House Research
Act Summary

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TOPIC: Health and Human Services Omnibus

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Articles

Article 1: Department of Health

Overview

This article modifies Health Department programs, establishes new public health initiatives, modifies various fees charged by the Health Department, and makes other changes to Health Department statutes.

Sections 3 to 23 modify fees for the well program.

The following sections establish or modify other fees charged by the Health Department. Section 29 establishes fees for licensing of radioactive material and nuclear material. Section 30 modifies licensing fees for various health care facilities. Section 35 modifies the vital records surcharge. Section 38 modifies environmental laboratory certification fees. Section 54 modifies fees charged to food, beverage and lodging establishments.

Sections 24 to 26 address the immunization schedule. Section 24 requires disclosure of certain information on immunizations. Sections 25 and 26 authorize the commissioner of health to modify the immunization schedule by rule.

Sections 40 to 44 and 57 establish disclosure requirements for housing with services establishments that have special programs or units for people with Alzheimer's disease or other dementias.

Section 45 directs the commissioner of health to undertake specified suicide prevention activities.

Section 48 establishes a program to eliminate health disparities.

Sections 49 to 53 sunset existing targeted and universally offered home visiting programs and establish a consolidated program to fund family home visiting programs.

1 **Repealer.** Amends § 62J.152, subd. 8. Extends the health technology advisory committee for four more years, until July 1, 2005.

2 **Health care electronic data interchange system.** Amends § 62J.451, subd. 5. Eliminates the requirement that the Health Data Institute operate the Minnesota center for health care electronic data interchange.

3-23 **Fees for well program.** Amends sections in chapter 103I. These sections modify and place in statute several fees for the well program. Fees modified or established include fees for variances, well notification fees, permit fees, the fee for disclosure of wells to buyers, fees for well contractor licenses, fees for well/boring contractor licenses, fees for limited well/boring contractor licenses, fees for elevator shaft contractor licenses, fees for monitoring well contractor registration, and fees for drilling machines and pump hoists. One section exempts federal agencies from fees related to the well program. All fees are effective July 1, 2002.

24 **Disclosures required.** Adds subd. 3a to § 121A.15. Paragraph (a) requires information on immunization requirements provided to certain persons or their parents or guardians by one of the listed entities to describe the exemptions from immunizations listed elsewhere in statute. Requires the information on exemptions to be in the same font size, same font style, and on the same page as the immunization requirements. Paragraph (b) lists information that an immunization provider must provide in writing to a person being immunized or that person's parent or guardian.

25 **Modifications to schedule.** Adds subd. 12 to § 121A.15. Allows the commissioner of health to modify by rule the immunization requirements of section 121A.15, which apply to persons enrolled in schools and child care facilities. Paragraph (a) requires a proposed modification to the schedule to be part of the current immunization recommendations of the listed organizations, and lists the

persons with whom the commissioner must consult and the criteria that must be considered. Paragraph (b) requires the commissioner to notify the appropriate house and senate chairs before adopting a modification to the schedule. If the chairs schedule a hearing on the proposed modification, prohibits the commissioner from adopting the modification until after the hearing. Paragraph (c) requires the commissioner to comply with chapter 14 in modifying the immunization schedule. Paragraph (d) requires the commissioner to inform immunization providers of adopted changes to the immunization schedule in a timely manner.

26 **Modifications to schedule.** Adds subd. 7 to § 135A.14. Allows the commissioner of health to modify by rule the immunization requirements of section 135A.14, which apply to students of post-secondary educational institutions. Paragraph (a) requires a proposed modification to the schedule to be part of the current immunization recommendations of the listed organizations, and lists the persons with whom the commissioner must consult and the criteria that must be considered. Paragraph (b) requires the commissioner to notify the appropriate house and senate chairs before adopting a modification to the schedule. If the chairs schedule a hearing on the proposed modification, prohibits the commissioner from adopting the modification until after the hearing. Paragraph (c) requires the commissioner to comply with chapter 14 in modifying the immunization schedule. Paragraph (d) requires the commissioner to inform immunization providers of adopted changes to the immunization schedule in a timely manner.

27 **Health standards.** Adds § 144.0751. Requires safe drinking water or air quality standards established or revised by the commissioner of health to (1) be based on scientifically acceptable, peer-reviewed information, and (2) include a reasonable margin of safety to adequately protect infant, child, and adult health, by considering risks to the listed health outcomes. Defines peer-reviewed.

28 **Agreement; conditions of implementation.** Amends § 144.1202, subd. 4. Postpones by one year, from August 1, 2002 to August 1, 2003, implementation of the agreement between the state and the U.S. Nuclear Regulatory Commission for the state to assume licensing and regulatory authority over by-product, source, and special nuclear materials.

29 **Radioactive material; source and special nuclear material; fees; inspection.** Adds § 144.1205. Sets application procedures and fees for licensing of radioactive materials or sources. This section is effective July 1, 2002.

Subd. 1. Application and license renewal fee. When a license is required for radioactive material or source or special nuclear material, requires an application fee to be paid upon initial application. Requires a licensee to renew the license 60 days before the license expires by paying a license renewal fee. Addresses when licenses expire.

Subd. 2. Annual fee. Requires licensees to pay an annual fee at least 60 days before the anniversary date of the license's issuance, and specifies that the annual fee is 80 percent of the application fee.

Subd. 3. Fee categories; incorporation of federal licensing categories. Specifies that the fee categories used under this section are equivalent to the federal licensing categories used by the federal Nuclear Regulatory Commission, except for the category of "Academic, small."

Subd. 4. Application fee. Establishes application fees for the listed fee categories.

Subd. 5. Penalty for late payment. Establishes a penalty for late payment of fees of 25 percent of the fee due.

Subd. 6. Inspections. Requires the commissioner to make periodic safety inspections of the

radioactive material and source and special nuclear material of a licensee, and allows the commissioner to determine the frequency of inspections.

Subd. 7. Recovery of reinspection cost. If the commissioner finds a violation of public health violations during an inspection, requires the licensee to pay for all costs associated with any reinspections, and specifies what those costs include.

Subd. 8. Reciprocity fee. Establishes fees for licensees submitting applications for reciprocity recognition of a materials license issued by other state or the NRC: for a period of 180 days or less, one-half the established application fee; and for 181 days or more, the entire established application fee.

Subd. 9. Fees for license amendments. Establishes fees that must be paid if a licensee wishes to amend a license.

30 **License, permit, and survey fees.** Amends § 144.122. Modifies the following licensing fees charged by the commissioner of health:

- JCAHO hospitals, from $1,017 to $7,055;
- non-JCAHO hospitals, from $762 plus $34 per bed to $4,680 plus $234 per bed;
- nursing homes, from $78 plus $19 per bed to $183 plus $91 per bed;
- outpatient surgical centers, from $517 to $1,512;
- boarding care homes, from $78 plus $19 per bed to $183 plus $91 per bed; and
- supervised living facilities, from $78 plus $19 per bed to $183 plus $91 per bed.

31 **Summer health care interns.** Amends § 144.1464. Expands the summer health care intern program to include nursing facilities and home care providers as allowable sites. Eliminates the requirement that participating entities pay interns within a specified wage range, and eliminates the requirement that applicants provide facilities with a letter of recommendation from a health occupations or science educator. Allows the program to accept interns who intend to complete health care training programs, as well as two- or four-year degree programs.

32 **Program.** Amends § 144.148, subd. 2. Increases the grant limit for rural hospital capital improvement grants from $300,000 per hospital to $500,000 per hospital. Also allows certain rural hospitals that meet additional criteria to obtain up to $1,500,000 in grant funds for a capital improvement project. The additional criteria that must be met are being the only hospital in a county, having 25 or fewer beds and a specific net operating margin, being located in a medically underserved area or health professional shortage area, serving significant numbers of migrant workers, and having not received a rural hospital capital improvement grant before July 1, 1999. Currently three hospitals-those in Warren, Wheaton, and Arlington-meet the additional criteria and would be eligible for grants of up to $1,500,000.

33 **Promotion of health care and long-term care careers.** Adds § 144.1499. Requires the commissioner of health, in consultation with an organization representing health care employers, long-term care employers, and educational institutions, to make grants to qualifying consortia for intergenerational programs to encourage middle and high school students to work and volunteer in health care and long-term care settings. Specifies criteria for programs.

34 **Dentists loan forgiveness.** Adds § 144.1502. Establishes a loan forgiveness program for dentists who care for substantial numbers of state public program participants and uninsured patients.

Subd. 1. Definition. Defines qualifying educational loans.

Subd. 2. Creation of account; loan forgiveness program. Establishes a dentist education account

in the general fund, and directs the commissioner of health to use money from the fund to establish a loan forgiveness program for dentists who care for substantial numbers of state public program participants and other low- to moderate-income uninsured patients.

Subd. 3. Eligibility. Establishes eligibility requirements for participation in the program, and requires students accepted into the program to serve at least three years during which at least 25 percent of the dentists's yearly patient encounters are state public program enrollees or patients receiving sliding fee schedule discounts. If fewer than 14 applications are submitted by dental students, allows the commissioner to consider applications from licensed dentists.

Subd. 4. Loan forgiveness. Allows the commissioner to accept up to 14 applicants per year for the program. Requires the commissioner to give preference to applicants who have attended dentistry school in Minnesota and who are closest to completing their training. For each year that a participant meets the service obligations, up to four years, the commissioner shall make annual disbursements of $10,000 per year, not to exceed the lesser of $40,000 or the balance of the qualifying loans.

Subd. 5. Penalty for nonfulfillment. If a participant does not fulfill the service obligations, requires the commissioner to collect from the participant the entire amount of loan payments made under the program, plus interest. Directs this money to be deposited in the dentist education account.

Subd. 6. Suspension or waiver of obligation. Makes payment or service obligations cancel on a participant's death. Authorizes the commissioner to waive or suspend payment or service obligations in certain cases of disability, and directs the commissioner to evaluate other requests for suspension or waivers on a case-by-case basis.

35 **Vital records surcharge.** Amends § 144.226, subd. 4. Reduces from $3 to $2 the surcharge that applies for each copy of a certified or noncertified birth or death record. Eliminates the June 30, 2002 sunset on this surcharge, making it permanent.

36 **Expenditures.** Amends § 144.395, subd. 2. In a subdivision governing expenditures from the tobacco use prevention and local public health endowment fund, increases-from $1.1 million to $1.25 million-the amount of each annual appropriation that the commissioner may use for base level funding for the department's tobacco prevention and control programs and activities.

37 **Restricted construction or modification.** Amends § 144.551, subd. 1. Exempts from the hospital construction moratorium, a hospital construction project involving the addition of up to eight new beds to an existing 100-bed hospital in Otter Tail County.

38 **Fees.** Amends § 144.98, subd. 3. Modifies fees for certification as an environmental laboratory and establishes new fees for certification in certain test categories. The base certification fee is raised from $500 to $1,200, and the fee for laboratories outside the state that require an on-site survey is raised from $1,200 to $2,500. Authorizes the assessment of change fees and variance fees. Prohibits a laboratory from being certified until all fees are paid.

39 **Statement of rights.** Amends § 144A.44, subd. 1. Adds to the home care bill of rights the requirement that home care providers give recipients of services at least 10 days' advance notice of termination of service by the provider, except in cases: (a) where the recipient engages in conduct that alters the conditions of employment or creates an abusive or unsafe work environment; or (b) an emergency for the informal caregiver or a significant change in recipient condition results in service needs that exceed the provider agreement and which cannot be safely met by the provider.

40 **License required.** Amends § 144A.4605, subd. 4. Amends a subdivision establishing licensing

requirements for various establishments, to require an assisted living home care provider to comply with the disclosure requirements in section 57 of this act, if the provider gives specialized care or services to patients with Alzheimer's disease or related disorder. Makes this section effective October 1, 2001.

41 **Registration information.** Amends § 144D.03, subd. 2. To register as a housing with services establishment an establishment must verify compliance with the disclosure requirements in section 57 of this act if the provider gives specialized care or services to patients with Alzehemier's disease or related disorder. Makes this section effective October 1, 2001.

42 **Contents of contract.** Amends § 144D.04, subd. 2. Requires elderly housing with services contracts to include the toll-free phone number for the complaint line of the office of ombudsman for older Minnesotans. Makes this section effective October 1, 2001.

43 **Contracts in permanent files.** Amends § 144D.04, subd. 3. Provides that elderly housing with services contracts, including the written disclosures required under section 57 of this act that apply to providers that give specialized care or services to patients with Alzheimer's disease or a related disorder, must be made available for on-site inspection by the commissioner. Makes this section effective October 1, 2001.

44 **Other laws.** Amends § 144D.06. Requires housing with services establishments to comply with the disclosure requirements in section 57. Makes this section effective October 1, 2001.

45 **Suicide prevention.** Adds § 145.56. Establishes suicide prevention activities to be undertaken by the commissioner of health.

Subd. 1. Suicide prevention plan. Directs the commissioner to refine, coordinate, and implement the state's suicide prevention plan using an evidence-based public health approach focused on prevention, in collaboration with the listed commissioners and organizations.

Subd. 2. Community-based programs. Directs the commissioner to establish a grant program to fund community-based programs to provide education, outreach and advocacy services to populations at risk of suicide; to educate natural community helpers and gatekeepers on how to prevent suicide; to educate school staff, parents, and students in kindergarten through grade 12 on suicide prevention and intervention strategies; and to educate populations at risk of suicide and others on other aspects of suicide and mental illness.

Subd. 3. Workplace and professional education. Directs the commissioner, in collaboration with employer and professional associations, unions, and safety councils, to promote the use of employee assistance and workplace programs to support employees with psychiatric illnesses and substance abuse disorders and refer them to services. Also directs the commissioner to assist local public health and community-based professionals in implementing best practices for suicide prevention.

Subd. 4. Collecting and reporting suicide data. Directs the commissioner to coordinate with other relevant agencies to collect, analyze, and annually report to the public on Minnesota-specific data on suicide and suicidal behaviors.

Subd. 5. Periodic evaluations; biennial reports. Directs the commissioner to evaluate the outcomes of implementing the state's suicide prevention plan, and to make biennial reports of the results of those evaluations, beginning July 1, 2002, to the chairs of the House and Senate health and human services policy and finance committees.

46 **Duties.** Amends § 145.881, subd. 2. Adds to the duties of the maternal and child advisory task

force, the duty of reviewing the measures used to define the variables of the funding distribution formula every two years and making recommendations for changes to the commissioner.

47. **Community clinic grants.** Adds § 145.9268. Establishes a grant program for community clinics that serve as safety-net providers.

Subd. 1. Definition. Defines eligible community clinic.

Subd. 2. Grants authorized. Directs the commissioner to award grants to eligible community clinics to ensure the ongoing viability of Minnesota's clinic-based safety net providers, support the capacity of clinics to serve low-income populations, reduce uncompensated care burdens, or provide for improved infrastructure. Requires grants to be awarded to clinics in metro and rural areas of the state, and requires geographic representation in grant awards among all regions of the state.

Subd. 3. Allocation of grants. To receive a grant, requires an eligible community clinic to apply to the commissioner. Specifies what the application must include. Directs the commissioner to establish criteria to evaluate applications, and lists some criteria that must be used. Specifies that failure to provide the requested information disqualifies an applicant. Limits grants to $300,000 or less per eligible community clinic. Lists criteria that the commissioner must use to give preference to grant applications.

Subd. 4. Evaluation and report. Requires the commissioner to evaluate the overall effectiveness of the grant program. Also requires the commissioner to biennially report to the legislature on priority areas for grants and recommendations for changing these areas.

48 **Eliminating health disparities.** Adds § 145.928. Establishes a program to eliminate health disparities, administered by the commissioner of health.

Subd. 1. Goal; establishment. States that it is the goal of the state to reduce by 50 percent by 2010, disparities in infant mortality rates and child and adult immunization rates for American Indians and populations of color as compared with rates for whites. Directs the commissioner to establish a grant program to address health disparities in infant mortality, breast and cervical cancer screening, HIV/AIDS and sexually transmitted infections, immunizations, cardiovascular disease, diabetes, and accidental injuries and violence.

Subd. 2. State-community partnerships; plan. Directs the commissioner to consult with the listed groups and develop and implement a comprehensive, coordinated plan to reduce health disparities in the listed priority areas.

Subd. 3. Measurable outcomes. Requires the commissioner, in consultation with the listed community partners, to establish measurable outcomes to achieve the goal in subdivision 1 and to determine the effectiveness of grants awarded. Requires the outcomes to be developed before any funds are distributed.

Subd. 4. Statewide assessment. Requires the commissioner to use and enhance current statewide assessments of the risk behaviors associated with the listed priority areas to establish a baseline for measuring the statewide effect of activities funded under this section. Directs the commissioner to conduct the assessment so results can be compared with national data.

Subd. 5. Technical assistance. Directs the commissioner to provide technical assistance to grant applicants to ensure submitted proposals are likely to be successful, and to grant recipients to identify the best strategies to use to reduce health disparities. Also directs the commissioner to help grant recipients evaluate local community activities.

Subd. 6. Process. Directs the commissioner, in consultation with the partners listed in subdivision 2, to develop criteria and procedures to allocate grants under this section. Requires grant recipients to coordinate activities with other grant recipients in the recipient's service area.

Subd. 7. Community grant program; immunization rates and infant mortality rates. Directs the commissioner to award grants for local or regional projects to reduce racial and ethnic health disparities in infant mortality rates and adult and child immunization rates. Allows up to 20 percent of funds to be awarded as planning grants. Lists who may be considered an eligible applicant. Lists project criteria to which the commissioner will give priority when awarding grants.

Subd. 8. Community grant program; other health disparities. Directs the commissioner to award grants for local or regional projects to reduce racial and ethnic disparities in morbidity and mortality in the following areas: breast and cervical cancer, HIV/AIDS and sexually transmitted infections, cardiovascular disease, diabetes, and accidental injuries and violence. Allows up to 20 percent of funds to be awarded as planning grants. Lists who may be considered an eligible applicant. Lists project criteria to which the commissioner will give priority when awarding grants.

Subd. 9. Health of foreign-born persons. Directs the commissioner to distribute funds to community health boards for health screening and follow-up services for tuberculosis for foreign-born persons. Requires the commissioner to distribute funds according to the following formula: $1,500 per foreign-born person with pulmonary TB, $500 per foreign-born person with extrapulmonary TB, $500 per month of directly observed therapy provided by the community health board for each uninsured foreign-born person with TB, and $50 per foreign-born person. Requires the amounts paid to be proportionately increased or decreased to fit the actual amount appropriated for that fiscal year.

Subd. 10. Tribal governments. Directs the commissioner to award grants to tribal governments to implement community interventions to reduce health disparities in the listed priority areas. Requires community interventions to be targeted to achieve outcomes established, and requires tribal governments to submit proposals to the commissioner and demonstrate partnerships with local public health entities. Directs the commissioner, in consultation with the tribal governments, to establish the distribution formula.

Subd. 11. Coordination. Directs the commissioner to coordinate the projects funded under this section with other efforts to avoid duplication.

Subd. 12. Evaluation. Directs the commissioner to conduct a biennial evaluation of the community grant programs funded under this section.

Subd. 13. Report. Requires biennial reports, beginning in 2003, on the projects funded under this section and the results of the biennial evaluations. Specifies what the report must include.

Subd. 14. Supplantation of existing funds. Prohibits funds distributed under this section from being used to replace current county or tribal expenditures.

49 **Establishment.** Amends § 145A.15, subdivision 1. Amends a subdivision governing targeted home visiting programs to reduce child abuse, neglect, and juvenile delinquency, by providing that no new grants may be awarded for these home visiting programs after June 30, 2001, and allowing grant contracts in effect as of July 1, 2001 to continue until they expire.

50 **Expiration.** Adds subd. 5 to § 145A.15. Makes the section governing funding for the targeted home visiting programs to reduce child abuse, neglect, and juvenile delinquency expire June 30, 2003.

51 **Establishment.** Amends § 145A.16, subd. 1. Amends the subdivision establishing a grant program to fund universally offered home visiting programs, by providing that no new grants may be awarded for these programs after June 30, 2001, and making competitive grant contracts in effect as of July 1, 2001 expire December 31, 2003.

52 **Expiration.** Adds subd. 10 to § 145A.16. Makes the section governing a grant program to fund universally offered home visiting programs expire December 31, 2003.

53 **Family home visiting programs.** Adds § 145A.17. Establishes a program operated by the commissioner of health to fund family home visiting programs.

Subd. 1. Establishment; goals. Directs the commissioner to establish a program to fund family home visiting programs, and lists goals for the programs. Specifies that family home visiting programs must serve families at or below 200 percent of federal poverty guidelines and other families at risk. Requires programs to give priority to families in need of services, including families with the listed characteristics.

Subd. 2. Allocation of funds. Makes community health boards and tribal governments eligible for funds under this section. For distribution of funds to community health boards, requires each board to receive $25,000 per year, and requires remaining funds to be distributed according to the formula in section 256J.625, subd. 3. Requires the commissioner, in consultation with tribal governments, to establish a distribution formula for tribal governments.

Subd. 3. Requirements for programs; process. Before receiving an allocation, requires a community health board or tribal government to submit a proposal to the commissioner that identifies the populations that will be served. Lists activities that programs that receive funds must perform. Prohibits home visiting funds from being used to provide medical services, allows the commissioner to establish an administrative cost limit for recipients of funds, and requires the commissioner to specify outcome measures to fund recipients when the funds are distributed. Establishes data practices provisions for data held by home visiting programs.

Subd. 4. Training. Requires the commissioner to establish training requirements for home visitors and minimum supervision requirements. Lists topics that must be included in the training.

Subd. 5. Technical assistance. Requires the commissioner to provide administrative and technical assistance to each program, and allows the commissioner to request research and evaluation support from the University of Minnesota.

Subd. 6. Outcome measures. Directs the commissioner to establish outcomes to determine the impact of family home visiting programs on the listed areas, and on any additional goals or measures established by the commissioner.

Subd. 7. Evaluation. Requires the commissioner to conduct ongoing evaluations of the programs funded under this section. Requires cooperation by community health boards and tribal governments. As part of the evaluations, requires the commissioner to rate the impact of the programs on the outcomes listed in subdivision 6 and to determine whether home visiting programs are the best way to achieve qualitative goals for the program. If they are not the best way to achieve these goals, requires the commissioner to provide the legislature with alternatives.

Subd. 8. Report. Beginning January 15, 2002, requires the commissioner to biennially report to the legislature on the family home visiting programs funded under this section.

Subd. 9. No supplanting of existing funds. Provides that funding provided under this section cannot be used to replace nonstate funds being used for home visiting services as of July 1, 2001.

54. **Establishment fees; definitions.** Amends § 157.16, subd. 3. Modifies license fees for food, beverage, and lodging establishments and resorts, with the new fees effective January 1, 2002. Specifies that the license fee for a new operator previously licensed under this chapter for the same calendar year is half the appropriate annual fee, plus any penalty. Also, the license fee for operators opening or after October 1 is half the appropriate annual fee, plus any penalty. Specifies that school food and beverage services are not exempt from these fees.

55 **Exemptions.** Amends § 157.22. Amends a section listing exemptions from the licensing and inspection requirements for food, beverage, and lodging establishments, to specify that the food code does not apply to home schools in which children are provided instruction at home.

56 **Local regulations.** Amends § 326.38. Authorizes the Metropolitan Airports Commission to adopt local regulations on plumbing permits, bonds, approval of plans, and plumbing inspections, provided these regulations do not conflict with the plumbing standards on the same subject established by the commissioner of health.

57 **Disclosure of special care status required.** Adds § 325F.691. Establishes written disclosure requirements for housing with services establishments that have a special program or special unit for people with Alzheimer's disease or other dementias. Makes this section effective October 1, 2001.

Subd. 1. Persons to whom disclosure is required. Defines special care unit as a housing with services establishment that secures, segregates, or provides a special program or unit for residents with a diagnosis of probable Alzheimer's disease or a related disorder, or promotes the establishment as providing specialized care for patients with these disorders. Requires all special care units to provide a written disclosure to the commissioner of health (if requested), the office of ombudsman for older Minnesotans, and each person seeking placement within a special care unit or that person's authorized representative before a contract is entered into.

Subd. 2. Content. Lists what the written disclosure must include: a statement of overall philosophy and how it reflects the special needs of the residents being served; criteria for determining who may reside in the special unit; the process used for assessment and establishment of the service plan or agreement; staffing credentials and duties and job descriptions; physical environment characteristics that specifically address the needs of these residents; frequency and type of programs and activities for residents; involvement of families and availability of family support programs; fee schedules for additional services; and a statement that residents will be given written notice 30 days before changes in the fee schedule.

Subd. 3. Duty to update. If there is a substantial change in the content of the disclosures required under subdivision 2, requires the change to be reported to the parties listed in subdivision 1 when it is made.

Subd. 4. Remedy. Allows the attorney general to seek remedies established in section 8.31 (including injunctive relief and payment of civil penalties of up to $25,000) for repeated and intentional violations of this section. Specifies that a private right of action is not created.

58 **Recommendations; incentives for magnet hospitals.** Directs the commissioner of health to develop recommendations for incentives to increase the number of magnet hospitals in Minnesota, and requires recommendations to be reported to chairs of the relevant committees by December 1, 2001.

59 **Study; factors influencing patient care and patient safety.** Directs the commissioner of health, in consultation with relevant stakeholders, to identify major factors influencing patient care and

safety. Requires the report to be coordinated with other studies on health quality and patient safety authorized in 2001. Requires a report of the study's findings to the chairs of the relevant committees by February 15, 2002.

60 **Study; impact of workforce shortage on health care costs.** Directs the commissioner of health to study the effects of the health care workforce shortage and its impact on health care costs. Requires a report of findings and recommendations to the chairs of the relevant committees by February 15, 2002.

61 **Medications dispensed in schools study.** Directs the commissioner of health, in consultation with the Board of Nursing, to study the relationship between the Nurse Practice Act and a statute governing the administration of medications in schools, and the activities authorized under these sections. Directs the commissioner to make recommendations on statutory changes needed to promote student health and safety in administering medications in schools. Requires the commissioner to convene a work group to assist in the study and recommendations. Requires the recommendations to be submitted to the legislature by January 15, 2002.

62 **Repealer.** Paragraph (a) repeals a subdivision sunsetting the rural hospital capital improvement grant program (repealing the sunset makes the program permanent). Paragraph (b) repeals a subdivision authorizing the commissioner of health to suspend an immunization requirement if the requirement is not necessary to protect public health, and a section establishing the bone marrow donor education program. Paragraph (a) is effective the day following final enactment.

Article 2: Health Care

Overview

This article contains provisions related to health care programs administered by the commissioner of human services. Selected provisions in the article:

Raise the prescription drug program income limit for enrollees age 65 and over to 135 percent of the federal poverty guidelines, and raise the income limit for enrollees under age 65 to 120 percent of the poverty guidelines (sections 7 and 8).

Modify the MA earned income disregard for families with children (sections 16 and 18).

Provide extended eligibility under MA for employed persons with disabilities (sections 19 and 28).

Establish a uniform asset limit for MA and MinnesotaCare (sections 20 and 67).

Raise the base MA income standard to 100 percent of poverty, effective July 1, 2001 for aged, blind, or disabled individuals and effective July 1, 2002 for families and children (section 21). Raise the MA income standard for children age one through 18 to 170 percent of poverty, effective July 1, 2002 (section 25).

Raise the excess income (spenddown standard) under MA for families and children to 100 percent of the poverty guidelines effective July 1, 2002, and raise the excess income standard in stages for aged, blind, or disabled persons, to 75 percent of the poverty guidelines effective July 1, 2002 (section 24).

Provide MA coverage for home-based intensive early intervention behavior therapy for children with autism, effective January 1, 2003 (section 31).

Establish a new intergovermental transfer for nonstate, government hospitals, to provide funding for higher hospital rates, increased DRG payments for nonmetro hospitals, forgiveness of small rural hospital overpayments, rural hospital capital improvement grants, and community clinic grants (section 46).

Raise the GAMC income and excess income standards in stages, to 75 percent of the poverty guidelines effective July 1, 2002 (section 56).

Provide a 12-month exemption from MinnesotaCare premiums for children with family incomes that do not exceed 217 percent of poverty (section 65).

1 **Applicability.** Amends § 62A.095, subd. 1. Clarifies that when a health plan is providing coverage under a contract with the commissioner of human services any third party payments are primary and subject to the right of subrogation under Minnesota Statutes, section 256B.37 and the lien provisions under chapters 256, 256B, 256D, and 256L.

2 **Transfers from the commissioner of human services.** Amends § 62J.692, subd. 7. Distributes the $2.537 million transferred from capitation rates under section 50 as follows: (1) 50 percent to the University of Minnesota board of regents for primary care initiatives; (2) 24 percent to Hennepin County Medical Center for clinical medical education; and (3) 26 percent for clinical medical education innovation grants under section 3. Provides that if federal approval is not obtained for matching funds, 100 percent of the transfer shall be used for primary care initiatives under clause (1).

3 **Clinical medical education innovation grants.** Amends § 62J.692, by adding subd. 7a. Directs the commissioner of health to award grants to teaching institutions and clinical training sites for projects to increase dental access for the underserved and promote innovative clinical training of dental professionals. Lists factors to be considered in awarding grants and requires the commissioner to periodically evaluate priorities in awarding grants.

4 **Condition.** Amends § 137.38, subd. 1. Requires the board of regents of the University of Minnesota, if it accepts the amount transferred under section 2 for primary care initiatives, to comply with the duties for which the transfer is made.

5 **Limited authorization for dental hygienists.** Amends § 150A.10, subd. 1a. Authorizes dental hygienists to be employed or retained by a health care facility to perform certain dental hygiene services without the patient first being examined by a dentist. Requires the dental hygienist to have two years practical experience with a licensed dentist within the preceding five years and have entered into a collaborative agreement with a licensed dentist that designates authorization for the services preformed by the dental hygienist. Permits a dentist to enter into a collaborative agreement with up to four dental hygienists. Requires that the agreement be maintained by the dentist and dental hygienist and made available to the board of dentistry if requested. Defines "health care facility" and "collaborative agreement."

6. **Specific powers.** Amends § 256.01, subd. 2. Gives the commissioner of human services authority to collect the MA prescription drug rebate for drugs dispensed or administered in an outpatient setting. Requires the commissioner to incorporate cost reimbursement claims from the greater Twin Cities United Way into the federal claims processes and regulations and to disburse any reimbursements to the greater Twin Cities United Way.

7. **Eligibility.** Amends § 256.955, subd. 2a. Effective January 1, 2002, raises the prescription drug program income limit for Medicare enrollees age 65 and older to 135 percent of the federal poverty guidelines.

8. **Eligibility.** Amends § 256.955, subd. 2b. Effective July 1, 2002, raises the prescription drug program income limit for Medicare enrollees under age 65, to 120 percent of the federal poverty guidelines.

9. **Purchasing alliance stop-loss fund.** Adds § 256.956. Establishes a stop-loss fund to reimburse health insurers for certain claims paid on behalf of employees in purchasing alliances.

   Subd. 1. Definitions. Defines terms used in the bill. The key definitions involve defining "qualifying employer" as one having one to ten employees or being a sole proprietor or farmer, and defining "qualifying purchasing alliance" as one serving an area of out-state Minnesota, not including Duluth. Allows purchasing alliances to enroll employers after July 1, 2001, with enrollment ending by December 31, 2003.

   Subd. 2. Creation of account. Creates a new account in the general fund to establish a stop-loss fund, administered by the commissioner of human services. This fund would reimburse health insurers for certain claims paid in connection with employees of employers in the purchasing alliance. The claims would be those that are above the threshold established in subdivision 3. The money in the fund is to come from legislative appropriations.

   Subd. 3. Reimbursement. Provides that the reimbursement to insurers from the stop-loss fund would be 90 percent of claims paid between $30,000 and $100,000 in a year for any qualifying employee.

   Subd. 4. Request process. Specifies the procedure for health insurers to request reimbursement from the stop-loss account.

   Subd. 5. Distribution. Provides that claims will be paid after the end of the year. If there is not enough money in the fund, the claims will be paid pro rata. If more money is in the fund than is needed, the surplus is carried over to the next calendar year.

   Subd. 6. Data. Requires the health insurers to provide data requested by the commissioner of employee relations. Classifies that data as private or nonpublic.

   Subd. 7. Delegation. Permits the commissioner of human services to delegate duties under this section.

   Subd. 8. Report. Requires the commissioner of commerce to study the extent to which this stop-loss fund increases the availability of employer-subsidized health coverage in the areas served by the purchasing alliances.

   Subd. 9. Sunset. Provides a January 1, 2005 sunset for this section.

10. **Retired dentist program.** Adds § 256.958. Requires the commissioner to establish a program to reimburse retired dentists providing volunteer services for the cost of license fees and malpractice insurance.

11. **Dental practice donation program.** Adds § 256.959. Establishes a dental practice donation program.

    Subd. 1. Establishment. Requires the commissioner of human services to establish a dental practice donation program that coordinates the donation of a dental practice with a practicing dentist willing to take over the donated practice.

    Subd. 2. Qualifying dental practice. Requires the dental practice to be donated to meet the following requirements:

(1) must be owned by the donating dentist;

(2) must be located in a designated underserved area of the state; and

(3) must be equipped with the basic dental equipment necessary to maintain a dental practice.

Subd. 3. Coordination. Requires the commissioner to coordinate the donation of the practice to a qualified charitable organization if it meets the required criteria and there is a dentist who is interested in entering into an agreement to practice at the donated practice site.

Subd. 4. Donated dental practice agreement. Requires the dentist accepting the donated practice to enter into an agreement with the charitable organization to maintain the dental practice for a minimum of five years at the donated practice site. The agreement must include the terms for the recovery of the donated dental practice if the accepting dentist does not fulfill the service commitment. Any costs associated with the operation of the practice during the five-year service commitment time period are the responsibility of the accepting dentist.

12. **Hospital surcharge.** Amends § 256.9657, subd. 2. Provides that the hospital surcharge is not an allowable cost for purposes of MA rate setting.

13. **Greater Minnesota payment adjustment after June 30, 2001.** Amends § 256.969, by adding subd. 26. For MA admissions for specified DRGs occurring after June 30, 2001, requires the commissioner to pay hospitals located outside of the seven-county metro area at the higher of: (1) the hospital's current rate, exclusive of disproportionate population and hospital payment adjustments; or (2) 90 percent of the average payment rate for hospitals in the seven-county metropolitan area, exclusive of disproportionate population and hospital payment adjustments. (This provision also applies to GAMC fee-for-service rates, since MA hospital payment provisions apply to that program unless specifically stated. DHS adjusts capitation rates to reflect fee-for-service rate increases.)

14. **Contract for administrative services for American Indian children.** Amends § 256B.04, by adding subd. 1b. Allows the commissioner to contract with Indian tribes to provide early and periodic screening, diagnosis, and treatment outreach services.

15. **Families with children.** Amends § 256B.055, subd. 3a. Effective July 1, 2002, allows MA to be paid for a person who is: (1) a child under age 18; (2) age 18 if a full-time student in secondary school or in the equivalent level of vocational or technical training, and reasonably expected to complete the program before reaching age 19; (3) the parent of a dependent child, including a pregnant woman; or (4) the caretaker relative of a dependent child.

16. **Income and assets generally.** Amends § 256B.056, subd. 1a. Effective July 1, 2001, prohibits increases in social security benefits from being counted as income until July 1 of each year. Effective upon federal approval, for children eligible under TEFRA or a home and community-based waiver for which eligibility is determined without regard to parental income, excludes child support payments and social security payments from income. Effective July 1, 2002, replaces the current law earned income disregard for families and children with the new earned income disregard established in section 18.

17. **Aged, blind, and disabled income methodology.** Amends § 256B.056, by adding subd. 1b. Effective July 1, 2001, provides that the $20 general income disregard allowed by SSI is included in the MA income standard for the aged, blind, and disabled, and is not allowed as a deduction for these individuals.

18. **Families with children income methodology.** Amends § 256B.056, by adding subd. 1c. (a) Effective July 1, 2002, for children age one through five with countable family incomes no greater than 170 percent of poverty, allows 21 percent of countable income to be disregarded for up to four months. (This has the effect of establishing a gross income standard of 217 percent of poverty for the first four months.)

    (b) Effective July 1, 2002, for families with children with incomes up to 100 percent of poverty, allows 17 percent of countable income to be disregarded for up to four months. (This has the effect of establishing a gross income standard of 120 percent of poverty for the first four months.)

    (c) If the disregard has been applied for four months, provides that the disregard cannot be applied again until the wage earner's income has not been considered in determining MA eligibility for 12 consecutive months.

19. **Asset limitations for elderly and disabled individuals.** Amends § 256B.056, subd. 3. Effective upon federal approval, provides that for a person who no longer qualifies for MA as an employed person with a disability due to loss of earnings, assets allowed while eligible for MA as an employed person with a disability are not considered for 12 months for purposes of MA eligibility, as long as the individual's total assets do not exceed the asset limit for the MA for employed persons with disabilities eligibility category ($20,000 after specified exclusions).

20. **Asset limitations for families and children.** Amends § 256B.056, by adding subd. 3a. Effective July 1, 2002, modifies the asset limit for families and children under MA. Sets the asset limit at $30,000 in total net assets for a household of two or more persons, and $15,000 for a household of one person. Excludes as countable assets those assets excluded under the AFDC state plan, and also excludes:

    (1) household goods and personal effects;

    (2) capital and operating assets of a trade or business of up to $200,000;

    (3) one motor vehicle for each person of legal age who is employed or seeking employment;

    (4) one burial plot and all other burial expenses equal to the SSI asset limit;

    (5) court-ordered settlements of up to $10,000;

    (6) individual retirement accounts and funds; and

    (7) assets owned by children.

21. **Income.** Amends § 256B.056, subd. 4. Effective July 1, 2001, increases the MA income standard for persons who are aged, blind, or disabled to 100 percent of the federal poverty guidelines. Effective July 1, 2002, sets the base MA income standard for families and children at 100 percent of the federal poverty guidelines.

22. **Income verification.** Amends § 256B.056, subd. 4b. Requires the commissioner or county agency to use electronic verification as the primary method of income verification under MA.

23. **Excess income.** Amends § 256B.056, subd. 5. Makes a conforming change related to the changes to the excess income standard made in section 24.

24. **Excess income standard.** Amends § 256B.056, by adding subd. 5c. (a) Provides that for the first year, the excess income (spenddown) standard for families and children remains at the level specified in current law (133 and 1/3 percent of the AFDC standard in effect on July 16, 1996, increased by three percent effective July 1, 2002; this is between 67 to 69 percent of the federal

poverty guidelines, depending on household size). Effective July 1, 2002, this standard is increased to 100 percent of the federal poverty guidelines.

(b) Effective July 1, 2001, sets the excess income (spenddown) standard for persons who are aged, blind, or disabled at 70 percent of the federal poverty guidelines. Effective July 1, 2002, sets this standard at 75 percent of the federal poverty guidelines.

25. **Children.** Amends § 256B.057, subd. 2. Effective July 1, 2002, sets the MA income standard for children one through 18 at 170 percent of the federal poverty guidelines. (This does not apply to children eligible under current law at a higher standard).

26. **Qualified Medicare beneficiaries.** Amends § 256B.057, subd. 3. Provides that increases in social security benefits for qualified Medicare beneficiaries are not to be counted as income until July 1 of each year.

27. **Waiver of maintenance of effort requirement.** Amends § 256B.057, subd. 7. Updates a cross-reference to MA asset standards for children, to reflect the changes made in section 20.

28. **Employed persons with disabilities.** Amends § 256B.057, subd. 9. Effective November 1, 2001, extends a person's medical assistance eligibility for up to four months, if the person is eligible as an employed person with disabilities and is temporarily unable to work, and is without earned income due to a medical condition as verified by a physician or has involuntarily lost employment. Also modifies the premium schedule for persons eligible for MA as employed persons with disabilities, effective November 1, 2001.

29. **Certain persons needing treatment for breast or cervical cancer.** Amends § 256B.057, by adding subd. 10. Effective July 1, 2002, allows medical assistance to be paid for a person who: has been screened for breast or cervical cancer by the Minnesota breast and cervical cancer control program using program funds; needs treatment for breast or cervical cancer; meets the income eligibility guidelines for the Minnesota breast and cervical cancer control program; is under age 65; is not otherwise eligible for MA; and is not otherwise covered by health insurance. Specifies that MA covers only services provided during the time the person is being treated for cancer. Specifies that a person is eligible even if the person does not meet specified MA income and asset eligibility criteria.

30. **Telemedicine consultations.** Amends § 256B.0625, subd. 3b. Removes the July 1, 2001 sunset for MA coverage of telemedicine consultations.

31. **Intensive early intervention behavior therapy services for children with autism spectrum disorders.** Amends § 256B.0625, by adding subd. 5a. Effective January 1, 2003, provides MA coverage for home-based intensive early intervention behavior therapy for children with autistic spectrum disorders. Specifies eligibility requirements, covered services, supervision and other requirements, and payment rates.

32. **Drugs.** Amends § 256B.0625, subd. 13. Makes several changes related to reimbursement for prescription drugs.

    Provides an honorarium of $100 per meeting plus reimbursement for mileage to members of the drug formulary committee.

    Places in statute the current dispensing fees for intravenous solutions, cancer chemotherapy products, and total parenteral nutritional products.

    Allows MA to reimburse drugs that have had their wholesale prices reduced due to actions of the National Association of Medicaid Fraud Control Units at the average wholesale price

(AWP), rather than AWP minus 9 percent.

Reduces reimbursement for drugs administered in outpatient settings from AWP to AWP minus 5 percent.

33. **Drug utilization review board.** Amends § 256B.0625, subd. 13a. Increases from $50 to $100 per meeting the honorarium provided to members of the drug utilization review board, and provides reimbursement for mileage.

34. **Transportation costs.** Amends § 256B.0625, subd. 17. Increases mileage reimbursement for special transportation services from $1.20 to $1.40 per mile. Also makes changes in terminology.

35. **Payment for ambulance services.** Amends § 256B.0625, subd. 17a. Requires the medical assistance program to pay for ambulance services provided on or after July 1, 2001, at the greater of: (1) the current Medicare reimbursement rate; or (2) the MA payment rate in effect July 1, 2000.

36. **Access to medical services.** Amends § 256B.0625, subd. 18a. Provides MA coverage for oral language interpreter services when provided by a health care provider to an enrolled recipient with limited English proficiency.

37. **Other clinic services.** Amends § 256B.0625, subd. 30. Effective January 1, 2001, allows federally qualified health centers and rural health clinics to elect to be paid under the federal prospective payment system or an alternative payment methodology based on 100 percent of cost.

38. **Indian health services facilities.** Amends § 256B.0625, subd. 34. Allows the commissioner to receive a 100 percent federal match for MinnesotaCare payments to facilities of the Indian health service and tribal facilities, for enrollees eligible for federal financial participation. Provides that MinnesotaCare payments for enrollees not eligible for federal financial participation shall be at the regular MA rate.

39. **Targeted case management services.** Amends § 256B.0625, by adding subd. 43. Provides MA coverage for case management services to vulnerable adults and persons with developmental disabilities who are not receiving home and community-based waiver services.

40. **Increased employment.** Amends § 256B.0635, subd. 1. Effective July 1, 2002, increases the income standard for extended MA to 100 percent of the federal poverty guidelines for persons who lose MA eligibility due to an increase in hours of employment, employment income, or loss of an earned income disregard.

41. **Increased child or spousal support.** Amends § 256B.0635, subd. 2. Effective July 1, 2002, increases the income standard for extended MA to 100 percent of the federal poverty guidelines for persons who lose MA eligibility due to the collection of child or spousal support.

42. **Presumptive eligibility for certain persons needing treatment for breast or cervical cancer.** Adds § 256B.0637. Effective July 1, 2002, makes MA available during a presumptive eligibility period for persons needing treatment for breast or cervical cancer eligible for MA under section 256B.057, subdivision 10. Specifies that presumptive eligibility begins on the date an entity designated by the commissioner determines that the person meets the eligibility criteria based on preliminary information, and ends on the date a determination is made as to eligibility. If an application for MA is not submitted by the last day of the month following the month during which the determination is made, makes presumptive eligibility end on the last day of the month.

43. **Participation required for reimbursement under other state health care programs.** Amends § 256B.0644. Clarifies that patients seen by a provider on a volunteer basis at a location other than the provider's usual place of practice may be considered in meeting the 20 percent participation

requirement.

44. **Targeted case management services for vulnerable adults and persons with developmental disabilities.** Adds § 256B.0924. Effective January 1, 2002, provides MA coverage of targeted case management for vulnerable adults and persons with developmental disabilities.

Subd. 1. Purpose. States the purpose of the targeted case management program for vulnerable adults and persons with developmental disabilities, which is to decrease the need for more costly services by providing case management services.

Subd. 2. Definitions. Provides the definitions for the program.

Subd. 3. Eligibility. Provides the eligibility criteria for the program participants.

Subd. 4. Targeted case management service activities. Specifies what activities are included in targeted case management services.

Subd. 5. Provider standards. Makes county boards or providers who contract with the county eligible for medical assistance reimbursement for adult targeted case management services. Specifies provider qualifications.

Subd. 6. Payment for targeted case management. Paragraphs (a) to (d), detail how different providers will receive payment for services.

> **Paragraph (e)** provides that the nonfederal share of the costs for targeted case management must be provided by the recipient's county of responsibility from sources other than federal funds or funds used to match other federal funds.
>
> **Paragraph (f)** allows the commissioner to suspend, reduce, or terminate reimbursement to a provider that does not meet the reporting or other program requirements.
>
> **Paragraph (g)** requires the commissioner to 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.
>
> **Paragraph (h)** provides that payments to counties for targeted case management expenditures under this section must only be made from federal earnings from services provided under this section. Payments to contracted vendors must include both federal earnings and the county share.
>
> **Paragraph (i)** provides that payments made under this section must not be made to the state treasurer.
>
> **Paragraph (j)** specifies that payment for targeted case management services when a recipient is in a nursing facility, intermediate care facility, or hospital is limited to the last 180 days of the recipient's's residency in that facility and may not exceed more than six months in a calendar year.
>
> **Paragraph (k)** prohibits duplication of payments for targeted case management services.
>
> **Paragraph (l)** provides that any growth or increase in costs are the responsibility of the county.

Subd. 7. Implementation and evaluation. Requires the commissioner, in consultation with county boards, to establish the program specified in subdivisions 1 to 6. The commissioner is required to establish performance measures to evaluate the effectiveness of the targeted case management

services. If the county fails to meet the performance measures, the commissioner may authorize contracted providers other than the county based on the standards in subdivision 5.

45. **Additional portion of nonfederal share.** Amends § 256B.19, subd. 1c. Modifies an existing intergovernmental transfer (IGT-2), by including the amount that would have been collected from the intergovernmental transfer repealed in section 76, and using some of the proceeds to increase capitation payments to metropolitan health plan, to reflect higher than average medical education costs.

46. **Additional intergovernmental transfers; hospital payments.** Adds § 256B.195. Establishes a new intergovernmental transfer for non-state, government hospitals.

    Subd. 1. Federal approval required. Makes this section, community clinic grants under Article 1, section 47, and increased non-metro hospital DRG payments under section 13 contingent on federal approval and on current payment by governmental entities of intergovernmental transfers.

    Subd. 2. Payments from governmental entities. Effective July 15, 2001, requires governmental entities to make the following monthly payments: (1) Hennepin county, $2 million (of which 71 percent must be paid directly to Hennepin County Medical Center); and (2) Ramsey county, $1 million (of which 71 percent must be paid directly to Regions hospital).

    Subd. 3. Payments to certain safety net providers. (a) Effective July 15, 2001, requires the commissioner to make provide to Hennepin County Medical Center and Regions hospital any federal match obtained for the payments received under subdivision 2, to increase payments for MA admissions and to recognize higher MA costs in institutions that provide high levels of charity care.

    (b) Effective July 15, 2001, requires the commissioner to retain the following percentages of transfers under subdivision 2, for deposit into the general fund: (1) 18 percent, plus any federal matching funds, to be allocated in specified percentages for increased non-metro hospital DRG payments, small rural hospital overpayments, and rural hospital capital improvement grants; and (2) 11 percent, to fund community clinic grants.

    (c) States that this subdivision applies only to fee-for-service payments, and shall not increase capitation payments.

    (d) States that MA rate or payment changes, including those necessary to obtain federal financial participation for medical education and research costs, precede determination of the intergovernmental transfer amounts. Also provides that participation in the intergovernmental transfer program shall not offset any provider's receipt of MA payments increases, other than in relation to hospital-specific charge limits and limits on disproportionate share hospital payments.

    Subd. 4. Adjustments permitted. Allows the commissioner to adjust intergovernmental transfers and payments, based on determination of Medicare upper payment limits, hospital-specific charge limits, and hospital specific limitations on disproportionate share payments.

    Subd. 5. Inclusion of Fairview University Medical Center. Upon federal approval of the inclusion of Fairview university medical center in the nonstate government category, requires the commissioner to establish an intergovernmental transfer with the University of Minnesota, based on the increase in the Medicare upper payment limit due solely to the inclusion of Fairview, and limited by hospital-specific charge limits and the hospital-specific disproportionate share limit. Allocates proceeds of the transfer in the same manner as provided in subdivisions 2 and 3.

47. **Dental access grants.** Adds § 256B.53. Continues the grant program for initiatives to expand

dental access to public program recipients.

48. **Dental access advisory committee.** Adds § 256B.55. Establishes a dental access advisory committee. Requires the committee to make recommendations on activities and initiatives to increase access to dental services, and requires the commissioner of human services to report on the activities and recommendations of the advisory committee. Sunsets the committee on June 30, 2003.

49. **Limitation of choice.** Amends § 256B.69, subd. 4. Effective July 1, 2002, allows the commissioner to exempt from prepaid medical assistance, persons needing treatment for breast or cervical cancer eligible for MA under section 256B.057, subdivision 10.

50. **Medical education and research fund.** Amends § 256B.69, subd. 5c. Beginning July 1, 2001, requires the commissioner of human services to transfer each year, to the medical education and research fund, $2.537 million in capitation rates plus any federal matching funds.

51. **Dental services demonstration project.** Amends § 256B.69, by adding subd. 6c. Requires the commissioner to establish a dental services demonstration project in Crow Wing, Todd, Morrison, Wadena, and Cass counties to provide dental services to MA, GAMC, and MinnesotaCare recipients. Allows the commissioner to contract on a prepaid basis with a nonprofit health service plan corporation, an HMO, or a community integrated service network to provide services, or to administer a fee-for-service system.

52. **Alternative integrated long-term care services; elderly and disabled persons.** Amends § 256B.69, subd.23. Allows enrollment for persons with disabilities in the integrated long-term care services demonstration projects to remain voluntary.

53. **Hospital outpatient reimbursement.** Amends § 256B.75. Effective for services provided on or after July 1, 2002, requires rates based on the Medicare outpatient prospective payment system to be replaced by a budget neutral prospective payment system based on MA data. Requires DHS to present a proposal to the 2002 legislature to define and implement this provision.

54. **Physician and dental reimbursement.** Amends § 256B.76. Effective January 1, 2002, sets payment rates for diagnostic examinations and dental x-rays for children at the lower of the submitted charge or 85 percent of the median of 1999 charges. Effective January 1, 2002, allows the commissioner to designate dentists and dental clinics as critical access providers, and to increase reimbursement to these providers by 50 percent above what they would otherwise receive. Provide criteria for review and requires the commissioner to adjust prepaid health plan rates to reflect increased reimbursement to critical access providers. Also makes a technical change.

55. **Medical assistance demonstration project for family planning services.** Adds § 256B.78. Directs the commissioner, effective upon federal approval, to establish an MA demonstration project to determine whether improved access to prepregnancy family planning services reduces MA and MFIP costs.

56. **General assistance medical care; eligibility.** Amends § 256D.03, subd. 3. Sets the GAMC income and spenddown standards at the MA standard for aged, blind, or disabled persons (70 percent of the federal poverty guidelines, and effective July 1, 2002, 75 percent of the federal poverty guidelines).

57. **Right to discontinue cash assistance.** Amends § 256J.31, subd. 12. Effective July 1, 2002, eliminates a reference to automatic MA eligibility for MFIP participants who discontinue receipt of cash assistance.

58. **Notification of program.** Amends § 256K.03, subd. 1. Effective July 1, 2002, eliminates the

requirement that work first participants be notified of automatic MA eligibility.

59. **Eligibility for food stamps and child care.** Amends § 256K.07. Effective July 1, 2002, eliminates automatic MA eligibility for work first participants.

60. **Copayments for certain children.** Amends § 256L.03, by adding subd. 5a. For the period July 1, 2002 through June 30, 2006, requires children enrolled in MinnesotaCare who, under section 65, opt not to pay premiums, to pay $5 copayments for nonpreventive physician services, chiropractic services, and hospital outpatient services, as determined by the commissioner.

61. **Commissioner's duties.** Amends § 256L.05, subd. 2. Requires the commissioner or county agency to use electronic verification as the primary method of income verification in the MinnesotaCare program.

62. **Administration and commissioner's duties.** Amends § 256L.06, subd. 3. Requires MinnesotaCare enrollees to be disenrolled for nonpayment of premium effective for the calendar month for which the premium was unpaid. (Under current law, disenrollment occurs in the month following the month in which the premium was due.)

63. **Must not have access to employer-subsidized coverage.** Amends § 256L.07, subd. 2. Addresses a situation where a family or individual is enrolled in MinnesotaCare, disenrolls because employer subsidized coverage is made available through their employer, and then the employer terminates coverage within six months of offering coverage. Effective July 1, 2001, or upon receipt of federal approval, whichever is later, exempts a family or individual in this situation from the 18 month no employer subsidized coverage barrier if the family or individual reapplies to MinnesotaCare within six months of disenrollment.

64. **Coverage at Indian health service facilities.** Amends § 256L.12, by adding subd. 11. Allows the MinnesotaCare program to pay for health care services provided at Indian Health Service facilities and tribal facilities at an enhanced rate.

65. **Premium determination.** Amends § 256L.15, subd. 1. For the period July 1, 2002 through June 30, 2006, gives children with gross family incomes at or below 217 percent of poverty the option of not paying MinnesotaCare premiums for the first 12 months following termination from MA.

66. **Payment rates; services for families and children under the MinnesotaCare health care reform waiver.** Amends § 256L.16. Provides that a limitation on reimbursement for federally qualified health centers, rural health clinics, and Indian health service facilities does not apply for services provided to families with children on MinnesotaCare. (This provision is related to compliance with the terms of a federal waiver.)

67. **Limit on total assets.** Amends § 256L.17, subd. 2. Effective July 1, 2002, modifies the MinnesotaCare asset standard, by replacing existing MinnesotaCare asset exclusions with the MA asset standard exclusions in section 20.

68. **Empowerment zones; administrative simplification of welfare laws.** Amends Laws 1995, chapter 178, article 2, section 36. Eliminates the statutory authority for the commissioner to require income or eligibility reviews for extended MA no more frequently than annually, and to permit households to only report gifts worth $100 or more per month.

69. **Programs for senior citizens.** Amends Laws 1999, chapter 245, article 4, section 110. Extends from June 30, 2001 to January 15, 2002 the submission date for a DHS report on coordination of cash assistance and health care programs for elderly Minnesotans.

70. **Regulatory simplification for state health care program providers.** Requires the commissioner

of human services, in consultation with providers participating in state health care programs, to identify barriers to increased provider enrollment and retention, and implement procedures to address these barriers. Specifies areas to be examined and requires the commissioner to report to the legislature by February 15, 2002, on any changes that will be implemented and also to present recommendations for any necessary changes in state law.

71. **Expand dental auxiliary personnel; foreign trained dentists; dental clinics.**

    Subd. 1. Development. Requires the board of dentistry, in consultation with other interested parties, to develop new expanded duties for dental assistants and dental hygienists. These duties must include the placement of restorations and any other reversible procedures that the board deems appropriate. The board must establish educational qualifications necessary to perform the new duties. Requires the board to also make recommendations on permitting a foreign trained dentist to practice as a dental hygienist or as a dental restorative practitioner. Requires the board to submit proposed statutory changes to the legislature by January 15, 2002.

    Subd. 2. Dental clinics. Requires the commissioner of health to determine capital improvements needed to establish community-based dental clinics at MNSCU sites and submit the necessary capital improvement costs for start-up equipment and necessary infrastructure as part of the 2002 legislative capital budget requests.

72. **Notice of premium changes in the employed persons with disabilities program.** Requires the commissioner of human services to provide persons eligible for MA as employed persons with disabilities with two months prior notice of the new premium schedule.

73. **Additional training requirements.** Allows the board of dentistry to make recommendations to the 2002 legislature on additional training requirements for dental hygienists practicing under limited authorization.

74. **Eligibility exception to the prescription drug program.** For the period March 1, 2001 to June 30, 2002, modifies the definition of "qualified individual" for the prescription drug program to include certain individuals enrolled prior to March 1, 2001 in a Medicare risk plan to which an annual prescription drug benefit of $400 was added on March 1, 2001.

75. **MinnesotaCare eligibility for self-employed farmers.** Directs the commissioner of human services to seek federal approval to modify the definition of gross income for the farm self-employed, to exclude carryover loss and net operating loss. Upon receipt of federal approval, requires the commissioner to inform the legislature. Prohibits any change in the definition from being implemented without further action by the legislature.

76. **Repealer.** (a) Effective July 1, 2001, repeals section 256B.0635, subdivision 3 (extended MA for MFIP participants who discontinue cash assistance) and section 256B.19, subdivision 1b (intergovernmental transfer, referred to as IGT-1).

    (b) Effective January 1, 2003, repeals section 256L.02, subdivision 4 (requiring payments out of general fund for certain MinnesotaCare enrollees).

Article 3: Continuing Care

Overview

This article contains provisions related to health care services for persons with developmental and other

disabilities. Selected provisions in the article:

Change maximum grant levels for the consumer support grant program, allow exceptions to these grant levels, and make other modifications to the program (sections 9 to 15).
Provide MA coverage for relocation targeted case management and home care targeted case management (sections 20 to 28).
Modify requirements for the provision of private duty nursing, personal care assistant, and other home care services (sections 29 to 41).
Require the commissioner to establish a consumer-directed home care demonstration project for MA recipients receiving certain home care services (section 37).
Modify provisions related to the region 10 quality assurance project (sections 48 to 57).
Consolidate the authority for the commissioner to operate home and community-based waivers for persons under age 65 who need nursing home or hospital care, and require the commissioner to develop a common service menu for these waivers (sections 58 to 67).
Establish a pilot project to provide respite care payments to family adult foster care providers (section 71).

1. **Rate recommendation.** Amends § 245A.13, subd. 7. Updates a reference to the ICF/MR payment system, in a section dealing with review of rates for residential programs that are in receivership.

2. **Adjustment to the rate.** Amends § 245A.13, subd. 8. Clarifies and revises language related to rate adjustments for residential programs in receivership, and provides procedures for recovering amounts paid as rate adjustments, upon the sale, closure, or transfer of the residential program.

3. **Guaranteed floor.** Amends § 252.275, subd. 4b. Modifies the method of calculating county semi-independent living services grants, by eliminating the concept of the guaranteed floor minimum index and establishing a guaranteed floor of $1,000.

4. **Reserve account.** Amends § 254B.02, subd. 3. Provides that funds in the chemical dependency reserve account in excess of those needed to meet obligations for services cancel to the general fund, effective July 1, 2001.

5. **Local agency duties.** Amends § 254B.03, subd. 1. For calendar years 2002 and 2003, limits increases to chemical dependency vendors to three percent above the previous year's rate. For calendar years 2004 and 2005, prohibits rates from exceeding the rate in effect on January 1, 2003.

6. **Eligibility.** Amends § 254B.04, subd. 1. Specifies the income standards for persons eligible for, but not entitled to, chemical dependency fund services in terms of the federal poverty guidelines. Also provides that these groups of individuals shall be served within the limits of funds appropriated for each groups.

7. **Payments to improve services to American Indians.** Amends § 254B.09, by adding subd. 8. Allows the commissioner to set rates for tribal facilities providing chemical dependency services at the higher federally approved encounter rate, instead of the county-negotiated rate.

8. **Grants for case management services to persons with HIV or AIDS.** Amends § 256.01, by adding subd. 19. Allows the commissioner of human services to award grants for the development, implementation, and evaluation of case management services for persons with HIV. This provision is related to the transfer of funding for this activity from the department of health to DHS.

Sections 9 to 15 modify the consumer support grant program for persons with functional limitations. The program makes grants to eligible persons to purchase their own services directly from providers.

9. **Purpose and goals.** Amends § 256.476, subd. 1. Revises the statement of goals for the consumer support grant program. Eliminates a reference to the alternative care program, to conform to a change made elsewhere.

10. **Definitions.** Amends § 256.476, subd. 2. Clarifies terminology.

11. **Eligibility to apply for grants.** Amends § 256.476, subd. 3. Strikes language that allows persons eligible for alternative care services to apply for grants. (This reflects the availability of cash options under the alternative care program.) Strikes language limiting participation of nursing facility and ICF/MR residents.

12. **Support grants; criteria and limitations.** Amends § 256.476, subd. 4. Allows the commissioner to contract with another county or entity to provide consumer support grant services in counties that have not chosen to participate by July 1, 2002. Eliminates a reference to the alternative care program, to conform to a change made elsewhere.

13. **Reimbursement, allocations, and reporting.** Amends § 256.476, subd. 5. Deletes a provision in the consumer support grant program that allows a county to estimate a person's grant in cases where services under the former program are unavailable. The estimate is currently based on the county's estimate of the nonfederal dollars that would have been expended if their services would have been available. This section also allows a consumer support grant to equal 100 percent of the total nonfederal dollars expended on a client by the person's former program and deletes current law which sets the cap at 80 percent of the nonfederal share but allows for exceptions.

14. **Commissioner responsibilities.** Amends § 256.476, subd. 8. Strikes obsolete language.

15. **Consumer support grant program after July 1, 2001.** Amends § 256.476, by adding subd. 11. (a) Effective July 1, 2001, requires the commissioner to allocate consumer support grant resources to serve additional individuals based on a review of Medicaid authorization and payment information. Requires maximum grant levels to be based on actual payments or nonfederal dollars expended.

    (b) Allows persons receiving consumer support grants prior to July 1, 2001 to continue to receive the same grant amount.

    (c) Allows the commissioner to provide up to 200 exception grants, including grants provided under paragraph (b). Allows these grants to be based on the nonfederal share of the service authorization.

16. **Private duty nursing.** Amends § 256B.0625, subd. 7. Expands the circumstances under which private duty nursing can be provided outside the home, and allows private duty nursing services to be reimbursed when provided by the spouse, parent, or legal guardian.

17. **Personal care assistant services.** Amends § 256B.0625, subd. 19a. Expands the circumstances under which personal care services can be provided outside the home and eliminates the July 1, 2001 sunset on language that allows noncorporate legal guardians or conservators to be reimbursed for personal care services.

18. **Personal care.** Amends § 256B.0625, subd. 19c. Makes conforming changes related to supervision of personal care assistants.

19. **Mental health case management.** Amends § 256B.0625, subd. 20. Allows mental health case management to be provided up to 180 days before discharge from a facility, and for up to six months in a calendar year. (Current limits are 30 days and two months.)

    Sections 20 to 28 establish a targeted case management program for persons living in institutions who wish to return to the community and for recipients of home care services.

20. **Targeted case management.** Amends § 256B.0625, by adding subd. 43. Defines terms related to targeted case management under MA.

21. **Eligibility.** Amends § 256B.0625, by adding subd. 43a. Provides that MA eligible persons residing in institutions who chose to move to the community are eligible for relocation targeted case management services, and that MA eligible persons receiving home care services, who are not eligible for other MA reimbursable case management services, are eligible for home care targeted case management services beginning January 1, 2003.

22. **Relocation targeted case management provider qualifications.** Amends § 256B.0625, by adding subd. 43b. Specifies qualifications and certification standards for providers of relocation targeted case management.

23. **Home care targeted case management provider qualifications.** Amends § 256B.0625, by adding subd. 43c. Specifies qualifications and certification standards for providers of home care targeted case management.

24. **Eligible services.** Amends § 256B.0625, by adding subd. 43d. Lists the services eligible for MA reimbursement as targeted case management.

25. **Time lines.** Amends § 256B.0625, by adding subd. 43e. Requires case managers to visit a recipient eligible for relocation targeted case management within 20 working days of the request for a case manager. Allows recipients to obtain targeted relocation case management services from a home care targeted case management provider, if a county agency does not provide case management services as required. Requires recipients eligible for home care targeted case management to be assigned a case manager within 20 working days of requesting one.

26. **Evaluation.** Amends § 256B.0625, by adding subd. 43f. Requires the commissioner to evaluate the delivery of targeted case management.

27. **Contact documentation.** Amends § 256B.0625, by adding subd. 43g. Requires case managers to document each face-to-face and telephone contact with recipients and others involved in the individual service plan.

28. **Payment rates.** Amends § 256B.0625, by adding subd. 43h. Requires the commissioner to set payment rates for targeted case management, and specifies criteria for billing.

Sections 29 to 41 modify policy regarding home care services.

29. **Definition.** Amends § 256B.0627, subd. 1. Defines "activities of daily living," "complex and regular private duty nursing care," "health-related functions," "instrumental activities of daily living," and "telehome care."

30. **Services covered.** Amends § 256B.0627, subd. 2. Makes conforming changes.

31. **Personal care assistant services.** Amends § 256B.0627, subd. 4. Clarifies and broadens the scope of personal care assistant services that are eligible for reimbursement. Allows the recipient or responsible party to supervise the personal care assistant, or have a qualified professional provide this supervision.

32. **Limitation on payments.** Amends § 256B.0627, subd. 5. Increases the number of skilled nurse visits allowed without prior authorization from five to nine, and increases from one to two the number of skilled nurse visits per day that can be authorized. Makes conforming changes related to supervision. Corrects a cross-reference.

33. **Noncovered home care services.** Amends § 256B.0627, subd. 7. Allows home care services

provided to persons receiving Medicare hospice benefits to be reimbursed. Makes a technical change.

34. **Shared personal care assistant services.** Amends § 256B.0627, subd. 8. Modifies the language governing provision of shared personal care assistant services, to conform to changes made earlier that allow recipients or responsible parties to supervise the care provided.

35. **Fiscal intermediary option available for personal care assistant services.** Amends § 256B.0627, subd. 10. Renames the fiscal agent option the fiscal intermediary option and revises language governing this option. Clarifies that the recipient or responsible party supervises and evaluates the personal care assistant, with assistance as needed from a physician or qualified professional.

36. **Shared private duty nursing option.** Amends § 256B.0627, subd. 11. Clarifies that the payment rate for shared private duty nursing care is based on the regular private duty nursing rate.

37. **Consumer-directed home care demonstration project.** Amends § 256B.0627, by adding subd. 13. (a) Requires the commissioner, after receiving federal authority, to implement a consumer-directed home care demonstration project for MA recipients receiving certain home care services. Provides that the project will be administered locally.

    (b) Requires grants to persons receiving personal care, home health aide, or private duty nursing services for 12 consecutive months or more prior to enrollment to be determined on a case-by-case basis using historical expenditure data. Sets grant awards at 90 percent of the average monthly expenditure.

    (c) Requires grants to persons receiving the specified services for less than 12 consecutive months to be calculated on a case-by-case basis using the service authorization in place, adjusted by the average difference statewide between authorization and utilization. Sets grant awards at 90 percent of the estimated monthly expenditure.

    (d) Exempts the state, counties, and other entities from liability for damages, injuries, or liabilities sustained by participants in the consumer directed home care demonstration project.

    (e) Allows the commissioner to adjust the methodologies in paragraphs (b) and (c) to simplify administration, improve consistency, and maximize federal financial participation.

38. **Telehomecare; skilled nurse visits.** Amends § 256B.0627, by adding subd. 14. Allows MA coverage for skilled nurse visits provided via telehomecare. Specifies requirements for coverage.

39. **Therapies through home health agencies.** Amends § 256B.0627, by adding subd. 15. Allows provision of physical therapy and occupational therapy services to individuals receiving home care services. Allows services provided by physical therapy assistants and occupational therapy assistants to be reimbursed when services are provided under the direction of a therapist who is not on premise.

40. **Hardship criteria; private duty nursing.** Amends § 256B.0627, by adding subd. 16. Allows payment for extraordinary services that require specialized nursing skills provided by parents of minor children, spouses, and legal guardians providing private duty nursing care, if specified hardship criteria are met.

41. **Quality assurance plan for personal care assistant services.** Amends § 256B.0627, by adding subd. 17. Requires the commissioner to establish a quality assurance plan for personal care services that includes performance-based provider agreements, consumer input, ongoing monitoring, and an ongoing public process for development, implementation, and review of the plan.

42. **Preadmission screening of individuals under 65 years of age.** Amends § 256B.0911, by adding subd. 4a. Sets requirements for preadmission screening of individuals under age 65, and individuals under age 21, in order to ensure that individuals with disabilities or chronic illness are served in the most appropriate setting and have information necessary to make choices about home and community-based service options. Allows the commissioner to pay counties directly for face-to-face assessments of certain individuals under age 65.

43. **Statewide availability of consumer-directed community support services.** Amends § 256B.0916, by adding subd. 6a. Requires the commissioner to submit a federal waiver amendment to the home and community-based waiver for persons with developmental disabilities, to make consumer directed support services available in every county by January 1, 2002. Requires the commissioner to contract for the provision of these services in counties that decline to meet program requirements. Exempts the state, counties, and other entities from liability for damages, injuries, or liabilities sustained by persons receiving consumer-directed community support services.

44. **Annual report by commissioner.** Amends § 256B.0916, subd. 7. Changes the reporting date from October 1 to November 1 of each year, for the commissioner's report on county and state use of resources for the home and community-based waiver for persons with mental retardation and related conditions.

45. **Legal representative participation exception.** Amends § 256B.0916, subd. 9. Provides that legal representatives providing support under the home and community-based waiver for persons with mental retardation shall not be considered to have a service provider interest (this has the effect of allowing a broader group of individuals beyond those providing services under consumer directed community support services to be reimbursed).

46. **Federal waivers.** Amends § 256B.092, subd. 5. Requires the commissioner, in administering home and community-based waivers for persons with mental retardation and related conditions, to ensure that day services are not provided by a person's residential service provider, unless the person is offered a choice of providers and agrees to this in writing. In this situation, requires individual service plans to provide for contact with persons other than the residential service provider.

47. **Traumatic brain injury program duties.** Amends § 256B.093, subd. 3. Eliminates the requirement that the commissioner approve traumatic brain injury waiver eligibility and care plans.

Sections 48 to 57 modify provisions related to the region 10 quality assurance project.

48. **Quality assurance project established.** Amends § 256B.095. Extends the expiration date for the region 10 quality assurance project from June 30, 2001 to June 30, 2005 and removes references to a "pilot" project.

49. **Membership.** Amends § 256B.0951, subd. 1. Extends the expiration date for the region 10 quality assurance commission from June 30, 2001 to June 30, 2005.

50. **Commission duties.** Amends § 256B.0951, subd. 3. Requires the commissioner of human services, in consultation with the commission, to examine the feasibility of expanding the project and identify barriers to expansion. Requires a report to the legislature by December 15, 2004. Removes references to a pilot project.

51. **Commission's authority to recommend variances of licensing standards.** Amends § 256B.0951, subd. 4. Clarifies that the commission can recommend variances if the alternative licensing system does not "adversely" affect the health or safety of persons being served.

52. **Variance of certain standards prohibited.** Amends § 256B.0951, subd. 5. Clarifies that the commission can make recommendations related to alternatives or modifications of procedures, as well as rules. Removes a reference to a pilot project.

53. **Waiver of rules.** Amends § 256B.0951, subd. 7. Strikes an outdated reference to a waiver application.

54. **Federal waiver.** Amends § 256B.0951, by adding subd. 8. Requires the commissioner to seek federal authority to waive provisions of ICF/MR regulations to enable the demonstration and evaluation of the alternative quality assurance system for ICFs/MR under the project.

55. **Evaluation.** Amends § 256B.0951, by adding subd. 9. Requires the commission, in consultation with the commissioner, to conduct an evaluation of the alternative quality assurance system, and report to the commissioner by June 30, 2004.

56. **Notification.** Amends § 256B.0952, subd. 1. For each year of the project, requires region 10 counties that intend to join the project to give notice to the commissioners of human services and health by March 15, and to commit to participate until June 30, 2005. Requires counties already participating in the project to give notice of intent to continue by March 15, 2001, and to participate until June 30, 2005. Eliminates outdated language related to county participation.

57. **Appointment of quality assurance manager.** Amends § 256B.0952, subd. 4. Requires the quality assurance manager to provide reports from quality assurance teams to the commissioners of health and human services upon request. (Under current law, these reports are required to be provided to the commissioners.)

Sections 58 to 67 relate to MA waiver programs.

58. **Authority.** Amends § 256B.49, by adding subd. 11. Consolidates the authority for the commissioner to apply for home and community-based waivers to serve persons under the age of 65 who require nursing home or hospital care (the CADI, TBI, and CAC waivers).

59. **Informed choice.** Amends § 256B.49, by adding subd. 12. Requires the commissioner to provide persons requiring nursing facility or hospital care with information on home and community-based alternatives, and to be given a choice between institutional and community care.

60. **Case management.** Amends § 256B.49, by adding subd. 13. Requires recipients of home and community-based waivers to be provided case management services, and specifies requirements for these services.

61. **Assessment and reassessment.** Amends § 256B.49, by adding subd. 14. Sets requirements for assessment, reassessment, and screening of waiver clients, and allows waiver clients who become eligible before age 65 to remain eligible after age 65.

62. **Individualized service plan.** Amends § 256B.49, by adding subd. 15. Requires recipients of home and community-based waivered services to have a written plan of care and specifies requirements for this plan.

63. **Services and supports.** Amends § 256B.49, by adding subd. 16. Requires services and supports included in home and community-based waivers for persons with disabilities to meet federal requirements. Beginning January 1, 2003, requires the commissioner to establish a common service menu available to recipients regardless of age, disability type, or waiver program. Requires consumer directed community support services to be offered as an option to all persons eligible for the CADI, CAC, and TBI waivers, by January 1, 2002. Exempts the state, counties, and other entities from liability for damages, injuries, or liabilities sustained by persons receiving consumer

directed community support services.

64. **Cost of services and supports.** Amends § 256B.49, by adding subd. 17. (a) Requires the commissioner to ensure that average waiver expenditures do not exceed institutional costs.

    (b) Requires the commissioner to implement on January 1, 2002, methods of allocating to local agencies the waiver resources available for recipients with disabilities needing nursing home or hospital care.

    (c) Until the allocation methods are implemented, sets the annual allowable waiver reimbursement at the greater of: (1) the statewide average payment amount assigned to the recipient under the current waiver system, modified by any provider rate increases; or (2) an amount approved by the commissioner based on the recipient's extraordinary needs that cannot be met under the current reimbursement level. Allows the additional reimbursement to be used for environmental modifications; assistive technology and equipment; and increased costs for supervision, training, and support services.

    (d) Beginning July 1, 2001, requires medically necessary private duty nursing to be authorized as complex and regular care. Prohibits reductions in current reimbursement rates for RN or LPN waiver services.

65. **Payments.** Amends § 256B.49, by adding subd. 18. Requires the commissioner to reimburse vendors for waivered services using the invoice processing procedures of the Medicaid management information system.

66. **Health and welfare.** Amends § 256B.49, by adding subd. 19. Requires the commissioner to take necessary safeguards to protect the health and welfare of persons receiving waivered services.

67. **Traumatic brain injury and related conditions.** Amends § 256B.49, by adding subd. 20. Requires the commissioner to seek to amend the traumatic brain injury waiver to include, as eligible persons, individuals with an acquired or degenerative disease diagnosis where cognitive impairment is present, such as multiple sclerosis.

68. **Institution.** Amends § 256D.35, by adding subd. 11a. Defines institution for purposes of the MSA shelter needy payment.

69. **Shelter costs.** Amends § 256D.35, by adding subd. 18a. Defines shelter costs for purposes of the MSA shelter needy payment.

70. **Special needs.** Amends § 256D.44, subd. 5. Provides MSA recipients who are under the age of 65, relocating from an institution, and shelter needy (spend 40 percent or more of gross income on housing) with an additional payment equal to the maximum food stamp allotment for a single individual.

71. **Respite care pilot project for family adult foster care providers.** Adds section 256I.07. Requires the commissioner of human services to establish a pilot project to provide respite care payments to family adult foster care providers.

    Subd. 1. Program established. Requires the commissioner to establish a two-year respite care pilot project for family adult foster care providers in three counties.

    Subd. 2. Eligibility. States that a family adult foster care home provider who has been licensed for six months is eligible for 30 days of respite care per calendar year. Allows county social services agencies to waive the six-month licensing requirement in cases of emergency. Requires providers to take time away from their residents in order to receive respite payment from group residential

housing and alternative care.

Subd. 3. Payment structure. (a) Requires the respite care payment rate for a resident eligible only for group residential housing to be based on the group residential housing base rate and the maximum difficulty of care rate.

(b) Requires the respite care payment rate for a resident eligible for alternative care funds to be based on the alternative care foster care rate.

(c) Requires the respite care payment rate for a resident eligible for MA home and community-based waiver funds to be based on the group residential housing base rate.

(d) Provides that the total amount available to pay for respite care shall the based on the number of residents currently served and the source of funding for each resident. Requires respite care to be paid on a per diem basis and for a full day.

Subd. 4. Private pay residents. Requires payment for respite care for private pay residents to be arranged between the provider and the resident or resident's family.

72. **Task force.** Amends Laws 1999, chapter 152, section 1. Adds a representative of the commissioner of human services to the day training and habilitation task force.

73. **Semi-independent living services (SILS) study.** Requires the commissioner of human services to develop recommendations to revise the funding methodology for SILS, and report by January 15, 2002 to relevant committee chairs.

74. **Waiver request regarding spousal income.** Requires the commissioner of human services, by September 1, 2001, to seek federal approval to allow persons served under the CADI, CAC, and TBI waivers to choose either a waiver of deeming spousal income or the spousal impoverishment provisions.

75. **Federal waiver requests.** Requires the commissioner of human services to submit to the federal Health Care Financing Administration, by September 1, 2001, a request for a home and community-based services waiver for day services, including community inclusion, supported employment, and day training and habilitation services, for persons eligible for the home and community-based waiver for persons with mental retardation and related conditions.

76. **Repealer.** (a) Repeals section 256B.0951, subd. 6 (waiver of rules for region 10 commission).

    (b) Repeals sections 145.9245 (AIDS case management grants), 256.476, subd. 7 (consumer support grant program federal funding maximization), 256B.0912 (AC and waiver restructuring), 256B.0915, subds. 3a, 3b, and 3c (county-specific EW rates), and 256B.49, subd. 1-10 (home and community-based waiver for chronically ill children and disabled persons).

    (c) Repeals Laws 1995, chapter 178, article 2, section 48, subd. 6 (funding for county costs associated with minor caretaker evaluations).

    (d) Repeals specified rules related to the alternative care program and the CADI and CAC waivers.

Article 4: ConsumerInformation

Overview

This article contains provisions related to community-based services for the elderly. Selected provisions

in the article:

Expand the scope of consumer information and assistance services provided to seniors through the board on aging's senior linkage line (section 2).
Provide community services development grants (section 3) and community service grants (section 32).
Reorganize and revise law governing the preadmission screening program, and rename the program long-term care consultation services (sections 4 to 14).
Equalize rates between the alternative care and elderly waiver programs (sections 27 and 29) and modify requirements for these programs, in part to reflect the shift to a new resident assessment system (sections throughout).

1 **Expansion of bed distribution study.** Adds § 144A.35. Requires the commissioner of human services to monitor and analyze the distribution of older adult services, and report annually to the legislature on the geographic distribution of services, beginning June 1, 2002 and each January 15 thereafter.

2 **Consumer information and assistance; senior linkage.** Amends § 256.975, by adding subd. 7. Requires the board on aging to operate a statewide information and assistance service (the senior linkage line) to help elder Minnesotans and their families make informed choices about long-term care options and health care benefits. Specifies requirements for the service.

3 **Community services development grants program.** Adds § 256.9754. Requires the commissioner of human services to establish and administer a grant program for providers of older adult services.

Subd. 1. Definitions. Defines community, older adult services, and older adult.

Subd. 2. Creation. Establishes the community services development grants program within DHS.

Subd. 3. Purpose. Requires the commissioner to make grants available to communities, providers of older adult services, and consortia of providers, to establish older adult services. Grants may be used for capital costs, start-up and training, renovation, transportation, home-sharing, and other specified purposes.

Subd. 4. Eligibility. Requires a local match of 50 percent of project costs.

Subd. 5. Grant preference. Requires the commissioner, when awarding grants, to give preference to areas where nursing facility closures have occurred or are occurring. Allows the commissioner to award grants of up to $750,000 to the extent grants funds are available and applications approved. States that denial in one year does not preclude application in a subsequent year.

Sections 4 to 14 rename and restructure the preadmission screening program.

4. **Purpose and goal.** Amends § 256B.0911, subd. 1. Renames the preadmission screening program "long-term care consultation services" and states that the goal of the services is to assist persons with long-term or chronic care needs in making decisions and selecting options to meet their needs and reflect their preferences. Requires these services to be coordinated with the senior linkage services of the board on aging, the health care consumer assistance grant program, and services provided by other public and private agencies. Sections that follow make technical changes related to this name change and reorganize and revise the former preadmission screening statutes to reflect this broader emphasis.

5. **Definitions.** Amends § 256B.0911, by adding subd. 1a. (a) Defines "long-term care consultation

services" as including: (1) the provision of information on the availability of services; (2) an intake process; (3) assessment of individual needs; (4) assistance in identifying services to maintain an individual in the least restrictive environment; (5) provision of recommendations on cost-effective community services; (6) development of an individual's community support plan; (7) provision of information on eligibility for Minnesota health care programs; (8) preadmission screening; (9) preliminary determination of Minnesota health care program eligibility for individuals who need nursing facility level care; (10) provision of recommendations for nursing facility placement when no cost-effective community services are available; and (11) assistance to transition people back to the community after facility admission.

(b) Defines "Minnesota health care programs" as MA, the alternative care program, and the prescription drug program.

6. **Long-term care consultation team.** Amends § 256B.0911, subd. 3. Allows county boards to designate public health or social services as the lead agency for long-term care consultation services. Requires long-term care consultation teams to provide long-term care consultation services to all persons in their county who request the services, regardless of eligibility for Minnesota health care programs. Strikes language that is reinstated elsewhere and makes technical changes.

7. **Assessment and support planning.** Amends § 256B.0911, by adding subd. 3a. Requires persons requesting assessment, services planning, or other assistance to be visited by a long-term care consultation team within ten working days after the date on which an assessment was requested or recommended. Requires the team to conduct the assessment in a face-to-face interview, and specifies other requirements. Requires the team to provide the person, or the person's legal representative, with written recommendations for facility or community-based services, a written community support plan if the person chooses community-based services, and other specified information.

8. **Transition assistance.** Amends § 256B.0911, by adding subd. 3b. Requires long-term care consultation teams to provide transition assistance to persons residing in nursing facilities, hospitals, regional treatment centers, and ICFs/MR, including assessment, community support plan development, referrals to Minnesota health care programs, and referrals to housing assistance. Requires the county to develop transition processes with institutional social workers and discharge planners.

9. **Preadmission screening activities related to nursing facility admissions.** Amends § 256B.0911, by adding subd. 4a. Reorganizes language governing preadmission screening for nursing facility admissions, and clarifies state and federal requirements.

   (a) Requires all applicants to MA certified nursing facilities to be screened, except as provided in subdivision 4b (exemptions and emergency admissions). States that the purpose of screening is to determine the need for nursing facility care under paragraph (d) and to complete activities required under federal law related to mental illness and mental retardation under paragraph (b).

   (b) Requires persons with mental illness or mental retardation to be screened before admission regardless of exemptions, unless admission prior to screening is authorized by the local mental health authority, local developmental disabilities case manager, or the county agency according to Public Law 100-508. Specifies criteria for preadmission screening.

   (c) Allows the local county mental health authority or the state mental retardation authority to prohibit admission if the individual does not need nursing facility level care or needs specialized services.

(d) Requires the determination of need for nursing facility level care to be made according to criteria developed by the commissioner. Specifies requirements for inclusion or consultation with physicians or other personnel.

10. **Exemptions and emergency admissions.** Amends § 256B.0911, by adding subd. 4b. (a) Specifies persons who are exempt from federal screening requirements under subdivision 4a.

    (b) Specifies persons exempt from preadmission screening for purposes of determining the level of care.

    (c) Requires persons admitted to a nursing facility on an emergency basis, or from an acute care facility on a nonworking day, to be screened the first working day after admission.

    (d) Specifies when emergency admission to a nursing facility prior to screening is permitted.

11. **Screening requirements.** Amends § 256B.0911, by adding subd. 4c. (a) Allows persons to be screened for nursing facility admission by telephone or in a face-to-face consultation and lists categories of individual need.

    (b) Requires persons admitted on a nonemergency basis to a nursing facility to be screened prior to admission.

    (c) Requires the team to recommend case mix classifications when there is sufficient information. Authorizes the facility to conduct case mix assessments for persons for whom the county did not recommend a classification, or for persons admitted prior to a preadmission screening. States that the county retains responsibility for distributing case mix forms to the facility.

    (d) Requires county screening or intake activity to identify persons who may require transition assistance.

12. **Administrative activity.** Amends § 256B.0911, subd. 5. Makes conforming or technical changes.

13. **Payment for long-term care consultation services.** Amends § 256B.0911, subd. 6. Provides that payments for long-term care consultation services will be made to the two facilities nearest to the county seat, if a county has no nursing facility. In the event that the number of beds in a facility changes by 25 percent or more, DHS may adjust payments for long-term care consultation services. Allows the county to bill specified activities as case management services. Prohibits an individual or family member from being charged for an initial assessment or initial support plan development. Makes conforming changes.

14. **Reimbursement for certified nursing facilities.** Amends § 256B.0911, subd. 7. Prohibits a facility from billing a private pay individual for resident days that preceded the date of completion of screening activities. Makes conforming changes.

Sections 15 to 27 relate to the alternative care program

15. **Purpose and goals.** Amends § 256B.0913, subd. 1. Removes references to "frail" elderly and makes other revisions in existing language.

16. **Eligibility for services.** Amends § 256B.0913, subd. 2. Strikes obsolete provisions and clarifies existing language.

17. **Eligibility for funding for services for nonmedical assistance recipients.** Amends § 256B.0913, subd. 4.

    Sets the payment limit for the alternative care program, until the first day of the state fiscal

year in which the new resident assessment system is implemented, at 75 percent of the statewide weighted average monthly nursing facility rate for the case mix class to which the individual would be assigned under existing Minnesota rules, minus the individual's maintenance needs allowance.

Once the new system is implemented, sets this limit at the alternative care monthly cap for the case mix class to which the client would be assigned under existing Minnesota rules, in effect on the last day of the previous fiscal year, and adjusted by any legislatively adopted increase in rates for home and community-based services or nursing facilities.

Makes conforming changes related to long-term care consultation services.

Clarifies and revises existing language, and strikes obsolete language.

18. **Services covered under alternative care.** Amends § 256B.0913, subd. 5.

    Allows alternative care funding to be used for environmental modifications, and includes provision of "discretionary funds" in the definition of other covered services.

    Modifies language setting maximum payment rates for foster care services, assisted living services, and residential care services to conform to the changes made in subdivision 4.

    Places in the subdivision language governing procedures for cash payments under the alternative care program that was incorporated by cross-reference to the consumer support grant program.

    Clarifies and revises existing language, and strikes obsolete language and language that is in the state's waiver plan.

19. **Alternative care program administration.** Amends § 256B.0913, subd. 6. Allows the commissioner to contract with federally recognized Indian tribes to serve as the lead agencies responsible for local administration of the alternative care program.

20. **Case management.** Amends § 256B.0913, subd. 7. Clarifies current law, by prohibiting case managers from approving alternative care funding for a client in a setting in which the case manager cannot reasonably ensure the client's health and safety, and from approving a care plan in which the cost of services exceeds the alternative care program payment limit.

21. **Requirements for individual care plan.** Amends § 256B.0913, subd. 8. Eliminates the requirement that the lead agency verify to the commissioner that an individual's alternative care is not available through any public assistance or service program. Makes a technical change.

22. **Contracting provisions for providers.** Amends § 256B.0913, subd. 9. Eliminates the requirement that the lead agency document to the commissioner certain information related to provider contracts.

23. **Allocation formula.** Amends § 256B.0913, subd. 10. Clarifies language governing alternative care program allocations to counties and strikes obsolete language.

24. **Targeted funding.** Amends § 256B.0913, subd. 11. Changes from June 1 to November 1 of each year the date by which counties need to submit applications for targeted alternative care funding. and strikes unnecessary language.

25. **Client premiums.** Amends § 256B.0913, subd. 12. Clarifies provisions related to payment of premiums by alternative care clients. Requires the commissioner of human services to bill and collect alternative care premiums from clients. (Under current law, this is a county responsibility.)

Requires counties to record in the state's receivable system assessed premium amounts or the reason a premium has been waived, but provides an exception for alternative care pilot projects.

26. **County biennial plan.** Amends § 256B.0913, subd. 13. Makes conforming changes related to long-term care consultation services and strikes certain county biennial plan requirements.

27. **Payment and rate adjustments.** Amends § 256B.0913, subd. 14. Equalizes rates between the alternative care program and elderly waiver, by setting the rate limit for each alternative care services at the greater of the alternative care statewide maximum rate or the elderly waiver statewide maximum rate. Allows counties to negotiate individual service rates with vendors up to the statewide maximum. Also clarifies and revises language related to payment rates. Strikes language assessing a financial penalty against counties for collecting less than 50 percent of client premiums due (a conforming change related to the amendment to subd. 12).

Sections 28 to 30 relate to the elderly waiver program.

28. **Posteligibility treatment of income and resources for elderly waiver.** Amends § 256B.0915, subd. 1d. Strikes obsolete language.

29. **Limits of cases, rates, payments, and forecasting.** Amends § 256B.0915, subd. 3.

    Sets the monthly payment limit for the elderly waiver, until the first day of the state fiscal year in which the new resident assessment system is implemented, at the weighted average monthly nursing facility rate for the case mix class the individual would be assigned under existing Minnesota rules, minus the individual's maintenance needs allowance.

    Once the new system is implemented, sets this limit at the rate of the case mix class to which the client would be assigned under existing Minnesota rules, in effect on the last day of the previous fiscal year, and adjusted by any legislatively adopted increase in rates for home and community-based services or nursing facilities.

    Classifies environmental modifications as an allowable cost for elderly waiver clients.

    Modifies language setting maximum payment rates for assisted living and residential care services to conform to other changes made in this section.

    Equalizes rates between the elderly waiver and the alternative care program, by setting the rate limit for each elderly waiver service at the greater of the alternative care statewide maximum rate or the elderly waiver statewide maximum rate.

    Clarifies and revised existing language, and strikes obsolete language and language related to the waiver for persons with developmental disabilities.

30. **Reassessments for waiver clients.** Amends § 256B.0915, subd. 5. Strikes a reference to the waiver for persons with developmental disabilities.

31. **Contract.** Amends § 256B.0917, subd. 7. Provides that grants awarded under the living-at-home/block nurse program are to enable programs to continue or implement the living-at-home/block nurse program model. (Current law limits grants to programs currently operating.)

32. **Community service grants.** Amends § 256B.0917, by adding subd. 13. Authorizes grants to public and nonprofit agencies to strengthen the system of home and community-based services for elderly persons. Communities with a planned nursing facility closure are given priority for grants.

33. **Respite care.** Requires the Minnesota board on aging to report to the legislature by February 1, 2002, on the provision of respite care services on a sliding scale basis.

34. **Repealer.** Repeals provisions related to preadmission screening (§ 256B.0911, subd. 2, 2a, 4, and 9), the alternative care program (§ 256B.0913, subd. 3, 15a, 15b, 15c, and 16), and the elderly waiver (256B.0915, subd. 3a, 3b, and 3c). Also repeals rules for the preadmission screening and alternative care programs.

Article 5: Long-term Care System Reform andReimbursement

Overview

This article contains provisions related to reimbursement and regulation of long-term care facilities, and reimbursement of community-based providers. Selected provisions in the article:

Establish a new case mix assessment system for nursing facility residents, to be implemented between July 1, 2002 and January 1, 2003 (sections 2 and 28).
Increase the dollar threshold for nursing facility moratorium exceptions, make other changes in moratorium exception process requirements, and provide statutory exceptions to the moratorium (sections 3 to 8).
Establish requirements to govern the relocation of nursing facility residents (sections 9 and 10).
Require the commissioner of health to seek federal approval for an alternative nursing facility survey process (section 13).
Provide nursing facility rate increases (section 17), higher initial nursing facility rates (section 18), and rate adjustments for low rate facilities (section 19).
Establish a process for the voluntary closure of nursing facilities (section 27).
Provide rate increases for ICFs/MR (section 30) and community-based providers (section 37).
Require the commissioner of human services to develop a new nursing facility reimbursement system and report to the legislature by January 15, 2003, and prohibit the commissioner from implementing a performance-based contracting system prior to July 1, 2003 (section 35).

1 **Appropriateness and quality.** Amends § 144.0721, subd. 1. Eliminates the Minnesota Department of Health (MDH) quality of care assessments once the revised case mix system is implemented.

2. **Resident reimbursement classification.** Adds § 144.0724. Establishes a new case mix assessment system for nursing facility residents, based upon a 34 group, RUG-III model.

Subd. 1. Resident reimbursement classifications. Requires the commissioner of health to establish resident reimbursement classifications based upon resident assessments. Requires the classifications to be implemented after June 30, 2002, but no later than January 1, 2003.

Subd. 2. Definitions. Defines assessment reference date, case mix index, index maximization, minimum data set, representative, and resource utilization groups or RUG.

Subd. 3. Resident reimbursement classifications. (a) Requires resident reimbursement classifications to be based on the minimum data set or its successor. Directs the commissioner to establish resident classes according to the 34 group, RUG-III model. Requires the department of health to draft the facility manual for case mix classification and present the manual to the chairs of the health and human services legislative committees by December 31, 2001.

(b) Requires each resident to be assessed based upon information from the minimum data set according to the following general domains: extensive services, rehabilitation, special care, clinically complex status, impaired cognition, behavior problems, and reduced physical functioning.

(c) Requires the commissioner to establish resident classifications according to a 34 group model, based upon information on the minimum data set and within the general domains. Requires detailed descriptions of each resource utilization group to be provided in the facility manual for case mix classification. Specifies the 34 groups.

Subd. 4. Resident assessment schedule. Requires facilities to conduct and submit assessments in accordance with the federal assessment schedule for the minimum data set. Specifies timelines for new admission assessments, annual assessments, significant change assessments, and quarterly assessments.

Subd. 5. Short stays. Allows facilities to accept a default rate with a case mix index of 1.0, in lieu of an initial assessment for residents who stay less than 14 days. Allows residents who are admitted and readmitted on a frequent basis to be discharged on extended leave status that requires reassessment only in cases of significant change in resident status.

Subd. 6. Penalties for late or nonsubmission. Establishes a reduced rate, equal to the lowest rate for a facility, that applies when a facility fails to complete and submit assessments within seven days of the required timeline.

Subd. 7. Notice of resident reimbursement classification. Allows facilities to choose between two options for notifying residents of their case mix classifications.

Subd. 8. Request for reconsideration of resident classifications. Allows the resident, resident's representative, or nursing facility to request that the commissioner reconsider an assigned reimbursement classification. Requires the request to be submitted in writing within 30 days of receipt of a notice, and requires the commissioner to affirm or modify the original resident classification within 15 working days of receiving the request. Specifies other requirements for the reconsideration process.

Subd. 9. Audit authority. Directs the commissioner to audit the accuracy of resident assessments, through desk audits, on-site review of residents and their records, and interviews with staff and families. Gives the commissioner authority to conduct on-site audits without notice. Requires the commissioner to develop audit selection procedures, and specifies factors to be included.

Subd. 10. Transition. Allows classifications established under current law to be reconsidered under the provisions of current law.

3. **Findings.** Amends § 144A.071, subd. 1. Modifies a statement of legislative intent to conform with the increase in the dollar threshold for moratorium exceptions.

4. **Definitions.** Amends § 144A.071, subd. 1a. Specifies that construction costs for purposes of the moratorium includes the cost of new technology implemented as part of the construction project and includes a definition of technology.

5. **Moratorium.** Amends § 144A.071, subd. 2. Increases the dollar threshold above which nursing facilities need to obtain a moratorium exception, to $1,000,000 (current law specifies $750,000; this figure is indexed and is now $821,049.)

6. **Exceptions for replacement beds.** Amends § 144A.071, subd. 4a. Increases the moratorium dollar threshold to $1 million. Provides exceptions to the nursing home moratorium to allow:

   licensure and certification of beds in a facility that has undergone replacement or remodeling as part of a planned closure;

   licensure and certification of a total replacement project of up to 124 beds in Wilkin county

that are in need of relocation from a nursing home substantially destroyed by flood.

licensure of 9 additional rule 80 beds in a 240-bed nursing home in Duluth;

licensure and certification of up to 120 new beds to replace beds in a 98-bed facility in Anoka, provided the new facility is located in Anoka county, within four miles of the existing facility; and

transfer of up to 98 beds of a 129-bed facility in Anoka county that is closing, to a 122-bed facility in Columbia Heights or its affiliate, for placement on layaway.

7. **Request for proposals.** Amends § 144A.073, subd. 2. Adds a conforming reference to technology costs.

8. **Criteria for review.** Amends § 144A.073, subd. 4. Includes the extent to which a project increases the number of private or single bed rooms to the list of criteria the interagency long-term care planning committee must consider when evaluating moratorium exception proposals. Also eliminates an obsolete cross-reference.

9. **Nursing facility resident relocation.** Adds § 144A.161. Establishes procedures to protect and assist nursing facility residents during facility closures.

   Subd. 1. Definitions. Defines terms.

   Subd. 2. Initial notice from licensee. Requires the facility to notify specified governmental agencies when there is an intent to close, reduce, or change operations or services that would result in the relocation of residents. Specifies notice requirements.

   Subd. 3. Planning process. Requires the local agency to notify specified parties within five days of receipt of a notice to close, reduce, or change operations, and requires the local agency, licensee, and specified governmental entities to develop a relocation plan within 45 days of receipt of initial notice. Allows the commissioner of health to authorize the planning process to occur concurrent with the 60-day notice required to be provided to residents. Establishes requirements for the relocation plan.

   Subd. 4. Responsibilities of licensee for resident relocations. Makes the licensee responsible for the safe, orderly, and appropriate relocation of residents, and requires the licensee and facility staff to cooperate with government agencies.

   Subd. 5. Licensee responsibilities prior to relocation. Requires the licensee to establish an interdisciplinary team to coordinate and implement the plan, provide the local agency with specified information on each resident to be relocated, and consult with the local agency.

   Subd. 5a. Licensee responsibilities to provide notice. Requires the licensee to provide residents and other specified parties with at least 60 days' notice of a closure or reduction or change in operations. Specifies notice requirements.

   Subd. 5b. Licensee responsibility regarding medical information. Directs the licensee to request the attending physician to release medical information needed to update medical records and prepare required forms and discharge summaries.

   Subd. 5c. Licensee responsibility regarding placement information. Requires the licensee to assist residents in finding placements and prepare a resource list with several relocation options for each resident. Allows the Senior LinkAge line to make information relevant to relocation available through a Web site.

Subd. 5d. Licensee responsibility to meet with residents and families. Requires the licensee to conduct meetings to inform residents and other interested parties of the process for relocation.

Subd. 5e. Licensee responsibility for site visits. Requires the licensee to assist residents in making site visits, provide or arrange transportation for visits within a 50-mile radius, or within a larger radius if no suitable options are available within 50 miles, and provide written materials on new facilities and living options.

Subd. 5f. Licensee responsibility for personal property, personal funds, and telephone services. Requires the licensee to inventory personal possessions, and transfer these possessions within a 50-mile radius of the facility or within a larger radius if no suitable options are available within 50 miles. Also requires the licensee to account for and transfer personal funds, and to assist with the transfer and reconnection of service for telephones and other personal communication devices or services, and to pay for costs associated with reconnection.

Subd. 5g. Licensee responsibilities for final notice and records transfer. Requires the licensee to provide seven days' final written notice of relocation, to provide the receiving facility with resident records, and to consult with the receiving facility on special resident care needs.

Subd. 6. Responsibilities of the licensee during relocation. Requires the licensee to arrange or provide transportation to a new facility or placement within a 50-mile radius, or within a larger radius if no suitable options are available within 50 miles, and upon request, to provide a staff person to accompany the resident during transportation. Also requires the licensee to submit biweekly status reports to the commissioners of health and human services and to the local agency.

Subd. 7. Responsibilities of the licensee following relocation. Specifies responsibilities of the licensee related to resident records.

Subd. 8. Responsibilities of the local agency. Specifies responsibilities of the local agency related to the relocation process. These include participating in development of a relocation plan, providing written notice to residents and others on the county role in relocation, monitoring compliance with the plan, halting a relocation that endangers the resident, visiting relocated residents, and other specified duties.

Subd. 9. Penalties. Allows the commissioner of human services, upon recommendation of the commissioner of health, to eliminate a closure rate adjustment for violations of this section.

Subd. 10. Facility closure rate adjustment. Requires the commissioner of human services, upon the request of a closing facility, to provide the facility with a closure rate adjustment equal to a 50 percent payment increase, to pay for relocation costs and other costs related to closure. The increase is effective on the date the facility's occupancy decreases to 90 percent of occupancy days and can remain in effect for up to 60 days. Requires the commissioner to delay planned closure rate adjustments under section 27, to offset the cost of this rate adjustment.

Subd. 11. County costs. Requires the commissioner of human services to allocate up to $450 in total state and federal funds per nursing facility bed that is closing, within the limits of appropriations, for relocation costs incurred by counties under this section or section 27.

10. **Transfer of residents within facilities.** Adds § 144A.162. Requires the licensee to provide for the safe, orderly, and appropriate transfer of residents within the facility. Requires the licensee to minimize the number of intra-facility transfers needed to complete capital improvement projects or changes in operation, to provide reasonable accommodation to resident requests related to room transfers, and to provide notice to state ombudsmen of transfers meeting specified conditions.

11. **Reuse of facilities.** Adds § 144A.1888. Provides that any conversion or reuse of a nursing home that closes or that modifies its operations shall be considered a conforming use under local zoning laws if the facility converts to another long-term care service and serves fewer persons than before.

12. **Transition planning grants.** Adds § 144A.36. Requires the commissioner of health to establish and administer a transition planning grant program for nursing facilities.

    Subd. 1. Definitions. Defines eligible nursing home as a home licensed by MDH and participating in MA.

    Subd. 2. Grants authorized. Requires the commissioner to establish a grant program to assist facilities in developing strategic plans.

    Subd. 3. Allocation of grants. Establishes timelines for allocating grants.

    Subd. 4. Evaluation. Requires the commissioner to evaluate the program, and allows the commissioner to collect from homes information necessary for the evaluation.

13. **Alternative nursing home survey process.** Adds § 144A.37. Requires the commissioner of health to seek federal approval for an alternative process for nursing home surveys.

    Subd. 1. Alternative nursing home survey process. Requires the commissioner of health to seek federal approval to implement alternative procedures for the nursing home survey process. Prohibits implementation until funding is appropriated.

    Subd. 2. Survey intervals. Requires the commissioner to extend the time period between standard surveys up to 30 months, and provides that the requirement that the statewide average not exceed 12 months does not apply to the alternative survey schedule.

    Subd. 3. Compliance history. Requires the commissioner to develop a process to identify survey cycles for facilities based upon their compliance history. Provides criteria for this process and states that a facility with a finding of substandard care or immediate jeopardy cannot have a survey interval of greater than 12 months.

    Subd. 4. Criteria for survey interval classification. Sets requirements for public notice, modification of intervals, and obtaining information from residents and others in setting intervals.

    Subd. 5. Required monitoring. Sets criteria for monitoring visits. Requires at least one monitoring visit a year for each facility selected for a survey cycle of greater than 12 months.

    Subd. 6. Survey requirements for facilities not approved for extended survey intervals. Requires the commissioner to develop a process for surveying and monitoring facilities which require a survey interval of less than 15 months.

    Subd. 7. Impact on survey agency's budget. States that the alternative survey process must not result in any reduction in funding for the state survey agency.

    Subd. 8. Educational activities. Requires the commissioner to expand the state survey agency's ability to provide training and education for facilities, residents, and other entities.

    Subd. 9. Evaluation. Requires the commissioner to develop a process to evaluate the effectiveness of the alternative survey process.

14. **Innovations in quality demonstration grants.** Adds § 144A.38. Requires the commissioner of health and the commissioner of human services to establish a long-term care grant program that demonstrates best practices and innovation for long-term care service delivery and housing. Sets

criteria for the program and limits grants to $100,000 each.

15. **Contracts for services for ventilator-dependent persons.** Amends § 256B.431, subd. 2e. Modifies current law under which DHS may contract with nursing facilities to serve ventilator-dependent persons. Eliminates the requirement that the person must have been hospitalized for six months to be eligible under the contracting provision, requiring instead a hospitalization for an unspecified length of time. Sets the maximum negotiated rate at 200 percent of the case mix class K rate at the facility for persons admitted before July 1, 2001 who have their rate negotiated after that date, and at 300 percent of the case mix K rate at the facility for persons admitted on or after July 1, 2001.

16. **Special provisions for moratorium exceptions.** Amends § 256B.431, subd. 17. Eliminates the requirement that a project be authorized through the competitive moratorium exceptions process in order to receive higher investment-per-bed limits.

17. **Nursing facility rate increases beginning July 1, 2001, and July 1, 2002.** Amends § 256B.431, by adding subd. 31. For the next two rate years, requires the commissioner to provide three percent adjustments to the total operating payment rate of nursing facilities reimbursed under the cost-based and alternative payment systems.

18. **Payment during first 90 days.** Amends § 256B.431, by adding subd. 32. For rate years beginning on or after July 1, 2001, sets the total payment rate for a nursing facility under the cost-based or alternative payment systems, or any other payment system, at 120 percent of the facility's rate for each case mix class for the first 30 paid days, and at 110 percent of the facility's rate for each case mix class for the next 60 days. Beginning with day 91 after admission, sets the payment rate at the rate determined under the cost-based, alternative payment, or other relevant payment system. Provides that the subdivision applies to admissions occurring on or after July 1, 2001.

19. **Staged reduction in rate disparities.** Amends § 256B.431, by adding subd. 33. For the rate years beginning July 1, 2001 and July 1, 2002, sets rate floors for metro and nonmetro nursing facilities for each of the 11 case mix classifications. For metro facilities, the rate floor is set at the 38.2 percentile of all metro facilities. For nonmetro facilities, the floor is set at the 33.2 percentile of all facilities statewide, including metro facilities. Limits increases to 10 percent each year. Defines a facility as metro if it is located in Anoka, Carver, Dakota, Hennepin, Olmsted, Ramsey, Scott, or Washington counties, the cities of Moorhead or Breckenridge, or the Iron Range.

20. **Nursing facility rate increases beginning July 1, 2001, and July 1, 2002.** Amends § 256B.431, by adding subd. 34. Requires that two-thirds of the money resulting from the increase in section 17, and one-half the money resulting from the increases in sections 18 and 19, be used to increase the wages and benefits, and pay associated costs, of all employees except management fees, the administrator, and central office staff. Requires facilities to apply to the commissioner for that portion of the increases designated for wages and benefits, submit a distribution plan, and make a copy of the distribution plan available to all employees. Allows hospital attached nursing facilities to use the money to increase wages and benefits for employees providing shared services without regard to the specific distribution of work hours across facility type, if specified conditions are met. Also allows the commissioner to authorize facilities to raise per diem rates for private pay residents on July 1 to reflect the anticipated increase, if the amounts collected are placed in escrow until the MA rate is finalized.

21. **Exclusion of raw food cost adjustment.** Amends § 256B.431, by adding subd. 35. For rate years beginning on or after July 1, 2001, requires the commissioner to exclude raw food costs related to special diets based on religious beliefs, when arraying nursing facility payment rates to determine

future rate increases.

22. **Exemption from requirement for separate therapy billing.** Amends § 256B.433, subd. 3a. Excludes nursing facilities reimbursed under section 256B.431, the cost-based reimbursement system, from current restrictions on billing for therapy services.

    The current restrictions apply to nursing facilities that provide therapy services directly and to facilities that rent space to therapy providers. For facilities that provide their own therapy services, the facility per diem rate is reduced by any therapy revenues in excess of 108 percent of costs. For facilities that rent space, rental charges are limited to 108 percent of the recognized cost of that space.

    Under current law: (1) cost-based facilities in counties that do participate in PMAP are already exempt from these restrictions; and (2) facilities reimbursed under the alternative payment system and located in PMAP counties are exempt from the maximum therapy rent revenue provisions.

23. **Alternate rates for nursing facilities.** Amends § 256B.434, subd. 4. Requires nursing facility payment rates under the alternative payment system to be adjusted for increases in health department licensing fees. Provides that the inflation adjustment applies only to property costs for rate years beginning July 1, 2001 and July 1, 2002.

24. **Facility rate increases effective January 1, 2002.** Amends § 256B.434, by adding subd. 4c. For the rate period beginning January 1, 2002, and for the rate year beginning July 1, 2002, provides an 83-bed nursing facility in Morrison county with an increase of $2.54 in each case mix payment rate to offset property tax payments related to conversion to for-profit status.

25. **Facility rate increases effective July 1, 2001.** Amends § 256B.434, by adding subd. 4d. For the rate year beginning July 1, 2001, provides a 302-bed nursing facility in Hennepin county with an increase of 29 cents in each case mix payment rate to correct an error in the cost-reporting system.

26. **Rate increase effective July 1, 2001.** Amends § 256B.434, by adding subd. 4e. For a three year period beginning July 1, 2001, provides a 98-bed facility in Anoka county with a $10 increase in each case mix rate.

27. **Nursing facility voluntary closures; planning and development of community-based alternatives.** Adds § 256B.437. Establishes a nursing facility voluntary closure process.

    Subd. 1. Definitions. Defines terms.

    Subd. 2. Planning and development of community-based services. Requires the commissioner to establish a process to support the planning and development of community-based services. Establishes requirements for this planning process. Directs the commissioners of health and human services to provide data on long-term care facilities to counties, and requires counties to submit to the commissioner of human services, by October 15, 2001, a gaps analysis that identifies local service needs, new developments, and other issues. Also requires the analysis to be sent to the local area agency on aging and, if applicable, the local SAIL project, for review and comment. Requires annual addendums to biennial plans, that must include recommendations for the development of community-based services. Directs county boards to cooperate in the development of services with other counties. Requires the commissioners of health and human services, in cooperation with county boards, to report to the legislature each February 1, beginning February 1, 2002, on the development of community-based services, transition or closure of nursing facilities, and service gaps.

    Subd. 3. Applications for planned closure of nursing facilities. Requires the commissioner, by

August 15, 2001, to implement and announce a program for nursing facility closure or partial closure. Allows the commissioner to approve planned closures of at least 5,140 beds by June 30, 2003, less the number of beds in facilities that close without approved closure plans or have notified the commissioner of an intent to close. Allows facilities with an approved closure plan to assign a planned closure rate adjustment to another facility or facilities, or retain the adjustment in cases of partial closure. Allows facilities, including those without a closure plan or whose closure plan is not approved, to elect to have a planned closure rate adjustment or an equivalent amount used to provide equal rate adjustments to the five lowest rate facilities in the state development region. Specifies application criteria.

Subd. 4. Criteria for review of application. Establishes criteria to be considered by the commissioner in reviewing and approving closure proposals.

Subd. 5. Review and approval of proposals. Establishes an application review and approval process, under which proposals are approved or denied by the commissioner of human services, in consultation with the commissioner of health. Allows the commissioner of human services to appoint an advisory review panel.

Subd. 6. Planned closure rate adjustment. Provides a rate adjustment of $2,080 for each closed bed, which may be used for a property payment for a new facility or addition or as an operating payment rate adjustment.

Subd. 7. Other rate adjustments. States that facilities receiving planned closure rate adjustments are eligible for other rate increases provided by law.

Subd. 8. County costs. Requires the commissioner to allocate funds to counties for relocation costs as provided under section 9 (§ 144A.161, subd. 11).

28. **Implementation of a case mix system for nursing facilities based on the minimum data set.** Adds § 256B.438. Establishes a new case mix reimbursement system for nursing facilities, based upon a 34 group, RUG-III model.

Subd. 1. Scope. States that the section establishes the method and criteria to determine resident reimbursement classifications for nursing facilities, based upon the 34 group, RUG-III model. Requires reimbursement classifications to be implemented after June 30, 2002, but no later than January 1, 2003.

Subd. 2. Definitions. Defines assessment reference date, case mix index, index maximization, minimum data set, representative, and resource utilization groups or RUG.

Subd. 3. Case mix indices. Requires the commissioner of human services to assign a case mix index to each resident class, and requires the case mix indices assigned to each resident class to be published in the state register at least 120 days prior to implementation of the 34 group, RUG-III resident classification system. Requires an index maximization approach to be used and allows the commissioner to annually rebase case mix indices and base rates.

Subd. 4. Resident assessment schedule. Requires facilities to conduct and submit case mix assessments according to the schedule established by the commissioner of health, and specifies when classifications are effective.

Subd. 5. Notice of resident reimbursement classification. Requires facilities to provide notice to residents of their case mix classifications according to procedures established by the commissioner of health.

Subd. 6. Reconsideration of resident classification. Requires requests for reconsideration of

resident classifications to follow procedures established by the commissioner of health.

Subd. 7. Rate determination upon transition to RUG-III payment rates. Requires the commissioner of human services to determine payment rates at the time of transition to the RUG model in a facility-specific, budget-neutral manner, and specifies the methodology for this determination.

29. **Long-term care quality profiles.** Adds § 256B.439. Establishes a long-term care quality profiles system.

    Subd. 1. Development and implementation of quality profiles. Requires the commissioner of human services, in cooperation with the commissioner of health, to develop and implement a quality profile system for nursing facilities and, by July 1, 2003, for other long-term care services. The system must be designed to provide quality data to consumers, providers, and public and private purchasers of long-term care services.

    Subd. 2. Quality measurement tools. Requires the commissioners to identify and apply existing quality measurement tools.

    Subd. 3. Consumer surveys. Requires the commissioners, following identification of the measurement tool, to conduct surveys of long-term care service consumers in order to develop quality profiles of providers.

    Subd. 4. Dissemination of quality profiles. Requires the commissioners to begin disseminating the quality profiles by July 1, 2002.

30. **ICF/MR rate increases beginning July 1, 2001, and July 1, 2002.** Amends § 256B.501, by adding subd. 14. (a) For the rate periods beginning July 1, 2001, and July 1, 2002, requires the commissioner to provide 3.5 percent adjustments to the total operating payment rate of ICFs/MR.

    Of the increase, two-thirds must be used to increase employee wages and benefits and pay associated costs. As under current law, facilities must develop a wage plan and apply to the commissioner for the wage-related increase, and must make copies of the approved distribution plan available to all employees.

31. **Data management.** Amends § 626,557, subd. 12b. Modifies a current requirement in the vulnerable adults act that MDH and DHS prepare annual summaries of maltreatment reports involving licensed facilities. The new language requires a report to the legislature and the governor with specifics on the number of reports requiring investigation and the resolution of the investigations. The report must identify whether backlogs result in failure to meet statutory time frames for investigations and where additional funding and staff are required to provide adequate coverage.

32. **Facility certification.** Amends Laws 1995, chapter 207, article 3, section 21, as amended. Effective July 1, 2001, requires the commissioner of human services to fund the entire state share of MA costs for residential and day habilitation services provided to residents of an ICF/MR in Northfield. Under current law, the commissioner may transfer from each county's community service allocation an amount equal to one-half the state share of MA costs for services provided to clients for whom the county is financially responsible.

33. **State licensure conflicts with federal regulations.** Amends Laws 1999, ch. 245, art. 3, § 45. Extends from July 1, 2001 to July 1, 2003 the sunset for a provision allowing physicians to authorize longer intervals for checking incontinent residents.

34. **Moratorium exception process.** Amends Laws 2000, chapter 364, section 2. Extends for two years

a current requirement that MDH give priority in the administrative moratorium exception process to a proposal to build a replacement facility in the city of Anoka or within ten miles of the city of Anoka.

35. **Development of new nursing facility reimbursement system.** Requires the commissioner of human services to develop a new nursing facility reimbursement system, and report to the legislature by January 15, 2003. Outlines parameters for the new system. Prohibits the commissioner from implementing a performance-based contracting system for nursing facility reimbursement prior to July 1, 2003. (Under current law, a performance-based system must be implemented on July 1, 2001.)

36. **Minimum staffing standards report.** Requires the commissioners of health and human services to report to the legislature by January 15, 2002, on whether the current minimum nurse staffing standard should be translated to the RUG-III classification system, or whether different time-based standards should be established.

37. **Provider rate increases.** Requires the commissioner of human services to increase reimbursement rates by three percent each year of the biennium for specified community-based providers, and by 3.5 percent each year for day training and habilitation service providers. Requires providers to use two-thirds of the revenue received to increase wages and benefits and pay associated costs for all employees other than the administrator and central office staff. Requires providers to make copies of their plan for distributing increases to employees.

38. **Regulatory flexibility.** Requires the commissioners of health and human services, by September 1, 2001, to develop and disseminate a summary of federal regulations that place an undue burden on state flexibility with regard to regulation of nursing facilities and community long-term care services. Requires the commissioners to work with the federal Health Care Financing Administration and others to achieve maximum regulatory flexibility.

39. **Report.** Requires the commissioners of health and human services to report to the relevant legislative committees by January 15, 2003, on issues related to the nursing facility voluntary closure project.

40. **Instruction to revisor.** Instructs the revisor to delete references to section 144A.16, which is repealed in section 41.

41. **Repealer.** Repeals section 144A.16 (90-day notice of nursing facility reduction in operations) and nursing facility rules related to resident relocation. Also repeals section 256B.434, subd. 5. (This section allows facilities in the alternative payment system to elect to charge the Medicare rate to private pay residents who stay 100 days or less. If a private pay resident stays longer than 100 days, requires facilities to retroactively reduce the rate to the MA rate and reimburse the resident.)

Article 6: Workforce Recruitment and Retention

Overview

This article contains provisions related to long-term care system workforce issues. Provisions in this article:

Modify provisions related to the health care and human services worker training program (sections 1 to 5 and 8).
Increase nursing facility rates to pay for employee scholarships and provide job-related training in English as a second language (section 6).

Require DHS to seek waivers necessary to receive federal children's health insurance program (CHIP) funding to develop a long-term care employee health insurance program (section 7).

1 **Qualifying consortium.** Amends § 116L.11, subd. 4. Modifies the definition of "qualifying consortium" in the health care and human services worker training program.

2 **Grants.** Amends § 116L.12, subd. 4. Limits worker training grants to $400,000, to be consistent with other job skills partnership board (JSPB) programs, and it expands the worker training program beyond TANF funding, which is currently the only funding source, to include general fund appropriations and any other funding sources available to the board.

3 **Local match requirements.** Amends § 116L.12, subd. 5. Makes local match requirements in the worker training program consistent with other JSPB programs.

4 **Marketing and recruitment.** Amends § 116L.13, subd. 1. Requires recruitment strategies in the worker training program to include a process for modifying course work to meet the needs of non-English-speaking persons, where appropriate.

5 **Expedited grant process.** Adds § 116L.146. Allows the partnership board to authorize worker training program grants of up to $50,000, through an expedited process under certain circumstances.

6 **Employee scholarship costs and training in English as a second language.** Amends § 256B.431, by adding subd. 35. For the period July 1, 2001 through June 30, 2003, increases nursing facility reimbursement by 25 cents per day to pay for employee scholarships and provide job-related training on the job site in English as a second language.

7 **Chip waiver.** Requires DHS to seek the necessary waivers to receive federal children's health insurance program (CHIP) funds to develop a long-term care employee health insurance program.

8 **Repealer.** Repeals the following sections in the health care and human services worker training program:

- Section 116L.12, subdivision 2: Fiscal requirements.
- Section 116L.12, subdivision 7: Evaluation.

Article 7: Regulation of Supplemental Nursing Services Agencies

Overview

This article contains provisions related to the regulation of supplemental nursing services agencies (temporary nursing pools). The article requires background studies to be conducted on employees and controlling persons of temporary nursing pools (section 1), requires temporary nursing pools to be registered with the commissioner of health (sections 2 to 5), places limits on temporary nursing pool charges to nursing homes (section 6), and requires the commissioner of human services to report to the legislature on the use of temporary nursing pools (section 7).

1 **Background studies on licensees and supplemental nursing services agency personnel.** Amends § 144.057. Requires background studies to be conducted on employees and controlling persons of temporary nursing pools (called supplemental nursing services agencies in this legislation). Adds a cross reference. Clarifies that the commissioner's decision regarding a reconsideration of a disqualification is not the final administrative agency action in cases where the disqualification is: (1) based on a preponderance of evidence that the individual committed a disqualifying act; (2) based on a determination that the individual committed serious or recurring maltreatment; or (3) the individual is an employee of a public employer.

2 **Registration of supplemental nursing services agencies; definitions.** Adds § 144A.70. Defines terms.

3 **Supplemental nursing services agency registration.** Adds § 144A.71. Requires a person who operates a temporary nursing pool to register with the commissioner of health, provide requested information, and pay a fee.

4 **Registration requirements; penalties.** Adds § 144A.72. Establishes minimum requirements for registered temporary nursing pools, including a requirement that the pool document that temporary employees provided to health care facilities meet minimum licensing, training, and continuing education standards for their position. MDH may revoke or refuse to renew a registration for a pattern of failure to comply with this section. Violations of the limit on maximum charges in section 6 are subject to a 200 percent penalty.

5 **Complaint system.** Adds § 144A.73. Requires the commissioner of health to establish a system for reporting complaints against temporary nursing pools.

6 **Maximum charges.** Adds § 144A.74. Establishes maximums on temporary nursing pool charges to nursing homes. Pools must not bill or receive payments in excess of 150 percent of the average wage rate for the applicable employee classification for the geographic group in which the nursing facility is located. The maximum rate includes all administrative fees, contract fees, and other special charges in addition to employee wages.

7 **Report on supplemental nursing services agency use.** Adds § 256B.039. Beginning March 1, 2002, requires the commissioner of human services to report information on use of supplemental nursing services annually to the legislature.

Article 8: Long-term Care Insurance

Overview

This article changes the regulation of the premium rates of long-term care insurance using new model language recommended to the states by the National Association of Insurance Commissioners (NAIC). The change involves:

Abandoning regulation of premium rates through the requirement of an expected minium loss ratio, which is the ratio of expected payments by the insurer for long-term care benefits divided by expected premiums paid to the insurer.

Instead the change focuses on premium rate stability by:

Requiring insurers to prove that their initial premium rate schedules can reasonably be expected to be stable over the lifetime of the policy form.
Requiring insurers to provide more information to prospective policyholders about possible future premium increases.
Requiring insurers to provide some benefits to policyholders who drop coverage in response to unexpected premium rate increases.
Section 13 requires the Minnesota board on aging to promote the provision of employer-sponsored long-term care insurance.

1. **Loss ratio.** Amends § 62A.48, subd. 4. Provides that the loss ratio requirement for long-term care insurance under chapter 62A does not apply to policies issued after January 1, 2002 that comply with this article.

2. **Regulation of premiums and premium increases.** Amends § 62A.48, by adding subd. 10. Provides that the new provisions in this article, which are coded in chapter 62S, also apply to new policies issued under chapter 62A.

3. **Nonforfeiture benefits.** Amends § 62A.48, by adding subd. 11. Requires new policies issued under chapter 62A to offer nonforfeiture benefits required to be offered under chapter 62S.

4. **Exceptional increase.** Amends § 62S.01, by adding subd. 13a. Defines "exceptional increase" as a premium rate schedule increase requested by an insurer due to changes in laws or unforeseen general increases in long-term care utilization. The concept is that the premium increase is needed due to factors not under the control of the insurer and which the insurer could not have foreseen.

5. **Incidental.** Amends § 62S.01, by adding subd. 17a. Defines "incidental" as long-term care benefits that are part of another insurance policy (usually a life insurance policy) and constitute less than ten percent of the policy's value.

6. **Qualified actuary.** Amends § 62S.01, by adding subd. 23a. Defines this term.

7. **Similar policy form.** Amends § 62S.01, by adding subd. 25a. Defines "similar policy form" for purposes of disclosing past premium schedule increases. The term is used to specify what past premium rate schedule increases must be disclosed to prospective policyholders.

8. **Long-term care insurance; initial filing.** Adds § 62S.021. Requires insurers, before using a long-term policy form, to submit the proposed premium rate schedule to the commissioner 30 days before using the policy form, together with proof that the premium rate schedule can reasonably be expected to be sustainable over the life of the policy form. This is a file-and-use system, rather than prior approval of premium rates.

9. **Required disclosure of rating practices to consumers.** Adds 62S.081. Requires insurers to make certain disclosures to applicants for long-term care insurance. The disclosures involve the possibility of future premium rate schedule increases. Requires that the disclosures be given on forms prepared for this purpose by the National Association of Insurance Commissioners (NAIC).

10. **Loss ratio.** Amends § 62S.26. Provides that the loss ratio requirement of chapter 62S does not apply to new policies that comply with this article.

11. **Premium rate schedule increases.** Adds § 62S.265. Specifies requirements that insurers must meet to obtain permission to increase premium rate schedules on policies after they have been sold.

12. **Nonforfeiture benefit requirement.** Adds § 62S.266. Specifies the benefits that must be available if the policyholder allows the policy to lapse in connection with a premium rate schedule increase.

13. **Promotion of long-term care insurance.** Amends § 256.975, by adding subd. 8. Requires the Minnesota board on aging, directly or through contract, to promote the provision of employer-sponsored long-term care insurance. Directs the board to encourage employers to make long-term care insurance available, provide employers with information on the long-term care insurance product available to state employees, and provide technical assistance in designing and offering long-term care insurance.

Article 9: Mental Health and Civil Commitment

Overview

This article modifies provisions governing mental health and civil commitment.

Sections 1, 2, 3, and 28 address health plan coverage of specified health goods and services. Section 1 requires health plan companies from refusing to cover a health care service if the need for the service arose from a suicide or suicide attempt. Section 2 establishes health plan coverage of nonformulary drugs to treat mental illness or emotional disturbance. Sections 3 and 28 establishes health plan requirements for coverage of court-ordered mental health services. Sections 15 and 17 prohibit counties from requiring a child to demonstrate that mental health services were provided in a less restrictive setting and that the child did not make progress in that setting before the child may be served in a more restrictive setting.

Sections 20 to 36 modify provisions in the civil commitment act. Changes made include an expansion of the definition of mentally ill person, eliminating the requirement that danger must be imminent to allow an emergency hold or continue a judicial hold, modifying prepetition screening requirements, and allowing courts to order short-term hospitalization for up to 21 days as part of early intervention treatment.

Sections 37, 38, 49, and 51 establish a continuing care benefit program for persons with mental illness, require notice of the program to be provided, and require a study.

Sections 39, 40, and 42 establish Medical Assistance coverage for adult rehabilitative mental health services, adult mental health crisis response services, and mental health provider travel time.

1 **Exclusion for suicide attempts prohibited.** Adds § 62Q.471. Prohibits health plans from refusing to cover a health care service for an enrollee just because the need for the health care came about from a suicide or suicide attempt by the enrollee. Defines health plan. Makes this section effective January 1, 2002, and applicable to contracts issued or renewed on or after that date.

2 **Coverage of nonformulary drugs for mental illness and emotional disturbance.** Adds § 62Q.527. Provides for health plan coverage of nonformulary drugs to treat mental illness or emotional disturbance. This section is effective January 1, 2002, and applies to contracts issued or renewed on or after that date.

Subd. 1. Definitions. Defines emotional disturbance, mental illness, and health plan.

Subd. 2. Required coverage for antipsychotic drugs. Requires a health plan that covers prescription drugs to cover an antipsychotic drug to treat emotional disturbance or mental illness regardless of whether the drug is on the health plan's drug formulary, if the prescriber indicates that the prescription must be dispensed as communicated and certifies that the nonformulary drug will best treat the patient's condition. Specifies coverage is not required if a drug was removed from a formulary for safety reasons. Prohibits a health plan from imposing a special deductible or other payment requirement for such a drug, and from requiring written certification each time a prescription is renewed or refilled.

Subd. 3. Continuing care. Allows individuals receiving a drug to treat a mental illness or emotional disturbance to continue to receive the prescribed drug for up to one year without any special payment requirements being imposed, when a drug formulary changes or when the enrollee changes health plans. Lists criteria that must be met to be eligible for the continuing care benefit. Requires the continuing care benefit to be extended annually if the listed conditions are met. Specifies coverage is not required if a drug was removed from a formulary for safety reasons.

Subd. 4. Exception to formulary. Requires a health plan company to promptly grant an exception to the formulary if the health care provider prescribing the drug demonstrates that the formulary drug causes an adverse reaction in the patient; that the formulary drug is contraindicated for the patient; or that the prescription must be dispensed as written to give the patient maximum medical

benefit.

3 **Coverage for court-ordered mental health services.** Adds § 62Q.535. Establishes requirements for health plan coverage of court-ordered mental health services. This section is effective July 1, 2001, and applies to contracts issued or renewed on or after that date.

Subd. 1. Mental health services. Defines mental health services.

Subd. 2. Coverage required. Requires health plan companies that provide coverage for mental health services to cover or provide court-ordered mental health services. Requires the order to be based on a behavioral care evaluation performed by an appropriately trained psychiatrist or psychologist and requires the evaluation to include a diagnosis and individual treatment plan. Requires the health plan company to be given a copy of the court order and behavioral care evaluation. Specifies when the health plan company is liable for the evaluation if certain criteria are met. Specifies that a health plan company cannot conduct a separate medical necessity determination. Allows a party or interested person to make a court motion to modify a court-ordered plan of care.

4 **Discharge plans; offenders with serious and persistent mental illness.** Adds § 244.054. Directs the commissioner of human services to develop discharge plans for offenders with serious and persistent mental illness who are being released from a correctional facility, and specifies content of the plans.

Subd. 1. Offer to develop plan. Directs the commissioner of human services, in collaboration with the commissioner of corrections, to offer to develop a discharge plan for all offenders with serious and persistent mental illness who are being released from correctional facilities.

Subd. 2. Content of plan. If an offender chooses to have a plan developed, specifies what the plan must include and the timing of various elements of the plan.

5 **Day treatment services.** Amends § 245.462, subd. 8. Includes education and consultation provided to families and other individuals as part of the treatment process in the definition of day treatment under the adult mental health act.

6 **Mental health crisis services.** Adds § 245.462, subd. 14c. Defines "mental health crisis services" in the adult mental health act.

7 **Mental health professional.** Amends § 245.462, subd. 18. Amends the definition of mental health professional in the adult mental health act to allow psychological practitioners, in addition to psychologists, to qualify as mental health professionals.

8 **Significant impairment in functioning.** Amends § 245.462, by adding subd. 25a. Defines significant impairment in functioning in the adult mental health act.

9 **Staff safety training.** Adds subd. 4 to § 245.474. Requires the commissioner of human services to require all staff in mental health and support units at regional treatment centers who have contact with people with mental illness or severe emotional disturbance to be appropriately trained in violence reduction and violence prevention. Requires training programs to be developed with input from consumer organizations, and to use violence prevention techniques.

10 **Day treatment services.** Amends § 245.4871, subd. 10. Includes education and consultation provided to families and other individuals as part of the treatment process in the definition of day treatment under the children's mental health act.

11 **Mental health crisis services.** Adds § 245.4871, subd. 24c. Defines "mental health crisis services"

in the children's mental health act.

12 **Mental health professional.** Amends § 245.4871, subd. 27. Amends the definition of mental health professional to allow psychological practitioners, in addition to psychologists, to qualify as mental health professionals.

13 **Children's mental health services.** Amends § 245.4875, subd. 2. Adds mental health crisis services to the list of services that must be provided by the children's mental health system developed by each county board.

14 **Criteria.** Amends § 245.4876, subd. 1. Adds a cross-reference to section 15, to require children to receive mental health services in the most appropriate, least restrictive settings.

15 **Appropriate setting to receive services.** Adds subd. 1a to § 245.4876. Requires a child to be provided with mental health services in the least restrictive setting that is appropriate to meet the child's needs and current condition, and prohibits requiring the child to demonstrate that services were provided in a less restrictive setting and that the child failed to make progress in that setting before the child can access services in a more restrictive setting (like residential treatment or inpatient hospital treatment).

16 **Mental health crisis services.** Adds subd. 3 to § 245.488. Requires the county boards to provide or contract for enough mental health crisis services within the county to meet the needs of children with emotional disturbance residing in the county who are experiencing a mental health crisis or mental health emergency. Requires the services provided to be medically necessary and necessary for the safety of the child or others.

17 **Screening required.** Amends § 245.4885, subd. 1. Prohibits a county board from determining that inpatient treatment is not appropriate for a child solely because the child did not first receive services in a less restrictive setting and fail to make progress in that setting.

18 **Statewide program; establishment.** Amends § 245.4886, subd. 1. In a subdivision directing the commissioner of human services to establish a statewide program to help counties provide services with children with severe emotional disturbance, expands the scope of the program to allow children's mental health grants to be used to fund transition services to young adults between the ages of 18 and 21 and their families. Requires transition services to be designed to foster independent living in the community.

19 **Administration of crisis housing assistance.** Amends § 245.99, subd. 4. Specifies that the crisis housing assistance program for adults with mental illness is not an entitlement program. Also authorizes the commissioner to transfer funds from mental health grants in the same appropriation or impose specified statewide restrictions on the type and amount of assistance available to recipients, if the commissioner projects that funds are not sufficient to meet demand in a given fiscal year.

20 **Interested person.** Amends § 253B.02, subd. 10. Amends the definition of interested person in the civil commitment chapter, to include a health plan company providing coverage for a proposed patient.

21 **Mentally ill person.** Amends § 253B.02, subd. 13. Amends the definition of mentally ill person in the civil commitment chapter, to specify that the following pose a substantial likelihood of physical harm to self or others:

- an inability for reasons besides indigence to obtain necessary food, clothing, shelter, or medical care caused by a mental impairment, and it is more probable than not that the person will suffer one of the listed types of harm unless treatment and services are provided;

- recent and volitional conduct involving significant damage to substantial property.

This section is effective July 1, 2002.

22 **Periodic assessment.** Amends § 253B.03, subd. 5. Amends the law that gives committed patients a right to periodic medical assessment. Adds that if the treatment facility declines continuing care, the patient must be given specific reasons why care is declined.

23 **Notification.** Amends § 253B.03, subd. 10. Specifies the notice of patient rights regarding hospitalization and other treatment that must be provided to individuals admitted or committed to a treatment facility.

24 **Proxy.** Adds subd. 11 to § 253B.03. Amends the civil commitment act to state that a patient's rights may be exercised by a legally authorized health care proxy, agent, guardian, or conservator.

25 **Voluntary admission and treatment.** Amends § 253B.04, subd. 1. Specifies that in making decisions about voluntary admission, a treatment facility must use admission standards consistent with those of national adult and pediatric psychiatric associations. Requires the criteria to be no more restrictive than the requirements of a statute governing medical necessity for mental health care. Prohibits refusing voluntary admission to someone who does not meet criteria for an emergency hold or the definition of mental illness in the civil commitment act.

26 **Voluntary treatment or admission for persons with mental illness.** Amends § 253B.04, subd. 1a. Amends existing law granting immunity to a provider who treats a patient who lacks capacity to give consent. Extends the same immunity to a substitute decision maker appointed by the court.

27 **Court appointment of substitute decision maker.** Adds subd. 1b to § 253B.04. If the entity that provides civil commitment and mental health services declines to give informed consent for a person who is seeking treatment or admission to a treatment facility, the person seeking treatment or admission--or an interested person acting on that person's behalf--may petition for a substitute decision maker to give informed consent for voluntary treatment and services.

28 **Coverage.** Amends § 253B.045, subd. 6. Modifies a subdivision requiring health plan companies to cover mental health services ordered by a court pursuant to a civil commitment proceeding, to require health plan companies that provide coverage for court-ordered mental health services to cover or provide court-ordered mental health services. Requires the order to be based on a behavioral care evaluation performed by an appropriately trained psychiatrist or psychologist, and requires the evaluation to include a diagnosis and individual treatment plan. Requires the health plan company to be given a copy of the court order and behavioral care evaluation if certain criteria are met. Specifies that a health plan company cannot conduct a separate medical necessity determination. Defines mental health services.

29 **Emergency hold.** Amends § 253B.05, subd. 1. (a) Clarifies that emergency hold involves detention rather than restraint. Strikes the requirement that danger must be imminent in order to allow an emergency hold.

(b) Provides that if a proposed patient is brought in by another person, the examiner must make a good faith effort to obtain and consider information from that person in regard to a possible emergency hold. Requires the examiner to ask if the proposed patient has a health care directive or advance psychiatric directive.

30 **Early intervention criteria.** Amends § 253B.065, subd. 5. In current law, a court may order early intervention treatment if a court finds that a proposed patient satisfied three criteria, one of which is that the proposed patient refuses to accept appropriate mental health treatment. A new paragraph (c)

lists four situations that do not constitute a refusal to accept appropriate mental health treatment.

31 **Treatment alternatives.** Amends § 253B.066, subd. 1. Provides that if a court orders early intervention treatment for a patient, the court may order short-term hospitalization for up to 21 days (current law allows the court to order short-term hospitalization for up to 10 days).

32 **Prepetition screening.** Amends § 253B.07, subd. 1. (a) Excludes the petitioner in a civil commitment case from serving on the prepetition screening team. Modifies requirements for the screening team's investigation.

(b) When conducting a prepetition screening investigation, requires an interviewer to inform the proposed patient that any information the proposed patient provides may be included in the prepetition screening report and considered in the commitment proceedings. Allows the prepetition screening report to be admissible as evidence if counsel agrees.

(c) Requires the prepetition screening team to give notice, including the following information, to a proposed patient, the petitioner, persons named in an advance declaration by the patient, and other persons with the patient's consent: the patient's legal rights in connection with commitment, and the fact that, if the patient is committed to a state regional treatment center or group home, the patient may be billed for the costs of the care and the state can make a claim against the patient's estate for it. Requires the ombudsman for mental health and mental retardation to develop a form for the notice.

(d) Requires that the statement of facts in the prepetition screening team's written report recommending commitment meet certain requirements.

(e) Requires that notice of the prepetition screening team's decision to refuse to support a petition be given to the proposed patient.

(f) Requires that the county attorney determine whether or not to proceed with the petition when an interested person wishes to proceed with the petition contrary to the recommendation of the prepetition screening team.

33 **The petition.** Amends § 253B.07, subd. 2. Requires, rather than permits, the commitment petition and written statement to include an opinion regarding the proposed patient's need for neuroleptic medications. If the use of such medications is recommended by the treating physician, requires the commitment petition to be accompanied by a request for proceedings that must be followed to administer neuroleptic medications. Failure to include the required medication information or the request for an order is not a basis for dismissing the commitment petition.

34 **Preliminary hearing.** Amends § 253B.07, subd. 7. Removes the requirement that the threat of serious physical harm to the patient or others be imminent for a court to continue a judicial hold of a patient, after a preliminary hearing (current law requires the threat of serious physical harm to be imminent).

35 **Standard of proof.** Amends § 253B.09, subd. 1. Directs the court, when deciding on the least restrictive treatment program for a patient being committed, to consider a patient's willingness to voluntarily participate in the treatment ordered. Also directs the court to commit certain mentally ill patients to community-based programs that meet the patients' needs. This section is effective July 1, 2002.

36 **Private treatment.** Amends § 253B.10, subd. 4. Prohibits private treatment facilities from refusing to accept a civilly committed person for treatment solely because the treatment was court-ordered. Requires insurers to provide treatment as required by court order or by the chapter governing

utilization review.

37 **Payments.** Amends § 256.969, subd. 3a. Strikes language authorizing the commissioner of human services to establish contract beds, in which the commissioner contracts with hospitals for beds in which people with mental illness or chemical dependency may receive services for a length of stay longer than that allowed by the person's diagnostic category (portions of this language are being moved to section 256.9693). Adds a cross-reference to section 256.9693 to allow MA reimbursement for treatment of mental illness to not be based on diagnostic classification if services are provided in contract beds. This section is effective July 1, 2002.

38 **Continuing care program for persons with mental illness.** Adds § 256.9693. Directs the commissioner to establish a continuing care benefit program for persons with mental illness, to allow them to obtain acute care inpatient hospital treatment for mental illness for up to 45 days beyond that allowed by a diagnostic category. Allows MA-eligible persons to obtain treatment under this program in hospital beds for which the commissioner contracts. Allows the commissioner to contract with a utilization review organization to authorize access to the continuing care benefit, and directs the commissioner to establish admission criteria for accessing the benefit. Allows a person to be treated under this program as part of court-ordered inpatient treatment, but prohibits the commissioner from requiring a commitment or petition proceeding as a condition of accessing the program. Specifies that this benefit is not available for certain Medicare-eligible people. If a person is enrolled in a prepaid plan, specifies that this program is included in the plan's coverage. This section is effective July 1, 2002.

39 **Adult rehabilitative mental health services.** Adds § 256B.0623. Establishes medical assistance coverage for adult rehabilitative mental health services.

Subd. 1. Scope. Specifies that MA covers adult rehabilitative mental health services, subject to federal approval, if provided to eligible recipients, provided by qualified provider entities and qualified individual providers, and determined to be medically necessary.

Subd. 2. Definitions. Defines the following terms: adult rehabilitative mental health services, medication education services, and transition to community living services.

Subd. 3. Eligibility. Specifies eligibility criteria for adult rehabilitative mental health services: recipients must be age 18 or older, diagnosed with a medical condition for which adult rehabilitative mental health services are needed, have a substantial disability and functional impairment in three or more areas, and have a recent diagnostic assessment documenting that such services are medically necessary.

Subd. 4. Provider entity standards. Establishes 19 standards regarding provider capacity and skill, administrative ability, training, service delivery, flexibility in service delivery, quality assurance, and other areas that entities providing adult rehabilitative mental health services must meet. Requires a provider entity to be county-operated and certified by the state, or a private entity and certified by each county in which it provides services. Requires recertification at least every two years. Provides for decertification of provider entities. Requires the commissioner to develop statewide procedures for provider certification, including time lines for certification.

Subd. 5. Qualifications of provider staff. Requires services to be provided by qualified staff of a certified provider entity. To be qualified, requires staff to be a mental health professional; a mental health practitioner working under the clinical supervision of a mental health professional; or a mental health rehabilitation worker working under the direction of a practitioner or professional and under the clinical supervision of a professional and meeting specified criteria relating to education, training, and life experience with mental illness or providing care to a person with mental illness.

Subd. 6. Required training and supervision. Paragraph (a) requires mental health rehabilitation workers to receive at least 30 hours of continuing education every two years in relevant areas, and requires working under ongoing direction and clinical supervision. Paragraph (b) required mental health practitioners to receive continuing education as required by their professional license or at least 30 hours every two years in relevant areas, and requires working under ongoing clinical supervision. Paragraph (c) lists the tasks a mental health professional must perform when providing clinical supervision. Paragraph (d) requires a provider entity to have a treatment director who is a mental health practitioner or mental health professional, and specifies duties of the treatment director. Paragraph (e) requires a mental health practitioner who is serving as a treatment director to be supervised at least monthly by a mental health professional, and specifies duties of the supervising professional.

Subd. 7. Personnel file. Requires a provider entity to maintain a personnel file on each staff person working for the provider entity. Lists what must be included in the personnel file.

Subd. 8. Diagnostic assessment. Requires a service provider to complete a diagnostic assessment of a recipient of services within a specified time period, or to update a previous assessment, and specifies what must be included in the update.

Subd. 9. Functional assessment. Requires a service provider to complete a functional assessment of a recipient of services within 30 days of intake, and requires the assessment to be reviewed and updated at least every six months thereafter. If there is a significant change in functioning, also requires the assessment to be updated. Allows one functional assessment to meet the case management and adult rehabilitative mental health services requirements, if the recipient agrees. Requires the recipient of services to have significant participation in the functional assessment's development, unless the recipient refuses.

Subd. 10. Individual treatment plan. Requires providers to develop and implement individual treatment plans for each recipient. Defines individual treatment plan as a plan of intervention, treatment, and services for an individual recipient, based on diagnostic and functional assessments. Requires plans to be developed within 30 days of intake and updated every six months or whenever there is a change in situation, functioning, services, or service methods, or at the request of a recipient or legal guardian. Specifies what must be included in an individual treatment plan. Allows an individual community support plan developed under the adult mental health act to serve as the individual treatment plan if the recipient approves and if the mental health case manager is involved.

Subd. 11. Recipient file. Requires providers to maintain a file for each recipient of services. Lists what must be included in each recipient's file.

Subd. 12. Additional requirements. Requires providers to comply with the requirements relating to referrals for case management services in a section of the adult mental health act. Specifies where services may be provided and where they may not be provided. Allows services to be provided in group settings if appropriate for each recipient.

Subd. 13. Excluded services. Lists services for which reimbursement is prohibited: recipient transportation services, services by providers not enrolled to provide adult rehabilitative mental health services, services by volunteers, provider performance of household tasks, time spent on call, activities that are primarily social or recreational, job-specific skills services, provider service time included in case management reimbursement, outreach services to potential clients, mental health services that are not medically necessary, and services provided by a hospital, board and lodging, or residential facility to patients or residents.

Subd. 14. Billing when services are provide by qualified state staff. Includes state staff working

under the adult mental health pilot projects as part of the local provider entity that is certified, and allows the entity to bill MA for services provided by these state staff. Payments for services by state staff shall only be made from federal funds.

40 **Adult mental health crisis response services.** Adds § 256B.0624. Establishes medical assistance coverage for adult mental health crisis response services.

Subd. 1. Scope. Specifies that MA covers adult mental health crisis response services as defined in this section, subject to federal approval, if provided to an eligible recipient and provided by a qualified provider entity and by a qualified individual provider working within the provider's scope of practice, and if the services are medically necessary.

Subd. 2. Definitions. Defines the following terms for this section: mental health crisis, mental health emergency, mental health crisis assessment, mental health mobile crisis intervention services, and mental health crisis stabilization services.

Subd. 3. Eligibility. Specifies eligibility criteria for adult mental health crisis response services: recipients must be age 18 or older, screened as possibly experiencing a mental health crisis or emergency where a mental health crisis assessment is needed, and assessed as experiencing a mental health crisis or emergency and crisis intervention or stabilization services, or both, are determined to be medically necessary.

Subd. 4. Provider entity standards. Requires a provider entity to be a county board-operated entity or a provider entity under contract with the county board in the county where the crisis or emergency is taking place. Establishes 18 standards regarding provider capacity and skill, administrative ability, training, service delivery and coordination of services, flexibility in service delivery, quality assurance, and other areas that entities providing adult mental health crisis response services must meet. Requires a provider entity to be an enrolled MA provider.

Subd. 5. Mobile crisis intervention staff qualifications. Requires a mobile crisis intervention team to be comprised of at least two mental health professionals, or at least one mental health professional and one mental health practitioner with required mental health crisis training who is working under the clinical supervision of a mental health professional on the team. Specifies that the team must be composed of at least two people, with at least one member providing on-site crisis intervention services when needed. Lists skills team members must have. Requires the team to recommend and coordinate the team's services with appropriate local resources.

Subd. 6. Initial screening, crisis assessment, and mobile intervention treatment planning. Requires a screening to occur before initiating mobile crisis intervention services, to gather information, determine whether a crisis situation exists, identify parties involved, and determine an appropriate response. If a crisis exists, requires a crisis assessment to be completed, and specifies what a crisis assessment must include. If an assessment determines that mobile crisis intervention services are needed, requires the services to be provided promptly. Requires at least one of the team members to be on-site providing services. Requires the team to develop a crisis treatment plan as soon as appropriate but no later than 24 hours after the initial face-to-face intervention. Specifies what the plan must include. Requires the team to document which short-term goals have been met. Requires the team to provide referrals to other necessary services and to coordinate planning for further services with the recipient's case manager, if the recipient has one.

Subd. 7. Crisis stabilization services. Requires stabilization services to be provided by qualified staff of a provider entity. Requires a crisis stabilization treatment plan to be developed, requires staff providing services to satisfy the qualifications listed in another subdivision of this section, and requires services to be delivered according to the treatment plan and include face-to-face contact

with the recipient. Specifies how services must be provided if they are provided in a supervised, licensed residential setting. Lists staffing requirements that apply to services provided in a setting that serves 4 residents or fewer and staffing requirements that apply to services provided in a setting that serves more than 4 residents.

Subd. 8. Adult crisis stabilization staff qualifications. Requires mental health crisis stabilization services to be provided by qualified staff of a qualified provider entity. Specifies who are qualified staff: mental health professionals; mental health practitioners working under the qualified supervision of a mental health professional; and mental health rehabilitation workers who meet the education and training requirements in section 14, subdivision 5, clause (3), and who are working under the direction of a mental health practitioner of mental health professional and under the clinical supervision of a mental health professional. Requires mental health practitioners and mental health rehabilitation workers to have completed at least 30 hours of training in crisis intervention and stabilization in the past two years.

Subd. 9. Supervision. Establishes clinical supervision requirements that mental health practitioners must meet to provide crisis assessment and mobile crisis intervention services. Requires the mental health provider entity to accept full responsibility for the services provided. Also requires the mental health professional providing clinical supervision to be immediately available by phone or in person; to be consulted during the first three hours when on-site services are provided; to review, approve, and sign the crisis assessment and treatment plan; to contact the recipient face-to-face if mobile crisis intervention services continue into a second day; and to document and sign on-site observation.

Subd. 10. Recipient file. Requires providers of mobile crisis intervention or crisis stabilization services to maintain a file for each recipient of services, and specifies what each recipient's file must contain.

Subd. 11. Treatment plan. Lists what must be included in an individual crisis stabilization treatment plan.

Subd. 12. Excluded services. Lists services for which reimbursement is prohibited: room and board services, services delivered to a recipient in a hospital, recipient transportation costs, services provided by a provider who is not an enrolled MA provider, services provided by volunteers, time spent on call, provider service time included in reimbursement for case management services, outreach services to potential recipients, and services that are not medically necessary.

41 **Mental health case management.** Amends § 256.0625, subd. 20. Amends a subdivision authorizing MA reimbursement for mental health case management services, to allow Indian tribal agencies to enroll with the state as MA providers and receive reimbursement for case management services. (Under current law, a tribal agency can receive MA reimbursement for these services only if the agency has a county contract.) Specifies that if services are provided by a tribal agency, the nonfederal share of any costs for mental health case management services must be provided by the recipient's tribe instead of by the recipient's county of responsibility.

42 **Mental health provider travel time.** Adds subd. 46 to § 256B.0625. Provides MA coverage for provider travel time to provide MA-covered mental health services outside the provider's normal place of business, if the recipient's individual treatment plan so requires. Specifies that this does not include travel time included in other billable services.

43 **Reimbursement for mental health services.** Adds § 256B.761. For services rendered on or after July 1, 2001, requires medication management, outpatient mental health, day treatment, home-based mental health, and family community support services to be reimbursed at the lower of (1)

submitted charges or (2) 75.6 percent of the 50th percentile of 1999 charges.

44 **Mental health provider appeal process.** Adds § 256B.81. Allows a provider, or a recipient acting on the provider's behalf, to appeal to the commissioner if a county declines to contract with or certify a provider for the provision of mental health services under MA. Specifies that if the commissioner finds that the provider meets applicable standards, the commissioner shall enroll the provider as an authorized provider. Directs the commissioner to develop procedures for appeals of county decisions to refuse to contract with or certify a provider. After the commissioner makes a decision regarding an appeal, allows a provider, recipient, or county to request reconsideration of the decision. Specifies that the commissioner's reconsideration decision is final and not subject to further appeal.

45 **Prepaid plans and mental health rehabilitative services.** Adds § 256B.82. Allows medical assistance and Minnesota prepaid health plans to include coverage for adult mental health rehabilitative services under section 256B.0623 and adult mental health crisis response services under section 256B.0624, beginning January 1, 2004. By January 15, 2003, the commissioner is required to report on how these services should be included in the prepaid plans.

46 **Maintenance of effort for certain mental health services.** Adds § 256B.83. Requires the county to use any net increase in revenue that results from section 256B.0623 (rehabilitative services) or 256B.0624 (crisis response services) to expand mental health services as defined in the adult mental health act. Defines increased revenue.

47 **Dispositions.** Amends § 260C.201, subd. 1. Prohibits a court from transferring legal custody of a child with a disability because a parent is not able to provide specific treatment or care, unless the court makes specific written findings that a child's disability is a result of abuse or neglect by a parent or guardian. For children in need of protection or services, allows a court to order a child's health plan company to provide mental health services to the child.

48 **Development of payment system for adult residential services grants.** Requires the commissioner of human services to review funding methods for adult residential services grants and develop a payment system that takes into account client difficulty of care. Requires a report to the legislature by January 15, 2002.

49 **Notice regarding establishment of continuing care benefit program.** Requires the commissioner of human services to provide notice to counties, health plan companies, providers, and enrollees of the existence of the continuing care benefit program. This section is effective July 1, 2002.

50 **Study of children's mental health collaboratives.** Requires the commissioner to study the role of children's mental health collaboratives and family services collaboratives in the children's mental health system and report back to the legislature by January 15, 2003.

51 **Study; length of stay for Medicare-eligible persons.** Requires the commissioner of human services to study and make recommendations on how Medicare-eligible enrollees can access the continuing care benefit. Requires a report to the legislature by January 15, 2002.

52 **Data regarding county commitment costs.** Requires all counties to report to the commissioner of human services data on county costs for civil commitments that occur on or after July 1, 2002. Specifies what the fiscal data must include, at a minimum. Requires the commissioner to report this information to the legislature by January 15, 2004.

Article 10: Assistance Programs

Overview

Article 10 contains provisions related to non-health care assistance programs supervised by the commissioner of human services. Provisions in this article:

Delay, for one year, until July 1, 2003, the implementation of a provision that limits the Minnesota food assistance program to legal noncitizens who are age 50 and older (section 3);

Put two-parent MFIP families into a separate state program that can only be paid for with state general fund dollars (section 5);

Consolidate the MFIP application procedures that are currently located in various places within the MFIP statute (sections 8 to 12);

Provide for an annual adjustment to the MFIP earned income disregard so that most participants do not lose eligibility until the participant's income is 120 percent of the federal poverty guidelines (section 16);

Modify the sanction policy for MFIP applicants and participants who have been convicted of a drug-related offense (section 17);

Delay, for two years, until July 1, 2003, the date after which the first $100 of an MFIP recipient's federal housing subsidy will be counted against the recipient's MFIP grant (section 21);

Establish hardship extensions beyond the first 60 months on MFIP for certain categories of families (sections 23, 27, and 28);

Allow a county agency to annually modify its sanctions for noncompliant MFIP participants by implementing one of the sanction options established in the act (section 33);

Extend, from 12 to 24 months, the length of education and training programs that can be approved as a work activity (section 43 and 45);

Require the commissioner to provide to counties and the legislature, several quarterly reports relating to each county's performance on certain MFIP-related measures (section 54);

Delay, for two years, a provision that makes legal noncitizens ineligible for state-funded MFIP benefits (section 62).

1. **Immigration status verifications.** Amends § 256.01, subd. 18. Requires the commissioner to comply with current federal reporting requirements under 42 U.S.C. § 611a and any federal regulation or guidance adopted under that law. This federal law requires certain entities to report to the INS, at least four times annually, any individual who, under the TANF or Welfare-to-Work programs, the entity "knows is not lawfully present in the United States." Federal guidance was issued on September 28, 2000, that clarifies the circumstances for which an entity "knows" that an individual is not lawfully present in the United States.

2. **Disqualification from program.** Amends § 256.98, subd. 8. Adds group residential housing (GRH) to the list of programs for which a person can be disqualified if the person is found guilty of fraud under that program. Requires that a person who is disqualified from MFIP because of fraud also be disqualified from the food stamp program.

3. **Program established.** Amends § 256D.053, subd. 1. Delays for one year, until July 1, 2003, the implementation of a provision that limits the Minnesota food assistance program (MFAP) to certain legal noncitizens who are age 50 or older.

4. **Persons entitled to receive aid.** Amends § 256D.425, subd. 1. Clarifies that, in addition to the other eligibility requirements for Minnesota supplemental aid (MSA), in order to be eligible for that program, a person must be aged, blind, or at least 18 and disabled.

5. **Separate state program for use of state money**. Creates new § 256J.021. Beginning October 1, 2001, requires the commissioner to treat all assistance paid to a two-parent family with a minor child as expenditures under a separate state program. (This change means that federal TANF funds cannot be used to provide assistance to these families; only state monies may be used.)

6. **MFIP standard of need.** Amends § 256J.08, subd. 55a. Removes a reference to the interstate payment standard, which is being repealed, in this definition.

7. **Person trained in domestic violence.** Adds subd. 67a to § 256J.08. Defines a "person trained in domestic violence." Makes this section effective October 1, 2001.

8. **Where to apply**. Amends § 256J.09, subd. 1. Clarifies that to apply for assistance, a person must submit a signed application to the county agency where that person lives.

9. **County agency responsibility to provide information**. Amends § 256J.09, subd. 2. Clarifies that when a person inquires about assistance, a county agency must explain the eligibility requirements of, and how to apply for, diversionary assistance, emergency assistance, MFIP, or any other assistance for which the person may be eligible.

10. **Submitting the application form**. Amends § 256J.09, subd. 3. Paragraph (a) adds the following six items to the list of information that a county agency must disclose after the county agency provides application forms to a person who has inquired about assistance:

    the information the county agency will verify at application;

    the county's average application processing time and how the application will be processed;

    how to contact the county agency if the person's application information changes and how to withdraw the application;

    the next step in the application process and what a person must do if the application is approved;

    the child care and transportation services that are available to help caregivers attend the initial screening and orientation; and

    identify any language barriers and arrange for translation assistance during appointments, including but not limited to the screening, orientation, and initial assessment.

    New paragraph (c) relocates a provision that requires the county agency, upon the participant's request, to arrange for transportation and child care or reimburse the participant for transportation and child care expenses necessary to enable participants to attend the screening and orientation.

11. **Screening**. Adds new subd. 3a to § 256J.09. Relocates a provision that requires the county agency or, at county option, the county's employment and training service provider, to screen each applicant to determine immediate needs and whether the applicant may be eligible for another program not funded by TANF; diversionary assistance; or emergency assistance.

12. **Interview to determine referrals and services**. Adds new subd. 3b to § 256J.09. Provides that a county agency must do the following if an applicant is not diverted from applying for MFIP, and the applicant meets the MFIP eligibility requirements:

(1) identify applicants who are under age 20 and explain the assessment procedures and employment plan requirements for minor parents (relocates a provision that is being repealed in this article);

(2) explain the criteria for an exemption for victims of family violence and explain what a participant should do to develop an alternative employment plan;

(3) determine if an applicant qualifies for an exemption from employment and training services requirements, explain how to report status changes, and explain that a person who is exempt may volunteer to participate in employment and training services;

(4) for applicants who are not exempt from the orientation requirement, arrange for an orientation and initial assessment;

(5) inform an applicant who is not exempt from the orientation requirement that failure to attend the orientation is considered an occurrence of noncompliance and will result in a sanction; and

(6) explain how to contact the county agency for questions about compliance with program requirements.

13. **Income exclusions.** Amends § 256J.21, subd. 2. Specifies that the exclusion of SSI income when determining an MFIP family's available income encompasses any retroactive SSI payments and other income of an SSI recipient.

14. **Mandatory assistance unit composition.** Amends § 256J.24, subd. 2. Clarifies that in order for a minor child to be included in an assistance unit, the child must have a caregiver.

15. **Shared household standard; MFIP.** Amends § 256J.24, subd. 9. Makes terminology changes, replacing "domestic violence" with "family violence" and "approved safety plan" with "alternative employment plan."

16. **MFIP exit level**. Amends § 256J.24, subd. 10. Authorizes the commissioner to annually adjust the MFIP earned income disregard to ensure that most participants do not lose eligibility for MFIP until their income is greater than or equal to 120 percent of the federal poverty guidelines. (Strikes provisions that authorize the commissioner to make such adjustments in state fiscal years 2000 and 2001.)

17. **Person convicted of drug offenses**. Amends § 256J.26, subd. 1. Paragraph (a), clause (2), specifies the sanction for an MFIP participant who has been convicted of a drug-related offense and who fails a random drug test. Item (i) requires that for failing a random drug test the first time, the assistance unit's grant, after making vendor payments for rent and utilities, be reduced by 30 percent of the applicable MFIP standard of need. Requires a job counselor to attempt to meet with the person face-to-face and specifies that, during the face-to-face meeting, the job counselor must inform the participant of the consequences of a subsequent drug test failure and of the right to appeal. If a face-to-face meeting is not possible, requires the county to send a notice of adverse action, which must include the information required in the face-to-face meeting.

    Item (ii), permanently disqualifies a participant from MFIP if the participant has been convicted of a drug-related offense and fails a drug test two times. Reduces the assistance unit's grant by the amount that would have otherwise been made available to the disqualified participant. Clarifies that disqualification under this item does not make a participant ineligible for food stamps. Before the disqualification is imposed, requires the job counselor to attempt to meet with the participant face-to-face. During the face-to-face meeting, requires the job counselor to identify other resources that

may be available to meet the needs of the family and inform the participant of the right to appeal. If a face-to-face meeting is not possible, requires the county to send a notice of adverse action, which must include the information required during the face-to-face meeting.

Paragraph (a), clause (3), specifies that if a participant who fails a drug test the first time and is under sanction for failing to comply with other MFIP requirements, the participant is considered to have more than one occurrence of noncompliance and is subject to the applicable level of sanction.

Paragraph (b) makes applicants or participants who request or receive only food stamps and who have been convicted of a drug-related offense and who have failed a random drug test one or more times, subject to the same sanctions under paragraph (a) for applicants requesting or receiving both the cash and food portion of the MFIP grant. Also provides for the same face-to-face meeting requirements under paragraph (a).

18. **Participant's right to notice**. Amends § 256J.31, subd. 4. Provides that a notice of adverse action must be understandable at a seventh grade reading level. Requires a notice written in English, and including the Department of Human Services language block, to be sent to every applicable participant.

19. **Factors to be verified.** Amends § 256J.32, subd. 4. Makes terminology changes, replacing "domestic violence" with "family violence" and "deferral or exemption" with "waiver." Makes this section effective October 1, 2001.

20. **Requirement to report to immigration and naturalization services**. Amends § 256J.32, subd. 7a. Requires the commissioner to comply with current federal reporting requirements under 42 U.S.C. § 611a and any federal regulation or guidance adopted under that law. This federal law requires certain entities to report to the INS, at least four times annually, any individual who, under the TANF or Welfare-to-Work programs, the entity "knows is not lawfully present in the United States." Federal guidance was issued on September 28, 2000, that clarifies the circumstances for which an entity "knows" that an individual is not lawfully present in the United States.

21. **Unearned income.** Amends § 256J.37, subd. 9. Delays for two years, until July 1, 2003, the date after which the first $100 of the value of an MFIP recipient's public housing subsidy will be counted against the recipient's MFIP grant.

22. **Protective and vendor payments.** Amends § 256J.39, subd. 2. Removes a reference to the interstate payment standard, which is repealed by this act. Also authorizes a county agency director's designee to approve protective or vendor payments for money mismanagement and to make the required periodic approval of continuing these type of payments.

23. **Notice of time limit 12 months prior to 60-month time limit expiring.** Creates new § 256J.415. Requires a county agency to mail to an assistance unit a notice 12 months before it reaches the 60-month limit and each month thereafter. Specifies that the commissioner develop the notice and what information the notice must contain.

24. **Time limit.** Amends § 256J.42, subd. 1. Changes the phrase "minor who is the head of household or who is married to the head of a household" to "minor caregiver."

25. **Adults living in Indian country.** Amends § 256J.42, subd. 3. Replaces the phrase "Indian reservation" with "Indian country" to make consistent with terminology used in federal law (Public Law 104-193 and 45 CFR 260).

26. **Victims of family violence.** Amends § 256J.42, subd. 4. Changes the phrase "domestic violence" to "family violence." Clarifies that assistance received by an assistance unit in a month when a

caregiver complied with a safety plan, or after October 1, 2001, an alternative employment plan, does not count toward the 60-month lifetime limit on assistance.

27. **Case review**. Adds new subd. 6 to § 256J.42. Paragraph (a) requires a county agency or job counselor to review a participant's case within 180 days, but not less than 60 days, before the end of the participant's 60th month on MFIP, and to attempt to meet with the person face-to-face.

    Paragraph (b) specifies the information that the county agency or job counselor must explain to the participant during the face-to-face meeting.

    Paragraph (c) requires the county to send a notice of adverse action if a face-to-face meeting is not possible.

    Paragraph (d) requires the county to ensure the following before a participant's case is closed under this section: that the case has been reviewed by the job counselor's supervisor or the review team to determine if the criteria for a hardship extension were applied appropriately, and that the county agency or job counselor attempted to meet with the person face-to-face.

28. **Hardship extensions**. Creates new § 256J.425. Establishes hardship extensions for certain assistance units that have reached the 60-month limit.

    Subd. 1. Eligibility. Provides that a participant must be in compliance the month the participant is applying for the extension in order to be eligible for assistance beyond the first 60 months of assistance. Defines compliance as any month in which a participant has not been sanctioned.

    Subd. 1a. Review. Requires a county agency to review extended cases every 6 or 12 months, whichever is appropriate based on the participant's circumstances and the extension category.

    Subd. 2. Ill or incapacitated. Paragraph (a) provides that an assistance unit may be eligible to receive a hardship extension if the participant belongs to any of the following groups:

        (1) participants who are suffering from a certified illness, injury, or incapacity, which is expected to continue for more than 30 days, and prevents the person from finding or keeping a job, and who are following the treatment recommendations of the health care provider certifying the illness, injury or incapacity;

        (2) participants who are needed in the home, as a caregiver, to care for a household member who is certified to be ill or incapacitated, and the illness or incapacity is expected to continue for more than 30 days; or

        (3) caregivers with a household member who meets certain disability or medical criteria, or certain criteria for severe emotional disturbance, or serious and persistent mental illness.

        Paragraph (b) allows an assistance unit receiving assistance under a hardship extension under this subdivision to continue to receive assistance as long as the participant continues to belong to one of the groups under paragraph (a).

    Subd. 3. Hard-to-employ participants. Provides that an assistance unit may be eligible to receive a hardship extension if the participant belongs to any of the following groups:

        (1) a person who is diagnosed as having mental retardation or mental illness, and that condition prevents the person from obtaining or retaining unsubsidized employment;

        (2) a person who (i) has been assessed by a vocational specialist or the county agency to be unemployable, or (ii) has an IQ below 80 who has been assessed by a vocational specialist or the county agency to be employable, but not at a level that makes the participant eligible

for an extension for employed participants under subdivision 4, or in the case of a non-English-speaking person for whom it is not possible to provide a determination due to language barriers or absence of culturally appropriate assessment tools, is determined by a qualified professional to have an IQ below 80; or

(3) a person who is determined by the county agency to have a learning disability, or in the case of a non-English-speaking person for whom it is not possible to provide a determination due to language barriers or absence of culturally appropriate assessment tools, is determined by a qualified professional to have a learning disability. Clarifies that if a rehabilitation plan is developed or approved by the county, the plan must be incorporated into the participant's employment plan. Specifies that a rehabilitation plan does not replace the requirement to develop and comply with an employment plan.

Subd. 4. Employed participants. Paragraph (a) provides that an assistance unit may be eligible to receive a hardship extension if the participant belongs to:

a one-parent assistance unit in which the participant is participating in work activities for at least 30 hours per week, of which an average of at least 25 hours per week are spent participating in employment; or

a two-parent assistance unit in which the participants are participating in work activities for at least 55 hours per week, of which an average of at least 45 hours per week are spent participating in employment.

Defines employment as: unsubsidized employment; subsidized employment; on-the-job training; an apprenticeship; supported work; a combination of the aforementioned activities; or providing child care services to a participant who is working in a community service program if it is in combination with paid employment.

Paragraph (b) allows the number of hours required under a child protection plan under chapter 260C to count toward the number of hours required under this subdivision.

Paragraph (c) requires a county to provide the opportunity for subsidized employment to participants who need that type of employment, within available appropriations.

Paragraph (d) requires a participant in a one-parent assistance unit or both parents in a two-parent assistance unit to be in compliance for at least 10 out of the 12 months immediately preceding the participant's 61st month on MFIP. For a two-parent assistance unit, provides that if only one parent does not meet the compliance requirement, the assistance unit may chose to have the noncompliant participant disqualified from the assistance unit. Provides that if the noncompliant participant is disqualified, the assistance unit must be treated as a one-parent assistance unit for the purposes of meeting the work requirements under this subdivision and the assistance unit's MFIP grant must be calculated using the shared household standard. (The cash portion of the shared household standard is equal to 90 percent of the cash portion of the transitional standard.)

Paragraph (e), for cases extended under this subdivision, provides that the participant's employment plan must contain the number of hours specified under paragraph (a) related to employment and work activities. Requires the job counselor and the participant to sign the employment plan, indicating agreement on the contents of the plan.

Paragraph (f) provides that participants who fail to meet the work requirements under paragraph (a), without good cause, are subject to sanction or permanent disqualification under subdivision 6. Specifies that good cause may only be granted for the portion of the

month for which the good cause reason applies. Requires participants to meet all other requirements in the employment plan.

Paragraph (g) provides an exemption from the work requirements under this subdivision for one month if the noncompliance is due to an involuntary loss of employment. The exemption is provided twice in a 12-month period.

Paragraph (h) makes this subdivision expire on June 30, 2004.

Subd. 5. Accrual of certain exempt months. Paragraph (a) establishes a hardship extension for a caregiver who is no longer eligible for a hardship extension under subdivision 2, paragraph (a), clause (3) (extension for participants caring for a disabled household member) and the person received assistance that counted toward the federal 60-month limit while, at the same time, the person was exempt from employment and training requirements because the participant was needed in the home to care for a disabled household member. Extends assistance for a period of time equal to the number of months that were counted toward the federal 60-month time limit while the participant was exempt from the employment and training requirements.

Paragraph (b) establishes a hardship extension for caregivers who received TANF assistance that counted toward the federal 60-month limit while, at the same time, met the state's exemption criteria under § 256J.42, subdivisions 4 (victims of family violence) and 5 (minor caregivers, caregivers over age 60, months in which an assistance unit received emergency or diversionary assistance). Extends assistance for a period of time equal to the number of months that were counted toward the federal time limit while the caregiver met the state time limit exemption criteria.

(Currently, months in which a caregiver meets the criteria for a *state* exemption from the time limit, are paid for with state-only funds. This has the effect of stopping the federal clock. Before the final TANF regulation was released in April 1999, the state was uncertain how to handle state exemptions to the time limit and, in some cases, used federal, or a combination of state and federal money to provide assistance to exempt assistance units. Under this paragraph, an extension would be granted to give back those months of eligibility that the assistance unit would have had if the assistance would have been paid for using state-only money.)

Subd. 6. Sanctions for extended cases. Paragraph (a) makes the sanctions under this subdivision apply to assistance units receiving an extension for hard-to-employ participants (subdivision 3) and employed participants (subdivision 4). Establishes the following sanctions:

- for a first occurrence of noncompliance, the assistance unit's MFIP grant is reduced by 10 percent of the applicable MFIP standard of need;

- for a second or third occurrence of noncompliance, the assistance unit's shelter costs, and at county option, utilities are vendor paid and the residual amount of the grant after vendor payment, if any, is reduced by 30 percent of the applicable MFIP standard of need; and

- for a fourth occurrence of noncompliance, the assistance unit is disqualified from MFIP.

Allows a participant to claim a good cause exception under § 256.57, but does not allow a participant to claim an exemption from work requirements under § 256J.56.

Paragraph (b) specifies that if both parents in a two-parent assistance unit are out of compliance at the same time, it is considered one occurrence.

Subd. 7. Status of disqualified participants. Paragraph (a) allows a participant who was

disqualified under subdivision 6 to be approved for MFIP if the participant is in compliance for one month, during which time no assistance is paid.

Paragraph (b) establishes sanctions for participants who have been disqualified and who reapply under paragraph (a). For a first occurrence of noncompliance, the assistance unit's MFIP grant must be reduced by 10 percent of the applicable MFIP standard of need, and for a subsequent occurrence of noncompliance, the assistance unit is permanently disqualified.

Paragraph (c) establishes sanctions for two-parent assistance units in which one participant is out of compliance. When one parent in a two-parent assistance unit is out of compliance, the assistance unit may choose to have the noncompliant parent disqualified from MFIP. If the noncompliant parent is disqualified, the assistance unit must be treated as a one-parent assistance unit for the purposes of meeting the work requirements for the employed participant's extension and the assistance unit's MFIP grant must be calculated using the shared household standard. (The cash portion of the shared household standard is equal to 90 percent of the cash portion of the transitional standard.)

Allows a disqualified participant to reapply for MFIP under paragraph (a). Permanently disqualifies a participant if a participant is disqualified under this subdivision a second time.

Paragraph (d) requires a county agency to review the participant's case and to attempt to meet with the participant face-to-face before the assistance unit is disqualified under this subdivision. Also requires a county agency to send a notice of adverse action if a face-to-face meeting is not conducted. Specifies what a county agency must do during the face-to-face meeting.

Subd. 8. County extension request. Allows a county to request, and the commissioner to approve, an extension for a category of participants that are not extended under the hardship extensions under § 256J.425. Provides that the category must be consistent with the existing extension policy in which an extension is provided to participants whose MFIP requirements conflict with other statutory requirements or obligations.

Directs the commissioner to report to the chairs and ranking minority members of the house and senate health and human services committees, by January 15 of each year, the extensions that were granted during the previous calendar year. Provides that the legislature must act in order for the extensions to continue. Makes the extensions that were granted during the previous calendar year expire on June 30 if the legislature does not act.

29. **County agency to provide orientation**. Amends § 256J.45, subd. 1. Makes a technical change, revising the provision concerning who must receive an orientation to directly specify, rather than specifying by internal cross-reference, the caregivers who are exempt because they are working enough hours.

30. **General information.** Amends § 256J.45, subd. 2. Adds two kinds of information to the list of what must be covered in the MFIP orientation: (1) the availability of the federal earned income tax credit and the state working family tax credit; and (2) effective October 1, 2001, information about the 60-month time limit exemption and waivers of regular employment and training requirements for victims of family violence and referral information about shelters and programs for these persons.

31. **Participants not complying with program requirements**. Amends § 256J.46, subd. 1. Paragraph (a) clarifies that before a sanction may be imposed, a county must send a notice of intent to sanction and, when applicable, a notice of adverse action.

New paragraph (b) requires an alternative employment plan to be reviewed to determine if the plan's activities are still appropriate before a sanction can be imposed on a victim of family violence who fails to comply with the plan. If the activities are not appropriate, requires that the plan be revised with a person trained in domestic violence and approved by a job counselor or the county agency. Requires the participant to comply with regular employment services activities if the participant fails to comply with an alternative employment plan that is still appropriate and does not need to be revised.

Paragraph (c) corrects a cross-reference.

Paragraph (d), clauses (1) and (2), update terminology to refer to an "assistance unit" rather than a "household" and rephrase terminology related to two-parent assistance units. Clarifies that a participant's case must be reviewed as required under paragraph (e) if an assistance unit is sanctioned under this clause.

Paragraph (e) requires the county agency to determine, when a 30 percent sanction is in effect, if the employment services plan is still appropriate and to attempt to meet with the participant face-to-face. Allows a participant to bring an advocate to the meeting. If a face-to-face meeting is not possible, requires the county agency to send a written notice that contains the information that the county agency must cover during the face-to-face meeting.

New clause (1) of paragraph (b) lists the topics that the county agency must cover with the participant during the face-to-face meeting.

Clause (2) adds qualification of for a family violence waiver to the situations in which the grant must be restored retroactively to the first day of the month that the participant was found to qualify. Also adds cross-references.

Makes the family violence provisions effective October 1, 2001.

32. **Dual sanctions.** Amends § 256J.46, subd. 2a. Paragraph (b) clarifies that a participant who was subject to sanction for noncompliance with program requirements before being subject to sanction for noncooperation with support requirements (or vice versa) is considered to have a second occurrence of noncompliance. Specifies that each subsequent occurrence of noncompliance is considered an additional occurrence and the participant is subject to the applicable level of sanction.

    Paragraph (c) clarifies that, for a participant who first becomes subject to sanction for both noncompliance with program requirements and for noncooperation with support requirements at the same time, the participant is subject to the applicable level of sanction for a second or subsequent occurrence of noncompliance and noncooperation. Corrects cross-references throughout the subdivision.

33. **Sanctions; county options.** Creates new § 256J.462. Establishes additional sanctions that a county may implement and procedures that a county must follow before implementing additional sanctions.

    Subd. 1. County sanction policy plan. Allows a county to annually modify its sanctions for noncompliant MFIP participants by implementing one of the sanction options under subdivision 3 for a sixth or subsequent occurrence of noncompliance.

    Subd. 2. Procedure. Paragraph (a) requires a county agency to develop and submit to the commissioner, by April 15, as part of its local service unit plan, a proposed sanction policy plan that describes the sanctions imposed for each occurrence of noncompliance.

    Paragraph (b) requires a county agency to send a written notice to all MFIP participants at

least 60 days before the implementation of the modified sanction policy. Requires a county agency to send a notice of adverse action before imposing one of the sanction options under subdivision 3.

Paragraph (c) makes only occurrences of noncompliance that occur after the effective date of the modified sanctions count for the purposes of applying sanctions under this section. For participants who are in 30 percent sanction in the month the modified sanctions take effect, makes that month count as the first occurrence, but retains the 30 percent sanction.

Paragraph (d) clarifies how participants who move to a county with more severe sanctions must be treated. Participants who are in sanction status in one county, and move to a county with more severe sanctions, are subject to the level of sanction imposed in the previous county for the first six months in the new county, or until the participant comes into compliance, whichever occurs earlier.

Paragraph (e) clarifies that, if both participants in a two-parent assistance unit are out of compliance at the same time, it is considered one occurrence of noncompliance.

Subd. 3. Sanction options. Allows a county to modify its sanction policy by implementing one of the following sanctions for a sixth or subsequent occurrence of noncompliance:

(a) Allows vendor payment of the assistance unit's shelter or utility costs, or both costs, up to the amount of the assistance unit's cash portion of the MFIP grant. Reduces any residual amount after vendor payment to zero. Provides that the sanction must be in effect for a minimum of one month and must be removed the month following the month in which the participant returns to compliance. For a two-parent assistance unit, provides that the sanction must be removed the month following the month in which both parents return to compliance. Also provides that the vendor payment must be removed six months after the month in which the participant returns to compliance.

(b) Allows a county agency to disqualify an assistance unit from MFIP. Provides that the disqualification must be in effect for one month and clarifies that disqualification does not make a participant automatically ineligible for food stamps. Directs the county to determine eligibility for food stamps and to assist the participant in applying for food stamps, if eligible.

Subd. 4. Case review. Requires a county agency to conduct a case review before a sanction under this section is imposed.

Subd. 5. Eligibility after disqualification due to noncompliance. Allows a county agency to propose restrictions on assistance units that reapply for MFIP after disqualification. Prohibits a county from permanently disqualifying an assistance unit for noncompliance under this section. Requires the restrictions to be limited to the first six months of MFIP eligibility following reapplication, provided that the participant complies with work requirements for the entire six months. Provides that the restrictions may include the following:

requiring participants to comply with work requirements for a period not to exceed one month before the assistance unit is eligible to reapply for MFIP;

requiring that reapplying assistance units remain in 10 percent sanction for six months; and

changing the policy for subsequent sanctions for noncompliance to shorten the time frame before disqualification.

Subd. 6. Sanction policy review. Allows the commissioner to review a county's sanction policies

and practices if the county has a high or low sanction rate for certain hard-to-serve participants. Requires the commissioner to require a county agency to complete corrective actions to remedy identified agency errors or misapplications of policy. Also allows the commissioner to suspend a county's authority to impose sanctions under this section until corrective actions are taken.

Makes this section effective March 1, 2002.

34. **Processing emergency applications.** Adds subd.1a to § 256J.48. Requires an applicant for emergency assistance (EA) to be notified within seven days (or earlier, if the situation warrants it) whether the application is approved, denied, or is pending.

35. **Alternative employment plan.** Adds subd.1a to § 256J.49. Defines "alternative employment plan." Makes this section effective October 1, 2001.

36. **Family violence.** Amends § 256J.49, subd. 2. Makes a terminology change in the definition of this term, from "domestic violence" to "family violence." Also requires that claims of family violence be documented by the applicant or participant providing a sworn statement, supported by collateral documentation. Makes this section effective October 1, 2001.

37. **Work activity.** Amends § 256J.49, subd.13. Makes a terminology change in clause (26) of the definition of work activity, from "safety plan" to "alternative employment plan." Makes this section effective October 1, 2001.

38. **Employment and training services component of MFIP**. Amends § 256J.50, subd. 1. Requires counties to provide employment and training services within 30 days of receipt of a request from a caregiver who is no longer eligible for MFIP due to reaching the 60-month time limit, and whose income is below 120 percent of the federal poverty guidelines. Requires a caregiver to request employment and training services within 12 months after the caregiver's case was closed.

39. **Local service unit plan**. Amends § 256J.50, subd. 7. Adds a requirement that a local service unit's plan must address how it will use local intervention grants for self sufficiency (LIGSS) to target and provide outreach to caregivers who, within the last 12 months, are no longer eligible for MFIP due to reaching the 60-month time limit, and whose income is below 120 percent of the federal poverty guidelines.

40. **Required notification to victims of family violence.** Amends § 256J.50, subd. 10. Makes terminology changes, from "domestic violence" to "family violence."

    Makes terminology changes to conform with family violence provisions in this act. Specifies what a county or job counselor must do if an alternative plan is denied. Makes this section effective October 1, 2001.

41. **Access to persons trained in domestic violence.** Adds subd. 12 to § 256J.50. Requires a county that lacks a staff person trained in domestic violence to work with the nearest organization to ensure that domestic violence victims have access to a person who is trained in domestic violence. Makes this section effective October 1, 2001.

42. **Overview of employment and training services.** Amends § 256J.515. Adds referral information about shelters and programs, the time limit exemption, and waivers of regular employment and training requirements for victims of family violence to the list of topics to be covered during the employment and training services overview.

    Effective October 1, 2001, makes an MFIP participant who is complying with or developing an alternative employment plan exempt from the requirement to attend the overview of MFIP employment and training services.

43. **Initial assessment.** Amends § 256J.52, subd. 2. Extends the length of education or training programs that can be approved by the job counselor from 12 months to 24 months. Strikes requirement that an education and training program must be likely to lead to monthly employment earnings which, after subtracting the earnings disregard, equal or exceed the applicable family wage level.

44. **Alternative employment plan and family violence waiver provisions.** Amends § 256J.52, subd. 6. Strikes language in subdivision 3, which delineates safety plan requirements. Replaces the stricken language with new alternative employment plan and family violence waiver provisions, as follows:

    Requires that participants who currently have a safety plan have the safety plan converted to an alternative employment plan at their current plan renewal time. Specifies when an alternative employment plan must be reviewed and how participants are notified when the plan is up for review.

    If the participant does not want to renew the plan or if the participant fails to respond, requires the participant to participate in regular employment services activities. Requires that the participant receive assistance from a person trained in domestic violence if the participant requests a plan renewal or if there is dispute over whether the plan is still appropriate.

    If a person trained in domestic violence recommends that the activities are still appropriate, requires the job counselor to renew the alternative employment plan. Explains what a job counselor must do if he or she does not agree that the alternative employment plan activities are appropriate.

    If the person trained in domestic violence finds that the activities are not appropriate, requires that the plan be revised. Requires that job counselor approve the revised plan. Explains what a job counselor must do if he or she does not approve the revised plan.

    After the first six months, permits reviews to take place quarterly.

45. **Length of program.** Amends § 256J.53, subd. 1. Extends the length of education or training programs that can be approved as a work activity from 12 months to 24 months. Eliminates the requirement that education and training programs lasting up to 24 months be approved on an exception basis.

46. **Employment and training services component; exemptions.** Amends § 256J.56. Updates terminology to refer to a "participant" rather than "caregiver" or "individual." Specifies that a participant is exempt from employment and training requirements if the participant is needed in the home, as a caregiver, to care for an ill or incapacitated household member, when the illness or incapacity is expected to continue for more than 30 days.

    Strikes exemptions for individuals who are employed at least 35 hours per week; and for second parents in a two-parent family who are employed at least 20 hours per week while the other parent is employed at least 35 hours per week.

    Specifies that families experiencing a crisis related to family violence should not result in an exemption, but should be addressed through the development or revision of an alternative employment plan.

47. **Notice of intent to sanction**. Amends § 256J.57, subd. 2. When a job counselor or the county sends a notice of intent to sanction, provides that a notice written in English, including the Department of

Human Services language block, must be sent to every applicable participant.

48. **Caseload-based funds allocation.** Amends § 256J.62, subd. 2a. Removes the provision that set aside $1 million to provide funding to county or tribal providers who experience an unforeseen influx of participants or other emergent situations. Also removes the provision which specifies how the set-aside funds are allocated.

49. **Continuation of certain services.** Amends § 256J.62, subd. 9. Authorizes the continuation of case management, counseling, or other supportive services for participants who are no longer eligible for MFIP because they have reached the 60-month limit.

    Also removes a limitation that prevents a county from spending funds for the duration of an employment and training service if the funds have not been obligated before the participant loses MFIP eligibility.

50. **Establishment; guaranteed minimum allocation**. Amends § 256J.625, subd. 1. Allows counties or tribes to use the guaranteed minimum allocation of local intervention grants for self-sufficiency (LIGSS) money to serve participants who, within the last 12 months, have been determined to be ineligible for MFIP because they have reached the 60-month limit, and whose income is below 120 percent of the federal poverty guidelines.

51. **Set-aside funds**. Amends § 256J.625, subd. 2. Allows counties or tribes that are awarded additional LIGSS funds to use those additional funds to serve participants who are no longer eligible for MFIP because they have reached the 60-month limit, and whose income is below 120 percent of the federal poverty guidelines.

52. **Use of funds**. Amends § 256J.625, subd. 4. Prohibits the use of LIGSS funds for benefits defined under federal law as "assistance" for assistance units that are no longer eligible for MFIP due to reaching the 60-month time limit.

53. **Indian tribe MFIP employment services.** Amends § 256J.645. Strikes obsolete funding formula for the distribution of employment funds to Indian tribes. Specifies that funds must be allocated according to the formula under § 256J.62, subd. 1 and 2a (allocation of county employment and training services block grant).

54. **County performance management**. Amends § 256J.751. Modifies the county performance management section to include a quarterly report to each county on that particular county's performance on certain measures; a quarterly report to all counties on each county's performance on certain measures; and an annual report to all counties and the legislature.

    Subd. 1. **Quarterly county caseload report**. Directs the commissioner to report quarterly to each county on that particular county's performance on the following 11 measures:

    (1) number of MFIP cases receiving only the food portion;

    (2) number of child-only cases;

    (3) number of minor caregivers;

    (4) number of cases that are exempt from the 60-month time limit, by exemption category;

    (5) number of participants who are exempt from employment and training services requirements, by exemption category;

    (6) number of assistance units receiving assistance under a hardship extension;

(7) number of participants and number of months spent in each level of sanction;

(8) number of MFIP cases that have left assistance;

(9) federal participation requirements as specified in Title I of the federal welfare reform law;

(10) median placement wage rate; and

(11) of each county's total MFIP caseload, less the number of cases in clause (1) to (6), the number of one-parent cases; number of two-parent cases; percent of one-parent cases that are working more than 20 hours per week; percent of two-parent cases that are working more than 20 hours per week; and percent of cases that have received more than 36 months of assistance.

Subd. 2. Quarterly comparison report. Directs the commissioner to report quarterly to all counties on each county's performance on the following measures:

(1) percent of MFIP caseload working in paid employment;

(2) percent of MFIP caseload receiving only the food portion of assistance;

(3) number of MFIP cases that have left assistance;

(4) federal participation requirements as specified in Title I of Public Law Number 104-193;

(5) median placement wage rate; and

(6) caseload by months of TANF assistance.

Subd. 3. Annual report. Directs the commissioner to report to all counties and to the legislature, beginning January 1, 2002 and each January 1 thereafter, on each county's annual performance on the measures required under subd. 1 by race and ethnic group. Specifies that the report must also include each county's performance on the number of out-of-wedlock births and births to teen mothers; and MFIP cases by racial and ethnic group.

Subd. 4. Development of performance measures. Adds a specific date (January 1, 2002) by which the commissioner, in consultation with counties, must develop measures for county performance and adds the appropriateness of services provided to minority groups to the list of items that the commissioner must consider when developing these measures.

Subd. 5. Failure to meet federal performance standards. Makes technical changes to conform with this section.

55. **Establishment and purpose.** Amends § 256K.25, subd. 1. Strikes a provision that specifies that the supportive housing and managed care pilot projects must be located in two counties, one within the metro area and one outside the metro area.

56. **County eligibility.** Amends § 256K.25, subd. 3. Paragraph (a) adds the following item to the list of requirements that a county must comply with before it requests funding: the county must address, within its pilot design, the prevalence of mental illness, history of substance abuse, or HIV in the homeless population served.

    New paragraph (b) allows preference to be given to counties that cooperate with other counties that are participating in the pilot project for purposes of evaluation and to counties that provide additional funding.

57. **Participant eligibility.** Amends § 256K.25, subd. 4. (a) Strikes mental illness, a history of substance abuse, and HIV from the list of required eligibility criteria for the pilot project.

    New paragraph (d) permits counties participating in the project to initiate disenrollment criteria, subject to the commissioner's approval.

58. **Funding.** Amends § 256K.25, subd. 5. Strikes a reference to "TANF eligible" project participants, allowing the county to request general funds for any project participant. (The 2000 Legislature funded the project with TANF funds, which limited the use of those dollars to TANF eligible participants.) Also permits the commissioner to redirect funds to the pilot project.

59. **Report.** Amends § 256K.25, subd. 6. Provides that an assessment of the feasibility of financing the supportive housing and managed care pilot project through other health and human services programs must be included in the annual report.

60. **Tax for support of poor.** Amends § 261.062. Permits, rather than requires, a county board to levy a tax annually sufficient to defray the cost of supporting and relieving the poor.

61. **Specific powers.** Amends § 268.0122, subd. 2. Directs the commissioner of economic security to require all general employment and training programs that receive state funds to make available information about opportunities for women in nontraditional careers in the trades and technical occupations.

62. **Ineligibility for state funded programs.** Amends Laws 1997, chapter 203, article 9, section 21, as amended by Laws 1998, chapter 407, article 6, section 111, and Laws 2000, chapter 488, article 10, section 28. Delays for two years, until July 1, 2003, a provision that makes legal noncitizens ineligible for state-funded MFIP benefits.

63. **Domestic violence training for county agencies.** Requires the commissioner to provide training for county agency staff to receive specialized domestic violence training. Specifies that the training must be similar to the training provided to individuals who work for an organization designated by the Minnesota center for crime victims services as providing services to victims of domestic violence.

64. **Report on assessment of county performance.** Requires the commissioner, in consultation with counties, to report on a proposal for assessing county performance using a methodology that controls for demographic, economic, and other variables that may impact county achievement of MFIP performance outcomes. Provides that the proposal must recommend how state and federal funds may be allocated to counties to encourage and reward high performance.

65. **Extension rulemaking authority.** Authorizes the commissioner to adopt exempt rules if rulemaking is required to implement the MFIP hardship extension provisions.

66. **Revisor instruction.** Directs the revisor of statutes to change all remaining statutory and rule references from "MFIP-S" to "MFIP."

67. **Repealer.** Repeals the following provisions:

    (a) § 256J.08, subd. 50a, the definition of "interstate transitional standard"; § 256J.12, subd. 3, relating to the interstate payment standard for new residents; § 256J.43, specifying an interstate payment standard for new Minnesota residents who apply for MFIP; and § 256J.53, subd. 4, relating to repayment of post-secondary education or training lasting more than 12 months.

    (b) § 256J.49, subd. 11, the definition of "safety plan." (This provision is repealed October

1, 2001.)

(c) § 256D.066, relating to the interstate transitional standard.

(d) § 256J.46, subd. 1a, an obsolete transitional sanction provision.

(e) § 256J.44, relating to the initial screening of MFIP applicants. The provisions of this section are relocated in sections 10 to 12 of this act.

Article 11: Child Welfare and Foster Care

Overview

This article contains provisions related to child protection, child welfare, and foster care. Provisions in this article:

create a child maltreatment review panel (sections 1, 3, 10, and 11);
limit the type of foster care providers eligible for liability insurance purchased by the commissioner of human services (section 2);
make various policy and technical changes to the Maltreatment of Minors Act (sections 6 to 9 and 12);
require the commissioners of human services and corrections to train child abuse services professionals in appropriate methods to interview alleged victims of child abuse where the child is disabled (section 13);
require the commissioner of human services to report on child maltreatment; the feasibility and cost of creating a single-benefit package for all children removed from the care of a parent or guardian; and outcomes for African American children in child welfare out-of-home placements (sections 4, 14, and 15).

1 **Maltreatment review panels.** Amends § 13.461, subd. 17. Technical. Adds cross-reference.

2 **Insurance for foster home providers.** Amends§ 245.814, subd. 1. Amends provision that requires the commissioner of human services to purchase and provide liability insurance for individuals licensed as foster home providers by limiting coverage to providers licensed as family adult foster care homes as defined in section 144D.01, subd. 7.

3 **Child maltreatment review panel.** Adds § 256.022.

Subd. 1. Creation. Requires the commissioner of human services to establish a panel to review investigating agency child maltreatment determinations in response to a request for reconsideration of the determination. The panel must consist of the following members or their designees: the commissioners of health, human services, children, families and learning, and corrections; the ombudsman for crime victims; and the ombudsman for mental health and mental retardation.

Subd. 2. Review procedure. Requires quarterly meetings to respond to requests for reviews of child maltreatment determinations and establishes various procedures for the review. Provides for review of the final determination regarding maltreatment and any other pertinent or necessary data. Requires the panel to notify the alleged perpetrator that a review has been requested upon receipt of a request for a review. Requires the panel to notify the investigating agency within 30 days after its review whether it agrees with the agency determination or whether the agency must reconsider the determination. In the latter case, the panel must make specific recommendations to the agency. Requires the agency to report back to the panel within 30 days with its reconsidered determination

and the rationale.

Subd. 3. Report. Requires an annual report to the legislature each January from the panel about the requests for review and any recommendations to improve the review or investigative process.

Subd. 4. Data. Provides that data the review panel creates are private data on individuals.

4 **Annual report.** Amends § 257.0725. Requires the commissioner of human services to publish an annual report on child maltreatment. Requires the commissioner to work with other interested parties and organizations to improve the content and utility of the report and specifies what the child maltreatment report must include.

5 **Required termination of parental rights.** Amends § 260C.301, subd. 3, as amended by Laws 2001, chapter 178, article 1, section 34. Provides that a county attorney shall file a termination of parental rights petition within 30 days of the responsible social services agency determining that another child of the parent is subject to an order involuntarily transferring permanent legal and physical custody of the child to a relative.

6 **Duties of local welfare agency and local law enforcement agency upon receipt of a report.** Amends § 626.556, subd. 10, as amended by Laws 2001, chapter 178, article 2, section 11. Gives the local welfare agency or agency responsible for assessing or investigating a report of child maltreatment access to a child's medical records for purposes of evaluating alleged child maltreatment.

7 **Duties of commissioner; neglect or abuse in facility.** Amends § 626.556, subd. 10b. Provides that the agency responsible for assessing or investigating a report of child maltreatment must immediately investigate a report that alleges a child is the victim of maltreatment in a facility.

8 **Notification of neglect or abuse in facility.** Amends § 626.556, subd. 10d, as amended by Laws 2001, chapter 178, article 2, section 13. Adds references to maltreatment of a child in a facility. Requires the commissioner or local welfare agency to provide a written memorandum regarding the maltreatment investigation to the parent, guardian, or legal custodian of each child in a facility who had contact with the individual responsible for the maltreatment. Also requires the commissioner or local welfare agency to give notice to the parent, guardian, or legal custodian of each child receiving services in the population of the facility where maltreatment occurred if the facility is the responsible party for the maltreatment. Requires this notice to be given until the individual responsible for maltreatment is no longer in contact with children at the facility.

9 **Determinations.** Amends § 626.556, subd. 10e. Amends the statute on the determination an agency must make after investigating or assessing a child abuse report. Adds reference to maltreatment of a child in a facility.

10 **Notice of determinations.** Amends § 626.556, subd. 10f. Technical. Adds cross reference to the child maltreatment review panel.

11 **Records.** Amends § 626.556, subd. 11. Requires an investigating agency to exchange not public data with the child maltreatment review panel if the data are pertinent and necessary to a review. After the review is completed, data received by the panel must be returned to the investigating agency.

12 **Duties of facility operators.** Amends § 626.556, subd. 12. Requires a facility covered by the child abuse reporting act to notify mandated reporters who are employed by or associated with the facility of (1) their reporting duties, and (2) the ban on retaliation for good faith reports.

13 **Joint training.** Amends § 626.559, subd. 2. Amends provision that requires the commissioners of

human services and public safety to develop a joint training program for child abuse professionals. Requires that the training program include appropriate methods for interviewing and conducting investigations in cases where the alleged abuse victim is disabled.

14 **Child welfare cost consolidation report.** Requires the commissioner of human services to report to the legislature by January 15, 2002 on the feasibility and cost of creating a single-benefit package for all children removed from the care of a parent or guardian. Specifies what the report must include and who must be consulted in the development of the report.

15 **Study of outcomes for children in the child protection system.** Requires the commissioner of human services to study why African American children are disproportionately represented in child welfare out-of-home placements. Specifies what the commissioner must study and who the commissioner must consult with as part of the study. Requires the commissioner to report and make legislative recommendations to the legislature by January 15, 2002. Also specifies what the report must include.

Article 12: Child Support

Overview

This article contains provisions related to the child support enforcement program. Provisions in this article:

- authorize the commissioner of human services to pay a financial institution up to $150 each quarter for participation in the federally required financial institution data match (section 1);
- require the commissioner to pay paternity and child support order establishment bonus incentives to counties on a per child, instead of per case, basis (sections 5 and 6);
- authorize the public authority to sanction an employer or payor of funds for failing to comply with an order for income withholding or subpoena (sections 7 and 8);
- establish procedures for the public authority's handling of unclaimed support funds (sections 10 and 11);
- modify procedures for collecting arrears and contesting a cost-of-living adjustment (sections 13 and 15 to 18);
- permit modification of a support obligation for an obligor who is institutionalized or incarcerated (sections 14 and 19).

1 **Fees.** Amends § 13B.06, subd. 7. Permits the commissioner of human services to pay a quarterly fee of up to $150 to a financial institution that provides account information that can be compared with the department's database of child support obligors. (This section implements a federal law requirement that the state establish a financial institution data match enforcement mechanism for child support enforcement.)

Requires that the fee be paid only if the commissioner and financial institution enter a signed agreement in compliance with federal law. Also requires the commissioner to develop procedures for the financial institutions to charge and collect the fee. Limits the payment of the fee to the amount appropriated for this purpose, and specifies the procedures to be followed if the amount appropriated is insufficient or if excess funds are available.

Strikes obsolete language requiring the commissioner to study, determine, and report to the legislature on a fee structure. Requires the commissioner to evaluate whether the fee paid to financial institutions compensates them for their actual costs and report to the legislature by July 1,

2002 with a recommendation for retaining or modifying the fee.

2 **Public assistance.** Amends § 256.741, subd. 1. Defines direct support.

3 **Cooperation with child support enforcement.** Amends § 256.741, subd. 5. Strikes obsolete language requiring a caregiver to repay the public authority for child support the caregiver receives after becoming eligible for public assistance. (This language is obsolete because section 256.741, subd. 15, requires the state to distribute child support directly to a person receiving public assistance.) Requires the commissioner to count direct support received by a caregiver as unearned income when determining the assistance payment amount. Also requires that direct support retained by a caregiver be repaid to the child support agency for any month when direct support is greater than the court-ordered child support and assistance payment and the obligor owes support arrears.

4 **Refusal to cooperate with support requirements.** Amends § 256.741, subd. 8. Strikes language regarding direct support that is relocated in section 3.

5 **Paternity establishment and child support order establishment and modification bonus incentives.** Amends § 256.979, subd. 5. Modifies the bonus incentive system by requiring the commissioner to pay a $100 per child bonus, instead of a per case bonus, to a county child support agency for each child for which the agency completes a paternity or a child support order establishment or modification.

6 **Claims for bonus incentive.** Amends § 256.979, subd. 6. Provides that only one county may receive a bonus payment for the paternity establishment or child support order establishment or modification for each child. Strikes obsolete language defining case.

7 **Administrative penalties.** Amends § 393.07, by adding subd. 9a. (a) Provides that the public authority may sanction an employer or payor of funds $25 per day, up to $500 per incident, for failing to comply with an order for income withholding of child support or subpoena to provide information promptly on the employment, compensation, and benefits of an employee or contractor, if:

- the public authority gives the employer or payor of funds notice by certified mail of the administrative sanction; and

- the employer or payor of funds fails to correct the violation before the effective date of the sanction.

(Federal law requires that the state agency responsible for child support enforcement have the authority to impose these sanctions.)

(b) Requires the public authority to include notice of the appeal rights as part of the notice of administrative sanction sent to the employer or payor of funds.

(c) Provides that the administrative determination is final and binding if the employer or payor of funds does not appeal the sanction.

8 **Administrative authority.** Amends § 518.5513, subd. 5. Gives the public authority the authority to sanction a party for failure to respond to a subpoena. Also permits the public authority to sanction an employer or payor of funds for failure to comply with an income withholding notice or a subpoena. (Federal law requires that the state agency responsible for child support enforcement have the authority to impose these sanctions.)

9 **Making names public.** Amends § 518.575, subd. 1. Amends provision requiring the commissioner to publish a list of the names of certain delinquent child support obligors each year by permitting,

not requiring, the commissioner to publish the list each year.

10 **Unclaimed support funds.** Amends § 518.5851, by adding subd. 7. Defines unclaimed support funds.

11 **Unclaimed support funds.** Amends § 518.5853, by adding subd. 12. (a) Requires the public authority to try to locate an obligee for one year from the date the public authority cannot disburse support payments to the obligee because the obligee cannot be located.

(b) Provides that, if the public authority is unable to locate the obligee after one year, the public authority must send written notice to the obligee's last known address giving the obligee 60 days to contact the public authority. If the obligee does not contact the public authority within 60 days from the date of the notice, the public authority must:

- close the nonpublic assistance portion of the case;

- disburse unclaimed support funds to pay public assistance arrears. Permits the public authority to continue to enforce and collect child support until all public assistance arrears are paid. Also provides that the public authority must return the remaining unclaimed support funds to the obligor if there are no public assistance arrears or the arrears have been paid; and

- notify the obligor that incoming withholding is terminated and that the case is closed because the obligee could not be located.

(c) Provides that, if the public authority cannot locate the obligor to return the unclaimed support funds, the public authority must attempt to locate the obligor for one year. If the public authority cannot locate the obligor, requires the funds to be treated as unclaimed property.

12 **Payor of funds responsibilities.** Amends § 518.6111, subd. 5. Provides that a payor of funds who fails to withhold court-ordered child support is liable under the income withholding statute only if the noncompliance is intentional.

13 **Collection; arrears only.** Amends § 518.6195. (d) Provides that, absent a court order to the contrary, if an arrearage exists at the time a support order would otherwise terminate, and income withholding is not available, the obligor must repay the arrearage in an amount equal to the current support until the arrears are paid in full.

(e) Establishes procedures for collecting an arrearage when a support order fails to establish monthly support in a specific dollar amount. Provides that a public authority or obligee enter a payment agreement with an obligor for the amount the obligor would pay under the guidelines plus 20 percent until the arrears are paid in full. Also provides that an obligee or public authority may get a court order establishing repayment terms if the obligor does not enter a payment agreement.

14 **Modification.** Amends § 518.64, subd. 2, as amended by Laws 2001, chapter 51, section 16. Permits a modification of support or maintenance to be made retroactive if a court makes the express finding that the party seeking modification was institutionalized or incarcerated for an offense not relating to nonsupport of a child.

15 **Requirement.** Amends § 518.641, subd. 1. Clarifies that an order establishing, modifying, or enforcing maintenance or child support must provide for a cost-of-living adjustment.

16 **Notice.** Amends § 518.641, subd. 2. Strikes provisions regarding notice requirements for cost-of-living adjustments that are relocated in section 15. Provides that the public authority or obligee send notice of the intended adjustment to the obligor, including the date on which the adjustment

becomes effective.

17 **Procedures for contesting adjustment.** Amends § 518.641, by adding subd. 2a. (a) Establishes procedures for an obligor to contest a cost-of-living adjustment if the obligee has applied for or receives collection services, other than income withholding, from the public authority. Provides that a hearing must take place in the expedited child support process.

(b) Establishes procedures for an obligor to contest a cost-of-living adjustment initiated by an obligee who is not receiving collection services, or who receives income withholding services only, from the public authority. Provides that a hearing must take place in district court.

(c) Requires a court to stay a cost-of-living adjustment upon receipt of a motion contesting the adjustment.

(d) Requires the court administrator to make forms available to pro se obligors for contesting cost-of-living adjustments.

18 **Result of hearing.** Amends § 518.641, subd. 3. Clarifies that a child support magistrate in the expedited process may order that all or part of an adjustment not take effect.

19 **Child support judgment by operation of law.** Amends § 548.091, subd. 1a. Provides that a court may order interest on a child support debt to stop accruing if the court finds that an obligor is institutionalized or incarcerated for a crime other than for nonsupport of a child, and is otherwise financially unable to pay.

20 **Repealer.** Repeals section 518.641, subdivision 4 (requiring the department of human services to develop a form to be used to request a hearing for a cost-of-living adjustment) and subdivision 5 (requiring a request for cost-of-living clause to be included in a motion to enforce or modify an existing maintenance or child support order).

Article 13: Miscellaneous

Overview

This article makes changes to various health and human services-related statutes. Provisions in this article:

Modify provisions relating to nursing licensure (sections 2 and 3);
Require the commissioner of health to report a participant in the loan repayment program to a health-related licensing board and permit a health-related licensing board to refuse to grant a license or impose disciplinary action against a person regulated by the board if the person intentionally defaults on federal loans or service obligations (sections 1 and 6);
Modify requirements relating to public guardianship (sections 7 to 13, 24, and 29);
Modify the supplementary service rate for certain facilities and modify the supplementary rate for a certain group residential housing provider (sections 14 to 16);
Require the commissioner of human services to convene an interagency workgroup to study and develop recommendations regarding deaf/blind services (section 23);
Create a day training and habilitation payment structure pilot project (sections 18, 25 to 28).

1 **Penalties for breach of contract.** Amends § 144.1491, subd. 1. Requires the commissioner of health to report a participant in the loan repayment program to the appropriate health-related licensing board if the participant fails to complete a service obligation and fails to repay the amount

paid or fails to pay any financial penalty owed.

2 **Temporary permit.** Amends § 148.212. Allows the board of nursing to issue a temporary permit to practice as a registered nurse to an applicant who has been issued a Commission on Graduates of Foreign Nursing Schools certificate and meets other criteria.

3 **Certification of advanced practice registered nurses.** Amends § 148.284. Clarifies that the exemption to the certification requirement to practice advanced practice registered nursing does not apply to a nurse who is within six months of completion of the required course of study and awaiting certification if the person has previously failed the certification examination.

4 **Background checks.** Amends § 148B.21, subd. 6a. Directs the Board of Social Work to deposit all fees collected to conduct background checks on applicants for social work licensure into the miscellaneous special revenue fund, and to reimburse the Bureau of Criminal Apprehension for the cost of the background checks.

5 **Background checks.** Amends § 148B.22, subd. 3. Directs the Board of Social Work to deposit all fees collected to conduct background checks on social work licensees into the miscellaneous special revenue fund, and to reimburse the Bureau of Criminal Apprehension for the cost of the background checks. (The background check requirement in this subdivision applies to social work licensees applying for license renewal who did not undergo a background check as part of the application for initial licensure.)

6 **Health-related licensing boards; default on federal loans or service obligations.** Adds § 214.105. Authorizes a health-related licensing board to refuse to grant or impose disciplinary action against a person's license if the person is intentionally in nonpayment, default, or breach of a repayment or service obligation under a federal educational loan, loan repayment, or service obligation scholarship program.

7 **Guardianship service providers.** Amends § 252A.02, by adding subd. 3a. Defines guardianship service providers.

8 **Comprehensive evaluation.** Amends § 252A.02, subd. 12. Clarifies the definition of comprehensive evaluation. Provides that a case manager's report must include the most current individual service plan under section 256B.092, subdivision 1b. (Section 256B.092, subdivision 1b, identifies nine required components of an individual service plan for a person with mental retardation or a related condition.)

9 **Case manager.** Amends § 252A.02, subd. 13. Clarifies the definition of case manager. Provides that a case manager is the person designated under section 256B.092. (Section 256B.092 requires a county of financial responsibility to provide case management services to a person diagnosed as having mental retardation or a related condition.) Strikes language from current law providing that a case manager means the person designated by the county board to provide case management services.

10 **Special duties.** Amends § 252A.111, subd. 6. Adds requirement that the commissioner, in exercising the powers and duties of a public guardian or conservator, must protect and exercise the legal rights of the ward. Strikes obsolete provision from current law requiring the commissioner to prohibit filming of a ward.

11 **Review required.** Amends § 252A.16, subd. 1. Clarifies that the commissioner must require an annual review of the physical, mental, and social adjustment and progress of every ward and conservatee. Also clarifies that the review must contain the information required under Minnesota Rules, part 9525.3065, subpart 1.

12 **Petition.** Amends § 252A.19, subd. 2. Provides that procedures in section 525.61, subdivision 3, relating to the appointment of a new guardian or conservator do not apply to a petition to remove a public guardian. (Section 525.61, subdivision 3, provides that a court, upon a motion to remove a guardian or conservator, shall appoint a new guardian or conservator if the court finds: (1) the existing guardian or conservator failed to perform duties or provide for the best interests of the ward or conservatee; and (2) the ward's or conservatee's best interests would be served by the appointment of a new guardian or conservator.)

13 **Witness and attorney fees.** Amends § 252A.20, subd. 1. Strikes language prohibiting reimbursement for the services and travel of physicians, psychologists, or social workers who assist in the preparation of the comprehensive evaluation and who are employed by an area mental health mental retardation board.

14 **Supplementary service rates for certain facilities serving persons with mental illness or chemical dependency.** Amends § 256I.05, subd. 1d. Provides that, until June 30, 2002, the supplementary service rate for qualifying facilities may be increased by up to 15 percent of the rate in effect on January 1, 2001, for the facility. Provides that qualifying facilities with no supplementary service rate may negotiate a rate not to exceed $300 per month.

15 **Supplementary rate for certain facilities.** Amends § 256I.05, subd. 1e. Beginning July 1, 2001, increases the supplementary rate that a county agency must negotiate with a group residential housing provider that meets specific requirements from 25 to 46 percent of the supplementary service rate in subdivision 1a, including any legislatively authorized inflationary adjustments. Also modifies the description of a group residential housing provider under this subdivision.

16 **Supplementary service rate increases on or after July 1, 2001.** Amends § 256I.05, by adding subd. 1f. Increases the supplementary services rate for recipients of the group residential housing program who reside in a residence that is licensed by the commissioner of health as a boarding care home, but is not certified for purposes of the medical assistance program, by up to 32 percent of the rate in effect for that facility on January 1, 2001. Requires that the new rate not exceed the nonfederal share of the statewide weighted average monthly medical assistance nursing facility payment rate for case mix A in effect on January 1, 2001.

17 **Suicide statistics.** Adds § 299A.76. Prohibits the commissioner of public safety from (1) including any statistics on committing suicide or attempting suicide in any compilation of crime statistics published by the commissioner or (2) labeling as a crime statistic data on committing or attempting suicide. Allows the crimes of aiding suicide, aiding attempted suicide, and statistics directly related to the commission of a crime, to be included in published crime statistic compilations or labeled as crime statistics.

18 **Report.** Amends Laws 1999, chapter 152, section 4. Requires the day training and habilitation task force to make recommendations to the commissioner of human services on implementation of the pilot project for the individualized payment rate structure. Provides a December 30, 2003 expiration date for the task force.

19 **Repealer.** Amends Laws 1999, chapter 245, article 10, section 10, as amended by Laws 2000, chapter 488, article 9, section 30. Strikes a repealer of the home sharing grant program that would have been effective June 30, 2002.

20 **Definitions.** Amends Laws 2001, chapter 154, section 1, subdivision 1. Modifies the definition of genetic test provided in section 181.974. (Section 181.974 regulates the use of protected genetic information in employment.)

21 **Sunset.** Amends Laws 2001, chapter 161, section 45. Makes the statute that provides that the council on disability shall not sunset until June 30, 2003, effective July 1, 2001.

22 **Funding for day services programs.**

Subd. 1. Federal waiver requests. Requires the commissioner of human services to submit a request to the federal Health Care Financing Administration by September 1, 2001, for a home and community-based services waiver for day services.

Subd. 2. County funding of nonfederal share. Requires the county to pay the nonfederal share of medical assistance costs for day training for persons receiving services under the day services waiver on the later of July 1, 2003, or July 1 of the second calendar year after the federal Health Care Financing Administration grants the waiver under subdivision 1.

23 **Deaf/blind services study.** Requires the commissioner of human services to convene and lead an interagency workgroup for the purpose of study and development of recommendations regarding how to: (1) better use state appropriations and other resources to provide services to deaf/blind individuals and their families; (2) enhance and ensure better service delivery; and (3) remove barriers to effective service delivery. Specifies the members of the work group. Requires that the workgroup report its finding and recommendations to the legislature by February 1, 2002.

24 **Public guardianship alternatives.** Requires the commissioner of human services to provide county agencies with funds up to the amount appropriated for public guardianship alternatives based upon the counties' proposals to establish private alternatives.

25 **Day training and habilitation payment structure pilot project.** Requires the commissioner of human services to implement a pilot project and phase-in for an individualized day training and habilitation service payment structure.

Subd. 1. Individualized payment rate structure. Requires the commissioner of human services to initiative a pilot project and statewide phase-in for the individualized payment structure. Allows the project to initially include all or some vendors in up to eight counties, with no more than two counties from the seven-county metro area.

Subd. 2. Sunset. States that the pilot project sunsets upon implementation of a new statewide rate structure according to the implementation plan developed by the day training and habilitation task force in its report to the legislature. Requires rates of pilot project vendors to be modified to be consistent with this rate structure.

Subd. 3. Task force responsibilities. Requires the task force to evaluate the pilot project and report to the relevant committee chairs on how and when the individualized payment rate structure will be implemented statewide. Specifies other requirements for the implementation plan.

Subd. 4. Rate setting. (a) States that the rate structure is intended to allow a county to authorize an individual rate for each client in a vendor's program, based on the needs and expected outcomes of the individual client. Specifies other rate requirements.

(b) Allows vendors, with county concurrence, to establish up to four levels of service, A through D, based on the intensity of services provided.

(c) Requires county boards to establish for each vendor a dollar value for one hour of service at each of the service levels, based on the formula and guidelines developed by the day training and habilitation task force.

(d) Allows vendors to maintain a single transportation rate or establish up to five specified

types of transportation services. Sets rate requirements.

(e) Requires county boards to translate a vendor's existing program and transportation rates to the rates and values in the pilot project using the conversion calculations contained in the day training and habilitation task force's recommendations to the legislature. Provides the methodology for conversion.

Subd. 5. Individual rate authorization. Requires counties to authorize and document service and transportation packages, according to specified criteria.

Subd. 6. Billing for services. Requires vendors to bill and be reimbursed for the service package rate and transportation package rate as authorized by the county.

Subd. 7. Notification of change in client needs. Requires vendors to notify case managers within 30 days of changes in client need.

26 **County board responsibilities.** Requires county boards to document information submitted by day training vendors participating in the pilot project, and to establish a package period of one week, two weeks, or one month.

27 **Study of day training and habilitation vendor rates.** Requires the commissioner to identify vendors with the lowest rates or underfunded programs, and make recommendations to reconcile the discrepancies prior to implementation of the individualized payment rate structure.

28 **Federal approval.** Requires the commissioner of human services to seek any Medicaid plan amendments or federal waivers necessary to implement the day training pilot project.

29 **Repealer.** Repeals section 252A.111, subd. 3 (requirements relating to a ward receiving outpatient services or temporary care from a regional treatment center).

Article 14: DHS Licensing and Licensing Background Studies

Overview

This article makes various policy and technical changes to human services licensing, data practices, maltreatment of minors, and vulnerable adults statutes. Provisions in this article:

Modify and clarify requirements relating to background studies, disqualifications, maltreatment determinations, licensing actions based on those determinations, and appeal rights associated with those determinations (sections 2, 8, 11 to 17, 19 to 22, 24 to 29, and 31);
Permit the commissioner of human services and county agencies to share certain information regarding substantiated maltreatment with licensed programs and other agency and licensing boards (section 1);
Require background studies to be conducted on employees and controlling persons of temporary nursing pools (section 2);
Authorize health-related licensing boards to take disciplinary action against individuals the boards regulate based on a report of substantiated maltreatment or background study (sections 3 and 15);
Provide that an interested person acting on behalf of a child may request a review of a maltreatment determination by the maltreatment review panel (section 29);
Modify the definition of neglect and related reporting provisions under the Vulnerable Adults Act (sections 30 to 32).

1 **Licensing data.** Amends § 13.46, subd. 4. Paragraph (b), clause (1) amends the Data Practices Act by making the date of receipt of a completed application and the dates of licensure public data. Clarifies provisions making certain data regarding negative licensing actions and complaints public data. Also makes the identity of a licensee who is a substantiated perpetrator of maltreatment public data under certain circumstances.

Paragraph (b), clause (2) makes certain data on applicants for licensure who withdraw their application before the license is issued or denied public data.

Paragraph (b), clause (3) makes certain data on applicants for licensure who are denied a license public data.

Paragraph (b), clause (5) permits the commissioner of human services, local social services agency, or county welfare agency to inform a license holder of the identity of a substantiated perpetrator and victim of maltreatment when both the perpetrator and victim are affiliated with the licensed program.

Paragraph (e) makes a conforming terminology change.

Paragraph (g) adds cross-references to the definition of report and destruction of data provisions in the Vulnerable Adults Act.

Paragraph (h) permits the department of health to have access to not public data relating to a report of substantiated maltreatment for the purposes of completing background studies.

Paragraph (i) permits the department of human services to share data on individuals relating to licensing activities or maltreatment investigations with certain state agencies and regulatory boards when there is reason to believe that the laws or standards under the jurisdiction of those agencies or boards may have been violated.

Paragraph (j) requires the commissioner or local social services agency to notify the head of a facility that an individual is a substantiated perpetrator of child maltreatment based on sexual abuse, when the commissioner or agency knows that the individual is responsible for a child's care in that facility. Specifies notice requirements.

2 **Background studies on licensees and supplemental nursing services agency personnel.** Amends § 144.057.

Subd. 1. Background studies required. Requires the commissioner of health to contract with the commissioner of human services to conduct background studies on individuals who perform direct contact services in a nursing home, home care agency, or boarding care home. Defines the term access. Also requires background studies to be conducted on employees and controlling persons of temporary nursing pools (called supplemental nursing services agencies in this act).

Subd. 2. Responsibilities of department of human services. Adds references to supplemental nursing services agencies.

Subd. 3. Reconsiderations. Adds a cross-reference. Strikes reference to the rules establishing procedures and standards for background studies, which are repealed by this act.

Effective date: Makes this subdivision effective January 1, 2002.

Subd. 4. Responsibilities of facilities and agencies. Adds references to supplemental nursing services agencies and registrants. Requires supplemental nursing services agencies to maintain records verifying compliance with background study requirements.

3 **Health-related licensing boards; determinations regarding maltreatment.** Amends § 214.104. Paragraph (a) provides that a health-related licensing board must determine whether a regulated person under the board's jurisdiction should be the subject of disciplinary or corrective action because of a report of substantiated maltreatment or a background study that shows substantiated maltreatment. Strikes obsolete language.

Paragraph (b) requires the board to notify the commissioner of human services of a report of substantiated maltreatment and whether the board has jurisdiction in the matter. If the board does not have jurisdiction, requires the commissioner of human services to make an appropriate disqualification decision. Also requires the board to immediately notify the commissioners of health and human services if the board knows that a facility or program is allowing a regulated person to provide direct contact services in violation of requirements placed on the person.

Paragraph (c) permits the board to temporarily suspend the license, deny a credential, or require continuous supervision of a regulated person if the board finds there is probable cause to believe the person poses an immediate risk of harm to vulnerable persons. Provides that a board must consider certain information as part of its licensing action. Establishes notice and appeal rights regarding the action.

4 **Scope.** Amends § 245A.02, subd. 1. Provides that the definitions in the human services licensing act apply to chapter 245B (standards governing services to persons with mental retardation or related conditions).

5 **Certification.** Amends § 245A.02, by adding subd. 3a. Defines certification.

6 **License holder.** Amends § 245A.02, subd. 9. Amends definition of license holder by inserting a cross-reference to chapter 245B.

7 **Exclusion from licensure.** Amends § 245A.03, subd. 2. Excludes from licensure certain consumer-directed community support services funded under the Medicaid waiver for persons with mental retardation or related conditions.

8 **Exception.** Amends § 245A.03, subd. 2b. Makes terminology change.

9 **Right to seek certification.** Amends § 245A.03, by adding subd. 6. Allows a residential program licensed by the commissioner of corrections to serve children to seek certification from the commissioner of human services for program services for which certification standards have been adopted.

10 **Grant of emergency license.** Amends § 245A.035, subd. 1. Corrects a cross-reference.

11 **Background study of the applicant; definitions.** Amends § 245A.04, subd. 3. Paragraph (a) clarifies background study requirements for applicants, license holders, and other entities required to initiate background studies. Provides that a 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.

Paragraph (b) consolidates definitions that were previously found in other sections and rules.

Paragraph (c) expands background study authority to allow the commissioner to study persons age 10 to 12 who reside in the home where licensed services are provided and persons who may have unsupervised access to clients in family foster care and family child care, when the commissioner has reasonable cause.

Paragraph (d) provides circumstances in which the commissioner must review juvenile court records

as part of a background study.

Paragraph (e) requires the commissioner, beginning August 1, 2001, to conduct all background studies initiated by temporary nursing pools and requires the commissioner to recover the cost of the background studies by charging temporary nursing pools a fee of no more than $8 per study.

Paragraph (f) strikes a rule reference and the definition of direct contact, which is relocated in paragraph (b) of this subdivision.

Paragraph (g) specifies that the required background studies must be conducted at least upon application for initial license for all license types or registration for supplemental nursing services agencies and at re-application for licensure or registration for family child care, child foster care, and adult foster care.

Paragraphs (h) and (i) update cross-references.

Paragraph (j) makes a terminology change and defines conviction for the purposes of this paragraph.

Paragraph (k) provides that the subject of a background study must provide the applicant or license holder with certain information, including all other names by which the individual has been known and state identification number.

Paragraph (l) clarifies language and updates cross-references.

Paragraph (n) adds reference to supplemental nursing services agencies.

Paragraph (p) authorizes the commissioner to allow a disqualified person to continue in a position involving direct contact with or access to persons served by a licensed program under certain circumstances.

Paragraph (q) corrects a cross-reference.

12 **Notification to subject and license holder of study results; determination of risk of harm.** Amends § 245A.04, subd. 3a. Paragraph (a) requires the commissioner to notify the applicant, license holder, or registrant and the subject of a background study of the results of the study within 15 working days or that more time is needed to complete the study. Provides that the commissioner may notify an agency initiating a background study of the basis for an individual's disqualification, when the individual is disqualified for failing to cooperate with the background study or for substantiated maltreatment of a minor or vulnerable adult.

Paragraph (b) adds a cross-reference and changes the term supervision to direct supervision.

13 **Reconsideration of disqualification.** Amends § 245A.04, subd. 3b. Paragraph (a) allows a disqualified individual to request more time to obtain information, not to exceed 30 days. Provides that an individual who is disqualified based on serious or recurring maltreatment of a minor or vulnerable adult may request reconsideration of both the maltreatment and disqualification determinations within 30 days of receipt of the notice of disqualification. Provides that a maltreatment determination is deemed conclusive if an individual does not request reconsideration. Also adds references to registered temporary nursing pools.

Paragraph (b) requires the commissioner to rescind a disqualification if the information relied upon to disqualify the subject is incorrect. Provides that the commissioner, in determining whether an individual poses a risk of harm to persons served by an applicant, license holder, or registrant must consider the nature and severity of the event, the age of the victim, the harm suffered by the victim, and the similarity between the victim and persons served by the program. Also adds references to registered temporary nursing pools.

Paragraph (c), adds a ten-year bar to setting aside a disqualification in family child 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, for a felony conviction involving alcohol or drug use. Also adds a permanent bar for setting aside a disqualification in the same programs for the involuntary termination of parental rights. Adds references to registered temporary nursing pools.

Paragraph (d) requires the commissioner to respond to a request for reconsideration within 45 working days after receiving the request if the request is based on both risk of harm and the accuracy and completeness of the information relied upon to disqualify the individual.

Paragraph (e) strikes language making the commissioner's decision to disqualify an individual the final administrative agency action. Provides that a disqualified person may request a fair hearing to review the disqualification if the person is disqualified based on a preponderance of the evidence that the person committed a disqualifying act or a failure to make a mandated report required by the Maltreatment of Minors Act or Vulnerable Adults Act. Provides that the commissioner's final order following a fair hearing is conclusive on the issue of disqualification and is the only administrative appeal of the final agency determination regarding the disqualification.

Paragraph (f) provides that a reconsideration of a maltreatment determination and disqualification based on the maltreatment determination must be consolidated into one reconsideration and specifies the scope of the hearing. Provides that the commissioner's final order following a fair hearing is the only administrative appeal of the maltreatment determination and disqualification.

14 **Contested case.** Amends § 245A.04, subd. 3c. Paragraph (a) provides that, when an employee of a public employer is disqualified based on a maltreatment determination, the scope of the contested case hearing must include the maltreatment determination and disqualification.

Paragraph (b) provides that, when a disqualification is the basis for a denial of a license or a licensing sanction, the license holder has the right to a contested case hearing. Specifies the procedures for, and scope of, the hearing.

Paragraph (c) provides that, when the disqualified person is not the license holder and the disqualification is the basis for a denial of a license or licensing sanction, there may be one consolidated contested case hearing with the consent of the parties and administrative law judge.

Paragraph (d) provides that the commissioner's final order is conclusive and that the contested case hearing is the only administrative appeal of the final agency determination regarding the maltreatment and disqualification.

Effective date. Makes this section effective January 1, 2002.

15 **Disqualification.** Amends § 245A.04, subd. 3d. Paragraph (a) permits the commissioner to disqualify an individual upon receipt of certain information. Adds references to registered temporary nursing pools. Provides that persons over the age 13 and persons ages 10 to 12 living in the household where a licensed program will be provided, and persons who may have unsupervised access to children in the licensed program, must be disqualified from access to persons receiving services from the license holder if a background study shows that the person has been convicted of certain crimes or has admitted to or committed a disqualifying act. Amends the list of disqualifying crimes so that it is consistent with the changes made in section 13 of the act. Clarifies that a determination or disposition of failure to report maltreatment of a minor or vulnerable adult under certain circumstances is a disqualifying act. Defines access for purposes of this section.

Paragraph (b) establishes the relationship between the commissioner of human services and health-related licensing boards related to background studies and disqualifications, including notice

requirements and the commissioner's authority to monitor a facility's compliance with the requirements that a board places on a regulated person or facility.

16 **Variance for a disqualified person.** Amends § 245A.04, by adding subd. 3e. Paragraph (a) clarifies existing variance authority that is in rule that allows the commissioner to grant a time-limited variance for persons who have been disqualified. Specifies the information the commissioner must include in the variance.

Paragraph (b) provides that, except for 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 may not grant a variance for a disqualified individual unless it is requested and the disqualified individual gives written consent for the commissioner to disclose the reason for the disqualification.

Paragraph (c) provides that the commissioner must immediately terminate a variance and may fine or sanction a license holder for allowing a disqualified individual to violate the conditions of the variance.

Paragraph (d) allows the commissioner to terminate a variance for a disqualified person at any time for cause.

Paragraph (e) makes the commissioner's decision to grant or deny a variance request final and not subject to appeal.

17 **Commissioner's evaluation.** Amends § 245A.04, subd. 6. Makes a terminology change.

18 **Education program; additional requirement.** Amends § 245A.04, subd. 11. Paragraph (b) allows certain residential programs to serve persons through the age of 19 provided that:

(1) the admission is necessary for a person to complete secondary school;

(2) the facility develops policies, procedures, and plans as required for license holders caring for vulnerable adults;

(3) the facility develops necessary risk reduction measures; and

(4) the age difference among residents in the facility does not exceed five years.

Paragraph (c) allows the license holder to seek other variances from the commissioner.

19 **Denial of application.** Amends § 245A.05. Permits the commissioner to deny a license if an applicant fails to comply with laws or rules or knowingly withholds or gives false or misleading information to the commissioner. Adds cross-reference to the rules that will govern a hearing regarding the denial of an application.

Effective date. Makes this section effective January 1, 2002.

20 **Correction order and conditional license.** Amends § 245A.06.

Subd. 1. **Contents of correction orders and conditional licenses.** Provides that the commissioner may order a conditional license, instead of imposing a fine, when an applicant or license holder fails to comply with an applicable rule or law that does not imminently endanger the persons served by the program. Specifies factors the commissioner must consider when issuing a conditional license and information that must be included in the conditional license. Strikes language regarding imposing fines.

Subd. 3. Failure to comply. Permits the commissioner to impose a fine and order other licensing sanctions when an applicant or license holder has not corrected the violations specified in the

conditional license. Strikes language regarding imposing fines and taking other licensing actions for failure to correct a violation.

Subd. 4. Notice of conditional license; reconsideration of conditional license. Specifies requirements for notifying a license holder that a license is conditional. Also specifies procedures for a license holder to request reconsideration of the order of conditional license.

Subds. 5, 5a, 6, and 7. Strike provisions relating to fines, which are relocated in section 21 of this act.

21 **Sanctions.** Amends § 245A.07.

Subd. 1. Sanctions available. Clarifies language regarding sanctions that the commissioner may order.

Subd. 2. Temporary immediate suspension. Provides that the commissioner may temporarily suspend a license when the license holder's actions or failure to comply with applicable law or rule poses an imminent risk of harm to persons served by the program. Provides for an expedited hearing instead of a contested case hearing.

Subd. 2a. Immediate suspension expedited hearing. Specifies procedures and time lines for an expedited hearing of an immediate suspension of a license.

Subd. 3. License suspension, revocation, or fine. Clarifies provisions regarding the commissioner's authority to suspend or revoke a license or impose a fine. Strikes provisions regarding conditional licenses that are relocated in the act. Specifies procedures for providing notice, appeal, and payment of fines. Also specifies the amount of fines for certain violations of law or rule.

Effective date. Makes this section effective January 1, 2002.

22 **Hearings.** Amends § 245A.08.

Subd. 1. Receipt of appeal; conduct of hearing. Adds cross-references.

Subd. 2. Conduct of hearings. Adds cross-references.

Subd. 2a. Consolidated contested case hearings for sanctions based on maltreatment determinations and disqualifications. Specifies the scope of contested case hearings under certain circumstances; provides that the county attorney must defend sanctions issued in family child care, child foster care, and adult foster care homes; provides that the commissioner's final order following the contested case hearing is the final agency action and is not subject to further review; and provides for consolidation of hearings in certain circumstances.

Subd. 3. Burden of proof. Clarifies provisions regarding the burden of proof at a hearing on a licensing sanction. Corrects cross-reference.

Subd. 5. Notice of the commissioner's final order. Adds cross-references.

Effective date. Makes this section effective January 1, 2002.

23 **Reduction of risk of sudden infant death syndrome in child care programs.** Creates new § 245A.144. Requires that license holders ensure that, before staff, caregivers, and helpers assist in the care of infants, they receive training on reducing the risk of sudden infant death syndrome. Allows the training to be provided as orientation training, initial training, in-service training, or ongoing training. Also requires that training be completed at least once every five years.

24 **Delegation of authority to agencies.** Amends § 245A.16, subd. 1. Makes conforming language

changes. Specifies variances that may be issued only by the commissioner.

25 **Sanctions available.** Amends § 245B.08, subd. 3. Makes conforming language changes.

26 **State agency hearings.** Amends § 256.045, subd. 3. Paragraph (a) provides for a state agency hearing for persons disqualified for serious or recurring maltreatment; persons disqualified on the basis that a preponderance of the evidence indicates they committed a disqualifying act; and persons who fail to make reports required by the Maltreatment of Minors Act or Vulnerable Adults Act. Specifies procedures for consolidation and scope of review of the hearings. Adds cross-reference.

27 **Standard of evidence for maltreatment and disqualification hearings.** Amends § 256.045, subd. 3b. Specifies the evidentiary standard that a referee must find to affirm a proposed disqualification determination at a hearing regarding a disqualification. Adds cross-reference.

28 **Conduct of hearings.** Amends § 256.045, subd. 4. Adds cross-references.

29 **Administrative reconsideration of final determination of maltreatment and disqualification based on serious or recurring maltreatment; review panel.** Amends § 626.556, subd. 10i, as amended by Laws 2001, chapter 178, article 2, section 15. Paragraph (a) provides that an interested person acting on behalf of a child may request reconsideration of a maltreatment determination. Provides that, effective January 1, 2002, an individual determined to have maltreated a child or who was disqualified on the basis of serious or recurring maltreatment may request reconsideration of the maltreatment determination and disqualification. Specifies that an individual must request reconsideration within 30 days of receiving notice of the disqualification.

Paragraph (b) adds a cross reference. Provides that an interested person acting on behalf of a child may request a review of the maltreatment determination by the maltreatment review panel under section 256.022.

Paragraph (c) adds a cross-reference.

Paragraph (d) adds a cross-reference.

Paragraph (e) provides that, effective January 1, 2002, a request for reconsideration of a maltreatment determination, and a request for reconsideration of a disqualification based on the maltreatment determination, must be consolidated into one reconsideration or fair hearing. Specifies that the scope of the hearing must include the maltreatment determination and disqualification.

Paragraph (f) provides that, effective January 1, 2002, if a licensing sanction is based on a maltreatment determination or disqualification based on a maltreatment determination, the license holder has the right to a contested case hearing. Specifies the scope of the hearing and provides for consolidation of the hearings.

Paragraph (g) defines interested person acting on behalf of a child.

30 **Timing of report.** Amends § 626.557, subd. 3, of the Vulnerable Adults Act. Paragraph (e) requires a mandated reporter to report an error in the provision of therapeutic care to a vulnerable adult that results in injury or harm to the vulnerable adult, which reasonably requires the care of a physician. Requires the reporter to provide information explaining how the reported error is not neglect, if the reporter believes that to be the case. Requires the investigating agency to consider this information when assessing the case.

Effective date. Makes this section effective August 1, 2001.

31 **Administrative reconsideration of final disposition of maltreatment and disqualification based on serious or recurring maltreatment; review panel.** Amends § 626.557, subd. 9d, of the

Vulnerable Adults Act. Paragraph (a) provides that an individual determined to have maltreated a vulnerable adult or who was disqualified on the basis of serious or recurring maltreatment may request reconsideration of the maltreatment determination and disqualification. Specifies that an individual must request reconsideration within 30 days of receiving notice of the disqualification.

Effective date: Makes this paragraph effective January 1, 2002.

Paragraph (b) adds cross-reference.

Effective date: Makes this paragraph effective January 1, 2002.

Paragraph (e) provides that a request for reconsideration of a maltreatment determination, and a request for reconsideration of a disqualification based on the maltreatment determination, must be consolidated into one reconsideration or fair hearing. Specifies that the scope of the hearing.

Effective date: Makes this paragraph effective January 1, 2002.

Paragraph (f) provides that, if a licensing sanction is based on a maltreatment determination or disqualification based on a maltreatment determination, the license holder has the right to a contested case hearing. Specifies the scope of the hearing and provides for consolidation of the hearings.

Effective date: Makes this paragraph effective January 1, 2002.

Paragraph (g) provides that, until August 1, 2002, an individual or facility determined to be responsible for neglect that occurred after October 1, 1995, and before August 1, 2001, may request reconsideration of the neglect determination if they believe that the finding does not meet the amended definition of neglect. Specifies notice requirements. Provides that the commissioner must review and make a determination on the reconsideration request within 15 calendar days and that the commissioner's decision is the final agency action. Specifies procedures for destructing data and rescinding disqualification determinations when a determination of substantiated maltreatment has been changed.

Effective date: Makes this paragraph effective the day following final enactment.

32 **Neglect.** Amends § 626.5572, subd. 17. Paragraph (c) modifies definition of neglect in the Vulnerable Adults Act. Provides that a vulnerable adult is not neglected when an individual makes an error in providing therapeutic contact that results in injury or harm to the vulnerable adult, which reasonably requires the care of a physician if: the necessary care is timely provided; after receiving care, the health status of the vulnerable adult can reasonably be expected to be restored to the vulnerable adult's preexisting condition; the error is not part of a pattern of errors; and, if the error occurs in a facility, the error is immediately reported, corrective action is taken, and the report and corrective action are sufficiently documented.

Paragraph (e) provides that a facility is subject to a correction order for not immediately reporting, correcting, or documenting its compliance if it is determined that the facility's failure to take these actions is the sole reason for the maltreatment determination.

33 **Federal law change request or waiver.** Requires the commissioner of health or human services to pursue federal law changes necessary to allow greater discretion on disciplinary activities of unlicensed health care workers and to apply for necessary federal waivers or approval that would permit a disqualification set aside process for nurse aides in nursing homes by July 1, 2002.

34 **Waiver from federal rules and regulations.** Requires the commissioner of health, by January 2002, to examine federal rules and regulations prohibiting neglect, abuse, and financial exploitation

of residents in nursing facilities and apply for federal waivers to allow the use of Minnesota law in: (1) the identification and prevention of maltreatment of residents in nursing facilities and (2) the disqualification or discipline of persons providing services in nursing facilities.

35 **Instruction to revisor.** Instructs the Revisor to correct certain cross-references in this act.

36 **Repealer.** Repeals the background study rules. The provisions from the background study rules are incorporated throughout this act.

Article 15: Vital Statistics

Overview

This article makes technical and substantive changes to statutes governing vital statistics, in part to conform with Health Department rules adopted in 2000. Technical changes include modifying terms used. Substantive changes include the following.

Section 12 allows unmarried parents to determine together their child's surname.
Section 23 modifies the birth data that a mother may designate as public when the mother and father are unmarried when the child is conceived and born, lowers the age at which a child who is the subject of a birth record may access birth data from 18 to 16 years of age, and clarifies that the commissioner of human services may access birth records for certain purposes without a court order.
Section 24 gives the commissioner of human services access to health data associated with birth registration to administer public health care programs and for other public health purposes.
Section 26 allows adoption agencies to access certified birth or death records to complete postadoption searches and requires issuance of a certified death record to certain individuals if a mortician provides an issuing registrar with a properly completed attestation.
Section 28 in part exempts certain applicants for replacement birth records from a $20 fee and subjects certain record amendments to a $20 fee.

1 **Delayed registration.** Amends § 144.212, subd. 2a. Amends a subdivision defining delayed registration, by modifying a term used throughout the statutes on vital statistics (birth certificate and death certificate are being changed to birth record and death record). Also clarifies that a delayed registration is one filed one or more years after the date of the birth or death being registered.

2 **File.** Amends § 144.212, subd. 3. Amends the definition of file, to mean presenting a vital record or report to the office of the state registrar and having the record or report accepted by the state registrar.

3 **Registration.** Amends § 144.212, subd. 5. Amends the definition of registration, to mean the process by which vital records are completed, filed, and incorporated into the official records of the office of the state registrar.

4 **System of vital statistics.** Amends § 144.212, subd. 7. Amends the definition of system of vital statistics, to specify that it includes the dissemination of vital statistics.

5-7 Amends § 144.212, subds. 8, 9, and 11. Amends the definitions of vital record, vital statistics, and consent to disclosure by modifying terms used. Section 5 also specifies that the birth record is not the medical record of the mother or child.

8 **Districts.** Amends § 144.214, subd. 1. Eliminates the city of St. Paul as a separate district for the

registration of vital statistics. Also specifies that the local registrar in each county is designated by the county board of commissioners, instead of designating the district court administrator for each county as the local registrar.

9 **Duties.** Amends § 144.214, subd. 3. Eliminates from the list of duties for local registrars, the duties of examining each birth or death certificate and registering complete certificates only.

10 **Designated morticians.** Amends § 144.214, subd. 4. Modifies a term used.

11 **When and where to file.** Amends § 144.215, subd. 1. Requires birth records to be filed with the state registrar, instead of allowing the record to be filed with either the state registrar or the appropriate local registrar. Modifies a term used.

12 **Father's name; child's name.** Amends § 144.215, subd. 3. Modifies a term used. Also authorizes unmarried parents who voluntarily establish paternity to determine together their child's surname, rather than requiring the child's surname to be that of the father.

13 **Social security number registration.** Amends § 144.215, subd. 4. Modifies a term used. Requires parents' social security numbers to be reported to the office of the state registrar instead of the office of vital statistics and makes a conforming change.

14 **Births occurring outside an institution.** Amends § 144.215, subd. 6. Modifies a term used. For births occurring outside an institution, moves the order of preference for a mother to file her child's birth certificate to after the father of the child but before the person responsible for the premises where the child is born (in current law, the mother has the same level of preference as the father).

15 **Evidence required to register a noninstitution birth within the first year of birth.** Amends § 144.215, subd. 7. Modifies a term used. For births occurring outside an institution, requires evidence supporting the facts of the birth to be filed in all cases, as part of filing a birth record (current law requires such evidence only when the state and local registrar do not have personal knowledge of the facts of the birth).

16 **Delayed records of birth.** Amends § 144.217. Modifies terms used and makes technical changes. Prohibits registration of a delayed record of birth for a deceased person. Strikes a subdivision requiring certified copies of court orders regarding registration of delayed birth records to be forwarded to local registrars, and allowing certified copies of court orders to be admissible as birth certificates.

17 **Replacement birth records.** Amends § 144.218. Modifies terms used. Allows information contained in the original birth record, except for the registration number, to be provided upon request to a parent who is named in the original record. Makes submission of an adoption certificate for a foreign-born person sufficient for the state registrar to register a birth record in the adopted person's new name. A new subdivision 5 requires a replacement birth record to be registered upon a court order, at the request of a court in another state, or upon a filing of a declaration of parentage or recognition of parentage.

18 **When and where to file.** Amends § 144.221, subd. 1. Modifies terms used, and allows death records to be filed with the state registrar, local registrar, or designated mortician.

19 **When no body is found.** Amends § 144.221, subd. 3. Eliminates a requirement that a court order finding death has occurred be attached to a death record, when a death record is registered when circumstances suggest a death has occurred but no body is found.

20 **Sudden infant death.** Amends § 144.222, subd. 2. Requires reports of sudden infant deaths to be filed with the state registrar within five days, instead of promptly as in current law.

21 **Report of marriage.** Amends § 144.223. Modifies terms used and makes technical changes.

22 **Public information; access to vital records.** Amends § 144.225, subd. 1. Modifies a cross-reference from a section being repealed to a section being created in this bill, and makes a technical change.

23 **Data about births.** Amends § 144.225, subd. 2. When a child's mother and father are not married at the time of the child's conception and birth, allows the mother to designate demographic data (rather than all data) about the birth as public data. Lowers the age at which a child who is the subject of the record may access the data, from 18 to 16 years of age. Clarifies that the commissioner of human services may access birth records without a court order to administer public health care programs, for child support enforcement, and for other public health purposes.

24 **Health data associated with birth registration.** Amends § 144.225, subd. 2a. Allows the commissioner of human services to access health data associated with birth registration to administer public health care programs and for other public health purposes.

25 **Laws and rules for preparing vital records.** Amends § 144.225, subd. 3. Modifies a term used, and amends the subdivision title.

26 **Certified birth or death record.** Amends § 144.225, subd. 7. Modifies terms used. A new item (xi) in paragraph (a) gives an adoption agency access to certified copies of birth or death records to complete postadoption searches. A new paragraph (b) requires a state or local registrar to issue a certified death record to certain individuals with a tangible interest in the death record, if a mortician provides the registrar with a properly completed attestation. Specifies that the attestation need not be notarized.

27 **Access to original birth record after adoption.** Adds § 144.2252. Directs the state registrar to act according to section 259.89 when an adopted person asks for information on the person's original birth record. Requires the state registrar to provide a transcript of an adopted person's original birth record to a federally recognized Indian tribe, for the sole purpose of determining the adopted person's eligibility for enrollment or membership. Prohibits information given to an Indian tribe from being used to give the adopted person information about the person's birth parents, except as otherwise allowed in statute. (This is a recodification of section 144.1761, which is being repealed.)

28 **Which services are for fee.** Amends § 144.226, subd. 1. In paragraph (a), makes technical changes and clarifies that the fee will be waived for issuance of a new birth or death record within one year of the original's issuance only if the vital record is amended. In paragraph (b), specifies that applications for replacement birth records when recognitions of parentage are filed are not subject to the $20 replacement fee. In paragraph (d), specifies that any amendment to a vital record made more than 45 days after the record is filed is subject to a $20 fee (in current law, parties have up to one year to amend a vital record without having to pay a fee).

29 **Birth record surcharge.** Amends § 144.226, subd. 3. Modifies terms used, and specifies that the $3 birth record surcharge is nonrefundable.

30 **Penalties.** Amends § 144.227. Modifies terms used and makes technical changes.

31 **Rights of terminated parent.** Amends § 260C.317, subd. 4. Modifies a cross-reference from a section being repealed to a section created in the bill, and makes technical changes.

32 **Revisor's instruction.** Directs the Revisor of Statutes to modify terms used in Minnesota Statutes and Minnesota Rules.

33 **Repealer.** Repeals the following statutes: 144.1761 (access to adoption records); 144.217, subd. 4

(filing court orders regarding delayed birth certificates); and 144.219 (amendment of vital records).

Article 16: Patient Protection

Overview

This article modifies existing patient protection provisions and establishes new patient protections for health plan enrollees. Most provisions in this article were included in Chapter 196 (H. F. 560/S. F. 491), the patient protection bill that was vetoed during the 2001 regular session.

Sections 1 and 3 require part of any administrative penalty obtained from a health plan company to be distributed to any enrollees affected by the violation, unless certain circumstances apply.
Section 2 requires disclosure of certain information regarding coverage of clinical trials, and section 9 requires the commissioners of health and commerce to study and develop recommendations on health plan coverage of clinical trials.
Section 6 requires certain health plan companies to employ Minnesota-licensed physicians as medical directors.
Section 7 modifies requirements governing continuity of care, and section 8 modifies standing referral requirements and establishes requirements for mandatory standing referrals.

1 **Violations and penalties.** Amends § 45.027, subd. 6. In a subdivision authorizing the commissioner of commerce to impose civil penalties for violations of law, requires the commissioner to divide 50 percent of any civil penalty imposed on a health carrier among enrollees affected by the violation, unless the commissioner certifies that distribution would be too administratively complex or that each affected enrollee would receive less than $50.

2 **Services associated with clinical trials.** Adds § 62D.109. Requires an HMO to inform an enrollee participating in a clinical trial, if the enrollee asks, that clinical trial coverage shall be provided as required under the enrollee's health maintenance contract or state or federal statute or rule.

3 **Administrative penalty.** Amends § 62D.17, subd. 1. In a subdivision authorizing the commissioner of health to impose administrative penalties on health maintenance organizations for violations of law, requires the commissioner to divide 50 percent of any penalty levied among any enrollees affected by the violation, unless the commissioner certifies that distribution would be too administratively complex or that each affected enrollee would receive less than $50.

4 **Cost containment data from group purchasers.** Amends § 62J.38. In a section requiring group purchasers to submit certain cost containment data to the commissioner of health, requires expenditure data that is submitted to distinguish between costs incurred for patient care and administrative costs. Allows patient care and administrative costs to include only expenses incurred on behalf of health plan members, and prohibits inclusion of the cost of providing services for nonmembers at group purchaser-owned facilities. Specifies what must be included in administrative costs. Requires the reports of cost containment data from group purchasers to separately identify expenses for taxes, fees, and assessments, and to include payments made to acquire a health care facility, payments made pursuant to a partnership or other agreement with a health care provider, and payments made during the calendar year for these purposes. Directs the commissioner to make public, by group purchaser, data collected under this paragraph using the procedures established in another section. Exempts workers compensation and automobile insurance plans from complying with this paragraph.

5 **Utilization review organization.** Amends § 62M.02, subd. 21. Modifies the definition of utilization

review organization to exempt from regulation as a utilization review organization, a clinic or health care system that performs utilization review activities according to a written delegation agreement with a utilization review organization. Makes the utilization review organization that contracts with the clinic or health care system accountable for any delegated utilization review activities.

6 **Licensure of medical directors.** Adds § 62Q.121. Requires all health plan companies with three percent or more of the health plan market to employ only Minnesota-licensed physicians as medical directors, if they make recommendations or decisions that affect enrollees in this state. Defines medical director. Requires all health plan companies subject to this section to provide the commissioner with names and licensure information for all medical directors, and to update this information not later than 30 days after any changes.

7 **Continuity of care.** Amends § 62Q.56. Modifies provisions governing continuity of care for enrollees when enrollees must change providers or health plans.

Subd. 1. Change in health care provider; general notification. In paragraph (a), expands the requirement that a health plan company must establish a written plan for continuity of care if a contract between the health plan company and a provider is terminated, to include specialists. In paragraphs (b) and (c) language is stricken governing referrals when the contract termination is for cause or not for cause. Paragraph (b) also specifies that termination includes nonrenewal of a contract. The language in paragraph (c) is being moved to a new subdivision 1b.

Subd. 1a. Change in health care provider; termination not for cause. Provides additional detail as to when a health plan company must authorize services with a terminated provider when the provider's contract termination was not for cause. Paragraph (a) establishes notification requirements when a provider contract is terminated not for cause. Paragraph (b) requires authorization for services for up to 120 days if an enrollee is engaged in a current course of treatment for an acute condition, has a life-threatening physical or mental illness, is pregnant after the first trimester, has a physical or mental disability, or has a disabling or chronic condition in an acute phase. Also requires authorization for services for the rest of an enrollee's life if the enrollee is expected to live 180 days or less. Paragraph (c) requires a health plan company to establish a process for coverage determinations for up to 120 days of continuity of care for enrollees receiving culturally appropriate services and for enrollees who do not speak English, if the health plan company does not have an appropriate provider sufficiently close to the enrollee.

Subd. 1b. Change in health care provider; termination for cause. Requires a health plan company to notify enrollees of a change in health care provider and to transfer enrollees to a participating provider if the provider's contract was terminated for cause. (This subdivision is existing law and is being moved from subdivision 1.)

Subd. 2. Change in health plans. When an enrollee is subject to a change in health plans, paragraph (a) provides additional detail as to when the enrollee's new health plan company must authorize services with the enrollee's current provider. Requires authorization for services for up to 120 days if an enrollee is engaged in a current course of treatment for an acute condition, has a life-threatening physical or mental illness, is pregnant after the first trimester, has a physical or mental disability, or has a disabling or chronic condition in an acute phase. Also requires authorization for services for the rest of an enrollee's life if the enrollee is expected to live 180 days or less.

Paragraph (b) requires a health plan company to establish a process for coverage determinations for up to 120 days of continuity of care for enrollees receiving culturally appropriate services and for enrollees who do not speak English, if the health plan company does not have an appropriate provider sufficiently close to the enrollee.

Subd. 2a. Limitations. Makes the requirements in subdivisions 1, 1a, 1b, and 2 apply only if the enrollee's health care provider will accept either the health plan company's reimbursement rate or the provider's regular fee, whichever is lower; follow the health plan company's preauthorization requirements; and give the health plan company all necessary medical information regarding the care provided. Specifies that this section does not require a health plan company to cover a service or treatment not covered under the enrollee's health plan.

Subd. 2b. Request for authorization. Allows a health plan company to require submission of medical records and other supporting documents with a request for authorization. If the authorization is denied, requires the health plan company to explain the criteria used for its decision, and if the authorization is granted, requires the health plan company to explain how continuity of care will be provided.

Subd. 3. Disclosure. Requires information on an enrollee's right to continuity of care to be included in member contracts or certificates of coverage and to be provided, upon request, to an enrollee or prospective enrollee.

8 **Access to specialty care.** Amends § 62Q.58. Modifies provisions governing standing referrals to specialists.

Subd. 1. Standing referral. Requires health plan companies to grant standing referrals to specialists if appropriate. Also requires health plan company procedures for obtaining a standing referral to specify the managed care review and approval that must be obtained before a standing referral will be granted.

Subd. 1a. Mandatory standing referral. Requires health plan companies to grant standing referrals, upon request, to any enrollee with one of the following conditions: a chronic health condition, a life-threatening physical or mental illness, pregnancy after the first trimester, a degenerative disease or disability, or any other condition or disease of sufficient seriousness and complexity to require treatment by a specialist. Specifies that this section does not affect a separate law permitting direct access to obstetricians and gynecologists. Also specifies that this subdivision does not apply to health plans issued by DOER.

Subd. 2. Coordination of services. Strikes language making a primary care provider responsible for coordinating the care of an enrollee with a standing referral, and prohibiting a specialist from making referrals without prior approval of the primary care provider. Permits a specialist to whom an enrollee has a standing referral, in agreement with the enrollee and primary care provider, to authorize tests and services and make secondary referrals. Allows the health plan company to limit the primary care services, tests, and secondary referrals made by the specialist to those related to the condition for which the standing referral was made.

Subd. 3. Disclosure. No changes made to this subdivision.

Subd. 4. Referral. If a standing referral is authorized or mandatory, requires a health plan company to provide a referral to a reasonably available participating specialist or to a nonparticipating specialist, at no additional cost to the enrollee beyond what the enrollee would otherwise pay, if the health plan company does not have a reasonably available participating specialist.

9 **Coverage of clinical trials.** Requires the commissioners of health and commerce, in consultation with the commissioner of employee relations, to convene a work group to study health plan coverage of clinical trials. Specifies who must be included in the work group and what the work group must address. Requires the commissioners to submit findings and recommendations to the chairs of the health policy and finance committees in the Senate and House by January 15, 2002.

Makes this section effective the day following final enactment.

10 **Quality of patient care.** Requires the commissioner of health to evaluate the feasibility of collecting data on the quality of patient care provided in hospitals, outpatient surgical centers, and other facilities, and requires distribution of a written report on the subject by January 15, 2002.

11 **Effective date.** Establishes effective dates:

sections 1 and 3 are effective for violations committed on or after August 1, 2001;

section 4 is effective beginning with the report for the 2001 calendar year;

sections 2, 5, and 10 are effective the day following final enactment; and

sections 7 and 8 are effective January 1, 2002 and apply to health plans issued or renewed on or after that date.

Article 17: Health and Human Services Appropriations

Overview

Article 17 contains the appropriations and riders for the Omnibus Health and Human Services Appropriations bill. This summary briefly summarizes the riders that are included in this article. Note: This article does not include the detailed line-item appropriations and base amounts that are contained in the fiscal tracking sheet. The tracking sheet is created and maintained by the Fiscal Analysis Department analyst assigned to the health and human services committee, and is a separate document.

1 **Health and human services appropriations.** Specifies that the total appropriations, for all state funds and federal TANF funds, made in the article are $3.646 billion in FY 2002 and $4.024 billion in FY 2003.

Commissioner of human services.

2 **Subd. 1. Total Appropriation.** Specifies that the total human services appropriations, for all state funds and federal TANF funds, made in this article are appropriations of $3.467 billion in FY 2002 and $3.843 billion in FY 2003. Contains the following riders:

Receipts for systems projects. Requires the state appropriations and federal receipts for the department's major computer systems to be deposited in the department's state systems account. Permits money appropriated for computer projects to be transferred between projects, and from development to operations, as needed. Permits unexpended funds to be available for ongoing development and operations.

Gifts. Permits the commissioner to accept nonstate funds to finance the cost of assistance program grants, or to finance administrative costs.

Systems continuity. Permits the commissioner, in the event that the department's technical systems or computer operations are disrupted, to use available grant appropriations to ensure that payments for maintaining the health, safety, and well-being of the people served by the programs continue uninterrupted.

Special revenue fund information. Requires the commissioner to provide detailed fund balance information for each special revenue fund account to the chairs of the house health and human services finance committee and the senate health, human services, and corrections budget division.

Federal administrative reimbursement. Appropriates certain federal administrative reimbursement to the commissioner.

Nonfederal share transfers. Allows the nonfederal share of activities for which federal administrative reimbursement is appropriated to the commissioner to be transferred to the special revenue fund.

TANF funds appropriated to other entities. Requires expenditures from the TANF block grant to be expended according to the federal welfare reform law, and any applicable federal regulation. Requires the commissioner to ensure that the funds are expended in compliance with federal law and that federal reporting requirements are met. Specifies that an entity receiving TANF funds must implement a memorandum of understanding that assures compliance prior to the expenditure of funds. Requires the commissioner to receipt TANF funds appropriated to other state agencies and to coordinate all related interagency accounting transactions necessary to implement these appropriations. Specifies that unexpended TANF funds cancel at the end of the state fiscal year unless appropriating language permits otherwise.

TANF funds transferred to other federal grants. Delineates requirements that the commissioner must follow when transferring TANF funds to other federal grants.

TANF maintenance of effort (MOE). (a) Specifies which non-federal expenditures the commissioner is permitted to report as TANF MOE.

(b) Requires the commissioner to ensure that sufficient expenditures are made to meet the state's TANF MOE requirement. Specifies that, of the activities listed in paragraph (a), the commissioner may only report those activities that are excluded from the federal definition of assistance.

(c) Requires the commissioner to make a preliminary determination of whether the state will meet its annual work participation requirement, after adjusting for any caseload reduction credit. If the state will meet its work participation rate, allows the commissioner to reduce the expenditures reported as MOE to the extent allowed under federal law.

(d) Beginning with FY 2003, provides that the MOE used for the February and November forecasts must be comprised of at least 25 percent MFIP cash and food assistance.

(e) to (h) delineates procedures that the commissioner must follow if the nonfederal expenditures in paragraph (a) are insufficient to meet the state's work participation requirement.

(i) Provides that a statute dealing with federal grants or aids does not apply if the grants or aids are federal TANF funds.

(j) Makes paragraph (a), clause (1) to (5), and paragraphs (b) to (j) expire on June 30, 2005.

Capitation rate increase. Specifies an amount from the health care access fund appropriations to the University of Minnesota in the higher education omnibus appropriation bill to be used to increase the capitation payments for a prepayment demonstration project.

Subd. 2. Agency management.

(a) Financial operations.

(b) Legal and regulation operations.

(c) Management operations. Contains the following riders:

Core licensing activities. Specifies an amount to support 14 new licensor positions and an amount to cover maintenance and operational costs for a new computer system. Lists outcomes that the commissioner must meet by January 1, 2003, in order to receive continued appropriations for these purposes.

Updating federal poverty guidelines. Specifies that, for certain health care programs, the annual updates to the federal poverty guidelines are effective each July 1 following publication by the U.S. Department of Health and Human Services.

Subd. 3. Administrative reimbursement/pass through.

Subd. 4. Children's services grants. Contains the following riders:

Adoption assistance incentive grants. Appropriates to the commissioner federal funds that are available in FY 2002 and FY 2003 for adoption incentive grants.

Federal child welfare outcomes funding. Allows the commissioner to seek and expend federal funds to assist in evaluating strategies to improve outcomes for children in the child welfare services system.

Adoption assistance and relative custody assistance. Allows the commissioner to transfer unencumbered appropriation balances for adoption assistance and relative custody assistance between fiscal years and between programs.

TANF transfer to social services. Requires the commissioner to authorize a transfer of funds from the TANF block grant to the state's social services block grant.

Social services block grant funds for concurrent permanency planning. Specifies an amount from the social services block grant that are to be distributed to counties for concurrent permanency planning.

Subd. 5. Children's services management. Contains the following rider:

Federal financial participation maximization for out-of-home care. Requires the commissioners of human services and corrections to cooperate in efforts to maximize federal financial participation in the costs of providing out-of-home placements for juveniles.

Subd. 6. Basic health care grants.

(a) MinnesotaCare grants. Contains the following riders:

MinnesotaCare federal receipts. Requires that any receipts received as a result of federal participation pertaining to administrative costs of the Minnesota health care reform waiver must be deposited as nondedicated revenue into the health care access fund. Specifies how the funds must be used.

MinnesotaCare funding. Allows the commissioner to expend money appropriated from the health care access fund for MinnesotaCare in either year of the biennium.

MinnesotaCare payments for pregnant women and children under the age of two. Provides that payments for pregnant women and children under the age of two must be paid from the health care access fund effective January 1, 2003.

Dental access grants. Specifies an amount for dental access grants and specifies how unspent funds must be used.

(b) MA basic health care grants - families and children.

Indian health services federal match. Establishes requirements that the commissioner must follow in the event that the federal medical assistance percentage rate increases to 100 percent for services provided as a result of a referral by the federal Indian health services or a tribal provider. Specifies how unspent state medical assistance appropriations resulting from the increase must be used.

Immunization information service. Specifies an amount to support maintenance of current registry activities related to tracking medical assistance-eligible children. Reduces base funding for immunization registries.

(c) MA basic health care grants - elderly and disabled.

(d) General assistance medical care.

(e) Health care grants - other assistance. Contains the following rider:

Stop loss fund account. Specifies an amount to be deposited in the stop loss fund account.

Subd. 7. Basic health care management.

(a) Health care policy administration. Contains the following riders:

Enrollment study. Specifies an amount for a study on the enrollment of children in MinnesotaCare and medical assistance. Specifies requirements for the study.

Dedication of federal match. Specifies how certain enhanced federal match funds must be used.

(b) Health care operations. Contains the following rider:

Prepaid medical programs. Specifies that the nonfederal share of the prepaid medical assistance program fund must be disbursed as grants using either a reimbursement or block grant mechanism and how the money can be transferred.

Subd. 8. State-operated services. Contains the following riders:

Mitigation related to state-operated services restructuring. Allows money for mitigation expenses related to restructuring state-operated services programs and administrative services to be transferred between fiscal years within the biennium.

State-operated services chemical dependency programs. Relates to cash-flow transfers between the state-operated services CD fund and the general fund when the operation of state-operated services chemical dependency fund is affected by cash deficiencies because receivables have been delayed.

State-operated services restructuring. Relates to the options for state-operated services employees whose positions are being eliminated under the restructuring.

Repairs and betterments. Authorizes the commissioner to spend unencumbered appropriations balances for state residential facilities repairs and betterments and special equipment in either year of the biennium.

Names required on monuments. Makes a one-time appropriation for purchasing and placing cemetery grave markers or memorial monuments at cemeteries located at regional treatment centers operated or formerly operated by the commissioner. Specifies eligibility

requirements for the receipt of a grant.

Building remodeling. Specifies an amount from the appropriation for repairs and betterments to remodel certain buildings at the Brainerd regional human services center. Requires the Brainerd school district to reimburse the commissioner for a specified amount through a lease agreement.

Subd. 9. Continuing care grants.

(a) Community social services block grants. Contains the following riders:

CSSA traditional appropriation. Requires the principal portion of the CSSA appropriation to be allocated to counties in proportion to the amount of aid received by a county in CY 2000.

Social services grant reduction. Specifies how any reduction to social services supplemental grants base budgets must be applied.

(b) Aging adult service grants. Contains the following riders:

Aging and adult service grant carryforward authority. Provides that money appropriated for Senior LinkAge line, community services grants, and access demonstration project grants must be used to maximize federal reimbursement. Allows unexpended funds in FY 2002 to be available in FY 2003.

Home-sharing grants. Specifies an amount in fiscal year 2003 for the home-sharing grant program.

The center for victims of torture. Makes a one-time appropriation for a grant to the center for victims of torture. Specifies how the funds must be used. Requires a one-to-one, nonstate, in-kind match, and makes the funds available until expended.

Planning and service development. Specifies an amount for the distribution to county boards and area agencies on aging for planning and development of community-based services. Specifies how funds must be distributed.

(c) Deaf and hard-of-hearing services grants. Contains the following riders:

Services to deaf persons with mental illness. Specifies an amount for a grant to a nonprofit agency that currently serves deaf and heard of hearing adults with mental illness through residential programs and supportive housing outreach activities. Specifies how the grant must be used.

Commission serving deaf and hard-of-hearing people. Specifies an amount for the Minnesota commission serving deaf and hard-of-hearing people.

(d) Mental health grants. Contains the following riders:

Transfer to DOER. Specifies an amount for a transfer to the commissioner of employee relations for the costs associated with modification in the Mental Health Commitment Act.

Mental health counseling for farm families. Makes a one-time appropriation to be transferred to the board of trustees of the Minnesota state colleges and universities for mental health counseling support to farm families and business operators through the farm business management program at Central Lakes College and Ridgewater College.

Costs associated with state inmates with mental illness. Specifies an amount for

evaluation and support staff to do discharge planning for persons with serious and persistent mental illness being discharged from prison. Specifies amounts that must be transferred to the commissioner for certain purposes.

Compulsive gambling. Makes a one-time appropriation from the lottery prize fund for a grant to a compulsive gambling council located in St. Louis county. Makes the unencumbered balance in the first year of the biennium available in the second year.

(e) Medical assistance long-term care facilities.

(f) Community support grants. Contains the following rider:

Region 10 quality assurance commission. Specifies an amount to be allocated to the region 10 quality assurance commission for certain projects and evaluations.

(g) Medical assistance long-term care waivers and home care. Contains the following riders:

Nursing facility operated by the Red Lake band of Chippewa Indians. Specifies how the medical assistance payment rates for the 47-bed nursing facility operated by the band must be calculated and requires the commissioner to provide certain rate adjustments in each year.

Moratorium exceptions. Relates to the approval of certain moratorium exception projects.

Long-term care consultation services. Specifies how long-term care consultation services payments must be calculated and distributed to counties.

(h) Alternative care grants. Contains the following riders:

Alternative care transfer. Provides that unspent funds allocated for the alternative care program do not cancel, but are transferred to the medical assistance account.

Alternative care appropriation. Permits the commissioner to expend the money appropriated for the alternative care program in either year of the biennium.

(i) Group residential housing.

(j) Chemical dependency entitlement grants. Contains the following rider:

Federal substance abuse prevention and treatment block grant allocation. Requires the commissioner to allocate an amount from the federal substance abuse prevention and treatment block grant to chemical dependency services provided to tier I-eligible persons. Also allocates an amount from the block grant for the same purpose in the 2004-2005 biennium.

(k) Chemical dependency non-entitlement grants.

Subd. 10. Continuing care management. Contains the following riders:

Day training task force. Makes a one-time appropriation for the day training and habilitation restructuring task force.

County involvement costs. Specifies an amount that must be allocated to counties for resident relocation costs resulting from planned closures and resident relocations. Provides that unexpended funds in the first year do not cancel, but are available in the second year.

Relocation and diversion funding carryforward. Makes funds for administrative activities related to relocating or diverting persons with disabilities under age 65 from institutional

settings available in either year of the biennium.

Starter grant. If the commissioner receives a federal grant for a Real Choice System Change Starter Grant, appropriates the money to the commissioner for the purposes defined in the federal application.

Subd. 11. Economic support grants.

(a) Assistance to families grants. .

(b) Work grants. Contains the following riders:

Local intervention grants for self-sufficiency carryforward. Provides that unexpended LIGSS funds in FY 2002 do not cancel, but are available in FY 2003.

Supported work. Specifies an amount from the federal TANF fund to the commissioner for counties and tribes that submit information about the county's supported work program. Specifies how the funds must be allocated. Allows unspent funds to be reallocated each January based on the number of approved supported work plans and the documented need.

Modification of prior TANF appropriation. Modifies a rider enacted by the 2000 Legislature that appropriates TANF funds to the commissioner to contract with the board of trustees of the Minnesota state colleges and universities to provide tuition waivers for certain people.

Welfare-to-work grants. Specifies an amount from the federal TANF fund for certain welfare-to-work programs, specifies how the money must be distributed, and requires the commissioner of economic security to report on the uses of state and federal funds for welfare-to-work programs and the effectiveness of such programs.

(c) Economic support grants - other assistance. Contains the following riders:

TANF transfer to child care and development block grant. Specifies an amount to be transferred from the federal TANF block grant to the child care and development block grant (CCDBG).

Minnesota food assistance program Specifies an amount in FY 2003 for the Minnesota food assistance program.

(d) Child support enforcement. Contains the following rider:

Child support payment center. Requires that payments for services performed by the child support payment center must be deposited into the state systems account and are appropriated to the commissioner for the operation of the child support payment center or system.

(e) General assistance. Contains the following rider:

General assistance standard. Sets the monthly GA standard of assistance for a single adult at $203.

(f) Minnesota supplemental aid.

(g) Refugee services.

Subd. 12. Economic support management.

(a) Economic support policy administration. Contains the following riders:

Food stamp administrative reimbursement. Requires the commissioner to reduce quarterly food stamp administrative reimbursement to counties in FY 2002 and FY 2003 by a specified amount. Specifies how the reductions must be allocated to each county and how adjustments to medical assistance administrative reimbursement are to be distributed.

Employment services tracking system. Specifies a one-time appropriation from the federal TANF fund for the development of an employment tracking system. Provides that unexpended funds in FY 2002 do not cancel, but are available in FY 2003.

Financial institution data match and payment of fees. Authorizes the commissioner to allocate a specified amount from the PRISM special revenue account for payments to financial institutions in exchange for performing data matches between account information held by financial institutions and the public authority's database of child support obligors.

(b) Economic support operations. Contains the following rider:

Spending authority for food stamp enhanced funding. Provides that if the state qualifies for food stamp enhanced funding, the commissioner shall retain an amount sufficient to fund the Minnesota food assistance program in FY 2002. Requires 25 percent of the remaining balance to be retained by the commissioner, and the remaining 75 percent to be distributed to counties, based on each county's impact on the statewide food stamp error rate.

3 **Commissioner of health.**

Subd. 1. Total appropriation. Specifies that the total health department appropriations, for all state funds and federal TANF funds, made in this article are appropriations of $132.3 million in FY 2002 and $133.852 million in FY 2003.

Subd. 2. Family and community health. Contains the following riders:

Health disparities. Specifies an amount for reducing health disparities and how the appropriations must be used.

MN ENABL. Specifies an amount from the federal TANF fund for the MN ENABL program.

MN ENABL carryforward. Allows unexpended balance of the TANF funds appropriated for MN ENABL in the first year of the biennium to be available in the second year.

TANF local public health promotion program. Specifies an amount from the federal TANF fund for local public health promotion and protection related to high risk behaviors in youth and evaluation and technical assistance activities related to the local public health promotion program.

TANF local public health promotion carryforward. Allows the unexpended balance of the TANF funds appropriated for local public health promotion and protection in the first year of the biennium to be available in the second year.

Infant mortality reduction. Specifies an amount from the federal TANF fund for grants to reduce infant mortality.

Reducing infant mortality carryforward. Allows the unexpended balance of the TANF funds appropriated for reducing infant mortality in the first year of the biennium to be available in the second year.

Home visiting program. Specifies an amount from the federal TANF fund for the home

visiting program under Minnesota Statutes, section 145A.17.

Poison information system. Specifies a one-time appropriation for poison control system grants.

WIC transfers. Permits the appropriation for the WIC program to be transferred between fiscal years, in order to maximize federal funds or to minimize fluctuations in the number of participants.

Minnesota children with special health needs carryforward. Provides that general fund appropriations for treatment services in the services for Minnesota children with special health needs program are available for either year of the biennium.

Health status improvement grants. Specifies an amount for grants to improve the quality of health care services provided to children. Specifies how priority must be given to grant applicants.

Family home visiting carryforward. Allows the unexpended balance of the TANF funds appropriated for the family home visiting program in the first year of the biennium to be available in the second year.

Suicide prevention. Specifies an amount for suicide prevention activities and how the appropriation must be used.

Rural health technology demonstration project. Allows the commissioner to include, as an eligible activity through the department's rural health grant programs, a demonstration project that meets certain criteria.

One-time reduction for family planning special project grants. Reduces the base-level funding for the family planning special project grants for FY 2003.

Subd. 3. Access and quality improvement. Contains the following riders:

Purchasing alliances. Specifies a one-time appropriation from the health care access fund for grants to organizations developing health care purchasing alliances. Specifies how the funds must be allocated and requires that state grants must be matched on a one-to-one basis by nonstate funds.

Supplemental nursing services agency registration effective date. Requires a supplemental nursing services agency to register with the commissioner no later than August 31, 2001.

Initial Medicare certification costs. Specifies an amount from the state government special revenue fund for initial Medicare certification surveys. Specifies how the appropriation must be recovered and requires any unspent portion of the appropriation to be deposited in the state government special revenue fund.

Health care safety net. Specifies an appropriation from the health care access fund for a grant program to provide rural hospital capital improvement grants. Requires the commissioner of finance to make certain base-level adjustments for FY 2004 funding for this program.

Home care providers fee waiver. Allows the commissioner to waive license fees for certain home care providers for the purpose of reducing surplus home care fees in the state government special revenue fund.

Rural ambulance study. Requires the commissioner to direct the rural health advisory committee to conduct a study and make recommendations regarding the challenges faced by rural ambulance services. Lists the requirements that the committee must follow when conducting the study.

License fees. Allows certain health care facilities to submit the required fee for licensure renewal in quarterly installments and explains the procedure to do so.

Subd. 4. Health protection. Contains the following riders:

Emerging health threats. Specifies amounts to increase the state capacity to identify and respond to emerging health threats; to expand state laboratory capacity; and to train, consult, and assist local officials responding to clandestine drug laboratories and minimizing health risks to responders and the public.

Base funding transfer prohibition. Prohibits the transfer of base funds from grants to operations within the health protection program.

Community health education and promotion program on food safety. Specifies a one-time appropriation for a grant to the city of Minneapolis to establish a community-based health education and promotion program on food safety in certain communities.

Subd. 5. Management and support services.

4 **Veterans nursing homes board.** Specifies that the total veterans nursing homes board appropriations, for all state funds, made in this article are appropriations of $30.948 million in FY 2002 and $30.030 million in FY 2003. Contains the following riders:

Veterans homes special revenue account. Transfers the general funds that are appropriated to the board to the veterans homes special revenue account, and appropriates the monies from that account to the board, for the board's facilities and programs.

Setting cost of care. Sets the cost of care for the domiciliary residents at the Minneapolis veterans home at 100 percent occupancy at each facility.

Deficiency funding. Specifies an amount, with the approval of the commissioner of finance. Provides that approval is contingent upon review of a report from the board.

5 **Health-related boards.**

Subd. 1. Total appropriations. Specifies that the total health-related boards appropriations, for all state funds, made in this article are appropriations of $11.179 million in FY 2002 and $11.424 million in FY 2003. Contains the following riders:

State government special revenue fund. Specifies that all appropriations to the health-related boards are from the state government special revenue fund.

No spending in excess of revenues. Prohibits the commissioner of finance from permitting a board to spend money appropriated in this section that is in excess of its anticipated biennial revenues or accumulated surplus revenues from fee collections.

Subd. 2. Board of chiropractic examiners.

Subd. 3. Board of dentistry. Contains the following rider:

Expanded duties. Specifies a one-time appropriation for the costs associated with the expanded duties relative to the regulation of dental hygienists and foreign-trained dentists.

Subd. 4. Board of dietetic and nutrition practice.

Subd. 5. Board of marriage and family therapy. Contains the following rider:

Fee increase. Allows the board to increase its fees to meet the requirements of section 214.06.

Subd. 6. Board of medical practice.

Subd. 7. Board of nursing. Contains the following riders:

Health professional services activity. Specifies an amount for the health professional services activity.

Fee increase. Allows the board to increase its fees to meet the requirements of section 214.06.

Subd. 8. Board of nursing home administrators.

Subd. 9. Board of optometry.

Subd. 10. Board of pharmacy. Contains the following rider:

Administrative services unit. Specifies the portion of this appropriation that is for the health board's administrative services unit.

Subd. 11. Board of physical therapy.

Subd. 12. Board of podiatry.

Subd. 13. Board of psychology.

Subd. 14. Board of social work.

Subd. 15. Board of veterinary medicine.

6 **Emergency medical services board.** Specifies that the total emergency medical services board appropriations, for all state funds, made in this article are appropriations of $2.770 million in FY 2002 and $2.775 million in FY 2003. Contains the following riders:

Comprehensive advanced life support (CALS) educational program. Specifies an amount for the CALS educational program.

Automatic defibrillator study. Specifies an amount to the board, in consultation with the commissioner of public safety, to study and report to the legislature on the availability of automatic defibrillators outside of the seven-county metropolitan area.

7 **Council on disability.** Specifies that the total council on disability appropriations, for all state funds, made in this article are appropriations of $692,000 in FY 2002 and $714,000 in FY 2003.

8 **Ombudsman for mental health and mental retardation.** Specifies that the total ombudsman for mental health and mental retardation appropriations, for all state funds, made in this article are appropriations of $1.419 million in FY 2002 and $1.462 million in FY 2003.

9 **Ombudsman for families.** Specifies that the total ombudsman for families appropriations, for all state funds, made in this article are appropriations of $236,000 in FY 2002 and $245,000 in FY 2003.

10 **Transfers.**

Subd. 1. Grants. Authorizes the commissioner of human services, with the approval of the commissioner of finance, and after notifying the chairs of the senate health, human services and corrections budget division and the house health and human services finance committee, to transfer unencumbered appropriations balances within fiscal years between the following programs: MFIP; GA; GAMC; MA; MSA; GRH; and the entitlement portion of the consolidated chemical dependency treatment fund (CCDTF).

Subd. 2. Administration. Permits the commissioners of health and human services, and the veterans nursing homes board, to transfer positions, salary money, and nonsalary administrative money within the departments, and within the board's programs, with the advance approval of the commissioner of finance. Requires quarterly reports to the chairs of the appropriate legislative committees about transfers made under this subdivision.

Subd. 3. Prohibited transfers. Prohibits grant money from being transferred to operations within the departments of human services and health and within the programs operated by the veterans nursing homes board without legislative approval.

11 **Indirect costs not to fund programs.** Prohibits the commissioners of health and of human services from using indirect cost allocations to pay for the operational costs of any program for which they are responsible.

12 **Carryover limitation.** Prohibits any of the funding in this article that is allowed to be carried forward from the first to the second year from becoming part of an activity's base level funding, unless specifically directed.

13 **Sunset of uncodified language.** Provides that all uncodified language in this article expires June 30, 2003, unless there is a different expiration date explicit in the language of an uncoded provision.

14 **Reimbursement to local governments.** If a county or local unit of government advances money from its own resources to carry out a program under state law and the advance of local money was due to a delay in the appropriation of state or federal money, requires the state agency administering the program to reimburse a county or other local unit of government for the advance of local money that was used to pay obligations that would have otherwise been paid from state or federal money.

15 **Retroactivity.** Allows a contract encumbered or a grant awarded by the commissioners of health, human services, or corrections before September 1, 2001 to be made retroactive to July 1, 2001.

16 **Project labor.** Codifies a rider relating to project laborers in section 246.141.

17 **Effective date.** Unless a different date is specified, makes the provisions in this act effective July 1, 2001.

Article 18: Criminal Justice

Overview

This article contains the appropriations for the board of public defense, department of corrections, corrections ombudsman, and sentencing guidelines commission. It also contains various statutory changes related to these agencies and increases the surcharge on certain offenders.

1-7 **Criminal justice appropriations.** These sections contain the appropriations for the board of public defense, department of corrections, corrections ombudsman, and sentencing guidelines commission (see spreadsheet). These sections also contain appropriations to the commissioner of

public safety and attorney general for costs related to the felony-level penalty for driving while impaired.

8 **Ranges for other judicial positions.** Requires the state board of public defense to fix the salary of the state public defender at a level not to exceed the salary of a district court judge.

9 **Use of fees.** Redirects correctional fees for probation costs from the general fund to the county treasurer in the county where supervision is provided. Specifies how the fees may be used.

10 **Emergency housing rental agreements.** Allows the commissioner of corrections to enter into rental agreements per industry standards for emergency housing of inmates.

11 **Publication of recommendations; reports.** Changes the ombudsman for corrections reporting requirement from a biennial one to an annual one.

12 **Charges to counties.** Requires the commissioner of corrections to continue charging counties 65 percent of the actual per diem for the use of the Red Wing juvenile facility until June 30, 2002.

13-14 **Contracting with other states and federal government.** Requires the commissioner of corrections to charge other states and the federal government for housing or temporary custody of non-Minnesota prisoners, to the extent possible, at a per diem rate equal to or greater than the amount that it costs to do the same for a Minnesota inmate at the same facility.

15 **Surcharges on criminal and traffic offenders.** Raises the surcharge on a person convicted of a felony, gross misdemeanor, or misdemeanor offense from $25 to $35.

16 **Disbursement of surcharges by state treasurer.** Changes the mechanism for distribution of the surcharge discussed in section 15. Requires the state treasurer to credit $3 of each surcharge received to a criminal justice special projects account in the special revenue fund. Specifies that this account is available for appropriation to the commissioner of public safety for grants to law enforcement agencies and for other purposes specified by the legislature. Requires $7 of the new $10 surcharge to be credited to the general fund.

17 **Legislative recommendations; state policy plan.** Requires the department of corrections to submit recommendations to the legislature regarding the updated interstate compact on adult offenders. Requires development of a state policy plan for handling interstate transfers of adult offenders.

18 **Office of state public defender; appointment; salary.** Conforming statutory change consistent with section 8.

19 **Instruction to revisor.** Specifies that the surcharge increase contained in this act supersedes any other increases to the surcharge enacted in the 2001 First Special Session.

20 **Use of Byrne grant funds for restorative justice grants.** Requires the commissioner of public safety to use the same amount of federal Byrne grant funds for grants in fiscal years 2002 and 2003 as was used in fiscal year 2001.

21 **Study on ombudsman for corrections.** Requires the office of the governor, in consultation with the department of administration, to conduct a study of various models to deliver the services provided by the ombudsman for corrections, including the effects of privatizing certain functions of the ombudsman for corrections. Requires a report to the legislature by February 1, 2002.

22 **Effective date.** July 1, 2001.

Article 19: Felony Driving While Impaired Provisions

Overview

This article creates a felony-level penalty for certain repeat DWI offenders. The language in sections 2 to 15 is identical to the language in Laws 2001, first special session, chapter 8, article 11, sections 1 to 14. The effective dates in this article supersede any contrary effective dates in chapter 8, article 11.

1 **Coverage for chemical dependency treatment provided by the department of corrections.** Requires any health plan providing chemical dependency treatment coverage to cover chemical dependency treatment provided to an enrollee by the department of corrections while the enrollee is committed to the commissioner of corrections following a felony-level driving while impaired offense, provided that treatment is deemed appropriate by the court and department of corrections.

2-3 **Degrees of DWI crimes.** Conforming amendment to update the tiered schema to accommodate the new felony level DWI crime as "first degree."

4 **First-degree driving while Impaired.**

Subd. 1. Degree described. Provides that a DWI violation is classified as first-degree if a person has three prior DWI incidents within the last ten years *in addition to* the current violation. Therefore, this is a "4th-in-10" provision. Also provides that a DWI violation is first-degree if a person ever was previously convicted of first-degree DWI.

Subd. 2. Criminal penalty. Provides that a first-degree violation is a felony. Provides that a person convicted of felony DWI is subject to the mandatory penalties in section 8 of this article.

5 **Second-degree DWI.** Conforming amendment.

6 **Third-degree DWI.** Conforming amendment.

7 **Fourth-degree DWI.** Conforming amendment.

8 **Mandatory penalties; nonfelony violations.** Provides cross-references indicating that the sentence for a felony DWI offender is governed first by Minn. Stat. § 169A.276 (section 8 of this article). The remainder of the section is current law and provides the minimum incarceration period for a felony DWI offender whose prison term is not executed: for a 4th-time offense, 180 days in local jail, with at least 30 of those days served consecutively (unless the offender is sentenced to certain intensive probation programs for DWI offenders); and for a 5th or more offense, one year in local jail, with at least 60 of those days served consecutively.

The current law reproduced in this section also provides the sentence for an offender's fourth *qualified prior impaired driving incident* in ten years (not necessarily a felony), as opposed to the fourth *conviction* (a felony under this article). By definition, a conviction always counts as an incident, but an incident may not result in a conviction.

Also specifies that the requirement for the court to sentence to the level of care recommended in the chemical use assessment is inapplicable if the person is sentenced to prison.

9 **Mandatory penalties; felony violations.**

Subd. 1. Mandatory prison sentence. (a) Provides that felony DWI offenders must be sentenced to at least 3 years in prison (this does not necessarily mean 3 years of executed and served prison time; see paragraphs (b) through (e)).

(b) Provides that the court may not stay imposition of the sentence nor impose a sentence of less than 3 years, but it may stay execution of the sentence as provided in subdivision 2.

(c) Provides that if the court executes the prison sentence for a felony DWI conviction, the offender is not eligible for earlier release unless the person has successfully completed chemical dependency treatment while in prison.

(d) Following release from prison, the offender must be placed on conditional release for a period of 5 years. The commissioner may impose any conditions of release deemed appropriate, and must require as a condition of release that the person complete a program of intensive probation. If the person fails to comply, the commissioner may revoke the person's conditional release and require the person to serve all or part of the remaining period of conditional release in prison. The commissioner may not release the person from supervision before the conditional release period expires. Conditional release is governed by provisions relating to supervised release.

(e) The commissioner must require the offender to pay as much of the cost of conditional and supervised release as possible.

Subd. 2. Stay of mandatory sentence. Provides that if the court does not *execute* the sentence under subdivision 1, the provisions of Minn. Stat. §§ 169A.275 and 169A.283 apply. Therefore, if the court stays the execution of the prison sentence, the minimum incarceration for a 4th-in-10 DWI offender is 180 days in local jail, with at least 30 of those days served consecutively and no more than 150 days on home detention, *unless* the offender is sentenced to certain intensive probation programs for DWI offenders.

Subd. 3. Driver's license revocation; no stay permitted. Provides that the court may not stay execution of a driver's license revocation.

10 **Stay authorized.** Primarily a conforming amendment. Provides that, subject first to the mandatory penalties and required conditions of stayed sentences under §§ 169A.275 and 169A.276, if the court stays execution of a sentence for a DWI offender it must require the offender to submit to the level of care recommended in a chemical use assessment report (or state on the record its reasons for not doing so).

11 **Custodial arrest.** Adds felony DWI to the DWI offenses requiring custodial arrest.

12 **Definitions; "designated offense."** Adds felony DWI to the DWI offenses that trigger vehicle forfeiture.

13 **Driver's license reinstatement fee increase.** Increases the fee for reinstatement of a person's driver's license following revocation for an implied consent and/or DWI violation from the current $290 ($40 surcharge) to $395 ($145 surcharge) beginning July 1, 2002, and to $630 ($380 surcharge) beginning July 1, 2003. This applies to all DWI violators and, under additional 2001 legislation (in Article 12, of this Act), to persons convicted of criminal vehicular homicide or injury, as well. The fee increases will be reflected in the surcharge portion of the reinstatement fee, which will continue to be accounted for in the remote electronic alcohol monitoring account for direct pass-through to the state's general fund.

14 **Supervision level.** Clarifies that nothing in this act should be construed to require a different level of supervision for offenders than is currently required by law.

15 **Study required.** Requires the commissioner of corrections each year to conduct a study of felony DWI by tracking several specific data items of relevance.

16 **Report on insurance coverage.** Requires the commissioner of corrections to report to the legislature on the number of cases in which a felony DWI offender had private health insurance coverage for chemical dependency treatment and the results of attempts to obtain coverage under section 1.

17 **Effective dates.** Sections 1 to 12 and 14 to 16 are effective August 1, 2002, and apply to crimes committed on or after that date. Specifies that violations occurring before August 1, 2002, that are listed in section 169A.03, subdivisions 20 and 21, are considered qualified prior driving while impaired driving incidents for the purpose of this act. Section 13 is effective July 1, 2001.