CHAPTER 375—S.F.No. 3099

An act relating to human services; modifying provisions for certain government data; modifying the Human Services Licensing Act; modifying certain hearing provisions; modifying provisions for reporting maltreatment of minors and vulnerable adults; modifying continuing care provisions; modifying moratorium provisions on certification of nursing home beds; modifying eligibility for transition planning grants; providing for optional registration as housing with services establishment; modifying case manager continuing education requirements; modifying provisions for interstate contracts for mental health services; modifying commissioner's authority to administer a supplemental drug rebate program; designating state agent to carry out responsibilities under the Ryan White Comprehensive AIDS Resources Emergency Act; allowing certain nursing homes to elect to participate in the medical assistance program; modifying medical assistance provisions; modifying group residential housing provisions; modifying MinnesotaCare provisions; modifying prior appropriations; providing for the use of certain grants to develop certain housing options; providing for deaf-blind services; modifying provisions for funding medical education; providing for special education; providing for identification of certain deceased individuals; modifying provisions for rural hospital capital improvement grants; modifying provisions for costs associated with patient records; requiring legislative approval of Clean Indoor Air Act rules; modifying acupuncture provisions; modifying provisions for county relief of the poor; requiring studies, reports, and recommendations; appropriating money; amending Minnesota Statutes 2000, sections 13.41, subdivision 1; 13.46, subdivision 3; 62J.692, subdivision 4, as amended; 125A.76, subdivision 5; 144.05, by adding a subdivision; 144.335, subdivision 5; 144.417, subdivision 1; 144D.01, subdivision 4; 147B.02, subdivision 9; 245.462, subdivision 4; 245.4871, subdivision 4; 245.50, subdivisions 1, 2, 5; 245A.02, by adding subdivisions; 245A.035, subdivision 3; 245A.04, by adding a subdivision; 256.01, by adding a subdivision; 256.9657, subdivision 1, as amended; 256B.0625, subdivisions 26, as amended, 35, by adding a subdivision; 256B.0915, subdivisions 4, 6, by adding a subdivision; 256B.19, subdivision 1, as amended; 256B.431, subdivisions 14, 30; 256B.5012, subdivision 2; 256B.69, subdivision 5a, as amended; 256I.04, subdivision 2a; 256L.12, subdivision 9, as amended; 261.063; 626.557, subdivision 3a; Minnesota Statutes 2001 Supplement, sections 13.46, subdivisions 1, 4; 125A.515; 144.148, subdivision 2; 144A.071, subdivision 1a; 144A.36, subdivision 1; 149A.90, subdivision 1; 245A.03, subdivision 2; 245A.04, subdivisions 3, 3a, 3b; 245A.07, subdivisions 2a, 3; 245A.144; 245A.16, subdivision 1; 256.01, subdivision 2, as amended; 256.045, subdivisions 3b, 4; 256B.0625, subdivision 13, as amended; 256B.0627, subdivision 10; 256B.0911, subdivisions 4b, 4d; 256B.0913, subdivisions 4, 5, 8, 10, 12, 14; 256B.0915, subdivisions 3, 5; 256B.0924, subdivision 6; 256B.0951, subdivisions 7, 8; 256B.431, subdivisions 2e, 33; 256B.437, subdivisions 3, 6; 256B.438, subdivision 1; 256B.76; 626.556, subdivision 10i; 626.557, subdivision 9d; Laws 2002, chapter 220, article 17, section 2, subdivision 6; proposing coding for new law in Minnesota Statutes, chapters 144D; 245A; repealing Minnesota Statutes 2000, section 147B.01, subdivisions 8, 15; Minnesota Statutes 2001 Supplement, section 256B.0621, subdivision 1.

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

ARTICLE 1

LICENSING

Section 1. Minnesota Statutes 2000, section 13.41, subdivision 1, is amended to read:

Subdivision 1. **DEFINITION.** As used in this section "licensing agency" means any board, department or agency of this state which is given the statutory authority to issue professional or other types of licenses, except the various agencies primarily administered by the commissioner of human services. Data pertaining to persons or agencies licensed or registered under authority of the commissioner of human services shall be administered pursuant to section 13.46, ~~subdivision~~ 4.

Sec. 2. Minnesota Statutes 2001 Supplement, section 13.46, subdivision 1, is amended to read:

Subdivision 1. **DEFINITIONS.** As used in this section:

(a) "Individual" means an individual according to section 13.02, subdivision 8, but does not include a vendor of services.

(b) "Program" includes all programs for which authority is vested in a component of the welfare system according to statute or federal law, including, but not limited to, the aid to families with dependent children program formerly codified in sections 256.72 to 256.87, Minnesota Family Investment Program, medical assistance, general assistance, general assistance medical care, and child support collections.

(c) "Welfare system" includes the department of human services, local social services agencies, county welfare agencies, private licensing agencies, the public authority responsible for child support enforcement, human services boards, community mental health center boards, state hospitals, state nursing homes, the ombudsman for mental health and mental retardation, and persons, agencies, institutions, organizations, and other entities under contract to any of the above agencies to the extent specified in the contract.

(d) "Mental health data" means data on individual clients and patients of community mental health centers, established under section 245.62, mental health divisions of counties and other providers under contract to deliver mental health services, or the ombudsman for mental health and mental retardation.

(e) "Fugitive felon" means a person who has been convicted of a felony and who has escaped from confinement or violated the terms of probation or parole for that offense.

(f) "Private licensing agency" means an agency licensed by the commissioner of human services under chapter 245A to perform the duties under section 245A.16.

Sec. 3. Minnesota Statutes 2000, section 13.46, subdivision 3, is amended to read:

Subd. 3. **INVESTIGATIVE DATA.** (a) Data on persons, including data on vendors of services and data on licensees, that is collected, maintained, used, or

disseminated by the welfare system in an investigation, authorized by statute and relating to the enforcement of rules or law, is confidential data on individuals pursuant to section 13.02, subdivision 3, or protected nonpublic data not on individuals pursuant to section 13.02, subdivision 13, and shall not be disclosed except:

~~(a)~~ (1) pursuant to section 13.05;

~~(b)~~ (2) pursuant to statute or valid court order;

~~(c)~~ (3) to a party named in a civil or criminal proceeding, administrative or judicial, for preparation of defense; or

~~(d)~~ (4) to provide notices required or permitted by statute.

The data referred to in this subdivision shall be classified as public data upon its submission to an administrative law judge or court in an administrative or judicial proceeding. Inactive welfare investigative data shall be treated as provided in section 13.39, subdivision 3.

(b) Notwithstanding any other provision in law, the commissioner of human services shall provide all active and inactive investigative data, including the name of the reporter of alleged maltreatment under section 626.556 or 626.557, to the ombudsman for mental health and retardation upon the request of the ombudsman.

Sec. 4. Minnesota Statutes 2001 Supplement, section 13.46, subdivision 4, is amended to read:

Subd. 4. **LICENSING DATA.** (a) As used in this subdivision:

(1) "licensing data" means all data collected, maintained, used, or disseminated by the welfare system pertaining to persons licensed or registered or who apply for licensure or registration or who formerly were licensed or registered under the authority of the commissioner of human services;

(2) "client" means a person who is receiving services from a licensee or from an applicant for licensure; and

(3) "personal and personal financial data" means social security numbers, identity of and letters of reference, insurance information, reports from the bureau of criminal apprehension, health examination reports, and social/home studies.

(b)(1) Except as provided in paragraph (c), the following data on current and former licensees are public: name, address, telephone number of licensees, date of receipt of a completed application, dates of licensure, licensed capacity, type of client preferred, variances granted, type of dwelling, name and relationship of other family members, previous license history, class of license, and the existence and status of complaints. When a correction order or fine has been issued, a license is suspended, immediately suspended, revoked, denied, or made conditional, or a complaint is resolved, the following data on current and former licensees are public: the substance and investigative findings of the complaint, licensing violation, or substantiated maltreatment; the record of informal resolution of a licensing violation; orders of hearing; findings of fact; conclusions of law; specifications of the final correction order,

fine, suspension, immediate suspension, revocation, denial, or conditional license contained in the record of licensing action; and the status of any appeal of these actions. When an individual licensee is a substantiated perpetrator of maltreatment, and the substantiated maltreatment is a reason for the licensing action, the identity of the licensee as a perpetrator is public data. For purposes of this clause, a person is a substantiated perpetrator if the maltreatment determination has been upheld under section 626.556, subdivision 10i, 626.557, subdivision 9d, or 256.045, or an individual or facility has not timely exercised appeal rights under these sections.

(2) For applicants who withdraw their application prior to licensure or denial of a license, the following data are public: the name of the applicant, the city and county in which the applicant was seeking licensure, the dates of the commissioner's receipt of the initial application and completed application, the type of license sought, and the date of withdrawal of the application.

(3) For applicants who are denied a license, the following data are public: the name of the applicant, the city and county in which the applicant was seeking licensure, the dates of the commissioner's receipt of the initial application and completed application, the type of license sought, the date of denial of the application, the nature of the basis for the denial, and the status of any appeal of the denial.

(4) The following data on persons subject to disqualification under section 245A.04 in connection with a license to provide family day care for children, child care center services, foster care for children in the provider's home, or foster care or day care services for adults in the provider's home, are public: the nature of any disqualification set aside under section 245A.04, subdivision 3b, and the reasons for setting aside the disqualification; and the reasons for granting any variance under section 245A.04, subdivision 9.

(5) When maltreatment is substantiated under section 626.556 or 626.557 and the victim and the substantiated perpetrator are affiliated with a program licensed under chapter 245A, the commissioner of human services, local social services agency, or county welfare agency may inform the license holder where the maltreatment occurred of the identity of the substantiated perpetrator and the victim.

(c) The following are private data on individuals under section 13.02, subdivision 12, or nonpublic data under section 13.02, subdivision 9: personal and personal financial data on family day care program and family foster care program applicants and licensees and their family members who provide services under the license.

(d) The following are private data on individuals: the identity of persons who have made reports concerning licensees or applicants that appear in inactive investigative data, and the records of clients or employees of the licensee or applicant for licensure whose records are received by the licensing agency for purposes of review or in anticipation of a contested matter. The names of reporters under sections 626.556 and 626.557 may be disclosed only as provided in section 626.556, subdivision 11, or 626.557, subdivision 12b.

(e) Data classified as private, confidential, nonpublic, or protected nonpublic under this subdivision become public data if submitted to a court or administrative law

judge as part of a disciplinary proceeding in which there is a public hearing concerning a license which has been suspended, immediately suspended, revoked, or denied.

(f) Data generated in the course of licensing investigations that relate to an alleged violation of law are investigative data under subdivision 3.

(g) Data that are not public data collected, maintained, used, or disseminated under this subdivision that relate to or are derived from a report as defined in section 626.556, subdivision 2, or 626.5572, subdivision 18, are subject to the destruction provisions of sections 626.556, subdivision 11c, and 626.557, subdivision 12b.

(h) Upon request, not public data collected, maintained, used, or disseminated under this subdivision that relate to or are derived from a report of substantiated maltreatment as defined in section 626.556 or 626.557 may be exchanged with the department of health for purposes of completing background studies pursuant to section 144.057 and with the department of corrections for purposes of completing background studies pursuant to section 241.021.

(i) Data on individuals collected according to licensing activities under chapter 245A, and data on individuals collected by the commissioner of human services according to maltreatment investigations under sections 626.556 and 626.557, may be shared with the department of human rights, the department of health, the department of corrections, the ombudsman for mental health and retardation, and the individual's professional regulatory board when there is reason to believe that laws or standards under the jurisdiction of those agencies may have been violated.

(j) In addition to the notice of determinations required under section 626.556, subdivision 10f, if the commissioner or the local social services agency has determined that an individual is a substantiated perpetrator of maltreatment of a child based on sexual abuse, as defined in section 626.556, subdivision 2, and the commissioner or local social services agency knows that the individual is a person responsible for a child's care in another facility, the commissioner or local social services agency shall notify the head of that facility of this determination. The notification must include an explanation of the individual's available appeal rights and the status of any appeal. If a notice is given under this paragraph, the government entity making the notification shall provide a copy of the notice to the individual who is the subject of the notice.

Sec. 5. Minnesota Statutes 2000, section 245A.02, is amended by adding a subdivision to read:

Subd. 2a. **ADULT DAY CARE.** "Adult day care" means a program operating less than 24 hours per day that provides functionally impaired adults with an individualized and coordinated set of services including health services, social services, and nutritional services that are directed at maintaining or improving the participants' capabilities for self-care. Adult day care does not include programs where adults gather or congregate primarily for purposes of socialization, education, supervision, caregiver respite, religious expression, exercise, or nutritious meals.

Sec. 6. Minnesota Statutes 2000, section 245A.02, is amended by adding a subdivision to read:

Subd. 2b. **ANNUAL OR ANNUALLY.** "Annual" or "annually" means prior to or within the same month of the subsequent calendar year.

Sec. 7. Minnesota Statutes 2001 Supplement, section 245A.03, subdivision 2, is amended to read:

Subd. 2. **EXCLUSION FROM LICENSURE.** (a) This chapter does not apply to:

(1) residential or nonresidential programs that are provided to a person by an individual who is related unless the residential program is a child foster care placement made by a local social services agency or a licensed child-placing agency, except as provided in subdivision 2a;

(2) nonresidential programs that are provided by an unrelated individual to persons from a single related family;

(3) residential or nonresidential programs that are provided to adults who do not abuse chemicals or who do not have a chemical dependency, a mental illness, mental retardation or a related condition, a functional impairment, or a physical handicap;

(4) sheltered workshops or work activity programs that are certified by the commissioner of economic security;

(5) programs for children enrolled in kindergarten to the 12th grade and prekindergarten special education in a school as defined in section 120A.22, subdivision 4, and programs serving children in combined special education and regular prekindergarten programs that are operated or assisted by the commissioner of children, families, and learning;

(6) nonresidential programs primarily for children that provide care or supervision, without charge for ten or fewer days a year, and for periods of less than three hours a day while the child's parent or legal guardian is in the same building as the nonresidential program or present within another building that is directly contiguous to the building in which the nonresidential program is located;

(7) nursing homes or hospitals licensed by the commissioner of health except as specified under section 245A.02;

(8) board and lodge facilities licensed by the commissioner of health that provide services for five or more persons whose primary diagnosis is mental illness who have refused an appropriate residential program offered by a county agency. ~~This exclusion expires on July 1, 1990~~;

(9) homes providing programs for persons placed there by a licensed agency for legal adoption, unless the adoption is not completed within two years;

(10) programs licensed by the commissioner of corrections;

(11) recreation programs for children or adults that operate for fewer than 40 calendar days in a calendar year or programs operated by a park and recreation board of a city of the first class whose primary purpose is to provide social and recreational

activities to school age children, provided the program is approved by the park and recreation board;

(12) programs operated by a school as defined in section 120A.22, subdivision 4, whose primary purpose is to provide child care to school-age children, provided the program is approved by the district's school board;

(13) Head Start nonresidential programs which operate for less than 31 days in each calendar year;

(14) noncertified boarding care homes unless they provide services for five or more persons whose primary diagnosis is mental illness or mental retardation;

(15) nonresidential programs for nonhandicapped children provided for a cumulative total of less than 30 days in any 12-month period;

(16) residential programs for persons with mental illness, that are located in hospitals, until the commissioner adopts appropriate rules;

(17) the religious instruction of school-age children; Sabbath or Sunday schools; or the congregate care of children by a church, congregation, or religious society during the period used by the church, congregation, or religious society for its regular worship;

(18) camps licensed by the commissioner of health under Minnesota Rules, chapter 4630;

(19) mental health outpatient services for adults with mental illness or children with emotional disturbance;

(20) residential programs serving school-age children whose sole purpose is cultural or educational exchange, until the commissioner adopts appropriate rules;

(21) unrelated individuals who provide out-of-home respite care services to persons with mental retardation or related conditions from a single related family for no more than 90 days in a 12-month period and the respite care services are for the temporary relief of the person's family or legal representative;

(22) respite care services provided as a home and community-based service to a person with mental retardation or a related condition, in the person's primary residence;

(23) community support services programs as defined in section 245.462, subdivision 6, and family community support services as defined in section 245.4871, subdivision 17;

(24) the placement of a child by a birth parent or legal guardian in a preadoptive home for purposes of adoption as authorized by section 259.47;

(25) settings registered under chapter 144D which provide home care services licensed by the commissioner of health to fewer than seven adults; or

(26) consumer-directed community support service funded under the Medicaid waiver for persons with mental retardation and related conditions when the individual who provided the service is:

(i) the same individual who is the direct payee of these specific waiver funds or paid by a fiscal agent, fiscal intermediary, or employer of record; and

(ii) not otherwise under the control of a residential or nonresidential program that is required to be licensed under this chapter when providing the service.

(b) For purposes of paragraph (a), clause (6), a building is directly contiguous to a building in which a nonresidential program is located if it shares a common wall with the building in which the nonresidential program is located or is attached to that building by skyway, tunnel, atrium, or common roof.

(c) Nothing in this chapter shall be construed to require licensure for any services provided and funded according to an approved federal waiver plan where licensure is specifically identified as not being a condition for the services and funding.

Sec. 8. Minnesota Statutes 2000, section 245A.035, subdivision 3, is amended to read:

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

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

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

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

(4) if the county determines, prior to the issuance of an emergency license, that anyone requiring a background study may be disqualified under section 245A.04, and the disqualification is one which the commissioner cannot set aside, an emergency license shall not be issued.

Sec. 9. Minnesota Statutes 2001 Supplement, section 245A.04, subdivision 3, is amended to read:

Subd. 3. **BACKGROUND STUDY OF THE APPLICANT; DEFINITIONS.** (a) Individuals and organizations that are required in statute to initiate background studies under this section shall comply with the following requirements:

(1) Applicants for licensure, license holders, and other entities as provided in this section must submit completed background study forms to the commissioner before

individuals specified in paragraph (c), clauses (1) to (4), (6), and (7), begin positions allowing direct contact in any licensed program.

(2) Applicants and license holders under the jurisdiction of other state agencies who are required in other statutory sections to initiate background studies under this section must submit completed background study forms to the commissioner prior to the background study subject beginning in a position allowing direct contact in the licensed program, or where applicable, prior to being employed.

(3) Organizations required to initiate background studies under section 256B.0627 for individuals described in paragraph (c), clause (5), must submit a completed background study form to the commissioner before those individuals begin a position allowing direct contact with persons served by the organization. The commissioner shall recover the cost of these background studies through a fee of no more than $12 per study charged to the organization responsible for submitting the background study form. The fees collected under this paragraph are appropriated to the commissioner for the purpose of conducting background studies.

Upon receipt of the background study forms from the entities in clauses (1) to (3), the commissioner shall complete the background study as specified under this section and provide notices required in subdivision 3a. Unless otherwise specified, the subject of a background study may have direct contact with persons served by a program after the background study form is mailed or submitted to the commissioner pending notification of the study results under subdivision 3a. A county agency may accept a background study completed by the commissioner under this section in place of the background study required under section 245A.16, subdivision 3, in programs with joint licensure as home and community-based services and adult foster care for people with developmental disabilities when the license holder does not reside in the foster care residence and the subject of the study has been continuously affiliated with the license holder since the date of the commissioner's study.

(b) The definitions in this paragraph apply only to subdivisions 3 to 3e.

(1) "Background study" means the review of records conducted by the commissioner to determine whether a subject is disqualified from direct contact with persons served by a program, and where specifically provided in statutes, whether a subject is disqualified from having access to persons served by a program.

(2) "Continuous, direct supervision" means an individual is within sight or hearing of the supervising person to the extent that supervising person is capable at all times of intervening to protect the health and safety of the persons served by the program.

(3) "Contractor" means any person, regardless of employer, who is providing program services for hire under the control of the provider.

(4) "Direct contact" means providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the program.

(5) "Reasonable cause" means information or circumstances exist which provide the commissioner with articulable suspicion that further pertinent information may

exist concerning a subject. The commissioner has reasonable cause when, but not limited to, the commissioner has received a report from the subject, the license holder, or a third party indicating that the subject has a history that would disqualify the person or that may pose a risk to the health or safety of persons receiving services.

(6) "Subject of a background study" means an individual on whom a background study is required or completed.

(c) The applicant, license holder, registrant under section 144A.71, subdivision 1, bureau of criminal apprehension, commissioner of health, and county agencies, after written notice to the individual who is the subject of the study, shall help with the study by giving the commissioner criminal conviction data and reports about the maltreatment of adults substantiated under section 626.557 and the maltreatment of minors in licensed programs substantiated under section 626.556. If a background study is initiated by an applicant or license holder and the applicant or license holder receives information about the possible criminal or maltreatment history of an individual who is the subject of the background study, the applicant or license holder must immediately provide the information to the commissioner. The individuals to be studied shall include:

(1) the applicant;

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

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

(4) volunteers or student volunteers who have direct contact with persons served by the program to provide program services, if the contact is not ~~directly supervised by the individuals~~ under the continuous, direct supervision by an individual listed in clause (1) or (3);

(5) any person required under section 256B.0627 to have a background study completed under this section;

(6) persons ages 10 to 12 living in the household where the licensed services will be provided when the commissioner has reasonable cause; and

(7) persons who, without providing direct contact services at a licensed program, may have unsupervised access to children or vulnerable adults receiving services from the program licensed to provide family child care for children, foster care for children in the provider's own home, or foster care or day care services for adults in the provider's own home when the commissioner has reasonable cause.

(d) According to paragraph (c), clauses (2) and (6), the commissioner shall review records from the juvenile courts. For persons under paragraph (c), clauses (1), (3), (4), (5), and (7), who are ages 13 to 17, the commissioner shall review records from the juvenile courts when the commissioner has reasonable cause. The juvenile courts shall help with the study by giving the commissioner existing juvenile court records on individuals described in paragraph (c), clauses (2), (6), and (7), relating to delinquency

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

(e) Beginning August 1, 2001, the commissioner shall conduct all background studies required under this chapter and initiated by supplemental nursing services agencies registered under section 144A.71, subdivision 1. Studies for the agencies must be initiated annually by each agency. The commissioner shall conduct the background studies according to this chapter. The commissioner shall recover the cost of the background studies through a fee of no more than $8 per study, charged to the supplemental nursing services agency. The fees collected under this paragraph are appropriated to the commissioner for the purpose of conducting background studies.

(f) For purposes of this section, a finding that a delinquency petition is proven in juvenile court shall be considered a conviction in state district court.

(g) A study of an individual in paragraph (c), clauses (1) to (7), shall be conducted at least upon application for initial license for all license types or registration under section 144A.71, subdivision 1, and at reapplication for a license ~~or registration~~ for family child care, child foster care, and adult foster care. The commissioner is not required to conduct a study of an individual at the time of reapplication for a license or if the individual has been continuously affiliated with a foster care provider licensed by the commissioner of human services and registered under chapter 144D, other than a family day care or foster care license, if: (i) a study of the individual was conducted either at the time of initial licensure or when the individual became affiliated with the license holder; (ii) the individual has been continuously affiliated with the license holder since the last study was conducted; and (iii) the procedure described in paragraph (j) has been implemented and was in effect continuously since the last study was conducted. For the purposes of this section, a physician licensed under chapter 147 is considered to be continuously affiliated upon the license holder's receipt from the commissioner of health or human services of the physician's background study results. For individuals who are required to have background studies under paragraph (c) and who have been continuously affiliated with a foster care provider that is licensed in more than one county, criminal conviction data may be shared among those counties in which the foster care programs are licensed. A county agency's receipt of criminal conviction data from another county agency shall meet the criminal data background study requirements of this section.

(h) The commissioner may also conduct studies on individuals specified in paragraph (c), clauses (3) and (4), when the studies are initiated by:

(i) personnel pool agencies;

(ii) temporary personnel agencies;

(iii) educational programs that train persons by providing direct contact services in licensed programs; and

(iv) professional services agencies that are not licensed and which contract with licensed programs to provide direct contact services or individuals who provide direct contact services.

(i) Studies on individuals in paragraph (h), items (i) to (iv), must be initiated annually by these agencies, programs, and individuals. Except as provided in paragraph (a), clause (3), no applicant, license holder, or individual who is the subject of the study shall pay any fees required to conduct the study.

(1) At the option of the licensed facility, rather than initiating another background study on an individual required to be studied who has indicated to the licensed facility that a background study by the commissioner was previously completed, the facility may make a request to the commissioner for documentation of the individual's background study status, provided that:

(i) the facility makes this request using a form provided by the commissioner;

(ii) in making the request the facility informs the commissioner that either:

(A) the individual has been continuously affiliated with a licensed facility since the individual's previous background study was completed, or since October 1, 1995, whichever is shorter; or

(B) the individual is affiliated only with a personnel pool agency, a temporary personnel agency, an educational program that trains persons by providing direct contact services in licensed programs, or a professional services agency that is not licensed and which contracts with licensed programs to provide direct contact services or individuals who provide direct contact services; and

(iii) the facility provides notices to the individual as required in paragraphs (a) to (j), and that the facility is requesting written notification of the individual's background study status from the commissioner.

(2) The commissioner shall respond to each request under paragraph (1) with a written or electronic notice to the facility and the study subject. If the commissioner determines that a background study is necessary, the study shall be completed without further request from a licensed agency or notifications to the study subject.

(3) When a background study is being initiated by a licensed facility or a foster care provider that is also registered under chapter 144D, a study subject affiliated with multiple licensed facilities may attach to the background study form a cover letter indicating the additional facilities' names, addresses, and background study identification numbers. When the commissioner receives such notices, each facility identified by the background study subject shall be notified of the study results. The background study notice sent to the subsequent agencies shall satisfy those facilities' responsibilities for initiating a background study on that individual.

(j) If an individual who is affiliated with a program or facility regulated by the department of human services or department of health or who is affiliated with any type of home care agency or provider of personal care assistance services, is convicted of a crime constituting a disqualification under subdivision 3d, the probation officer or

corrections agent shall notify the commissioner of the conviction. For the purpose of this paragraph, "conviction" has the meaning given it in section 609.02, subdivision 5. The commissioner, in consultation with the commissioner of corrections, shall develop forms and information necessary to implement this paragraph and shall provide the forms and information to the commissioner of corrections for distribution to local probation officers and corrections agents. The commissioner shall inform individuals subject to a background study that criminal convictions for disqualifying crimes will be reported to the commissioner by the corrections system. A probation officer, corrections agent, or corrections agency is not civilly or criminally liable for disclosing or failing to disclose the information required by this paragraph. Upon receipt of disqualifying information, the commissioner shall provide the notifications required in subdivision 3a, as appropriate to agencies on record as having initiated a background study or making a request for documentation of the background study status of the individual. This paragraph does not apply to family day care and child foster care programs.

(k) The individual who is the subject of the study must provide the applicant or license holder with sufficient information to ensure an accurate study including the individual's first, middle, and last name and all other names by which the individual has been known; home address, city, county, and state of residence for the past five years; zip code; sex; date of birth; and driver's license number or state identification number. The applicant or license holder shall provide this information about an individual in paragraph (c), clauses (1) to (7), on forms prescribed by the commissioner. By January 1, 2000, for background studies conducted by the department of human services, the commissioner shall implement a system for the electronic transmission of: (1) background study information to the commissioner; and (2) background study results to the license holder. The commissioner may request additional information of the individual, which shall be optional for the individual to provide, such as the individual's social security number or race.

(l) For programs directly licensed by the commissioner, a study must include information related to names of substantiated perpetrators of maltreatment of vulnerable adults that has been received by the commissioner as required under section 626.557, subdivision 9c, paragraph (i), and the commissioner's records relating to the maltreatment of minors in licensed programs, information from juvenile courts as required in paragraph (c) for persons listed in paragraph (c), clauses (2), (6), and (7), and information from the bureau of criminal apprehension. For child foster care, adult foster care, and family day care homes, the study must include information from the county agency's record of substantiated maltreatment of adults, and the maltreatment of minors, information from juvenile courts as required in paragraph (c) for persons listed in paragraph (c), clauses (2), (6), and (7), and information from the bureau of criminal apprehension. The commissioner may also review arrest and investigative information from the bureau of criminal apprehension, the commissioner of health, a county attorney, county sheriff, county agency, local chief of police, other states, the courts, or the Federal Bureau of Investigation if the commissioner has reasonable cause to believe the information is pertinent to the disqualification of an individual listed in paragraph (c), clauses (1) to (7). The commissioner is not required to conduct more

than one review of a subject's records from the Federal Bureau of Investigation if a review of the subject's criminal history with the Federal Bureau of Investigation has already been completed by the commissioner and there has been no break in the subject's affiliation with the license holder who initiated the background study.

(m) When the commissioner has reasonable cause to believe that further pertinent information may exist on the subject, the subject shall provide a set of classifiable fingerprints obtained from an authorized law enforcement agency. For purposes of requiring fingerprints, the commissioner shall be considered to have reasonable cause under, but not limited to, the following circumstances:

(1) information from the bureau of criminal apprehension indicates that the subject is a multistate offender;

(2) information from the bureau of criminal apprehension indicates that multistate offender status is undetermined; or

(3) the commissioner has received a report from the subject or a third party indicating that the subject has a criminal history in a jurisdiction other than Minnesota.

(n) The failure or refusal of an applicant, license holder, or registrant under section 144A.71, subdivision 1, to cooperate with the commissioner is reasonable cause to disqualify a subject, deny a license application or immediately suspend, suspend, or revoke a license or registration. Failure or refusal of an individual to cooperate with the study is just cause for denying or terminating employment of the individual if the individual's failure or refusal to cooperate could cause the applicant's application to be denied or the license holder's license to be immediately suspended, suspended, or revoked.

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

(p) No person in paragraph (c), clauses (1) to (7), who is disqualified as a result of this section may be retained by the agency in a position involving direct contact with persons served by the program ~~or in a position allowing~~ and no person in paragraph (c), clauses (2), (6), and (7), or as provided elsewhere in statute who is disqualified as a result of this section may be allowed access to persons served by the program ~~as provided for in statutes~~, unless the commissioner has provided written notice to the agency stating that:

(1) the individual may remain in direct contact during the period in which the individual may request reconsideration as provided in subdivision 3a, paragraph (b), clause (2) or (3);

(2) the individual's disqualification has been set aside for that agency as provided in subdivision 3b, paragraph (b); or

(3) the license holder has been granted a variance for the disqualified individual under subdivision 3e.

(q) Termination of affiliation with persons in paragraph (c), clauses (1) to (7), made in good faith reliance on a notice of disqualification provided by the commis-

sioner shall not subject the applicant or license holder to civil liability.

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

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

(t) An individual subject to disqualification under this subdivision has the applicable rights in subdivision 3a, 3b, or 3c.

(u) For the purposes of background studies completed by tribal organizations performing licensing activities otherwise required of the commissioner under this chapter, after obtaining consent from the background study subject, tribal licensing agencies shall have access to criminal history data in the same manner as county licensing agencies and private licensing agencies under this chapter.

(v) County agencies shall have access to the criminal history data in the same manner as county licensing agencies under this chapter for purposes of background studies completed by county agencies on legal nonlicensed child care providers to determine eligibility for child care funds under chapter 119B.

Sec. 10. Minnesota Statutes 2001 Supplement, section 245A.04, subdivision 3a, is amended to read:

Subd. 3a. **NOTIFICATION TO SUBJECT AND LICENSE HOLDER OF STUDY RESULTS; DETERMINATION OF RISK OF HARM.** (a) Within 15 working days, the commissioner shall notify the applicant, license holder, or registrant under section 144A.71, subdivision 1, and the individual who is the subject of the study, in writing or by electronic transmission, of the results of the study or that more time is needed to complete the study. When the study is completed, a notice that the study was undertaken and completed shall be maintained in the personnel files of the program. For studies on individuals pertaining to a license to provide family day care or group family day care, foster care for children in the provider's own home, or foster care or day care services for adults in the provider's own home, the commissioner is not required to provide a separate notice of the background study results to the individual who is the subject of the study unless the study results in a disqualification of the individual.

The commissioner shall notify the individual studied if the information in the study indicates the individual is disqualified from direct contact with persons served by the program. The commissioner shall disclose the information causing disqualification and instructions on how to request a reconsideration of the disqualification to the individual studied. An applicant or license holder who is not the subject of the study shall be informed that the commissioner has found information that disqualifies the subject from direct contact with persons served by the program. However, only the individual studied must be informed of the information contained in the subject's background study unless the basis for the disqualification is failure to cooperate, substantiated maltreatment under section 626.556 or 626.557, the Data Practices Act

provides for release of the information, or the individual studied authorizes the release of the information. When a disqualification is based on the subject's failure to cooperate with the background study or substantiated maltreatment under section 626.556 or 626.557, the agency that initiated the study shall be informed by the commissioner of the reason for the disqualification.

(b) Except as provided in subdivision 3d, paragraph (b), if the commissioner determines that the individual studied has a disqualifying characteristic, the commissioner shall review the information immediately available and make a determination as to the subject's immediate risk of harm to persons served by the program where the individual studied will have direct contact. The commissioner shall consider all relevant information available, including the following factors in determining the immediate risk of harm: the recency of the disqualifying characteristic; the recency of discharge from probation for the crimes; the number of disqualifying characteristics; the intrusiveness or violence of the disqualifying characteristic; the vulnerability of the victim involved in the disqualifying characteristic; and the similarity of the victim to the persons served by the program where the individual studied will have direct contact. The commissioner may determine that the evaluation of the information immediately available gives the commissioner reason to believe one of the following:

(1) The individual poses an imminent risk of harm to persons served by the program where the individual studied will have direct contact. If the commissioner determines that an individual studied poses an imminent risk of harm to persons served by the program where the individual studied will have direct contact, the individual and the license holder must be sent a notice of disqualification. The commissioner shall order the license holder to immediately remove the individual studied from direct contact. The notice to the individual studied must include an explanation of the basis of this determination.

(2) The individual poses a risk of harm requiring continuous, direct supervision while providing direct contact services during the period in which the subject may request a reconsideration. If the commissioner determines that an individual studied poses a risk of harm that requires continuous, direct supervision, the individual and the license holder must be sent a notice of disqualification. The commissioner shall order the license holder to immediately remove the individual studied from direct contact services or assure that the individual studied is ~~within sight or hearing~~ under the continuous, direct supervision of another staff person when providing direct contact services during the period in which the individual may request a reconsideration of the disqualification. If the individual studied does not submit a timely request for reconsideration, or the individual submits a timely request for reconsideration, but the disqualification is not set aside for that license holder, the license holder will be notified of the disqualification and ordered to immediately remove the individual from any position allowing direct contact with persons receiving services from the license holder.

(3) The individual does not pose an imminent risk of harm or a risk of harm requiring continuous, direct supervision while providing direct contact services during the period in which the subject may request a reconsideration. If the commissioner

determines that an individual studied does not pose a risk of harm that requires continuous, direct supervision, only the individual must be sent a notice of disqualification. The license holder must be sent a notice that more time is needed to complete the individual's background study. If the individual studied submits a timely request for reconsideration, and if the disqualification is set aside for that license holder, the license holder will receive the same notification received by license holders in cases where the individual studied has no disqualifying characteristic. If the individual studied does not submit a timely request for reconsideration, or the individual submits a timely request for reconsideration, but the disqualification is not set aside for that license holder, the license holder will be notified of the disqualification and ordered to immediately remove the individual from any position allowing direct contact with persons receiving services from the license holder.

(c) County licensing agencies performing duties under this subdivision may develop an alternative system for determining the subject's immediate risk of harm to persons served by the program, providing the notices under paragraph (b), and documenting the action taken by the county licensing agency. Each county licensing agency's implementation of the alternative system is subject to approval by the commissioner. Notwithstanding this alternative system, county licensing agencies shall complete the requirements of paragraph (a).

Sec. 11. Minnesota Statutes 2001 Supplement, section 245A.04, subdivision 3b, is amended to read:

Subd. 3b. **RECONSIDERATION OF DISQUALIFICATION.** (a) The individual who is the subject of the disqualification may request a reconsideration of the disqualification.

The individual must submit the request for reconsideration to the commissioner in writing. A request for reconsideration for an individual who has been sent a notice of disqualification under subdivision 3a, paragraph (b), clause (1) or (2), must be submitted within 30 calendar days of the disqualified individual's receipt of the notice of disqualification. Upon showing that the information in clause (1) or (2) cannot be obtained within 30 days, the disqualified individual may request additional time, not to exceed 30 days, to obtain that information. A request for reconsideration for an individual who has been sent a notice of disqualification under subdivision 3a, paragraph (b), clause (3), must be submitted within 15 calendar days of the disqualified individual's receipt of the notice of disqualification. An individual who was determined to have maltreated a child under section 626.556 or a vulnerable adult under section 626.557, and who was disqualified under this section on the basis of serious or recurring maltreatment, may request reconsideration of both the maltreatment and the disqualification determinations. The request for reconsideration of the maltreatment determination and the disqualification must be submitted within 30 calendar days of the individual's receipt of the notice of disqualification. Removal of a disqualified individual from direct contact shall be ordered if the individual does not request reconsideration within the prescribed time, and for an individual who submits a timely request for reconsideration, if the disqualification is not set aside. The individual must present information showing that:

(1) the information the commissioner relied upon in determining that the underlying conduct giving rise to the disqualification occurred, and for maltreatment, that the maltreatment was serious or recurring, is incorrect ~~or inaccurate. If the basis of a reconsideration request is that a maltreatment determination or disposition under section 626.556 or 626.557 is incorrect, and the commissioner has issued a final order in an appeal of that determination or disposition under section 256.045 or 245A.08, subdivision 5, the commissioner's order is conclusive on the issue of maltreatment. If the individual did not request reconsideration of the maltreatment determination, the maltreatment determination is deemed conclusive~~; or

(2) the subject of the study does not pose a risk of harm to any person served by the applicant, license holder, or registrant under section 144A.71, subdivision 1.

(b) The commissioner shall rescind the disqualification if the commissioner finds that the information relied on to disqualify the subject is incorrect. The commissioner may set aside the disqualification under this section if the commissioner finds that the individual does not pose a risk of harm to any person served by the applicant, license holder, or registrant under section 144A.71, subdivision 1. In determining that an individual does not pose a risk of harm, the commissioner shall consider the nature, severity, and consequences of the event or events that lead to disqualification, whether there is more than one disqualifying event, the age and vulnerability of the victim at the time of the event, the harm suffered by the victim, the similarity between the victim and persons served by the program, the time elapsed without a repeat of the same or similar event, documentation of successful completion by the individual studied of training or rehabilitation pertinent to the event, and any other information relevant to reconsideration. In reviewing a disqualification under this section, the commissioner shall give preeminent weight to the safety of each person to be served by the license holder, applicant, or registrant under section 144A.71, subdivision 1, over the interests of the license holder, applicant, or registrant under section 144A.71, subdivision 1.

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

(1) less than ten years have passed since the discharge of the sentence imposed for the offense; and the individual has been convicted of a violation of any offense listed in sections 609.20 (manslaughter in the first degree), 609.205 (manslaughter in the second degree), criminal vehicular homicide under 609.21 (criminal vehicular homicide and injury), 609.215 (aiding suicide or aiding attempted suicide), felony violations under 609.221 to 609.2231 (assault in the first, second, third, or fourth degree), 609.713 (terroristic threats), 609.235 (use of drugs to injure or to facilitate crime), 609.24 (simple robbery), 609.245 (aggravated robbery), 609.25 (kidnapping), 609.255 (false imprisonment), 609.561 or 609.562 (arson in the first or second degree), 609.71 (riot), burglary in the first or second degree under 609.582 (burglary), 609.66 (dangerous weapon), 609.665 (spring guns), 609.67 (machine guns and short-barreled shotguns), 609.749 (harassment; stalking), 152.021 or 152.022 (controlled substance

crime in the first or second degree), 152.023, subdivision 1, clause (3) or (4), or subdivision 2, clause (4) (controlled substance crime in the third degree), 152.024, subdivision 1, clause (2), (3), or (4) (controlled substance crime in the fourth degree), 609.224, subdivision 2, paragraph (c) (fifth-degree assault by a caregiver against a vulnerable adult), 609.228 (great bodily harm caused by distribution of drugs), 609.23 (mistreatment of persons confined), 609.231 (mistreatment of residents or patients), 609.2325 (criminal abuse of a vulnerable adult), 609.233 (criminal neglect of a vulnerable adult), 609.2335 (financial exploitation of a vulnerable adult), 609.234 (failure to report), 609.265 (abduction), 609.2664 to 609.2665 (manslaughter of an unborn child in the first or second degree), 609.267 to 609.2672 (assault of an unborn child in the first, second, or third degree), 609.268 (injury or death of an unborn child in the commission of a crime), 617.293 (disseminating or displaying harmful material to minors), a felony level conviction involving alcohol or drug use, a gross misdemeanor offense under 609.324, subdivision 1 (other prohibited acts), a gross misdemeanor offense under 609.378 (neglect or endangerment of a child), a gross misdemeanor offense under 609.377 (malicious punishment of a child), 609.72, subdivision 3 (disorderly conduct against a vulnerable adult); or an attempt or conspiracy to commit any of these offenses, as each of these offenses is defined in Minnesota Statutes; or an offense in any other state, the elements of which are substantially similar to the elements of any of the foregoing offenses;

(2) regardless of how much time has passed since the involuntary termination of parental rights under section 260C.301 or the discharge of the sentence imposed for the offense, the individual was convicted of a violation of any offense listed in sections 609.185 to 609.195 (murder in the first, second, or third degree), 609.2661 to 609.2663 (murder of an unborn child in the first, second, or third degree), a felony offense under 609.377 (malicious punishment of a child), a felony offense under 609.324, subdivision 1 (other prohibited acts), a felony offense under 609.378 (neglect or endangerment of a child), 609.322 (solicitation, inducement, and promotion of prostitution), 609.342 to 609.345 (criminal sexual conduct in the first, second, third, or fourth degree), 609.352 (solicitation of children to engage in sexual conduct), 617.246 (use of minors in a sexual performance), 617.247 (possession of pictorial representations of a minor), 609.365 (incest), a felony offense under sections 609.2242 and 609.2243 (domestic assault), a felony offense of spousal abuse, a felony offense of child abuse or neglect, a felony offense of a crime against children, or an attempt or conspiracy to commit any of these offenses as defined in Minnesota Statutes, or an offense in any other state, the elements of which are substantially similar to any of the foregoing offenses;

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

(4) within the seven years preceding the study, the individual was determined under section 626.557 to be the perpetrator of a substantiated incident of maltreatment of a vulnerable adult that resulted in substantial bodily harm as defined in section

609.02, subdivision 7a, or substantial mental or emotional harm as supported by competent psychological or psychiatric evidence.

In the case of any ground for disqualification under clauses (1) to (4), if the act was committed by an individual other than the applicant, license holder, or registrant under section 144A.71, subdivision 1, residing in the applicant's or license holder's home, or the home of a registrant under section 144A.71, subdivision 1, the applicant, license holder, or registrant under section 144A.71, subdivision 1, may seek reconsideration when the individual who committed the act no longer resides in the home.

The disqualification periods provided under clauses (1), (3), and (4) are the minimum applicable disqualification periods. The commissioner may determine that an individual should continue to be disqualified from licensure or registration under section 144A.71, subdivision 1, because the license holder, applicant, or registrant under section 144A.71, subdivision 1, poses a risk of harm to a person served by that individual after the minimum disqualification period has passed.

(d) The commissioner shall respond in writing or by electronic transmission to all reconsideration requests for which the basis for the request is that the information relied upon by the commissioner to disqualify is incorrect or inaccurate within 30 working days of receipt of a request and all relevant information. If the basis for the request is that the individual does not pose a risk of harm, the commissioner shall respond to the request within 15 working days after receiving the request for reconsideration and all relevant information. If the request is based on both the correctness or accuracy of the information relied on to disqualify the individual and the risk of harm, the commissioner shall respond to the request within 45 working days after receiving the request for reconsideration and all relevant information. If the disqualification is set aside, the commissioner shall notify the applicant or license holder in writing or by electronic transmission of the decision.

(e) Except as provided in subdivision 3c, if a disqualification for which reconsideration was requested is not set aside or is not rescinded, an individual who was disqualified on the basis of a preponderance of evidence that the individual committed an act or acts that meet the definition of any of the crimes ~~lists~~ listed in subdivision 3d, paragraph (a), clauses (1) to (4); or for failure to make required reports under section 626.556, subdivision 3, or 626.557, subdivision 3, pursuant to subdivision 3d, paragraph (a), clause (4), may request a fair hearing under section 256.045. Except as provided under subdivision 3c, the ~~commissioner's final order for an individual under this paragraph is conclusive on the issue of maltreatment and disqualification, including for purposes of subsequent studies conducted under subdivision 3, and~~ fair hearing is the only administrative appeal of the final agency determination, specifically, including a challenge to the accuracy and completeness of data under section 13.04.

(f) Except as provided under subdivision 3c, if an individual was disqualified on the basis of a determination of maltreatment under section 626.556 or 626.557, which was serious or recurring, and the individual has requested reconsideration of the maltreatment determination under section 626.556, subdivision 10i, or 626.557,

subdivision 9d, and also requested reconsideration of the disqualification under this subdivision, reconsideration of the maltreatment determination and reconsideration of the disqualification shall be consolidated into a single reconsideration. For maltreatment and disqualification determinations made by county agencies, the consolidated reconsideration shall be conducted by the county agency. If the county agency has disqualified an individual on multiple bases, one of which is a county maltreatment determination for which the individual has a right to request reconsideration, the county shall conduct the reconsideration of all disqualifications. Except as provided under subdivision 3c, if an individual who was disqualified on the basis of serious or recurring maltreatment requests a fair hearing on the maltreatment determination under section 626.556, subdivision 10i, or 626.557, subdivision 9d, and requests a fair hearing on the disqualification, which has not been set aside or rescinded under this subdivision, the scope of the fair hearing under section 256.045 shall include the maltreatment determination and the disqualification. Except as provided under subdivision 3c, ~~the commissioner's final order for an individual under this paragraph is conclusive on the issue of maltreatment and disqualification, including for purposes of subsequent studies conducted under subdivision 3, and~~ a fair hearing is the only administrative appeal of the final agency determination, specifically, including a challenge to the accuracy and completeness of data under section 13.04.

Sec. 12. Minnesota Statutes 2000, section 245A.04, is amended by adding a subdivision to read:

Subd. 3f. **CONCLUSIVE DETERMINATIONS OR DISPOSITIONS.** Unless otherwise specified in statute, the following determinations or dispositions are deemed conclusive:

(1) a maltreatment determination or disposition under section 626.556 or 626.557, if:

(i) the commissioner has issued a final order in an appeal of that determination or disposition under section 245A.08, subdivision 5, or 256.045;

(ii) the individual did not request reconsideration of the maltreatment determination or disposition under section 626.556 or 626.557; or

(iii) the individual did not request a hearing of the maltreatment determination or disposition under section 256.045; and

(2) a determination that the information relied upon to disqualify an individual under subdivision 3d, was correct based on serious or recurring maltreatment; or

(3) a preponderance of evidence shows that the individual committed an act or acts that meet the definition of any of the crimes listed in subdivision 3d, paragraph (a), clauses (1) to (4); or the individual's failure to make required reports under section 626.556, subdivision 3, or 626.557, subdivision 3, if:

(i) the commissioner has issued a final order in an appeal of that determination under section 245A.08, subdivision 5, or 256.045, or a court has issued a final decision;

(ii) the individual did not request reconsideration of the disqualification under this section; or

(iii) the individual did not request a hearing on the disqualification under section 256.045.

Sec. 13. Minnesota Statutes 2001 Supplement, section 245A.07, subdivision 2a, is amended to read:

Subd. 2a. **IMMEDIATE SUSPENSION EXPEDITED HEARING.** (a) Within five working days of receipt of the license holder's timely appeal, the commissioner shall request assignment of an administrative law judge. The request must include a proposed date, time, and place of a hearing. A hearing must be conducted by an administrative law judge within 30 calendar days of the request for assignment, unless an extension is requested by either party and granted by the administrative law judge for good cause. The commissioner shall issue a notice of hearing by certified mail at least ten working days before the hearing. The scope of the hearing shall be limited solely to the issue of whether the temporary immediate suspension should remain in effect pending the commissioner's final order under section 245A.08, regarding a licensing sanction issued under subdivision 3 following the immediate suspension. The burden of proof in expedited hearings under this subdivision shall be limited to the commissioner's demonstration that reasonable cause exists to believe that the license holder's actions or failure to comply with applicable law or rule poses an imminent risk of harm to the health, safety, or rights of persons served by the program.

(b) The administrative law judge shall issue findings of fact, conclusions, and a recommendation within ten working days from the date of hearing. The commissioner's final order shall be issued within ten working days from receipt of the recommendation of the administrative law judge. Within 90 calendar days after a final order affirming an immediate suspension, the commissioner shall make a determination regarding whether a final licensing sanction shall be issued under subdivision 3. The license holder shall continue to be prohibited from operation of the program during this 90-day period.

(c) When the final order under paragraph (b) affirms an immediate suspension, and a final licensing sanction is issued under subdivision 3, and the license holder appeals that sanction, the license holder continues to be prohibited from operation of the program pending a final commissioner's order under section 245A.08, subdivision 5, regarding the final licensing sanction.

Sec. 14. Minnesota Statutes 2001 Supplement, section 245A.07, subdivision 3, is amended to read:

Subd. 3. **LICENSE SUSPENSION, REVOCATION, OR FINE.** The commissioner may suspend or revoke a license, or impose a fine if a license holder fails to comply fully with applicable laws or rules, or knowingly withholds relevant information from or gives false or misleading information to the commissioner in connection with an application for a license, in connection with the background study status of an individual, or during an investigation. A license holder who has had a license

suspended, revoked, or has been ordered to pay a fine must be given notice of the action by certified mail. The notice must be mailed to the address shown on the application or the last known address of the license holder. The notice must state the reasons the license was suspended, revoked, or a fine was ordered.

(a) If the license was suspended or revoked, the notice must inform the license holder of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8510 to 1400.8612 and successor rules. The license holder may appeal an order suspending or revoking a license. The appeal of an order suspending or revoking a license must be made in writing by certified mail and must be received by the commissioner within ten calendar days after the license holder receives notice that the license has been suspended or revoked. Except as provided in subdivision 2a, paragraph (c), a timely appeal of an order suspending or revoking a license shall stay the suspension or revocation until the commissioner issues a final order.

(b)(1) If the license holder was ordered to pay a fine, the notice must inform the license holder of the responsibility for payment of fines and the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8510 to 1400.8612 and successor rules. The appeal of an order to pay a fine must be made in writing by certified mail and must be received by the commissioner within ten calendar days after the license holder receives notice that the fine has been ordered.

(2) The license holder shall pay the fines assessed on or before the payment date specified. If the license holder fails to fully comply with the order, the commissioner may issue a second fine or suspend the license until the license holder complies. If the license holder receives state funds, the state, county, or municipal agencies or departments responsible for administering the funds shall withhold payments and recover any payments made while the license is suspended for failure to pay a fine. A timely appeal shall stay payment of the fine until the commissioner issues a final order.

(3) A license holder shall promptly notify the commissioner of human services, in writing, when a violation specified in the order to forfeit a fine is corrected. If upon reinspection the commissioner determines that a violation has not been corrected as indicated by the order to forfeit a fine, the commissioner may issue a second fine. The commissioner shall notify the license holder by certified mail that a second fine has been assessed. The license holder may appeal the second fine as provided under this subdivision.

(4) Fines shall be assessed as follows: the license holder shall forfeit $1,000 for each determination of maltreatment of a child under section 626.556 or the maltreatment of a vulnerable adult under section 626.557; the license holder shall forfeit $200 for each occurrence of a violation of law or rule governing matters of health, safety, or supervision, including but not limited to the provision of adequate staff-to-child or adult ratios, and failure to submit a background study; and the license holder shall forfeit $100 for each occurrence of a violation of law or rule other than those subject to a $1,000 or $200 fine above. For purposes of this section, "occurrence" means each violation identified in the commissioner's fine order.

(5) When a fine has been assessed, the license holder may not avoid payment by closing, selling, or otherwise transferring the licensed program to a third party. In such

an event, the license holder will be personally liable for payment. In the case of a corporation, each controlling individual is personally and jointly liable for payment.

Sec. 15. **[245A.085] CONSOLIDATION OF HEARINGS; RECONSIDERATION.**

Hearings authorized under this chapter and sections 256.045, 626.556, and 626.557, shall be consolidated if feasible and in accordance with other applicable statutes and rules. Reconsideration under sections 245A.04, subdivision 3c; 626.556, subdivision 10i; and 626.557, subdivision 9d, shall also be consolidated if feasible.

Sec. 16. Minnesota Statutes 2001 Supplement, section 245A.144, is amended to read:

245A.144 **REDUCTION OF RISK OF SUDDEN INFANT DEATH SYNDROME IN CHILD CARE PROGRAMS.**

License holders must ensure that before staff persons, caregivers, and helpers assist in the care of infants, they receive training on reducing the risk of sudden infant death syndrome. The training on reducing the risk of sudden infant death syndrome may be provided as orientation training under Minnesota Rules, part 9503.0035, subpart 1, as initial training under Minnesota Rules, part 9502.0385, subpart 2, as in-service training under Minnesota Rules, part 9503.0035, subpart 4, or as ongoing training under Minnesota Rules, part 9502.0385, subpart 3. Training required under this section must be at least one hour in length and must be completed at least once every five years. At a minimum, the training must address the risk factors related to sudden infant death syndrome, means of reducing the risk of sudden infant death syndrome in child care, and license holder communication with parents regarding reducing the risk of sudden infant death syndrome. Training for family and group family child care providers must be approved by the county licensing agency according to Minnesota Rules, part 9502.0385.

Sec. 17. **[245A.151] FIRE MARSHAL INSPECTION.**

When licensure under this chapter requires an inspection by a fire marshal to determine compliance with the Minnesota Uniform Fire Code under section 299F.011, a local fire code inspector approved by the state fire marshal may conduct the inspection. If a community does not have a local fire code inspector or if the local fire code inspector does not perform the inspection, the state fire marshal must conduct the inspection. A local fire code inspector or the state fire marshal may recover the cost of these inspections through a fee of no more than $50 per inspection charged to the applicant or license holder. The fees collected by the state fire marshal under this section are appropriated to the commissioner of public safety for the purpose of conducting the inspections.

Sec. 18. Minnesota Statutes 2001 Supplement, section 245A.16, subdivision 1, is amended to read:

Subdivision 1. **DELEGATION OF AUTHORITY TO AGENCIES.** (a) County agencies and private agencies that have been designated or licensed by the commis-

sioner to perform licensing functions and activities under section 245A.04, to recommend denial of applicants under section 245A.05, to issue correction orders, to issue variances, and recommend a conditional license under section 245A.06, or to recommend suspending or revoking a license or issuing a fine under section 245A.07, shall comply with rules and directives of the commissioner governing those functions and with this section. The following variances are excluded from the delegation of variance authority and may be issued only by the commissioner:

(1) dual licensure of family child care and child foster care, dual licensure of child and adult foster care, and adult foster care and family child care;

(2) adult foster care maximum capacity;

(3) adult foster care minimum age requirement;

(4) child foster care maximum age requirement;

(5) variances regarding disqualified individuals except that county agencies may issue variances under section 245A.04, subdivision 3e, regarding disqualified individuals when the county is responsible for conducting a consolidated reconsideration according to section 245A.04, subdivision 3b, paragraph (f), of a county maltreatment determination and a disqualification based on serious or recurring maltreatment; and

(6) the required presence of a caregiver in the adult foster care residence during normal sleeping hours.

(b) County agencies must report information about disqualification reconsiderations under section 245A.04, subdivision 3b, paragraph (f), and variances granted under paragraph (a), clause (5), to the commissioner at least monthly in a format prescribed by the commissioner.

(c) For family day care programs, the commissioner may authorize licensing reviews every two years after a licensee has had at least one annual review.

Sec. 19. Minnesota Statutes 2001 Supplement, section 256.045, subdivision 3b, is amended to read:

Subd. 3b. **STANDARD OF EVIDENCE FOR MALTREATMENT AND DISQUALIFICATION HEARINGS.** (a) The state human services referee shall determine that maltreatment has occurred if a preponderance of evidence exists to support the final disposition under sections 626.556 and 626.557. For purposes of hearings regarding disqualification, the state human services referee shall affirm the proposed disqualification in an appeal under subdivision 3, paragraph (a), clause (9), if a preponderance of the evidence shows the individual has:

(1) committed maltreatment under section 626.556 or 626.557, which is serious or recurring;

(2) committed an act or acts meeting the definition of any of the crimes listed in section 245A.04, subdivision 3d, paragraph (a), clauses (1) to (4); or

(3) failed to make required reports under section 626.556 or 626.557, for incidents in which:

~~(i)~~ the final disposition under section 626.556 or 626.557 was substantiated maltreatment~~; and~~

~~(ii) the maltreatment was recurring or serious; or substantiated serious or recurring maltreatment of a minor under section 626.556 or of a vulnerable adult under section 626.557 for which there is a preponderance of evidence that the maltreatment occurred, and that the subject was responsible for the maltreatment~~ that was serious or recurring.

(b) If the disqualification is affirmed, the state human services referee shall determine whether the individual poses a risk of harm in accordance with the requirements of section 245A.04, subdivision 3b.

(c) The state human services referee shall recommend an order to the commissioner of health, children, families, and learning, or human services, as applicable, who shall issue a final order. The commissioner shall affirm, reverse, or modify the final disposition. Any order of the commissioner issued in accordance with this subdivision is conclusive upon the parties unless appeal is taken in the manner provided in subdivision 7. ~~Except as provided under section 245A.04, subdivisions 3b, paragraphs (e) and (f), and 3e,~~ In any licensing appeal under chapter 245A and sections 144.50 to 144.58 and 144A.02 to 144A.46, the commissioner's determination as to maltreatment is conclusive, as provided under section 245A.04, subdivision 3f.

Sec. 20. Minnesota Statutes 2001 Supplement, section 256.045, subdivision 4, is amended to read:

Subd. 4. **CONDUCT OF HEARINGS.** (a) All hearings held pursuant to subdivision 3, 3a, 3b, or 4a shall be conducted according to the provisions of the federal Social Security Act and the regulations implemented in accordance with that act to enable this state to qualify for federal grants-in-aid, and according to the rules and written policies of the commissioner of human services. County agencies shall install equipment necessary to conduct telephone hearings. A state human services referee may schedule a telephone conference hearing when the distance or time required to travel to the county agency offices will cause a delay in the issuance of an order, or to promote efficiency, or at the mutual request of the parties. Hearings may be conducted by telephone conferences unless the applicant, recipient, former recipient, person, or facility contesting maltreatment objects. The hearing shall not be held earlier than five days after filing of the required notice with the county or state agency. The state human services referee shall notify all interested persons of the time, date, and location of the hearing at least five days before the date of the hearing. Interested persons may be represented by legal counsel or other representative of their choice, including a provider of therapy services, at the hearing and may appear personally, testify and offer evidence, and examine and cross-examine witnesses. The applicant, recipient, former recipient, person, or facility contesting maltreatment shall have the opportunity to examine the contents of the case file and all documents and records to be used by the county or state agency at the hearing at a reasonable time before the date of the hearing and during the hearing. In hearings under subdivision 3, paragraph (a), clauses (4), (8), and (9), either party may subpoena the private data

relating to the investigation prepared by the agency under section 626.556 or 626.557 that is not otherwise accessible under section 13.04, provided the identity of the reporter may not be disclosed.

(b) The private data obtained by subpoena in a hearing under subdivision 3, paragraph (a), clause (4), (8), or (9), must be subject to a protective order which prohibits its disclosure for any other purpose outside the hearing provided for in this section without prior order of the district court. Disclosure without court order is punishable by a sentence of not more than 90 days imprisonment or a fine of not more than $700, or both. These restrictions on the use of private data do not prohibit access to the data under section 13.03, subdivision 6. Except for appeals under subdivision 3, paragraph (a), clauses (4), (5), (8), and (9), upon request, the county agency shall provide reimbursement for transportation, child care, photocopying, medical assessment, witness fee, and other necessary and reasonable costs incurred by the applicant, recipient, or former recipient in connection with the appeal. All evidence, except that privileged by law, commonly accepted by reasonable people in the conduct of their affairs as having probative value with respect to the issues shall be submitted at the hearing and such hearing shall not be "a contested case" within the meaning of section 14.02, subdivision 3. The agency must present its evidence prior to or at the hearing, and may not submit evidence after the hearing except by agreement of the parties at the hearing, provided the petitioner has the opportunity to respond.

(c) In hearings under subdivision 3, paragraph (a), clauses (4), (8), and (9), involving determinations of maltreatment or disqualification made by more than one county agency, by a county agency and a state agency, or by more than one state agency, the hearings may be consolidated into a single fair hearing upon the consent of all parties and the state human services referee.

Sec. 21. Minnesota Statutes 2001 Supplement, section 626.556, subdivision 10i, is amended to read:

Subd. 10i. **ADMINISTRATIVE RECONSIDERATION OF FINAL DETERMINATION OF MALTREATMENT AND DISQUALIFICATION BASED ON SERIOUS OR RECURRING MALTREATMENT; REVIEW PANEL.** (a) Except as provided under paragraph (e), an individual or facility that the commissioner of human services, a local social service agency, or the commissioner of children, families, and learning determines has maltreated a child, an interested person acting on behalf of the child, regardless of the determination, who contests the investigating agency's final determination regarding maltreatment, may request the investigating agency to reconsider its final determination regarding maltreatment. The request for reconsideration must be submitted in writing to the investigating agency within 15 calendar days after receipt of notice of the final determination regarding maltreatment or, if the request is made by an interested person who is not entitled to notice, within 15 days after receipt of the notice by the parent or guardian of the child. Effective January 1, 2002, an individual who was determined to have maltreated a child under this section and who was disqualified on the basis of serious or recurring maltreatment under section 245A.04, subdivision 3d, may request reconsideration of the maltreatment determination and the disqualification. The request for reconsideration of the

maltreatment determination and the disqualification must be submitted within 30 calendar days of the individual's receipt of the notice of disqualification under section 245A.04, subdivision 3a.

(b) Except as provided under paragraphs (e) and (f), if the investigating agency denies the request or fails to act upon the request within 15 calendar days after receiving the request for reconsideration, the person or facility entitled to a fair hearing under section 256.045 may submit to the commissioner of human services or the commissioner of children, families, and learning a written request for a hearing under that section. Section 256.045 also governs hearings requested to contest a final determination of the commissioner of children, families, and learning. For reports involving maltreatment of a child in a facility, an interested person acting on behalf of the child may request a review by the child maltreatment review panel under section 256.022 if the investigating agency denies the request or fails to act upon the request or if the interested person contests a reconsidered determination. The investigating agency shall notify persons who request reconsideration of their rights under this paragraph. The request must be submitted in writing to the review panel and a copy sent to the investigating agency within 30 calendar days of receipt of notice of a denial of a request for reconsideration or of a reconsidered determination. The request must specifically identify the aspects of the agency determination with which the person is dissatisfied.

(c) If, as a result of a reconsideration or review, the investigating agency changes the final determination of maltreatment, that agency shall notify the parties specified in subdivisions 10b, 10d, and 10f.

(d) Except as provided under paragraph (f), if an individual or facility contests the investigating agency's final determination regarding maltreatment by requesting a fair hearing under section 256.045, the commissioner of human services shall assure that the hearing is conducted and a decision is reached within 90 days of receipt of the request for a hearing. The time for action on the decision may be extended for as many days as the hearing is postponed or the record is held open for the benefit of either party.

(e) Effective January 1, 2002, if an individual was disqualified under section 245A.04, subdivision 3d, on the basis of a determination of maltreatment, which was serious or recurring, and the individual has requested reconsideration of the maltreatment determination under paragraph (a) and requested reconsideration of the disqualification under section 245A.04, subdivision 3b, reconsideration of the maltreatment determination and reconsideration of the disqualification shall be consolidated into a single reconsideration. If reconsideration of the maltreatment determination is denied or the disqualification is not set aside or rescinded under section 245A.04, subdivision 3b, the individual may request a fair hearing under section 256.045. If an individual ~~disqualified on the basis of a determination of maltreatment, which was serious or recurring~~ requests a fair hearing ~~under paragraph (b)~~ on the maltreatment determination and the disqualification, the scope of the fair hearing shall include both the maltreatment determination and the disqualification.

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

(f) Effective January 1, 2002, if a maltreatment determination or a disqualification based on serious or recurring maltreatment is the basis for a denial of a license under section 245A.05 or a licensing sanction under section 245A.07, the license holder has the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8510 to 1400.8612 and successor rules. As provided for under section 245A.08, subdivision 2a, the scope of the contested case hearing shall include the maltreatment determination, disqualification, and licensing sanction or denial of a license. In such cases, a fair hearing regarding the maltreatment determination shall not be conducted under paragraph (b). If the disqualified subject is an individual other than the license holder and upon whom a background study must be conducted under section 245A.04, subdivision 3, the hearings of all parties may be consolidated into a single contested case hearing upon consent of all parties and the administrative law judge.

(g) For purposes of this subdivision, "interested person acting on behalf of the child" means a parent or legal guardian; stepparent; grandparent; guardian ad litem; adult stepbrother, stepsister, or sibling; or adult aunt or uncle; unless the person has been determined to be the perpetrator of the maltreatment.

Sec. 22. Minnesota Statutes 2000, section 626.557, subdivision 3a, is amended to read:

Subd. 3a. **REPORT NOT REQUIRED.** The following events are not required to be reported under this section:

(a) A circumstance where federal law specifically prohibits a person from disclosing patient identifying information in connection with a report of suspected maltreatment, unless the vulnerable adult, or the vulnerable adult's guardian, conservator, or legal representative, has consented to disclosure in a manner which conforms to federal requirements. Facilities whose patients or residents are covered by such a federal law shall seek consent to the disclosure of suspected maltreatment from each patient or resident, or a guardian, conservator, or legal representative, upon the patient's or resident's admission to the facility. Persons who are prohibited by federal law from reporting an incident of suspected maltreatment shall immediately seek consent to make a report.

(b) Verbal or physical aggression occurring between patients, residents, or clients of a facility, or self-abusive behavior by these persons does not constitute abuse unless the behavior causes serious harm. The operator of the facility or a designee shall record incidents of aggression and self-abusive behavior to facilitate review by licensing agencies and county and local welfare agencies.

(c) Accidents as defined in section 626.5572, subdivision 3.

(d) Events occurring in a facility that result from an individual's ~~single mistake~~ error in the provision of therapeutic conduct to a vulnerable adult, as ~~defined~~ provided in section 626.5572, subdivision 17, paragraph (c), clause (4).

(e) Nothing in this section shall be construed to require a report of financial exploitation, as defined in section 626.5572, subdivision 9, solely on the basis of the transfer of money or property by gift or as compensation for services rendered.

Sec. 23. Minnesota Statutes 2001 Supplement, section 626.557, subdivision 9d, is amended to read:

Subd. 9d. **ADMINISTRATIVE RECONSIDERATION OF FINAL DISPOSITION OF MALTREATMENT AND DISQUALIFICATION BASED ON SERIOUS OR RECURRING MALTREATMENT; REVIEW PANEL.** (a) Except as provided under paragraph (e), any individual or facility which a lead agency determines has maltreated a vulnerable adult, or the vulnerable adult or an interested person acting on behalf of the vulnerable adult, regardless of the lead agency's determination, who contests the lead agency's final disposition of an allegation of maltreatment, may request the lead agency to reconsider its final disposition. The request for reconsideration must be submitted in writing to the lead agency within 15 calendar days after receipt of notice of final disposition or, if the request is made by an interested person who is not entitled to notice, within 15 days after receipt of the notice by the vulnerable adult or the vulnerable adult's legal guardian. An individual who was determined to have maltreated a vulnerable adult under this section and who was disqualified on the basis of serious or recurring maltreatment under section 245A.04, subdivision 3d, may request reconsideration of the maltreatment determination and the disqualification. The request for reconsideration of the maltreatment determination and the disqualification must be submitted within 30 calendar days of the individual's receipt of the notice of disqualification under section 245A.04, subdivision 3a.

(b) Except as provided under paragraphs (e) and (f), if the lead agency denies the request or fails to act upon the request within 15 calendar days after receiving the request for reconsideration, the person or facility entitled to a fair hearing under section 256.045, may submit to the commissioner of human services a written request for a hearing under that statute. The vulnerable adult, or an interested person acting on behalf of the vulnerable adult, may request a review by the vulnerable adult maltreatment review panel under section 256.021 if the lead agency denies the request or fails to act upon the request, or if the vulnerable adult or interested person contests a reconsidered disposition. The lead agency shall notify persons who request reconsideration of their rights under this paragraph. The request must be submitted in writing to the review panel and a copy sent to the lead agency within 30 calendar days of receipt of notice of a denial of a request for reconsideration or of a reconsidered disposition. The request must specifically identify the aspects of the agency determination with which the person is dissatisfied.

(c) If, as a result of a reconsideration or review, the lead agency changes the final disposition, it shall notify the parties specified in subdivision 9c, paragraph (d).

(d) For purposes of this subdivision, "interested person acting on behalf of the vulnerable adult" means a person designated in writing by the vulnerable adult to act on behalf of the vulnerable adult, or a legal guardian or conservator or other legal representative, a proxy or health care agent appointed under chapter 145B or 145C, or an individual who is related to the vulnerable adult, as defined in section 245A.02, subdivision 13.

(e) If an individual was disqualified under section 245A.04, subdivision 3d, on the basis of a determination of maltreatment, which was serious or recurring, and the

individual has requested reconsideration of the maltreatment determination under paragraph (a) and reconsideration of the disqualification under section 245A.04, subdivision 3b, reconsideration of the maltreatment determination and requested reconsideration of the disqualification shall be consolidated into a single reconsideration. If reconsideration of the maltreatment determination is denied or if the disqualification is not set aside or rescinded under section 245A.04, subdivision 3b, the individual may request a fair hearing under section 256.045. If an individual ~~who was disqualified on the basis of serious or recurring maltreatment~~ requests a fair hearing ~~under paragraph (b)~~ on the maltreatment determination and the disqualification, the scope of the fair hearing shall include both the maltreatment determination and the disqualification.

(f) If a maltreatment determination or a disqualification based on serious or recurring maltreatment is the basis for a denial of a license under section 245A.05 or a licensing sanction under section 245A.07, the license holder has the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8510 to 1400.8612 and successor rules. As provided for under section 245A.08, the scope of the contested case hearing shall include the maltreatment determination, disqualification, and licensing sanction or denial of a license. In such cases, a fair hearing shall not be conducted under paragraph (b). If the disqualified subject is an individual other than the license holder and upon whom a background study must be conducted under section 245A.04, subdivision 3, the hearings of all parties may be consolidated into a single contested case hearing upon consent of all parties and the administrative law judge.

(g) Until August 1, 2002, an individual or facility that was determined by the commissioner of human services or the commissioner of health to be responsible for neglect under section 626.5572, subdivision 17, after October 1, 1995, and before August 1, 2001, that believes that the finding of neglect does not meet an amended definition of neglect may request a reconsideration of the determination of neglect. The commissioner of human services or the commissioner of health shall mail a notice to the last known address of individuals who are eligible to seek this reconsideration. The request for reconsideration must state how the established findings no longer meet the elements of the definition of neglect. The commissioner shall review the request for reconsideration and make a determination within 15 calendar days. The commissioner's decision on this reconsideration is the final agency action.

(1) For purposes of compliance with the data destruction schedule under subdivision 12b, paragraph (d), when a finding of substantiated maltreatment has been changed as a result of a reconsideration under this paragraph, the date of the original finding of a substantiated maltreatment must be used to calculate the destruction date.

(2) For purposes of any background studies under section 245A.04, when a determination of substantiated maltreatment has been changed as a result of a reconsideration under this paragraph, any prior disqualification of the individual under section 245A.04 that was based on this determination of maltreatment shall be rescinded, and for future background studies under section 245A.04 the commissioner must not use the previous determination of substantiated maltreatment as a basis for

disqualification or as a basis for referring the individual's maltreatment history to a health-related licensing board under section 245A.04, subdivision 3d, paragraph (b).

ARTICLE 2

CONTINUING CARE AND HEALTH CARE

Section 1. Minnesota Statutes 2001 Supplement, section 144A.071, subdivision 1a, is amended to read:

Subd. 1a. **DEFINITIONS.** For purposes of sections 144A.071 to 144A.073, the following terms have the meanings given them:

(a) "Attached fixtures" has the meaning given in Minnesota Rules, part 9549.0020, subpart 6.

(b) "Buildings" has the meaning given in Minnesota Rules, part 9549.0020, subpart 7.

(c) "Capital assets" has the meaning given in section 256B.421, subdivision 16.

(d) "Commenced construction" means that all of the following conditions were met: the final working drawings and specifications were approved by the commissioner of health; the construction contracts were let; a timely construction schedule was developed, stipulating dates for beginning, achieving various stages, and completing construction; and all zoning and building permits were applied for.

(e) "Completion date" means the date on which a certificate of occupancy is issued for a construction project, or if a certificate of occupancy is not required, the date on which the construction project is available for facility use.

(f) "Construction" means any erection, building, alteration, reconstruction, modernization, or improvement necessary to comply with the nursing home licensure rules.

(g) "Construction project" means:

(1) a capital asset addition to, or replacement of a nursing home or certified boarding care home that results in new space or the remodeling of or renovations to existing facility space;

(2) the remodeling or renovation of existing facility space the use of which is modified as a result of the project described in clause (1). This existing space and the project described in clause (1) must be used for the functions as designated on the construction plans on completion of the project described in clause (1) for a period of not less than 24 months; or

(3) capital asset additions or replacements that are completed within 12 months before or after the completion date of the project described in clause (1).

(h) "New licensed" or "new certified beds" means:

(1) newly constructed beds in a facility or the construction of a new facility that would increase the total number of licensed nursing home beds or certified boarding care or nursing home beds in the state; or

(2) newly licensed nursing home beds or newly certified boarding care or nursing home beds that result from remodeling of the facility that involves relocation of beds but does not result in an increase in the total number of beds, except when the project involves the upgrade of boarding care beds to nursing home beds, as defined in section 144A.073, subdivision 1. "Remodeling" includes any of the type of conversion, renovation, replacement, or upgrading projects as defined in section 144A.073, subdivision 1.

(i) "Project construction costs" means the cost of the facility capital asset additions, replacements, renovations, or remodeling projects, construction site preparation costs, and related soft costs. Project construction costs include the cost of any remodeling or renovation of existing facility space which is modified as a result of the construction project. Project construction costs also includes the cost of new technology implemented as part of the construction project. Project construction costs also include the cost of new technology implemented as part of the construction project and depreciable equipment directly identified to the project. Any new technology and depreciable equipment included in the project construction costs shall, at the written election of the facility, be included in the facility's appraised value for purposes of Minnesota Rules, part 9549.0020, subpart 5, and debt incurred for its purchase shall be included as allowable debt for purposes of Minnesota Rules, part 9549.0060, subpart 5, items A and C. Any new technology and depreciable equipment included in the project construction costs that the facility elects not to include in its appraised value and allowable debt shall be treated as provided in section 256B.431, subdivision 17, paragraph (b). Written election under this paragraph must be included in the facility's request for the rate change related to the project, and this election may not be changed.

(j) "Technology" means information systems or devices that make documentation, charting, and staff time more efficient or encourage and allow for care through alternative settings including, but not limited to, touch screens, monitors, hand-helds, swipe cards, motion detectors, pagers, telemedicine, medication dispensers, and equipment to monitor vital signs and self-injections, and to observe skin and other conditions.

Sec. 2. Minnesota Statutes 2001 Supplement, section 144A.36, subdivision 1, is amended to read:

Subdivision 1. **DEFINITIONS.** "Eligible nursing home" means any nursing home licensed under sections 144A.01 to 144A.155 ~~and~~ or any boarding care facility, certified by the appropriate authority under United States Code, title 42, sections 1396-1396p, to participate as a vendor in the medical assistance program established under chapter 256B.

Sec. 3. Minnesota Statutes 2000, section 144D.01, subdivision 4, is amended to read:

Subd. 4. **HOUSING WITH SERVICES ESTABLISHMENT OR ESTABLISHMENT.** (a) "Housing with services establishment" or "establishment" means:

(1) an establishment providing sleeping accommodations to one or more adult residents, at least 80 percent of which are 55 years of age or older, and offering or providing, for a fee, one or more regularly scheduled health-related services or two or more regularly scheduled supportive services, whether offered or provided directly by the establishment or by another entity arranged for by the establishment; or

(2) an establishment that registers under section 144D.025.

(b) Housing with services establishment does not include:

(1) a nursing home licensed under chapter 144A;

(2) a hospital, certified boarding care home, or supervised living facility licensed under sections 144.50 to 144.56;

(3) a board and lodging establishment licensed under chapter 157 and Minnesota Rules, parts 9520.0500 to 9520.0670, 9525.0215 to 9525.0355, 9525.0500 to 9525.0660, or 9530.4100 to 9530.4450, or under chapter 245B;

(4) a board and lodging establishment which serves as a shelter for battered women or other similar purpose;

(5) a family adult foster care home licensed by the department of human services;

(6) private homes in which the residents are related by kinship, law, or affinity with the providers of services;

(7) residential settings for persons with mental retardation or related conditions in which the services are licensed under Minnesota Rules, parts 9525.2100 to 9525.2140, or applicable successor rules or laws;

(8) a home-sharing arrangement such as when an elderly or disabled person or single-parent family makes lodging in a private residence available to another person in exchange for services or rent, or both;

(9) a duly organized condominium, cooperative, common interest community, or owners' association of the foregoing where at least 80 percent of the units that comprise the condominium, cooperative, or common interest community are occupied by individuals who are the owners, members, or shareholders of the units; or

(10) services for persons with developmental disabilities that are provided under a license according to Minnesota Rules, parts 9525.2000 to 9525.2140 in effect until January 1, 1998, or under chapter 245B.

Sec. 4. **[144D.025] OPTIONAL REGISTRATION.**

An establishment that meets all the requirements of this chapter except that fewer than 80 percent of the adult residents are age 55 or older may, at its option, register as a housing with services establishment.

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

Sec. 5. Minnesota Statutes 2000, section 245.462, subdivision 4, is amended to read:

Subd. 4. **CASE MANAGEMENT SERVICE PROVIDER.** (a) "Case management service provider" means a case manager or case manager associate employed by the county or other entity authorized by the county board to provide case management services specified in section 245.4711.

(b) A case manager must:

(1) be skilled in the process of identifying and assessing a wide range of client needs;

(2) be knowledgeable about local community resources and how to use those resources for the benefit of the client;

(3) have a bachelor's degree in one of the behavioral sciences or related fields including, but not limited to, social work, psychology, or nursing from an accredited college or university or meet the requirements of paragraph (c); and

(4) meet the supervision and continuing education requirements described in paragraphs (d), (e), and (f), as applicable.

(c) Case managers without a bachelor's degree must meet one of the requirements in clauses (1) to (3):

(1) have three or four years of experience as a case manager associate as defined in this section;

(2) be a registered nurse without a bachelor's degree and have a combination of specialized training in psychiatry and work experience consisting of community interaction and involvement or community discharge planning in a mental health setting totaling three years; or

(3) be a person who qualified as a case manager under the 1998 department of human service waiver provision and meet the continuing education and mentoring requirements in this section.

(d) A case manager with at least 2,000 hours of supervised experience in the delivery of services to adults with mental illness must receive regular ongoing supervision and clinical supervision totaling 38 hours per year of which at least one hour per month must be clinical supervision regarding individual service delivery with a case management supervisor. The remaining 26 hours of supervision may be provided by a case manager with two years of experience. Group supervision may not constitute more than one-half of the required supervision hours. Clinical supervision must be documented in the client record.

(e) A case manager without 2,000 hours of supervised experience in the delivery of services to adults with mental illness must:

(1) receive clinical supervision regarding individual service delivery from a mental health professional at least one hour per week until the requirement of 2,000 hours of experience is met; and

(2) complete 40 hours of training approved by the commissioner in case management skills and the characteristics and needs of adults with serious and persistent mental illness.

(f) A case manager who is not licensed, registered, or certified by a health-related licensing board must receive 30 hours of continuing education and training in mental illness and mental health services ~~annually~~ every two years.

(g) A case manager associate (CMA) must:

(1) work under the direction of a case manager or case management supervisor;

(2) be at least 21 years of age;

(3) have at least a high school diploma or its equivalent; and

(4) meet one of the following criteria:

(i) have an associate of arts degree in one of the behavioral sciences or human services;

(ii) be a registered nurse without a bachelor's degree;

(iii) within the previous ten years, have three years of life experience with serious and persistent mental illness as defined in section 245.462, subdivision 20; or as a child had severe emotional disturbance as defined in section 245.4871, subdivision 6; or have three years life experience as a primary caregiver to an adult with serious and persistent mental illness within the previous ten years;

(iv) have 6,000 hours work experience as a nondegreed state hospital technician; or

(v) be a mental health practitioner as defined in section 245.462, subdivision 17, clause (2).

Individuals meeting one of the criteria in items (i) to (iv), may qualify as a case manager after four years of supervised work experience as a case manager associate. Individuals meeting the criteria in item (v), may qualify as a case manager after three years of supervised experience as a case manager associate.

(h) A case management associate must meet the following supervision, mentoring, and continuing education requirements:

(1) have 40 hours of preservice training described under paragraph (e), clause (2);

(2) receive at least 40 hours of continuing education in mental illness and mental health services annually; and

(3) receive at least five hours of mentoring per week from a case management mentor.

A "case management mentor" means a qualified, practicing case manager or case management supervisor who teaches or advises and provides intensive training and clinical supervision to one or more case manager associates. Mentoring may occur

while providing direct services to consumers in the office or in the field and may be provided to individuals or groups of case manager associates. At least two mentoring hours per week must be individual and face-to-face.

(i) A case management supervisor must meet the criteria for mental health professionals, as specified in section 245.462, subdivision 18.

(j) An immigrant who does not have the qualifications specified in this subdivision may provide case management services to adult immigrants with serious and persistent mental illness who are members of the same ethnic group as the case manager if the person:

(1) is currently enrolled in and is actively pursuing credits toward the completion of a bachelor's degree in one of the behavioral sciences or a related field including, but not limited to, social work, psychology, or nursing 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 this subdivision are met.

Sec. 6. Minnesota Statutes 2000, section 245.4871, subdivision 4, is amended to read:

Subd. 4. **CASE MANAGEMENT SERVICE PROVIDER.** (a) "Case management service provider" means a case manager or case manager associate 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.

(b) A case manager must:

(1) have experience and training in working with children;

(2) have at least a bachelor's degree in one of the behavioral sciences or a related field including, but not limited to, social work, psychology, or nursing from an accredited college or university or meet the requirements of paragraph (d);

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

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

(5) meet the supervision and continuing education requirements of paragraphs (e), (f), and (g), as applicable.

(c) A 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) A case manager without a bachelor's degree must meet one of the requirements in clauses (1) to (3):

(1) have three or four years of experience as a case manager associate;

(2) be a registered nurse without a bachelor's degree who has a combination of specialized training in psychiatry and work experience consisting of community interaction and involvement or community discharge planning in a mental health setting totaling three years; or

(3) be a person who qualified as a case manager under the 1998 department of human services waiver provision and meets the continuing education, supervision, and mentoring requirements in this section.

(e) A case manager with at least 2,000 hours of supervised experience in the delivery of mental health services to children must receive regular ongoing supervision and clinical supervision totaling 38 hours per year, of which at least one hour per month must be clinical supervision regarding individual service delivery with a case management supervisor. The other 26 hours of supervision may be provided by a case manager with two years of experience. Group supervision may not constitute more than one-half of the required supervision hours.

(f) A case manager 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 one hour each week until the requirement of 2,000 hours of experience is met.

(g) A case manager who is not licensed, registered, or certified by a health-related licensing board must receive 30 hours of continuing education and training in severe emotional disturbance and mental health services ~~annually~~ every two years.

(h) 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.

(i) 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.

(j) A case manager associate (CMA) must:

(1) work under the direction of a case manager or case management supervisor;

(2) be at least 21 years of age;

(3) have at least a high school diploma or its equivalent; and

(4) meet one of the following criteria:

(i) have an associate of arts degree in one of the behavioral sciences or human services;

(ii) be a registered nurse without a bachelor's degree;

(iii) have three years of life experience as a primary caregiver to a child with serious emotional disturbance as defined in section 245.4871, subdivision 6, within the previous ten years;

(iv) have 6,000 hours work experience as a nondegreed state hospital technician; or

(v) be a mental health practitioner as defined in subdivision 26, clause (2).

Individuals meeting one of the criteria in items (i) to (iv) may qualify as a case manager after four years of supervised work experience as a case manager associate. Individuals meeting the criteria in item (v) may qualify as a case manager after three years of supervised experience as a case manager associate.

(k) Case manager associates must meet the following supervision, mentoring, and continuing education requirements;

(1) have 40 hours of preservice training described under paragraph (f), clause (1);

(2) receive at least 40 hours of continuing education in severe emotional disturbance and mental health service annually; and

(3) receive at least five hours of mentoring per week from a case management mentor. A "case management mentor" means a qualified, practicing case manager or case management supervisor who teaches or advises and provides intensive training and clinical supervision to one or more case manager associates. Mentoring may occur while providing direct services to consumers in the office or in the field and may be provided to individuals or groups of case manager associates. At least two mentoring hours per week must be individual and face-to-face.

(l) A case management supervisor must meet the criteria for a mental health professional as specified in section 245.4871, subdivision 27.

(m) An immigrant who does not have the qualifications specified in this subdivision may provide case management services to child immigrants with severe emotional disturbance of the same ethnic group as the immigrant if the person:

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

(2) completes 40 hours of training as specified in this subdivision; and

(3) receives clinical supervision at least once a week until the requirements of obtaining a bachelor's degree and 2,000 hours of supervised experience are met.

Sec. 7. Minnesota Statutes 2000, section 245.50, subdivision 1, is amended to read:

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

(a) "Bordering state" means Iowa, North Dakota, South Dakota, or Wisconsin.

(b) "Receiving agency ~~or facility~~" means a public or private hospital, mental health center, or other person or organization ~~authorized by a state to provide~~ which provides mental health services under this section to individuals from a state other than the state in which the agency is located.

(c) "Receiving state" means the state in which a receiving agency is located.

(d) "Sending agency" means a state or county agency which sends an individual to a bordering state for treatment under this section.

(e) "Sending state" means the state in which the sending agency is located.

Sec. 8. Minnesota Statutes 2000, section 245.50, subdivision 2, is amended to read:

Subd. 2. **PURPOSE AND AUTHORITY.** (a) The purpose of this section is to enable appropriate treatment to be provided to individuals, across state lines from the individual's state of residence, in qualified facilities that are closer to the homes of individuals than are facilities available in the individual's home state.

(b) Unless prohibited by another law and subject to the exceptions listed in subdivision 3, a county board or the commissioner of human services may contract with an agency or facility in a bordering state for mental health services for residents of Minnesota, and a Minnesota mental health agency or facility may contract to provide services to residents of bordering states. Except as provided in subdivision 5, a person who receives services in another state under this section is subject to the laws of the state in which services are provided. A person who will receive services in another state under this section must be informed of the consequences of receiving services in another state, including the implications of the differences in state laws, to the extent the individual will be subject to the laws of the receiving state.

Sec. 9. Minnesota Statutes 2000, section 245.50, subdivision 5, is amended to read:

Subd. 5. **SPECIAL CONTRACTS; ~~WISCONSIN~~ BORDERING STATES.** ~~The commissioner of the Minnesota department of human services must enter into negotiations with appropriate personnel at the Wisconsin department of health and social services and must develop an agreement that conforms to the requirements of subdivision 4, to enable the placement in Minnesota of patients who are on emergency holds or who have been involuntarily committed as mentally ill or chemically dependent in Wisconsin and to enable the temporary placement in Wisconsin of patients who are on emergency holds in Minnesota under section 253B.05, provided that the Minnesota courts retain jurisdiction over Minnesota patients, and the state of Wisconsin affords to Minnesota patients the rights under Minnesota law. Persons committed by the Wisconsin courts and placed in Minnesota facilities shall continue to be in the legal custody of Wisconsin and Wisconsin's laws governing length of commitment, reexaminations, and extension of commitment shall continue to apply to these residents. In all other respects, Wisconsin residents placed in Minnesota facilities~~

~~are subject to Minnesota laws. The agreement must specify that responsibility for payment for the cost of care of Wisconsin residents shall remain with the state of Wisconsin and the cost of care of Minnesota residents shall remain with the state of Minnesota. The commissioner shall be assisted by attorneys from the Minnesota attorney general's office in negotiating and finalizing this agreement. The agreement shall be completed so as to permit placement of Wisconsin residents in Minnesota facilities and Minnesota residents in Wisconsin facilities beginning July 1, 1994.~~ (a) An individual who is detained, committed, or placed on an involuntary basis under chapter 253B may be confined or treated in a bordering state pursuant to a contract under this section. An individual who is detained, committed, or placed on an involuntary basis under the civil law of a bordering state may be confined or treated in Minnesota pursuant to a contract under this section. A peace or health officer who is acting under the authority of the sending state may transport an individual to a receiving agency that provides services pursuant to a contract under this section and may transport the individual back to the sending state under the laws of the sending state. Court orders valid under the law of the sending state are granted recognition and reciprocity in the receiving state for individuals covered by a contract under this section to the extent that the court orders relate to confinement for treatment or care of mental illness. Such treatment or care may address other conditions that may be co-occurring with the mental illness. These court orders are not subject to legal challenge in the courts of the receiving state. Individuals who are detained, committed, or placed under the law of a sending state and who are transferred to a receiving state under this section continue to be in the legal custody of the authority responsible for them under the law of the sending state. Except in emergencies, those individuals may not be transferred, removed, or furloughed from a receiving agency without the specific approval of the authority responsible for them under the law of the sending state.

(b) While in the receiving state pursuant to a contract under this section, an individual shall be subject to the sending state's laws and rules relating to length of confinement, reexaminations, and extensions of confinement. No individual may be sent to another state pursuant to a contract under this section until the receiving state has enacted a law recognizing the validity and applicability of this section.

(c) If an individual receiving services pursuant to a contract under this section leaves the receiving agency without permission and the individual is subject to involuntary confinement under the law of the sending state, the receiving agency shall use all reasonable means to return the individual to the receiving agency. The receiving agency shall immediately report the absence to the sending agency. The receiving state has the primary responsibility for, and the authority to direct, the return of these individuals within its borders and is liable for the cost of the action to the extent that it would be liable for costs of its own resident.

(d) Responsibility for payment for the cost of care remains with the sending agency.

(e) This subdivision also applies to county contracts under subdivision 2 which include emergency care and treatment provided to a county resident in a bordering state.

Sec. 10. Minnesota Statutes 2001 Supplement, section 256.01, subdivision 2, as amended by Laws 2002, chapter 220, article 15, section 4, is amended to read:

Subd. 2. **SPECIFIC POWERS.** Subject to the provisions of section 241.021, subdivision 2, the commissioner of human services shall:

(1) Administer and supervise all forms of public assistance provided for by state law and other welfare activities or services as are vested in the commissioner. Administration and supervision of human services activities or services includes, but is not limited to, assuring timely and accurate distribution of benefits, completeness of service, and quality program management. In addition to administering and supervising human services activities vested by law in the department, the commissioner shall have the authority to:

(a) require county agency participation in training and technical assistance programs to promote compliance with statutes, rules, federal laws, regulations, and policies governing human services;

(b) monitor, on an ongoing basis, the performance of county agencies in the operation and administration of human services, enforce compliance with statutes, rules, federal laws, regulations, and policies governing welfare services and promote excellence of administration and program operation;

(c) develop a quality control program or other monitoring program to review county performance and accuracy of benefit determinations;

(d) require county agencies to make an adjustment to the public assistance benefits issued to any individual consistent with federal law and regulation and state law and rule and to issue or recover benefits as appropriate;

(e) delay or deny payment of all or part of the state and federal share of benefits and administrative reimbursement according to the procedures set forth in section 256.017;

(f) make contracts with and grants to public and private agencies and organizations, both profit and nonprofit, and individuals, using appropriated funds; and

(g) enter into contractual agreements with federally recognized Indian tribes with a reservation in Minnesota to the extent necessary for the tribe to operate a federally approved family assistance program or any other program under the supervision of the commissioner. The commissioner shall consult with the affected county or counties in the contractual agreement negotiations, if the county or counties wish to be included, in order to avoid the duplication of county and tribal assistance program services. The commissioner may establish necessary accounts for the purposes of receiving and disbursing funds as necessary for the operation of the programs.

(2) Inform county agencies, on a timely basis, of changes in statute, rule, federal law, regulation, and policy necessary to county agency administration of the programs.

(3) Administer and supervise all child welfare activities; promote the enforcement of laws protecting handicapped, dependent, neglected and delinquent children, and

children born to mothers who were not married to the children's fathers at the times of the conception nor at the births of the children; license and supervise child-caring and child-placing agencies and institutions; supervise the care of children in boarding and foster homes or in private institutions; and generally perform all functions relating to the field of child welfare now vested in the state board of control.

(4) Administer and supervise all noninstitutional service to handicapped persons, including those who are visually impaired, hearing impaired, or physically impaired or otherwise handicapped. The commissioner may provide and contract for the care and treatment of qualified indigent children in facilities other than those located and available at state hospitals when it is not feasible to provide the service in state hospitals.

(5) Assist and actively cooperate with other departments, agencies and institutions, local, state, and federal, by performing services in conformity with the purposes of Laws 1939, chapter 431.

(6) Act as the agent of and cooperate with the federal government in matters of mutual concern relative to and in conformity with the provisions of Laws 1939, chapter 431, including the administration of any federal funds granted to the state to aid in the performance of any functions of the commissioner as specified in Laws 1939, chapter 431, and including the promulgation of rules making uniformly available medical care benefits to all recipients of public assistance, at such times as the federal government increases its participation in assistance expenditures for medical care to recipients of public assistance, the cost thereof to be borne in the same proportion as are grants of aid to said recipients.

(7) Establish and maintain any administrative units reasonably necessary for the performance of administrative functions common to all divisions of the department.

(8) Act as designated guardian of both the estate and the person of all the wards of the state of Minnesota, whether by operation of law or by an order of court, without any further act or proceeding whatever, except as to persons committed as mentally retarded. For children under the guardianship of the commissioner whose interests would be best served by adoptive placement, the commissioner may contract with a licensed child-placing agency or a Minnesota tribal social services agency to provide adoption services. A contract with a licensed child-placing agency must be designed to supplement existing county efforts and may not replace existing county programs, unless the replacement is agreed to by the county board and the appropriate exclusive bargaining representative or the commissioner has evidence that child placements of the county continue to be substantially below that of other counties. Funds encumbered and obligated under an agreement for a specific child shall remain available until the terms of the agreement are fulfilled or the agreement is terminated.

(9) Act as coordinating referral and informational center on requests for service for newly arrived immigrants coming to Minnesota.

(10) The specific enumeration of powers and duties as hereinabove set forth shall in no way be construed to be a limitation upon the general transfer of powers herein contained.

(11) Establish county, regional, or statewide schedules of maximum fees and charges which may be paid by county agencies for medical, dental, surgical, hospital, nursing and nursing home care and medicine and medical supplies under all programs of medical care provided by the state and for congregate living care under the income maintenance programs.

(12) Have the authority to conduct and administer experimental projects to test methods and procedures of administering assistance and services to recipients or potential recipients of public welfare. To carry out such experimental projects, it is further provided that the commissioner of human services is authorized to waive the enforcement of existing specific statutory program requirements, rules, and standards in one or more counties. The order establishing the waiver shall provide alternative methods and procedures of administration, shall not be in conflict with the basic purposes, coverage, or benefits provided by law, and in no event shall the duration of a project exceed four years. It is further provided that no order establishing an experimental project as authorized by the provisions of this section shall become effective until the following conditions have been met:

(a) The secretary of health and human services of the United States has agreed, for the same project, to waive state plan requirements relative to statewide uniformity.

(b) A comprehensive plan, including estimated project costs, shall be approved by the legislative advisory commission and filed with the commissioner of administration.

(13) According to federal requirements, establish procedures to be followed by local welfare boards in creating citizen advisory committees, including procedures for selection of committee members.

(14) Allocate federal fiscal disallowances or sanctions which are based on quality control error rates for the aid to families with dependent children program formerly codified in sections 256.72 to 256.87, medical assistance, or food stamp program in the following manner:

(a) One-half of the total amount of the disallowance shall be borne by the county boards responsible for administering the programs. For the medical assistance and the AFDC program formerly codified in sections 256.72 to 256.87, disallowances shall be shared by each county board in the same proportion as that county's expenditures for the sanctioned program are to the total of all counties' expenditures for the AFDC program formerly codified in sections 256.72 to 256.87, and medical assistance programs. For the food stamp program, sanctions shall be shared by each county board, with 50 percent of the sanction being distributed to each county in the same proportion as that county's administrative costs for food stamps are to the total of all food stamp administrative costs for all counties, and 50 percent of the sanctions being distributed to each county in the same proportion as that county's value of food stamp benefits issued are to the total of all benefits issued for all counties. Each county shall pay its share of the disallowance to the state of Minnesota. When a county fails to pay the amount due hereunder, the commissioner may deduct the amount from reimbursement otherwise due the county, or the attorney general, upon the request of the commissioner, may institute civil action to recover the amount due.

(b) Notwithstanding the provisions of paragraph (a), if the disallowance results from knowing noncompliance by one or more counties with a specific program instruction, and that knowing noncompliance is a matter of official county board record, the commissioner may require payment or recover from the county or counties, in the manner prescribed in paragraph (a), an amount equal to the portion of the total disallowance which resulted from the noncompliance, and may distribute the balance of the disallowance according to paragraph (a).

(15) Develop and implement special projects that maximize reimbursements and result in the recovery of money to the state. For the purpose of recovering state money, the commissioner may enter into contracts with third parties. Any recoveries that result from projects or contracts entered into under this paragraph shall be deposited in the state treasury and credited to a special account until the balance in the account reaches $1,000,000. When the balance in the account exceeds $1,000,000, the excess shall be transferred and credited to the general fund. All money in the account is appropriated to the commissioner for the purposes of this paragraph.

(16) Have the authority to make direct payments to facilities providing shelter to women and their children according to section 256D.05, subdivision 3. Upon the written request of a shelter facility that has been denied payments under section 256D.05, subdivision 3, the commissioner shall review all relevant evidence and make a determination within 30 days of the request for review regarding issuance of direct payments to the shelter facility. Failure to act within 30 days shall be considered a determination not to issue direct payments.

(17) Have the authority to establish and enforce the following county reporting requirements:

(a) The commissioner shall establish fiscal and statistical reporting requirements necessary to account for the expenditure of funds allocated to counties for human services programs. When establishing financial and statistical reporting requirements, the commissioner shall evaluate all reports, in consultation with the counties, to determine if the reports can be simplified or the number of reports can be reduced.

(b) The county board shall submit monthly or quarterly reports to the department as required by the commissioner. Monthly reports are due no later than 15 working days after the end of the month. Quarterly reports are due no later than 30 calendar days after the end of the quarter, unless the commissioner determines that the deadline must be shortened to 20 calendar days to avoid jeopardizing compliance with federal deadlines or risking a loss of federal funding. Only reports that are complete, legible, and in the required format shall be accepted by the commissioner.

(c) If the required reports are not received by the deadlines established in clause (b), the commissioner may delay payments and withhold funds from the county board until the next reporting period. When the report is needed to account for the use of federal funds and the late report results in a reduction in federal funding, the commissioner shall withhold from the county boards with late reports an amount equal to the reduction in federal funding until full federal funding is received.

(d) A county board that submits reports that are late, illegible, incomplete, or not in the required format for two out of three consecutive reporting periods is considered noncompliant. When a county board is found to be noncompliant, the commissioner shall notify the county board of the reason the county board is considered noncompliant and request that the county board develop a corrective action plan stating how the county board plans to correct the problem. The corrective action plan must be submitted to the commissioner within 45 days after the date the county board received notice of noncompliance.

(e) The final deadline for fiscal reports or amendments to fiscal reports is one year after the date the report was originally due. If the commissioner does not receive a report by the final deadline, the county board forfeits the funding associated with the report for that reporting period and the county board must repay any funds associated with the report received for that reporting period.

(f) The commissioner may not delay payments, withhold funds, or require repayment under paragraph (c) or (e) if the county demonstrates that the commissioner failed to provide appropriate forms, guidelines, and technical assistance to enable the county to comply with the requirements. If the county board disagrees with an action taken by the commissioner under paragraph (c) or (e), the county board may appeal the action according to sections 14.57 to 14.69.

(g) Counties subject to withholding of funds under paragraph (c) or forfeiture or repayment of funds under paragraph (e) shall not reduce or withhold benefits or services to clients to cover costs incurred due to actions taken by the commissioner under paragraph (c) or (e).

(18) Allocate federal fiscal disallowances or sanctions for audit exceptions when federal fiscal disallowances or sanctions are based on a statewide random sample for the foster care program under title IV-E of the Social Security Act, United States Code, title 42, in direct proportion to each county's title IV-E foster care maintenance claim for that period.

(19) Be responsible for ensuring the detection, prevention, investigation, and resolution of fraudulent activities or behavior by applicants, recipients, and other participants in the human services programs administered by the department.

(20) Require county agencies to identify overpayments, establish claims, and utilize all available and cost-beneficial methodologies to collect and recover these overpayments in the human services programs administered by the department.

(21) Have the authority to administer a drug rebate program for drugs purchased pursuant to the prescription drug program established under section 256.955 after the beneficiary's satisfaction of any deductible established in the program. The commissioner shall require a rebate agreement from all manufacturers of covered drugs as defined in section 256B.0625, subdivision 13. Rebate agreements for prescription drugs delivered on or after July 1, 2002, must include rebates for individuals covered under the prescription drug program who are under 65 years of age. For each drug, the amount of the rebate shall be equal to the basic rebate as defined for purposes of the

federal rebate program in United States Code, title 42, section 1396r-8(c)(1). This basic rebate shall be applied to single-source and multiple-source drugs. The manufacturers must provide full payment within 30 days of receipt of the state invoice for the rebate within the terms and conditions used for the federal rebate program established pursuant to section 1927 of title XIX of the Social Security Act. The manufacturers must provide the commissioner with any information necessary to verify the rebate determined per drug. The rebate program shall utilize the terms and conditions used for the federal rebate program established pursuant to section 1927 of title XIX of the Social Security Act.

(22) Have the authority to administer the federal drug rebate program for drugs purchased under the medical assistance program as allowed by section 1927 of title XIX of the Social Security Act and according to the terms and conditions of section 1927. Rebates shall be collected for all drugs that have been dispensed or administered in an outpatient setting and that are from manufacturers who have signed a rebate agreement with the United States Department of Health and Human Services.

(23) Have the authority to administer a supplemental drug rebate program for drugs purchased under the medical assistance program ~~and under the prescription drug program established in section 256.955~~. The commissioner may enter into supplemental rebate contracts with pharmaceutical manufacturers and may require prior authorization for drugs that are from manufacturers that have not signed a supplemental rebate contract. Prior authorization of drugs shall be subject to the provisions of section 256B.0625, subdivision 13~~, paragraph (b)~~.

(24) Operate the department's communication systems account established in Laws 1993, First Special Session chapter 1, article 1, section 2, subdivision 2, to manage shared communication costs necessary for the operation of the programs the commissioner supervises. A communications account may also be established for each regional treatment center which operates communications systems. Each account must be used to manage shared communication costs necessary for the operations of the programs the commissioner supervises. The commissioner may distribute the costs of operating and maintaining communication systems to participants in a manner that reflects actual usage. Costs may include acquisition, licensing, insurance, maintenance, repair, staff time and other costs as determined by the commissioner. Nonprofit organizations and state, county, and local government agencies involved in the operation of programs the commissioner supervises may participate in the use of the department's communications technology and share in the cost of operation. The commissioner may accept on behalf of the state any gift, bequest, devise or personal property of any kind, or money tendered to the state for any lawful purpose pertaining to the communication activities of the department. Any money received for this purpose must be deposited in the department's communication systems accounts. Money collected by the commissioner for the use of communication systems must be deposited in the state communication systems account and is appropriated to the commissioner for purposes of this section.

(25) Receive any federal matching money that is made available through the medical assistance program for the consumer satisfaction survey. Any federal money

received for the survey is appropriated to the commissioner for this purpose. The commissioner may expend the federal money received for the consumer satisfaction survey in either year of the biennium.

(26) Incorporate cost reimbursement claims from First Call Minnesota and Greater Twin Cities United Way into the federal cost reimbursement claiming processes of the department according to federal law, rule, and regulations. Any reimbursement received is appropriated to the commissioner and shall be disbursed to First Call Minnesota and Greater Twin Cities United Way according to normal department payment schedules.

(27) Develop recommended standards for foster care homes that address the components of specialized therapeutic services to be provided by foster care homes with those services.

Sec. 11. Minnesota Statutes 2000, section 256.01, is amended by adding a subdivision to read:

Subd. 20. **RYAN WHITE COMPREHENSIVE AIDS RESOURCES EMERGENCY ACT.** The commissioner shall act as the designated state agent for carrying out responsibilities required under Title II of the federal Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. These responsibilities include:

(1) coordinating statewide HIV/AIDS needs assessment activities;

(2) developing the state's plan to meet identified health and support service needs of people living with HIV/AIDS;

(3) administering federal funds designed to provide comprehensive health and support services to persons living with HIV/AIDS;

(4) administering federal funds designated for the AIDS drug assistance program (ADAP);

(5) collecting rebates from pharmaceutical manufacturers on drugs purchased with federal ADAP funds; and

(6) utilizing ADAP rebate funds in accordance with guidelines of the federal Health Resources and Services Administration.

Rebates collected under this subdivision shall be deposited into the ADAP account in the special revenue fund and are appropriated to the commissioner for purposes of this subdivision.

Sec. 12. Minnesota Statutes 2000, section 256.9657, subdivision 1, as amended by Laws 2002, chapter 220, article 14, section 5, is amended to read:

Subdivision 1. **NURSING HOME LICENSE SURCHARGE.** (a) Effective July 1, 1993, each non-state-operated nursing home licensed under chapter 144A shall pay to the commissioner an annual surcharge according to the schedule in subdivision 4. The surcharge shall be calculated as $620 per licensed bed. If the number of licensed beds is reduced, the surcharge shall be based on the number of remaining licensed beds the second month following the receipt of timely notice by the commissioner of human

services that beds have been delicensed. The nursing home must notify the commissioner of health in writing when beds are delicensed. The commissioner of health must notify the commissioner of human services within ten working days after receiving written notification. If the notification is received by the commissioner of human services by the 15th of the month, the invoice for the second following month must be reduced to recognize the delicensing of beds. Beds on layaway status continue to be subject to the surcharge. The commissioner of human services must acknowledge a medical care surcharge appeal within 30 days of receipt of the written appeal from the provider.

(b) Effective July 1, 1994, the surcharge in paragraph (a) shall be increased to $625.

(c) Effective August 15, 2003, the surcharge under paragraph (b) shall be increased by an amount necessary to ensure a net gain to the general fund of $9,620,000 during fiscal year 2004 as a result of:

(1) the total transfers anticipated during the fiscal year ending June 30, 2004, under section 256B.19, subdivision 1d, paragraph (c);

(2) the county nursing home payment adjustments under section 256B.431, subdivision 23, paragraph (c);

(3) the surcharges under this paragraph; and

(4) the nursing facility rate increases under section 256B.431, subdivision 37.

The increase under this paragraph shall not exceed $365 per bed.

(d) Effective August 15, 2004, the surcharge under paragraph (c) shall be equal to an amount necessary to ensure a net gain to the general fund each fiscal year of $10,228,000 as a result of:

(1) the total transfers anticipated during the fiscal year under section 256B.19, subdivision 1d, paragraph (c);

(2) the county nursing home payment adjustments under section 256B.431, subdivision 23, paragraph (c);

(3) the surcharges under this paragraph; and

(4) the nursing facility rate increases under section 256B.431, subdivision 37.

The surcharge under this paragraph shall not exceed $365 per bed.

(e) Between April 1, 2002, and August 15, 2003, a facility governed by this subdivision may elect to assume full participation in the medical assistance program by agreeing to comply with all of the requirements of the medical assistance program, including the rate equalization law in section 256B.48, subdivision 1, paragraph (a), and all other requirements established in law or rule, and to begin intake of new medical assistance recipients. Rates will be determined under Minnesota Rules, parts 9549.0010 to 9549.0080. Notwithstanding section 256B.431, subdivision 27, paragraph (i), rate calculations will be subject to limits as prescribed in rule and law. Other

than the adjustments in sections 256B.431, subdivisions 30 and 32; 256B.437, subdivision 3, paragraph (b), Minnesota Rules, part 9549.0057, and any other applicable legislation enacted prior to the finalization of rates, facilities assuming full participation in medical assistance under this paragraph are not eligible for any rate adjustments until the July 1 following their settle-up period.

EFFECTIVE DATE. This section is effective April 1, 2002.

Sec. 13. Minnesota Statutes 2001 Supplement, section 256B.0625, subdivision 13, as amended by Laws 2002, chapter 220, article 15, section 13, is amended to read:

Subd. 13. **DRUGS.** (a) Medical assistance covers drugs, except for fertility drugs when specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed by a licensed pharmacist, by a physician enrolled in the medical assistance program as a dispensing physician, or by a physician or a nurse practitioner employed by or under contract with a community health board as defined in section 145A.02, subdivision 5, for the purposes of communicable disease control. The commissioner, after receiving recommendations from professional medical associations and professional pharmacist associations, shall designate a formulary committee to advise the commissioner on the names of drugs for which payment is made, recommend a system for reimbursing providers on a set fee or charge basis rather than the present system, and develop methods encouraging use of generic drugs when they are less expensive and equally effective as trademark drugs. The formulary committee shall consist of nine members, four of whom shall be physicians who are not employed by the department of human services, and a majority of whose practice is for persons paying privately or through health insurance, three of whom shall be pharmacists who are not employed by the department of human services, and a majority of whose practice is for persons paying privately or through health insurance, a consumer representative, and a nursing home representative. Committee members shall serve three-year terms and shall serve without compensation. Members may be reappointed once.

(b) The commissioner shall establish a drug formulary. Its establishment and publication shall not be subject to the requirements of the Administrative Procedure Act, but the formulary committee shall review and comment on the formulary contents.

The formulary shall not include:

(i) drugs or products for which there is no federal funding;

(ii) over-the-counter drugs, except for antacids, acetaminophen, family planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults with documented vitamin deficiencies, vitamins for children under the age of seven and pregnant or nursing women, and any other over-the-counter drug identified by the commissioner, in consultation with the drug formulary committee, as necessary, appropriate, and cost-effective for the treatment of certain specified chronic diseases, conditions or disorders, and this determination shall not be subject to the requirements of chapter 14;

(iii) anorectics, except that medically necessary anorectics shall be covered for a recipient previously diagnosed as having pickwickian syndrome and currently diag-

nosed as having diabetes and being morbidly obese;

(iv) drugs for which medical value has not been established; and

(v) drugs from manufacturers who have not signed a rebate agreement with the Department of Health and Human Services pursuant to section 1927 of title XIX of the Social Security Act.

The commissioner shall publish conditions for prohibiting payment for specific drugs after considering the formulary committee's recommendations. An honorarium of $100 per meeting and reimbursement for mileage shall be paid to each committee member in attendance.

(c) The basis for determining the amount of payment shall be the lower of the actual acquisition costs of the drugs plus a fixed dispensing fee; the maximum allowable cost set by the federal government or by the commissioner plus the fixed dispensing fee; or the usual and customary price charged to the public. The pharmacy dispensing fee shall be $3.65, except that the dispensing fee for intravenous solutions which must be compounded by the pharmacist shall be $8 per bag, $14 per bag for cancer chemotherapy products, and $30 per bag for total parenteral nutritional products dispensed in one liter quantities, or $44 per bag for total parenteral nutritional products dispensed in quantities greater than one liter. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. The actual acquisition cost of a drug shall be estimated by the commissioner, at average wholesale price minus nine percent, except that where a drug has had its wholesale price reduced as a result of the actions of the National Association of Medicaid Fraud Control Units, the estimated actual acquisition cost shall be the reduced average wholesale price, without the nine percent deduction. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to, but no higher than, the maximum amount paid by other third-party payors in this state who have maximum allowable cost programs. The commissioner shall set maximum allowable costs for multisource drugs that are not on the federal upper limit list as described in United States Code, title 42, chapter 7, section 1396r-8(e), the Social Security Act, and Code of Federal Regulations, title 42, part 447, section 447.332. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act. An additional dispensing fee of $.30 may be added to the dispensing fee paid to pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities when a unit dose blister card system, approved by the department, is used. Under this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister card must be identified on the claim to the department. The unit dose blister card containing the drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider will be required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse. Over-the-counter medications must be dispensed in the manufacturer's unopened package. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply. Whenever a generically equivalent product is available, payment shall be on the basis

of the actual acquisition cost of the generic drug, unless the prescriber specifically indicates "dispense as written - brand necessary" on the prescription as required by section 151.21, subdivision 2.

(d) For purposes of this subdivision, "multisource drugs" means covered outpatient drugs, excluding innovator multisource drugs for which there are two or more drug products, which:

(1) are related as therapeutically equivalent under the Food and Drug Administration's most recent publication of "Approved Drug Products with Therapeutic Equivalence Evaluations";

(2) are pharmaceutically equivalent and bioequivalent as determined by the Food and Drug Administration; and

(3) are sold or marketed in Minnesota.

"Innovator multisource drug" means a multisource drug that was originally marketed under an original new drug application approved by the Food and Drug Administration.

(e) The formulary committee shall review and recommend drugs which require prior authorization. The formulary committee may recommend drugs for prior authorization directly to the commissioner, as long as opportunity for public input is provided. Prior authorization may be requested by the commissioner based on medical and clinical criteria and on cost before certain drugs are eligible for payment. Before a drug may be considered for prior authorization at the request of the commissioner:

(1) the drug formulary committee must develop criteria to be used for identifying drugs; the development of these criteria is not subject to the requirements of chapter 14, but the formulary committee shall provide opportunity for public input in developing criteria;

(2) the drug formulary committee must hold a public forum and receive public comment for an additional 15 days; ~~and~~

(3) the drug formulary committee must consider data from the state Medicaid program if such data is available; and

(4) the commissioner must provide information to the formulary committee on the impact that placing the drug on prior authorization will have on the quality of patient care and on program costs, and information regarding whether the drug is subject to clinical abuse or misuse.

Prior authorization may be required by the commissioner before certain formulary drugs are eligible for payment. If prior authorization of a drug is required by the commissioner, the commissioner must provide a 30-day notice period before implementing the prior authorization. If a prior authorization request is denied by the department, the recipient may appeal the denial in accordance with section 256.045. If an appeal is filed, the drug must be provided without prior authorization until a decision is made on the appeal.

(f) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider; the average wholesale price minus five percent; or the maximum allowable cost set by the federal government under United States Code, title 42, chapter 7, section 1396r-8(e), and Code of Federal Regulations, title 42, section 447.332, or by the commissioner under paragraph (c).

(g) Prior authorization shall not be required or utilized for any antipsychotic drug prescribed for the treatment of mental illness where there is no generically equivalent drug available unless the commissioner determines that prior authorization is necessary for patient safety. This paragraph applies to any supplemental drug rebate program established or administered by the commissioner.

(h) Prior authorization shall not be required or utilized for any antihemophilic factor drug prescribed for the treatment of hemophilia and blood disorders where there is no generically equivalent drug available unless the commissioner determines that prior authorization is necessary for patient safety. This paragraph applies to any supplemental drug rebate program established or administered by the commissioner. This paragraph expires July 1, 2003.

Sec. 14. Minnesota Statutes 2000, section 256B.0625, subdivision 26, as amended by Laws 2002, chapter 294, section 6, is amended to read:

Subd. 26. **SPECIAL EDUCATION SERVICES.** (a) Medical assistance covers medical services identified in a recipient's individualized education plan and covered under the medical assistance state plan. Covered services include occupational therapy, physical therapy, speech-language therapy, clinical psychological services, nursing services, school psychological services, school social work services, personal care assistants serving as management aides, assistive technology devices, transportation services, health assessments, and other services covered under the medical assistance state plan. Mental health services eligible for medical assistance reimbursement must be provided or coordinated through a children's mental health collaborative where a collaborative exists if the child is included in the collaborative operational target population. The provision or coordination of services does not require that the individual education plan be developed by the collaborative.

The services may be provided by a Minnesota school district that is enrolled as a medical assistance provider or its subcontractor, and only if the services meet all the requirements otherwise applicable if the service had been provided by a provider other than a school district, in the following areas: medical necessity, physician's orders, documentation, personnel qualifications, and prior authorization requirements. The nonfederal share of costs for services provided under this subdivision is the responsibility of the local school district as provided in section 125A.74. Services listed in a child's individual education plan are eligible for medical assistance reimbursement only if those services meet criteria for federal financial participation under the Medicaid program.

(b) Approval of health-related services for inclusion in the individual education plan does not require prior authorization for purposes of reimbursement under this

chapter. The commissioner may require physician review and approval of the plan not more than once annually or upon any modification of the individual education plan that reflects a change in health-related services.

(c) Services of a speech-language pathologist provided under this section are covered notwithstanding Minnesota Rules, part 9505.0390, subpart 1, item L, if the person:

(1) holds a masters degree in speech-language pathology;

(2) is licensed by the Minnesota board of teaching as an educational speech-language pathologist; and

(3) either has a certificate of clinical competence from the American Speech and Hearing Association, has completed the equivalent educational requirements and work experience necessary for the certificate or has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(d) Medical assistance coverage for medically necessary services provided under other subdivisions in this section may not be denied solely on the basis that the same or similar services are covered under this subdivision.

(e) The commissioner shall develop and implement package rates, bundled rates, or per diem rates for special education services under which separately covered services are grouped together and billed as a unit in order to reduce administrative complexity.

(f) The commissioner shall develop a cost-based payment structure for payment of these services.

(g) Effective July 1, 2000, medical assistance services provided under an individual education plan or an individual family service plan by local school districts shall not count against medical assistance authorization thresholds for that child.

(h) Nursing services as defined in section 148.171, subdivision 15, and provided as an individual education plan health-related service, are eligible for medical assistance payment if they are otherwise a covered service ~~in~~ under the medical ~~assistant~~ assistance program. Medical assistance covers the administration of prescription medications by a licensed nurse who is employed by or under contract with a school district when the administration of medications is identified in the child's individualized education plan. The simple administration of medications alone is not covered under medical assistance when administered by a provider other than a school district or when it is not identified in the child's individualized education plan.

EFFECTIVE DATE. This section is effective for services provided on or after April 1, 2002, upon federal approval, if federal approval is required.

Sec. 15. Minnesota Statutes 2000, section 256B.0625, subdivision 35, is amended to read:

Subd. 35. **FAMILY COMMUNITY SUPPORT SERVICES.** (a) Medical assistance covers family community support services as defined in section 245.4871,

subdivision 17. In addition to the provisions of section 245.4871, and to the extent authorized by rules promulgated by the state agency, medical assistance covers the following services as family community support services:

(1) services identified in an individual treatment plan when provided by a trained mental health behavioral aide under the direction of a mental health practitioner or mental health professional;

(2) mental health crisis intervention and crisis stabilization services provided outside of hospital inpatient settings; and

(3) the therapeutic components of preschool and therapeutic camp programs.

(b) Notwithstanding the provisions of Minnesota Rules, parts 9505.0324, subpart 2, 9505.0326, subpart 2, and 9505.0327, subpart 2, a provider of family community support services, home-based mental health services, or therapeutic support of foster care services under contract with a county may continue to provide existing services, and may provide new services, to a child if that child is placed in foster care, or the child and family relocate, outside the original county of residence.

Sec. 16. Minnesota Statutes 2000, section 256B.0625, is amended by adding a subdivision to read:

Subd. 44. **TARGETED CASE MANAGEMENT SERVICES.** Medical assistance covers case management services for vulnerable adults and adults with developmental disabilities, as provided under section 256B.0924.

Sec. 17. Minnesota Statutes 2001 Supplement, section 256B.0627, subdivision 10, is amended to read:

Subd. 10. **FISCAL INTERMEDIARY OPTION AVAILABLE FOR PERSONAL CARE ASSISTANT SERVICES.** (a) The commissioner may allow a recipient of personal care assistant services to use a fiscal intermediary to assist the recipient in paying and accounting for medically necessary covered personal care assistant services authorized in subdivision 4 and within the payment parameters of subdivision 5. Unless otherwise provided in this subdivision, all other statutory and regulatory provisions relating to personal care assistant services apply to a recipient using the fiscal intermediary option.

(b) The recipient or responsible party shall:

(1) recruit, hire, and terminate a qualified professional, if a qualified professional is requested by the recipient or responsible party;

(2) verify and document the credentials of the qualified professional, if a qualified professional is requested by the recipient or responsible party;

(3) develop a service plan based on physician orders and public health nurse assessment with the assistance of a qualified professional, if a qualified professional is requested by the recipient or responsible party, that addresses the health and safety of the recipient;

(4) recruit, hire, and terminate the personal care assistant;

(5) orient and train the personal care assistant with assistance as needed from the qualified professional;

(6) supervise and evaluate the personal care assistant with assistance as needed from the recipient's physician or the qualified professional;

(7) monitor and verify in writing and report to the fiscal intermediary the number of hours worked by the personal care assistant and the qualified professional; and

(8) enter into a written agreement, as specified in paragraph (f).

(c) The duties of the fiscal intermediary shall be to:

(1) bill the medical assistance program for personal care assistant and qualified professional services;

(2) request and secure background checks on personal care assistants and qualified professionals according to section 245A.04;

(3) pay the personal care assistant and qualified professional based on actual hours of services provided;

(4) withhold and pay all applicable federal and state taxes;

(5) verify and keep records of hours worked by the personal care assistant and qualified professional;

(6) make the arrangements and pay unemployment insurance, taxes, workers' compensation, liability insurance, and other benefits, if any;

(7) enroll in the medical assistance program as a fiscal intermediary; and

(8) enter into a written agreement as specified in paragraph (f) before services are provided.

(d) The fiscal intermediary:

(1) may not be related to the recipient, qualified professional, or the personal care assistant;

(2) must ensure arm's length transactions with the recipient and personal care assistant; and

(3) shall be considered a joint employer of the personal care assistant and qualified professional to the extent specified in this section.

The fiscal intermediary or owners of the entity that provides fiscal intermediary services under this subdivision must pass a criminal background check as required in section 256B.0627, subdivision 1, paragraph (e).

(e) If the recipient or responsible party requests a qualified professional, the qualified professional providing assistance to the recipient shall meet the qualifications specified in section 256B.0625, subdivision 19c. The qualified professional shall assist the recipient in developing and revising a plan to meet the recipient's needs, as

assessed by the public health nurse. In performing this function, the qualified professional must visit the recipient in the recipient's home at least once annually. The qualified professional must report any suspected abuse, neglect, or financial exploitation of the recipient to the appropriate authorities.

(f) The fiscal intermediary, recipient or responsible party, personal care assistant, and qualified professional shall enter into a written agreement before services are started. The agreement shall include:

(1) the duties of the recipient, qualified professional, personal care assistant, and fiscal agent based on paragraphs (a) to (e);

(2) the salary and benefits for the personal care assistant and the qualified professional;

(3) the administrative fee of the fiscal intermediary and services paid for with that fee, including background check fees;

(4) procedures to respond to billing or payment complaints; and

(5) procedures for hiring and terminating the personal care assistant and the qualified professional.

(g) The rates paid for personal care assistant services, shared care services, qualified professional services, and fiscal intermediary services under this subdivision shall be the same rates paid for personal care assistant services and qualified professional services under subdivision 2 respectively. Except for the administrative fee of the fiscal intermediary specified in paragraph (f), the remainder of the rates paid to the fiscal intermediary must be used to pay for the salary and benefits for the personal care assistant or the qualified professional.

(h) As part of the assessment defined in subdivision 1, the following conditions must be met to use or continue use of a fiscal intermediary:

(1) the recipient must be able to direct the recipient's own care, or the responsible party for the recipient must be readily available to direct the care of the personal care assistant;

(2) the recipient or responsible party must be knowledgeable of the health care needs of the recipient and be able to effectively communicate those needs;

(3) a face-to-face assessment must be conducted by the local county public health nurse at least annually, or when there is a significant change in the recipient's condition or change in the need for personal care assistant services;

(4) ~~the recipient cannot select the shared services option as specified in subdivision 8~~ recipients who choose to use the shared care option as specified in subdivision 8 must utilize the same fiscal intermediary; and

(5) parties must be in compliance with the written agreement specified in paragraph (f).

(i) The commissioner shall deny, revoke, or suspend the authorization to use the fiscal intermediary option if:

(1) it has been determined by the qualified professional or local county public health nurse that the use of this option jeopardizes the recipient's health and safety;

(2) the parties have failed to comply with the written agreement specified in paragraph (f); or

(3) the use of the option has led to abusive or fraudulent billing for personal care assistant services.

The recipient or responsible party may appeal the commissioner's action according to section 256.045. The denial, revocation, or suspension to use the fiscal intermediary option shall not affect the recipient's authorized level of personal care assistant services as determined in subdivision 5.

Sec. 18. Minnesota Statutes 2001 Supplement, section 256B.0911, subdivision 4b, is amended to read:

Subd. 4b. **EXEMPTIONS AND EMERGENCY ADMISSIONS.** (a) Exemptions from the federal screening requirements outlined in subdivision 4a, paragraphs (b) and (c), are limited to:

(1) a person who, having entered an acute care facility from a certified nursing facility, is returning to a certified nursing facility; ~~and~~

(2) a person transferring from one certified nursing facility in Minnesota to another certified nursing facility in Minnesota; and

(3) a person, 21 years of age or older, who satisfies the following criteria, as specified in Code of Federal Regulations, title 42, section 483.106(b)(2):

(i) the person is admitted to a nursing facility directly from a hospital after receiving acute inpatient care at the hospital;

(ii) the person requires nursing facility services for the same condition for which care was provided in the hospital; and

(iii) the attending physician has certified before the nursing facility admission that the person is likely to receive less than 30 days of nursing facility services.

(b) Persons who are exempt from preadmission screening for purposes of level of care determination include:

(1) persons described in paragraph (a);

(2) an individual who has a contractual right to have nursing facility care paid for indefinitely by the veterans' administration;

(3) an individual enrolled in a demonstration project under section 256B.69, subdivision 8, at the time of application to a nursing facility;

(4) an individual currently being served under the alternative care program or under a home and community-based services waiver authorized under section 1915(c) of the federal Social Security Act; and

(5) individuals admitted to a certified nursing facility for a short-term stay, which is expected to be 14 days or less in duration based upon a physician's certification, and who have been assessed and approved for nursing facility admission within the previous six months. This exemption applies only if the consultation team member determines at the time of the initial assessment of the six-month period that it is appropriate to use the nursing facility for short-term stays and that there is an adequate plan of care for return to the home or community-based setting. If a stay exceeds 14 days, the individual must be referred no later than the first county working day following the 14th resident day for a screening, which must be completed within five working days of the referral. The payment limitations in subdivision 7 apply to an individual found at screening to not meet the level of care criteria for admission to a certified nursing facility.

(c) Persons admitted to a Medicaid-certified nursing facility from the community on an emergency basis as described in paragraph (d) or from an acute care facility on a nonworking day must be screened the first working day after admission.

(d) Emergency admission to a nursing facility prior to screening is permitted when all of the following conditions are met:

(1) a person is admitted from the community to a certified nursing or certified boarding care facility during county nonworking hours;

(2) a physician has determined that delaying admission until preadmission screening is completed would adversely affect the person's health and safety;

(3) there is a recent precipitating event that precludes the client from living safely in the community, such as sustaining an injury, sudden onset of acute illness, or a caregiver's inability to continue to provide care;

(4) the attending physician has authorized the emergency placement and has documented the reason that the emergency placement is recommended; and

(5) the county is contacted on the first working day following the emergency admission.

Transfer of a patient from an acute care hospital to a nursing facility is not considered an emergency except for a person who has received hospital services in the following situations: hospital admission for observation, care in an emergency room without hospital admission, or following hospital 24-hour bed care.

(e) A nursing facility must provide a written notice to persons who satisfy the criteria in paragraph (a), clause (3), regarding the person's right to request and receive long-term care consultation services as defined in subdivision 1a. The notice must be provided prior to the person's discharge from the facility and in a format specified by the commissioner.

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

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

Sec. 19. Minnesota Statutes 2001 Supplement, section 256B.0911, subdivision 4d, is amended to read:

Subd. 4d. **PREADMISSION SCREENING OF INDIVIDUALS UNDER 65 YEARS OF AGE.** (a) It is the policy of the state of Minnesota to ensure that individuals with disabilities or chronic illness are served in the most integrated setting appropriate to their needs and have the necessary information to make informed choices about home and community-based service options.

(b) Individuals under 65 years of age who are admitted to a nursing facility from a hospital must be screened prior to admission as outlined in subdivisions 4a through 4c.

(c) Individuals under 65 years of age who are admitted to nursing facilities with only a telephone screening must receive a face-to-face assessment from the long-term care consultation team member of the county in which the facility is located or from the recipient's county case manager within 20 working days of admission.

(d) Individuals under 65 years of age who are admitted to a nursing facility without preadmission screening according to the exemption described in subdivision 4b, paragraph (a), clause (3), and who remain in the facility longer than 30 days must receive a face-to-face assessment within 40 days of admission.

(e) At the face-to-face assessment, the long-term care consultation team member or county case manager must perform the activities required under subdivision 3b.

~~(e)~~ (f) For individuals under 21 years of age, a screening interview which recommends nursing facility admission must be face-to-face and approved by the commissioner before the individual is admitted to the nursing facility.

~~(f)~~ (g) In the event that an individual under 65 years of age is admitted to a nursing facility on an emergency basis, the county must be notified of the admission on the next working day, and a face-to-face assessment as described in paragraph (c) must be conducted within 20 working days of admission.

~~(g)~~ (h) At the face-to-face assessment, the long-term care consultation team member or the case manager must present information about home and community-based options so the individual can make informed choices. If the individual chooses home and community-based services, the long-term care consultation team member or case manager must complete a written relocation plan within 20 working days of the visit. The plan shall describe the services needed to move out of the facility and a time line for the move which is designed to ensure a smooth transition to the individual's home and community.

~~(h)~~ (i) An individual under 65 years of age residing in a nursing facility shall receive a face-to-face assessment at least every 12 months to review the person's service choices and available alternatives unless the individual indicates, in writing, that annual visits are not desired. In this case, the individual must receive a face-to-face assessment at least once every 36 months for the same purposes.

~~(i)~~ (j) Notwithstanding the provisions of subdivision 6, the commissioner may pay county agencies directly for face-to-face assessments for individuals under 65 years of age who are being considered for placement or residing in a nursing facility.

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

Sec. 20. Minnesota Statutes 2001 Supplement, section 256B.0913, subdivision 4, is amended to read:

Subd. 4. **ELIGIBILITY FOR FUNDING FOR SERVICES FOR NONMEDICAL ASSISTANCE RECIPIENTS.** (a) Funding for services under the alternative care program is available to persons who meet the following criteria:

(1) the person has been determined by a community assessment under section 256B.0911 to be a person who would require the level of care provided in a nursing facility, but for the provision of services under the alternative care program;

(2) the person is age 65 or older;

(3) the person would be eligible for medical assistance within 180 days of admission to a nursing facility;

(4) the person is not ineligible for the medical assistance program due to an asset transfer penalty;

(5) the person needs services that are not funded through other state or federal funding; and

(6) the monthly cost of the alternative care services funded by the program for this person does not exceed 75 percent of the statewide weighted average monthly nursing facility rate of the case mix resident class to which the individual alternative care client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, less the recipient's maintenance needs allowance as described in section 256B.0915, subdivision 1d, paragraph (a), until the first day of the state fiscal year in which the resident assessment system, under section 256B.437, for nursing home rate determination is implemented. Effective on the first day of the state fiscal year in which a resident assessment system, under section 256B.437, for nursing home rate determination is implemented and the first day of each subsequent state fiscal year, the monthly cost of alternative care services for this person shall not exceed the alternative care monthly cap for the case mix resident class to which the alternative care client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, which was in effect on the last day of the previous state fiscal year, and adjusted by the greater of any legislatively adopted home and community-based services cost-of-living percentage increase or any legislatively adopted statewide percent rate increase for nursing facilities. This monthly limit does not prohibit the alternative care client from payment for additional services, but in no case may the cost of additional services purchased under this section exceed the difference between the client's monthly service limit defined under section 256B.0915, subdivision 3, and the alternative care program monthly service limit defined in this paragraph. If medical supplies and equipment or environmental modifications are or will be purchased for an alternative care services

recipient, the costs may be prorated on a monthly basis for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's other alternative care services exceeds the monthly limit established in this paragraph, the annual cost of the alternative care services shall be determined. In this event, the annual cost of alternative care services shall not exceed 12 times the monthly limit described in this paragraph.

(b) Alternative care funding under this subdivision is not available for a person who is a medical assistance recipient or who would be eligible for medical assistance without a spenddown or waiver obligation. A person whose initial application for medical assistance is being processed may be served under the alternative care program for a period up to 60 days. If the individual is found to be eligible for medical assistance, medical assistance must be billed for services payable under the federally approved elderly waiver plan and delivered from the date the individual was found eligible for the federally approved elderly waiver plan. Notwithstanding this provision, upon federal approval, alternative care funds may not be used to pay for any service the cost of which is payable by medical assistance or which is used by a recipient to meet a medical assistance income spenddown or waiver obligation.

(c) Alternative care funding is not available for a person who resides in a licensed nursing home, certified boarding care home, hospital, or intermediate care facility, except for case management services which are provided in support of the discharge planning process to a nursing home resident or certified boarding care home resident ~~who is ineligible for case management funded by medical assistance~~.

Sec. 21. Minnesota Statutes 2001 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 services;

(14) chore services;

(15) companion services;

(16) nutrition services;

(17) training for direct informal caregivers;

(18) ~~telemedicine~~ telehome care devices to monitor recipients in their own homes as an alternative to hospital care, nursing home care, or home visits;

(19) other services which includes discretionary funds and direct cash payments to clients, following approval by the commissioner, subject to the provisions of paragraph (j). Total annual payments for "other services" for all clients within a county may not exceed ~~either ten~~ 25 percent of that county's annual alternative care program base allocation ~~or $5,000, whichever is greater. In no case shall this amount exceed the county's total annual alternative care program base allocation~~; and

(20) environmental modifications.

(b) The county agency must ensure that the funds are not used to supplant services available through other public assistance or services programs.

(c) Unless specified in statute, the services, service definitions, and standards for alternative care services shall be the same as the services, service definitions, and standards specified in the federally approved elderly waiver plan. Except for the county agencies' approval of direct cash payments to clients as described in paragraph (j) or for a provider of supplies and equipment when the monthly cost of the supplies and equipment is less than $250, persons or agencies must be employed by or under a contract with the county agency or the public health nursing agency of the local board of health in order to receive funding under the alternative care program. Supplies and equipment may be purchased from a vendor not certified to participate in the Medicaid program if the cost for the item is less than that of a Medicaid vendor.

(d) The adult foster care rate shall be considered a difficulty of care payment and shall not include room and board. The adult foster care rate shall be negotiated between the county agency and the foster care provider. The alternative care payment for the foster care service in combination with the payment for other alternative care services, including case management, must not exceed the limit specified in subdivision 4, paragraph (a), clause (6).

(e) Personal care services must meet the service standards defined in the federally approved elderly waiver plan, except that a county agency may contract with a client's relative who meets the relative hardship waiver requirement as defined in section 256B.0627, subdivision 4, paragraph (b), clause (10), to provide personal care services if the county agency ensures supervision of this service by a ~~registered nurse or mental health practitioner~~ qualified professional as defined in section 256B.0625, subdivision 19c.

(f) For purposes of this section, residential care services are services which are provided to individuals living in residential care homes. Residential care homes are currently licensed as board and lodging establishments and are registered with the department of health as providing special services under section 157.17 and are not subject to registration under chapter 144D. Residential care services are defined as "supportive services" and "health-related services." "Supportive services" means the provision of up to 24-hour supervision and oversight. Supportive services includes: (1) transportation, when provided by the residential care home only; (2) socialization, when socialization is part of the plan of care, has specific goals and outcomes established, and is not diversional or recreational in nature; (3) assisting clients in setting up meetings and appointments; (4) assisting clients in setting up medical and social services; (5) providing assistance with personal laundry, such as carrying the client's laundry to the laundry room. Assistance with personal laundry does not include any laundry, such as bed linen, that is included in the room and board rate. "Health-related services" are limited to minimal assistance with dressing, grooming, and bathing and providing reminders to residents to take medications that are self-administered or providing storage for medications, if requested. Individuals receiving residential care services cannot receive homemaking services funded under this section.

(g) For the purposes of this section, "assisted living" refers to supportive services provided by a single vendor to clients who reside in the same apartment building of three or more units which are not subject to registration under chapter 144D and are licensed by the department of health as a class A home care provider or a class E home care provider. Assisted living services are defined as up to 24-hour supervision, and oversight, supportive services as defined in clause (1), individualized home care aide tasks as defined in clause (2), and individualized home management tasks as defined in clause (3) provided to residents of a residential center living in their units or apartments with a full kitchen and bathroom. A full kitchen includes a stove, oven, refrigerator, food preparation counter space, and a kitchen utensil storage compartment. Assisted living services must be provided by the management of the residential center or by providers under contract with the management or with the county.

(1) Supportive services include:

(i) socialization, when socialization is part of the plan of care, has specific goals and outcomes established, and is not diversional or recreational in nature;

(ii) assisting clients in setting up meetings and appointments; and

(iii) providing transportation, when provided by the residential center only.

(2) Home care aide tasks means:

(i) preparing modified diets, such as diabetic or low sodium diets;

(ii) reminding residents to take regularly scheduled medications or to perform exercises;

(iii) household chores in the presence of technically sophisticated medical equipment or episodes of acute illness or infectious disease;

(iv) household chores when the resident's care requires the prevention of exposure to infectious disease or containment of infectious disease; and

(v) assisting with dressing, oral hygiene, hair care, grooming, and bathing, if the resident is ambulatory, and if the resident has no serious acute illness or infectious disease. Oral hygiene means care of teeth, gums, and oral prosthetic devices.

(3) Home management tasks means:

(i) housekeeping;

(ii) laundry;

(iii) preparation of regular snacks and meals; and

(iv) shopping.

Individuals receiving assisted living services shall not receive both assisted living services and homemaking services. Individualized means services are chosen and designed specifically for each resident's needs, rather than provided or offered to all residents regardless of their illnesses, disabilities, or physical conditions. Assisted living services as defined in this section shall not be authorized in boarding and lodging establishments licensed according to sections 157.011 and 157.15 to 157.22.

(h) For establishments registered under chapter 144D, assisted living services under this section means either the services described in paragraph (g) and delivered by a class E home care provider licensed by the department of health or the services described under section 144A.4605 and delivered by an assisted living home care provider or a class A home care provider licensed by the commissioner of health.

(i) Payment for assisted living services and residential care services shall be a monthly rate negotiated and authorized by the county agency based on an individualized service plan for each resident and may not cover direct rent or food costs.

(1) The individualized monthly negotiated payment for assisted living services as described in paragraph (g) or (h), and residential care services as described in paragraph (f), shall not exceed the nonfederal share in effect on July 1 of the state fiscal year for which the rate limit is being calculated of the greater of either the statewide or any of the geographic groups' weighted average monthly nursing facility payment rate of the case mix resident class to which the alternative care eligible client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, less the maintenance needs allowance as described in section 256B.0915, subdivision 1d, paragraph (a), until the first day of the state fiscal year in which a resident assessment system, under section 256B.437, of nursing home rate determination is implemented. Effective on the first day of the state fiscal year in which a resident assessment system, under section 256B.437, of nursing home rate determination is implemented and the first day of each subsequent state fiscal year, the individualized monthly negotiated payment for the services described in this clause shall not exceed the limit described in this clause which was in effect on the last day of the previous state fiscal year and which has been adjusted by the greater of any legislatively adopted home and community-based

services cost-of-living percentage increase or any legislatively adopted statewide percent rate increase for nursing facilities.

(2) The individualized monthly negotiated payment for assisted living services described under section 144A.4605 and delivered by a provider licensed by the department of health as a class A home care provider or an assisted living home care provider and provided in a building that is registered as a housing with services establishment under chapter 144D and that provides 24-hour supervision in combination with the payment for other alternative care services, including case management, must not exceed the limit specified in subdivision 4, paragraph (a), clause (6).

(j) A county agency may make payment from their alternative care program allocation for "other services" which include use of "discretionary funds" for services that are not otherwise defined in this section and direct cash payments to the client for the purpose of purchasing the services. The following provisions apply to payments under this paragraph:

(1) a cash payment to a client under this provision cannot exceed ~~80 percent of~~ the monthly payment limit for that client as specified in subdivision 4, paragraph (a), clause (6);

(2) a county may not approve any cash payment for a client who meets either of the following:

(i) has been assessed as having a dependency in orientation, unless the client has an authorized representative. An "authorized representative" means an individual who is at least 18 years of age and is designated by the person or the person's legal representative to act on the person's behalf. This individual may be a family member, guardian, representative payee, or other individual designated by the person or the person's legal representative, if any, to assist in purchasing and arranging for supports; or

(ii) is concurrently receiving adult foster care, residential care, or assisted living services;

(3) cash payments to a person or a person's family will be provided through a monthly payment and be in the form of cash, voucher, or direct county payment to a vendor. Fees or premiums assessed to the person for eligibility for health and human services are not reimbursable through this service option. Services and goods purchased through cash payments must be identified in the person's individualized care plan and must meet all of the following criteria:

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

(ii) they must be directly attributable to the person's functional limitations;

(iii) they must have the potential to be effective at meeting the goals of the program;

(iv) they must be consistent with the needs identified in the individualized service plan. The service plan shall specify the needs of the person and family, the form and

amount of payment, the items and services to be reimbursed, and the arrangements for management of the individual grant; and

(v) the person, the person's family, or the legal representative shall be provided sufficient information to ensure an informed choice of alternatives. The local agency shall document this information in the person's care plan, including the type and level of expenditures to be reimbursed;

(4) the state of Minnesota, county, lead agency under contract, or tribal government under contract to administer the alternative care program shall not be liable for damages, injuries, or liabilities sustained through the purchase of direct supports or goods by the person, the person's family, or the authorized representative with funds received through the cash payments under this section. Liabilities include, but are not limited to, workers' compensation, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA);

(5) persons receiving grants under this section shall have the following responsibilities:

(i) spend the grant money in a manner consistent with their individualized service plan with the local agency;

(ii) notify the local agency of any necessary changes in the grant expenditures;

(iii) arrange and pay for supports; and

(iv) inform the local agency of areas where they have experienced difficulty securing or maintaining supports; and

(6) the county shall report client outcomes, services, and costs under this paragraph in a manner prescribed by the commissioner.

~~(k) Upon implementation of direct cash payments to clients under this section, any person determined eligible for the alternative care program who chooses a cash payment approved by the county agency shall receive the cash payment under this section and not under section 256.476 unless the person was receiving a consumer support grant under section 256.476 before implementation of direct cash payments under this section.~~

Sec. 22. Minnesota Statutes 2001 Supplement, section 256B.0913, subdivision 8, is amended to read:

Subd. 8. **REQUIREMENTS FOR INDIVIDUAL CARE PLAN.** (a) The case manager shall implement the plan of care for each alternative care client and ensure that a client's service needs and eligibility are reassessed at least every 12 months. The plan shall include any services prescribed by the individual's attending physician as necessary to allow the individual to remain in a community setting. In developing the individual's care plan, the case manager should include the use of volunteers from families and neighbors, religious organizations, social clubs, and civic and service organizations to support the formal home care services. The county shall be held harmless for damages or injuries sustained through the use of volunteers under this

subdivision including workers' compensation liability. The lead agency shall provide documentation in each individual's plan of care and, if requested, to the commissioner that the most cost-effective alternatives available have been offered to the individual and that the individual was free to choose among available qualified providers, both public and private. The case manager must give the individual a ten-day written notice of any ~~decrease in or~~ denial, termination, or reduction of alternative care services.

(b) If the county administering alternative care services is different than the county of financial responsibility, the care plan may be implemented without the approval of the county of financial responsibility.

Sec. 23. Minnesota Statutes 2001 Supplement, section 256B.0913, subdivision 10, is amended to read:

Subd. 10. **ALLOCATION FORMULA.** (a) The alternative care appropriation for fiscal years 1992 and beyond shall cover only alternative care eligible clients. ~~Prior to~~ By July 1 of each year, the commissioner shall allocate to county agencies the state funds available for alternative care for persons eligible under subdivision 2.

(b) The adjusted base for each county is the county's current fiscal year base allocation plus any targeted funds approved during the current fiscal year. Calculations for paragraphs (c) and (d) are to be made as follows: for each county, the determination of alternative care program expenditures shall be based on payments for services rendered from April 1 through March 31 in the base year, to the extent that claims have been submitted and paid by June 1 of that year.

(c) If the alternative care program expenditures as defined in paragraph (b) are 95 percent or more of the county's adjusted base allocation, the allocation for the next fiscal year is 100 percent of the adjusted base, plus inflation to the extent that inflation is included in the state budget.

(d) If the alternative care program expenditures as defined in paragraph (b) are less than 95 percent of the county's adjusted base allocation, the allocation for the next fiscal year is the adjusted base allocation less the amount of unspent funds below the 95 percent level.

(e) If the annual legislative appropriation for the alternative care program is inadequate to fund the combined county allocations for a biennium, the commissioner shall distribute to each county the entire annual appropriation as that county's percentage of the computed base as calculated in paragraphs (c) and (d).

Sec. 24. Minnesota Statutes 2001 Supplement, section 256B.0913, subdivision 12, is amended to read:

Subd. 12. **CLIENT PREMIUMS.** (a) A premium is required for all alternative care eligible clients to help pay for the cost of participating in the program. The amount of the premium for the alternative care client shall be determined as follows:

(1) when the alternative care client's income less recurring and predictable medical expenses is greater than the recipient's maintenance needs allowance as defined in section 256B.0915, subdivision 1d, paragraph (a), but less than 150 percent

of the federal poverty guideline effective on July 1 of the state fiscal year in which the premium is being computed, and total assets are less than $10,000, the fee is zero;

(2) when the alternative care client's income less recurring and predictable medical expenses is greater than 150 percent of the federal poverty guideline effective on July 1 of the state fiscal year in which the premium is being computed, and total assets are less than $10,000, the fee is 25 percent of the cost of alternative care services or the difference between 150 percent of the federal poverty guideline effective on July 1 of the state fiscal year in which the premium is being computed and the client's income less recurring and predictable medical expenses, whichever is less; and

(3) when the alternative care client's total assets are greater than $10,000, the fee is 25 percent of the cost of alternative care services.

For married persons, total assets are defined as the total marital assets less the estimated community spouse asset allowance, under section 256B.059, if applicable. For married persons, total income is defined as the client's income less the monthly spousal allotment, under section 256B.058.

All alternative care services except case management shall be included in the estimated costs for the purpose of determining 25 percent of the costs.

~~The monthly premium shall be calculated based on the cost of the first full month of alternative care services and shall continue unaltered until the next reassessment is completed or at the end of 12 months, whichever comes first.~~ Premiums are due and payable each month alternative care services are received unless the actual cost of the services is less than the premium.

(b) The fee shall be waived by the commissioner when:

(1) a person who is residing in a nursing facility is receiving case management only;

(2) a person is applying for medical assistance;

(3) a married couple is requesting an asset assessment under the spousal impoverishment provisions;

(4) a person is found eligible for alternative care, but is not yet receiving alternative care services; or

(5) a person's fee under paragraph (a) is less than $25.

(c) The county agency must record in the state's receivable system the client's assessed premium amount or the reason the premium has been waived. The commissioner will bill and collect the premium from the client. Money collected must be deposited in the general fund and is appropriated to the commissioner for the alternative care program. The client must supply the county with the client's social security number at the time of application. The county shall supply the commissioner with the client's social security number and other information the commissioner requires to collect the premium from the client. The commissioner shall collect unpaid premiums using the Revenue Recapture Act in chapter 270A and other methods

available to the commissioner. The commissioner may require counties to inform clients of the collection procedures that may be used by the state if a premium is not paid. This paragraph does not apply to alternative care pilot projects authorized in Laws 1993, First Special Session chapter 1, article 5, section 133, if a county operating under the pilot project reports the following dollar amounts to the commissioner quarterly:

(1) total premiums billed to clients;

(2) total collections of premiums billed; and

(3) balance of premiums owed by clients.

If a county does not adhere to these reporting requirements, the commissioner may terminate the billing, collecting, and remitting portions of the pilot project and require the county involved to operate under the procedures set forth in this paragraph.

~~(d) The commissioner shall begin to adopt emergency or permanent rules governing client premiums within 30 days after July 1, 1991, including criteria for determining when services to a client must be terminated due to failure to pay a premium.~~

Sec. 25. Minnesota Statutes 2001 Supplement, section 256B.0913, subdivision 14, is amended to read:

Subd. 14. **PROVIDER REQUIREMENTS, PAYMENT, AND RATE ADJUSTMENTS.** (a) Unless otherwise specified in statute, providers must be enrolled as Minnesota health care program providers and abide by the requirements for provider participation according to Minnesota Rules, part 9505.0195.

(b) Payment for provided alternative care services as approved by the client's case manager shall ~~be~~ occur through the invoice processing procedures of the department's Medicaid Management Information System (MMIS). To receive payment, the county or vendor must submit invoices within 12 months following the date of service. The county agency and its vendors under contract shall not be reimbursed for services which exceed the county allocation.

~~(b)~~ (c) The county shall negotiate individual rates with vendors and may authorize service payment for actual costs up to the county's current approved rate. Notwithstanding any other rule or statutory provision to the contrary, the commissioner shall not be authorized to increase rates by an annual inflation factor, unless so authorized by the legislature. To improve access to community services and eliminate payment disparities between the alternative care program and the elderly waiver program, the commissioner shall establish statewide maximum service rate limits and eliminate county-specific service rate limits.

(1) Effective July 1, 2001, for service rate limits, except those in subdivision 5, paragraphs (d) and (i), the rate limit for each service shall be the greater of the alternative care statewide maximum rate or the elderly waiver statewide maximum rate.

(2) Counties may negotiate individual service rates with vendors for actual costs up to the statewide maximum service rate limit.

Sec. 26. Minnesota Statutes 2001 Supplement, section 256B.0915, subdivision 3, is amended to read:

Subd. 3. **LIMITS OF CASES, RATES, PAYMENTS, AND FORECASTING.** (a) The number of medical assistance waiver recipients that a county may serve must be allocated according to the number of medical assistance waiver cases open on July 1 of each fiscal year. Additional recipients may be served with the approval of the commissioner.

(b) The monthly limit for the cost of waivered services to an individual elderly waiver client shall be the weighted average monthly nursing facility rate of the case mix resident class to which the elderly waiver client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, less the recipient's maintenance needs allowance as described in subdivision 1d, paragraph (a), until the first day of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented. Effective on the first day of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented and the first day of each subsequent state fiscal year, the monthly limit for the cost of waivered services to an individual elderly waiver client shall be the rate of the case mix resident class to which the waiver client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, in effect on the last day of the previous state fiscal year, adjusted by the greater of any legislatively adopted home and community-based services cost-of-living percentage increase or any legislatively adopted statewide percent rate increase for nursing facilities.

(c) If extended medical supplies and equipment or environmental modifications are or will be purchased for an elderly waiver client, the costs may be prorated for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's waivered services exceeds the monthly limit established in paragraph (b), the annual cost of all waivered services shall be determined. In this event, the annual cost of all waivered services shall not exceed 12 times the monthly limit of waivered services as described in paragraph (b).

(d) For a person who is a nursing facility resident at the time of requesting a determination of eligibility for elderly waivered services, a monthly conversion limit for the cost of elderly waivered services may be requested. The monthly conversion limit for the cost of elderly waiver services shall be the resident class assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, for that resident in the nursing facility where the resident currently resides until July 1 of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented. Effective on July 1 of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented, the monthly conversion limit for the cost of elderly waiver services shall be the per diem nursing facility rate as determined by the resident

assessment system as described in section 256B.437 for that resident in the nursing facility where the resident currently resides multiplied by 365 and divided by 12, less the recipient's maintenance needs allowance as described in subdivision 1d. The initially approved conversion rate may be adjusted by the greater of any subsequent legislatively adopted home and community-based services cost-of-living percentage increase or any subsequent legislatively adopted statewide percentage rate increase for nursing facilities. The limit under this clause only applies to persons discharged from a nursing facility after a minimum 30-day stay and found eligible for waivered services on or after July 1, 1997. The following costs must be included in determining the total monthly costs for the waiver client:

(1) cost of all waivered services, including extended medical supplies and equipment and environmental modifications; and

(2) cost of skilled nursing, home health aide, and personal care services reimbursable by medical assistance.

(e) 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.

(f) A county is not required to contract with a provider of supplies and equipment if the monthly cost of the supplies and equipment is less than $250.

(g) The adult foster care rate shall be considered a difficulty of care payment and shall not include room and board. The adult foster care service rate shall be negotiated between the county agency and the foster care provider. The elderly waiver payment for the foster care service in combination with the payment for all other elderly waiver services, including case management, must not exceed the limit specified in paragraph (b).

(h) Payment for assisted living service shall be a monthly rate negotiated and authorized by the county agency based on an individualized service plan for each resident and may not cover direct rent or food costs.

(1) The individualized monthly negotiated payment for assisted living services as described in section 256B.0913, subdivision 5, paragraph (g) or (h), and residential care services as described in section 256B.0913, subdivision 5, paragraph (f), shall not exceed the nonfederal share, in effect on July 1 of the state fiscal year for which the rate limit is being calculated, of the greater of either the statewide or any of the geographic groups' weighted average monthly nursing facility rate of the case mix resident class to which the elderly waiver eligible client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, less the maintenance needs allowance as described in subdivision 1d, paragraph (a), until the July 1 of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented. Effective on July 1 of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented and July 1 of each subsequent state fiscal year, the individualized monthly negotiated payment for the services described in this clause

shall not exceed the limit described in this clause which was in effect on June 30 of the previous state fiscal year and which has been adjusted by the greater of any legislatively adopted home and community-based services cost-of-living percentage increase or any legislatively adopted statewide percent rate increase for nursing facilities.

(2) The individualized monthly negotiated payment for assisted living services described in section 144A.4605 and delivered by a provider licensed by the department of health as a class A home care provider or an assisted living home care provider and provided in a building that is registered as a housing with services establishment under chapter 144D and that provides 24-hour supervision in combination with the payment for other elderly waiver services, including case management, must not exceed the limit specified in paragraph (b).

(i) The county shall negotiate individual service rates with vendors and may authorize payment for actual costs up to the county's current approved rate. Persons or agencies must be employed by or under a contract with the county agency or the public health nursing agency of the local board of health in order to receive funding under the elderly waiver program, except as a provider of supplies and equipment when the monthly cost of the supplies and equipment is less than $250.

(j) Reimbursement for the medical assistance recipients under the approved waiver shall be made from the medical assistance account through the invoice processing procedures of the department's Medicaid Management Information System (MMIS), only with the approval of the client's case manager. The budget for the state share of the Medicaid expenditures shall be forecasted with the medical assistance budget, and shall be consistent with the approved waiver.

(k) To improve access to community services and eliminate payment disparities between the alternative care program and the elderly waiver, the commissioner shall establish statewide maximum service rate limits and eliminate county-specific service rate limits.

(1) Effective July 1, 2001, for service rate limits, except those described or defined in paragraphs (g) and (h), the rate limit for each service shall be the greater of the alternative care statewide maximum rate or the elderly waiver statewide maximum rate.

(2) Counties may negotiate individual service rates with vendors for actual costs up to the statewide maximum service rate limit.

(l) 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. 27. Minnesota Statutes 2000, section 256B.0915, subdivision 4, is amended to read:

Subd. 4. **TERMINATION NOTICE.** The case manager must give the individual a ten-day written notice of any ~~decrease in~~ denial, reduction, or termination of waivered services.

Sec. 28. Minnesota Statutes 2001 Supplement, section 256B.0915, subdivision 5, is amended to read:

Subd. 5. **ASSESSMENTS AND REASSESSMENTS FOR WAIVER CLIENTS.** Each client shall receive an initial assessment of strengths, informal supports, and need for services in accordance with section 256B.0911, subdivisions 3, 3a, and 3b. A reassessment of a client served under the elderly waiver must be conducted at least every 12 months and at other times when the case manager determines that there has been significant change in the client's functioning. This may include instances where the client is discharged from the hospital.

Sec. 29. Minnesota Statutes 2000, section 256B.0915, subdivision 6, is amended to read:

Subd. 6. **IMPLEMENTATION OF CARE PLAN.** Each elderly waiver client shall be provided a copy of a written care plan that meets the requirements outlined in section 256B.0913, subdivision 8. If the county administering waivered services is different than the county of financial responsibility, the care plan may be implemented without the approval of the county of financial responsibility.

Sec. 30. Minnesota Statutes 2000, section 256B.0915, is amended by adding a subdivision to read:

Subd. 8. **SERVICES AND SUPPORTS.** (a) Services and supports shall meet the requirements set out in United States Code, title 42, section 1396n.

(b) Services and supports shall promote consumer choice and be arranged and provided consistent with individualized, written care plans.

(c) The state of Minnesota, county, or tribal government under contract to administer the elderly waiver shall not be liable for damages, injuries, or liabilities sustained through the purchase of direct supports or goods by the person, the person's family, or the authorized representatives with funds received through consumer-directed community support services under the federally approved waiver plan. Liabilities include, but are not limited to, workers' compensation liability, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA).

Sec. 31. Minnesota Statutes 2001 Supplement, section 256B.0924, subdivision 6, is amended to read:

Subd. 6. **PAYMENT FOR TARGETED CASE MANAGEMENT.** (a) Medical assistance and MinnesotaCare payment for targeted case management shall be made on a monthly basis. In order to receive payment for an eligible adult, the provider must document at least one contact per month and not more than two consecutive months without a face-to-face contact with the adult or the adult's legal representative, family, primary caregiver, or other relevant persons identified as necessary to the development or implementation of the goals of the personal service plan.

(b) Payment for targeted case management provided by county staff under this subdivision shall be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph (b), calculated as one combined average rate together with

adult mental health case management under section 256B.0625, subdivision 20, except for calendar year 2002. In calendar year 2002, the rate for case management under this section shall be the same as the rate for adult mental health case management in effect as of December 31, 2001. Billing and payment must identify the recipient's primary population group to allow tracking of revenues.

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

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

(e) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for targeted case management shall be provided by the recipient's county of responsibility, as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds used to match other federal funds.

(f) The commissioner may suspend, reduce, or terminate reimbursement to a provider that does not meet the reporting or other requirements of this section. The county of responsibility, as defined in sections 256G.01 to 256G.12, is responsible for any federal disallowances. The county may share this responsibility with its contracted vendors.

(g) The commissioner shall set aside five percent of the federal funds received under this section for use in reimbursing the state for costs of developing and implementing this section.

(h) Notwithstanding section 256.025, subdivision 2, payments to counties for targeted case management expenditures under this section shall only be made from federal earnings from services provided under this section. Payments to contracted vendors shall include both the federal earnings and the county share.

(i) Notwithstanding section 256B.041, county payments for the cost of case management services provided by county staff shall not be made to the state treasurer. For the purposes of targeted case management services provided by county staff under this section, the centralized disbursement of payments to counties under section 256B.041 consists only of federal earnings from services provided under this section.

(j) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital, and the recipient's institutional care is paid by medical assistance, payment

for targeted case management services under this subdivision is limited to the last 180 days of the recipient's residency in that facility and may not exceed more than six months in a calendar year.

(k) Payment for targeted case management services under this subdivision shall not duplicate payments made under other program authorities for the same purpose.

(l) Any growth in targeted case management services and cost increases under this section shall be the responsibility of the counties.

Sec. 32. Minnesota Statutes 2001 Supplement, section 256B.0951, subdivision 7, is amended to read:

Subd. 7. **WAIVER OF RULES.** If a federal waiver is approved under subdivision 8, the commissioner of health may exempt residents of intermediate care facilities for persons with mental retardation (ICFs/MR) who participate in the ~~three-year~~ alternative quality assurance ~~pilot~~ project established in section 256B.095 from the requirements of Minnesota Rules, chapter 4665~~, upon approval by the federal government of a waiver of federal certification requirements for ICFs/MR~~.

Sec. 33. Minnesota Statutes 2001 Supplement, section 256B.0951, subdivision 8, is amended to read:

Subd. 8. **FEDERAL WAIVER.** The commissioner of human services shall seek ~~federal authority to waive provisions of intermediate care facilities for persons with mental retardation (ICFs/MR) regulations to enable the demonstration and evaluation of the alternative quality assurance system for ICFs/MR under the project. The commissioner of human services shall apply for any necessary waivers as soon as practicable.~~ a federal waiver to allow intermediate care facilities for persons with mental retardation (ICFs/MR) in region 10 of Minnesota to participate in the alternative licensing system. If it is necessary for purposes of participation in this alternative licensing system for a facility to be decertified as an ICF/MR facility according to the terms of the federal waiver, when the facility seeks recertification under the provisions of ICF/MR regulations at the end of the demonstration project, it will not be considered a new ICF/MR as defined under section 252.291 provided the licensed capacity of the facility did not increase during its participation in the alternative licensing system. The provisions of sections 252.82, 252.292, and 256B.5011 to 256B.5015 will remain applicable for counties in region 10 of Minnesota and the ICFs/MR located within those counties notwithstanding a county's participation in the alternative licensing system.

Sec. 34. Minnesota Statutes 2000, section 256B.19, subdivision 1, as amended by Laws 2002, chapter 220, article 14, section 7, is amended to read:

Subdivision 1. **DIVISION OF COST.** The state and county share of medical assistance costs not paid by federal funds shall be as follows:

(1) ~~ninety~~ 90 percent state funds and ten percent county funds, unless otherwise provided below;

(2) beginning January 1, 1992, 50 percent state funds and 50 percent county funds for the cost of placement of severely emotionally disturbed children in regional treatment centers; and

(3) beginning January 1, 2003, 80 percent state funds and 20 percent county funds for the costs of nursing facility placements of persons with disabilities under the age of 65 that have exceeded 90 days. This clause shall be subject to chapter 256G and shall not apply to placements in facilities not certified to participate in medical assistance.

For counties that participate in a Medicaid demonstration project under sections 256B.69 and 256B.71, the division of the nonfederal share of medical assistance expenses for payments made to prepaid health plans or for payments made to health maintenance organizations in the form of prepaid capitation payments, this division of medical assistance expenses shall be 95 percent by the state and five percent by the county of financial responsibility.

In counties where prepaid health plans are under contract to the commissioner to provide services to medical assistance recipients, the cost of court ordered treatment ordered without consulting the prepaid health plan that does not include diagnostic evaluation, recommendation, and referral for treatment by the prepaid health plan is the responsibility of the county of financial responsibility.

Sec. 35. Minnesota Statutes 2001 Supplement, section 256B.431, subdivision 2e, is amended to read:

Subd. 2e. **CONTRACTS FOR SERVICES FOR VENTILATOR-DEPENDENT PERSONS.** The commissioner may ~~contract~~ negotiate with a nursing facility eligible to receive medical assistance payments to provide services to a ventilator-dependent person identified by the commissioner according to criteria developed by the commissioner, including:

(1) nursing facility care has been recommended for the person by a preadmission screening team;

(2) the person has been hospitalized and no longer requires inpatient acute care hospital services; and

(3) the commissioner has determined that necessary services for the person cannot be provided under existing nursing facility rates.

~~The commissioner may issue a request for proposals to provide services to a ventilator-dependent person to nursing facilities eligible to receive medical assistance payments and shall select nursing facilities from among respondents according to criteria developed by the commissioner, including:~~

~~(1) the cost-effectiveness and appropriateness of services;~~

~~(2) the nursing facility's compliance with federal and state licensing and certification standards; and~~

~~(3) the proximity of the nursing facility to a ventilator-dependent person identified by the commissioner who requires nursing facility placement.~~

The commissioner may negotiate an adjustment to the operating cost payment rate for a nursing facility ~~selected by the commissioner from among respondents to the request for proposals~~ with a resident who is ventilator-dependent, for that resident. The negotiated adjustment must reflect only the actual additional cost of meeting the specialized care needs of a ventilator-dependent person identified by the commissioner for whom necessary services cannot be provided under existing nursing facility rates and which are not otherwise covered under Minnesota Rules, parts 9549.0010 to 9549.0080 or 9505.0170 to 9505.0475. For persons who are initially admitted to a nursing facility before July 1, 2001, and have their payment rate under this subdivision negotiated after July 1, 2001, the negotiated payment rate must not exceed 200 percent of the highest multiple bedroom payment rate for the facility, as initially established by the commissioner for the rate year for case mix classification K; or, upon implementation of the RUGs-based case mix system, 200 percent of the highest RUGs rate. For persons initially admitted to a nursing facility on or after July 1, 2001, the negotiated payment rate must not exceed 300 percent of the facility's multiple bedroom payment rate for case mix classification K; or, upon implementation of the RUGs-based case mix system, 300 percent of the highest RUGs rate. The negotiated adjustment shall not affect the payment rate charged to private paying residents under the provisions of section 256B.48, subdivision 1.

Sec. 36. Minnesota Statutes 2000, section 256B.431, subdivision 14, is amended to read:

Subd. 14. **LIMITATIONS ON SALES OF NURSING FACILITIES.** (a) For rate periods beginning on October 1, 1992, and for rate years beginning after June 30, 1993, a nursing facility's property-related payment rate as established under subdivision 13 shall be adjusted by either paragraph (b) or (c) for the sale of the nursing facility, including sales occurring after June 30, 1992, as provided in this subdivision.

(b) If the nursing facility's property-related payment rate under subdivision 13 prior to sale is greater than the nursing facility's rental rate under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section prior to sale, the nursing facility's property-related payment rate after sale shall be the greater of its property-related payment rate under subdivision 13 prior to sale or its rental rate under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section calculated after sale.

(c) If the nursing facility's property-related payment rate under subdivision 13 prior to sale is equal to or less than the nursing facility's rental rate under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section prior to sale, the nursing facility's property-related payment rate after sale shall be the nursing facility's property-related payment rate under subdivision 13 plus the difference between its rental rate calculated under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section prior to sale and its rental rate calculated under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section calculated after sale.

(d) For purposes of this subdivision, "sale" means the purchase of a nursing facility's capital assets with cash or debt. The term sale does not include a stock

purchase of a nursing facility or any of the following transactions:

(1) a sale and leaseback to the same licensee that does not constitute a change in facility license;

(2) a transfer of an interest to a trust;

(3) gifts or other transfers for no consideration;

(4) a merger of two or more related organizations;

(5) a change in the legal form of doing business, other than a publicly held organization that becomes privately held or vice versa;

(6) the addition of a new partner, owner, or shareholder who owns less than 20 percent of the nursing facility or the issuance of stock; and

(7) a sale, merger, reorganization, or any other transfer of interest between related organizations other than those permitted in this section.

(e) For purposes of this subdivision, "sale" includes the sale or transfer of a nursing facility to a close relative as defined in Minnesota Rules, part 9549.0020, subpart 38, item C, upon the death of an owner, due to serious illness or disability, as defined under the Social Security Act, under United States Code, title 42, section 423(d)(1)(A), or upon retirement of an owner from the business of owning or operating a nursing home at 62 years of age or older. For sales to a close relative allowed under this paragraph, otherwise nonallowable debt resulting from seller financing of all or a portion of the debt resulting from the sale shall be allowed and shall not be subject to Minnesota Rules, part 9549.0060, subpart 5, item E, provided that in addition to existing requirements for allowance of debt and interest, the debt is subject to repayment through annual principal payments and the interest rate on the related organization debt does not exceed three percentage points above the posted yield for standard conventional fixed rate mortgages of the Federal Home Loan Mortgage Corporation for delivery in 60 days in effect on the day of sale. If at any time, the seller forgives the related organization debt allowed under this paragraph for other than equal amount of payment on that debt, then the buyer shall pay to the state the total revenue received by the nursing facility after the sale attributable to the amount of allowable debt which has been forgiven. Any assignment, sale, or transfer of the debt instrument entered into by the close relatives, either directly or indirectly, which grants to the close relative buyer the right to receive all or a portion of the payments under the debt instrument shall, effective on the date of the transfer, result in the prospective reduction in the corresponding portion of the allowable debt and interest expense. Upon the death of the close relative seller, any remaining balance of the close relative debt must be refinanced and such refinancing shall be subject to the provisions of Minnesota Rules, part 9549.0060, subpart 7, item G. This paragraph shall not apply to sales occurring on or after June 30, 1997.

(f) For purposes of this subdivision, "effective date of sale" means the later of either the date on which legal title to the capital assets is transferred or the date on which closing for the sale occurred.

(g) The effective day for the property-related payment rate determined under this subdivision shall be the first day of the month following the month in which the effective date of sale occurs or October 1, 1992, whichever is later, provided that the notice requirements under section 256B.47, subdivision 2, have been met.

(h) Notwithstanding Minnesota Rules, part 9549.0060, subparts 5, item A, subitems (3) and (4), and 7, items E and F, the commissioner shall limit the total allowable debt and related interest for sales occurring after June 30, 1992, to the sum of clauses (1) to (3):

(1) the historical cost of capital assets, as of the nursing facility's most recent previous effective date of sale or, if there has been no previous sale, the nursing facility's initial historical cost of constructing capital assets;

(2) the average annual capital asset additions after deduction for capital asset deletions, not including depreciations; and

(3) one-half of the allowed inflation on the nursing facility's capital assets. The commissioner shall compute the allowed inflation as described in paragraph ~~(h)~~ (i).

(i) For purposes of computing the amount of allowed inflation, the commissioner must apply the following principles:

(1) the lesser of the Consumer Price Index for all urban consumers or the Dodge Construction Systems Costs for Nursing Homes for any time periods during which both are available must be used. If the Dodge Construction Systems Costs for Nursing Homes becomes unavailable, the commissioner shall substitute the index in subdivision 3f, or such other index as the secretary of the health care financing administration may designate;

(2) the amount of allowed inflation to be applied to the capital assets in paragraph (g), clauses (1) and (2), must be computed separately;

(3) the amount of allowed inflation must be determined on an annual basis, prorated on a monthly basis for partial years and if the initial month of use is not determinable for a capital asset, then one-half of that calendar year shall be used for purposes of prorating;

(4) the amount of allowed inflation to be applied to the capital assets in paragraph (g), clauses (1) and (2), must not exceed 300 percent of the total capital assets in any one of those clauses; and

(5) the allowed inflation must be computed starting with the month following the nursing facility's most recent previous effective date of sale or, if there has been no previous sale, the month following the date of the nursing facility's initial occupancy, and ending with the month preceding the effective date of sale.

(j) If the historical cost of a capital asset is not readily available for the date of the nursing facility's most recent previous sale or if there has been no previous sale for the date of the nursing facility's initial occupancy, then the commissioner shall limit the total allowable debt and related interest after sale to the extent recognized by the

Medicare intermediary after the sale. For a nursing facility that has no historical capital asset cost data available and does not have allowable debt and interest calculated by the Medicare intermediary, the commissioner shall use the historical cost of capital asset data from the point in time for which capital asset data is recorded in the nursing facility's audited financial statements.

(k) The limitations in this subdivision apply only to debt resulting from a sale of a nursing facility occurring after June 30, 1992, including debt assumed by the purchaser of the nursing facility.

Sec. 37. Minnesota Statutes 2000, section 256B.431, subdivision 30, is amended to read:

Subd. 30. **BED LAYAWAY AND DELICENSURE.** (a) For rate years beginning on or after July 1, 2000, a nursing facility reimbursed under this section which has placed beds on layaway shall, for purposes of application of the downsizing incentive in subdivision 3a, paragraph ~~(d)~~ (c), and calculation of the rental per diem, have those beds given the same effect as if the beds had been delicensed so long as the beds remain on layaway. At the time of a layaway, a facility may change its single bed election for use in calculating capacity days under Minnesota Rules, part 9549.0060, subpart 11. The property payment rate increase shall be effective the first day of the month following the month in which the layaway of the beds becomes effective under section 144A.071, subdivision 4b.

(b) For rate years beginning on or after July 1, 2000, notwithstanding any provision to the contrary under section 256B.434, a nursing facility reimbursed under that section which has placed beds on layaway shall, for so long as the beds remain on layaway, be allowed to:

(1) aggregate the applicable investment per bed limits based on the number of beds licensed immediately prior to entering the alternative payment system;

(2) retain or change the facility's single bed election for use in calculating capacity days under Minnesota Rules, part 9549.0060, subpart 11; and

(3) establish capacity days based on the number of beds immediately prior to the layaway and the number of beds after the layaway.

The commissioner shall increase the facility's property payment rate by the incremental increase in the rental per diem resulting from the recalculation of the facility's rental per diem applying only the changes resulting from the layaway of beds and clauses (1), (2), and (3). If a facility reimbursed under section 256B.434 completes a moratorium exception project after its base year, the base year property rate shall be the moratorium project property rate. The base year rate shall be inflated by the factors in section 256B.434, subdivision 4, paragraph (c). The property payment rate increase shall be effective the first day of the month following the month in which the layaway of the beds becomes effective.

(c) If a nursing facility removes a bed from layaway status in accordance with section 144A.071, subdivision 4b, the commissioner shall establish capacity days

based on the number of licensed and certified beds in the facility not on layaway and shall reduce the nursing facility's property payment rate in accordance with paragraph (b).

(d) For the rate years beginning on or after July 1, 2000, notwithstanding any provision to the contrary under section 256B.434, a nursing facility reimbursed under that section, which has delicensed beds after July 1, 2000, by giving notice of the delicensure to the commissioner of health according to the notice requirements in section 144A.071, subdivision 4b, shall be allowed to:

(1) aggregate the applicable investment per bed limits based on the number of beds licensed immediately prior to entering the alternative payment system;

(2) retain or change the facility's single bed election for use in calculating capacity days under Minnesota Rules, part 9549.0060, subpart 11; and

(3) establish capacity days based on the number of beds immediately prior to the delicensure and the number of beds after the delicensure.

The commissioner shall increase the facility's property payment rate by the incremental increase in the rental per diem resulting from the recalculation of the facility's rental per diem applying only the changes resulting from the delicensure of beds and clauses (1), (2), and (3). If a facility reimbursed under section 256B.434 completes a moratorium exception project after its base year, the base year property rate shall be the moratorium project property rate. The base year rate shall be inflated by the factors in section 256B.434, subdivision 4, paragraph (c). The property payment rate increase shall be effective the first day of the month following the month in which the delicensure of the beds becomes effective.

(e) For nursing facilities reimbursed under this section or section 256B.434, any beds placed on layaway shall not be included in calculating facility occupancy as it pertains to leave days defined in Minnesota Rules, part 9505.0415.

(f) For nursing facilities reimbursed under this section or section 256B.434, the rental rate calculated after placing beds on layaway may not be less than the rental rate prior to placing beds on layaway.

(g) A nursing facility receiving a rate adjustment as a result of this section shall comply with section 256B.47, subdivision 2.

(h) A facility that does not utilize the space made available as a result of bed layaway or delicensure under this subdivision to reduce the number of beds per room or provide more common space for nursing facility uses or perform other activities related to the operation of the nursing facility shall have its property rate increase calculated under this subdivision reduced by the ratio of the square footage made available that is not used for these purposes to the total square footage made available as a result of bed layaway or delicensure.

Sec. 38. Minnesota Statutes 2001 Supplement, section 256B.431, subdivision 33, is amended to read:

Subd. 33. **STAGED REDUCTION IN RATE DISPARITIES.** (a) For the rate years beginning July 1, 2001, and July 1, 2002, the commissioner shall adjust the operating payment rates for low-rate nursing facilities reimbursed under this section or section 256B.434.

(b) For the rate year beginning July 1, 2001, for each case mix level, if the amount computed under subdivision ~~32~~ 31 is less than the amount in clause (1), the commissioner shall make available the lesser of the amount in clause (1) or an increase of ten percent over the rate in effect on June 30, 2001, as an adjustment to the operating payment rate. For the rate year beginning July 1, 2002, for each case mix level, if the amount computed under subdivision ~~32~~ 31 is less than the amount in clause (2), the commissioner shall make available the lesser of the amount in clause (2) or an increase of ten percent over the rate in effect on June 30, 2002, as an adjustment to the operating payment rate. For purposes of this subdivision, nursing facilities shall be considered to be metro if they are located in Anoka, Carver, Dakota, Hennepin, Olmsted, Ramsey, Scott, or Washington counties; or in the cities of Moorhead or Breckenridge; or in St. Louis county, north of Toivola and south of Cook; or in Itasca county, east of a north south line two miles west of Grand Rapids:

(1) Operating Payment Rate Target Level for July 1, 2001:

Case Mix Classification	Metro	Nonmetro
A	$ 76.00	$ 68.13
B	$ 83.40	$ 74.46
C	$ 91.67	$ 81.63
D	$ 99.51	$ 88.04
E	$107.46	$ 94.87
F	$107.96	$ 95.29
G	$114.67	$100.98
H	$126.99	$111.31
I	$131.42	$115.06
J	$138.34	$120.85
K	$152.26	$133.10

(2) Operating Payment Rate Target Level for July 1, 2002:

Case Mix Classification	Metro	Nonmetro
A	$ 78.28	$ 70.51
B	$ 85.91	$ 77.16
C	$ 94.42	$ 84.62
D	$102.50	$ 91.42
E	$110.68	$ 98.40
F	$111.20	$ 98.84
G	$118.11	$104.77
H	$130.80	$115.64
I	$135.38	$119.50
J	$142.49	$125.38
K	$156.85	$137.77

Sec. 39. Minnesota Statutes 2001 Supplement, section 256B.437, subdivision 3, is amended to read:

Subd. 3. **APPLICATIONS FOR PLANNED CLOSURE OF NURSING FACILITIES.** (a) By August 15, 2001, the commissioner of human services shall implement and announce a program for closure or partial closure of nursing facilities. Names and identifying information provided in response to the announcement shall remain private unless approved, according to the timelines established in the plan. The announcement must specify:

(1) the criteria in subdivision 4 that will be used by the commissioner to approve or reject applications;

(2) a ~~requirement for the submission of a letter of intent before the submission of an application;~~

~~(3)~~ the information that must accompany an application; and

~~(4)~~ (3) that applications may combine planned closure rate adjustments with moratorium exception funding, in which case a single application may serve both purposes.

Between August 1, 2001, and June 30, 2003, the commissioner may approve planned closures of up to 5,140 nursing facility beds, less the number of ~~licensed~~ beds delicensed in facilities ~~that close~~ during the same time period without approved closure plans or that have notified the commissioner of health of their intent to close without an approved closure plan.

(b) A facility or facilities reimbursed under section 256B.431 or 256B.434 with a closure plan approved by the commissioner under subdivision 5 may assign a planned closure rate adjustment to another facility or facilities that are not closing or in the case of a partial closure, to the facility undertaking the partial closure. A facility may also elect to have a planned closure rate adjustment shared equally by the five nursing facilities with the lowest total operating payment rates in the state development region designated under section 462.385, in which the facility that is closing is located. The planned closure rate adjustment must be calculated under subdivision 6. Facilities that ~~close~~ delicense beds without a closure plan, or whose closure plan is not approved by the commissioner, are not eligible to assign a planned closure rate adjustment under subdivision 6~~.~~, unless they are delicensing five or fewer beds, or less than six percent of their total licensed bed capacity, whichever is greater, are located in a county in the top three quartiles of beds per 1,000 persons aged 65 or older, and have not delicensed beds in the prior three months. Facilities meeting these criteria are eligible to assign the amount calculated under subdivision 6 to themselves. If a facility is delicensing the greater of six or more beds, or six percent or more of its total licensed bed capacity, and does not have an approved closure plan or is not eligible for the adjustment under subdivision 6, the commissioner shall calculate the amount the facility would have been eligible to assign under subdivision 6, and shall use this amount to provide equal rate adjustments to the five nursing facilities with the lowest total operating payment rates in the state development region designated under section 462.385, in which the

facility that ~~closed~~ delicensed beds is located.

(c) To be considered for approval, an application must include:

(1) a description of the proposed closure plan, which must include identification of the facility or facilities to receive a planned closure rate adjustment ~~and the amount and timing of a planned closure rate adjustment proposed for each facility~~;

(2) the proposed timetable for any proposed closure, including the proposed dates for announcement to residents, commencement of closure, and completion of closure;

(3) if available, the proposed relocation plan for current residents of any facility designated for closure. ~~The proposed~~ If a relocation plan is not available, the application must include a statement agreeing to develop a relocation plan ~~must be~~ designed to comply with ~~all applicable state and federal statutes and regulations, including, but not limited to,~~ section 144A.161;

(4) a description of the relationship between the nursing facility that is proposed for closure and the nursing facility or facilities proposed to receive the planned closure rate adjustment. If these facilities are not under common ownership, copies of any contracts, purchase agreements, or other documents establishing a relationship or proposed relationship must be provided;

(5) documentation, in a format approved by the commissioner, that all the nursing facilities receiving a planned closure rate adjustment under the plan have accepted joint and several liability for recovery of overpayments under section 256B.0641, subdivision 2, for the facilities designated for closure under the plan; and

(6) an explanation of how the application coordinates with planning efforts under subdivision 2. If the planning group does not support a level of nursing facility closures that the commissioner considers to be reasonable, the commissioner may approve a planned closure proposal without its support.

(d) The application must address the criteria listed in subdivision 4.

Sec. 40. Minnesota Statutes 2001 Supplement, section 256B.437, subdivision 6, is amended to read:

Subd. 6. **PLANNED CLOSURE RATE ADJUSTMENT.** (a) The commissioner of human services shall calculate the amount of the planned closure rate adjustment available under subdivision 3, paragraph (b), for up to 5,140 beds according to clauses (1) to (4):

(1) the amount available is the net reduction of nursing facility beds multiplied by $2,080;

(2) the total number of beds in the nursing facility or facilities receiving the planned closure rate adjustment must be identified;

(3) capacity days are determined by multiplying the number determined under clause (2) by 365; and

(4) the planned closure rate adjustment is the amount available in clause (1), divided by capacity days determined under clause (3).

(b) A planned closure rate adjustment under this section is effective on the first day of the month following completion of closure of the facility designated for closure in the application and becomes part of the nursing facility's total operating payment rate.

(c) Applicants may use the planned closure rate adjustment to allow for a property payment for a new nursing facility or an addition to an existing nursing facility or as an operating payment rate adjustment. Applications approved under this subdivision are exempt from other requirements for moratorium exceptions under section 144A.073, subdivisions 2 and 3.

(d) Upon the request of a closing facility, the commissioner must allow the facility a closure rate adjustment as provided under section 144A.161, subdivision 10.

(e) A facility that has received a planned closure rate adjustment may reassign it to another facility that is under the same ownership at any time within three years of its effective date. The amount of the adjustment shall be computed according to paragraph (a).

(f) If the per bed dollar amount specified in paragraph (a), clause (1), is increased, the commissioner shall recalculate planned closure rate adjustments for facilities that delicense beds under this section on or after July 1, 2001, to reflect the increase in the per bed dollar amount. The recalculated planned closure rate adjustment shall be effective from the date the per bed dollar amount is increased.

Sec. 41. Minnesota Statutes 2001 Supplement, section 256B.438, subdivision 1, is amended to read:

Subdivision 1. **SCOPE.** This section establishes the method and criteria used to determine resident reimbursement classifications based upon the assessments of residents of nursing homes and boarding care homes whose payment rates are established under section 256B.431, 256B.434, or 256B.435. Resident reimbursement classifications shall be established according to the 34 group, resource utilization groups, version III or RUG-III model as described in section 144.0724. Reimbursement classifications established under this section shall be implemented after June 30, 2002, but no later than January 1, 2003. Reimbursement classifications established under this section shall be implemented no earlier than six weeks after the commissioner mails notices of payment rates to the facilities.

Sec. 42. Minnesota Statutes 2000, section 256B.5012, subdivision 2, is amended to read:

Subd. 2. **OPERATING PAYMENT RATE.** (a) The operating payment rate equals the facility's total payment rate in effect on September 30, 2000, minus the property rate. The operating payment rate includes the special operating rate and the efficiency incentive in effect as of September 30, 2000. Within the limits of appropriations specifically for this purpose, the operating payment shall be increased for each rate year by the annual percentage change in the Employment Cost Index for

Private Industry Workers - Total Compensation, as forecasted by the commissioner of finance's economic consultant, in the second quarter of the calendar year preceding the start of each rate year. In the case of the initial rate year beginning October 1, 2000, and continuing through December 31, 2001, the percentage change shall be based on the percentage change in the Employment Cost Index for Private Industry Workers - Total Compensation for the 15-month period beginning October 1, 2000, as forecast by Data Resources, Inc., in the first quarter of 2000.

(b) Effective October 1, 2000, the operating payment rate shall be adjusted to reflect an occupancy rate equal to 100 percent of the facility's capacity days as of September 30, 2000.

(c) Effective July 1, 2001, the operating payment rate shall be adjusted for the increases in the department of health licensing fees that were authorized in Laws 2001, First Special Session chapter 9, article 1, section 30.

Sec. 43. Minnesota Statutes 2000, section 256B.69, subdivision 5a, as amended by Laws 2002, chapter 220, article 15, section 15, is amended to read:

Subd. 5a. **MANAGED CARE CONTRACTS.** (a) Managed care contracts under this section and sections 256L.12 and 256D.03, shall be entered into or renewed on a calendar year basis beginning January 1, 1996. Managed care contracts which were in effect on June 30, 1995, and set to renew on July 1, 1995, shall be renewed for the period July 1, 1995 through December 31, 1995 at the same terms that were in effect on June 30, 1995.

(b) A prepaid health plan providing covered health services for eligible persons pursuant to chapters 256B, 256D, and 256L, is responsible for complying with the terms of its contract with the commissioner. Requirements applicable to managed care programs under chapters 256B, 256D, and 256L, established after the effective date of a contract with the commissioner take effect when the contract is next issued or renewed.

(c) Effective for services rendered on or after January 1, 2003, the commissioner shall withhold five percent of managed care plan payments under this section for the prepaid medical assistance and general assistance medical care programs pending completion of performance targets. The withheld funds ~~will~~ must be returned no sooner than July of the following year if performance targets in the contract are achieved. The commissioner may exclude special demonstration projects under subdivision 23. A managed care plan may include as admitted assets under section 62D.044 any amount withheld under this paragraph that is reasonably expected to be returned.

Sec. 44. Minnesota Statutes 2001 Supplement, section 256B.76, is amended to read:

256B.76 **PHYSICIAN AND DENTAL REIMBURSEMENT.**

(a) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for physician services as follows:

(1) payment for level one Health Care Finance Administration's common procedural coding system (HCPCS) codes titled "office and other outpatient services," "preventive medicine new and established patient," "delivery, antepartum, and postpartum care," "critical care," cesarean delivery and pharmacologic management provided to psychiatric patients, and HCPCS level three codes for enhanced services for prenatal high risk, shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992. If the rate on any procedure code within these categories is different than the rate that would have been paid under the methodology in section 256B.74, subdivision 2, then the larger rate shall be paid;

(2) payments for all other services shall be paid at the lower of (i) submitted charges, or (ii) 15.4 percent above the rate in effect on June 30, 1992;

(3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases except that payment rates for home health agency services shall be the rates in effect on September 30, 1992;

(4) effective for services rendered on or after January 1, 2000, payment rates for physician and professional services shall be increased by three percent over the rates in effect on December 31, 1999, except for home health agency and family planning agency services; and

(5) the increases in clause (4) shall be implemented January 1, 2000, for managed care.

(b) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for dental services as follows:

(1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992;

(2) dental rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases;

(3) effective for services rendered on or after January 1, 2000, payment rates for dental services shall be increased by three percent over the rates in effect on December 31, 1999;

(4) the commissioner shall award grants to community clinics or other nonprofit community organizations, political subdivisions, professional associations, or other organizations that demonstrate the ability to provide dental services effectively to public program recipients. Grants may be used to fund the costs related to coordinating access for recipients, developing and implementing patient care criteria, upgrading or establishing new facilities, acquiring furnishings or equipment, recruiting new providers, or other development costs that will improve access to dental care in a region. In awarding grants, the commissioner shall give priority to applicants that plan to serve areas of the state in which the number of dental providers is not currently sufficient to meet the needs of recipients of public programs or uninsured individuals. The commissioner shall consider the following in awarding the grants:

(i) potential to successfully increase access to an underserved population;

(ii) the ability to raise matching funds;

(iii) the long-term viability of the project to improve access beyond the period of initial funding;

(iv) the efficiency in the use of the funding; and

(v) the experience of the proposers in providing services to the target population.

The commissioner shall monitor the grants and may terminate a grant if the grantee does not increase dental access for public program recipients. The commissioner shall consider grants for the following:

(i) implementation of new programs or continued expansion of current access programs that have demonstrated success in providing dental services in underserved areas;

(ii) a pilot program for utilizing hygienists outside of a traditional dental office to provide dental hygiene services; and

(iii) a program that organizes a network of volunteer dentists, establishes a system to refer eligible individuals to volunteer dentists, and through that network provides donated dental care services to public program recipients or uninsured individuals;

(5) beginning October 1, 1999, the payment for tooth sealants and fluoride treatments shall be the lower of (i) submitted charge, or (ii) 80 percent of median 1997 charges;

(6) the increases listed in clauses (3) and (5) shall be implemented January 1, 2000, for managed care; and

(7) effective for services provided on or after January 1, 2002, payment for diagnostic examinations and dental x-rays provided to children under age 21 shall be the lower of (i) the submitted charge, or (ii) 85 percent of median 1999 charges.

(c) Effective for dental services rendered on or after January 1, 2002, the commissioner may, within the limits of available appropriation, increase reimbursements to dentists and dental clinics deemed by the commissioner to be critical access dental providers. Reimbursement to a critical access dental provider may be increased by not more than 50 percent above the reimbursement rate that would otherwise be paid to the provider. Payments to health plan companies shall be adjusted to reflect increased reimbursements to critical access dental providers as approved by the commissioner. In determining which dentists and dental clinics shall be deemed critical access dental providers, the commissioner shall review:

(1) the utilization rate in the service area in which the dentist or dental clinic operates for dental services to patients covered by medical assistance, general assistance medical care, or MinnesotaCare as their primary source of coverage;

(2) the level of services provided by the dentist or dental clinic to patients covered by medical assistance, general assistance medical care, or MinnesotaCare as their primary source of coverage; and

(3) whether the level of services provided by the dentist or dental clinic is critical to maintaining adequate levels of patient access within the service area.

In the absence of a critical access dental provider in a service area, the commissioner may designate a dentist or dental clinic as a critical access dental provider if the dentist or dental clinic is willing to provide care to patients covered by medical assistance, general assistance medical care, or MinnesotaCare at a level which significantly increases access to dental care in the service area.

(d) Effective July 1, 2001, the medical assistance rates for outpatient mental health services provided by an entity that operates:

(1) a Medicare-certified comprehensive outpatient rehabilitation facility; and

(2) a facility that was certified prior to January 1, 1993, with at least 33 percent of the clients receiving rehabilitation services in the most recent calendar year who are medical assistance recipients, will be increased by 38 percent, when those services are provided within the comprehensive outpatient rehabilitation facility and provided to residents of nursing facilities owned by the entity.

(e) An entity that operates both a Medicare certified comprehensive outpatient rehabilitation facility and a facility which was certified prior to January 1, 1993, that is licensed under Minnesota Rules, parts 9570.2000 to 9570.3600, and for whom at least 33 percent of the clients receiving rehabilitation services in the most recent calendar year are medical assistance recipients, shall be reimbursed by the commissioner for rehabilitation services at rates that are 38 percent greater than the maximum reimbursement rate allowed under paragraph (a), clause (2), when those services are (1) provided within the comprehensive outpatient rehabilitation facility and (2) provided to residents of nursing facilities owned by the entity.

Sec. 45. Minnesota Statutes 2000, section 256I.04, subdivision 2a, is amended to read:

Subd. 2a. **LICENSE REQUIRED.** A county agency may not enter into an agreement with an establishment to provide group residential housing unless:

(1) the establishment is licensed by the department of health as a hotel and restaurant; a board and lodging establishment; a residential care home; a boarding care home before March 1, 1985; or a supervised living facility, and the service provider for residents of the facility is licensed under chapter 245A. However, an establishment licensed by the department of health to provide lodging need not also be licensed to provide board if meals are being supplied to residents under a contract with a food vendor who is licensed by the department of health;

(2) the residence is licensed by the commissioner of human services under Minnesota Rules, parts 9555.5050 to 9555.6265, or certified by a county human services agency prior to July 1, 1992, using the standards under Minnesota Rules, parts 9555.5050 to 9555.6265; or

(3) the establishment is registered under chapter 144D and provides three meals a day, except that an establishment registered under section 144D.025 is not eligible for

an agreement to provide group residential housing.

The requirements under clauses (1), (2), and (3) do not apply to establishments exempt from state licensure because they are located on Indian reservations and subject to tribal health and safety requirements.

Sec. 46. Minnesota Statutes 2000, section 256L.12, subdivision 9, as amended by Laws 2002, chapter 220, article 15, section 23, is amended to read:

Subd. 9. **RATE SETTING.** (a) Rates will be prospective, per capita, where possible. The commissioner may allow health plans to arrange for inpatient hospital services on a risk or nonrisk basis. The commissioner shall consult with an independent actuary to determine appropriate rates.

(b) For services rendered on or after January 1, 2003, the commissioner shall withhold .5 percent of managed care plan payments under this section pending completion of performance targets. The withheld funds ~~will~~ must be returned no sooner than July 1 and no later than July 31 of the following year if performance targets in the contract are achieved. A managed care plan may include as admitted assets under section 62D.044 any amount withheld under this paragraph that is reasonably expected to be returned.

Sec. 47. Laws 2002, chapter 220, article 17, section 2, subdivision 6, is amended to read:

Subd. 6. Continuing Care Grants		
General	(8,907,000)	(26,227,000)
The amounts that may be spent from this appropriation for each purpose are as follows:		
(a) Aging Adult Service Grants		
General	-0-	(2,638,000)

PLANNING AND SERVICE DEVELOPMENT. The planning and service development grant from Laws 2001, First Special Session chapter 9, article 17, section 2, subdivision 9, is eliminated for fiscal year 2003. Base funding for the 2004-2005 biennium shall be $550,000 each year. Notwithstanding Laws 2001, First Special Session chapter 9, article 17, section 2, subdivision 9, beginning in fiscal year 2004, the commissioner shall annually distribute $5,000 to each county. Counties with more than 10,000 persons over age 65

shall receive a distribution of an additional 25 cents for each person over age 65. The amount distributed to each area agency on aging shall be $2,500.

COMMUNITY SERVICES DEVELOPMENT GRANTS. For fiscal year 2003, base level funding for community services development grants under Minnesota Statutes, section 256.9754, is reduced by $1,478,000. For fiscal year 2004, base level funding for these grants is reduced by $768,000. For fiscal year 2005, base level funding shall be $3,000,000, and this amount shall be the base funding level for these grants for the biennium beginning July 1, 2005. Notwithstanding section 5, this provision shall not expire.

(b) Medical Assistance Long-Term Care Waivers and Home Care Grants		
General	18,471,000	12,833,000
(c) Medical Assistance Long-Term Care Facilities Grants		
General	(27,382,000)	(31,922,000)
(d) Group Residential Housing Grants		
General	4,000	574,000

~~**FEDERAL FUNDING FOR GROUP RESIDENTIAL HOUSING COSTS.** The commissioner shall seek federal funding to offset costs for group residential housing services under Minnesota Statutes, chapter 256I. Any federal funding received shall be distributed to counties on a pro rata basis according to county spending under Minnesota Statutes, section 256B.19, subdivision 1, clause (3), for the costs of nursing facility placements of persons with disabilities under the age of 65 that have exceeded 90 days. The commissioner shall report to the legislature by January 15, 2003, on the status of additional federal funding for group residential housing costs.~~

(e) Chemical Dependency Entitlement Grants

General	-0-	(84,000)

CONSOLIDATED CHEMICAL DEPENDENCY TREATMENT FUND RESERVE TRANSFER. In fiscal year 2003, $8,544,000 of funds available in the consolidated chemical dependency treatment fund general reserve account is transferred to the general fund.

(f) Community Social Services Block Grants

General	-0-	(4,990,000)

CSSA TRADITIONAL APPROPRIATION REDUCTION. For fiscal year 2003, base level funding for community social service aids under Minnesota Statutes, section 256E.06, subdivisions 1 and 2, is reduced by $4,700,000. This reduction shall become part of base level funding for the biennium beginning July 1, 2003. Notwithstanding section 5, this provision shall not expire.

CSSA GRANTS FOR FORMER GRH RECIPIENTS. For fiscal year 2003, base level funding for community social service aids under Minnesota Statutes, section 256E.06, subdivision 2b, is reduced by $290,000. This reduction shall become part of base level funding for the biennium beginning July 1, 2003. These reductions shall be made on a pro rata basis to each affected county. Notwithstanding section 5, this provision shall not expire.

Sec. 48. **CASE MANAGEMENT STUDY.**

The commissioner of human services shall study case management services for persons with disabilities, in consultation with consumers, providers, consumer advocates, and local social service and public health agencies. The commissioner shall report to the chairs and ranking minority members of the house and senate committees having jurisdiction over health and human services policy and funding, by January 15, 2003, on strategies that:

(1) streamline administration;

(2) improve case management service availability across the state;

(3) enhance consumer access to needed services and supports;

(4) improve accountability and the use of performance measures;

(5) provide for consumer choice of vendor; and

(6) improve the financing of case management services.

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

Sec. 49. **MENTAL HEALTH SERVICES RATE INCREASE PASS-THROUGH.**

Prepaid health plans must pass through to service providers the rate increases provided under Minnesota Statutes, section 256B.761.

Sec. 50. **COMMUNITY SERVICES DEVELOPMENT GRANTS USAGE.**

For fiscal year 2003, the commissioner of human services may make grants under the community services development grants program in Minnesota Statutes, section 256.9754, for the development of housing options for persons under age 65 residing in nursing facilities.

Sec. 51. **ACCESS TO AFFORDABLE HOUSING.**

The commissioners of human services and the Minnesota housing finance agency shall make recommendations to the long-term care task force by January 15, 2003, on ways to increase the ability of persons with disabilities to access affordable housing. The recommendations shall include:

(1) income supplement or housing subsidy options that support efforts to relocate persons under the age of 65 from nursing facilities or to divert them from a nursing facility placement;

(2) an analysis of the impacts of the state using a fixed amount attributable to room and board costs for home and community-based waiver recipients in group residential settings;

(3) options to maximize federal funding that result in no additional costs to the state. These options may include the transfer of state funds between income maintenance programs and the Medicaid program. These options may be implemented prior to the report to the task force. Any additional funds made available through implementation of these options and not utilized to support persons relocating from nursing facilities shall be used to reduce the county share enacted in Laws 2002, chapter 220, article 14, section 8; and

(4) alternatives that provide additional incentives to county agencies that successfully discharge persons with disabilities under the age of 65 from nursing facilities.

Sec. 52. **PRIOR AUTHORIZATION REPORT.**

The commissioner of human services shall review prior authorization of prescription drugs in the fee-for-service medical assistance program in terms of the cost effectiveness achieved through prior authorization on prescription drug costs and on other medical assistance costs and evaluate the effect that placing a drug on prior authorization has had on the quality of patient care. The commissioner shall submit the results to the chairs and ranking minority members of the senate and house of representatives committees having jurisdiction over human services funding by January 15, 2004.

Sec. 53. **PILOT PROGRAM FOR DEAF-BLIND SERVICES.**

(a) The commissioners of human services; children, families, and learning; and state services for the blind shall meet with deaf-blind citizens, parents of deaf-blind children, and the Minnesota commission serving deaf and hard-of-hearing individuals to determine which agency can most efficiently and effectively develop and administer a pilot program for consumer-directed services to provide needed services to deaf-blind adults, children, and families.

(b) The planning for this pilot program must proceed using current appropriations. The agency that develops the pilot program described in paragraph (a) shall provide a report to the senate and house of representatives policy and fiscal committees having jurisdiction over human services issues by January 1, 2003, that addresses future funding for the program. The report shall include the program proposal, recommendations, and a fiscal note.

Sec. 54. **SERVICES FOR DEAF-BLIND PERSONS.**

(a) Effective for fiscal years beginning on or after July 1, 2003, the commissioner of human services shall combine the existing $1,000,000 biennial base level funding for deaf-blind services into a single grant program. Within the limits of the appropriation for this purpose, each biennium at least $350,000 shall be awarded for services to deaf-blind children and their families and at least $250,000 shall be awarded for services to deaf-blind adults.

(b) The commissioner may make grants:

(1) for services provided by organizations; and

(2) to develop and administer consumer-directed services.

(c) Any entity that is able to satisfy the grant criteria is eligible to receive a grant under paragraph (a).

(d) Deaf-blind service providers are not required to, but may, provide intervenor services as part of the service package provided with grant funds under this section.

Sec. 55. **FEASIBILITY ASSESSMENT OF MEDICAL ASSISTANCE EXPANSION TO COVER DEAF-BLIND SERVICES.**

(a) The commissioner of human services shall study and report to the legislature by January 15, 2003, with a feasibility assessment of the costs and policy implications, including the necessity of federal waivers, to expand benefits covered under medical

assistance and under medical assistance waiver programs to include the following services for deaf-blind persons:

(1) sign language interpreters;

(2) intervenors;

(3) support service persons;

(4) orientation and mobility services; and

(5) rehabilitation teaching services.

(b) Notwithstanding Laws 2001, First Special Session chapter 9, article 17, section 10, subdivision 3, the commissioner may transfer $20,000 of deaf and hard-of-hearing grants to operations for purposes of paragraph (a). The study and report under paragraph (a) is exempt from the consulting contract moratorium in Laws 2002, chapter 220, article 10, section 37.

Sec. 56. **REPEALER; TARGETED CASE MANAGEMENT.**

Minnesota Statutes 2001 Supplement, section 256B.0621, subdivision 1, is repealed.

ARTICLE 3

MISCELLANEOUS

Section 1. Minnesota Statutes 2000, section 62J.692, subdivision 4, as amended by Laws 2002, chapter 220, article 15, section 1, is amended to read:

Subd. 4. **DISTRIBUTION OF FUNDS.** (a) The commissioner shall annually distribute medical education funds to all qualifying applicants based on the following criteria:

(1) total medical education funds available for distribution;

(2) total number of eligible trainee FTEs in each clinical medical education program; and

(3) the statewide average cost per trainee as determined by the application information provided in the first year of the biennium, by type of trainee, in each clinical medical education program.

(b) Funds distributed shall not be used to displace current funding appropriations from federal or state sources.

(c) Funds shall be distributed to the sponsoring institutions indicating the amount to be distributed to each of the sponsor's clinical medical education programs based on the criteria in this subdivision and in accordance with the commissioner's approval letter. Each clinical medical education program must distribute funds to the training

sites as specified in the commissioner's approval letter. Sponsoring institutions, which are accredited through an organization recognized by the department of education or the health care financing administration, may contract directly with training sites to provide clinical training. To ensure the quality of clinical training, those accredited sponsoring institutions must:

(1) develop contracts specifying the terms, expectations, and outcomes of the clinical training conducted at sites; and

(2) take necessary action if the contract requirements are not met. Action may include the withholding of payments under this section or the removal of students from the site.

(d) Any funds not distributed in accordance with the commissioner's approval letter must be returned to the medical education and research fund within 30 days of receiving notice from the commissioner. The commissioner shall distribute returned funds to the appropriate training sites in accordance with the commissioner's approval letter.

(e) The commissioner shall distribute ~~no later than~~ by June 30 of each year an amount equal to the funds transferred under section 62J.694, subdivision 2a, paragraph (b), plus five percent interest ~~at a rate equal to the average earnings paid under section 62J.694, subdivision 2a,~~ to the University of Minnesota board of regents for the costs of the academic health center as specified under section 62J.694, subdivision 2a, paragraph (a).

Sec. 2. Minnesota Statutes 2001 Supplement, section 125A.515, is amended to read:

125A.515 **PLACEMENT OF ~~CHILDREN WITHOUT DISABILITIES~~ STUDENTS; APPROVAL OF EDUCATION PROGRAM.**

Subdivision 1. **APPROVAL OF EDUCATION PROGRAMS.** The commissioner shall approve education programs ~~in care and treatment facilities~~ for placement of children ~~without disabilities~~ and youth in care and treatment facilities including detention centers, before being licensed by the department of human services under Minnesota Rules, parts 9545.0905 to 9545.1125 and 9545.1400 to 9545.1480, or the department of corrections under Minnesota Rules, chapters 2925, 2930, 2935, and 2950. ~~For the purposes of this section, care and treatment facilities includes adult facilities that admit children and provide an education program specifically designed for children who are residents of the facility including chemical dependency and other substance abuse programs, shelter care facilities, hospitals, correctional facilities, mental health programs, and detention facilities.~~ Education programs in these facilities shall conform to state and federal education laws including the Individuals with Disabilities Education Act (IDEA).

Subd. 2. **DEFINITION OF CARE AND TREATMENT PLACEMENT.** Students placed in the following public or private facilities are considered to be placed for care and treatment:

(1) group foster home, department of corrections;

(2) secure juvenile detention facilities, department of corrections;

(3) juvenile residential facilities, department of corrections;

(4) temporary holdover - eight day, department of corrections;

(5) group homes, department of human services;

(6) residential academies, department of human services;

(7) transitional programs, department of human services;

(8) shelter care, department of human services and department of corrections;

(9) shelter for homeless, department of human services;

(10) adult facilities that admit persons under the age of 22; and

(11) residential treatment programs.

Subd. 3. **RESPONSIBILITIES FOR PROVIDING EDUCATION.** (a) The district in which the facility is located must provide education services, including special education if eligible, to all students placed in a facility for care and treatment.

(b) For education programs operated by the department of corrections, the providing district shall be the department of corrections. For students remanded to the commissioner of corrections, the providing and resident district shall be the department of corrections.

(c) Placement for care and treatment does not automatically make a student eligible for special education. A student placed in a care and treatment facility is eligible for special education under state and federal law including the Individuals with Disabilities Education Act under United States Code, title 20, chapter 33.

Subd. 4. **EDUCATION SERVICES REQUIRED.** (a) Education services must be provided to a student beginning within three business days after the student enters the care and treatment facility. The first four days of the student's placement may be used to screen the student for educational and safety issues.

(b) If the student does not meet the eligibility criteria for special education, regular education services must be provided to that student.

Subd. 5. **EDUCATION PROGRAMS FOR STUDENTS PLACED IN FACILITIES FOR CARE AND TREATMENT.** (a) When a student is placed in a care and treatment facility that has an on-site education program, the providing district, upon notice from the care and treatment facility, must contact the resident district within one business day to determine if a student has been identified as having a disability, and to request at least the student's transcript, and for students with disabilities, the most recent individualized education plan (IEP) and evaluation report, and to determine if the student has been identified as a student with a disability. The resident district must send a facsimile copy to the providing district within two business days of receiving the request.

(b) If a student placed for care and treatment has been identified as having a disability and has an individual education plan in the resident district:

(1) the providing agency must conduct an individualized education plan meeting to reach an agreement about continuing or modifying special education services in accordance with the current individualized education plan goals and objectives and to determine if additional evaluations are necessary; and

(2) at least the following people shall receive written notice or documented phone call to be followed with written notice to attend the individualized education plan meeting:

(i) the person or agency placing the student;

(ii) the resident district;

(iii) the appropriate teachers and related services staff from the providing district;

(iv) appropriate staff from the care and treatment facility;

(v) the parents or legal guardians of the student; and

(vi) when appropriate, the student.

(c) For a student who has not been identified as a student with a disability, a screening must be conducted by the providing districts as soon as possible to determine the student's educational and behavioral needs and must include a review of the student's educational records.

Subd. 6. **EXIT REPORT SUMMARIZING EDUCATIONAL PROGRESS.** If a student has been placed in a care and treatment facility for 15 or more business days, the providing district must prepare an exit report summarizing the regular education, special education, evaluation, educational progress, and service information and must send the report to the resident district and the next providing district if different, the parent or legal guardian, and any appropriate social service agency. For students with disabilities, this report must include the student's IEP.

Subd. 7. **MINIMUM EDUCATIONAL SERVICES REQUIRED.** At a minimum, the providing district is responsible for:

(1) the education necessary, including summer school services, for a student who is not performing at grade level as indicated in the education record or IEP; and

(2) a school day, of the same length as the school day of the providing district, unless the unique needs of the student, as documented through the IEP or education record in consultation with treatment providers, requires an alteration in the length of the school day.

Subd. 8. **PLACEMENT, SERVICES, AND DUE PROCESS.** When a student's treatment and educational needs allow, education shall be provided in a regular educational setting. The determination of the amount and site of integrated services must be a joint decision between the student's parents or legal guardians and the treatment and education staff. When applicable, educational placement decisions must

be made by the IEP team of the providing district. Educational services shall be provided in conformance with the least restrictive environment principle of the Individuals with Disabilities Education Act. The providing district and care and treatment facility shall cooperatively develop discipline and behavior management procedures to be used in emergency situations that comply with the Minnesota Pupil Fair Dismissal Act and other relevant state and federal laws and regulations.

Subd. 9. **REIMBURSEMENT FOR EDUCATION SERVICES.** (a) Education services provided to students who have been placed for care and treatment are reimbursable in accordance with special education and general education statutes.

(b) Indirect or consultative services provided in conjunction with regular education prereferral interventions and assessment provided to regular education students suspected of being disabled and who have demonstrated learning or behavioral problems in a screening are reimbursable with special education categorical aids.

(c) Regular education, including screening, provided to students with or without disabilities is not reimbursable with special education categorical aids.

Subd. 10. **STUDENTS UNABLE TO ATTEND SCHOOL BUT NOT PLACED IN CARE AND TREATMENT FACILITIES.** Students who are absent from, or predicted to be absent from, school for 15 consecutive or intermittent days, at home or in facilities not licensed by the departments of corrections or human services are not students placed for care and treatment. These students include students with and without disabilities who are home due to accident or illness, in a hospital or other medical facility, or in a day treatment center. These students are entitled to education services through their district of residence.

Sec. 3. Minnesota Statutes 2000, section 125A.76, subdivision 5, is amended to read:

Subd. 5. **SCHOOL DISTRICT SPECIAL EDUCATION AID.** (a) A school district's special education aid for fiscal year 2000 and later equals the state total special education aid, minus the amount determined under paragraphs (b) and (c), times the ratio of the district's adjusted special education base revenue to the state total adjusted special education base revenue. If the commissioner of children, families, and learning modifies its rules for special education in a manner that increases a district's special education obligations or service requirements, the commissioner shall annually increase each district's special education aid by the amount necessary to compensate for the increased service requirements. The additional aid equals the cost in the current year attributable to rule changes not reflected in the computation of special education base revenue, multiplied by the appropriate percentages from subdivision 2.

(b) Notwithstanding paragraph (a), if the special education base revenue for a district equals zero, the special education aid equals the amount computed according to subdivision 2 using current year data.

(c) Notwithstanding paragraphs (a) and (b), if the special education base revenue for a district is greater than zero, and the base year amount for the district under

subdivision 2, paragraph (a), clause (7), equals zero, the special education aid equals the sum of the amount computed according to paragraph (a), plus the amount computed according to subdivision 2, paragraph (a), clause (7), using current year data.

(d) A charter school under section 124D.10 shall generate state special education aid based on current year expenditures for its first four years of operation and only in its fifth and later years shall paragraphs (a), (b), and (c) apply.

EFFECTIVE DATE. This section is effective July 1, 2002.

Sec. 4. Minnesota Statutes 2000, section 144.05, is amended by adding a subdivision to read:

Subd. 4. **IDENTIFICATION OF DECEASED INDIVIDUALS.** Upon receiving notice under section 149A.90, subdivision 1, of the death of an individual who cannot be identified, the commissioner must post on the department's Web site information regarding the individual for purposes of obtaining information that may aid in identifying the individual and for purposes of notifying relatives who may be seeking the individual. The information must remain on the Web site continuously until the person's identity is determined.

Sec. 5. Minnesota Statutes 2001 Supplement, section 144.148, subdivision 2, is amended to read:

Subd. 2. **PROGRAM.** (a) The commissioner of health shall award rural hospital capital improvement grants to eligible rural hospitals. Except as provided in paragraph (b), a grant shall not exceed $500,000 per hospital. Prior to the receipt of any grant, the hospital must certify to the commissioner that at least one-quarter of the grant amount, which may include in-kind services, is available for the same purposes from nonstate resources. Notwithstanding any law to the contrary, funds awarded to grantees in a grant agreement do not lapse until expended by the grantee.

(b) A grant shall not exceed $1,500,000 per eligible rural hospital that also satisfies the following criteria:

(1) is the only hospital in a county;

(2) has 25 or fewer licensed hospital beds with a net hospital operating margin not greater than an average of two percent over the three fiscal years prior to application;

(3) is located in a medically underserved community (MUC) or a health professional shortage area (HPSA);

(4) is located near a migrant worker employment site and regularly treats significant numbers of migrant workers and their families; and

(5) has not previously received a grant under this section prior to July 1, 1999.

Sec. 6. Minnesota Statutes 2000, section 144.335, subdivision 5, is amended to read:

Subd. 5. **COSTS.** (a) When a patient requests a copy of the patient's record for purposes of reviewing current medical care, the provider must not charge a fee.

(b) When a provider or its representative makes copies of patient records upon a patient's request under this section, the provider or its representative may charge the patient or the patient's representative no more than 75 cents per page, plus $10 for time spent retrieving and copying the records, unless other law or a rule or contract provide for a lower maximum charge. This limitation does not apply to x-rays. The provider may charge a patient no more than the actual cost of reproducing X-rays, plus no more than $10 for the time spent retrieving and copying the x-rays.

(c) The respective maximum charges of 75 cents per page and $10 for time provided in this subdivision are in effect for calendar year 1992 and may be adjusted annually each calendar year as provided in this subdivision. The permissible maximum charges shall change each year by an amount that reflects the change, as compared to the previous year, in the consumer price index for all urban consumers, Minneapolis-St. Paul (CPI-U), published by the department of labor.

(d) A provider or its representative must not charge a fee to provide copies of records requested by a patient or the patient's authorized representative if the request for copies of records is for purposes of appealing a denial of social security disability income or social security disability benefits under title II or title XVI of the Social Security Act. For the purpose of further appeals, a patient may receive no more than two medical record updates without charge, but only for medical record information previously not provided. For purposes of this paragraph, a patient's authorized representative does not include units of state government engaged in the adjudication of social security disability claims.

Sec. 7. Minnesota Statutes 2000, section 144.417, subdivision 1, is amended to read:

Subdivision 1. **RULES.** (a) The state commissioner of health shall adopt rules necessary and reasonable to implement the provisions of sections 144.411 to 144.417, except as provided for in section 144.414.

(b) Rules implementing sections 144.411 to 144.417 adopted after January 1, 2002, may not take effect until approved by a law enacted after January 1, 2002. This paragraph does not apply to a rule or severable portion of a rule governing smoking in office buildings, factories, warehouses, or similar places of work, or in health care facilities. This paragraph does not apply to a rule changing the definition of "restaurant" to make it the same as the definition in section 157.15, subdivision 12.

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

Sec. 8. Minnesota Statutes 2000, section 147B.02, subdivision 9, is amended to read:

Subd. 9. **RENEWAL.** (a) To renew a license an applicant must:

(1) annually, or as determined by the board, complete a renewal application on a form provided by the board;

(2) submit the renewal fee;

(3) ~~provide evidence annually of one hour of continuing education in the subject of infection control, including blood borne pathogen diseases;~~

~~(4)~~ provide documentation of current and active NCCAOM certification; or

~~(5)~~ (4) if licensed under subdivision 5 or 6, meet the same NCCAOM professional development activity requirements as those licensed under subdivision 7.

(b) An applicant shall submit any additional information requested by the board to clarify information presented in the renewal application. The information must be submitted within 30 days after the board's request, or the renewal request is nullified.

Sec. 9. Minnesota Statutes 2001 Supplement, section 149A.90, subdivision 1, is amended to read:

Subdivision 1. **DEATH RECORD.** (a) Except as provided in this section, a death record must be completed and filed for every known death by the mortician, funeral director, or other person lawfully in charge of the disposition of the body.

(b) If the body is that of an individual whose identity is unknown, the person in charge of the disposition of the body must notify the commissioner for purposes of compliance with section 144.05, subdivision 4.

Sec. 10. Minnesota Statutes 2000, section 261.063, is amended to read:

261.063 **TAX LEVY FOR SOCIAL SERVICES; BOARD DUTY; PENALTY.**

(a) The board of county commissioners of each county shall annually levy taxes and fix a rate sufficient to produce the full amount required for poor relief, general assistance, Minnesota family investment program, county share of county and state supplemental aid to supplemental security income applicants or recipients, and any other social security measures wherein there is now or may hereafter be county participation, sufficient to produce the full amount necessary for each such item, including administrative expenses, for the ensuing year, within the time fixed by law in addition to all other tax levies and tax rates, however fixed or determined, and any commissioner who shall fail to comply herewith shall be guilty of a gross misdemeanor and shall be immediately removed from office by the governor. For the purposes of this paragraph, "poor relief" means county services provided under sections 261.035, 261.04, and 261.21 to 261.231.

(b) Nothing within the provisions of this section shall be construed as requiring a county agency to provide income support or cash assistance to needy persons when they are no longer eligible for assistance under general assistance, the Minnesota family investment program, or Minnesota supplemental aid.

Sec. 11. **REPEALER.**

Minnesota Statutes 2000, section 147B.01, subdivisions 8 and 15, are repealed.

Presented to the governor May 16, 2002

Signed by the governor May 18, 2002, 7:10 p.m.

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