, "Excluded time" also means that time during which an applicant participates in a rehabilitation facility as defined in section 268A.01, or is receiving personal care assistant services pursuant to section 256B.0625, subdivision 19.; or any facility based on an emergency hold under sections 253B.05, subdivisions 1 and 2, and 253B.07, subdivision 6;

(b) any period an applicant spends on a placement basis in a training and habilitation program, including a rehabilitation facility or work or employment program as defined in section 268A.01; or receiving personal care assistant services pursuant to section 256B.0627, subdivision 4; semi-independent living services provided under section 252.275, and Minnesota Rules, parts 9525.0500 to 9525.0660; day training and habilitation programs, and community-based services and assisted living services; and

(c) any placement for a person with an indeterminate commitment, including independent living.

Sec. 45. Minnesota Statutes 1994, section 256G.03, is amended to read:

256G.03 ESTABLISHING RESIDENCE.

Subdivision 1. **STATE RESIDENCE.** For purposes of this chapter, a resident of any Minnesota county is considered a state resident. For purposes of eligibility for general assistance or work readiness, residency must be substantiated according to section 256D.02, subdivision 12a.

Subd. 2. **NO DURATIONAL TEST.** Except as otherwise provided in sections 256.73, subdivisions 1 and 1b; 256B.056, subdivision 1; and 256D.02, subdivision 12a, for purposes of this chapter, no waiting period is required before securing county or state residence. A person cannot, however, gain residence while physically present in an excluded time facility unless otherwise specified in this chapter or in a federal regulation controlling a federally funded human service program.

Subd. 3. **USE OF CODE OF FEDERAL REGULATIONS.** In the event that federal legislation eliminates the federal regulatory basis for medical assistance, the state shall continue to determine eligibility for Minnesota's medical assistance program using the provisions of Code of Federal Regulations, title 42, as construed on the day prior to their federal repeal, except as expressly superseded in chapter 256B, or as superseded by federal law, or as modified by state rule or by regulatory waiver granted to the state.

Sec. 46. Minnesota Statutes 1994, section 256G.06, is amended to read:

256G.06 DETOXIFICATION SERVICES.

The county of financial responsibility for detoxification services is the county where the client is physically present when the need for services is identified. If that need is identified while the client is a resident of a chemical dependency facility, the provisions of section 256G.02, subdivision 4, paragraphs ~~(b)~~, (c), and ~~(e)~~ (d), apply.

Sec. 47. Minnesota Statutes 1994, section 256G.07, subdivision 1, is amended to read:

Subdivision 1. **EFFECT OF MOVING.** Except as provided in subdivision 4, a person who has applied for and is receiving services or assistance under a program governed

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by this chapter, in any county in this state, and who moves to another county in this state, is entitled to continue to receive that ~~assistance service~~ service from the county from which that person has moved until that person has resided in ~~nonexcluded~~ nonexcluded status for two full calendar months in the county to which that person has moved. ~~For purposes of general assistance and general assistance medical care, this time period is, however, one full calendar month.~~

Sec. 48. Minnesota Statutes 1994, section 256G.07, subdivision 2, is amended to read:

Subd. 2. **TRANSFER OF RECORDS.** Before the person has resided in nonexcluded status for two calendar months ~~or one calendar month in the case of general assistance and general assistance medical care~~, in the county to which that person has moved, the local agency of the county from which the person has moved shall complete an eligibility review and transfer all necessary records relating to that person to the local agency of the county to which the person has moved.

Sec. 49. Minnesota Statutes 1994, section 256G.08, subdivision 1, is amended to read:

Subdivision 1. **COMMITMENTS COMMITMENT ACT PROCEEDINGS.** In cases of voluntary admission or commitment to state or other institutions, the committing county shall initially pay for all costs. This includes the expenses of the taking into custody, confinement, emergency holds under sections 253B.05, subdivisions 1 and 2, and 253B.07, examination, commitment, conveyance to the place of detention, and rehearing.

Sec. 50. Minnesota Statutes 1994, section 256G.09, subdivision 2, is amended to read:

Subd. 2. **FINANCIAL DISPUTES.** (a) If the county receiving the transmittal does not believe it is financially responsible, it should provide to the department and the initially responsible county a statement of all facts and documents necessary for the department to make the requested determination of financial responsibility. The submission must clearly state the program area in dispute and must state the specific basis upon which the submitting county is denying financial responsibility.

(b) The initially responsible county then has 15 calendar days to submit its position and any supporting evidence to the department. The absence of a submission by the initially responsible county does not limit the right of the department to issue a binding opinion based on the evidence actually submitted.

(c) A case must not be submitted until the local agency taking the application or making the commitment has made an initial determination about eligibility and financial responsibility, and services ~~or assistance~~ has ~~have~~ been initiated. This paragraph does not prohibit the submission of closed cases that otherwise meet the applicable statute of limitations.

Sec. 51. Minnesota Statutes 1994, section 256G.10, is amended to read:

256G.10 DERIVATIVE SETTLEMENT ELIMINATED.

~~Except as described in section 256G.02, subdivision 4, paragraph (e), residence under this chapter must be determined independently for each applicant.~~ The residence of

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the parent of a minor child, with whom that child last lived in a nonexcluded time setting, or guardian ~~does not of a ward shall determine the residence of the child or ward for all social services governed by this chapter.~~

For purposes of this chapter, a minor child is defined as being under 18 years of age unless otherwise specified in a program administered by the commissioner.

Physical or legal custody has no bearing on residence determinations. This section does not, however, apply to situations involving another state or, limit the application of an interstate compact, or apply to situations involving state wards where the commissioner is defined by law as the guardian.

Sec. 52. Minnesota Statutes 1994, section 256I.05, is amended by adding a subdivision to read:

Subd. 7c. DEMONSTRATION PROJECT. The commissioner is authorized to pursue a demonstration project under federal food stamp regulation for the purpose of gaining federal reimbursement of food and nutritional costs currently paid by the state group residential housing program.

Sec. 53. Minnesota Statutes 1994, section 325F.71, subdivision 2, is amended to read:

Subd. 2. **SUPPLEMENTAL CIVIL PENALTY.** (a) In addition to any liability for a civil penalty pursuant to Minnesota Statutes, sections 325D.43 to 325D.48, regarding deceptive trade practices; 325F.67, regarding false advertising; and 325F.68 to 325F.70, regarding consumer fraud; a person who engages in any conduct prohibited by those statutes, and whose conduct is perpetrated against one or more senior citizens or handicapped persons, is liable for an additional civil penalty not to exceed \$10,000 for each violation, if one or more of the factors in paragraph (b) are present.

(b) In determining whether to impose a civil penalty pursuant to paragraph (a), and the amount of the penalty, the court shall consider, in addition to other appropriate factors, the extent to which one or more of the following factors are present:

(1) whether the defendant knew or should have known that the defendant's conduct was directed to one or more senior citizens or handicapped persons;

(2) whether the defendant's conduct caused senior citizens or handicapped persons to suffer: loss or encumbrance of a primary residence, principal employment, or source of income; substantial loss of property set aside for retirement or for personal or family care and maintenance; substantial loss of payments received under a pension or retirement plan or a government benefits program; or assets essential to the health or welfare of the senior citizen or handicapped person;

(3) whether one or more senior citizens or handicapped persons are more vulnerable to the defendant's conduct than other members of the public because of age, poor health or infirmity, impaired understanding, restricted mobility, or disability, and actually suffered physical, emotional, or economic damage resulting from the defendant's conduct; or

(4) whether the defendant's conduct caused senior citizens or handicapped persons to make an uncompensated asset transfer that resulted in the person being found ineligible for medical assistance.

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Sec. 54. Minnesota Statutes 1994, section 524.2-403, is amended to read:

524.2-403 EXEMPT PROPERTY.

(a) If there is a surviving spouse, then, in addition to the homestead and family allowance, the surviving spouse is entitled from the estate to:

(1) property not exceeding \$10,000 in value in excess of any security interests there-in, in household furniture, furnishings, appliances, and personal effects, subject to an award of sentimental value property under section 525.152; and

(2) one automobile, if any, without regard to value.

(b) If there is no surviving spouse, the decedent's children are entitled jointly to the same property as provided in paragraph (a).

(c) If encumbered chattels are selected and the value in excess of security interests, plus that of other exempt property, is less than \$10,000, or if there is not \$10,000 worth of exempt property in the estate, the surviving spouse or children are entitled to other personal property of the estate, if any, to the extent necessary to make up the \$10,000 value.

(d) Rights to exempt property and assets needed to make up a deficiency of exempt property have priority over all claims against the estate, but the right to any assets to make up a deficiency of exempt property abates as necessary to permit earlier payment of the family allowance.

(e) The rights granted by this section are in addition to any benefit or share passing to the surviving spouse or children by the decedent's will, unless otherwise provided by in-estate succession or by way of elective share.

(f) A claim under section 246.53, 261.04, 256B.15, or 256D.16 takes precedence over any rights granted to a decedent's adult children under this section.

Sec. 55. Minnesota Statutes 1994, section 524.3-801, is amended to read:

524.3-801 NOTICE TO CREDITORS.

(a) Unless notice has already been given under this section, upon appointment of a general personal representative in informal proceedings or upon the filing of a petition prescribed by court rule, shall be given under the direction of the court administrator by publication once a week for two successive weeks in a legal newspaper in the county wherein the proceedings are pending giving the name and address of the general personal representative and notifying creditors of the estate to present their claims within four months after the date of the court administrator's notice which is subsequently published or be forever barred, unless they are entitled to further service of notice under paragraph (b) or (c).

(b)(1) Within three months after: (i) the date of the first publication of the notice; or (ii) June 16, 1989, whichever is later, the personal representative may determine, in the personal representative's discretion, that it is or is not advisable to conduct a reasonably diligent search for creditors of the decedent who are either not known or not identified. If the personal representative determines that a reasonably diligent search is advisable, the personal representative shall conduct the search.

(2) If the notice is first published after June 16, 1989, the personal representative shall, within three months after the date of the first publication of the notice, serve a copy of the notice upon each then known and identified creditor in the manner provided in paragraph (c). If the decedent or a predeceased spouse of the decedent received assistance for which a claim could be filed under section 246.53, 256B.15, 256D.16, or 261.04, the personal representative shall serve a copy of the notice on the commissioner of human services in the manner provided in paragraph (c) on or before the date of the first publication of the notice. The copy of the notice served on the commissioner of human services shall include the full name, date of birth, and social security number of the decedent or the predeceased spouse who received assistance for which a claim could be filed under any of the sections listed in this paragraph. Notwithstanding any will or other instrument or law to the contrary, except as allowed in this paragraph no property subject to administration by the estate may be distributed by the estate or the personal representative until 70 days after the date the notice is served upon the commissioner, as provided in paragraph (c) unless the local agency consents. An affidavit of service shall be prima facie evidence of service and, if it contains a legal description of the affected real property, may be filed or recorded in the office of the county recorder or registrar of titles to establish compliance with the notice requirement established in this paragraph. This restriction on distribution does not apply to the personal representative's sale of real or personal property while the estate is open but does apply to the net proceeds the estate receives from the sale. If notice was first published under the applicable provisions of law under the direction of the court administrator before June 16, 1989, and if a personal representative is empowered to act at any time after June 16, 1989, the personal representative shall, within three months after June 16, 1989, serve upon the then known and identified creditors in the manner provided in paragraph (c) a copy of the notice as published, together with a supplementary notice requiring each of the creditors to present any claim within one month after the date of the service of the notice or be forever barred.

(3) Under this section, a creditor is "known" if: (i) the personal representative knows that the creditor has asserted a claim that arose during the decedent's life against either the decedent or the decedent's estate; or (ii) the creditor has asserted a claim that arose during the decedent's life and the fact is clearly disclosed in accessible financial records known and available to the personal representative. Under this section, a creditor is "identified" if the personal representative's knowledge of the name and address of the creditor will permit service of notice to be made under paragraph (c).

(c) The personal representative shall serve a copy of any notice and any supplementary notice required by paragraph (b), clause (1) or (2), upon each creditor of the decedent who is then known to the personal representative and identified, except a creditor whose claim has either been presented to the personal representative or paid, either by delivery of a copy of the required notice to the creditor, or by mailing a copy of the notice to the creditor by certified, registered, or ordinary first class mail addressed to the creditor at the creditor's office or place of residence.

Sec. 56. INDIVIDUAL COMPULSIVE GAMBLING TREATMENT PILOT PROJECT.

Subdivision 1. ESTABLISHMENT. The commissioner of human services shall establish a pilot project in the southeast area of the state to provide compulsive gambling treatment services to individuals seeking treatment. The pilot project shall directly reim-

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burse qualified providers for treatment to individuals on a case-by-case basis. The pilot project shall seek to utilize existing qualified providers and shall provide treatment reimbursement to the maximum number of persons who qualify for treatment.

Subd. 2. PLAN. The commissioner shall submit to the legislature by December 15, 1996, a plan for expansion of the treatment pilot project to all areas of the state. The plan shall include the necessary legislative changes needed to move from a treatment center model to a provider reimbursement model.

Sec. 57. REPORT ON COMPENSATING CLIENTS ON PUBLIC HEALTH CARE PROGRAMS.

The commissioner of human services shall study and report to the legislature by January 15, 1997, the advisability and feasibility of compensating clients on the public health care programs if a client has successfully reversed a private insurer's denial of health insurance. The report shall also include recommendations on reducing the parental fees under Minnesota Statutes, section 252.27, subdivision 2a, if a parent has successfully reversed a private insurer's denial of insurance. The commissioner shall ask clients, advocates, other interested persons, and the parental fee advisory committee to assist with the study.

Sec. 58. WAIVER AUTHORITY.

The commissioner of human services shall seek federal waivers as necessary to implement section 8.

Sec. 59. SEVERABILITY.

If any provision of sections 8 and 39 are found to be unconstitutional or void by a court of competent jurisdiction, all remaining provisions of the law shall remain valid and shall be given full effect.

Sec. 60. AUGMENTATIVE COMMUNICATION DEVICES.

Augmentative communication devices that are prior authorized through pass through vendors during the period July 1, 1995, to December 31, 1996, and have not been delivered shall be paid under the medical assistance program at the actual price charged the pass through vendor for the device as limited to the suggested retail price on March 1, 1996. For retroactive periods in which a state plan had not been submitted to reflect this payment, the state shall not seek a federal share. The governor's advisory council on technology for people with disabilities, in consultation with the commissioner of human services, shall study alternatives to this payment approach and make recommendations to the legislature by December 31, 1996, related to effective methods of cost control and the following:

(1) comparative payment equity between augmentative communication device vendors and other provider groups that provide equipment to medical assistance recipients;

(2) methods, including competitive bidding, that create incentives for dealers and manufacturers to provide augmentative communication devices at a price that is discounted from retail;

(3) substitution between augmentative communication devices and alternative methods of access by recipients to augmentative communication devices; and

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(4) payment equity between pass through vendors and distributors of augmentative communication devices.

Sec. 61. REPEALER.

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

Sec. 62. EFFECTIVE DATE; APPLICATION.

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

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

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

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

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

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

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

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ARTICLE 3

LONG-TERM CARE

Section 1. Minnesota Statutes 1995 Supplement, 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;

(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; or

(e) to certify four existing beds in a facility in Winona with 139 beds, of which 129 beds are certified.

Sec. 2. Minnesota Statutes 1995 Supplement, 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.

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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

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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

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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, 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

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improvements in a nursing home that, as of January 1, 1994, met the following conditions: the nursing home was located in Ramsey county; was not owned by a hospital corporation; had a licensed capacity of 64 beds; and had been ranked among the top 15 applicants by the 1993 moratorium exceptions advisory review panel. The total project construction cost estimate for this project must not exceed the cost estimate submitted in connection with the 1993 moratorium exception process;

(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 2j, shall be the same as it was prior to relocation. The nursing facility's property-related payment rate resulting from the project authorized in this paragraph shall become effective no earlier than April 1, 1996. For purposes of calculating the incremental change in the facility's rental per diem resulting from this project, the allowable appraised value of the nursing facility portion of the existing health care facility physical plant prior to the renovation and relocation may not exceed \$2,490,000;

(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

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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; or

(w) to relocate 36 beds in Crow Wing county and four beds from Hennepin county to a 160-bed facility in Crow Wing county, provided all the affected beds are under common ownership.

Sec. 3. Minnesota Statutes 1995 Supplement, section 256B.431, subdivision 25, is amended to read:

Subd. 25. **CHANGES TO NURSING FACILITY REIMBURSEMENT BEGINNING JULY 1, 1995.** The nursing facility reimbursement changes in paragraphs (a) to ~~(g)~~ (h) 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 diem 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

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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

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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 standard 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 clauses (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.

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(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).

(h) A nursing facility licensed for 302 beds on September 30, 1993, that was approved under the moratorium exception process in section 144A.073 for a partial replacement, and completed the replacement project in December 1994, is exempt from paragraphs (b) to (d) for rate years beginning on or after July 1, 1995.

(i) Notwithstanding section 11, paragraph (h), for the rate years beginning on July 1, 1996, July 1, 1997, and July 1, 1998, a nursing facility licensed for 40 beds effective May 1, 1992, with a subsequent increase of 20 Medicare/Medicaid certified beds, effective January 26, 1993, in accordance with an increase in licensure is exempt from paragraphs (b) to (d).

Sec. 4. Minnesota Statutes 1995 Supplement, section 256B.501, subdivision 5b, is amended to read:

Subd. 5b. ICF/MR OPERATING COST LIMITATION AFTER SEPTEMBER 30, 1995. (a) For the rate years year beginning on October 1, 1995, and ~~October 1, 1996~~ and for rate years beginning on or after October 1, 1997, 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

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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.

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(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). Facilities that have undergone a class A to class B conversion since January 1, 1990, are exempt from the limitations in this clause for six years after the completion of the conversion process.

(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).

(g) For the rate year beginning on October 1, 1996, the commissioner shall exempt a facility from the reductions in this subdivision if the facility is involved in a bed relocation project where more than 25 percent of the facility's beds are transferred to another facility, the relocated beds are six or fewer, there is no change in the total number of ICF/MR beds for the parent organization of the facility, and the relocation is not part of an interim or settle-up rate.

Sec. 5. Minnesota Statutes 1995 Supplement, section 256B.501, subdivision 5c, is amended to read:

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Subd. 5c. **OPERATING COSTS AFTER SEPTEMBER 30, 1997 1999.** (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~~ may 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. The commissioner may also consider the findings of projects examining services to persons with developmental disabilities, including outcome-based quality assurance methods, and the inclusion of persons with developmental disabilities in managed care alternative service delivery models.

(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~~ 1998, 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~~ 1999.

(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~~ 1998. By January 15, ~~1997~~ 1999, 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~~ 1999.

Sec. 6. Minnesota Statutes 1994, section 256B.501, is amended by adding a subdivision to read:

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Subd. 5d. **ADJUSTMENT FOR OUTREACH CRISIS SERVICES.** An ICF/MR with crisis services developed under the authority of Laws 1992, chapter 513, article 9, section 40, shall have its operating cost per diem calculated according to paragraphs (a) and (b).

(a) Effective for services rendered from April 1, 1996, to September 30, 1996, and for rate years beginning on or after October 1, 1996, the maintenance limitation in Minnesota Rules, part 9553.0050, subpart 1, item A, subitem (2), shall be calculated to reflect capacity as of October 1, 1992. The maintenance limit shall be the per diem limitation otherwise in effect adjusted by the ratio of licensed capacity days as of October 1, 1992, divided by resident days in the reporting year ending December 31, 1993.

(b) Effective for rate years beginning on or after October 1, 1996, the operating cost per service unit, for purposes of the cost per service unit limit in section 256B.501, subdivision 5b, paragraph (d), clauses (7) and (8), shall be calculated after excluding the costs directly identified to the provision of outreach crisis services and a four-bed crisis unit.

(c) The efficiency incentive paid to an ICF/MR shall not be increased as a result of this subdivision.

Sec. 7. Minnesota Statutes 1994, section 256B.501, is amended by adding a subdivision to read:

Subd. 5e. **RATE ADJUSTMENT FOR CARE PROVIDED TO A MEDICALLY FRAGILE INDIVIDUAL.** Beginning July 1, 1996, the commissioner shall increase reimbursement rates for a facility located in Chisholm and licensed as an intermediate care facility for persons with mental retardation and related conditions since 1972, to cover the cost to the facility for providing 24-hour licensed practical nurse care to a medically fragile individual admitted on March 8, 1996. The commissioner shall include in this higher rate a temporary adjustment to reimburse the facility for costs incurred between March 8, 1996, and June 30, 1996. Once this resident is discharged, the commissioner shall reduce the facility's payment rate by the amount of the cost of the 24-hour licensed practical nurse care.

Sec. 8. Minnesota Statutes 1994, section 256I.05, subdivision 1c, is amended to read:

Subd. 1c. **RATE INCREASES.** A county agency may not increase the rates negotiated for group residential housing above those in effect on June 30, 1993, except: as provided in paragraphs (a) to (g).

(a) A county may increase the rates for group residential housing settings to the MSA equivalent rate for those settings whose current rate is below the MSA equivalent rate.

(b) A county agency may increase the rates for residents in adult foster care whose difficulty of care has increased. The total group residential housing rate for these residents must not exceed the maximum rate specified in subdivisions 1 and 1a. County agencies must not include nor increase group residential housing difficulty of care rates for adults in foster care whose difficulty of care is eligible for funding by home and community-based waiver programs under title XIX of the Social Security Act.

(c) The room and board rates will be increased each year when the MSA equivalent rate is adjusted for SSI cost-of-living increases by the amount of the annual SSI increase,

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less the amount of the increase in the medical assistance personal needs allowance under section 256B.35.

(d) When a group residential housing rate is used to pay for an individual's room and board, or other costs necessary to provide room and board, the rate payable to the residence must continue for up to 18 calendar days per incident that the person is temporarily absent from the residence, not to exceed 60 days in a calendar year, if the absence or absences have received the prior approval of the county agency's social service staff. Prior approval is not required for emergency absences due to crisis, illness, or injury.

(e) For facilities meeting substantial change criteria within the prior year. Substantial change criteria exists if the group residential housing establishment experiences a 25 percent increase or decrease in the total number of its beds, if the net cost of capital additions or improvements is in excess of 15 percent of the current market value of the residence, or if the residence physically moves, or changes its licensure, and incurs a resulting increase in operation and property costs.

(f) Until June 30, 1994, a county agency may increase by up to five percent the total rate paid for recipients of assistance under sections 256D.01 to 256D.21 or 256D.33 to 256D.54 who reside in residences that are licensed by the commissioner of health as a boarding care home, but are not certified for the purposes of the medical assistance program. However, an increase under this clause must not exceed an amount equivalent to 65 percent of the 1991 medical assistance reimbursement rate for nursing home resident class A, in the geographic grouping in which the facility is located, as established under Minnesota Rules, parts 9549.0050 to 9549.0058.

(g) For the rate year beginning July 1, 1996, a county agency may increase the total rate paid for recipients of assistance under sections 256D.01 to 256D.21 or 256D.33 to 256D.54 who reside in a residence that meets the following criteria:

- (1) it is licensed by the commissioner of health as a boarding care home;
- (2) it is not certified for the purposes of the medical assistance program;
- (3) at least 50 percent of its residents have a primary diagnosis of mental illness;
- (4) it has at least 17 beds; and
- (5) it provides medication administration to residents.

The rate following an increase under this paragraph must not exceed an amount equivalent to the average 1995 medical assistance payment for nursing home resident class A under the age of 65, in the geographic grouping in which the facility is located, as established under Minnesota Rules, parts 9549.0010 to 9549.0080.

Sec. 9. **VENDOR RATE ADJUSTMENT.**

Notwithstanding the requirements of Minnesota Statutes, section 252.46, subdivisions 3 and 6, the commissioner of human services shall, at the request of the responsible board of county commissioners and subject to conditions the commissioner finds appropriate consistent with the service principles in Minnesota Statutes, section 252.42, grant a variance to the payment rate for vendors defined in Minnesota Statutes, section 252.41, subdivision 9, and located in Hennepin county that serve persons with very severe self-injurious or assaultive behavior, as those terms are used in Minnesota Statutes, section 252.46, subdivision 4, paragraph (b). The adjusted rate shall:

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- (1) be limited to provisions of services to no more than 42 such persons;
- (2) not exceed 200 percent of the statewide average rate as calculated in accordance with Minnesota Statutes, section 252.46, subdivision 4, paragraph (b);
- (3) become effective July 1, 1996; and
- (4) be used as the basis for calculating the rate maximum for that vendor for calendar year 1997 in accordance with the requirements of Minnesota Statutes, section 252.46, subdivision 3.

Sec. 10. **DOWNSIZING PILOT PROJECT.**

(a) The commissioner of human services shall establish a pilot project in Pennington county to downsize to 11 beds an existing 15-bed intermediate care facility for persons with mental retardation or related conditions, and develop a four-bed supportive living service facility utilizing the conversion of ICF/MR slots to medical assistance waiver conversion slots for the displaced residents. The project must be approved by the commissioner under Minnesota Statutes, section 252.28, and must include criteria for determining how individuals are selected for alternative services and the use of a request for proposal process in selecting the vendors for alternative services. The project must include:

- (1) alternative services for the residents being relocated;
- (2) timelines for resident relocation and decertification of beds; and
- (3) adjustment of the facility's operating cost rate under Minnesota Rules, part 9553.0075, as necessary to implement the project.

(b) The facility's aggregate investment-per-bed limit in effect before downsizing must be the facility's investment-per-bed limit after downsizing. The facility's total revenues after downsizing must not increase as a result of the downsizing project. The facility's total revenues before downsizing are determined by multiplying the payment rate in effect the day before the downsizing is effective by the number of resident days for the reporting year preceding the downsizing project. For the purpose of this project, the average medical assistance rate for home and community-based services must not exceed the rate made available under Laws 1995, chapter 207, article 8, section 34.

Sec. 11. **NURSING FACILITY REIMBURSEMENT FOR FISCAL YEAR 1997.**

(a) Notwithstanding any contrary provisions of Minnesota Statutes, section 256B.431, subdivision 25, the provisions of this section shall apply for the rate year beginning July 1, 1996.

(b) The commissioner of human services 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 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

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exclude the raw food cost per diem related to providing special diets that are based on religious beliefs, as determined in Minnesota Statutes, section 256B.431, subdivision 2b, paragraph (h). For those nursing facilities in each grouping whose case mix A operating cost per diem:

(1) is at or above the median plus 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 (d), or the current reporting year's corresponding allowable operating cost per diem;

(2) is between .5 standard deviation and 1.0 standard deviation above 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 (d), increase by one percentage point, or the current reporting year's corresponding allowable operating cost per diem; or

(3) is equal to or below .5 standard deviation above 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 (d), increased by two percentage points, or the current reporting year's corresponding allowable operating cost per diem.

(c) For the rate year beginning July 1, 1996, the provisions of Minnesota Statutes, section 256B.431, subdivision 25, paragraph (d), shall not apply.

(d) For the rate year beginning July 1, 1996, the forecasted index for operating cost limits referred to in Minnesota Statutes, section 256B.431, subdivision 21, paragraph (b), shall be based on the change in the nursing home market basket as forecasted by Data Resources Inc., for the 12-month period between the midpoints of the two reporting years preceding the rate year.

(e) For the rate year beginning July 1, 1996, the operating cost limits established in Minnesota Statutes, section 256B.431, subdivisions 2b, 2i, and 3c, and any previously effective corresponding limits in law or rule shall not apply, except that these cost limits shall still be calculated for purposes of determining efficiency incentive per diems.

(f) For the rate year beginning July 1, 1996, the commissioner shall exempt all rule 80 facilities from any limits described in Minnesota Statutes, section 256B.431, subdivision 25, paragraph (b), clause (2), that affect care-related operating per diems. For the rate year beginning July 1, 1996, the operating cost per diem referred to in paragraph (b), clause (2), is the sum of the care-related and other operating cost per diems for a given case mix class.

(g) Any reductions to the combined operating per diem shall be divided proportionately between the care-related and other operating per diems.

(h) Notwithstanding paragraphs (a) to (f), the commissioner must also compute nursing facility payment rates based on the laws in effect on March 1, 1996, and use the resulting allowable care-related and other operating cost per diems as the basis for the spend-up limits for the rate year beginning July 1, 1997.

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Sec. 12. ICF/MR REIMBURSEMENT OCTOBER 1, 1996, TO OCTOBER 1, 1997.

(a) Notwithstanding any contrary provisions of Minnesota Statutes, section 256B.501, for the rate year beginning October 1, 1996, the commissioner of human services shall, for purposes of the spend-up limit, array facilities within each grouping in Minnesota Statutes, section 256B.501, subdivision 5b, paragraph (d), clause (4), by each facility's cost per resident day. A facility's cost per resident day shall be determined by dividing its allowable historical general operating cost for the reporting year by the facility's resident days for that reporting year. Facilities with a cost per resident day at or above the median shall be limited to the lesser of: (1) the current reporting year's cost per resident day; or (2) the prior reporting year's cost per resident day plus the inflation factor as established in Minnesota Statutes, section 256B.501, subdivision 3c, clause (2), increased by three percentage points. However, in no case shall the amount of this reduction exceed: three percent for a facility with a licensed capacity greater than 16 beds; two percent for a facility with a licensed capacity of nine to 16 beds; and one percent for a facility with a licensed capacity of eight or fewer beds.

(b) The commissioner must not apply the limits in Minnesota Statutes, section 256B.501, subdivision 5b, paragraph (d), clause (8), for the rate year beginning October 1, 1996.

(c) Notwithstanding paragraphs (a) and (b), the commissioner must also compute facility payment rates based on the laws in effect on March 1, 1996, and use the resulting allowable operating cost per diems as the basis for the spend-up limits for the rate year beginning October 1, 1997.

ARTICLE 4

**HEALTH DEPARTMENT AND
HEALTH PLAN REGULATIONS**

Section 1. [62J.69] MEDICAL EDUCATION AND RESEARCH TRUST FUND.

Subdivision 1. DEFINITIONS. For purposes of this section, the following definitions apply:

(a) "Medical education" means the accredited clinical training of physicians (medical students and residents), dentists, advanced practice nurses (clinical nurse specialist, certified registered nurse anesthetists, nurse practitioners, and certified nurse midwives), and physician assistants.

(b) "Clinical training" means accredited training that occurs in both inpatient and ambulatory care settings.

(c) "Trainee" means students involved in an accredited clinical training program for medical education as defined in paragraph (a).

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(d) "Health care research" means approved clinical, outcomes, and health services investigations that are funded by patient out-of-pocket expenses or a third-party payer.

(e) "Commissioner" means the commissioner of health.

(f) "Teaching institutions" means any hospital, medical center, clinic, or other organization that currently sponsors or conducts accredited medical education programs or clinical research in Minnesota.

Subd. 2. ALLOCATION AND FUNDING FOR MEDICAL EDUCATION AND RESEARCH. (a) The commissioner may establish a trust fund for the purposes of funding medical education and research activities in the state of Minnesota.

(b) By January 1, 1997, the commissioner may appoint an advisory committee to provide advice and oversight on the distribution of funds from the medical education and research trust fund. If a committee is appointed, the commissioner shall: (1) consider the interest of all stakeholders when selecting committee members; (2) select members that represent both urban and rural interest; and (3) select members that include ambulatory care as well as inpatient perspectives. The commissioner shall appoint to the advisory committee representatives of the following groups: medical researchers, public and private academic medical centers, managed care organizations, Blue Cross and Blue Shield of Minnesota, commercial carriers, Minnesota Medical Association, Minnesota Nurses Association, medical product manufacturers, employers, and other relevant stakeholders, including consumers. The advisory committee is governed by Minnesota Statutes, section 15.059, for membership terms and removal of members and will sunset on June 30, 1999.

(c) Eligible applicants for funds are accredited medical education teaching institutions, consortia, and programs. Applications must be received by September 30 of each year for distribution by January 1 of the following year. An application for funds must include the following:

(1) the official name and address of the institution, facility, or program that is applying for funding;

(2) the name, title, and business address of those persons responsible for administering the funds;

(3) the total number, type, and specialty orientation of eligible trainees in each accredited medical education program applying for funds;

(4) audited clinical training costs per trainee for each medical education program;

(5) a description of current sources of funding for medical education costs including a description and dollar amount of all state and federal financial support;

(6) other revenue received for the purposes of clinical training;

(7) a statement identifying unfunded costs; and

(8) other supporting information the commissioner, with advice from the advisory committee, determines is necessary for the equitable distribution of funds.

(d) The commissioner shall distribute medical education funds to all qualifying applicants based on the following basic criteria: (1) total medical education funds available;

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(2) total trainees in each eligible education program; and (3) the statewide average cost per trainee, by type of trainee, in each medical education program. Funds distributed shall not be used to displace current funding appropriations from federal or state sources.

(e) Medical education programs receiving funds from the trust fund must submit annual cost and program reports based on criteria established by the commissioner. The reports must include:

- (1) the total number of eligible trainees in the program;
- (2) the type of programs and residencies funded;
- (3) the average cost per trainee and a detailed breakdown of the components of those costs;
- (4) other state or federal appropriations received for the purposes of clinical training;
- (5) other revenue received for the purposes of clinical training; and
- (6) other information the commissioner, with advice from the advisory committee, deems appropriate to evaluate the effectiveness of the use of funds for clinical training.

The commissioner, with advice from the advisory committee, will provide an annual summary report to the legislature on program implementation due February 15 of each year.

(f) The commissioner is authorized to distribute funds made available through:

- (1) voluntary contributions by employers or other entities;
- (2) allocations for the department of human services to support medical education and research; and
- (3) other sources as identified and deemed appropriate by the legislature for inclusion in the trust fund.

(g) The advisory committee shall continue to study and make recommendations on:

- (1) the funding of medical research consistent with work currently mandated by the legislature and under way at the department of health; and
- (2) the costs and benefits associated with medical education and research.

Sec. 2. Minnesota Statutes 1995 Supplement, section 62Q.03, subdivision 8, is amended to read:

Subd. 8. **GOVERNANCE.** (a) The association shall be governed by an interim 19-member board as follows: one provider member appointed by the Minnesota Hospital Association; one provider member appointed by the Minnesota Medical Association; one provider member appointed by the governor; three members appointed by the Minnesota Council of HMOs to include an HMO with at least 50 percent of total membership enrolled through a public program; three members appointed by Blue Cross and Blue Shield of Minnesota, to include a member from a Blue Cross and Blue Shield of Minnesota affiliated health plan with fewer than 50,000 enrollees and located outside the Minneapolis-St. Paul metropolitan area; two members appointed by the Insurance Federation

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Joint Commission on Accreditation of Healthcare Organizations (JCAHO hospitals)	\$1,017
Non-JCAHO hospitals	\$762 plus \$34 per bed
Nursing home	\$78 plus \$19 per bed

For fiscal years 1996 and beyond, the commissioner shall set license fees for outpatient surgical centers, boarding care homes, and supervised living facilities at the following levels:

Outpatient surgical centers	\$517
Boarding care homes	\$78 plus \$19 per bed
Supervised living facilities	\$78 plus \$19 per bed.

(e) Unless prohibited by federal law, the commissioner of health shall charge applicants the following fees to cover the cost of any initial certification surveys required to determine a provider's eligibility to participate in the Medicare or Medicaid program:

<u>Prospective payment surveys for hospitals</u>	<u>\$ 900</u>
<u>Swing bed surveys for nursing homes</u>	<u>\$1200</u>
<u>Psychiatric hospitals</u>	<u>\$1400</u>
<u>Rural health facilities</u>	<u>\$1100</u>
<u>Portable X-ray providers</u>	<u>\$ 500</u>
<u>Home health agencies</u>	<u>\$1800</u>
<u>Outpatient therapy agencies</u>	<u>\$ 800</u>
<u>End stage renal dialysis providers</u>	<u>\$2100</u>
<u>Independent therapists</u>	<u>\$ 800</u>
<u>Comprehensive rehabilitation outpatient facilities</u>	<u>\$1200</u>
<u>Hospice providers</u>	<u>\$1700</u>
<u>Ambulatory surgical providers</u>	<u>\$1800</u>
<u>Hospitals</u>	<u>\$4200</u>
<u>Other provider categories or additional resurveys required to complete initial certification</u>	<u>Actual surveyor costs: average surveyor cost x number of hours for the survey process.</u>

These fees shall be submitted at the time of the application for federal certification and shall not be refunded. All fees collected after the date that the imposition of fees is not

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prohibited by federal law shall be deposited in the state treasury and credited to the state government special revenue fund.

Sec. 6. [144.2215] BIRTH DEFECTS REGISTRY SYSTEM.

The commissioner of health shall develop a statewide birth defects registry system to provide for the collection, analysis, and dissemination of birth defects information. The commissioner shall consult with representatives and experts in epidemiology, medicine, insurance, health maintenance organizations, genetics, consumers, and voluntary organizations in developing the system and may phase in the implementation of the system.

Sec. 7. Minnesota Statutes 1994, section 144.572, is amended to read:

144.572 INSTITUTIONS EXCEPTED.

No rule nor requirement shall be made, nor standard established under sections 144.50 to 144.56 for any sanitarium, ~~conducted in accordance with the practice and principles of the body known as the Church of Christ, Scientist by and for the adherents of any recognized church or religious denomination for the purpose of providing care and treatment for those who select and depend upon spiritual means through prayer alone, in lieu of medical care, for healing, except as to the sanitary and safe condition of the premises, cleanliness of operation, and its physical equipment.~~

Sec. 8. Minnesota Statutes 1994, section 144.71, subdivision 1, is amended to read:

Subdivision 1. **HEALTH AND SAFETY.** The purpose of sections 144.71 to 144.74 is to protect the health and safety of children persons in attendance at children's youth camps.

Sec. 9. Minnesota Statutes 1994, section 144.71, subdivision 2, is amended to read:

Subd. 2. **DEFINITION.** For the purpose of such sections a children's youth camp is defined as a parcel or parcels of land with permanent buildings, tents or other structures together with appurtenances thereon, established or maintained as living quarters where both food and beverage service and lodging or the facilities therefor are provided for ten or more people, operated continuously for a period of five days or more each year for educational, recreational or vacation purposes, and the use of the camp is offered to minors free of charge or for payment of a fee.

Sec. 10. Minnesota Statutes 1994, section 144.72, subdivision 1, is amended to read:

Subdivision 1. **PERMITS.** The state commissioner of health is authorized to issue permits for the operation of such children's youth camps and such camps which are required to obtain such the permits.

Sec. 11. Minnesota Statutes 1994, section 144.72, subdivision 2, is amended to read:

Subd. 2. **APPLICATION.** On or before June first annually, every person, partnership, limited liability company or corporation, operating or seeking to operate a children's youth camp, shall make application in writing to the commissioner for a permit to conduct a children's youth camp. Such application shall be in such form and shall contain such information as the commissioner may find necessary to determine that the children's youth camp will be operated and maintained in such a manner as to protect and

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preserve the health and safety of the persons using the camp. Where a person, partnership, limited liability company or corporation operates or is seeking to operate more than one children's youth camp, a separate application shall be made for each camp.

Sec. 12. Minnesota Statutes 1994, section 144.73, subdivision 1, is amended to read:

Subdivision 1. **INSPECTION OF CAMPS.** It shall be the duty of the state commissioner of health to make an annual inspection of each children's youth camp, and where, upon inspection it is found that there is a failure to protect the health and safety of the persons using the camp, or a failure to comply with the camp rules prescribed by the commissioner, the commissioner shall give notice to the camp operator of such failure, which notice shall set forth the reason or reasons for such failure.

Sec. 13. Minnesota Statutes 1994, section 144.74, is amended to read:

144.74 RULES, STANDARDS.

The state commissioner of health is authorized to adopt and enforce such reasonable rules and standards as the commissioner determines necessary to protect the health and safety of children persons in attendance at children's youth camps. Such rules and standards may include reasonable restrictions and limitations on the following:

- (1) Camp sites and buildings, including location, layout, lighting, ventilation, heating, plumbing, drainage and sleeping quarters;
- (2) Sanitary facilities, including water supply, toilet and shower facilities, sewage and excreta disposal, waste and garbage disposal, and the control of insects and rodents, and
- (3) Food service, including storage, refrigeration, sanitary preparation and handling of food, the cleanliness of kitchens and the proper functioning of equipment.

Sec. 14. Minnesota Statutes 1995 Supplement, section 144.9503, subdivision 6, is amended to read:

Subd. 6. **VOLUNTARY LEAD HAZARD REDUCTION.** The commissioner shall monitor the lead hazard reduction methods adopted under section 144.9508 in cases of voluntary lead hazard reduction. All contractors hired to do voluntary lead hazard reduction must be licensed lead contractors. If a property owner does not use a lead contractor for voluntary lead hazard reduction, the property owner shall provide the commissioner with a plan for lead hazard reduction at least ten working days before beginning the lead hazard reduction. The plan must include the details required in section 144.9505, and notice as to when lead hazard reduction activities will begin. Within the limits of appropriations, the commissioner shall review plans and shall approve or disapprove them as to compliance with the requirements in section 144.9505. No penalty shall be assessed against a property owner for discontinuing voluntary lead hazard reduction before completion of the plan, provided that the property owner discontinues the plan in a manner that leaves the property in a condition no more hazardous than its condition before the plan implementation.

Sec. 15. Minnesota Statutes 1995 Supplement, section 144.9503, subdivision 8, is amended to read:

Subd. 8. **CERTIFICATION FOR LEAD-SAFE HOUSING.** The commissioner shall propose to the legislature a program to certify residences as lead safe by February 15, ~~1996~~ 1997.

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Sec. 16. Minnesota Statutes 1995 Supplement, section 144.9503, subdivision 9, is amended to read:

Subd. 9. **LANDLORD TENANT STUDY.** Within the limits of appropriations, the commissioner of health shall ~~conduct or contract for~~ a study of the legal responsibilities of tenants and landlords in the prevention of lead hazards, and shall report the findings to the legislature, along with recommendations as to any changes needed to clarify or modify current law ~~by January 15, 1996~~. In conducting the study, the commissioner shall convene any public meetings necessary to hear the testimony and recommendations of interested parties, and shall invite and consider written public comments.

Sec. 17. Minnesota Statutes 1995 Supplement, section 144.9504, subdivision 2, is amended to read:

Subd. 2. **LEAD INSPECTION.** (a) An inspecting agency shall conduct a lead inspection of a residence according to the venous blood lead level and time frame set forth in clauses (1) to (4) for purposes of secondary prevention:

(1) within 48 hours of a child or pregnant female in the residence being identified to the agency as having a venous blood lead level equal to or greater than 70 micrograms of lead per deciliter of whole blood;

(2) within five working days of a child or pregnant female in the residence being identified to the agency as having a venous blood lead level equal to or greater than 45 micrograms of lead per deciliter of whole blood;

(3) within ten working days of a child or pregnant female in the residence being identified to the agency as having a venous blood lead level equal to or greater than 20 micrograms of lead per deciliter of whole blood; or

(4) within ten working days of a child or pregnant female in the residence being identified to the agency as having a venous blood lead level that persists in the range of 15 to 19 micrograms of lead per deciliter of whole blood for 90 days after initial identification.

(b) Within the limits of available state and federal appropriations, an inspecting agency may also conduct a lead inspection for children with any elevated blood lead level.

(c) In a building with two or more dwelling units, an inspecting agency shall inspect the individual unit in which the conditions of this section are met and shall also inspect all common areas. If a child visits one or more other sites such as another residence, or a residential or commercial child care facility, playground, or school, the inspecting agency shall also inspect the other sites. The inspecting agency shall have one additional day added to the time frame set forth in this subdivision to complete the lead inspection for each additional site.

(d) Within the limits of appropriations, the inspecting agency shall identify the known addresses for the previous 12 months of the child or pregnant female with elevated blood lead levels; notify the property owners, landlords, and tenants at those addresses that an elevated blood lead level was found in a person who resided at the property; and give them a copy of the lead inspection guide. This information shall be classified as private data on individuals as defined under section 13.02, subdivision 12.

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(e) The inspecting agency shall conduct the lead inspection according to rules adopted by the commissioner under section 144.9508. An inspecting agency shall have lead inspections performed by lead inspectors licensed by the commissioner according to rules adopted under section 144.9508. If a property owner refuses to allow an inspection, the inspecting agency shall begin legal proceedings to gain entry to the property and the time frame for conducting a lead inspection set forth in this subdivision no longer applies. An inspector or inspecting agency may observe the performance of lead hazard reduction in progress and shall enforce the provisions of this section under section 144.9509. Deteriorated painted surfaces, bare soil, dust, and drinking water must be tested with appropriate analytical equipment to determine the lead content, except that deteriorated painted surfaces or bare soil need not be tested if the property owner agrees to engage in lead hazard reduction on those surfaces.

(f) A lead inspector shall notify the commissioner and the board of health of all violations of lead standards under section 144.9508, that are identified in a lead inspection conducted under this section.

(g) Each inspecting agency shall establish an administrative appeal procedure which allows a property owner to contest the nature and conditions of any lead order issued by the inspecting agency. Inspecting agencies must consider appeals that propose lower cost methods that make the residence lead safe.

(h) Sections 144.9501 to 144.9509 neither authorize nor prohibit an inspecting agency from charging a property owner for the cost of a lead inspection.

Sec. 18. Minnesota Statutes 1995 Supplement, section 144.9504, subdivision 7, is amended to read:

Subd. 7. **RELOCATION OF RESIDENTS.** (a) An Within the limits of appropriations, the inspecting agency shall ensure that residents are relocated from rooms or dwellings during a lead hazard reduction process that generates leaded dust, such as removal or disruption of lead-based paint or plaster that contains lead. Residents shall not remain in rooms or dwellings where the lead hazard reduction process is occurring. An inspecting agency is not required to pay for relocation unless state or federal funding is available for this purpose. The inspecting agency shall make an effort to assist the resident in locating resources that will provide assistance with relocation costs. Residents shall be allowed to return to the residence or dwelling after completion of the lead hazard reduction process. An inspecting agency shall use grant funds under section 144.9507 if available, in cooperation with local housing agencies, to pay for moving costs and rent for a temporary residence for any low-income resident temporarily relocated during lead hazard reduction. For purposes of this section, "low-income resident" means any resident whose gross household income is at or below 185 percent of federal poverty level.

(b) A resident of rental property who is notified by an inspecting agency to vacate the premises during lead hazard reduction, notwithstanding any rental agreement or lease provisions:

(1) shall not be required to pay rent due the landlord for the period of time the tenant vacates the premises due to lead hazard reduction;

(2) may elect to immediately terminate the tenancy effective on the date the tenant vacates the premises due to lead hazard reduction; and

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(3) shall not, if the tenancy is terminated, be liable for any further rent or other charges due under the terms of the tenancy.

(c) A landlord of rental property whose tenants vacate the premises during lead hazard reduction shall:

(1) allow a tenant to return to the dwelling unit after lead hazard reduction and clearance inspection, required under this section, is completed, unless the tenant has elected to terminate the tenancy as provided for in paragraph (b); and

(2) return any security deposit due under section 504.20 within five days of the date the tenant vacates the unit, to any tenant who terminates tenancy as provided for in paragraph (b).

Sec. 19. Minnesota Statutes 1995 Supplement, section 144.9504, subdivision 8, is amended to read:

Subd. 8. PROPERTY OWNER RESPONSIBILITY. Property owners shall comply with lead orders issued under this section within 60 days or be subject to enforcement actions as provided under section 144.9509. For orders or portions of orders concerning external lead hazards, property owners shall comply within 60 days, or as soon thereafter as weather permits. If the property owner does not use a lead contractor for compliance with the lead orders, the property owner shall submit a plan for approval by to the inspecting agency within 30 days after receiving the orders. The plan must include the details required in section 144.9505 as to how the property owner intends to comply with the lead orders and notice as to when lead hazard reduction activities will begin. Within the limits of appropriations, the commissioner shall review plans and shall approve or disapprove them as to compliance with the requirements in section 144.9505, subdivision 5.

Sec. 20. Minnesota Statutes 1995 Supplement, section 144.9505, subdivision 4, is amended to read:

Subd. 4. NOTICE OF LEAD ABATEMENT OR LEAD HAZARD REDUCTION WORK. (a) At least five working days before starting work at each lead abatement or lead hazard reduction worksite, the person performing the lead abatement or lead hazard reduction work shall give written notice and an approved work plan as required in this section to the commissioner and the appropriate board of health. Within the limits of appropriations, the commissioner shall review plans and shall approve or disapprove them as to compliance with the requirements in section 144.9505, subdivision 5.

(b) This provision does not apply to swab team workers performing work under an order of an inspecting agency.

Sec. 21. Minnesota Statutes 1994, section 144A.04, is amended by adding a subdivision to read:

Subd. 7a. DIRECTOR OF NURSING SERVICES. Except as otherwise provided by this subdivision, a nursing home must have a full-time director of nursing services who is assigned full time to the nursing services of the nursing home. For purposes of this requirement, "full time" means working at least 35 hours per week. The director of nursing services of a nursing home may also serve as the director of nursing services of a physically attached hospital if:

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(1) the hospital has an average daily census of ten patients or less in the most recent reporting year for which data is available;

(2) the total combined beds of the hospital and nursing home do not exceed 100; and

(3) the management of the two facilities is under the control and direction of the same governing body.

Sec. 22. Minnesota Statutes 1994, section 144A.09, subdivision 1, is amended to read:

Subdivision 1. **CHURCH OF CHRIST, SCIENTIST SPIRITUAL MEANS FOR HEALING.** No rule established under sections 144A.01 to 144A.16 other than a rule relating to sanitation and safety of premises, to cleanliness of operation or to physical equipment, shall apply to a nursing home conducted in accordance with the teachings of the body known as the Church of Christ, Scientist by and for the adherents of any recognized church or religious denomination for the purpose of providing care and treatment for those who select and depend upon spiritual means through prayer alone, in lieu of medical care, for healing.

Sec. 23. Minnesota Statutes 1994, section 144A.20, subdivision 2, is amended to read:

Subd. 2. **EXCEPTION.** Notwithstanding any law to the contrary, no person desiring to be licensed to administer a nursing home operated exclusively in accordance with the teachings of the body known as the Church of Christ, Scientist by and for the adherents of any recognized church or religious denomination for the purpose of providing care and treatment for those who select and depend upon spiritual means through prayer alone, in lieu of medical care, for healing, shall be required to demonstrate proficiency in any medical technique or meet any medical educational qualification or medical standard which is not in accord with the type of remedial care and treatment provided in a nursing home operated exclusively in accordance with the teachings of that body.

Sec. 24. Minnesota Statutes 1994, section 145.61, subdivision 5, is amended to read:

Subd. 5. "Review organization" means a nonprofit organization acting according to clause (k) or a committee whose membership is limited to professionals, administrative staff, and consumer directors, except where otherwise provided for by state or federal law, and which is established by one or more of the following: a hospital, a clinic, a nursing home, one or more state or local associations of professionals, an organization of professionals from a particular area or medical institution, a health maintenance organization as defined in chapter 62D, a nonprofit health service plan corporation as defined in chapter 62C, a preferred provider organization, a professional standards review organization established pursuant to United States Code, title 42, section 1320c-1 et seq., a medical review agent established to meet the requirements of section 256B.04, subdivision 15, or 256D.03, subdivision 7, paragraph (b), the department of human services, a health provider cooperative operating under sections 62R.17 to 62R.26, or a corporation organized under chapter 317A that owns, operates, or is established by one or more of the above referenced entities, to gather and review information relating to the care and treatment of patients for the purposes of:

(a) evaluating and improving the quality of health care rendered in the area or medical institution or by the entity or organization that established the review organization;

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(b) reducing morbidity or mortality;

(c) obtaining and disseminating statistics and information relative to the treatment and prevention of diseases, illness and injuries;

(d) developing and publishing guidelines showing the norms of health care in the area or medical institution or in the entity or organization that established the review organization;

(e) developing and publishing guidelines designed to keep within reasonable bounds the cost of health care;

(f) reviewing the quality or cost of health care services provided to enrollees of health maintenance organizations, health service plans, preferred provider organizations, and insurance companies;

(g) acting as a professional standards review organization pursuant to United States Code, title 42, section 1320c-1 et seq.;

(h) determining whether a professional shall be granted staff privileges in a medical institution, membership in a state or local association of professionals, or participating status in a nonprofit health service plan corporation, health maintenance organization, preferred provider organization, or insurance company, or whether a professional's staff privileges, membership, or participation status should be limited, suspended or revoked;

(i) reviewing, ruling on, or advising on controversies, disputes or questions between:

(1) health insurance carriers, nonprofit health service plan corporations, health maintenance organizations, self-insurers and their insureds, subscribers, enrollees, or other covered persons;

(2) professional licensing boards and health providers licensed by them;

(3) professionals and their patients concerning diagnosis, treatment or care, or the charges or fees therefor;

(4) professionals and health insurance carriers, nonprofit health service plan corporations, health maintenance organizations, or self-insurers concerning a charge or fee for health care services provided to an insured, subscriber, enrollee, or other covered person;

(5) professionals or their patients and the federal, state, or local government, or agencies thereof;

(j) providing underwriting assistance in connection with professional liability insurance coverage applied for or obtained by dentists, or providing assistance to underwriters in evaluating claims against dentists;

(k) acting as a medical review agent under section 256B.04, subdivision 15, or 256D.03, subdivision 7, paragraph (b);

(l) providing recommendations on the medical necessity of a health service, or the relevant prevailing community standard for a health service;

(m) reviewing a provider's professional practice as requested by the data analysis unit under section 62J.32;

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(n) providing quality assurance as required by United States Code, title 42, sections 1396r(b)(1)(b) and 1395i-3(b)(1)(b) of the Social Security Act;

(o) providing information to group purchasers of health care services when that information was originally generated within the review organization for a purpose specified by this subdivision; or

(p) providing information to other, affiliated or nonaffiliated review organizations, when that information was originally generated within the review organization for a purpose specified by this subdivision, and as long as that information will further the purposes of a review organization as specified by this subdivision.

Sec. 25. [145.951] CHILDREN HELPED IN LONG-TERM DEVELOPMENT; IMPLEMENTATION PLAN.

The commissioner of health, in consultation with the commissioners of children, families, and learning; corrections; public safety; and human services, and with the directors of the office of strategic and long-range planning, the council on disability, and the councils and commission under Minnesota Statutes, sections 3.922 to 3.9226, may develop an implementation plan for the establishment of a statewide program to assist families in developing the full potential of their children. The program must be designed to strengthen the family, to reduce the risk of abuse to children, and to promote the long-term development of children in their home environments. The program must also be designed to use volunteers to provide support to parents, and to link parents with existing public health, education, and social services as appropriate.

Sec. 26. [145.952] DEFINITIONS.

Subdivision 1. SCOPE. The definitions in this section apply to sections 145.951 to 145.957.

Subd. 2. ABUSE. "Abuse" means physical abuse, sexual abuse, neglect, mental injury, and threatened injury, as those terms are defined in section 626.556, subdivision 2.

Subd. 3. CHILD PROGRAM OR PROGRAM. "CHILD program" or "program" means the children helped in long-term development program that the commissioner shall plan to be implemented under sections 145.951 to 145.957.

Subd. 4. COMMISSIONER. "Commissioner" means the commissioner of health or the commissioner's designee.

Subd. 5. LOCAL ORGANIZATION. "Local organization" means an organization that contracts with the commissioner under section 145.953, subdivision 1, to administer the CHILD program on a local level.

Sec. 27. [145.953] PROGRAM STRUCTURE.

Subdivision 1. LOCAL ADMINISTRATION OF PROGRAM. The implementation plan must require the commissioner to contract with appropriate private non-profit and governmental organizations to administer the CHILD program on a local level. The local organization, in collaboration and coordination with the department of health, shall be responsible for recruiting, screening training, and overseeing volunteers for the program.

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Subd. 2. **VOLUNTEER COMPONENT.** The implementation plan must provide that a volunteer will be matched with a family to provide ongoing support in parenting. The volunteer shall provide the family with information on the CHILD program and other social services available. Through home visits and frequent contact, the volunteer shall provide support and guidance on raising the child and coping with stresses that may increase the risk of abuse. The volunteer shall also assist the family in obtaining other needed services from existing social services programs.

Sec. 28. [145.954] STANDARDS FOR PROGRAM.

In planning for the implementation of the program, the commissioner shall:

(1) establish mechanisms to encourage families to participate in the CHILD program;

(2) establish mechanisms to identify families who may wish to participate in the CHILD program and to match volunteers with these families either before or as soon as possible after a child is born;

(3) ensure that local organizations coordinate with services already provided by the departments of health, human services, and children, families, and learning to ensure that participating families receive a continuum of care;

(4) coordinate with local social services agencies, local health boards, and community health boards;

(5) ensure that services provided through the program are community-based and that the special needs of minority communities are addressed;

(6) develop and implement appropriate systems to gather data on participating families and to monitor and evaluate their progress; and

(7) evaluate the program's effectiveness.

Sec. 29. [145.955] DUTIES OF LOCAL ORGANIZATION.

The implementation plan shall require the local organizations to:

(1) recruit and train volunteers to serve families under the program, according to section 145.956;

(2) provide ongoing supervision and consultation to volunteers; and

(3) develop resource and referral booklets that volunteers can distribute to families served by the program. The booklets shall contain comprehensive information on the spectrum of services available to assist the family and to reduce the risk of abuse.

Sec. 30. [145.956] TRAINING AND RECRUITMENT OF VOLUNTEERS.

Subdivision 1. TRAINING REQUIREMENTS. (a) The implementation plan shall require the local organization to carefully screen and train volunteers to provide program services. Training must prepare volunteers to:

(1) identify signs of abuse or other indications that a child may be at risk of abuse;

(2) help families develop communications skills;

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(3) teach and reinforce healthy discipline techniques;

(4) provide other support a family needs to cope with stresses that increase the risk of abuse; and

(5) refer the family to other appropriate public health, education, and social services.

(b) The implementation plan shall also include procedures whereby the local agency will provide ongoing support, supervision, and training for all volunteers. Training must be culturally appropriate and community-based, and must incorporate input from parents who will be using the program's services.

Subd. 2. RECRUITMENT OF VOLUNTEERS. The implementation plan must require that the local organization recruit minority volunteers to serve communities of color.

Sec. 31. [145.957] ELIGIBILITY.

The implementation plan must ensure that all residents of Minnesota are eligible for services under the program. The plan must make services available on a sliding fee basis. The commissioner shall develop a sliding fee scale for the program.

Sec. 32. Minnesota Statutes 1995 Supplement, section 148C.01, subdivision 12, is amended to read:

Subd. 12. **SUPERVISED ALCOHOL AND DRUG COUNSELING EXPERIENCE.** Except during the transition period, "supervised alcohol and drug counseling experience" means practical experience gained by a student, volunteer, or intern, and supervised by a person either licensed under this chapter or exempt under its provisions; either before, during, or after the student completes a program from an accredited school or educational program of alcohol and drug counseling.

Sec. 33. Minnesota Statutes 1995 Supplement, section 148C.01, subdivision 13, is amended to read:

Subd. 13. **ALCOHOL AND DRUG COUNSELING PRACTICUM.** "Alcohol and drug counseling practicum" means formal experience gained by a student and supervised by a person either licensed under this chapter or exempt under its provisions, in an accredited school or educational program of alcohol and drug counseling as part of the education requirements of this chapter.

Sec. 34. Minnesota Statutes 1994, section 148C.01, is amended by adding a subdivision to read:

Subd. 17. **ALCOHOL AND DRUG COUNSELOR INTERNSHIP.** "Alcohol and drug counselor internship" means supervised, practical, on-the-job training as an intern, volunteer, or employee in alcohol and drug counseling.

Sec. 35. Minnesota Statutes 1995 Supplement, section 148C.02, subdivision 1, is amended to read:

Subdivision 1. **MEMBERSHIP.** The alcohol and drug counselors licensing advisory council consists of 13 members. The commissioner shall appoint:

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

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

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

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

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

Sec. 36. Minnesota Statutes 1995 Supplement, section 148C.02, subdivision 2, is amended to read:

Subd. 2. **DUTIES.** ~~(a)~~ The advisory council shall:

(1) provide advice and recommendations to the commissioner on the development of rules for the licensure of alcohol and drug counselors;

(2) provide advice and recommendations to the commissioner on the development of standards and procedures for the competency testing, licensing, and review of alcohol and drug counselors' professional conduct;

(3) provide advice and recommendations to the commissioner in disciplinary cases in the areas of counselor competency issues, counselor practice issues, and counselor impairment issues.

~~(b) The advisory council shall form an education committee, including a chair, and shall advise the commissioner on the administration of education requirements in section 148C.05, subdivision 2.~~

Sec. 37. Minnesota Statutes 1995 Supplement, section 148C.03, subdivision 1, is amended to read:

Subdivision 1. **GENERAL.** The commissioner shall, after consultation with the advisory council or a subcommittee or the special licensing criteria committee established under section 148C.11, subdivision 3, paragraph (b):

(a) adopt and enforce rules for licensure of alcohol and drug counselors, including establishing standards and methods of determining whether applicants and licensees are qualified under section 148C.04. The rules must provide for examinations and establish standards for the regulation of professional conduct. The rules must be designed to protect the public;

(b) hold or contract for the administration of examinations at least twice a year to assess applicants' knowledge and skills. The examinations must be written and oral and may be administered by the commissioner or by a private organization under contract with the commissioner to administer the licensing examinations. Examinations must minimize cultural bias and must be balanced in various theories relative to practice of alcohol and drug counseling;

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

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

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(e) adopt rules to establish and implement procedures, including a standard disciplinary process and rules of professional conduct;

(f) carry out disciplinary actions against licensees;

(g) establish, with the advice and recommendations of the advisory council, written internal operating procedures for receiving and investigating complaints and for taking disciplinary actions as appropriate. Establishment of the operating procedures are not subject to rulemaking procedures under chapter 14;

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

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

(j) set, collect, and adjust license fees for alcohol and drug counselors so that the total fees collected will as closely as possible equal anticipated expenditures during the biennium, as provided in section 16A.1285; fees for initial and renewal application and examinations; late fees for counselors who submit license renewal applications after the renewal deadline; and a surcharge fee. The surcharge fee must include an amount necessary to recover, over a five-year period, the commissioner's direct expenditures for the adoption of the rules providing for the licensure of alcohol and drug counselors. All fees received shall be deposited in the state treasury and credited to the special revenue fund; and

(k) prepare reports on activities related to the licensure of alcohol and drug counselors according to this subdivision by October 1 of each even-numbered year. Copies of the reports shall be delivered to the legislature in accordance with section 3.195 and to the governor. The reports shall contain the following information on the commissioner's activities relating to the licensure of ~~chemical dependency~~ alcohol and drug counselors, for the two-year period ending the previous June 30:

(1) a general statement of the activities;

(2) the number of staff hours spent on the activities;

(3) the receipts and disbursements of funds;

(4) the names of advisory council members and their addresses, occupations, and dates of appointment and reappointment;

(5) the names and job classifications of employees;

(6) a brief summary of rules proposed or adopted during the reporting period with appropriate citations to the State Register and published rules;

(7) the number of persons having each type of license issued by the commissioner as of June 30 in the year of the report;

(8) the locations and dates of the administration of examinations by the commissioner;

(9) the number of persons examined by the commissioner with the persons subdivided into groups showing age categories, sex, and states of residency;

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(10) the number of persons licensed by the commissioner after taking the examinations referred to in clause (8) with the persons subdivided by age categories, sex, and states of residency;

(11) the number of persons not licensed by the commissioner after taking the examinations referred to in clause (8) with the persons subdivided by age categories, sex, and states of residency;

(12) the number of persons not taking the examinations referred to in clause (8) who were licensed by the commissioner or who were denied licensing, the reasons for the licensing or denial, and the persons subdivided by age categories, sex, and states of residency;

(13) the number of persons previously licensed by the commissioner whose licenses were revoked, suspended, or otherwise altered in status with brief statements of the reasons for the revocation, suspension, or alteration;

(14) the number of written and oral complaints and other communications received by the commissioner which allege or imply a violation of a statute or rule which the commissioner is empowered to enforce;

(15) a summary, by specific category, of the substance of the complaints and communications referred to in clause (14) and, for each specific category, the responses or dispositions; and

(16) any other objective information which the commissioner believes will be useful in reviewing the commissioner's activities.

Sec. 38. Minnesota Statutes 1995 Supplement, section 148C.04, subdivision 3, is amended to read:

Subd. 3. **LICENSING REQUIREMENTS FOR ALCOHOL AND DRUG COUNSELORS; EVIDENCE FOR THE FIRST FIVE YEARS.** (a) For five years after the effective date of the rules authorized in section 148C.03, the applicant, unless qualified for initial licensure under this subdivision under section 148C.06 during the two-year period authorized therein, under section 148C.07, or under subdivision 4, must furnish evidence satisfactory to the commissioner that the applicant has met all the requirements in clauses (1) to (3). The applicant must have:

(1) ~~Except as provided in subdivision 4, the applicant must have received an associate degree including 270 clock hours of alcohol and drug counseling education from an accredited school or educational program and 880 clock hours of chemical dependency alcohol and drug counseling practicum;~~

(2) ~~The applicant must have completed a written case presentation and satisfactorily passed an oral examination that demonstrates competence in the core functions; and~~

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

(b) ~~Unless the applicant qualifies for licensure under this subdivision, an applicant must furnish evidence satisfactory to the commissioner that the applicant has met the requirements of paragraph (a), clauses (1) to (3).~~

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Beginning two years after the effective date of the rules authorized in section 148C.03, subdivision 1, no person may be licensed without meeting the requirements in section 148C.04, subdivision 4, paragraph (a), clauses (2) and (3), or the special licensing criteria established pursuant to section 148C.11, subdivision 4.

Sec. 39. Minnesota Statutes 1995 Supplement, section 148C.04, subdivision 4, is amended to read:

Subd. 4. **ADDITIONAL LICENSING REQUIREMENTS AFTER FIVE YEARS.** Beginning five years after the effective date of the rules authorized in section 148C.03, subdivision 1, an applicant for licensure must have received submit evidence to the commissioner that the applicant has met one of the following requirements:

(1) The applicant must have:

(i) received a bachelor's degree from an accredited school or educational program, and must have completed including 480 clock hours of alcohol and drug counseling education from an accredited school or educational program and 880 clock hours of alcohol and drug counseling practicum,

(ii) completed a written case presentation and satisfactorily passed an oral examination that demonstrates competence in the core functions, and

(iii) satisfactorily passed a written examination as established by the commissioner;
or

(2) The applicant must meet the requirements of section 148C.07.

Sec. 40. Minnesota Statutes 1995 Supplement, section 148C.04, is amended by adding a subdivision to read:

Subd. 5. **ADDITIONAL LICENSING REQUIREMENTS.** Applicants must also meet the special licensing requirements in section 148C.11, subdivision 4, and in the rules authorized in section 148C.03, subdivision 1, when applicable.

Sec. 41. Minnesota Statutes 1995 Supplement, section 148C.05, subdivision 1, is amended to read:

Subdivision 1. **RENEWAL REQUIREMENTS.** To renew a license, an applicant must:

(1) annually complete a renewal application every two years on a form provided by the commissioner and submit the annual biennial renewal fee by the deadline; and

(2) submit additional information if requested by the commissioner to clarify information presented in the renewal application. This information must be submitted within 30 days of the commissioner's request.

Sec. 42. Minnesota Statutes 1995 Supplement, section 148C.06, is amended to read:

148C.06 TRANSITION PERIOD.

For two years from the effective date of the rules authorized in section 148C.03, subdivision 1, the commissioner shall issue a license to an applicant if the applicant meets one of the following qualifications:

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

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

(b) has 6,000 hours of supervised alcohol and drug counselor experience as defined by the core functions, 270 clock hours of alcohol and drug training with a minimum of 60 hours of this training occurring within the past five years, 300 hours of alcohol and drug ~~practicum~~ counselor internship, and has successfully completed the requirements in section 148C.04, subdivision 3, paragraph (a), clauses (2) and (3);

(c) has 10,000 hours of supervised alcohol and drug counselor experience as defined by the core functions, 270 clock hours of alcohol and drug training with a minimum of 60 hours of this training occurring within the past five years, and has successfully completed the requirements in section 148C.04, subdivision 3, paragraph (a), clause (2) or (3), or is credentialed as a certified chemical dependency practitioner (CCDP) by the Institute for Chemical Dependency Professionals of Minnesota, Inc.;

(d) has 14,000 hours of supervised alcohol and drug counselor experience as defined by the core functions and 270 clock hours of alcohol and drug training with a minimum of 60 hours of this training occurring within the past five years; or

(e) has met the special licensing criteria established pursuant to section 148C.11.

Sec. 43. Minnesota Statutes 1994, section 148C.09, is amended by adding a subdivision to read:

Subd. 1a. BACKGROUND INVESTIGATION. The applicant must sign a release authorizing the commissioner to obtain information from the bureau of criminal apprehension, the Federal Bureau of Investigation, the office of mental health practice, the department of human services, the office of health facilities complaints, and other agencies specified in the rules. After the commissioner has given written notice to an individual who is the subject of a background investigation, the agencies shall assist the commissioner with the investigation by giving the commissioner criminal conviction data, reports about abuse or neglect of clients, and other information specified in the rules.

Sec. 44. Minnesota Statutes 1995 Supplement, section 148C.11, subdivision 1, is amended to read:

Subdivision 1. **OTHER PROFESSIONALS.** Nothing in sections 148C.01 to 148C.10 shall prevent members of other professions or occupations from performing functions for which they are qualified or licensed. This exception includes, but is not limited to, licensed physicians, registered nurses, licensed practical nurses, licensed psychological practitioners, members of the clergy, American Indian medicine men and women, licensed attorneys, probation officers, licensed marriage and family therapists, licensed social workers, licensed professional counselors, school counselors employed by a school district while acting within the scope of their employment as a school counselor, and registered occupational therapists or certified occupational therapist therapy assistants. These persons must not, however, use a title incorporating the words "alcohol and drug counselor" or "licensed alcohol and drug counselor" or otherwise hold themselves out to the public by any title or description stating or implying that they are licensed to engage in the practice of alcohol and drug counseling.

Sec. 45. Minnesota Statutes 1995 Supplement, section 148C.11, subdivision 3, is amended to read:

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

Subd. 3. **FEDERALLY RECOGNIZED TRIBES.** (a) Alcohol and drug counselors licensed to practice alcohol and drug counseling according to standards established by federally recognized tribes, while practicing under tribal jurisdiction, are exempt from the requirements of this chapter. In practicing alcohol and drug counseling under tribal jurisdiction, individuals licensed under that authority shall be afforded the same rights, responsibilities, and recognition as persons licensed pursuant to this chapter.

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

Sec. 46. Minnesota Statutes 1995 Supplement, section 157.011, subdivision 1, is amended to read:

Subdivision 1. **ESTABLISHMENTS.** The commissioner shall adopt rules establishing standards for food, and beverage service establishments, and hotels, motels, lodging establishments, and resorts.

Sec. 47. Minnesota Statutes 1995 Supplement, section 157.15, subdivision 4, is amended to read:

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 food and beverage service establishment where food or nonalcoholic beverages, or both, are furnished to five or more regular boarders, whether with or without sleeping accommodations, for periods of one week or more.

Sec. 48. Minnesota Statutes 1995 Supplement, section 157.15, subdivision 5, is amended to read:

Subd. 5. **FOOD AND BEVERAGE SERVICE ESTABLISHMENT.** "Food and beverage service establishment" means a restaurant, alcoholic beverage establishment, boarding establishment, mobile food unit, seasonal food stand, food cart, or special event food stand building, structure, enclosure, or any part of a building, structure, or enclosure used as, maintained as, advertised as, or held out to be an operation that prepares, serves, or otherwise provides food or beverages, or both, for human consumption.

Sec. 49. Minnesota Statutes 1995 Supplement, section 157.15, subdivision 6, is amended to read:

Subd. 6. **FOOD CART.** "Food cart" means a food and beverage service establishment that is 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 self-propelled by the operator.

Sec. 50. Minnesota Statutes 1995 Supplement, section 157.15, subdivision 9, is amended to read:

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

Subd. 9. **MOBILE FOOD UNIT.** "Mobile food unit" means a food and beverage service establishment that is a vehicle mounted unit, either motorized or trailered, operating no more than 14 days annually at any one place or is operated in conjunction with a permanent business at the site of the permanent business by the same individual or company, and readily movable, without disassembling, for transport to another location and remaining for no more than 14 days, annually, at any one place.

Sec. 51. Minnesota Statutes 1995 Supplement, section 157.15, subdivision 12, is amended to read:

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 food and beverage service establishment, whether the establishment serves alcoholic or nonalcoholic beverages, which operates from a location for more than 14 days annually. Restaurant does not include a food cart or a mobile food unit.

Sec. 52. Minnesota Statutes 1995 Supplement, section 157.15, is amended by adding a subdivision to read:

Subd. 12a. **SEASONAL PERMANENT FOOD STAND.** "Seasonal permanent food stand" means a food and beverage service establishment which is a permanent food service stand or building, but which operates no more than 14 days annually.

Sec. 53. Minnesota Statutes 1995 Supplement, section 157.15, subdivision 13, is amended to read:

Subd. 13. **SEASONAL TEMPORARY FOOD STAND.** "Seasonal temporary food stand" means a food and beverage service establishment that is a food stand that which is disassembled and moved from location to location, remaining but which operates 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 location.

Sec. 54. Minnesota Statutes 1995 Supplement, section 157.15, subdivision 14, is amended to read:

Subd. 14. **SPECIAL EVENT FOOD STAND.** "Special event food stand" means a food and beverage service establishment which is used in conjunction with celebrations and special events, used not more than twice annually, and remaining and which operates once or twice annually for no more than three consecutive seven total days at any one location.

Sec. 55. Minnesota Statutes 1995 Supplement, section 157.15, is amended by adding a subdivision to read:

Subd. 15. **SPECIAL EVENT FOOD STAND-LIMITED.** "Special event food stand-limited" means a fee category where food is served at special events that is prepared at another licensed location and is only held and served with no additional preparation at the serving site of the special event, and which operates once or twice annually for no more than seven total days.

Sec. 56. Minnesota Statutes 1995 Supplement, section 157.16, is amended to read:

157.16 LICENSES REQUIRED; FEES.

New language is indicated by underline, deletions by strikeout.

Subdivision 1. **LICENSE REQUIRED ANNUALLY.** A license is required annually for every person, firm, or corporation engaged in the business of conducting a food and beverage service establishment, hotel, motel, restaurant, alcoholic beverage establishment, boarding establishment, lodging establishment, or 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 specified in this section, and receive approval for operation, including plan review approval. Seasonal and temporary food stands and special event food stands are not required to submit plans. 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 food and beverage service establishment, hotel, motel, restaurant, alcoholic beverage establishment, boarding establishment, lodging establishment, or 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 food and beverage service establishments, hotels, motels, restaurants, alcoholic beverage establishments, lodging establishments, boarding establishments, and 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 submitted an application and 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 food and beverage service establishment operating without a license as a mobile food unit, a seasonal temporary or seasonal permanent food stand, and food cart operating without a license or a special event food stand, and a penalty of \$50 shall be added to the total of the license fee for all other food, beverage, and restaurants, food carts, hotels, motels, lodging establishments, and resorts operating without a license.

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) The following fees are required for food and beverage service establishments, hotels, motels, lodging establishments, and resorts licensed under this chapter. Food and beverage service establishments must pay the highest applicable fee under paragraph (e), clause (1), (2), (3), or (4), and establishments serving alcohol must pay the highest applicable fee under paragraph (e), clause (6) or (7).

(b) All food and beverage service establishments, except special event food stands, and all hotels, motels, lodging establishments, and resorts shall pay an annual base fee of \$100.

(c) A special event food stand shall pay a flat fee of \$60 annually. "Special event food stand" means a fee category where food is prepared or served in conjunction with celebrations, county fairs, or special events from a special event food stand as defined in section 157.15.

New language is indicated by underline, deletions by strikeout.

(d) A special event food stand-limited shall pay a flat fee of \$30.

(e) In addition to the base fee in paragraph (b), each food and beverage service establishment, other than a special event food stand, and each hotel, motel, lodging establishment, and resort shall pay an additional annual fee for each fee category as specified in this paragraph:

(1) Limited food menu selection, \$30.

(a) "Limited food menu selection" means a fee category that provides one or more of the following:

- (1) (i) prepackaged food that receives heat treatment and is served in the package;
- (2) (ii) frozen pizza that is heated and served;
- (3) (iii) a continental breakfast such as rolls, coffee, juice, milk, and cold cereal;
- (4) (iv) soft drinks, coffee, or nonalcoholic beverages; or

~~(5) does not prepare food on site, however serves food that was prepared elsewhere and provides (v) cleaning of for eating, drinking, or cooking utensils, when the only food served is prepared off site.~~

(2) Small menu selection with limited equipment, including boarding establishments, \$55.

(b) "Small menu selection with limited equipment" means a fee category that has no salad bar and provides meets one or more of the following:

- (1) (i) possesses food service equipment that is limited to consists of no more than a deep fat fryer, a grill, two hot holding containers, and one or more microwave ovens;
- (2) ~~service of~~ (ii) serves dipped ice cream or soft serve frozen desserts;
- (3) ~~service of~~ (iii) serves breakfast in an owner-occupied bed and breakfast establishment; or
- (4) (iv) is a boarding establishment.

(3) Small establishment with full menu selection, \$150.

(e) "Small establishment with full menu selection" means a fee category that provides meets one or more of the following:

- (1) (i) possesses food service equipment that includes a range, oven, steam table, salad bar, or salad preparation area;
- (2) (ii) possesses food service equipment that includes more than one deep fat fryer, one grill, or two hot holding containers; or
- (3) (iii) is an establishment where food is prepared at one location and served at one or more separate locations.

(4) Large establishment with full menu selection, \$250.

(d) "Large establishment with full menu selection" means either:

New language is indicated by underline, deletions by strikeout.

(i) a fee category that (1) meets the criteria in paragraph (e), clause (1) or (2) clause (3), subclause (i) or (ii), for a small establishment with full menu selection and: ~~(1), (2)~~ seats more than 175 people; ~~(2), and (3)~~ offers the full menu selection an average of five or more days a week during the weeks of operation; or means

(ii) a service fee category that (1) meets the criteria in paragraph (e), clause (3), subclause (iii), for a small establishment with full menu selection; and ~~(3) (2)~~ prepares and serves 500 or more 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.

(5) Other food and beverage service, including food carts, mobile food units, seasonal temporary food stands, and seasonal permanent food stands, \$30.

(6) Beer or wine table service, \$30.

(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.

(7) Alcoholic beverage service, other than beer or wine table service, \$75.

"Alcohol service other than beer or wine table service" means a fee category where alcoholic mixed drinks are served or where beer or wine are served from a bar.

(8) Lodging per sleeping accommodation unit, \$4, including hotels, motels, lodging establishments, and resorts, up to a maximum of \$400.

(j) "Lodging per sleeping accommodation unit" means a fee category including the number of guest rooms, cottages, or other rental units of a hotel, motel, lodging establishment, or resort; or the number of beds in a dormitory.

(9) First public swimming pool, \$100; each additional public swimming pool, \$50.

(k) "Public swimming pool" means a fee category that has the meaning given in Minnesota Rules, part 4717.0250, subpart 8.

(10) First spa, \$50; each additional spa, \$25.

(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.

(11) Private sewer or water, \$30.

New language is indicated by underline, deletions by strikeout.

"Individual private water" means a fee category with a water supply other than a community public water supply as defined in Minnesota Rules, chapter 4720. "Individual private sewer" means a fee category with an individual sewage treatment system which uses subsurface treatment and disposal.

(f) A fee is not required for a food and beverage service establishment operated by a school as defined in sections 120.05 and 120.101.

(g) A fee of \$150 for review of the construction plans must accompany the initial license application for food and beverage service establishments, hotels, motels, lodging establishments, or resorts.

(h) When existing food and beverage service establishments, hotels, motels, lodging establishments, or resorts are extensively remodeled, a fee of \$150 must be submitted with the remodeling plans.

(i) Seasonal temporary food stands, special event food stands, and special event food stands-limited are not required to submit construction or remodeling plans for review.

Subd. 4. **POSTING REQUIREMENTS.** Every food and beverage service establishment, hotel, motel, lodging establishment, or resort must have the license posted in a conspicuous place at the establishment.

Sec. 57. Minnesota Statutes 1995 Supplement, section 157.17, subdivision 2, is amended to read:

Subd. 2. **REGISTRATION.** At the time of licensure or license renewal, a board boarding and lodging establishment or a lodging establishment that provides supportive services or health supervision services must register be registered with the commissioner, and must register annually thereafter. The registration must include the name, address, and telephone number of the establishment, the name of the operator, 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.

Sec. 58. Minnesota Statutes 1995 Supplement, section 157.20, subdivision 1, is amended to read:

Subdivision 1. **INSPECTIONS.** It shall be the duty of the commissioner to inspect, or cause to be inspected, every food and beverage service establishment, hotel, motel, restaurant, alcoholic beverage establishment, boarding establishment, lodging establishment, or 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.

Sec. 59. Minnesota Statutes 1995 Supplement, section 157.20, is amended by adding a subdivision to read:

Subd. 2a. **RISK CATEGORIES.** (a) **HIGH-RISK ESTABLISHMENT.** "High-risk establishment" means any food and beverage service establishment, hotel, motel, lodging establishment, or resort that:

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

(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.

(b) MEDIUM-RISK ESTABLISHMENT. "Medium-risk establishment" means a food and beverage service establishment, hotel, motel, lodging establishment, or resort that:

(1) serves potentially hazardous foods but with minimal holding between preparation and service; or

(2) serves foods, such as pizza, that require extensive handling followed by heat treatment.

(c) LOW-RISK ESTABLISHMENT. "Low-risk establishment" means a food and beverage service establishment, hotel, motel, lodging establishment, or resort that is not a high-risk or medium-risk establishment.

(d) RISK EXCEPTIONS. Mobile food units, seasonal permanent and seasonal temporary food stands, food carts, and special event food stands are not inspected on an established schedule and therefore are not defined as high-risk, medium-risk, or low-risk establishments.

Sec. 60. Minnesota Statutes 1995 Supplement, section 157.21, is amended to read:

157.21 INSPECTION RECORDS.

The commissioner shall keep inspection records for all food and beverage service establishments, hotels, motels, restaurants, alcoholic beverage establishments, boarding establishments, lodging establishments, and resorts, mobile food units, seasonal food stands, food carts, and special event food stands, together with the name of the owner and operator.

Sec. 61. Minnesota Statutes 1994, section 327.14, subdivision 8, is amended to read:

Subd. 8. **RECREATIONAL CAMPING AREA.** "Recreational camping area" means any area, whether privately or publicly owned, used on a daily, nightly, weekly, or longer basis for the accommodation of five or more tents or recreational camping vehicles free of charge or for compensation. "Recreational camping area" excludes:

(1) children's camps;

(2) industrial camps;

(3) migrant labor camps, as defined in Minnesota Statutes and state commissioner of health rules;

(4) United States forest service camps;

New language is indicated by underline, deletions by strikeout.

(5) state forest service camps;

(6) state wildlife management areas or state-owned public access areas which are restricted in use to picnicking and boat landing; and

(7) temporary holding areas for self-contained recreational camping vehicles created by and adjacent to motor sports facilities, if the chief law enforcement officer of an affected jurisdiction determines that it is in the interest of public safety to provide a temporary holding area.

Sec. 62. **REPORT ON IMMUNIZATION LAW AND POLICY.**

By January 15, 1997, the commissioner of health shall report recommendations to the legislature and governor relating to Minnesota immunization law and policy regarding vaccine-preventable diseases for which immunization is not currently required by law, including, but not limited to, hepatitis A, hepatitis B, varicella, and other vaccine-preventable diseases identified by the commissioner.

Sec. 63. **REPORT ON THE BIRTH DEFECTS REGISTRY SYSTEM.**

The commissioner of health shall submit to the legislature a report by January 31, 1997, on the development of the birth defects registry system, including recommendations for additional statutory authority necessary to implement the system.

Sec. 64. **STUDY; PRICE CONTRACT FOR PRESCRIPTION DRUGS.**

The commissioners of health, human services, and administration shall develop a plan to provide prescription drugs at significantly discounted prices to individuals 65 years or older whose income is below 200 percent of the current federal poverty level. The commissioners shall submit a report detailing the plan by October 1, 1996, to the chairs of the house of representatives governmental operations committee, the house of representatives state government finance division, the house of representatives health and human services committee, the senate governmental operations and veterans committee, the state government division of the senate finance committee, the senate health care committee, and the senate health care and family services finance division.

Sec. 65. **MERC STUDY.**

The medical education and research cost advisory task force shall make recommendations to the commissioner of health and to the house health and human services committee and both finance divisions, and the senate health care committee and the senate health care and family services finance division by December 15, 1996, on potential sources of funding for medical education and research and on mechanisms for the distribution of such funding sources.

Sec. 66. **REPORT ON CHILD PROGRAM IMPLEMENTATION PLAN.**

By February 15, 1997, the commissioner of health shall present to the legislature an implementation plan for the establishment of a statewide CHILD program. The implementation plan must incorporate the requirements for program structure and standards, duties of participating local organizations, training and recruitment of volunteers, and eligibility, as provided in Minnesota Statutes, sections 145.953 to 145.957. The report shall include recommendations about which executive agency is the most appropriate one within which to house the CHILD program under Minnesota Statutes, sections 145.951 to 145.957.

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Sec. 67. STUDY; CORPORATE ADULT FOSTER CARE.

The commissioner of human services shall conduct a study of the current adult foster care licensure requirements as they are applied to corporate adult foster care homes, and shall recommend any appropriate changes to these licensure requirements following the implementation of the housing with services contract act under Minnesota Statutes, chapter 144D. The commissioner shall submit a report with the results and recommendations of this study to the house health and human services committee, the house health and human services finance division, the senate health care committee, and the senate health care and family services finance division by January 15, 1997.

Sec. 68. DAKOTA COUNTY ENHANCED AUTOMATION SYSTEM DEMONSTRATION PROJECT.

Dakota county may implement a demonstration project to develop an enhanced automation system to educate public assistance recipients on their health care options. This project may include a system that combines interactive touch screen video, clinic maps, text and audio both in multiple languages to assist clients in selecting a managed health care provider. The automated system must be located in kiosks in the county. Dakota county shall report to the house health and human services committee, the house health and human services finance division, the senate health care committee, and the senate health care and family services finance division by January 1, 1998, on the results of the demonstration project. The report shall include, at a minimum, information about savings realized by the county from the demonstration project.

Sec. 69. MIGRANT FARMWORKER DATA RESEARCH.

(a) The commissioner of health shall collect, analyze, and report information on collaborative resources and nutrition available to and economic contributions to the state by migrant farmworkers in Minnesota in consultation with an advisory committee made up of representatives from migrant-serving agencies, county economic assistance program staff, and migrant farmworkers and family members.

(b) The advisory committee members should include representatives from:

- (1) Migrant Health;
- (2) Migrant Education;
- (3) Migrant Head Start;
- (4) Migrant Legal Services;
- (5) Midwest Farmworkers Employment and Training;
- (6) Women, Infants, and Children's Supplemental Feeding Program (WIC);
- (7) Tri-Valley Opportunity Council;
- (8) Minnesota Food Shelf Association;
- (9) at least two county economic assistance offices from counties with large migrant populations during the agricultural season;
- (10) the Spanish Speaking Affairs Council;

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(11) the Minnesota department of health; and

(12) at least two migrant community members or advocates.

The advisory committee, in consultation with the department of health, shall develop the research, collection, and reporting requirements and ensure that the results are shared among all members of the advisory committee and all interested parties. The advisory committee and the department of health shall report the results of their research to the house health and human services finance division and the senate health care and family service finance division by January 15, 1997.

Sec. 70. **INSTRUCTION TO REVISOR.**

In each section of Minnesota Statutes referred to in column A, the revisor of statutes shall delete the reference in column B and insert the reference in column C. The references in column C may be changed by the revisor to the section of Minnesota Statutes in which the bill sections are compiled.

<u>Column A</u>	<u>Column B</u>	<u>Column C</u>
<u>28A.15, subdivision 5</u>	<u>157.03</u>	<u>157.16</u>
<u>157.15, subdivision 1</u>	<u>157.03</u>	<u>157.011</u>
<u>160.295, subdivision 3</u>	<u>157.03</u>	<u>157.16</u>
<u>256B.0913, subdivision 5</u>	<u>157.03</u>	<u>157.011</u>
<u>299F.46, subdivision 1</u>	<u>157.03</u>	<u>157.011</u>

Sec. 71. **REPEALER.**

Minnesota Statutes 1994, sections 144.691, subdivision 4; 146.14; and 146.20; Minnesota Statutes 1995 Supplement, sections 157.03; 157.15, subdivision 2; 157.18; and 157.19, are repealed.

Sec. 72. **EFFECTIVE DATE.**

Sections 32 to 45, 64, and 68 are effective the day following final enactment.

ARTICLE 5

DEPARTMENT OF HUMAN SERVICES TECHNICAL AND POLICY CHANGES

Section 1. Minnesota Statutes 1994, section 62D.04, subdivision 5, is amended to read:

Subd. 5. **PARTICIPATION; GOVERNMENT PROGRAMS.** Health maintenance organizations shall, as a condition of receiving and retaining a certificate of authority, participate in the medical assistance, general assistance medical care, and Minnesota-Care programs. The participation required from health maintenance organizations shall be pursuant to rules adopted under section 256B.0644. A health maintenance organization is required to submit proposals in good faith to serve individuals eligible for the above programs in a geographic region of the state if, at the time of publication of a re-

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quest for proposal, the percentage of recipients in the public programs in the region who are enrolled in the health maintenance organization is less than the health maintenance organization's percentage of the total number of individuals enrolled in health maintenance organizations in the same region. Geographic regions shall be defined by the commissioner of human services in the request for proposals.

Sec. 2. Minnesota Statutes 1994, section 62N.10, subdivision 4, is amended to read:

Subd. 4. **PARTICIPATION; GOVERNMENT PROGRAMS.** Integrated service networks shall, as a condition of licensure, participate in the medical assistance, general assistance medical care, and MinnesotaCare programs. An integrated service network is required to submit proposals in good faith to serve persons who are eligible for the above programs if, at the time of publication of a request for proposal, the percentage of recipients in the public programs in the region who are enrolled in the integrated service network is less than the integrated service network's percentage of the total number of individuals enrolled in integrated service networks in the same region. Geographic regions shall be defined by the commissioner of human services in the request for proposals. The commissioner shall adopt rules specifying the participation required of the networks. The rules must be consistent with Minnesota Rules, parts 9505.5200 to 9505.5260, governing participation by health maintenance organizations in public health care programs.

Sec. 3. Minnesota Statutes 1994, section 144.0722, is amended by adding a subdivision to read:

Subd. 2a. **SEMIANNUAL ASSESSMENT BY NURSING FACILITIES.** Notwithstanding Minnesota Rules, part 9549.0059, subpart 2, item B, the individual dependencies items 21 to 24 and 28 are required to be completed in accordance with the Facility Manual for Completing Case Mix Requests for Classification, July 1987, issued by the Minnesota department of health.

Sec. 4. Minnesota Statutes 1994, section 245.462, subdivision 4, is amended to read:

Subd. 4. **CASE MANAGER.** "Case manager" means an individual employed by the county or other entity authorized by the county board to provide case management services specified in section 245.4711. A case manager must have a bachelor's degree in one of the behavioral sciences or related fields from an accredited college or university and have at least 2,000 hours of supervised experience in the delivery of services to adults with mental illness, must be skilled in the process of identifying and assessing a wide range of client needs, and must be knowledgeable about local community resources and how to use those resources for the benefit of the client. The case manager shall meet in person with a mental health professional at least once each month to obtain clinical supervision of the case manager's activities. Case managers with a bachelor's degree but without 2,000 hours of supervised experience in the delivery of services to adults with mental illness must complete 40 hours of training approved by the commissioner of human services in case management skills and in the characteristics and needs of adults with serious and persistent mental illness and must receive clinical supervision regarding individual service delivery from a mental health professional at least once each week until the requirement of 2,000 hours of supervised experience is met. Clinical supervision must be documented in the client record.

Until June 30, 1996 1999, a refugee who does not have the qualifications specified in this subdivision may provide case management services to adult refugees with serious and persistent mental illness who are members of the same ethnic group as the case man-

New language is indicated by underline, deletions by strikeout.

ager if the person: (1) is actively pursuing credits toward the completion of a bachelor's degree in one of the behavioral sciences or a related field from an accredited college or university; (2) completes 40 hours of training as specified in this subdivision; and (3) receives clinical supervision at least once a week until the requirements of obtaining a bachelor's degree and 2,000 hours of supervised experience are met.

Sec. 5. Minnesota Statutes 1994, section 245.4871, subdivision 4, is amended to read:

Subd. 4. **CASE MANAGER.** (a) "Case manager" means an individual employed by the county or other entity authorized by the county board to provide case management services specified in subdivision 3 for the child with severe emotional disturbance and the child's family. A case manager must have experience and training in working with children.

(b) A case manager must:

(1) have at least a bachelor's degree in one of the behavioral sciences or a related field from an accredited college or university;

(2) have at least 2,000 hours of supervised experience in the delivery of mental health services to children;

(3) have experience and training in identifying and assessing a wide range of children's needs; and

(4) be knowledgeable about local community resources and how to use those resources for the benefit of children and their families.

(c) The case manager may be a member of any professional discipline that is part of the local system of care for children established by the county board.

(d) The case manager must meet in person with a mental health professional at least once each month to obtain clinical supervision.

(e) Case managers with a bachelor's degree but without 2,000 hours of supervised experience in the delivery of mental health services to children with emotional disturbance must:

(1) begin 40 hours of training approved by the commissioner of human services in case management skills and in the characteristics and needs of children with severe emotional disturbance before beginning to provide case management services; and

(2) receive clinical supervision regarding individual service delivery from a mental health professional at least once each week until the requirement of 2,000 hours of experience is met.

(f) Clinical supervision must be documented in the child's record. When the case manager is not a mental health professional, the county board must provide or contract for needed clinical supervision.

(g) The county board must ensure that the case manager has the freedom to access and coordinate the services within the local system of care that are needed by the child.

(h) Until June 30, 1996 ~~1999~~, a refugee who does not have the qualifications specified in this subdivision may provide case management services to child refugees with severe emotional disturbance of the same ethnic group as the refugee if the person:

(1) is actively pursuing credits toward the completion of a bachelor's degree in one of the behavioral sciences or related fields at an accredited college or university;

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- (2) completes 40 hours of training as specified in this subdivision; and
- (3) receives clinical supervision at least once a week until the requirements of obtaining a bachelor's degree and 2,000 hours of supervised experience are met.

Sec. 6. [245A.20] RULE CONSOLIDATION.

Subdivision 1. STANDARDS. For programs or services licensed pursuant to Minnesota Rules, parts 9525.0215 to 9525.0355; 9525.0500 to 9525.0660; 9525.1500 to 9525.1690; and 9525.2000 to 9525.2140, the following standards apply and supersede the requirements of the applicable rule parts for staff qualification, orientation, and training.

Subd. 2. STAFF QUALIFICATIONS. (a) The license holder must ensure that staff is competent through training, experience, and education to meet the consumer's needs as written in the individual service plan. The staff qualifications must be documented.

(b) Delivery and evaluation of services provided by the license holder to a consumer must be coordinated by a designated person. This designated person or coordinator must minimally have a four-year degree in a field related to service provision and one-year work experience with consumers with mental retardation or related conditions, a two-year degree in a field related to service provision, and two years work experience with consumers with mental retardation or related conditions, or a certificate of competence from an accredited post-secondary program in the area of developmental disabilities and two years work experience with consumers with mental retardation or related conditions. The coordinator must provide supervision, support, and evaluation of activities that include:

(1) oversight of the license holder's responsibilities designated in the individual service plan;

(2) instructions and assistance to staff implementing the individual service plan areas;

(3) evaluation of the effectiveness of service delivery, methodologies, and progress on consumer outcomes based on the condition set for objective change; and

(4) review of incident and emergency reports, identification of incident patterns, and implementation of corrective action as necessary to reduce occurrences.

(c) The coordinator is responsible for taking necessary actions to facilitate the accomplishment of the outcomes for each consumer as specified in the consumer's individual service plan.

(d) The license holder must provide for adequate supervision for direct care staff to ensure implementation of the individual service plan.

Subd. 3. STAFF ORIENTATION. (a) Within 60 days of hiring staff who provide direct service, the license holder must provide 30 hours of orientation. Direct care staff must complete 15 of the 30 hours before providing any direct service to a consumer without direct supervision. If the staff person has received orientation training from a license holder licensed under a program rule identified in this chapter, or provides semi-independent living services only, the 15-hour requirement may be reduced to eight hours. The total orientation of 30 hours may be reduced to 15 hours if the staff person has previously received orientation training from a license holder licensed by a program rule identified in this chapter.

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(b) The 30 hours of orientation must combine supervised on-the-job training with coverage of the material in clauses (1) to (8);

(1) review of the consumer's complete individual service plan to achieve an understanding of the consumer as a unique individual;

(2) review and instructions regarding the license holder's policies and procedures including their location and access;

(3) emergency procedures;

(4) explanation of specific job functions including implementing objectives from the consumer's individual service plan;

(5) explanation of responsibilities related to sections 626.556 and 626.557, and Minnesota Rules, parts 9555.8000 to 9555.8500, including requirements of rules promulgated thereunder; sections 245A.01 to 245A.16, the human services licensing act; and Minnesota Rules, parts 9525.2700 to 9525.2810, governing use of aversive and deprivation procedures;

(6) medication administration as it applies to the individual consumer;

(7) consumer rights; and

(8) other topics necessary as determined by the consumer's individual service plan or other areas identified by the license holder.

(c) The license holder must document each employee's orientation received.

Subd. 4. **STAFF TRAINING.** (a) The license holder shall ensure that direct service staff annually complete hours of training equal to two percent of the number of hours the staff person worked or one percent for license holders under Minnesota Rules, parts 9525.0500 to 9525.0660. If direct service staff have received training from a license holder licensed under a program rule identified in this chapter, the training may also count toward training requirements for other services and of other license holders.

(b) The license holder must document the training completed by each employee.

(c) Training shall address the staff competencies necessary to address the consumer needs as identified in the consumer's individual service plan and ensure consumer health, safety, and protection of rights. Training may also include other areas identified by the license holder.

Sec. 7. [245A.21] **RESIDENTIAL BASED HABILITATION SERVICES.**

Residential service sites controlled by license holders licensed under Minnesota Rules, parts 9525.2000 to 9525.2140, for four or fewer adults are exempt from compliance with Minnesota Rules, parts 9555.5505; 9555.5515; 9555.5605; 9555.5705; 9555.6125, subparts 4 to 6; and 9555.6185. The provisions of this chapter do not apply to foster care homes that do not provide residential habilitation services funded under the home and community-based waiver programs defined in section 256B.092. The commissioner may approve alternative methods of providing overnight supervision using the process and criteria for granting a variance in section 245A.04, subdivision 9.

Sec. 8. Minnesota Statutes 1994, section 253B.11, subdivision 2, is amended to read:

Subd. 2. **FACILITIES.** Each county or a group of counties shall maintain or provide by contract a facility for confinement of persons held temporarily for observation,

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evaluation, diagnosis, treatment, and care. When the confinement is provided at a regional center, the commissioner shall charge the county of financial responsibility for the costs of confinement of persons hospitalized under section 253B.05, subdivisions 1 and 2, and section 253B.07, subdivision 6, except that the commissioner shall bill the responsible prepaid plan for medically necessary hospitalizations for individuals enrolled in a prepaid plan under contract to provide medical assistance, general assistance medical care, or MinnesotaCare services. If the prepaid plan determines under the terms of the medical assistance, general assistance medical care, or MinnesotaCare contract that a hospitalization was not medically necessary, the county is responsible. "County of financial responsibility" means the county in which the person resides at the time of confinement or, if the person has no residence in this state, the county which initiated the confinement. The charge shall be based on the commissioner's determination of the cost of care pursuant to section 246.50, subdivision 5. When there is a dispute as to which county is the county of financial responsibility, the county charged for the costs of confinement shall pay for them pending final determination of the dispute over financial responsibility. Disputes about the county of financial responsibility shall be submitted to the commissioner to be settled in the manner prescribed in section 256G.09.

Sec. 9. Minnesota Statutes 1995 Supplement, section 256.045, subdivision 3, is amended to read:

Subd. 3. **STATE AGENCY HEARINGS.** (a) State agency hearings are available for the following: (1) any person applying for, receiving or having received public assistance 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; (2) any patient or relative aggrieved by an order of the commissioner under section 252.27; (3) a party aggrieved by a ruling of a prepaid health plan; or (4) an applicant aggrieved by an adverse decision to an application for a hardship waiver under section 256B.15; or (5) any individual or facility determined by a lead agency to have maltreated a vulnerable adult under section 626.557 after they have exercised their right to administrative reconsideration under section 626.557. Individuals and organizations specified in this section may contest the specified action, decision, or final disposition before the state agency by submitting a written request for a hearing to the state agency within 30 days after receiving written notice of the action, decision, or final disposition, or within 90 days of such written notice if the applicant, recipient, patient, or relative shows good cause why the request was not submitted within the 30-day time limit.

The hearing for an individual or facility under clause (4) is the only administrative appeal to the final lead agency disposition specifically, including a challenge to the accuracy and completeness of data under section 13.04.

For purposes of this section, bargaining unit grievance procedures are not an administrative appeal.

(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.

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(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. 10. Minnesota Statutes 1994, section 256.9355, subdivision 3, is amended to read:

Subd. 3. **EFFECTIVE DATE OF COVERAGE.** The effective date of coverage is the first day of the month following the month in which eligibility is approved and the first premium payment has been received. The effective date of coverage for eligible newborns or eligible newly adoptive children added to a family receiving covered health services is the date of entry into the family. The effective date of coverage for other new recipients added to the family receiving covered health services is the first day of the month following the month in which eligibility is approved and the first premium payment has been received. The premium must be received eight working days prior to the end of the month for coverage to begin the following month. Benefits are not available until the day following discharge if an enrollee is hospitalized on the first day of coverage. Notwithstanding any other law to the contrary, benefits under sections 256.9351 to 256.9361 are secondary to a plan of insurance or benefit program under which an eligible person may have coverage and the commissioner shall use cost avoidance techniques to ensure coordination of any other health coverage for eligible persons. The commissioner shall identify eligible persons who may have coverage or benefits under other plans of insurance or who become eligible for medical assistance.

Sec. 11. Minnesota Statutes 1995 Supplement, section 256.969, subdivision 1, is amended to read:

Subdivision 1. **HOSPITAL COST INDEX.** (a) The hospital cost index shall be 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 annual-compounded basis.

(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 through calendar year 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. 12. Minnesota Statutes 1995 Supplement, 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 al-

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lowable costs of the Medicare program in effect during the base year. Rates under the general assistance medical care program, medical assistance, and MinnesotaCare programs shall not be rebased to more current data on January 1, 1997. The base year operating payment rate per admission is standardized by the case mix index and adjusted by the hospital cost index, relative values, and disproportionate population adjustment. The cost and charge data used to establish operating rates shall only reflect inpatient services covered by medical assistance and shall not include property cost information and costs recognized in outlier payments.

Sec. 13. Minnesota Statutes 1995 Supplement, 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 of even-numbered years~~ 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.~~

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. 14. Minnesota Statutes 1994, section 256B.03, is amended by adding a subdivision to read:

Subd. 3. **AMERICAN INDIAN HEALTH FUNDING.** Notwithstanding subdivision 1 and sections 256B.0625 and 256D.03, paragraph (f), the commissioner may make payments to federally recognized Indian tribes with a reservation in the state to provide medical assistance to Indians, as defined under federal law, who reside on or near the reservation. The payments may be made in the form of a block grant or other payment mechanism determined in consultation with the tribe. Any alternative payment mechanism agreed upon by the tribes and the commissioner under this subdivision is not dependent upon county agreement but is intended to create a direct payment mechanism between the state and the tribe for the administration of the medical assistance program and for covered services.

For purposes of this subdivision, "Indian tribe" means a tribe, band, or nation, or other organized group or community of Indians that is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians and for which a reservation exists as is consistent with Public Law Number 100-485, as amended.

Payments under this subdivision may not result in an increase in expenditures that would not otherwise occur in the medical assistance program under this chapter or the general assistance medical care program under chapter 256D.

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Sec. 15. Minnesota Statutes 1995 Supplement, 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~~ has a physical or mental impairment that would prohibit the recipient from safely access accessing and use using a bus, taxi, other commercial transportation, or private automobile. Special transportation includes driver-assisted service to eligible individuals. Driver-assisted service includes passenger pickup at and return to the individual's residence or place of business, assistance with admittance of the individual to the medical facility, and assistance in passenger securement or in securing of wheelchairs or stretchers in the vehicle. The commissioner shall establish maximum medical assistance reimbursement rates for special transportation services for persons who need a wheelchair lift 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. 16. Minnesota Statutes 1995 Supplement, section 256B.0625, subdivision 30, is amended to read:

Subd. 30. **OTHER CLINIC SERVICES.** (a) Medical assistance covers rural health clinic services, federally qualified health center services, nonprofit community health clinic services, public health clinic services, and the services of a clinic meeting the criteria established in rule by the commissioner. Rural health clinic services and federally qualified health center services mean services defined in United States Code, title 42, section 1396d(a)(2)(B) and (C). Payment for rural health clinic and federally qualified health center services shall be made according to applicable federal law and regulation.

(b) A federally qualified health center that is beginning initial operation shall submit an estimate of budgeted costs and visits for the initial reporting period in the form and detail required by the commissioner. A federally qualified health center that is already in operation shall submit an initial report using actual costs and visits for the initial reporting period. Within 90 days of the end of its reporting period, a federally qualified health center shall submit, in the form and detail required by the commissioner, a report of its operations, including allowable costs actually incurred for the period and the actual number of visits for services furnished during the period, and other information required by the commissioner. Federally qualified health centers that file Medicare cost reports shall provide the commissioner with a copy of the most recent Medicare cost report filed with the

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Medicare program intermediary for the reporting year which support the costs claimed on their cost report to the state.

(c) In order to continue cost-based payment under the medical assistance program according to paragraphs (a) and (b), a federally qualified health center or rural health clinic must apply for designation as an essential community provider within six months of final adoption of rules by the department of health according to section 62Q.19, subdivision 7. For those federally qualified health centers and rural health clinics that have applied for essential community provider status within the six-month time prescribed, medical assistance payments will continue to be made according to paragraphs (a) and (b) for the first three years of essential community provider status after application. For federally qualified health centers and rural health clinics that either do not apply within the time specified above, ~~that are denied essential community provider status by the department of health,~~ or who have had essential community provider status for three years, medical assistance payments for health services provided by these entities shall be according to the same rates and conditions applicable to the same service provided by health care providers that are not federally qualified health centers or rural health clinics. This paragraph takes effect only if the Minnesota health care reform waiver is approved by the federal government, and remains in effect for as long as the Minnesota health care reform waiver remains in effect. When the waiver expires, this paragraph expires, and the commissioner of human services shall publish a notice in the State Register and notify the revisor of statutes.

Sec. 17. Minnesota Statutes 1994, section 256B.0627, subdivision 1, as amended by Laws 1995, chapter 207, article 6, sections 52 and 125, subdivision 9, is amended to read:

Subdivision 1. **DEFINITION.** (a) "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. An initial assessment for personal care services is conducted on individuals who are requesting personal care services or for those consumers who have never had a public health nurse assessment. The initial assessment must include: a face-to-face health status assessment and determination of baseline need, collection of initial case data, identification of appropriate services and service plan development, coordination of initial services, referrals and follow-up to appropriate payers and community resources, completion of required reports, obtaining service authorization, and consumer education. A reassessment visit for personal care services is conducted at least annually or when there is a significant change in consumer condition and need for services. The reassessment visit includes a review of initial baseline data, evaluation of service outcomes, redetermination of service need, modification of service plan and appropriate referrals, update of initial forms, obtaining service authorization, and on-going consumer education. Assessments for medical assistance home care services for mental retardation or related conditions and alternative care services for developmentally disabled home and community-based waived recipients may be conducted by the county public health nurse to ensure coordination and avoid duplication. Assessments must be completed on forms provided by the commissioner within 30 days of a request for home care services by a recipient or responsible party.

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(b) "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.

(c) "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 service 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.

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

(e) "Personal care assistant" means a person who: (1) is at least 18 years old, except for persons 16 to 18 years of age who participated in a related school-based job training program or have completed a certified home health aide competency evaluation; (2) is able to read, write, and speak English, or effectively communicate with sign language, as well as communicate with the recipient and personal care provider organization; (3) effective July 1, 1996, has completed one of the training requirements as specified in Minnesota Rules, part 9505.0335, subpart 3, items A to D; (4) has the ability to, and provides covered personal care services according to the recipient's care plan, responds appropriately to recipient needs, and reports changes in the recipient's condition to the supervising registered nurse; (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, unless the individual meets the rehabilitation criteria specified in Minnesota Rules, part 4668.0020, subpart 15.

(f) "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, and managerial officials are subject to a criminal history check background study as provided in section 245A.04 at the time of application. This applies to currently enrolled personal care provider organizations and those agencies seeking enrollment as a personal care provider organization. An organization will be barred from enrollment if an owner or managerial official of the organization has ever been convicted of a crime specified in Minnesota Rules, part 4668.0020, subpart 14, or a comparable crime in another jurisdiction, unless the owner or managerial official meets the rehabilitation criteria specified in Minnesota Rules, part 4668.0020, subpart 15; (2) the organization must maintain a surety bond and liability insurance throughout the duration of enrollment and provides proof thereof. The insurer must notify the department of human services of the cancellation or lapse of policy; and (3) the organization must maintain documentation of services as specified in Minnesota Rules, part 9505.2175, subpart 7, as well as evidence of compliance with personal care assistant training requirements.

(g) "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

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least 24 hours but not more than six months. The person delegated as a responsible party must be able to meet the definition of responsible party, except that the delegated responsible party is required to reside with the recipient only while serving as the responsible party. Foster care license holders may be designated the responsible party for residents of the foster care home if case management is provided as required in section 256B.0625, subdivision 19a. For persons who, as of April 1, 1992, are sharing personal care services in order to obtain the availability of 24-hour coverage, an employee of the personal care provider organization may be designated as the responsible party if case management is provided as required in section 256B.0625, subdivision 19a.

(h) "Service plan" means a written description of the services needed based on the assessment developed by the nurse who conducts the assessment together with the recipient or responsible party. The service plan shall include a description of the covered home care services, frequency and duration of services, and expected outcomes and goals. The recipient and the provider chosen by the recipient or responsible party must be given a copy of the completed service plan within 30 calendar days of the request for home care services by the recipient or responsible party.

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

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

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

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

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

Sec. 18. Minnesota Statutes 1994, section 256B.0627, subdivision 4, as amended by Laws 1995, chapter 207, article 6, sections 54 and 125, subdivision 11, 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) repetitive maintenance range of motion and, muscle strengthening exercises, and other tasks specific to maintaining a recipient's optimal level of function;
- (4) respiratory assistance;
- (5) transfers and ambulation;
- (6) bathing, grooming, and hairwashing necessary for personal hygiene;
- (7) turning and positioning;
- (8) assistance with furnishing medication that is self-administered;
- (9) application and maintenance of prosthetics and orthotics;
- (10) cleaning medical equipment;

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(11) dressing or undressing;

(12) assistance with eating and meal preparation and necessary grocery shopping;

(13) accompanying a recipient to obtain medical diagnosis or treatment; ~~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

(18) incidental household services that are an integral part of a personal care service described in clauses (1) to ~~(13)~~ (17).

For purposes of this subdivision, monitoring and observation means watching for outward visible signs that are likely to occur and for which there is a covered personal care service or an appropriate personal care intervention.

(b) The personal care services that are not eligible for payment are the following:

(1) services not ordered by the physician;

(2) assessments by personal care provider organizations or by independently enrolled registered nurses;

(3) services that are not in the service plan;

(4) services provided by the recipient's spouse, legal guardian for an adult or child recipient, or parent of a recipient under age 18;

(5) services provided by a foster care provider of a recipient who cannot direct their own care, unless monitored by a county or state case manager under section 256B.0625, subdivision 19a;

(6) services provided by the residential or program license holder in a residence for more than four persons;

~~(6)~~ (7) services that are the responsibility of a residential or program license holder under the terms of a service agreement and administrative rules;

~~(7)~~ (8) sterile procedures;

~~(8)~~ (9) injections of fluids into veins, muscles, or skin;

(9) (10) 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;

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(iv) the relative incurs substantial expenses by providing personal care for the recipient; or

(v) because of labor conditions or intermittent hours of care needed, the relative is needed in order to provide an adequate number of qualified personal care assistants to meet the medical needs of the recipient;

~~(10)~~ (11) homemaker services that are not an integral part of a personal care services;

~~(11)~~ (12) home maintenance, or chore services;

~~(12)~~ (13) services not specified under paragraph (a); and

~~(13)~~ (14) services not authorized by the commissioner or the commissioner's designee.

Sec. 19. Minnesota Statutes 1994, section 256B.0627, subdivision 5, as amended by Laws 1995, chapter 207, article 6, sections 55 and 125, subdivision 12, is amended to read:

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

(a) **LIMITS ON SERVICES WITHOUT PRIOR AUTHORIZATION.** A recipient may receive the following 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) assessments and reassessments (1) any initial assessment and; (2) up to two reassessments per year done to determine a recipient's need for personal care services.

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

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

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

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

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

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

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

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

(1) The amount and type of service authorized based upon the assessment and service plan will follow the recipient if the recipient chooses to change providers.

(2) If the recipient's medical need changes, the recipient's provider may assess the need for a change in service authorization and request the change from the county public health nurse. Within 30 days of the request, the public health nurse will determine whether to request the change in services based upon the provider assessment, or conduct a home visit to assess the need and determine whether the change is appropriate.

(3) To continue to receive personal care services when the recipient displays no significant change, the county public health nurse has the option to review with the commissioner, or the commissioner's designee, the service plan on record and receive authorization for up to an additional 12 months at a time for up to three years.

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

(1) **HOME HEALTH SERVICES.** All home health services provided by a licensed nurse or a home health aide that exceed the limits established in paragraph (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 assessments established in paragraph (a). The amount of personal care services authorized must be based on the recipient's home care rating. A child may not be found to be dependent in an activity of daily living if because of the child's age an adult would either perform the activity for the child or assist the child with the activity and the amount of assistance needed is similar to the assistance appropriate for a typical child of the same age. Based on medical necessity, the commissioner may authorize:

(A) up to 1.75 ~~two~~ times the average number of direct care hours provided in nursing facilities for the recipient's comparable case mix level; or

(B) up to 2.625 ~~three~~ times the average number of direct care hours provided in nursing facilities for recipients who have complex medical needs or are dependent in at least

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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, for care provided in a regional treatment center for recipients who have Level I behavior; plus any inflation adjustment as provided by the legislature for personal care service; or

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

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

(E) (F) a reasonable amount of time for the 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, ~~for the report year 1993, as established by July 11, 1994~~ May 1, 1992, shall be calculated and incorporated into the home care limits on July 1, ~~1996~~ 1992. These limits shall be calculated to the nearest quarter hour.

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

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

(A) daily tube feedings;

(B) daily parenteral therapy;

(C) wound or decubiti care;

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

(E) catheterization;

(F) ostomy care;

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(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);

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(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.

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

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

(h) **PRIOR AUTHORIZATION REQUESTS; TEMPORARY SERVICES.** The agency nurse, the independently enrolled private duty nurse, or county public health nurse may request a temporary authorization for home care services by telephone. The commissioner may approve a temporary level of home care services based on the assess-

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ment, and service or care plan information, and primary payer coverage determination information as required. Authorization for a temporary level of home care services including nurse supervision is limited to the time specified by the commissioner, but shall not exceed 45 days, unless extended because the county public health nurse has not completed the required assessment and service plan, or the commissioner's determination has not been made. The level of services authorized under this provision shall have no bearing on a future prior authorization.

(i) **PRIOR AUTHORIZATION REQUIRED IN FOSTER CARE SETTING.**

Home care services provided in an adult or child foster care setting must receive prior authorization by the department according to the limits established in paragraph (a).

The commissioner may not authorize:

(1) home care services that are the responsibility of the foster care provider under the terms of the foster care placement agreement and administrative rules. Requests for home care services for recipients residing in a foster care setting must include the foster care placement agreement and determination of difficulty of care;

(2) personal care services when the foster care license holder is also the personal care provider or personal care assistant unless the recipient can direct the recipient's own care, or case management is provided as required in section 256B.0625, subdivision 19a;

(3) personal care services when the responsible party is an employee of, or under contract with, or has any direct or indirect financial relationship with the personal care provider or personal care assistant, unless case management is provided as required in section 256B.0625, subdivision 19a;

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

~~(5)~~ (5) home care services when combined with foster care payments, other than room and board payments that exceed the total amount that public funds would pay for the recipient's care in a medical institution.

Sec. 20. Minnesota Statutes 1994, section 256B.0627, is amended by adding a subdivision to read:

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

(1) skilled nurse visits for the sole purpose of supervision of the home health aide;

(2) a skilled nursing visit:

(i) only for the purpose of monitoring medication compliance with an established medication program for a recipient; or

(ii) to administer or assist with medication administration, including injections, pre-filling syringes for injections, or oral medication set-up of an adult recipient, when as determined and documented by the registered nurse, the need can be met by an available pharmacy or the recipient is physically and mentally able to self-administer or prefill a medication;

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(3) home care services to a recipient who is eligible for covered services including hospice, if elected by the recipient, under the Medicare program or any other insurance held by the recipient;

(4) services to other members of the recipient's household;

(5) a visit made by a skilled nurse solely to train other home health agency workers;

(6) any home care service included in the daily rate of the community-based residential facility where the recipient is residing;

(7) nursing and rehabilitation therapy services that are reasonably accessible to a recipient outside their place of residence, excluding the assessment, counseling and education, and personal care;

(8) any home health agency service, excluding personal care assistant services and private duty nursing services, which are performed in a place other than the recipient's residence; and

(9) Medicare evaluation or administrative nursing visits on dual-eligible recipients that do not qualify for Medicare visit billing.

Sec. 21. Minnesota Statutes 1995 Supplement, 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

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(17) training for direct informal caregivers; and

(18) telemedicine devices to monitor recipients in their own homes as an alternative to hospital care, nursing home care, or home visits.

(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 medical supplies and equipment without prior approval from the commissioner when: (1) there is no other funding source; (2) the supplies and equipment are specified in the individual's care plan as medically necessary to enable the individual to remain in the community according to the criteria in Minnesota Rules, part 9505.0210, item A; and (3) the supplies and equipment represent an effective and appropriate use of alternative care funds. A county may use alternative care funds to purchase supplies and equipment from a non-Medicaid certified vendor if the cost for the items is less than that of a Medicaid vendor. A county is not required to contract with a provider of supplies and equipment if the monthly cost of the supplies and equipment is less than \$250.

(g) For purposes of this section, residential care services are services which are provided to individuals living in residential care homes. Residential care homes are currently licensed as board and lodging establishments and are registered with the department of health as providing special services. 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

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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.

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Assisted living services as defined in this section shall not be authorized in boarding and lodging establishments licensed according to sections 157.03 and 157.15 to 157.22.

(i) For the purposes of this section, reimbursement for assisted living services and residential care services shall be a monthly rate negotiated 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. For alternative care assisted living projects established under Laws 1988, chapter 689, article 2, section 256, monthly rates may not exceed 65 percent of the greater of either 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.

(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.

(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. 22. Minnesota Statutes 1994, section 256B.0913, subdivision 7, is amended to read:

Subd. 7. **CASE MANAGEMENT.** The lead agency shall appoint a social worker from the county agency or a registered nurse from the county public health nursing service of the local board of health to be the case manager for any person receiving services funded by the alternative care program. The case manager must ensure the health and safety of the individual client and is responsible for the cost-effectiveness of the alternative care individual care plan. The county may allow a case manager to delegate certain aspects of the case management activity to another individual employed by the county provided there is oversight of the individual by the case manager. The case manager may not delegate those aspects which require professional judgment including assessments, reassessments, and care plan development.

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Sec. 23. Minnesota Statutes 1994, section 256B.0915, subdivision 1b, is amended to read:

Subd. 1b. **PROVIDER QUALIFICATIONS AND STANDARDS.** The commissioner must enroll qualified providers of elderly case management services under the home and community-based waiver for the elderly under section 1915(c) of the Social Security Act. The enrollment process shall ensure the provider's ability to meet the qualification requirements and standards in this subdivision and other federal and state requirements of this service. An elderly case management provider is an enrolled medical assistance provider who is determined by the commissioner to have all of the following characteristics:

(1) the legal authority for alternative care program administration under section 256B.0913;

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

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

(4) the legal authority to provide preadmission screening under section 256B.0911, subdivision 4;

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

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

(7) the county may allow a case manager to delegate certain aspects of the case management activity to another individual employed by the county provided there is oversight of the individual by the case manager. The case manager may not delegate those aspects which require professional judgment including assessments, reassessments, and care plan development.

Sec. 24. Minnesota Statutes 1995 Supplement, 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 waived 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 wai-

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ered services exceeds the monthly limit established in this paragraph, the annual cost of the waived services shall be determined. In this event, the annual cost of waived services shall not exceed 12 times the monthly limit calculated in this paragraph. The statewide average payment rate is calculated by determining the statewide average monthly nursing home rate, effective July 1 of the fiscal year in which the cost is incurred, less the statewide average monthly income of nursing home residents who are age 65 or older, and who are medical assistance recipients in the month of March of the previous state fiscal year. The annual cost divided by 12 of elderly or disabled waived services for a person who is a nursing facility resident at the time of requesting a determination of eligibility for elderly or disabled waived services shall 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 waived 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, private duty nursing, home health aide, and personal care services for waiver recipients must be approved by the case manager and included in the individual care plan.

(d) ~~Expenditures for extended medical supplies and equipment that cost over \$150 per month~~ For both the elderly waiver and the nursing facility disabled waiver must have the commissioner's prior approval waivers, a county may purchase extended supplies and equipment without prior approval from the commissioner when there is no other funding source and the supplies and equipment are specified in the individual's care plan as medically necessary to enable the individual to remain in the community according to the criteria in Minnesota Rules, part 9505.0210, items A and B. 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 waived 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 waived 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

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mix classification to which the individual receiving foster care is assigned; the rate must allow for other waiver and medical assistance home care services to be authorized by the case manager.

(g) The assisted living and residential care service rates for elderly and community alternatives for disabled individuals (CADI) waivers shall be made to the vendor as a monthly rate negotiated with the county agency. 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. For alternative care assisted living projects established under Laws 1988, chapter 689, article 2, section 256, monthly rates may not exceed 65 percent of the greater of either the statewide or any of the geographic groups' weighted average monthly medical assistance nursing facility payment rate for the case mix resident class to which the elderly or disabled client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059. The rate may not cover direct rent or food costs.

(h) 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. 25. Minnesota Statutes 1995 Supplement, section 256B.093, subdivision 3, is amended to read:

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

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

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

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

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(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. 26. Minnesota Statutes 1995 Supplement, section 256B.15, subdivision 5, is amended 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. The commissioner shall have authority to hear claimant appeals, pursuant to section 256.045, when an application for a hardship waiver is denied in whole or part.

Sec. 27. Minnesota Statutes 1995 Supplement, 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 section 256B.431 and 256B.50.

Sec. 28. Minnesota Statutes 1995 Supplement, section 256B.434, subdivision 10, is amended to read:

Subd. 10. **EXEMPTIONS.** (a) To the extent permitted by federal law, (1) a facility that has entered into a contract under this section is not required to file a cost report, as defined in Minnesota Rules, part 9549.0020, subpart 13, for any year after the base year that is the basis for the calculation of the contract payment rate for the first rate year of the alternative payment demonstration project contract; and (2) a facility under contract is not subject to audits of historical costs or revenues, or paybacks or retroactive adjustments based on these costs or revenues, except audits, paybacks, or adjustments relating to the cost report that is the basis for calculation of the first rate year under the contract.

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(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 section~~ 144A.073. Nothing in this section prevents a nursing facility participating in the alternative payment demonstration project under this section from seeking approval of an exception to the moratorium through the process established in section ~~144A.071~~ 144A.073, 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.

Sec. 29. Minnesota Statutes 1995 Supplement, section 256B.49, subdivision 6, is amended to read:

Subd. 6. **ADMISSION CERTIFICATION.** In determining an individual's eligibility for the community alternative care (CAC) 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. 30. Minnesota Statutes 1995 Supplement, section 256B.49, subdivision 7, is amended 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 or the traumatic brain injury nursing facility 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. 31. Minnesota Statutes 1994, section 256B.49, is amended by adding a subdivision to read:

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Subd. 8. CASE MANAGEMENT SERVICES. The county may allow a case manager to delegate certain aspects of the case management activity to another individual employed by the county provided there is oversight of the individual by the case manager. The case manager may not delegate those aspects which require professional judgment including assessments, reassessments, and care plan development.

Sec. 32. Minnesota Statutes 1995 Supplement, 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. 33. Minnesota Statutes 1995 Supplement, section 256D.03, subdivision 4, is amended to read:

Subd. 4. **GENERAL ASSISTANCE MEDICAL CARE; SERVICES.** (a) For a person who is eligible under subdivision 3, paragraph (a), clause (3), general assistance medical care covers, except as provided in paragraph (c):

(1) inpatient hospital services;

(2) outpatient hospital services;

(3) services provided by Medicare certified rehabilitation agencies;

(4) prescription drugs and other products recommended through the process established in section 256B.0625, subdivision 13;

(5) equipment necessary to administer insulin and diagnostic supplies and equipment for diabetics to monitor blood sugar level;

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- (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;
 - (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) Except as provided in paragraph (c), for a recipient who is eligible under subdivision 3, paragraph (a), clause (1) or (2), general assistance medical care covers the services listed in paragraph (a) with the exception of special transportation services.
- (c) Gender reassignment surgery and related services are not covered services under this subdivision unless the individual began receiving gender reassignment services prior to July 1, 1995.

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

(d) In order to contain costs, the commissioner of human services shall select vendors of medical care who can provide the most economical care consistent with high medical standards and shall where possible contract with organizations on a prepaid capitation basis to provide these services. The commissioner shall consider proposals by counties and vendors for prepaid health plans, competitive bidding programs, block grants, or other vendor payment mechanisms designed to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided. Before implementing prepaid programs in counties with a county operated or affiliated public teaching hospital or a hospital or clinic operated by the University of Minnesota, the commissioner shall consider the risks the prepaid program creates for the hospital and allow the county or hospital the opportunity to participate in the program in a manner that reflects the risk of adverse selection and the nature of the patients served by the hospital, provided the terms of participation in the program are competitive with the terms of other participants considering the nature of the population served. Payment for services provided pursuant to this subdivision shall be as provided to medical assistance vendors of these services under sections 256B.02, subdivision 8, and 256B.0625, ~~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.

(e) 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

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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.

(f) Any county may, from its own resources, provide medical payments for which state payments are not made.

(g) Chemical dependency services that are reimbursed under chapter 254B must not be reimbursed under general assistance medical care.

(h) The maximum payment for new vendors enrolled in the general assistance medical care program after the base year shall be determined from the average usual and customary charge of the same vendor type enrolled in the base year.

(i) The conditions of payment for services under this subdivision are the same as the conditions specified in rules adopted under chapter 256B governing the medical assistance program, unless otherwise provided by statute or rule.

Sec. 34. Minnesota Statutes 1994, section 256I.04, subdivision 1, is amended to read:

Subdivision 1. **INDIVIDUAL ELIGIBILITY REQUIREMENTS.** An individual is eligible for and entitled to a group residential housing payment to be made on the individual's behalf if the county agency has approved the individual's residence in a group residential housing setting and the individual meets the requirements in paragraph (a) or (b).

(a) The individual is aged, blind, or is over 18 years of age and disabled as determined under the criteria used by the title II program of the Social Security Act, and meets

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the resource restrictions and standards of the supplemental security income program, and the individual's countable income after deducting the exclusions and disregards of the SSI program and the medical assistance personal needs allowance under section 256B.35 is less than the monthly rate specified in the county agency's agreement with the provider of group residential housing in which the individual resides.

(b) The individual meets a category of eligibility under section 256D.05, subdivision 1, paragraph (a), and the individual's resources are less than the standards specified by section 256D.08, and the individual's countable income as determined under sections 256D.01 to 256D.21, less the medical assistance personal needs allowance under section 256B.35 is less than the monthly rate specified in the county agency's agreement with the provider of group residential housing in which the individual resides.

Sec. 35. Minnesota Statutes 1995 Supplement, 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. Group residential housing agreements may be terminated with or without cause by either the county or the provider with two calendar months prior notice.

Sec. 36. Minnesota Statutes 1995 Supplement, 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; (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

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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 or, within the previous six months, has been 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), and receives a federal Section 8 housing subsidy, 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. A resident in a demonstration project site who no longer participates in the demonstration program shall retain eligibility for a group residential housing payment in an amount determined under section 256I.06, subdivision 8, using the MSA equivalent rate. Service funding under section 256I.05, subdivision 1a, ~~must will end June 30, 1997, if federal matching funds are available and the services can be provided through a managed care entity. If federal matching funds are not available, then service funding will continue under section 256I.05, subdivision 1a. 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.

Sec. 37. RECOMMENDATIONS ON HOME CARE PROVIDED IN FOSTER CARE SETTINGS.

The commissioner of human services, in consultation with counties, home care providers, foster care providers, and representatives of home care recipients who are both children and adults, shall review the provision of home care services to children and adults living in licensed foster care settings. By November 15, 1996, the commissioner shall report to the legislature on recommendations for standards to determine home care service authorization for foster care residents, which will assure appropriate care for recipients while avoiding duplication of services and payment.

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Sec. 38. COMMISSIONER'S TASK FORCE TO CONSOLIDATE MINNESOTA RULES; CONSUMER INFORMATION SYSTEM AND EDUCATIONAL MATERIALS.

The commissioner, in consultation with the commissioner of health and representatives of affected organizations, including counties, providers, the Minnesota Nurses Association, and advocacy groups shall develop proposed legislation consolidating Minnesota Rules, parts 9525.0215 to 9525.0355; 9525.0500 to 9525.0660; 9525.1500 to 9525.1690; and 9525.2000 to 9525.2140, new regulatory strategies to determine compliance with the new consolidated standard, and strategies to develop a consumer information system and educational materials. The purpose of the rule consolidation and regulatory strategies are to eliminate duplication, outmoded provisions and unnecessary paperwork and ensure adequate oversight and monitoring of medication administration, while protecting safety, health, rights and protection for persons using the services licensed under the above parts. The purpose of the consumer information systems and educational materials are to provide easy access to information for consumers and interested parties to make informed choices about service delivery. The commissioner shall provide recommended legislation to consolidate these rules and regulate the provisions of the rules more efficiently to the legislative commission on health care access by November 15, 1996.

Sec. 39. REPEALER.

Minnesota Rules, part 9505.5230, is repealed effective July 1, 1996.

Minnesota Statutes 1995 Supplement, section 256B.69, subdivision 4a, is repealed.

Sec. 40. EFFECTIVE DATES.

Sections 1 and 2 are effective for requests for proposals issued on or after July 1, 1996.

Section 14 is effective October 1, 1996, or upon receipt of any necessary federal approval, whichever date is later.

ARTICLE 6

MISCELLANEOUS

Section 1. Minnesota Statutes 1994, section 148.235, is amended by adding a subdivision to read:

Subd. 6. STANDARDS FOR WRITTEN AGREEMENTS; REVIEW AND FILING. Written agreements required by subdivisions 2 and 4 shall be maintained at the primary practice site of the nurse practitioner, clinical specialist in psychiatric and mental health nursing and the collaborating physician. The written agreement does not need to be filed with the board of nursing, provided that the information required to be filed with the board, either on initial application for prescribing privileges or on renewal of privileges, has been submitted.

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Sec. 2. Minnesota Statutes 1994, section 245.94, subdivision 2a, is amended to read:

Subd. 2a. **MANDATORY REPORTING.** Within 24 hours after a client suffers death or serious injury, the agency, facility, or program director shall notify the ombudsman of the death or serious injury.

Sec. 3. Minnesota Statutes 1994, section 245.94, subdivision 3, is amended to read:

Subd. 3. **COMPLAINTS.** The ombudsman may receive a complaint from any source concerning an action of an agency, facility, or program. After completing a review, the ombudsman shall inform the complainant and the agency, facility, or program. No client may be punished nor may the general condition of the client's treatment be unfavorably altered as a result of an investigation, a complaint by the client, or by another person on the client's behalf. An agency, facility, or program shall not retaliate or take adverse action, as defined in section 626.557, subdivision 17, paragraph (e), against a client or other person, who in good faith makes a complaint or assists in an investigation. The ombudsman may classify as confidential, the identity of a complainant, upon request of the complainant.

Sec. 4. Minnesota Statutes 1994, section 245.95, subdivision 2, is amended to read:

Subd. 2. **GENERAL REPORTS.** In addition to whatever conclusions or recommendations the ombudsman may make to the governor on an ad hoc basis, the ombudsman shall, at the end of each year biennium, report to the governor concerning the exercise of the ombudsman's functions during the preceding year biennium.

Sec. 5. Minnesota Statutes 1994, section 245.97, subdivision 6, is amended to read:

Subd. 6. **TERMS, COMPENSATION, AND REMOVAL AND EXPIRATION.** The membership terms, compensation, and removal of members of the committee and the filling of membership vacancies are governed by section 15.0575. ~~The ombudsman committee and the medical review subcommittee expire on June 30, 1994.~~

Sec. 6. Minnesota Statutes 1994, section 246.57, is amended by adding a subdivision to read:

Subd. 6. **DENTAL SERVICES.** The commissioner of human services shall authorize any regional treatment center or state-operated nursing home under the commissioner's authority to provide dental services to disabled persons who are eligible for medical assistance and are not residing at the regional treatment center or state-operated nursing home, provided that the reimbursement received for these services is sufficient to cover actual costs. To provide these services, regional treatment centers and state-operated nursing homes may participate under contract with health networks in their service area. Notwithstanding section 16B.06, subdivision 2, the commissioner of human services may delegate the execution of these dental services contracts to the chief executive officers of the regional centers or state-operated nursing homes. All receipts for these dental services shall be retained by the regional treatment center or state-operated nursing home that provides the services and shall be in addition to other funding the regional treatment center or state-operated nursing home receives.

Sec. 7. Minnesota Statutes 1994, section 256.482, is amended by adding a subdivision to read:

Subd. 8. **SUNSET.** Notwithstanding section 15.059, subdivision 5, the council on disability shall not sunset until June 30, 2001.

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Sec. 8. Minnesota Statutes 1994, section 256.73, subdivision 1, is amended to read:

Subdivision 1. **DEPENDENT CHILDREN.** Assistance shall be given under sections 256.72 to 256.87 to or on behalf of any dependent child who:

(1) Resides Has resided in Minnesota for at least 30 days or, if residing in the state for less than 30 days, the child or the child's caretaker relative meets one of the criteria specified in subdivision 1b;

(2) Is otherwise eligible; the child shall not be denied aid because of conditions of the home in which the child resides.

Sec. 9. Minnesota Statutes 1994, section 256.73, is amended by adding a subdivision to read:

Subd. 1b. **RESIDENCY CRITERIA.** A child or caretaker relative who has resided in Minnesota for less than 30 days is considered to be a Minnesota resident if:

(1) either the child or the caretaker relative was born in the state;

(2) either the child or the caretaker relative has, in the past, resided in this state for at least 365 consecutive days;

(3) either the child or the caretaker relative came to this state to join a close relative who has resided in this state for at least one year. For purposes of this clause, "close relative" means a parent, grandparent, brother, sister, spouse, or child; or

(4) the caretaker relative came to this state to accept a bona fide offer of employment and was eligible to accept the employment.

A county agency may waive the 30-day residency requirement in cases of emergency or where unusual hardship would result from denial of assistance. The county agency must report to the commissioner within 30 days on any waiver granted under this section. The county shall not deny an application solely because the applicant does not meet at least one of the criteria in this subdivision, but shall continue to process the application and leave the application pending until the residency requirement is met or until eligibility or ineligibility is established.

Sec. 10. [256.9752] **SENIOR NUTRITION PROGRAMS.**

Subdivision 1. **PROGRAM GOALS.** It is the goal of all agencies on aging and senior nutrition programs to support the physical and mental health of seniors living in the community by:

(1) promoting nutrition programs that serve senior citizens in their homes and communities; and

(2) providing, within the limit of funds available, the support services that will enable the senior citizen to access nutrition programs in the most cost-effective and efficient manner.

Subd. 2. **AUTHORITY.** The Minnesota board on aging shall allocate to area agencies on aging the federal funds which are received for the senior nutrition programs of congregate dining and home-delivered meals in a manner consistent with federal requirements.

Subd. 3. **NUTRITION SUPPORT SERVICES.** (a) Funds allocated to an area agency on aging for nutrition support services may be used for the following:

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(1) transportation of home-delivered meals and purchased food and medications to the residence of a senior citizen;

(2) expansion of home-delivered meals into unserved and underserved areas;

(3) transportation to supermarkets or delivery of groceries from supermarkets to homes;

(4) vouchers for food purchases at selected restaurants in isolated rural areas;

(5) food stamp outreach;

(6) transportation of seniors to congregate dining sites;

(7) nutrition screening assessments and counseling as needed by individuals with special dietary needs, performed by a licensed dietitian or nutritionist; and

(8) other appropriate services which support senior nutrition programs, including new service delivery models.

(b) An area agency on aging may transfer unused funding for nutrition support services to fund congregate dining services and home-delivered meals.

Sec. 11. SAFE HOUSE PROGRAM IN FERGUS FALLS.

Notwithstanding Minnesota Statutes, section 299A.28, another similar safe house program, primarily focusing on the safety and protection of children, may be developed and operate in the city of Fergus Falls if the program members have completed a criminal background check satisfactory to the Fergus Falls police department. However, the commissioner of public safety is not required to perform the duties listed under Minnesota Statutes, section 299A.28, subdivision 2, with respect to the program in Fergus Falls and is not accountable or liable for any act or failure to act by a member of that program.

Sec. 12. Laws 1995, chapter 207, article 1, section 2, subdivision 4, is amended to read:

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

New language is indicated by underline, deletions by strikeout.

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 256B.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

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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 nonstate 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.

Sec. 13. PLANNING FOR RESIDENTIAL FACILITY FOR PARENTS WITH HIV OR AIDS AND THEIR CHILDREN.

The commissioner of health shall report to the legislature by January 15, 1997, on the planning activities for HIV housing, in cooperation with the Coalition for Housing for People with AIDS, including consideration of appropriate housing options so that parents with HIV or AIDS may live with their children when the disease debilitates the parent so that the parent is not able to care for their children. The report shall also make appropriate recommendations concerning the development of such housing.

Sec. 14. WAIVER AUTHORITY.

The commissioner of human services shall seek federal waivers as necessary to implement sections 8 and 9.

Sec. 15. SEVERABILITY.

If any provision of sections 8 or 9 is found to be unconstitutional or void by a court of competent jurisdiction, all remaining provisions of the law shall remain valid and shall be given full effect.

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

Sec. 16. EFFECTIVE DATE.

Section 12 is effective the day following final enactment.

ARTICLE 7**STUDIES OF CADI PROGRAM AND OF FOSTER CARE****Section 1. COMMUNITY ALTERNATIVE CARE PROGRAM; EVALUATION AND RECOMMENDATIONS.**

The commissioner of human services shall review the administration of the community alternative care home and community-based waiver program, and evaluate the extent to which the program is administered in a consistent manner throughout the state. The commissioner shall also study and make recommendations about changing the community alternative care waiver program to a regionally administered program, following the model of the traumatic brain injury waiver program. The commissioner shall submit the evaluation and recommendations required under this section by February 1, 1997, to the chairs of the health and human services committee, the health and human services finance division, the health care committee, and the health care and family services finance division.

Sec. 2. STUDY OF FOSTER CARE FOR MEDICALLY FRAGILE AND TECHNOLOGY-DEPENDENT CHILDREN.

The commissioner of human services shall utilize staff in the families with children services division, the long-term care home and community-based services division, the division for persons with developmental disabilities, and the quality services division to examine and report on strategies for supporting families with medically fragile and technology-dependent children. The study must examine and report on the coordination and administration of medical assistance services, including services through the home and community-based waiver programs, with respect to the out-of-home placement of medically fragile and technology-dependent children. The study must also examine and recommend strategies for decreasing the number of these children who are hospitalized, or whose length of stay in a hospital is extended because appropriate foster care placements are not available or not affordable under the current reimbursement system for the medical assistance waiver programs. The commissioner shall submit the report to the legislature by January 15, 1997.

Presented to the governor April 4, 1996

Signed by the governor April 12, 1996, 10:05 a.m.

New language is indicated by underline, deletions by strikeout.