House Research
Act Summary

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Article 1: Welfare Reform

Overview

This article modifies welfare provisions. Significant changes are enacted including a greater focus on work, creation of a new divisionary work component, reduction of the income exit level, and modification of sanctions.

1 **Funding priority.** Amends § 119B.03, subd. 4. Amends the basic sliding fee child care statute by making persons who are no longer receiving or eligible for the diversionary work program eligible for basic sliding fee child care.

2 **Declaration.** Amends § 256.984, subd. 1. Makes technical changes.

3 **Emergency need.** Amends § 256D.06, subd. 2. Strikes obsolete language, clarifies that emergency general assistance grants may be made to the extent that funds are available, limits grant availability to a recipient to not more than once in any 12-month period. Limits funding for emergency general assistance to the appropriation. Creates an allocation formula for counties to receive emergency general assistance funds and requires that county expenditures above the county allocation be made with county funds.

4 **Special needs.** Amends § 256D.44, subd. 5. Adds language referring to special needs diets or dietary items. Requires that costs for special diets be determined as percentages of the allotment for a one-person household under the Thrifty Food Plan. Lists the types of diets and the percentages of the Thrifty Food Plan that are covered.

5 **Eligibility.** Amends § 256D.46, subd. 1. Clarifies that county agencies must grant emergency Minnesota supplemental aid to the extent that funds are available.

6 **Payment amount.** Amends § 256D.46, subd. 3. Limits grant availability to recipients to not more than once in any 12-month period. Limits funding for emergency supplemental aid grants to the appropriation. Creates an allocation formula for counties to receive emergency Minnesota supplemental aid funds and requires that county expenditures above the county allocation be made with county funds.

7 **Need for protective payee.** Amends § 256D.48, subd. 1. Makes a conforming change to be consistent with the limitation of receipt of emergency Minnesota supplemental aid once in any 12-month period.

8 **Compliance system.** Amends § 256J.01, subd. 5. Removes emergency assistance from the list of programs over which the commissioner supervises compliance.

9 **Use of money.** Amends § 256J.02, subd. 2. Updates the list of programs funded by TANF. Adds allowable uses for the diversionary work program, the MFIP consolidated fund, and the Minnesota Department of Health consolidated fund.

10 **Separate state program for use of state money.** Amends § 256J.021. Makes a technical change.

11 **Child only case.** Amends § 256J.08, adding subd. 11a. Defines “child only case” as a case that would be part of the child only TANF program.

12 **Diversionary work program or DWP.** Amends § 256J.08, by adding subd. 24b. Defines “diversionary work program” or “DWP”.

13 **Employable.** Amends § 256J.08, by adding subd. 28b. Defines “employable” as a person capable of performing existing positions in the local labor market, regardless of the current availability of openings for those positions.

14 **Family violence.** Amends § 256J.08, by adding subd. 34a. Defines “family violence” if

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committed against a family or household member by a family or household member, as:

- physical harm, bodily injury, or assault;
- the infliction of fear of imminent physical harm, bodily injury, or assault; or
- terroristic threats, criminal sexual conduct, or interference with an emergency call.

Also defines "family or household member" for purposes of this section.

15 **Family violence waiver.** Amends § 256J.08, by adding subd. 34b. Defines "family violence waiver" as a waiver of the 60-month time limit for victims of family violence who are complying with an employment plan.

16 **Family wage level.** Amends § 256J.08, subd. 35. Clarifies the definition of "family wage level" by referencing a statute.

17 **Learning disabled.** Amends § 256J.08, by adding subd. 51b. Defines "learning disabled" as a person who has a disorder on one or more of the psychological processes involved in perceiving, understanding, or using concepts through verbal language or nonverbal means. This definition excludes learning problems that are primarily the result of visual, hearing, or motor handicaps, mental retardation, emotional disturbance, or due to environmental, cultural, or economic disadvantage.

18 **Participant.** Amends § 256J.08, subd. 65. Makes technical and conforming changes to the definition of "participant."

19 **Participation requirements of TANF.** Amends § 256J.08, by adding subd. 65a. Defines "participation requirements of TANF" as activities and hourly requirements allowed under title IV-A of the federal Social Security Act.

20 **Qualified professional.** Amends § 256J.08, by adding subd. 73a. Defines "qualified professional" for physical illness, injury, or incapacity, mental retardation and intelligence testing, learning disabilities, and mental health.

21 **Sanction.** Amends § 256J.08, subd. 82. Makes technical changes to the definition of "sanction."

22 **SSI recipient.** Amends § 256J.08, by adding subd. 84a. Defines "SSI recipient" as a person who receives at least $1 in SSI benefit, or who is not receiving an SSI benefit due to recoupment or a one month suspension by the Social Security Administration due to excess income.

23 **Transition standard.** Amends § 256J.08, subd. 85. Makes technical and conforming changes to the definition of "transitional standard."

24 **Severe forms of trafficking in persons.** Amends § 256J.08, by adding subd. 90. Defines "severe forms of trafficking in persons" as sex trafficking in which a commercial sex act is induced or the person induced to perform the act has not attained the age of 18, or the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services through the use of force, fraud, or coercion for the purposes of subjection to involuntary servitude, peonage, debt bondage, or slavery.

25 **County agency responsibility to provide information.** Amends § 256J.09, subd. 2. Makes technical and conforming changes. Eliminates references to diversionary assistance and emergency assistance.

26 **Submitting the application form.** Amends§ 256J.09, subd. 3. Makes technical and conforming changes.

27 **Screening.** Amends § 256J.09, subd. 3a. Makes technical and conforming changes.

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Eliminates references to the diversionary assistance program and the emergency assistance program. Requires counties to make referrals to other appropriate programs, if applicants appear to be eligible for other programs.

28 **Interview to determine referrals and services.** Amends § 256J.09, subd. 3b. Removes language referring to emergency assistance and diversionary assistance. Adds language requiring counties to explain family violence waivers and options for caregivers under age 20.

29 **Additional applications.** Amends § 256J.09, subd. 8. Makes technical and conforming changes, adds references to the MFIP consolidated fund and eliminates references to emergency assistance.

30 **Applicants who do not meet eligibility requirements for MFIP or the diversionary work program.** Amends § 256J.09, subd. 10. Makes technical and conforming changes, adds references to the new diversionary work program, eliminates references to diversionary assistance and emergency assistance. Requires counties to inform applicants about resources available through the county or other agencies to meet short-term emergency needs.

31 **Eligibility for parenting or pregnant minors.** Amends § 256J.14. Makes a technical change requiring counties to advise minors of possible exemptions to school attendance requirements.

32 **Other property limitations.** Amends § 256J.20, subd. 3. Makes technical and conforming changes, eliminates references to emergency assistance and diversionary assistance and adds a reference to the MFIP consolidated fund.

33 **Income inclusions.** Amends § 256J.21, subd. 1. Clarifies that county agencies must verify the income of all MFIP applicants and recipients.

34 **Income exclusions.** Amends § 256J.21, subd. 2. Makes technical and conforming changes. Eliminates references to emergency assistance and adds references to the MFIP consolidated fund. Allows only a portion of SSI payments to be excluded (currently all SSI payments are excluded) from income.

35 **Individuals who must be excluded from an assistance unit.** Amends § 256J.24, subd. 3. Makes a technical change.

36 **MFIP transitional standard.** Amends § 256J.24, subd. 5. Clarifies that the MFIP transitional standard is based on the number of persons in the assistance unit eligible for both food and cash assistance unless restrictions on birth of a child apply. Creates new transitional standards effective October 1, 2002, including a breakdown of the cash and food portions.

37 **Family cap.** Amends § 256J.24, subd. 6. Prohibits MFIP assistance units from receiving an increase in the cash portion of the transitional standard as a result of the birth of a child unless certain conditions are met. Requires the child to be included in determining family size for purposes of determining the food portion of the transitional standard and the family wage level. Requires caregivers to assign support and cooperate with child support enforcement. Requires county agencies to inform applicants of this provision at the time of each application and at recertification. Requires that excluded children be deemed MFIP recipients for purposes of child care assistance.

38 **Family wage level.** Amends § 256J.24, subd. 7. Makes technical and conforming changes. Adds a reference to the family cap and shared household standard.

39 **MFIP exit level.** Amends § 256J.24, subd. 10. Changes the MFIP exit level from 120 to 115 percent of the federal poverty guidelines.

40 **Changes that must be reported.** Amends § 256J.30, subd. 9. Makes technical and conforming changes. Adds a requirement to report changes that affect the number of hours

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participants are able to work per week or the type of activity participants are able to perform. Eliminates a change in health care coverage from the list of changes that must be reported to the county agency.

41 **Documentation.** Amends § 256J.32, subd. 2. Limits the use of affidavits as a form of documentation that may be used to verify information required for MFIP eligibility.

42 **Factors to be verified.** Amends § 256J.32, subd. 4. Makes technical and conforming changes. Eliminates medical insurance from the list of factors to be verified.

43 **Inconsistent information.** Amends § 256J.32, subd. 5a. Makes a technical change.

44 **Affidavit.** Amends § 256J.32, by adding subd. 8. Allows the county agency to accept an affidavit from an applicant or recipient as sufficient documentation at the time of application or recertification only for certain factors, including:

- a claim of family violence if used as a basis to qualify for the family violence waiver;
- relationship of a minor child to caregivers in the assistance unit; and
- citizenship status from a noncitizen who reports to be, or is identified as, a victim of sever forms of trafficking in persons.

45 **Rental subsidies; unearned income.** Amends § 256J.37, by adding subd. 3a. Requires counties to count $50 of the value of public and assisted rental subsidies provided through HUD as unearned income to the cash portion of the MFIP grant. Requires the full amount of the subsidy to be counted as unearned income when the subsidy is less than $50. Excludes certain assistance units that include a participant who is:

- age 60 or older;
- a caregiver who is suffering from an illness, injury, or incapacity that has been certified by a qualified professional when the illness, injury, or incapacity is expected to continue for more than 30 days and prevents the person from obtaining or retaining employment; or
- a caregiver whose presence in the home is required due to the illness or incapacity of another member in the assistance unit, a relative in the household, or a foster child in the household when the illness is or incapacity has been certified by a qualified professional and is expected to continue for more than 30 days.

Prohibits this provision from applying to an MFIP assistance unit where the parental caregiver is an SSI recipient. Requires the commissioner to identify the MFIP participants subject to this provision and provide written notice to these participants at least 30 days before the first grant reduction. Lists information required in the notice.

46 **Treatment of supplemental security income.** Amends § 256J.37, by adding subd. 3b. Requires counties to reduce the cash portion of the MFIP grant by $125 per SSI recipient who resides in the household, and who would otherwise be included in the MFIP assistance unit, but is excluded solely due to the SSI recipient status. Requires that only the amount received be used in calculating the MFIP cash assistance payment if the SSI recipient receives less than $125 in SSI payments.

47 **Unearned income.** Amends § 256J.37, subd. 9. Makes technical and conforming changes. (Language in this section is moved to § 256J.37, subd. 3a.)

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48 **Recovering overpayments.** Amends § 256J.38, subd. 3. Clarifies that county agencies must initiate efforts to recover overpayments paid to former caregivers and that caregivers, both parental and nonparental, are liable for repayment of overpayments.

49 **Recouping overpayments from participants.** Amends § 256J.38, subd. 4. Clarifies that county agencies must recover overpayments from the overpaid assistance unit, including child only cases.

50 **Fair hearings.** Amends § 256J.40. Prohibits appeal requests from extending benefits for the diversionary work program beyond the four-month time limit.

51 **Victims of family violence.** Amends § 256J.42, subd. 4. Requires cash assistance received by an assistance unit that is the victim of family violence to comply with a safety plan, an alternative employment plan, or an employment plan in order to be exempt from the 60-month time limit. Currently, an assistance unit that is the victim of family violence must comply with a safety plan or an alternative employment plan.

52 **Exemption for certain families.** Amends § 256J.42, subd. 5. Makes technical and conforming changes. Adds language specifying that payments provided to meet short-term needs under the MFIP consolidated fund and diversionary work program benefits do not count toward the 60-month time limit.

53 **Case review.** Amends § 256J.42, subd. 6. Requires that a case be reviewed by the job counselor's supervisor or the review team designated by the county before a participant's case is closed. Under current law, cases must be reviewed by the job counselor's supervisor or by the review team designated in the county's approved local service unit plan.

54 **Eligibility.** Amends § 256J.425, subd. 1. Makes technical changes. Requires counties to give assistance units the option of disqualifying one parent in a two-parent assistance unit, if that parent is determined to be ineligible for a hardship extension. Requires the assistance unit to be treated as a one-parent assistance unit and the MFIP grant to be calculated using the shared household standard.

55 **Review.** Amends § 256J.425, subd. 1a. Requires hardship extension cases to be reviewed more frequently than once every six months if the extension is based on a condition that is subject to change in less than six months.

56 **Ill or incapacitated.** Amends § 256J.425, subd. 2. Makes technical and conforming changes.

57 **Hard-to-employ participants.** Amends § 256J.425, subd. 3. Makes technical changes. For the purpose of receiving a hardship extension, requires the determination of IQ level or learning disability to be made by a qualified professional. Requires IQ or learning disability determination of non-English speaking persons to be made by a qualified professional with experience conducting culturally appropriate assessments, whenever possible, allows the county to accept reports that identify an IQ range, and requires these reports to include a statement of confidence in the results. Requires rehabilitation plans to be incorporated into employment plans if a rehabilitation plan for a participant extended as learning disabled is developed or approved by the county.

58 **Employed participants.** Amends § 256J.425, subd. 4. Makes technical and conforming changes. Eliminates the June 30, 2004 expiration date.

59 **Sanctions for extended cases.** Amends § 256J.425, subd. 6. Makes technical changes.

60 **Status of disqualified participants.** Amends § 256J.425, subd. 7. Makes technical changes. Requires counties to inform participants of the family violence waiver provisions and make appropriate referrals if the waiver is requested during the face-to-face meeting.

61 **General information.** Amends § 256J.45, subd. 2. Makes technical and conforming

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changes. Changes the language referring to health care eligibility after an MFIP case closes. Reflects changes due to de-linking and updates terminology.

62 **Participants not complying with program requirements.** Amends § 256J.46, subd. 1. Makes technical and conforming changes. Eliminates references to alternative employment plans. Eliminates language requiring a participant who has had one or more sanctions imposed to remain in compliance for six months in order for a subsequent occurrence of noncompliance to be considered a first occurrence. 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. Requires counties to close an MFIP assistance unit's financial assistance case for a seventh occurrence of noncompliance. Requires the county to keep the case closed for a minimum of one full month. Requires that only occurrences of noncompliance that occur after the effective date of this section be considered for the purposes of applying sanctions. Allows assistance units whose cases have been closed for noncompliance to reapply. Requires any subsequent occurrence of noncompliance to result in case closure.

63 **Sanctions for refusal to cooperate with support requirements.** Amends § 256J.46, subd. 2. Makes technical and conforming changes. Increases the sanction for noncompliance with child support requirements from 25 percent to 30 percent. Eliminates language requiring MFIP caregivers who have had one or more sanctions imposed to remain in compliance for six months in order for a subsequent sanction to be considered a first occurrence.

64 **Dual sanctions.** Amends § 256J.46, subd. 2a. Makes technical and conforming changes. Eliminates language requiring MFIP participants who have had one or more sanctions imposed to remain in compliance for six months in order for a subsequent sanction to be considered a first occurrence.

65 **Employment and training service provider.** Amends § 256J.49, subd. 4. Makes technical and conforming changes.

66 **Employment plan.** Amends § 256J.49, subd. 5. Adds language to the definition of employment plan stating employment plans should identify any subsequent steps that support long-term economic stability. Requires employment plans to be developed by job counselors and participants, in consultation with a person trained in domestic violence for participants who request and qualify for a family violence waiver.

67 **Functional work literacy.** Amends § 256J.49, by adding subd. 6a. Defines "functional work literacy" as an intensive English as a second language program that is work focused and offers at least 20 hours of class time per week.

68 **Participant.** Amends § 256J.49, subd. 9. Makes technical and conforming changes to the definition of "participant."

69 **Supported work.** Amends § 256J.49, by adding subd. 12a. Defines "supported work" as a subsidized or unsubsidized work experience placement with a public or private sector employer, which may include services such as individual supervision and job coaching to support the participant in the job.

70 **Work activity.** Amends § 256J.49, subd. 13. Makes technical and conforming changes. Condenses list of allowable work activities. Requires that an activity lead to an employment goal.

71 **Employment and training services component of MFIP.** Amends § 256J.50, subd. 1. Makes technical changes. Eliminates obsolete language. Requires counties to provide employment and training services within 30 days after the caregiver is determined eligible for MFIP, or within ten days when the caregiver participated in the diversionary work program within the past 12 months.

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72 **Exception; financial hardship.** Amends § 256J.50, subd. 9. Makes technical and conforming changes.

73 **Required notification to victims of family violence.** Amends § 256J.50, subd. 10. Makes technical and conforming changes. Eliminates references to alternative employment plans and safety plans.

74 **Provider application.** Amends § 256J.51, subd. 1. Makes technical and conforming changes.

75 **Appeal; alternate approval.** Amends § 256J.51, subd. 2. Makes technical and conforming changes.

76 **Commissioner's review.** Amends § 256J.51, subd. 3. Makes technical and conforming changes.

77 **Revised service agreement required.** Amends § 256J.51, subd. 4. Makes technical and conforming changes.

78 **Assessment; employment plans.** Proposes coding for new law § 256J.521.

Subd. 1. Assessments. Defines assessment as a continuing process of gathering information related to employability for the purpose of identifying strengths and strategies for coping with issues that interfere with employment. Requires job counselors to use information from the assessment process to develop and update the employment plan. Defines the scope of the assessment. Requires information gathered during participation in the diversionary work program to be incorporated into the assessment process. Allows job counselors to require participants to complete a professional chemical use assessment or a professional psychological assessment as a component of the assessment process.

Subd. 2. Employment plan; contents. Requires the job counselor and the participant to develop an employment plan that includes participation in activities and hours that meet the MFIP requirements. States the purpose of the employment plan. Lists activities and other items that may be included in the employment plan. Requires participants who are determined to possess sufficient skills such that the participant is likely to succeed in obtaining unsubsidized employment to job search at least 30 hours per week for up to six weeks, and accept any offer of suitable employment. Allows activities and hourly requirements in the employment plan to be adjusted as necessary to accommodate the personal and family circumstances of participants. Requires employment plans to be reviewed every three months.

Subd. 3. Employment plan; family violence waiver. Requires participants with a family violence waiver to develop or revise an employment plan with a job counselor and a person trained in domestic violence. Lists the issues the plan may address including safety, legal, or emotional issues.

Subd. 4. Self-employment. Allows self-employment activities to be included in an employment plan contingent on the development of a business plan. Requires employment plans that include self-employment to be reviewed every three months. Allows requirements to be waived for participants who are enrolled in the self-employment investment demonstration program.

Subd. 5. Transition from the diversionary work program. Requires participants who become eligible for MFIP assistance after completing the diversionary work program, or who are deemed unable to benefit from the

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diversionary work program, to meet all assessment and employment plan requirements.

Subd. 6. Loss of employment. Requires participants who are laid off, quit with good cause, or are terminated from employment through no fault of their own to meet with a job counselor within 10 working days.

79 **Length of program.** Amends § 256J.53, subd. 1. Makes technical changes.

80 **Approval of post-secondary education or training.** Amends § 256J.53, subd. 2. Makes technical changes. Requires participants to be working in unsubsidized employment at least 20 hours per week in order for a post-secondary education or training program to be an approved activity. Lists documentation that participants seeking approval of post-secondary education or training must provide. Allows the hourly unsubsidized employment requirement to be reduced for intensive education or training programs lasting 12 weeks or less when full-time attendance is required. Allows current MFIP participants with an approved employment plan in place that includes more than 12 months of post-secondary education or training to complete that plan.

81 **Requirements after post-secondary education or training.** Amends § 256J.53, subd. 5. Limits job search upon completion of an approved education or training program to six weeks. Current law allows for three months of job search.

82 **Basic education; English as a second language.** Proposes coding for new law § 256J.531.

Subd. 1. Approval of adult basic education. Requires participants to have reading or math proficiency below a ninth grade level in order for adult basic education classes to be an approved work activity, with the exception of classes related to obtaining a GED.

Subd. 2. Approval of English as a second language. Requires participants to be below a certain level as measured by a nationally recognized test in order for ESL classes to be an approved work activity. Requires job counselors to give preference to enrollment in a functional work literacy program. Prohibits participants from being approved for more than a combined total of 24 months of ESL classes while participating in the diversionary work program and the employment and training services component of MFIP. Prohibits more than two-thirds of the participation requirements to be met through attending functional work literacy classes for participants enrolled in functional work literacy classes.

83 **Assessment of educational progress and needs.** Amends § 256J.54, subd. 1. Makes technical and conforming changes. Requires county agencies to give a caregiver, who is age 18 or 19 and has not obtained a high school diploma or its equivalent, the option to choose an employment plan with and education option.

84 **Responsibility for assessment and employment plan.** Amends 256J.54, subd. 2. Makes technical and conforming changes.

85 **Education option developed.** Amends § 256J.54, subd. 3. Makes technical and conforming changes.

86 **School attendance required.** Amends § 256J.54, subd. 5. Makes technical and conforming changes.

87 **Family violence waiver criteria.** Proposes coding for new law § 256J.545. Requires a claim of family violence to be documented in order to qualify for a family violence waiver. Lists approved documentation.

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88 **Participation requirements.** Amends § 256J.55, subd. 1. Requires all caregivers to participate in employment services, assessment, employment plans, education and training, and participation requirements concurrent with receipt of MFIP. Exempts participants who meet the exemptions under employment and training services from participation requirements until July 1, 2004. Requires all participants to develop an employment plan and meet hourly requirements, with certain exceptions. Requires job counselors and caregivers to develop employment plans with the appropriate amount of work activities dependent upon age of children and number of parents. Requires imposition of sanctions for failure to meet requirements without good cause.

89 **Duty to report.** Amends § 256J.55, subd. 2. Requires participants to inform the job counselor within 10 working days regarding any change in employment status. Current law requires participants to inform job counselors within three working days.

90 **Employment and training services component; exemptions.** Amends § 256J.56. Makes technical and conforming changes. Eliminates references to alternative employment plans. Establishes a June 30, 2004 expiration date.

91 **Universal participation required.** Proposes coding for new law § 256J.561.

Subd. 1. Implementation of universal participation requirements. Provides transition time between July 1, 2004 and June 30, 2005, for all MFIP participants who were exempt from participating in employment services under the employment and training exemptions. Requires all caregivers whose applications are received July 1, 2004 or after to comply with the participation requirements.

Subd. 2. Participation requirements. Requires all caregivers, with certain exceptions, to participate in employment services. Lists requirements of the employment plan. Requires employment plans for certain participants to be tailored to recognize the special circumstances of caregivers and families. Requires job counselors to review employment plans every three months. Requires counties to notify participants when a new or revised employment plan is needed.

Subd. 3. Child under 12 weeks of age. Exempts participants with a child under 12 weeks of age from participating in employment services until the child reaches 12 weeks of age. Lists certain conditions that must be met to receive this exemption. Makes this provision available only once in a caregiver's lifetime.

92 **Good cause; failure to comply; notice; conciliation conference.** Amends § 256J.57. Makes technical and conforming changes. Eliminates references to job search plans.

93 **Continuation of certain services.** Amends § 256J.62, subd. 9. Limits continuation of certain services to services that were approved as part of an employment plan prior to June 30, 2003, and to participants whose income remain below the MFIP exit level.

94 **MFIP consolidated fund.** Proposes coding for new law § 256J.626.

Subd. 1. Consolidated fund. Establishes the consolidated fund. Describes requirements and allowable uses of the funds.

Subd. 2. Allowable expenditures. Requires the commissioner to restrict expenditures under the consolidated fund to benefits and services allowed under title IV-A of the federal Social Security Act. Lists allowable expenditures, including, but not limited to:

- short-term, nonrecurring shelter and utility needs;

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- transportation needed to obtain or retain employment or to participate in other approved work activities; and
- supported work.

Limits administrative costs that are not matched with county funds to 7.5 percent of a county's or 15 percent of a tribe's reimbursement. Requires the commissioner to define administrative costs.

Subd. 3. Eligibility for services. Allows families with a minor child and income below 200 percent of the federal poverty guidelines to receive services funded under the consolidated fund. Requires counties to give priority to families currently receiving MFIP or diversionary work program services.

Subd. 4. County and tribal biennial service agreements. Requires each county and tribe to have in place an approved biennial service agreement, beginning January 1, 2004. In counties with a city of the first class with population of over 300,000, requires the county to consider a service agreement that includes a jointly developed plan for the delivery of employment services with the city. Allows counties to collaborate to develop multicounty, multitribal, or regional service agreements. Lists information the agreement must include. Requires the commissioner to provide each county and tribe with the information needed to complete an agreement. Requires counties to allow a period of not less than 30 days prior to submission of the agreement to solicit public comments on the contents of the agreement. Requires the commissioner to inform the county of service agreement approval within 60 days of receiving each agreement.

Subd. 5. Innovation projects. Requires the commissioner to use no more than $3 million of the funds annually appropriated for the consolidated fund for projects testing innovative approaches to improving outcomes for MFIP participants. Requires projects to be targeted to areas with poor outcomes or to subgroups within the MFIP caseload who are experiencing poor outcomes.

Subd. 6. Base allocation to counties and tribes. Defines "2002 historic spending base," "initial allocation," "final allocation," and "base programs." Creates a new allocation formula based on 2002 historic spending. For calendar year 2005, requires the commissioner to determine the initial allocation of funds to be made available in proportion to the county or tribe's initial allocation for the period of July 1, 2003, to December 31, 2004. Makes the formula expire on December 31, 2005.

Subd. 7. Performance base funds. Reserves five percent of consolidated funds for allocation based on performance, beginning with allocations for calendar year 2005. Lists criteria for allocating performance based funds. Makes funds remaining unallocated after the performance based allocations available to the commissioner for innovative projects. Requires the commissioner to proportionally reduce allocations for each county and tribe if there are insufficient funds available.

Subd. 8. Reporting requirement and reimbursement. Requires the commissioner to specify requirements for reporting. Requires that each county or tribe be reimbursed for eligible expenditures up to the limit of its allocation and subject to the availability of funds. Requires the commissioner to review county and tribal agency expenditures of the MFIP consolidated fund and allows the commissioner to reallocate unencumbered or unexpended funds appropriated to county and tribal

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agencies that can demonstrate a need for additional funds.

Subd. 9. Report. Requires the commissioner, in consultation with counties and tribes, to determine how performance based allocations will be allocated to groupings of counties and tribes when groupings are used to measure expected performance ranges and how allocations will be allocated to tribes. Requires the report by January 1, 2004.

95 **Funding.** Amends § 256J.645, subd. 3. Makes technical and conforming changes.

96 **Training and placement.** Amends § 256J.66, subd. 2. Makes technical change.

97 **Training and placement.** Amends § 256J.69, subd. 2. Makes technical and conforming changes.

98 **Responsibility for incorrect assistance payments.** Amends § 256J.75, subd. 3. Eliminates references to medical assistance.

99 **Monthly county caseload report.** Amends § 256J.751, subd. 1. Requires the commissioner to report monthly, rather than quarterly, to each county certain caseload information. Updates the list of caseload information that must be reported to counties by the commissioner.

100 **Quarterly comparison report.** Amends § 256J.751, subd. 2. Adds two pieces of information to the list of performance indicators that the commissioner must report to counties each quarter, the self-support index and the MFIP work participation rate.

101 **Failure to meet federal performance standards.** Amends 256J.751, subd. 5. Makes technical changes. Describes criteria for determining if a county or tribe is low-performing. Requires low-performing counties to engage in corrective action as defined by the commissioner. Allows the commissioner to coordinate technical assistance for low-performing counties.

102 **Diversionary work program.** Proposes coding for new law § 256J.95.

Subd. 1. Establishing a diversionary work program (DWP). Establishes the DWP program on July 1, 2003, to provide short-term diversionary benefits to eligible recipients that lead to unsubsidized employment, increase economic stability, and reduce the risk of families needing longer term assistance. Prohibits families meeting the DWP eligibility requirements from receiving MFIP assistance. Limits eligibility for DWP to a maximum of four months once in a 12-month period. Requires family maintenance needs to be vendor paid up to the cash portion of the MFIP standard of need for the same size household. Allows for a personal needs allowance of up to $70 per DWP recipient in the family. Allows counties to provide supportive and other allowable services funded by the MFIP consolidated fund to eligible participants.

Subd. 2. Definitions. Defines “diversionary work program,” “employment plan,” “employment services,” “family maintenance needs,” “family unit,” “Minnesota family investment program,” “personal needs allowance,” and “work activities.”

Subd. 3. Eligibility for DWP. Requires all family units who apply and are eligible for MFIP to participate in the diversionary work program, with certain exceptions. Lists exceptions.

Subd. 4. Cooperation with program requirements. Lists requirements with which applicants must comply in order to be eligible for DWP.

Subd. 5. Submitting application form. Establishes the date of eligibility for

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DWP. Lists items that counties must inform applicants of. Allows applicants to withdraw an application at any time prior to approval by giving written or oral notice to the county agency.

Subd. 6. Initial screening of applications. Requires counties to determine if an applicant is eligible for other benefits upon receipt of an application.

Subd. 7. Program and processing standards. Lists items the financial worker must discuss with the applicant at the intake interview. Requires counties to deny an application and inform the applicant if the county cannot determine eligibility for the DWP program within 30 days. Makes families eligible for a fair hearing.

Subd. 8. Verification requirements. Requires county agencies to only require verification of information necessary to determine eligibility and the amount of the payment. Prohibits county agencies from requesting information about an applicant or participant that is not a matter of public record from a source other than county agencies, DHS, or the U.S. DHHS without the person's prior written consent. Requires family maintenance needs to be verified before the expense is allowed in the calculation of the DWP grant.

Subd. 9. Property and income limitations. Makes the asset limits and exclusions for applicants and recipients of DWP the same as the asset limits and exclusions for applicants and recipients of MFIP. Requires counties to treat income for applicants and recipients of DWP the same as income is treated for applicants and recipients of MFIP.

Subd. 10. DWP grant. Bases the amount of cash benefits that a family unit is eligible for under DWP on the number of persons in the family unit, the family maintenance needs, personal needs allowance, and countable income. Bases the DWP grant on the family maintenance needs plus a personal needs allowance. Requires housing and utilities to be vendor paid. Creates a formula for determining the maximum monthly benefit amount available under DWP. Establishes the minimum cash benefit amount at $10. Makes recipients of DWP grants ineligible for MFIP or TANF cash programs.

Subd. 11. Universal participation required. Requires all DWP caregivers to participate in a DWP employment plan, except caregivers who meet certain criteria. Allows some DWP caregivers to develop employment plans that may contain alternate activities and reduced hours when approved by the job counselor.

Subd. 12. Conversion or referral to MFIP. Requires counties to convert or refer participants to MFIP if it is determined that a participant is unlikely to benefit from DWP. Lists reasons a participant would be determined to be unlikely to benefit from DWP. Prohibits counties from requiring additional verification of the information in the case file from the DWP application, unless the information in the case file is inaccurate, questionable, or no longer current. Prohibits counties from requesting a combined application form for a participant who has exhausted the four months of DWP, has continued need for cash and food assistance, and has completed, signed, and submitted a program change request form within 30 days of the fourth month of DWP.

Subd. 13. Immediate referral to employment services. Requires counties to refer all caregivers to employment services within one day of determination that the applicant is eligible for DWP, but before cash assistance is issued to the family. Lists

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information that must be contained in the referral.

Subd. 14. Employment plan; DWP benefits. Requires the employment services provider to provide the participant with an opportunity to meet to develop an employment plan within ten working days of being notified of DWP eligibility. Requires the employment services provider to notify the county within one working day after an initial employment plan has been signed. Requires the county to issue DWP benefits within one working day after receiving notice that the employment plan has been signed.

Subd. 15. Limitations on certain work activities. Allows employment activities that are allowable under the MFIP program to be allowable under DWP, with certain exceptions.

Subd. 16. Failure to comply with requirements. Requires family units that include a participant who fails to comply with DWP employment service or child support enforcement requirements to be disqualified from DWP. Prohibits the disqualification from applying to food support or health care benefits.

Subd. 17. Good cause for not complying with requirements. Allows participants who fail to meet the requirements of DWP to claim good cause for reasons listed under MFIP. Prohibits counties from imposing a disqualification if good cause exists.

Subd. 18. Reinstatement following disqualification. Allows participants who have been disqualified from DWP due to noncompliance with employment services to be reinstated by complying with program requirements. Allows participants who have been disqualified from DWP due to noncompliance with child support enforcement to be reinstated by complying with child support enforcement requirements. Requires the county to issue prorated benefits for the remaining portion of the month once a participant has been reinstated. Prohibits noncompliant participants from being eligible for MFIP or any other TANF cash program during the time of noncompliance.

Subd. 19. Recovery of overpayments. Requires overpayments to be recouped or recovered when the overpayment is due to an ATM error.

Subd. 20. Implementation of DWP. Allows counties to establish a diversionary work program any time after July 1, 2003. Requires counties to notify the commissioner prior to establishing a program. Requires all counties to implement a program no later than July 1, 2004.

103 **Tax levy for social services; board duty; penalty.** Amends § 261.063. Makes technical and conforming changes. Revises "poor law" to limit county liability with DWP and the MFIP consolidated fund if a participant or applicant is not eligible.

104 **Federal food stamp program and the maternal and child nutrition act.** Amends § 393.07, subd. 10. Makes technical changes. Allows the commissioner to seek a waiver from the USDA to allow the state to specify foods that may and may not be purchased in Minnesota with benefits funded by the federal Food Stamp Program. Requires the commissioner to consult with the legislature in developing the waiver and to seek legislative approval prior to implementing the waiver.

105 **Ineligibility for state funded programs.** Amends Laws 2001, First Special Session chapter 9, article 10, section 62. Makes changes to conform to changes in federal law and subsequent relevant enactments. Extends the expiration of eligibility of legal noncitizens for

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MFIP assistance funded entirely with state money to June 30, 2007.

106 **Revisor's instruction.** Requires the revisor to codify section 104, insert "food support" wherever "food stamp" appears in Minnesota Statutes and Rules, and delete internal cross-references where appropriate and make changes necessary to correct the punctuation, grammar, or structure of the remaining text and preserve its meaning for sections of Minnesota Statutes and Rules affected by repealed sections.

107 **Repealer.** Repeals sections 256J.02, subdivision 3 (TANF carryforward of federal money); 256J.08, subdivisions 28 and 70 (definitions of "emergency" and "professional certification"); 256J.24, subdivision 8 (assistance paid to eligible assistance units); 256J.30, subdivision 10 (cooperation with health care benefits); 256J.462 (sanctions; county options); 256J.47 (diversionary assistance program); 256J.48 (emergency assistance); 256J.49, subdivisions 1a, 2, 6, and 7 (definitions of "alternative employment plan," "family violence," "federal participation standards," and "intensive English as a second language program"); 256J.50, subdivisions 2, 3, 3a, 5, and 7 (pilot programs, transitional rule, participation requirements for all cases, and local service unit plan); 256J.52 (assessments; plans); 256J.55, subdivision 5 (option to utilize existing plan); 256J.62, subdivisions 1, 2a, 4, 6, 7, and 8 (allocation of county employment and training services block grant); 256J.625 (local intervention grants for self sufficiency); 256J.655 (nontraditional career assistance and training); 256J.74, subdivision 3 (emergency assistance, assistance unit with a minor child); 256J.751, subdivisions 3 and 4 (annual report and development of performance measures); 256J.76 (county administrative aid); 256K.30 (grants for nontraditional career assistance and training programs); and Laws 2000, chapter 488, article 10, section 29 (pilot projects for MFIP eligible families).

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Article 2: Long-Term Care

Overview

This article contains a variety of provisions related to state long-term care programs, funding, and policy. Provisions in the article:

- make changes related to long-term care insurance coverage (sections 1 to 6);
- provide nursing homes with greater regulatory flexibility (sections 7, 8, 10, 37, and 53);
- increase the nursing home license surcharge (sections 13 and 34) and establish an ICF-MR surcharge (section 14, 15, and 38);
- modify requirements for the alternative care program (sections 18 to 24) and increase client fees (section 25);
- allow claims against estates for alternative care services provided (sections 27 to 29, 47 to 52);
- modify payments to nursing homes for leave days (section 30) and for the first 90 days of care (section 32);
- eliminate group residential housing (GRH) supplementary room and board rates and make other changes (sections 42 to 45);
- require various reports on long-term care issues (sections 11, 54, and 55); and
- eliminate the home sharing grant program and the health care consumer assistance grant program (section 57).

1 **Accelerated benefits.** Amends § 61A.072, subd. 6. Permits life insurance policies to pay accelerated benefits (paid before death) to policyholders who need long-term care. Current law is more restrictive on when accelerated benefits may be paid under a life insurance policy.

2 **Extended basic Medicare supplement plan.** Amends § 62A.315. Increases the amount of coverage required under the extended basic Medicare supplement plan for at-home recovery services.

3 **Regulatory flexibility.** Amends § 62A.48, by adding subd. 12. Gives the commissioner of commerce the authority to waive compliance with a state law for a long-term care insurance policy, if the commissioner finds that necessary to permit marketing of a desirable innovative product. This section applies to the traditional type of long-term care policy, regulated under chapter 62A.

4 **Prohibited limitations.** Amends § 62A.49, by adding subd. 3. Adds to the regulation of traditional long-term care policies under chapter 62A, language enacted in chapter 62S, which regulates the newer type of "tax-qualified" long-term care insurance policies. The language prohibits certain exclusions from coverage of home care. Adds the new clause (10), prohibiting exclusions from home care coverage that are based on the type of "home" in which the recipient lives.

5 **Prohibited limitations.** Amends § 62S.22, subd. 1. Amends chapter 62S to add the same clause (10) added to chapter 62A in the preceding section. The effect is to make both types of policies subject to the same regulation of home care exclusions.

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6 **Regulatory flexibility.** Amends § 62S.34. Adds to chapter 62S language identical to that added to chapter 62A in an earlier section of this bill, providing authority for the commissioner to waive requirements if necessary to permit marketing an innovative product.

7 **Standards.** Amends § 144A.04, subd. 3. Requires the commissioner of health to make information on facility-specific waivers related to technology or physical plant available to other nursing homes. Requires the commissioner, upon the request of a facility, to extend a waiver granted to a specific facility related to technology or physical plant to the facility making the request, if certain conditions are met. Exempts a facility from seeking a waiver for room furniture or equipment when responding to resident-specific requests, if health and safety concerns have been discussed with the resident and this is documented in the patient record. Provides and immediate effective date. Provides an immediate effective date.

8 **Incontinent residents.** Amends § 144A.04, by adding subd. 11. Provides an exemption from the requirement that incontinent residents be checked every two hours, by requiring the resident to be checked according to a time interval specified in the care plan. Requires the attending physician to authorize any interval longer than two hours, unless the resident or representative of the resident agrees to waive physician involvement.

9 **Exceptions for replacement beds.** Amends § 144A.071, subd. 4c. Provides a nursing home moratorium exception to add 29 beds to a 69-bed facility in St. Louis County. The beds must be transferred from a 235-bed facility in the county. The project may not proceed unless approved and funded under the administrative exception process.

10 **Independent informal dispute resolution.** Amends § 144A.10, by adding subd. 16. Establishes an independent informal dispute resolution process, through the office of administrative hearings, for deficiency citations issued to nursing facilities. Specifies procedures and timelines, and the types of findings that can be issued. Specifies that the findings of the arbitrator are not binding on the commissioner. Requires the commissioner to reimburse the office of administrative hearings for the costs of arbitration proceedings, and requires facilities to reimburse the commissioner when deficiency citations are supported in full or in substance.

11 **Balancing long-term care: report required.** Adds § 144A.351. Requires the commissioners of health and human services, with the cooperation of counties and regional entities, to report to the legislature on January 15, 2004, and biennially thereafter, on the status of the range of long-term care services for the elderly. Specifies topics that the reports must address.

12 **License required.** Amends § 144A.4605, subd. 4. Makes a conforming change in statutory cross-references, to reflect recodification elsewhere in the article of language setting assisted living service rates for the alternative care program and adult foster care rates for the elderly waiver.

13 **Nursing home license surcharge.** Amends § 256.9657, subd. 1. Increases the nursing home surcharge from $990 to $2,815 per licensed bed, effective July 15, 2003, and allows the commissioner to reduce, and subsequently restore, the surcharge amount based on the commissioner's determination of a permissible surcharge. Extends by one year the date by which nursing facilities may elect to participate in MA.

14 **ICF/MR license surcharge.** Amends § 256.9657, by adding subd. 3a. Requires each nonstate-operated ICF/MR to pay to the commissioner an annual surcharge of $1,040 per licensed bed, effective July 1, 2003. Specifies procedures for adjusting the surcharge if the number of licensed beds is reduced. Allows the commissioner to reduce, and later restore, the surcharge based on the commissioner's determination of a permissible surcharge.

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15 **Payments into the account.** Amends § 256.9657, subd. 4. Requires the ICF/MR surcharge to be paid in monthly installments on the 15th of each month, beginning July 15, 2003.

16 **Assignment of benefits.** Amends § 256B.056, subd. 6. Clarifies language related to the requirement that MA enrollees agree to assign to the state any benefits received from a third party for the cost of medical care. Provides that by accepting or receiving assistance, a person is deemed to have assigned rights to medical support and third party payments. Includes prepaid health plans, children's mental health collaboratives, demonstration projects for persons with disabilities, nursing facilities under the alternative payment system, and county-based purchasing entities in the definition of "the department of human services or the state."

17 **Imposition of monetary recovery and sanctions.** Amends § 256B.064, subd. 2. Allows the commissioner to suspend or terminate a vendor's participation in MA without advance notice and an opportunity for a hearing, when the suspension or termination is required because of the vendor's exclusion from participation in Medicare. Requires the commissioner to provide notice within five days of taking action, and specifies the information that must be included in the notice.

18 **Eligibility for services.** Amends § 256B.0913, subd. 2. Eliminates redundant language related to eligibility for the alternative care program.

19 **Eligibility for funding for services for nonmedical assistance recipients.** Amends § 256B.0913, subd. 4. The amendment to (a) replaces statutory language describing the alternative care funding limit for an individual with a cross-reference to the elderly waiver rate limit. Establishes procedures for disenrolling persons whose premiums are over 60 days past due.

The amendment to (b) prohibits the use of alternative care funds to meet an MA spenddown for a person eligible to participate under the elderly waiver special income standard.

The amendment to (c) adds clarifying language related to the allowable use of alternative care funds for certain case management services.

The amendment to (d) prohibits alternative care funding for persons whose income is greater than the maintenance needs allowance (currently $741/month) but does not exceed 120 percent of FPG, who would be eligible for the elderly waiver with a waiver obligation.

20 **Services covered under alternative care.** Amends § 256B.0913, subd. 5. The amendment to subdivision 5 allows the alternative care program to provide direct cash payments, until approval and implementation of consumer directed services under the elderly waiver. Also clarifies coverage of current services and the limit on payments for discretionary services and direct cash payments.

A newly codified subd. 5a reinstates and rephrases a provision in current law that provides that the services, service definitions, and standards for alternative care services shall be the same as those for the elderly waiver, except for transitional services and unless otherwise specified in law. A new (c) places in statute relative hardship criteria for the provision of personal care services that current law incorporates through cross-reference, and also provides greater flexibility for a responsible party to provide personal care services.

A newly codified subd. 5b strikes language that cross-references the relative hardship

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criteria.

A newly codified subd. 5c replaces statutory definitions of supportive services and health-related services with the relevant statutory cross-references from law governing board and lodging facilities with special services.

A newly codified subd. 5d replaces statutory listings of supportive services, home care aide tasks, and home management tasks with the relevant statutory cross-references.

A newly codified subd. 5e makes conforming changes in a cross-reference.

A newly codified subd. 5f replaces statutory language describing the assisted living services payment limit with the appropriate cross-reference and also makes conforming changes.

A newly codified subd. 5g makes conforming changes related to the provision of direct cash payments and to recodification of the paragraph.

A newly codified subd. 5h reinstates language stricken in the following subdivision and changes internal references to reflect recodification.

A newly codified subd. 5i strikes language that is reinstated in the previous subdivision.

21 **Alternative care program administration.** Amends § 256B.0913, subd. 6. Specifies that alternative care pilot projects operate according to this section and the authorizing legislation in session law, under agreement with the commissioner. Requires each contract period to begin no later than the first payment cycle of a fiscal year and continue through the last payment cycle.

22 **Case management.** Amends § 256B.0913, subd. 7. Strikes language related to alternative care program case management that is not necessary, since the case management provisions for the elderly waiver apply.

23 **Requirements for individual care plan.** Amends § 256B.0913, subd. 8. Requires lead agencies to document that individuals were free to choose qualified case management and service coordination providers not employed by the lead agency.

24 **Allocation formula.** Amends § 256B.0913, subd. 10. Allows the commissioner, with the agreement of the lead agency, to reallocate alternative care base allocations to lead agencies in which the base amount exceeds program expenditures.

25 **Client fees.** Amends § 256B.0913, subd. 12. Modifies fees for the alternative care program, to require:

- individuals with incomes less than 100 percent of the FPG and with less than $10,000 in assets pay no fee
- individuals with incomes greater than or equal to 100 percent but less than 150 percent of FPG and assets less than $10,000 to pay 5 percent of the cost of services
- individuals with incomes greater than or equal to 150 percent but less than 200 percent of FPG, and less than $10,000 in assets pay a fee of 15 percent of the cost of services
- individuals with incomes equal to or greater than 200 percent of FPG and less

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than $10,000 in assets, pay a fee of 30 percent of the cost of services

- individuals with assets equal to or greater than $10,000 pay a fee of 30 percent of the cost of services.

Includes case management costs in the cost of services for purposes of determining premiums. Eliminates the requirement that fees be waived by the commissioner when an individual is applying for MA. Requires fees to be waived when an individual participates in a consumer-directed service plan for which the cost is no greater than the cost of the alternative care service plan minus the monthly premium.

26 **Limits of cases.** Amends § 256B.0915, subd. 3. Recodifies provisions related to the elderly waiver and makes conforming changes in cross-references.

27 **Definition.** Amends § 256B.15, subd. 1. Includes alternative care for non-MA recipients in the definition of medical assistance, for purposes of claims against estates.

28 **Estates subject to claims.** Amends § 256B.15, subd. 1a. Removes the exclusion of alternative care in a provision specifying when claims for medical assistance must be filed. Provides counties with ten percent of the collections for alternative care directly attributable to count effort.

29 **Limitations on claims.** Amends § 256B.15, subd. 2. Specifies that claim amounts for alternative care are net of all premiums paid on or after July 1, 2003, and are limited to services provided on or after that date.

30 **Payment restrictions on leave days.** Amends § 256B.431, subd. 2r. Beginning July 1, 2003, reduces payments to nursing homes for leave days from 79 percent of the total payment rate to 60 percent.

31 **Payment limitation.** Amends § 256B.431, by adding subd. 2t. Allows MA payment of Medicare copayments for nursing home stays only if the Medicare rate minus the resident's copayment responsibility is less than the MA payment rate. Specifies that the amount paid by MA is equal to the amount by which the MA rate exceeds the Medicare rate, less the copayment responsibility. Allows managed care plans to limit payment under this subdivision.

32 **Payment during first 90 days.** Amends § 256B.431, subd. 32. For rate years beginning on or after July 1, 2003, limits enhanced payments to 120 percent of the facility's MA rate for each RUG class for the first 30 days, for admissions occurring on or after July 1, 2003. (Under current law, facilities also receive a payment rate of 110 percent of the facility rate for each case mix class for the next 60 days; this enhanced payment is eliminated.) Effective January 1, 2004, the enhanced rate is not allowed if the person has resided during the previous 30 days in:

(1) the same nursing facility;

(2) a facility owned or operated by a related party; or

(3) a facility or part of a facility that closed.

33 **Employee scholarship costs and training in English as a second language.** Amends § 256B.431, subd. 36. Requires the commissioner, when reimbursing nursing facilities through their operating payment rate for the costs of employee scholarships and training related to English as a second language, to allow only costs related to tuition and direct educational expenses..

34 **Nursing home rate increases effective in fiscal year 2003.** Amends § 256B.431, by adding subd. 38. Effective June 1, 2003, requires the commissioner to provide each nursing home with an increase in each case mix payment rate equal to the increase in the surcharge, divided

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by 365, and further divided by .90. Provides that this increase is not subject to annual percentage increases and that the 30-day advance notice requirement for private pay residents does not apply. Prohibits the commissioner from adjusting this rate increase unless an adjustment due to a determination of a permissible surcharge is greater than 1.5 percent of the surcharge amount.

35 **Facility rates beginning on or after July 1, 2003.** Amends § 256B.431, by adding subd. 39. For rate years beginning on or after July 1, 2003, sets the July 1 operating payments rate for nursing facilities reimbursed under the cost-based system at the level of their operating payment rate in effect on the prior June 30th.

36 **Alternate rates for nursing facilities.** Amends § 256B.434, subd. 4. For the rate years beginning July 1, 2003, and July 1, 2004, limits inflation adjustments for nursing facilities in the alternative payment system to the property rate. Corrects a reference to the entity making the forecasts used in determining inflation adjustments.

37 **Exemptions.** Amends § 256B.434, subd. 10. Requires nursing facilities participating in the alternative payment system to either participate in the alternative payment system quality improvement program or submit information on their own quality improvement process to the commissioner for approval. Requires facilities that have received approval to report annually on at least one key area of quality improvement.

38 **Rate increase effective June 1, 2003.** Amends § 256B.5012, subd. 5. For rate periods beginning on or after June 1, 2003, requires the commissioner to increase the total operating payment rate of each ICF/MR by $3 per day. Specifies that this increase is not subject to any annual percentage increase.

39 **Physician and dental reimbursement.** Amends § 256B.76. Strikes language related to MA rates for outpatient mental health services that is incorrectly placed in a section of law dealing with physician and dental reimbursement.

40 **Reimbursement for mental health services.** Amends § 256B.761. Reinstates language previously stricken related to rates for outpatient mental health services, in a section of law dealing with that topic

41 **Claims; assignment of benefits.** Amends § 256D.03, subd. 3a. Makes technical changes. Strikes language prohibiting the assignment of rights to medical support or payments from affecting benefits paid or provided under automobile accident coverage and private health coverage until the person or organization providing the benefits has been notified of the assignment.

42 **Purpose.** Amends § 256I.02. Changes terminology related to the group residential housing (GRH) act, by specifying that the act establishes rates and payments for persons who reside in "the community." (Current law refers to "a group residence.")

43 **Moratorium on the development of group residential housing beds.** Amends § 256I.04, subd. 3. Eliminates language that allows county agencies, with DHS approval, to enter into agreements with adult foster care providers for new GRH beds with rates in excess of the MSA equivalent rate.

44 **Maximum rates.** Amends § 256I.05, subd. 1. Eliminates the authority for county agencies to negotiate supplementary room and board rates (that exceed the MSA equivalent rate) for corporate adult foster care facilities serving waiver clients. Provides an effective date of July 1, 2004, or upon federal waiver approval, whichever is later.

45 **Supplementary service rates.** Amends § 256I.05, subd. 1a. Eliminates references to the supplementary room and board rate.

46 **Demonstration project.** Amends § 256I.05, subd. 7c. Requires the commissioner to seek

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federal approval by January 1, 2004, for a demonstration project to obtain federal reimbursement of food and nutritional costs currently paid by GRH. Specifies that any reimbursement received is nondedicated revenue to the general fund.

47 **Alternative care liens; definitions.** Adds § 514.991. Defines terms. Provides that the section is effective July 1, 2003, for persons first enrolling in the alternative care program on or after that date and on the first day of the first eligibility renewal period for persons enrolled prior to that date. (This effective date also applies to the related sections that follow.)

48 **Alternative care lien.** Adds § 514.992. Specifies procedures for filing liens for alternative care program services.

Subd. 1. Property subject to lien; lien amount. Provides that payments made by an alternative care agency to a recipient or to the recipient's spouse constitute a lien in favor of the agency on all real property. Limits the amount of the lien to benefits paid for services provided on or after July 1, 2003, to recipients over age 55.

Subd. 2. Attachment. Specifies when a lien attaches and establishes notice requirements. Also prohibits an agency from filing a lien when certain individuals reside in the homestead.

Subd. 3. Continuation of lien. States that a lien remains effective from the time it is filed until it is paid, satisfied, discharged, or becomes unenforceable.

Subd. 4. Priority of lien. Specifies the priority of an alternative care lien.

Subd. 5. Settlement, subordination, and release. Allows an agency to settle or subordinate the lien to any other lien or encumbrance, upon the terms and conditions it deems appropriate. Specifies when an agency must release and discharge a lien.

Subd. 6. Length of lien. State that a lien applies for ten years from the date of attachment, except as otherwise provided, and may be renewed for one additional ten-year period. Provides that a lien is not enforceable to the extent there is a determination that there are insufficient assets due to specified exemptions, rights, and claims.

49 **Lien; contents and filing.** Adds § 514.993. Specifies contents of the lien and procedures for filing the lien.

50 **Enforcement; other remedies.** Adds § 514.994. Specifies procedures for enforcing a lien.

Subd. 1. Foreclosure or enforcement of lien. Allows an agency to enforce or foreclose a lien in the manner provided for liens against real estate or by a foreclosure by action under chapter 581.

Subd. 2. Homestead exemption. Prohibits a lien from being enforced against a homestead while the recipient or the spouse occupy the property as their lawful residence.

Subd. 3. Agency claim or remedy. Provides that the provisions on alternative care liens do not limit the agency's right to file claims against estates, and do not limit other claims for reimbursement or the availability of other remedies.

51 **Amounts received to satisfy lien.** Adds § 514.995. Requires amounts the agency receives to satisfy the lien to be deposited in the state treasury and credited to the fund from which

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benefits were paid.

52 **Classification of claims.** Amends § 524.3-805. Classifies a claim filed for alternative care services as an expense of the last illness of the decedent and also specifies the relative priority of different claims for expenses of the last illness. Provides an effective date of July 1, 2003, for decedents dying on or after that date.

53 **Imposition of federal certification remedies.** Requires the commissioner of health to seek changes in the federal policy that mandates the imposition of sanctions if a nursing facility has previous deficiencies.

54 **Report on long-term care.** Requires the January 15, 2004 report to the legislature on long-term care services required under section 144A.351 to also address the feasibility of offering government or private sector loans or lines of credit to individuals age 65 and over, for the purpose of long-term care services.

55 **Reports; potential savings to state from certain long-term care insurance purchase incentives.** Requires the commissioner of human services to report to the legislature by January 15, 2005, on long-term care financing reform. Requires the report to examine the feasibility of: (1) initiating a long-term care insurance partnership program to encourage the purchase of private long-term care insurance by increasing the amount of assets permitted for MA eligibility; (2) using state MA funds to subsidize the purchase of private long-term care insurance; and (3) adding a nursing facility benefit to Medicare Supplement coverage.

56 **Revisor's instruction.** For sections in statue and rule affected by the sections repealed in the article, directs the revisor to delete internal cross-references where appropriate and to make grammatical and other changes necessary to preserve the meaning of the text.

57 **Repealer.** (a) Repeals sections 256.973 (home sharing grant program); 256.9772 (health care consumer assistance grant program); and 256B.437, subdivision 2 (planning and development of community-based services), effective July 1, 2003.

(b) Repeals sections 62J.66 (definitions); 62J.68 (senior drug discount program); 144A.071, subdivision 5 (report related to the moratorium on certification of nursing home beds); and 144A.35 (expansion of bed distribution study).

(c) Repeals Laws 1998, chapter 407, article 4, section 63 (consumer price index report).

(d) Effective July 1, 2003, repeals Minnesota Rules, parts 9505.3045 to 9505.3140 (community alternatives for disabled individuals program); 9505.3680 (review and approval of CAC applications and care plan); 9505.3690 (billing for CAC services); and 9505.3700 (appeals).

(e) Repeals Laws 2003, chapter 55, sections 1 to 4, the day following final enactment. (Sections 1, 2, and 4 appear in this article in identical or similar form; section 3 exempts certain home care agencies from regulation as a supplemental nursing services agency.)

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Article 3: Continuing Care for Persons with Disabilities

Overview

This article makes changes to ICF/MRs, day training and habilitation programs, family support grants, consumer support grants, home- and community-based waivered services, and creates new intensive rehabilitation mental health services.

1 **Applicability.** Amends § 174.30, subd. 1. Provides an exemption from department of transportation's special transportation operating standards, for a provider licensed under chapter 245B to serve persons with developmental disabilities that provides transportation services to consumers or residents of other vendors licensed under that chapter and transports 15 or fewer persons.

2 **Leaving the residence.** Amends § 245B.06, subd. 8. Requires ICF/MR residents to leave their residence to receive services during the day, unless otherwise specified in the ISP.

3 **Travel time to and from a day training and habilitation site.** Amends § 245B.07, subd. 11. Allows providers licensed under chapter 245B to serve persons with developmental disabilities to transport consumers to day training and habilitation sites for up to 90 minutes per one-way trip (current law limits trips to one hour).

4 **Liability of county; reimbursement.** Amends § 246.54.

Subd. 1. County portion for cost of care. Adds language requiring counties to pay to the state a portion of the cost of care provided in a state nursing facility. Increases the payment rate counties are required to provide from 10 percent to 20 percent of the cost of care provided in a regional treatment center.

Subd. 2. Exceptions. Lists exceptions to the county portion for cost of care.

Makes this section effective January 1, 2004.

5 **Program established.** Amends § 252.32, subd. 1. Strikes language referring to children with mental retardation or related conditions and adds language referring to children with disabilities. This expands family support grants to children who are certified disabled through SMRT or SSI. Currently, the family support grant program is for children with developmental disabilities.

6 **Support grants.** Amends § 252.32, subd. 1a. Makes technical changes. Reduces eligibility from families who have dependents under age 22 to under age 21. Strikes language referring to mental retardation or related conditions and adds language referring to dependents who are certified disabled. Prohibits families who are receiving home and community-based waivered services from being eligible for support grants. Strikes language allowing one time grant payments to families receiving home and community-based waivered services. Strikes obsolete language. Prohibits families from concurrently receiving the consumer support grant.

7 **Amount of support grant; use.** Amends § 252.32, subd. 3. Makes technical changes. Adds language requiring the county to consider three factors in approving or denying applications:

- the extent and areas of the functional limitations of the disabled child;
- the degree of need in the home environment for additional support; and
- the potential effectiveness of the grant to maintain and support the person in the

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family environment.

Strikes language allowing counties to exceed $3,000 per state fiscal year per eligible dependent for emergency circumstances. Strikes obsolete language.

8 **County board responsibilities.** Amends § 252.32, subd. 3c. Modifies county board responsibilities. Requires county boards to submit a plan to DHS for the management of the family support grant program, including the number of families the county will serve and several policies and procedures.

9 **Day training and habilitation services for adults with mental retardation, related conditions.** Amends § 252.41, subd. 3. Removes the requirement that day training and habilitation services be provided in a place other than the adult's own home or residence unless medically contraindicated.

10 **Rates.** Amends § 252.46, subd. 1. Allows the commissioner to authorize participation in a voluntary individualized payment rate structure for day training and habilitation services, in order to allow counties to change from a site-based to an individual payment rate, in consultation with providers. Requires the commissioner to establish procedures for determining the structure of individualized rates to ensure there is no additional cost to the state and that the rate structure is cost-neutral for day training and habilitation service providers. Strikes language authorizing an hourly job coach rate.

11 **Purpose and goals.** § 256.476, subd. 1. Deletes a reference to Consumer Support Grant Program exception grants. Makes this section effective January 1, 2004.

12 **Eligibility to apply for grants.** Amends § 256.476, subd. 3. Provides that persons receiving private duty nursing services may not receive a consumer support grant. Makes individuals receiving home and community-based waivers ineligible for the consumer support grant, except for individuals receiving consumer support grants before July 1, 2003, as long as other eligibility criteria are met. Current law limits the participation of individuals receiving home and community-based waivers.

13 **Support grants; criteria and limitations.** Amends § 256.476, subd. 4. Makes technical and conforming changes.

14 **Reimbursement, allocations, and reporting.** Amends § 256.476, subd. 5. Limits consumer support grants so that they are an alternative only to the development disability family support program, personal care attendant services, home health aide services, and private duty nursing services.

15 **Consumer support grant program after July 1, 2001.** § 256.476, subd. 11. Eliminates DHS authority to provide exception grants for up to 200 persons. Persons currently receiving exception grants may request a reevaluation of their home care rating.

16 **Sunset.** Amends section 256.482, subdivision 8, to provide that the council on disability shall not expire until June 30, 2007. Amendment is effective May 30, 2003.

17 **Relocation targeted case management provider qualifications.** Amends § 256B.0621, subd. 4. Modifies the section that establishes qualifications for relocation targeted case management providers. This section deletes a reference to these providers being Acertified@ by DHS but requires DHS to determine that the provider satisfies necessary criteria. Allows relocation targeted case management providers to subcontract with other providers to deliver services.

18 **Time lines.** Amends § 256B.0621, subd. 7. Allows case management services recipients to obtain targeted relocation case management services from an alternative provider enrolled by the commissioner, if a county agency, its contractor or federally recognized tribe does not provide the services as required. Allows the commissioner to waive provider requirements

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under certain circumstances. Lists provider requirements. Makes this section effective the day following final enactment.

19 **Intensive rehabilitative mental health services.** Proposes coding for new law § 256B.0622.

Subd. 1. Scope. States the scope of intensive rehabilitative mental health services.

Subd. 2. Definitions. Defines "intensive nonresidential rehabilitative mental health services," "intensive residential rehabilitative mental health services," "evidence-based practices," "overnight staff," and "treatment team."

Subd. 3. Eligibility. Lists eligibility criteria for the services.

Subd. 4. Provider certification and contract requirements. Lists certification and contract requirements of intensive nonresidential rehabilitative mental health services providers.

Subd. 5. Standards applicable to both nonresidential and residential providers. Lists standards applicable to both nonresidential and residential providers.

Subd. 6. Additional standards applicable only to intensive residential rehabilitative mental health services. Lists additional standards applicable only to intensive residential rehabilitative mental health services.

Subd. 7. Additional standards for nonresidential services. Lists additional standards for nonresidential intensive rehabilitative mental health services.

Subd. 8. Medical assistance payment for intensive rehabilitative mental health services. Establishes payment standards for intensive rehabilitative mental health services.

Subd. 9. Provider enrollment; rate setting for county-operated entities. Requires counties that use their own staff to provide these services to apply directly to the commissioner for enrollment and rate setting.

Subd. 10. Provider enrollment; rate setting for specialized program. Allows a provider proposing to serve a subpopulation of eligible recipients to bypass the county approval procedures and receive approval for provider enrollment and rate setting directly from the commissioner under certain circumstances.

20 **Definitions.** Amends § 256B.0623, subd. 2. Allows physician's assistants to provide medication education services.

21 **Provider entity standards.** Amends § 256B.0623, subd. 4. Clarifies certification and recertification of adult rehabilitative mental health providers. Changes recertification from every two years to every three years. Strikes language requiring the commissioner to develop statewide procedures for provider certification.

22 **Qualifications of provider staff.** Amends § 256B.0623, subd. 5. Expands who may be considered a mental health professional under certain circumstances. Modifies a component of the definition of mental health rehabilitation worker requiring fluency in the non-English

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language or competency in the culture of the ethnic group to which at least 20 percent (reduced from 50 percent) of the mental health rehabilitation worker's clients belong.

23 **Required training and supervision.** Amends § 256B.0623, subd. 6. Allows clinical supervision to be provided by a full- or part-time qualified professional employed by or under contract with the provider entity. Allows clinical supervision to be provided by interactive videoconferencing according to procedures developed by the commissioner.

24 **Diagnostic assessment.** Amends § 256B.0623, subd. 8. Until June 30, 2005, allows a diagnostic assessment that reflects the recipient's current status and has been completed within the past three years preceding admission to be accepted for initial implementation of adult rehabilitative mental health services.

25 **Personal care.** Amends § 256B.0625, subd. 19c. Includes licensed social workers in the definition of "qualified professional."

26 **Definition.** Amends § 256B.0627, subd. 1. Modifies the definition of "responsible party." Requires responsible parties to be accessible to the recipient and the personal care assistant when personal care services are being provided, monitor the services at least weekly, be identified at the time of assessment, and be listed on the recipient's service agreement and care plan. Allows responsible parties to delegate the responsibility to another adult who is not the personal care assistant. Strikes the requirement of the responsible party to reside with a recipient of personal care assistant services.

27 **Personal care assistant services.** Amends § 256B.0627, subd. 4. Strikes services provided by parents of adult recipients, adult children, or siblings of the recipient from the list of services that are not eligible for payment. Makes technical changes.

28 **Flexible use of personal care assistant hours.** Amends § 256B.0627, subd. 9. Simplifies regulation of the flexible use option for personal care assistant services. Recipients may use their allocated hours flexibly without commissioner approval, without county public health nurse input, and without development of a written monthly plan.

29 **Preadmission screening of individuals under 65 years of age.** Amends § 256B.0911, subd. 4d. Modifies the timelines when a county must complete the face-to-face LTCC assessment for persons age 21 through 64, from 20 working days to 40 calendar days. Provides consistency with federal regulations and eases LTCC administration for counties.

30 **Tribal management of elderly waiver.** Amends § 256B.0915, by adding a subd. Allows DHS and the White Earth Reservation to pilot tribal management, including the provision of case management, of the Elderly Waiver program and tribal assessment for PCA services. The pilot will allow DHS and White Earth to design the administrative infrastructure needed in order for tribes to expand their prerogative in the provision of health care to include long-term care.

31 **Case management administration and services.** Amends § 256B.092, subd. 1a. Rearranges the list of administrative functions of case management and adds review and authorization of the ISP to the list. Modifies the list of case management service activities provided to or arranged for a person. Clarifies that case managers are responsible for the administrative duties and service provisions listed above. Requires case managers to work with consumers, families, legal representatives and relevant medical experts and service providers in the development and annual review of the ISP and/or habilitation plan. Requires DHS to offer ongoing education in case management and requires case managers to receive no less than ten hours of case management education and disability-related training per year.

32 **Federal waivers.** Amends § 256B.092, subd. 5. Requires the individualized service plan to address the appropriateness of receiving habilitative services outside the residence on weekdays. Requires the case manager to offer to meet with the individual or guardian in

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order to discuss prioritization of service needs within the ISP when a county is evaluating denials, reductions, or terminations of home- and community-based services.

33 **Quality assurance system established.** Amends § 256B.095. Extends the expiration date of the program from June 30, 2005, to June 30, 2007. Allows additional counties to apply to participate in the program. Allows any additional counties or groups of counties to establish a quality assurance system. Requires any new systems to be governed by a commission initially appointed by the commissioner. Makes this section effective July 1, 2003.

34 **Membership.** Amends § 256B.0951, subd. 1. Removes obsolete language in order to conform to expanding the program.

35 **Authority to hire staff; charge fees; provide technical assistance.** Amends § 256B.0951, subd. 2. Allows the commission to charge fees for its services and to provide technical assistance to other counties, families, providers, and advocates interested in participating in a quality assurance system. Makes this section effective July 1, 2003.

36 **Commission duties.** Amends § 256B.0951, subd. 3. Removes obsolete language. Requires the commission to work cooperatively to expand the system. Makes this section effective July 1, 2003.

37 **Variance of certain standards prohibited.** Amends § 256B.0951, subd. 5. Makes technical changes. Makes this section effective July 1, 2003.

38 **Waiver of rules.** Amends § 256B.0951, subd. 7. Makes technical change. Makes this section effective July 1, 2003.

39 **Evaluation.** Amends § 256B.0951, subd. 9. Makes technical and conforming changes. Makes this section effective July 1, 2003.

40 **Notification.** Amends 256B.0952, subd. 1. Makes technical and conforming changes. Removes obsolete language. Requires counties who choose to participate in the quality assurance system to commit for three years. Makes this section effective July 1, 2003.

41 **Licensure periods.** Amends § 256B.0953, subd. 2. Makes technical and conforming changes. Makes this section effective July 1, 2003.

42 **Duties of the commissioner of human services.** Amends § 256B.0955. Makes technical and conforming changes. Removes obsolete language. Makes this section effective July 1, 2003.

43 **Division of cost.** Amends § 256B.19, subd. 1. Beginning January 1, 2004, requires counties to pay 10 percent of the non-federal share of costs for placements that exceed 90 days in ICFs/MR with seven or more beds, including pass through payments for training and habilitation. Beginning January 1, 2004, requires counties to pay 20 percent of the non-federal share of costs for placements that exceed 90 days in nursing facilities classified as institutions for mental diseases. Makes this requirement subject to chapter 256G (unitary residence and financial responsibility).

44 **Notice to residents.** Amends § 256B.47, subd. 2. Clarifies language requiring advance notice to nursing facility residents of increases in their per diem rates. The purpose of this change is to clarify that notice may not be retroactive.

45 **Notice to residents.** Amends § 256B.47, subd. 2. Clarifies language requiring advance notice to nursing facility residents of increases in their per diem rates. The purpose of this change is to clarify that notice may not be retroactive.

46 **Individualized service plan.** Amends § 256B.49, subd. 15. Requires the case manager to offer to meet with the individual or guardian in order to discuss prioritization of service needs within the ISP when a county is evaluating denials, reductions, or terminations of home- and community-based services. Prohibits reductions in authorized services due to changes in funding from exceeding the amount needed to ensure medically necessary

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services.

47 **Definitions.** Amends § 256B.501, subd. 1. Defines habilitation services and services during the day.

48 **Services during the day.** Amends § 256B.501, by adding subd. 3m. Requires the commissioner, when establishing a rate for services during the day, to ensure that the services comply with the active treatment requirements for persons residing in an ICF/MR and that services are not provided by the residential service provider, unless a choice of providers is offered and the client or client's representative agrees in writing.

49 **Rate adjustments for short-term admissions for crisis or specialized medical care.** Amends § 256B.5013, subd. 4. Allows the commissioner to designate up to 25 ICF/MR beds statewide for short-term admissions due to crisis care needs or care for medically fragile individuals, and requires the commissioner to provide temporary rate adjustments for these beds.

50 **Pass-through of other services costs.** Amends § 256B.5015. Requires services during the day to be paid as a pass-through payment no later than January 1, 2004. Requires the commissioner to establish rates for these services at levels that do not exceed 75 percent of a recipient's day training and habilitation costs prior to the service change. Lists factors the commissioner must consider when establishing a rate and requires pass-through payments for services during the day to be paid separately by the commissioner.

51 **Prepaid plans and mental health rehabilitative services.** Amends § 256B.82. Allows intensive rehabilitative services to be included in the medical assistance and MinnesotaCare prepaid health plans. Requires the commissioner to report to the legislature how these services should be included in prepaid health plans by January 15, 2004.

52 **County share for certain nursing facility stays.** Adds § 256I.08. Beginning July 1, 2004, requires counties to pay 20 percent of the nonfederal share of costs for persons under the age of 65 whose stays in a nursing facility classified as an institution for mental diseases have exceeded 90 days and are paid for through group residential housing.

53 **Case management access for persons seeking community-based services.** Requires the county to determine whether a person qualifies for case management services under the home and community-based waiver services and to begin the screening process and ISP development within a reasonable time. Requires the county to contract for case management services if the county is unable to provide case management services.

54 **Case management services redesign.** Requires the commissioner to report to the legislature on the redesign of case management services and to consult with consumers, consumer advocates, counties, and service providers. Lists what must be included in the report. Requires the proposed legislation to be provided to the legislative committees with jurisdiction over health and human services issues by January 15, 2005.

55 **Vacancy listings.** Requires the commissioner of human services to work with interested stakeholders to provide useful information to consumers on bed vacancies for group residential and ICF/MR providers.

56 **Homeless services; state contracts.** Allows the commissioner to contract directly with nonprofit organizations providing homeless services in two or more counties.

57 **Governor's council on developmental disability, ombudsman for mental health and mental retardation, and council on disabilities.** Requires these councils and the centers for independent living to study the feasibility of (1) space coordination, (2) shared use of technology, (3) coordination of resource priorities, and (4) consolidation and make recommendations to the legislature by January 15, 2004.

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58 **Licensing change.** Requires the commissioner to allow an existing ICF/MR located in Goodhue county serving 39 children to be converted to four separately licensed or certified cottages serving up to six children each.

59 **Revisor's instruction.** Instructs the revisor to delete internal cross-references where appropriate and make changes necessary to correct the punctuation, grammar, or structure of the remaining text and preserve its meaning for sections in Minnesota Statutes and Rules affected by repealed sections.

60 **Repealer.** (a) Repeals section 252.32, subdivision 2 (individual service plan), and 256B.5013, subdivision 4 (temporary rate adjustments to address occupancy and access), effective July 1, 2003.

(b) Repeals Laws 2001, First Special Session chapter 9, article 13, section 24 (public guardianship alternatives) effective July 1, 2003.

Article 4: Children's Services

Overview

This article makes changes to various human services statutes related to children's services. Provisions in this article:

- require mental health screening for certain at-risk children (sections 2, 14, 15, 16, 17, and 18);
- authorize medical assistance reimbursement for an adolescent mental health crisis facility (sections 7 and 10);
- modify the children's mental health medical assistance benefit (sections 4 to 6, 8, 9, and 22);
- require the development of a plan to secure medical assistance funding for mental health services provided in out-of-home placement (section 21);
- permit family services collaboratives and children's mental health collaboratives to consolidate certain functions (sections 1 and 3);
- modify certification requirements for prospective adoptive homes in international adoptions (section 12);
- modify the adoption assistance program (section 13); and
- modify child welfare permanency requirements for children with developmental disabilities or emotional disturbances (section 19).

1 **Establishment.** Amends § 124D.23, subd. 1. Amends the family services collaboratives to allow two or more family services collaboratives or children=s mental health collaboratives to consolidate decision-making, pool resources, and collectively act on behalf of the individual collaboratives, based on a written agreement among participating collaboratives.

2 **Duties of county board.** Amends § 245.4874. Modifies the duties of a county board related to the use of its share of mental health and Community Social Services Act funds. This section adds a new clause (14), which requires the county board to arrange for or provide a children=s mental health screening to a child:

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- receiving child protective services or a child in out-of-home placement;
- for whom parental rights have been terminated;
- found to be delinquent; and
- found to have committed a juvenile petty offense for the third or subsequent time, unless a screening has been performed within the previous 180 days or the child is currently under the care of a mental health professional.

This section also specifies other requirements related to the screening. Makes this section effective July 1, 2004.

3 **Duties of certain coordinating bodies.** Amends § 245.493, subd. 1a. Amends the children=s mental health collaboratives to allow two or more family services collaboratives or children=s mental health collaboratives to consolidate decision-making, pool resources, and collectively act on behalf of the individual collaboratives, based on a written agreement among participating collaboratives.

4 **Day treatment services.** Amends § 256B.0625, subd. 23. Provides that the commissioner may set authorization thresholds for day treatment for adults. Effective July 1, 2004, provides that medical assistance covers day treatment services for children as specified under section 256B.0943.

5 **Children's mental health crisis response services.** Amends § 256B.0625, by adding subd. 35a. Provides that medical assistance covers children's mental health crisis response services under section 256B.0944. Makes this section effective July 1, 2004.

6 **Children's therapeutic services and supports.** Amends § 256B.0625, by adding subd. 35b. Provides that medical assistance covers children's therapeutic services and supports under section 256B.0943. Makes this section effective July 1, 2004.

7 **Subacute psychiatric care for persons under 21 years of age.** Amends § 256B.0625, by adding subd. 45. Provides that medical assistance covers subacute psychiatric care for persons under age 21 when:

- the services meet certain federal requirements regarding inpatient psychiatric services for individuals under age 21;
- the facility is accredited as a psychiatric treatment facility; and
- the facility is licensed by the commissioner of health.

Makes this section effective July 1, 2003.

8 **Children's therapeutic services and supports.** Adds § 256B.0943.

Subd. 1. Definitions. Defines the following terms for purposes of this section: children's therapeutic services and supports; clinical supervision; county board; crisis assistance; culturally competent provider; day treatment program for children; diagnostic assessment; direct service time; direction of mental health behavioral aide; emotional disturbance; individual behavioral plan; individual treatment plan; mental health professional; preschool program; and skills training.

Subd. 2. Covered service components of children's therapeutic services and supports. (a) Subject to federal approval, provides that medical assistance covers medically necessary children's therapeutic services and supports provided by eligible providers to eligible clients.

(b) Defines the service components of children's therapeutic services and supports.

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(c) Provides that service components may be combined to constitute therapeutic programs, but that medical assistance only pays for the service components listed in paragraph (b).

Subd. 3. Determination of client eligibility. Bases a client's eligibility to receive children's therapeutic services and supports under this section on a mental health professional's diagnostic assessment of the client that is performed within 180 days of the initial start of service. Specifies requirements related to the diagnostic assessment.

Subd. 4. Provider entity certification. (a) Effective July 1, 2003, requires the commissioner to establish an initial provider entity application and certification and recertification process to determine provider entity eligibility. Also requires the commissioner to establish a process for provider decertification.

(b) Specifies that a provider entity must be:

- an Indian health services facility or a facility owned and operated by a tribe or tribal organization certified by the state;
- a county-operated entity certified by the state; or
- a noncounty entity recommended by the provider's host county and certified by the state.

Subd. 5. Provider entity administrative infrastructure requirements. (a) Requires a provider entity to have an administrative infrastructure that establishes authority and accountability for decision-making and oversight of functions. Requires the provider to have written policies and procedures that it reviews and updates every three years, and to distribute the policies and procedures to staff.

(b) Specifies what a provider entity's administrative infrastructure written policies and procedures must include.

Subd. 6. Provider entity clinical infrastructure requirements. (a) Requires an eligible provider entity to have a clinical infrastructure that utilizes diagnostic assessment, an individualized treatment plan, service delivery, and individual treatment plan review that are culturally competent, child-centered, and family-driven. Requires a provider to review and update clinical policies and procedures every three years and distribute the policies and procedures to staff.

(b) Specifies what a provider entity's clinical infrastructure written policies and procedures must include.

Subd. 7. Qualifications of individual and team providers. Specifies the individual or team providers qualified to provide children's therapeutic services and supports under this section.

Subd. 8. Required preservice and continuing education. (a) Requires a provider entity to establish a plan to provide preservice and continuing education for staff.

(b) Requires a mental health behavioral aide to complete 30 hours of preservice training. Specifies the topics that must be covered in the training and the components of parent team training.

(c) Requires a mental health practitioner and mental health behavioral aide to complete

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20 hours of continuing education every two calendar years. Specifies the topics that must be covered in the training.

(d) Specifies requirements for a provider's annual documentation of the staff members' continuing education.

Subd. 9. Service delivery criteria. (a) Specifies the requirements that a certified provider entity must meet in delivering services under this section.

(b) Specifies additional requirements related to how a provider entity must deliver the service components of children's therapeutic services and supports.

Subd. 10. Service authorization. Requires the commissioner to publish in the *State Register* a list of health services that require prior authorization and the criteria and standards used to select health services on the list. Provides that the criteria and standards are not subject to the requirements in the Administrative Procedure Act (chapter 14). Also provides that the commissioner's prior authorization decision is not subject to administrative appeal.

Subd. 11. Documentation and billing. Specifies the documentation standards and billing requirements under this section.

Subd. 12. Excluded services. Specifies the services that are not eligible for medical assistance payment as children's therapeutic services and supports.

Makes this section effective July 1, 2004.

9 **Covered services; children's mental health crisis response services.** Adds § 256B.0944.

Subd. 1. Definitions. Defines the following terms for purposes of 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. 2. Medical assistance coverage. Provides that medical assistance covers medically necessary children's mental health crisis response services, subject to federal approval, if provided by a qualified provider entity to an eligible recipient and the services are identified in the recipient's individual crisis treatment plan.

Subd. 3. Eligibility. Provides that an eligible recipient is an individual who is:

- is eligible for medical assistance;
- is under age 21;
- is screened as possibly experiencing a mental health crisis or emergency where a mental health crisis assessment is needed;
- is assessed as experiencing a mental health crisis or emergency and mental health crisis intervention or crisis intervention and stabilization services are determined to be medically necessary; and
- meets the criteria for emotional disturbance or mental illness.

Subd. 4. Provider entity standards. (a) Specifies that a crisis intervention and stabilization provider entity must meet the administrative and clinical standards under

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this section and be:

- an Indian health service facility or a facility owned and operated by a tribe or tribal organization certified by the state;
- a county board-operated facility; or
- a provider entity under contract with a county board in the county where the potential crisis or emergency is occurring.

(b) Specifies additional requirements related to the children's mental health crisis response services that a provider entity must satisfy.

Subd. 5. Mobile crisis intervention staff qualifications. (a) Requires that a mobile crisis intervention team providing children's mental health mobile crisis intervention services include at least two mental health professionals or a combination of at least one mental health professional and one mental health practitioner.

(b) Requires the team to include at least two people with at least one team member providing on-site crisis intervention services when needed. Also requires the team members to have experience in mental health assessment, crisis intervention techniques, and clinical decision-making in emergencies; knowledge of local services and resources; and to coordinate services with local resources, if necessary.

Subd. 6. Initial screening, crisis assessment, and mobile intervention treatment planning. (a) Requires a mobile crisis intervention team to screen the potential crisis situation before initiating mobile crisis intervention services. This screening must gather information, identify the parties involved, and determine if a crisis exists and an appropriate response.

(b) If a crisis exists, requires a mobile crisis intervention team to complete a crisis assessment to evaluate any immediate needs for which emergency services are needed and, if time permits, more detailed information about the recipient.

(c) If services are needed, requires the mobile crisis intervention team to provide intervention services promptly. Requires at least two members of the team to confer directly or by telephone about the assessment, treatment plan, and actions taken, with at least one team member on site providing crisis intervention services.

(d) Requires the mobile crisis intervention team to develop an initial, brief crisis treatment plan as soon as appropriate, but no later than 24 hours after the initial intervention. Specifies what the team must address in the treatment plan, that the team must update the plan as needed, and that the team must involve the child and child's family in developing and implementing the plan.

(e) Requires the team to document which short-term goals have been met and when crisis intervention services are no longer required.

(f) Requires the team to provide a recipient whose crisis is stabilized with referrals if the recipient needs other services and to coordinate the referral with the recipient's case manager.

Subd. 7. Crisis stabilization services. Requires that qualified staff of a crisis stabilization services provider entity provide crisis stabilization services and that the staff meet certain standards regarding the treatment plan, staff qualifications, and

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services delivery.

Subd. 8. Treatment plan. Specifies what the individual crisis stabilization treatment plan must include and how it must be developed.

Subd. 9. Supervision. (a) Specifies the clinical supervision requirements that must be met for a mental health practitioner to provide crisis assessment and mobile crisis intervention services.

(b) If mobile crisis intervention services continue into a second day, requires a mental health professional to contact the client to provide services, update the crisis treatment plan, and document the on-site observation in the client's record.

Subd. 10. Client record. Requires a provider of mobile crisis intervention or crisis stabilization services to maintain a file for each client and specifies the information a provider must have in the file.

Subd. 11. Excluded services. Specifies the services excluded from medical assistance reimbursement under this section.

Makes this section effective July 1, 2004.

10 **Covered services.** Amends § 256B.0945, subd. 2. Removes requirements from current law regulating medical assistance reimbursement for facilities that are institutions for mental diseases or other approved facilities. Medical assistance coverage for subacute psychiatric care for persons under age 21 is provided under section 7 of this article.

11 **Payment rates.** Amends § 256B.0945, subd. 4. Makes a conforming language change.

12 **Importation; international adoptions.** Amends § 257.05, by adding subd. 3. Permits licensed adoption agencies and county social services agencies to certify that a prospective adoptive home of a child brought into the state from another county for purposes of adoption is a suitable home or meets the requirements for foster care licensure, if legal adoption is not contemplated.

13 **Eligibility conditions.** Amends § 259.67, subd. 4. Modifies the eligibility requirements for the adoption assistance program. Makes a child who has been a ward of a federally recognized tribal social services agency of Minnesota eligible for state-funded adoption assistance if the child is not eligible for adoption assistance under federal law. Also provides that a child's adoption according to tribal law without a termination of parental rights or relinquishment may be considered in determining whether a child is a child with special needs for purposes of adoption assistance.

14 **Investigation.** Amends § 260B.157, subd. 1. Requires a mental health screening and assessment, if necessary, for children who are found to be delinquent. Specifies requirements related to the screening. Makes this section effective July 1, 2004.

15 **Reasons for detention.** Amends § 260B.176, subd. 2. Requires a mental health screening and assessment, if necessary, for children who are being detained in a juvenile facility or program, or a jail or municipal lockup. Specifies requirements related to the screening. Makes this section effective July 1, 2004.

16 **Hearing and release requirements.** Amends § 260B.178, subd. 1. Requires that a child undergo a children=s mental health screening as a condition of release at a detention hearing. Makes this section effective July 1, 2004.

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17 **Consideration of reports.** Amends § 260B.193, subd. 2. Allows the court to consider the results of the children=s mental health screening before making a disposition in a case. Makes this section effective July 1, 2004.

18 **Alternative disposition.** Amends § 260B.235, subd. 6. Amends the section of law dealing with an alternative disposition for petty offenders by requiring the court to order a children=s mental health screening in the case of a third or subsequent finding that a child has committed a juvenile petty offense. Makes this section effective July 1, 2004.

19 **Review of foster care status.** Amends § 260C.141, subd. 2. Makes conforming changes to current law regarding child welfare permanency for children in voluntary out-of-home placement due solely to the children's developmental disabilities or emotional disturbances. Requires the court to review whether the responsible social services agency has made reasonable efforts to finalize a plan for the child's permanent placement.

20 **Revenue.** Amends § 626.559, subd. 5. Changes cross-reference.

21 **Medical assistance for mental health services provided in out-of-home placement settings.** Requires the commissioner of human services to develop a plan in conjunction with the commissioner of corrections and other interested stakeholders, to secure medical assistance funding for mental health-related services provided in out-of-home placement settings. The commissioner shall report on the plan to the legislature by January 15, 2004.

22 **Transition to children's therapeutic services and support.** Provides that, beginning July 1, 2003, the commissioner must use the provider entity certification process under section 256B.0943 instead of using the provider certification process in the rules being repealed in this article.

23 **Revisor's instruction.** Requires the revisor to delete internal cross-references and make necessary changes to correct punctuation, grammar, or structure in sections or rules affected by the repealed sections in this article.

24 **Repealer. (a)** Repeals section 256B.0945, subdivision 10 (requiring the commissioner to provide recommendations to the legislature by January 15, 2000, regarding amendments necessary before implementing the residential services for children with severe emotional disturbance section).

(b) Repeals section 256B.0625, subdivisions 35 (medical assistance coverage of family community support services) and 36 (medical assistance coverage of therapeutic support of foster care), effective July 1, 2004.

(c) Effective July 1, 2004, repeals Minnesota Rules, parts 9505.0324 (home-based mental health services); 9505.0326 (family community support services); and 9505.0327 (therapeutic support of foster care).

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Article 5: Occupational Licenses

Overview

This article codifies certain requirements for licensure of alcohol and drug counselors, which were previously in rules, and adds certain additional requirements.

1 § 148C.01, subd. 1a. Adds a definition for an "accrediting association" (from rules).

2 § 148C.01, subd. 2. Makes a technical change.

3 § 148C.01, subd. 2a. Adds a definition for "alcohol and drug counselor academic course work" (from rules).

4 § 148C.01, subd. 2b. Adds a definition for "alcohol and drug counselor continuing education activity" (from rules).

5 § 148C.01, subd. 2c. Adds a definition for "alcohol and drug counselor technician" (this is new).

6 § 148C.01, subd. 2d. Adds a definition for "alcohol and drug counselor training" (from rules).

7 § 148C.01, subd. 2f. Adds a definition for "clock hour" (from rules).

8 § 148C.01, subd. 2g. Adds a definition for "credential" (from rules).

9 § 148C.01, subd. 4a. Adds a definition for "licensee" (from rules).

10 § 148C.01, subd. 11a. Adds a definition for "student" (this is new).

11 § 148C.01, subd. 12. Adds a definition for "supervised alcohol and drug counselor" (this is new).

12 § 148C.01, subd. 12a. Adds a definition for "supervisor" (from rules with minor changes).

13 § 148C.03, subd. 1. Strikes language relating to the surcharge (this language is moved to the fee section).

14 § 148C.0351, subd. 1. Makes conforming changes.

15 § 148C.0351, subd. 4. Codifies the rule relating to the initial license.

16 § 148C.0355. Codifies the rule relating on the commissioner's action on applications for licensure.

17 § 148C.04. Makes changes to the requirements for licensure.

Subds. 1 and 2. Make conforming changes.

Subd. 3. Changes the licensure requirements for licensure before July 1, 2008.

Subd. 4. Changes the licensure requirements for licensure after July 1, 2008. Makes other conforming changes.

Subd. 5a. Adds a new subdivision that defines minimum academic course work requirements for licensure and advanced academic course work.

Subd. 6. Makes changes to the temporary practice requirements: changes the

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name to "temporary permit;" states the qualifications that must be met for a temporary permit to be issued; states that a person practicing under a temporary permit must practice under tribal jurisdiction or in a program under the direct, onsite supervision of a licensed alcohol and drug counselor; requires the person to use a title indicating that the person is a trainee; requires the person to annually submit a renewal application and that the permit may be renewed no more that five times; and states that the permit expires if it is not renewed, upon a change of employment, or upon the granting or denial by the commissioner of a license.

Subd. 7. Makes conforming changes.

Subdivisions 1, 2, 3, 4, and 5a are effective January 28, 2003.

18 § 148C.045. Permits an alcohol and drug counselor technician to perform screening, intake, and orientation functions while under the direct supervision of a licensed alcohol and drug counselor.

19 § 148C.05. Codifies the rule relating to license renewal.

20 **See section 19.**

21 **See section 19.**

22 **See section 19.**

23 § 148C.055. Codifies the rule relating to inactive license status.

24 § 148C.07. Codifies the rule relating to reciprocity.

25 § 148C.075. Codifies the rule relating to continuing education requirements. Requires 18 hours of cultural diversity training within the first four years after the licensee=s initial license effective date. (This is a change from the current requirement of 36 hours of specified training.)

26 § 148C.10, subd. 1. Makes conforming changes.

27 § 148C.10, subd. 2. Prohibits the use of the title incorporating the words "licensed alcohol and drug counselor" or otherwise hold themselves out to the public by any title implying licensure or otherwise qualified unless the person is licensed as an alcohol and drug counselor.

28 § 148C.11. Clarifies that this chapter does not prohibit a technician or resident manager in programs licensed by the Department of Human Services from performing their duties. States that any person who is exempt from this chapter but elects to obtain a license under this chapter is subject to the chapter to the same extent as other licensees. Requires alcohol and drug counselors who are employed by a hospital and city, county and state agency to be licensed effective January 1, 2006. Specifies that between July 1, 2003, and January 1, 2006, the commissioner must grant a license to any individual who has been employed at a Minnesota hospital or a city, county or state agency in Minnesota without licensure if the individual has 8,000 hours of alcohol and drug counselor work experience, has 270 clock hours of alcohol and drug counselor training with documentation that a minimum of 60 clock hours of the training occurred within the last five years, passes an oral and written examination, and meets the procedures for application.

29 § 148C.12. Codifies the rule relating to fees. Increases the application fee, the biennial renewal fee, the inactive renewal fee, and the surcharge. Creates a new fee for temporary

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permit, examination fee, fee to renew after expiration of license, and an additional fee for renewal following lapse in licensing status.

30 **Repealer.** Repeals portions of the rules that are being codified under the alcohol and drug counselor licensure.

Article 6: Human Services Licensing, County Initiatives, and Miscellaneous

Overview

This article makes changes to various human services-related statutes. Provisions in this article:

- modify the Human Services Licensing Act and the licensing standards for programs serving persons with mental retardation or related conditions (sections 4 to 8, and 11 to 20);
- increase human services licensing fees (section 9);
- increase adult foster care license capacity to five persons (sections 10, 50, and 51);
- restructure parental fees (section 39);
- update and clarify or remove obsolete terminology related to state-operated services and aligns statutory language with current practices (sections 2, 21 to 38, 40 to 44, 47, and 68, paragraph (a));
- modify the voluntary admissions and treatment standards and emergency hold provisions in the Civil Commitment Act (sections 45 and 46);
- modify the Minnesota merit system (sections 48 and 56);
- modify the hearing procedures for administrative hearings and appeals related to DHS programs and services (section 49);
- require the commissioner of human services to seek federal financial participation for certain programs (sections 3, 52, and 65);
- modify the definition of agency for purposes of adoption to include Minnesota federally recognized tribes (sections 53 and 54);
- remove certain requirements on counties (sections 55 and 57);
- require the public authority to charge a cost recovery fee for providing child support and maintenance collection services and modify the income withholding requirements (sections 58 to 62);
- require a state-operated services study and refinancing strategy, and permit the conveyance of certain state-operated services land (section 63, 64, and 66); and
- reduce the amount appropriated and transferred annually from the excess police state-aid holding account to the ambulance service personnel longevity award and incentive suspense account (section 1).

1 **Excess police state-aid holding account.** Amends § 69.021, subd. 11. Reduces the amount

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in the excess police state-aid holding account appropriated and annually transferred to the ambulance service personnel longevity award and incentive suspense account from $1,000,000 to $900,000.

2 **Designating special units and regional centers.** Amends § 245.0312. Strikes obsolete language from current law regarding hospitals for the mentally ill.

3 **Reimbursement to ombudsman for mental health and mental retardation.** Adds § 245.945. Requires the commissioner of human services to obtain federal financial participation funding for eligible activities of the ombudsman for mental health and mental retardation.

4 **Requirements for emergency license.** Amends § 245A.035, subd. 3. Corrects a cross-reference. Makes this section effective the day following final enactment.

5 **Background study of the applicant; definitions.** Amends § 245A.04, subd. 3. Clarifies background study requirements for an individual affiliated with a facility serving children or youth licensed by the department of corrections. Also clarifies when the commissioner of human services may review certain arrest and investigative information and require the subject of a background study to provide classifiable fingerprints obtained from an authorized law enforcement agency. Makes this section effective the day following final enactment.

6 **Reconsideration of disqualification.** Amends § 245A.04, subd. 3b. **(b)** Clarifies that, if the commissioner sets aside a background study subject's disqualification, the disqualified individual remains disqualified but may hold a license and have direct contact or access to persons receiving services. Provides that the disqualification set aside is limited solely to the licensed program, applicant, or agency unless otherwise specified. Also clarifies that the commissioner may rescind a previous disqualification set aside based on new information that the individual may pose a risk of harm to persons served by the licensed program. Also specifies the appeal rights if the commissioner rescinds a set aside of a disqualification.

(c) Corrects a cross-reference.

(e) Clarifies that, if an individual is disqualified for a determination of substantiated maltreatment of children or adults, the person may request a fair hearing if the commissioner does not set aside the disqualification. Also clarifies that, if a person is disqualified for the conviction or admission to certain crimes, the commissioner's reconsideration decision is the final agency determination for purposes of appeal.

Makes this section effective the day following final enactment.

7 **Disqualification.** Amends § 245A.04, subd. 3d. Corrects a cross-reference. Makes this section effective the day following final enactment.

8 **Regulatory methods.** Amends § 245A.09, subd. 7. Provides that the commissioner may implement alternative methods of regulation of licensed programs when the standards of another government agency or accreditation body require the same standards, methods, or alternative methods to achieve substantially the same intended outcomes as the licensing standards. Specifies that, if the commissioner accepts accreditation as documentation of compliance with licensing standards, the commissioner must continue to investigate complaints and take licensing actions for noncompliance with the standards. Also clarifies that the commissioner may conduct routine inspections of licensed programs biennially.

9 **Fees.** Amends § 245A.10. Makes various changes to human services licensing fees.

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Subd. 1. Application or license fee required, programs exempt from fee. (a) Provides that the commissioner of human services shall charge a fee for evaluating applications and inspecting programs licensed under chapter 245A, unless a program is exempt under paragraph (b).

(b) Except as provided under subdivision 2, provides that no application fee shall be charged for child foster care, adult foster care, family and group family child care, or state-operated programs, unless the state-operated program is an intermediate care facility for persons with mental retardation or related conditions (ICF/MR).

Subd. 2. County fees for background studies and licensing inspections in family and group family child care. (a) For purposes of family and group family child care, permits a county agency to charge a fee to an applicant or license holder to recover the actual cost of background studies, but in any case not to exceed $100 annually. Also permits a county agency to charge a fee to recover the actual cost of licensing inspections, but in any case not to exceed $150 annually.

(b) Permits a county agency to charge a fee to a legal nonlicensed child care provider or applicant to recover the actual cost of background studies completed under section 119B.125, but in any case not to exceed $100 annually.

(c) Provides that a county may elect to reduce or waive the fees in paragraphs (a) or (b) in cases of financial hardship, if the county has a shortage of providers, for new providers, or for providers who have attained at least 16 hours of training before seeking initial licensure.

(d) Permits the counties to allow providers to pay the fees under paragraphs (a) or (b) on an installment basis for up to one year. Also permits a provider receiving child care assistance payments from the state to have the fees deducted from the payments for up to one year and requires the state to reimburse the county for fees collected in this manner.

Subd. 3. Application fee for initial license or certification. For fees required under subdivision 1, requires an applicant for initial license or certification to submit a $500 application fee. Also specifies application fee requirements for a license to provide waivered services to persons with developmental disabilities or related conditions; semi-independent living services to persons with developmental disabilities or related conditions; and independent living assistance for youth.

Subd. 4. Annual license or certification fee for programs with licensed capacity. Specifies annual license or certification fees for child care centers and programs with a licensed capacity. Also specifies the license fee requirements for day training and habilitation programs serving persons with developmental disabilities or related conditions.

Subd. 5. Annual license or certification fee for programs without a licensed capacity. Requires a program without a licensed capacity to pay a $400 license or certification fee. Also requires a mental health center or mental health clinic requesting certification for purposes of insurance and subscriber contract

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reimbursement to pay a $1,000 annual certification fee.

Subd. 6. License not issued until license or certification fee is paid. Prohibits the commissioner from issuing a license or certification until the license or certification fee is paid. Specifies the process the commissioner must use for billing a license holder for the fee and notifying a license holder that the fee is past due. Requires that a program license expire on December 31 unless the license holder pays the fee before December 31. Also provides that, after a license expires, the former license holder must submit a new license application and application fee.

10 **Adult foster care license capacity.** Amends § 245A.11, subd. 2a. Provides that the commissioner may issue an adult foster care license with a capacity of five adults when recommended by the county licensing agency and if:

- the facility meets the physical environment requirements in the adult foster care rule;
- the five-bed living arrangement is specified for each resident in the resident's individualized plan of care, individual service plan, or individual resident placement agreement;
- the license holder obtains the resident's informed consent; and
- the facility was licensed for adult foster care before March 1, 2003.

Also prohibits the commissioner from issuing a new adult foster care license with a capacity of five adults after June 30, 2005. Requires the commissioner to allow a facility licensed under this section to continue with a capacity of five or six adults if the license holder continues to comply with the licensing requirements.

11 **Adult foster care; family adult day care.** Amends § 245A.11, subd. 2b. Modifies the capacity requirements for adult foster care and family adult day care programs. Current law permits an adult foster care license holder to seek a variance from the commissioner of human services to admit up to seven individuals for day care services if certain requirements are met. This section permits the license holder to seek a variance to admit up to seven individuals for day care services and one individual for respite care services, if the requirements are met.

12 **Adult foster care; variance for alternate overnight supervision.** Amends § 245A.11, by adding subd. 7. Permits the commissioner to grant a variance to the licensing rule requiring a caregiver to be present in an adult foster care home during normal sleeping hours to allow a license holder to provide alternative methods of overnight supervision. Requires that the county licensing agency recommends the variance and that:

- the county has approved the license holder's alternative plan and the plan protects residents' health, safety, and rights;
- the license holder has obtained informed consent from each resident; and
- the alternative method of providing overnight supervision is specified for each resident in the resident's individualized plan of care, individual service plan, or individual resident placement agreement.

Also requires that the license holder not have had a licensing action during the prior 24 months for failure to provide adequate supervision, health care services, or resident safety in

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the adult foster care home.

13 **Relationship to other standards governing services for persons with mental retardation or related conditions.** Amends § 245B.03, subd. 2. Makes residential service sites licensed for home and community-based waivered services for four or fewer adults exempt from the program abuse and individual abuse prevention plan requirements. Also specifies that residential service sites licensed for home and community-based waivered services for four or fewer children are exempt from certain licensing rules governing family foster care homes related to advance agency approval of supervision plans; the health of other persons living in the foster home; training requirements for foster care providers; data privacy; certain records requirements; and special services home requirements.

14 **Continuity of care.** Amends § 245B.03, by adding subd. 3. Specifies licensing standards for license holders when a consumer changes service to the same type of service provided under a different license held by the same license holder. Exempts the license holder from requirements related to initial risk management plans; service support plans; and providing consumers written policies and procedures. Also exempts a license holder from certain staff orientation requirements when a direct service staff person begins providing service under one or more licenses other than the license for which the staff person initially received staff orientation. Requires the staff person to receive orientation at new service locations. Also requires that, for consumers the staff person has not previously served, the staff person must review the consumer's service and risk management plans and medication administration.

15 **Service-related rights.** Amends § 245B.04, subd. 2. Modifies the consumer's service-related rights. Provides that notification of changes to charges for services be provided to consumers "upon request."

16 **Risk management plan.** Amends § 245B.06, subd. 2. Modifies the license holder's duties related to developing, documenting, and implementing consumers' risk management plans. Exempts the license holder from certain requirements governing maltreatment of vulnerable adults if the license holder meets the requirements of this section. Specifies requirements for what the risk management plan must address and how the license holder must assess a consumer's vulnerability. Specifies risk management plan requirements for license holders jointly providing services. Also requires that, before or upon initiating services, a license holder must develop an initial risk management plan. Requires the license holder to review the initial risk management plan at the meeting held 45 days after initiating service, revise the plan if necessary, and document the consumer's or consumer's legal representative's approval of the plan. After plan approval, requires the license holder to review the plan at least annually and update the plan, if necessary. Requires the license holder to document completion of the annual review and the consumer's or consumer's legal representative's approval of any plan changes.

17 **Progress reviews.** Amends § 245B.06, subd. 5. Removes requirement that a license holder provide quarterly written progress reports on consumers under public guardianship.

18 **Staff training.** Amends § 245B.07, subd. 6. Modifies direct services staff training requirements for license holders providing semi-independent living services.

19 **Availability of current written policies and procedures.** Amends § 245B.07, subd. 9. Specifies requirements related to a license holder providing all consumers or a consumer's legal representative and case manager with a copy and explanation of revisions to policies and procedures that affect consumers' service-related or protection-related rights, giving notice of revised policies and procedures, and informing employees before implementing revisions to policies and procedures.

20 **Alternative methods of determining compliance.** Amends § 245B.08, subd. 1. Corrects a

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cross-reference.

21 **Services.** Amends § 246.014. Requires the commissioner of human services to develop and maintain state-operated services consistent with the provisions in the adult and children's mental health acts and the provisions governing state hospitals for persons with mental illness, services for persons with mental retardation, treatment for alcohol and drug abuse, and chemical dependency treatment. Defines services included in state-operated services. Requires state-operated services to be provided in coordination with counties and other vendors. Also requires services to be statewide in character. Requires the commissioner to create and maintain forensic services programs. Defines community preparation services. Also permits the commissioner to establish policies and procedures to govern the operation of services and programs. Strikes obsolete language from current law regarding state hospitals.

22 **Consultative services; aftercare of patients; public information; funds.** Amends § 246.015, subd. 3. Updates terminology by including references to state-operate services. Permits the commissioner to authorize state-operated services to provide consultative services on a fee-for-service basis. Strikes obsolete language.

23 **Medical director.** Amends § 246.018, subd. 2. Requires the commissioner to appoint and set the salary of a licensed physician to serve as medical director to assist in establishing and maintaining the department's medical policies. Permits the commissioner to place the medical director's position in the unclassified service.

24 **Duties.** Amends § 246.018, subd. 3. Updates terminology and strikes obsolete language.

25 **State-operated services medical staff.** Amends § 246.018, subd. 4. Updates terminology and strikes obsolete language.

26 **Record of patients and residents in state-operated services.** Amends § 246.13. Updates terminology and strikes obsolete language.

27 **Money of patients or residents.** Amends § 246.15. Updates terminology. Clarifies the head of a state-operated services facility's responsibilities related to procedures and requirements for managing and accounting for patients' and residents' money.

28 **Unclaimed money or personal property of patients or residents.** Amends § 246.16. Updates terminology. Clarifies the procedures the head of a state-operated services facility must follow related to unclaimed money or personal property of patients or residents who die in a state-operated services facility.

29 **Authorized.** Amends § 246.57, subd. 1. Updates terminology. Strikes obsolete language.

30 **Shared staff or services.** Amends § 246.57, subd. 4. Updates terminology.

31 **Dental services.** Amends § 246.57, subd. 6. Updates terminology. Strikes obsolete language.

32 **Employee of a secure treatment facility or employee.** Amends § 246.71, subd. 4. Updates terminology.

33 **Secure treatment facility.** Amends § 246.71, subd. 5. Updates definition of secure treatment facility.

34 **Establishment of Minnesota sex offender program.** Amends § 246B.02. Updates terminology.

35 **Licensure.** Amends § 246B.03. Updates terminology.

36 **Rules; evaluation.** Amends § 246B.04. Updates terminology.

37 **Minnesota extended treatment options.** Amends § 252.025, subd. 7. Strikes obsolete language.

38 **Sheriff to transport persons.** Amends § 252.06. Updates terminology and strikes obsolete language.

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39 **Contribution amount.** Amends § 252.27, subd. 2a. Modifies the amount of the parental contributions for the costs of services for children with mental retardation or related conditions, or a physical or emotional disability that requires 24-hour care.

For households with adjusted gross income equal to or greater than 100 percent of federal guidelines, the following rate schedule applies:

- if adjusted gross income is equal to or greater than 100 percent and less than 175 percent of federal poverty guidelines, the parental contribution is $4 per month;
- if adjusted gross income is equal to or greater than 175 percent and less than or equal to 375 of federal poverty guidelines, the parental contribution is based on a sliding scale from one percent to 7.5 percent of adjusted gross income;
- if adjusted gross income is greater than 375 percent and less than 675 percent of federal poverty guidelines, the parental contribution is 7.5 percent of adjusted gross income;
- if adjusted gross income is equal to or greater than 675 percent and less than 975 percent of federal poverty guidelines, the parental contribution is 10 percent of adjusted gross income; and
- if adjusted gross income is equal to or greater than 975 percent of federal poverty guidelines, the parental contribution is 12.5 percent of adjusted gross income.

Specifies that, if a child lives with the parent, annual adjusted gross income is reduced by $2,400 before calculating the parental contribution. Also provides that, if the parents of a minor child do not live with each other, the amount of a parent's court-ordered child support payment must be deducted from adjusted gross income before calculating the parental contribution.

Makes this section effective July 1, 2003.

40 **State-operated services for persons with mental illness.** Amends § 253.015, subd. 1. Updates terminology and strikes obsolete language.

41 **Treatment provided by state-operated services.** Amends § 253.017. Updates terminology and strikes obsolete language.

42 **Minnesota security hospital.** Amends § 253.20. Updates terminology and strikes obsolete language.

43 **Transfers of patients or residents.** Amends § 253.26. Strikes obsolete language. Specifies when the commissioner may transfer a committed patient to the Minnesota Security Hospital.

44 **Secure treatment facility.** Amends § 253B.02, subd. 18a. Updates definition of secure treatment facility.

45 **Voluntary admission and treatment.** Amends § 253B.04, subd. 1. Provides that a person is not subject to civil commitment if the person is voluntarily participating in treatment for a mental illness and if the person:

- has given informed consent or, if lacking capacity, is a person for whom legally valid consent has been given; and

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- is participating in a medically appropriate course of treatment.

Provides that the limitation on commitment does not apply if, based on clinical assessment, the court finds it unlikely that the person will remain in and cooperate with a medically appropriate course of treatment absent commitment and the standards for commitment are otherwise met. Specifies circumstances in which this paragraph does not apply. Also specifies how legally valid substitute consent may be provided.

46 **Duration of hold.** Amends § 253B.05, subd. 3. Modifies the emergency hold provisions in the Civil Commitment Act.

(c) Provides that, if a person is intoxicated in public and held for detoxification, a treatment facility may release the person without providing the required notice as soon as the treatment facility determines the person is no longer a danger to themselves or others. Specifies that notice must be provided to the peace or health officer who transported the person or appropriate law enforcement agency if requested by the officer or agency.

(e) Requires a facility to release a person under a 72-hour emergency hold within 72 hours unless a court order to hold the person is obtained. Also prohibits the issuance of consecutive emergency hold orders under this section.

47 **Standard of proof.** Amends § 253B.09, subd. 1. Requires the court to order commitment of a person to the commissioner if the court commits the person as mentally ill, chemically dependent, or mentally retarded to a service provided by the commissioner. Also requires the commissioner to designate the placement of the person to the court.

48 **Minnesota merit system.** Amends § 256.012. Adds provisions to the section governing the administration of the merit system of personnel administration for county employees administering community social services or income maintenance programs, all employees of human services boards that have adopted the merit system rules, and all employees of local social services agencies. Specifies that the counties and other entities utilizing the merit system shall pay the cost of merit system operations and how the costs are allocated to participating counties. Also requires the commissioner to ensure that participating counties are consulted regularly on the management of the merit system.

49 **Hearing procedures.** Adds § 256.0451. Establishes hearing procedures.

Subd. 1. Scope. Provides the scope of the hearing procedures. The procedures in this section apply to all fair hearings and appeals related to DHS programs and services. This subdivision also defines the term “person” and “agency” for purposes of this section.

Subd. 2. Access to files. Establishes a person’s right to access their case file. A person involved in a fair hearing appeal has the right of access to the person’s complete case file and to examine all private welfare data. A person involved in an appeal also has the right to a free copy of all documents in the case file involved in the appeal.

Subd. 3. Agency appeal summary. Requires the agency involved in an appeal to prepare a state agency appeal summary for each fair hearing appeal. The summary must be mailed or delivered to the person involved with the appeal and the department=s appeal office at least three working days before the date of the hearing. The appeals referee must confirm that the appeal is mailed or delivered as required.

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This subdivision lists what must be included in the state agency appeal summary.

Subd. 4. Enforcing access to files. Provides that a person involved in a fair hearing appeal may enforce the right of access to data and copies of the case file by making a request to the appeals referee.

Subd. 5. Prehearing conferences. Allows the appeals referee to hold a prehearing conference prior to a fair hearing appeal. A person involved in a fair hearing appeal may also request a prehearing conference. This subdivision lists the issues that may be addressed in a prehearing conference.

Subd. 6. Appeal request for emergency assistance or urgent matter. Shortens the time line for the delivery of the state agency appeal summary, the scheduling of a hearing, and the written decision, when the issue to be resolved at the hearing involves emergency assistance or an urgent matter.

Subd. 7. Continuance, rescheduling, or adjourning a hearing. Allows a person to request a continuance of the hearing, reschedule the hearing, or request the adjournment of a hearing for a reasonable amount of time under certain circumstances. This section also provides how and when a request for a continuance or a request to reschedule a hearing is made.

Subd. 8. Subpoenas. Allows a person involved in a fair hearing to request a subpoena and allows an individual or entity served with a subpoena to petition the appeals referee to vacate or modify the subpoena.

Subd. 9. No ex parte contact. Prohibits ex parte contact on substantive issues between the appeals referee and the agency, a person, or witness involved in the fair hearing.

Subd. 10. Telephone or face-to-face hearing. Provides that a fair hearing appeal may be conducted by telephone, other electronic media, or in a face-to-face hearing.

Subd. 11. Hearing facilities and equipment. Requires the appeals referee to conduct the hearing in the county where the person involved resides, or an alternate location that is mutually agreed upon before the hearing. Certain hearings arising out of maltreatment determinations must be conducted in the county where the determination was made, unless an alternate location is agreed upon. This subdivision sets forth specific requirements related to the hearing room and equipment that must be available, if necessary, for the hearing.

Subd. 12. Interpreter and translation services. Imposes the duty on the appeals referee to inquire and determine whether interpretive or translator services are necessary at the hearing. The department is responsible for providing necessary services at no cost.

Subd. 13. Failure to appear; good cause. Allows the appeals referee to dismiss the appeal if a person involved in the fair hearing fails to appear at the hearing. The person may reopen the appeal if within ten working days the person submits information to the appeals referee that demonstrates good cause for failing to appear at the hearing. This section lists the good cause exceptions.

Subd. 14. Commencement of hearing. Sets forth specific duties of the appeals

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referee related to the commencement of the hearing, which include swearing in of witnesses, describing the hearing procedures and issues that will be addressed, and explaining the burden of proof. The appeals referee must ensure that the state agency appeal summary has been completed and provided to the person involved in the hearing.

Subd. 15. Conduct of the hearing. Provides specific requirements and guidelines related to the conduct of the hearing.

Subd. 16. Scope of issues addressed at the hearing. Requires that the issues addressed in the hearing include the correctness and legality of the agency=s action and must not be limited simply to a review of the propriety of the agency=s action. The person involved may raise and present evidence on legal claims or defenses under the law but may not raise constitutional claims beyond the jurisdiction of the fair hearing.

Subd. 17. Burden of persuasion. Provides that the burden of persuasion is governed by law. If there is no specific law, then the participant who asserts a claim has the burden to persuade the appeals referee that the claim is true.

Subd. 18. Inviting comment by department. Allows the appeals referee or commissioner to request in writing a written comment by the department about the policy implications of a specific legal issue in order to help resolve a pending appeal. The written request must also be provided to the person involved in the hearing and the agency or its representative. The person involved in the hearing and agency must be given adequate opportunity to review, evaluate, and respond to the written comment.

Subd. 19. Developing the record. Sets forth guidelines for developing the record from the hearing. The appeals referee is required to ensure that the record is sufficiently complete to make a fair and accurate decision.

Subd. 20. Unrepresented persons. Requires the appeals referee to assist an unrepresented person to identify and develop relevant facts necessary for making an informed decision. These steps may include, but are not limited to, asking questions of the witness, and referring the person to a legal services office.

Subd. 21. Closing of the record. Requires the agency to present the evidence prior to or at the hearing. The agency can submit evidence after the hearing only if agreed upon by the person involved, the agency, and the appeals referee. If evidence is submitted after the hearing, the record must remain open to permit the person and the agency to submit additional evidence.

Subd. 22. Decisions. Sets forth the requirements related to issuing decisions, which includes the timeliness of the decision and the contents of the hearing decision. The appeals referee is prohibited from independently investigating facts or otherwise relying on information that was not presented at the hearing. The chief appeals referee is required to review the recommended decision and accept or refuse to accept the decision.

Subd. 23. Refusal to accept recommended orders. Provides that when the commissioner refuses to accept the recommended order, a copy of the recommended order, explanation of the basis for refusing to accept the recommended order, and a

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proposed modified order must be sent to the parties involved.

The person involved and the agency have at least ten business days to respond to the modified order, and may submit a legal argument concerning the modified order and may propose to submit additional evidence.

Subd. 24. Reconsideration. Allows a reconsideration request to be submitted within 30 days of the date of the final order.

Subd. 25. Access to appeal decisions. Requires that appeal decisions be maintained so that the public has ready access to previous decisions, subject to safeguarding private data.

50 **Federal waivers.** Amends § 256B.092, subd. 5. Requires the commissioner of human services to seek an amendment to the existing "DD" federal waiver in order to allow properly licensed adult foster care homes to provide services to up to five developmentally disabled individuals. If the waiver is approved, adult foster care providers that can accommodate five individuals shall increase their capacity to five beds, provided they meet applicable licensing requirements.

51 **Increasing adult foster care capacity to serve five persons.** Amends § 256B.092, by adding subd. 5a. Requires the county agency to reduce the per diem cost for room and board and MR/RC waivered services when an adult foster care provider increases capacity of an existing home from four persons to five persons. Also requires the commissioner to reduce individual county MR/RC waiver allocations.

52 **Funding for the ombudsperson program.** Amends § 257.0769. Requires the commissioner of human services to obtain federal financial participation funding for eligible activities of the ombudsperson for families.

53 **Agency.** Amends § 259.21, subd. 6. Amends adoption statutes to include Minnesota federally recognized tribes in the definition of "agency" for purposes of placing children for adoption.

54 **Reimbursement of costs.** Amends § 259.67, subd. 7. Amends adoption statutes to include Minnesota federally recognized tribes in the definition of "agency" for purposes of placing children for adoption, and adds that a "tribal" social services agency may receive reimbursement for adoption services.

55 **Public child welfare program.** Amends § 393.07, subd. 1. Removes a requirement that the public child welfare program be available in divorce cases for investigations of children and home conditions and for supervision of children when directed by the court hearing the divorce.

56 **Compliance with federal social security act; merit system.** Amends § 393.07, subd. 5. Removes requirement that the commissioner report to the legislature on options for the delivery of merit-based employment by entities other than the department in order to reduce administrative costs to the state while maintaining compliance with federal requirements.

57 **Court order.** Amends § 518.167, subd. 1. In contested custody proceedings, permits the county to charge a fee if the county elects to conduct an investigation concerning custodial arrangements for a child. Also permits a private vendor to make the investigation and report.

58 **Fees and cost recovery fees for IV-D services.** Amends § 518.551, subd. 7. Current law requires a recipient of public assistance to assign to the state the recipient's rights to child support. Current law also requires the public authority to provide child support and maintenance collection services (called "IV-D services") to recipients of public assistance

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and persons who apply for the services.

(a) Requires the public authority to notify a recipient of IV-D services who no longer receives public assistance that, within five days of notification of ineligibility for public assistance, IV-D services will no longer be provided to the recipient unless the recipient elects to continue services. The notice must include information about the implications of continuing to receive IV-D services.

(b) Provides that persons who receive public assistance under the diversionary work program in section 256J.95 do not have to pay a $25 application fee for child support and maintenance collection services.

(c) Requires the public authority to charge a cost recovery fee of one percent of the amount collected if an obligee applies for full IV-D services. The public authority must deduct this amount from the amount of child support and maintenance collected before disbursement to the obligee. Specifies that the fee does not apply to an obligee who:

- is currently receiving assistance under the state's federal Title IV-A (MFIP), Title IV-E foster care, medical assistance, or MinnesotaCare programs; or
- has received assistance under the state's Title IV-A (MFIP) or IV-E foster care programs, until the person has not received this assistance for 24 consecutive months.

(d) Requires the public authority to charge a cost recovery fee of one percent of the monthly court-ordered child support and maintenance obligation if an obligor applies for full IV-D services. Provides that the public authority may collect the fee through income withholding or any other available enforcement remedy.

(f) Provides that cost recovery fees collected under paragraphs (c) and (d) must be considered child support program income and deposited in the cost recovery fee account. Requires the commissioner to elect to recover costs based on either actual or standardized costs.

(h) Authorizes the commissioner to establish a special revenue account to receive child support cost recovery fees. Requires the commissioner to retain and transfer to the child support system special revenue account a portion of the nonfederal share of the fees for expenditures necessary to administer the fee. Also requires the commissioner to retain and dedicate the remaining nonfederal share of the cost recovery fee to the child support general fund county performance-based grant account.

Makes this section effective July 1, 2004, except paragraph (d) is effective July 1, 2005.

59 **Application.** Amends § 518.6111, subd. 2. Broadens the public authority's income withholding authority. Makes this section effective July 1, 2004.

60 **Order.** Amends § 518.6111, subd. 3. Makes support orders subject to income withholding from the obligor's income. Under current law, income withholding is required. Provides that, if an obligee or obligor applies for full IV-D services or income withholding-only services, the public authority must withhold the full amount of the support order from the obligor's income. Makes this section effective July 1, 2004.

61 **Collection services.** Amends § 518.6111, subd. 4. **(a)** Requires the commissioner to prepare and make available to the courts a notice explaining the fees for child support and

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maintenance collection services.

(b) Permits either the obligee or obligor to apply to the public authority at any time for full IV-D services or income withholding-only services. Strikes obsolete language from current law.

(d) If the obligee does not receive public assistance, the person who applies for services may choose at any time to terminate services, regardless of whether income withholding is in place. Permits the obligee or obligor to reapply for services at any time. The public authority must charge a $25 application fee at the time of each application unless the applicant receives public assistance.

(e) Provides that the public authority may continue income withholding or other enforcement remedy if a person terminates IV-D services and an arrearage for public assistance exists. Income withholding shall be in an amount equal to 20 percent of the support order in effect at the time the services terminated.

Makes this section effective July 1, 2004.

62 **Waiver.** Amends § 518.6111, subd. 16. **(a)** Permits the court to waive income withholding requirements if the public authority is providing child support and maintenance enforcement services and:

- the court determines there is good cause and makes written findings that income withholding is not in the child's best interests. In cases involving support modification, the court must also make a finding that support payments have been timely made; or
- an obligee and obligor sign a written agreement providing for an alternative payment arrangement that is reviewed and entered into the record by the court.

(b) Also permits the court to waive income-withholding requirements if the public authority is not providing child support and maintenance services and child support is not assigned to the state if the parties sign a written agreement.

Makes this section effective July 1, 2004.

63 **State-operated services study.** Requires the commissioner to study services provided to persons with developmental disabilities who have complex care needs. Requires the commissioner to analyze various issues. Requires the commissioner to report on the results of the study under this section to the chairs of the house and senate committees with jurisdiction over state-operated services by January 15, 2004.

64 **State-operated services refinancing strategy.**

Subd. 1. Redesign of mental health safety net. (a) Requires the commissioner of human services to seek specific legislative authorizations to close any regional treatment center, state-operated nursing home, or any program at a regional treatment center or state-operated nursing home.

(b) Requires the commissioner to consider certain factors when developing and seeking legislative authorization for any proposals to restructure state-operated services.

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(c) Requires that the commissioner's proposals to close a regional treatment center, state-operated nursing home, or program operated by a regional treatment center or state-operated nursing home not result in a net reduction in the total number of services in any catchment area and that any new community-based programs are located in areas that are convenient to the individuals receiving services and their families.

(d) Clarifies the meaning of legislative authorization.

Subd. 2. Redevelopment plan. (a) When closing any regional treatment center or state-operated nursing home, requires the commissioner to develop a comprehensive redevelopment plan for any facilities or land vacated as a result of the proposal. Specifies who must be involved in developing the plan and what information must be included in the plan.

(b) Provides that the county board of commissioners in a county affected by a redevelopment plan must approve the plan before the commissioner implements it.

Subd. 3. Staffing. When closing or restructuring a regional treatment center or state-operated nursing home or program located at a regional treatment center or state-operated nursing home, requires the commissioner to comply with any applicable collective bargaining agreements.

Subd. 4. State-operated services costs. (a) Provides that programs remaining at a regional treatment center campus shall not be assessed any disproportional increase in fees, charges, or other costs associated with operating and maintaining the campus. Permits increased costs associated with inflation.

(b) Specifies that there shall be no increase in the county share of cost of care provided in state-operated services without legislative authority.

Subd. 5. Request for federal waiver. By January 1, 2004, requires the commissioner to apply for a waiver from federal Medicaid requirements to permit medical assistance coverage for (1) mental health treatment services provided by an existing program located at a regional treatment center with a capacity of more than 15 beds; and (2) mental health treatment services provided by a new program at a facility with a capacity of more than 15 beds.

65 **Federal grants to maintain independence and employment.** Requires the commissioner of human services to seek federal funding to participate in grant activities under the federal Ticket to Work and Work Incentives Improvement Act of 1999. The purpose of the federal grant funds are to establish (1) a demonstration project to improve the availability of health care services and benefits to workers with potentially severe physical or mental impairments that are likely to lead to disability without access to Medicaid; and (2) a comprehensive initiative to remove employment barriers that includes linkages to non-Medicaid programs. This section also lists what must be addressed in the state's proposal for the funds.

66 **Conveyance of surplus state land; Cass County.** Permits the commissioner of administration to convey to Cass county or a regional jail authority for no consideration all the buildings and land of the Ah-Gwah-Ching property. Specifies other requirements related to the conveyance.

67 **Revisor's instruction.** Requires the revisor to delete internal cross-references and make necessary changes to correct punctuation, grammar, or structure in sections or rules affected

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by the repealed sections in this article.

68 **Repealer. (a)** Repeals section 246.017, subdivision 2 (medical director); 246.022 (state hospital planning committee); 246.06 (reports); 246.07 (daily records); 246.08 (inspections; investigations; witnesses; contempt); 246.11 (inspection); 246.19 (protection against fire); 246.42 (food products, production and preservation); 252.025, subdivisions 1, 2, 4, 5, and 6 (state hospitals for persons with mental retardation); 252.032 (administrative structure); 252.10 (fees and expenses); 253.015, subdivisions 2 (plan for needed regional treatment center services), and 3 (services for persons with mental illness from Moose Lake regional treatment center); 253.10 (death or illness; notice given next of kin); 253.19 (annual report); 253.201 (Minnesota security hospital); 253.202 (management); 253.25 (commitment before conviction); 253.27 (correspondence without censorship); 256.05 (supervision over paroled patients; state agents appointed); 256.06 (guardianship of inmates); 256.08 (insane persons in state hospitals; consent to operation); 256.09 (no civil or criminal liability); 256.10 (records kept); and 268A.08 (rehabilitation facility boards).

(b) Repeals Minnesota Rules, parts 9545.2000 to 9545.2040 (procedures for the department of human services to determine and collect fees for issuing and renewing licenses for residential and nonresidential programs and agencies).

Article 7: Health Miscellaneous

Overview

This article contains a variety of provisions related to programs operated by or entities regulated by the commissioners of health and commerce. Provisions in the article modify regulation of Medicare supplement coverage and other forms of private-sector health coverage, modify duties of the commissioner of health related to infant testing, establish a health professional education loan forgiveness program that replaces separate programs for individual classes of providers, make changes to conform to the change in the funding source for tobacco use prevention and local public health promotion and protection grants, prohibit the construction of certain radiation therapy facilities, modify the allocation of emergency medical services regional grants, and make many other changes in policy and regulation.

1 **Definitions.** Amends § 41A.09, subd. 2a. Updates the technical definition of "ethanol" to refer to current specifications of the American Society for Testing and Materials (ASTM). This section is related to sections 55 to 66 and 69 to 81 of this article.

2 **Suspension based on entitlement to medical assistance.** Amends § 62A.31, subd. 1f. Amends a current law permitting Medicare supplement coverage to be suspended while an enrollee is eligible for medical assistance (MA) (which would duplicate med supp coverage), with a guaranteed right to be reinstated if eligibility for MA ends. The amendment permits the suspension to last for the period specified in federal regulations and makes eligibility for reinstatement contingent upon paying the med supp premium retroactive to the date of loss of MA coverage. Also makes technical changes to add references to "certificates" of coverage; this involves persons who get med supp coverage under a group policy.

3 **Guaranteed issue for eligible persons.** Amends § 62A.31, subd. 1u. Provides more specific language defining the period in which persons in various situations have the right to move from another type of coverage into traditional med supp coverage with guaranteed

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issue ("guaranteed issue" means they cannot be turned down). The general rule of 63 days is not changed, but this section specifies when the 63 days starts in various situations. Provides that persons enrolled in a Program of All Inclusive Care for the Elderly (PACE) are treated in the same manner as Medicare + Choice enrollees for the purpose of guaranteed issue rights to switch to med supp coverage.

4 **Medicare prescription drug benefit.** Amends § 62A.31, by adding subd.7. Provides that state law does not prohibit med supp insurers from offering a Medicare prescription drug benefit, if the federal government creates one to be offered by private insurers. That benefit could replace the one now required to be offered under state law.

5 **Extended basic Medicare supplement plan; coverage.** Amends § 62A.315. Specifies the benefits available under the "extended basic" plan, which is the most comprehensive and expensive level of med supp coverage. This clarifies that the coverage for Medicare Part B (basically physician coverage) co payments includes co payments (fixed dollar amounts) or co insurance (percentage of the charges), depending upon which is applicable.

6 **Basic Medicare supplement plan; coverage.** Amends § 62A.316. Amends the section of current law describing the "basic" med supp plan, which is the least comprehensive and least expensive. The change made here is the same change made in the "extended basic" plan in the preceding section.

7 **Short-term coverage.** Amends § 62A.65, subd.7. Extends the period of time for which a person may have short term individual coverage from six months out of 12 to 12 months out of 18. Short term coverage is sold by insurers to persons who would otherwise have a gap in coverage, such as the period between graduating from college and finding a job that provides health coverage.

8 **Co-payments.** Amends § 62D.095, subd. 2. Permits a health maintenance contract to impose a flat fee copayment on outpatient office visits not to exceed 40 percent and on prescription drugs not to exceed 50 percent of the median provider's chargers for similar services or goods received by the enrollee.

9 **Public programs.** Amends § 62D.095, by adding subd. 6. Provides that copayments permitted under this section do not apply in the case of the prepaid medical assistance program, the prepaid general assistance program, MinnesotaCare, or the federal Medicare program.

10 **Number three plan.** Amends § 62E.06, subd. 1. Requires the number three qualified health plan to meet the coverage requirement for hearing aids in section 24 of this article.

11 **Definitions.** Amends § 62J.17, subd. 2. For purposes of expenditure reporting, raises the dollar threshold for a major spending commitment to expenditures in excess of $1,000,000 (the threshold in current law is $500,000).

12 **Audits of exempt providers.** Amends § 62J.23, by adding subd. 5. Authorizes the commissioner of health to audit the referral patterns of providers that qualify for exceptions under the federal Stark Law. The commissioner is required to report to the legislature any audit results that reveal a pattern of referrals by a provider to an entity with which the provider has a direct or indirect financial relationship.

13 **Evaluation of proposed health coverage mandates.** Adds § 62J.26. Establishes a procedure for evaluation by the commissioner of commerce of proposed health benefit mandates. These proposed mandates involve requiring coverage of certain conditions or treatments in private state regulated health coverage.

14 **Uniform billing form HCFA 1450.** Amends § 62J.52, subd. 1. Removes home infusion therapy from the list of services required to be billed on the HCFA 1450 form.

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15 **Uniform billing form HCFA 1500.** Amends § 62J.52, subd. 2. Provides that home infusion therapy must be billed on the HCFA 1500 form. This section is related to the previous section.

16 **Application process.** Amends § 62J.692, subd. 3. Clarifies that a clinical medical education program to train physicians, pharmacists, dentists, chiropractors, or physician assistants is eligible for medical education and research cost (MERC) funds. States that a clinical medical education program for advanced practice nursing is eligible for MERC funds if the program meets certain requirements and is sponsored by the academic health center, the Mayo Foundation, or institutions that are part of the MnSCU system. States that only those training sites that host .5 FTE or more eligible trainees for a program may be included in the program's application.

17 **Distribution of funds.** Amends § 62J.692, subd. 4. Modifies the distribution of MERC funds.

The amendment to (a) states that the commissioner is to annually distribute 90 percent of available MERC funds to all qualifying applicants based on a distribution formula that reflects a summation of an education factor and a public program volume factor. Establishes the weight for each factor. Adds public revenue for the distribution formula.

A new (b) states that the commissioner is to annually distribute the remaining ten percent to all qualifying applicants based on a percentage received by each applicant under paragraph (a).

Strikes language regarding the distribution of funds received from the medical education endowment fund.

18 **Report.** Amends § 62J.692, subd. 5. Requires that an education grant verification report by a sponsoring institution include a statement describing the distribution of funds allocated under section 62J.692, subdivision 4, paragraph (b), and also include information on which clinical training sites received funding and the rationale used for determining funding priorities.

19 **Transfers from the commissioner of human services.** Amends § 62J.692, subd. 7. Makes conforming changes to the distribution formula in section 62J.692, subdivision 4, paragraph (a).

20 **Effective date.** Amends § 62J.694, by adding subd. 5. Specifies that the medical education endowment fund section is only in effect if there are funds in the medical education endowment fund.

21 **Benefits.** Amends § 62L.05, subd. 4. Provides that the two "small employer plans" required to be offered in the small employer market must include the coverage of hearing aids required under section 24 of this article.

22 **Designation.** Amends § 62Q.19.subd. 1. Removes the reference to a rural hospital that has qualified for a rural hospital assistance grant (this grant program is being repealed) and replaces it with a definition of "sole community hospital" for purposes of an essential community provider designation.

23 **Application.** Amends § 62Q.19, subd. 2. Requires the commissioner of health to accept an application for essential community provider designation from a nonprofit community clinic located in Hennepin County that provides health care to an underserved American Indian population and is collaborating with other neighboring organizations on a diabetes project and an immunization project. This application must be accepted by June 30, 2003.

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24 **Hearing aids; persons 18 or younger.** Adds § 62Q.675. Requires that private health coverage regulated by the state cover hearing aids for children whose hearing deficiency is caused by a congenital malformation. Limits the coverage to one hearing aid per ear every three years.

25 **Fees.** Amends § 144.1222, by adding subd. 1a. Establishes in law fees for the commissioner of health's approval of plans and specifications for public swimming pool and spa construction, installation, or alteration, and requests for variance. The fees must be paid before plan approval. (Currently, some fees for pool plan review are included in rule.)

26 **Tests of infants for heritable and congenital disorders.** Amends § 144.125. Changes the requirement that specified people test infants for "inborn errors of metabolism" to a requirement for tests for "heritable and congenital disorders." Provides criteria for determination of which tests should be performed. Mandates a $61 per specimen laboratory service fee. Provides that parents must be notified that: (1) blood and tissue samples and test results may be retained by the department of health; (2) the benefits of retaining the blood or tissue sample; and (3) that they may elect either to decline the tests or require that the test results be destroyed within 24 months. Provides that written objection to the tests by parents exempt an infant from these testing requirements and the registration requirements of section 144.128.

27 **Advisory committee on heritable and congenital disorders.** Adds § 144.1255. Establishes an advisory committee on heritable and congenital disorders. It outlines membership, functions, and objectives. States that this committee does not expire.

28 **Commissioner's duties.** Amends § 144.128. Modifies the commissioner's duties with regard to infant testing. The commissioner must make referrals for treatment of all diagnosed cases, rather than making arrangements for treatment for uninsured, low income families. Requires the commissioner to notify the physicians of newborns tested of the results of the tests performed.

29 **Establishment; membership.** Amends § 144.1481, subd.1. States that the rural health advisory committee does not expire.

30 **Rural health initiatives.** Amends § 144.1483. Eliminates the commissioner's administrative duties for the financial assistance to rural hospitals as part of the rural hospital financial assistance grant program. (This grant program is being repealed).

31 **Eligible health professionals.** Amends § 144.1488, subd. 4. Corrects a cross-reference to a federal agency.

32 **Penalties for breach of contract.** Amends § 144.1491, subd. 1. Modifies the penalty provision for health professionals who receive loans under the National Health Services Corps State Loan Repayment Program. The financial penalty stated in law is replaced by the penalty specified by the federal government.

33 **Health professional education loan forgiveness program.** Adds § 144.1501. Establishes a health professional education loan forgiveness program to replace the separate programs for physicians, midlevel practitioners, and nurses in nursing facilities and intermediate care facilities, all of which are being repealed.

Subd. 1. Definitions. Defines terms.

Subd. 2. Creation of account. Creates a health professional education loan forgiveness program account.

Subd. 3. Eligibility. Establishes eligibility requirements. Participants must be a medical resident or enrolled in an eligible training program and must agree to serve a

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minimum three year full time service obligation which must begin by March 31 following completion of training.

Subd. 4. Loan forgiveness. Requires available funds to be distributed proportionally among the eligible professions according to the vacancy rate for each in the required geographic area or facility type. Of the funds for physician loan forgiveness, 75 percent must be used for rural placements and 25 percent for underserved urban placements. For each year of participation, up to four years, the commissioner must pay each participant the equivalent of 15 percent of the average school debt for indebted graduates in the profession in the year closest to when the applicant was selected.

Subd. 5. Penalty for nonfulfillment. Establishes the penalty for nonfulfillment of an obligation. The participant must repay the total amount received plus interest. Waivers are allowed for emergency circumstances.

Subd. 6. Rules. Authorizes MDH to adopt rules for this program.

34 **Loan forgiveness.** Amends § 144.1502, subd. 4. Modifies the dentist loan forgiveness program to make the loan forgiveness amount equivalent to the program created in the previous section.

35 **Purpose.** Amends § 144.396, subd. 1. Modifies the goal set by the legislature to reduce tobacco use among youth by 25 percent by the year 2005. (This is a change from the goal of reducing tobacco use among youth by 30 percent and was changed to reflect the reduction in funds for this activity.)

36 **Statewide tobacco prevention grants.** Amends § 144.396, subd. 5. Specifies that the tobacco use prevention and local public health endowment fund is only in effect if there are funds available in the endowment fund.

37 **Conforming changes.** Amends § 144.396, subdivisions 7, 10, 11, and 12. Make conforming changes to reflect the change in the funding source for tobacco use prevention and local public health promotion and protection grants (from the endowment fund to the general fund).

38 **See section 37.**

39 **See section 37.**

40 **See section 37.**

41 **Health care facilities and clinics.** Amends § 144.414, subd. 3. Strikes language permitting smoking by patients in chemical dependency treatment programs or mental health programs in certain areas. (This is prohibited in section 67.)

42 **Radiation therapy facility construction.** Adds § 144.5509. Prohibits until August 1, 2008, the construction of a radiation therapy facility unless constructed by an entity that is owned, operated, or controlled by a hospital either alone or in cooperation with another entity.

43 **Restricted construction or modification.** Amends § 144.552, subd.1. Provides an exemption from the hospital construction moratorium for a 20 bed addition to be used for rehabilitation services in an existing hospital in Carver county and for a project involving the construction or relocation of up to 20 beds for up to two psychiatric facilities for children. The additional beds in the hospital in Carver County are not eligible for medical assistance reimbursement.

44 **Distribution.** Amends § 144E.50, subd. 5. Modifies the allocation of emergency medical

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services regional grants. Under the change, 95 percent of the money will go for grants and five percent for board administrative expenses. The current split is 93-1/3 percent for grants and 6-2/3 percent of administration.

45 **Composition of task force.** Amends § 145.881, subd.1. Extends the maternal and child health advisory task force to June 30, 2007.

46 **State and local advisory committees.** Amends § 145A.10, subd.10. States that the state community health advisory committee does not expire.

47 **Exemptions.** Amends § 147A.08. Corrects a cross-reference to conform with changes made in the loan forgiveness program.

48 **Fee proration.** Amends § 148.5194, subd. 1. Expands fee proration authority in the registration program for speech language pathologists and audiologists.

49 **Biennial registration fee.** Amends § 148.5194, subd. 2. Establishes a clinical fellowship registration fee for speech language pathologists and audiologists.

50 **Biennial registration fee for dual registration.** Amends § 148.5194, subd. 3. Establishes a fee for initial registration combined with clinical fellowship registration for speech language pathologists and audiologists.

51 **Verification of credential.** Amends § 148.5194, by adding subd. 6. Establishes a $25 fee for written verification of credentials for speech language pathologists and audiologists.

52 **Verification to other states.** Amends § 148.6445, subd. 7. Modifies language in the statute regulating occupational therapists by referring to the process of providing licensure information to other states as verification rather than certification.

53 **Fees.** Amends § 148C.12. Modifies the licensure fees for alcohol and drug counselors.

54 **Expenses; fees.** Amends § 153A.17. Adjusts certification fees for dispensers of hearing aids.

55 **Petroleum products.** Amends §§ 239.76 and 239.792. Update references to technical ASTM definitions of various petroleum products for purposes of testing by the Weights and Measures Division of the Department of Commerce.

56 **See section 55.**

57 **See section 55.**

58 **See section 55.**

59 **See section 55.**

60 **See section 55.**

61 **See section 55.**

62 **See section 55.**

63 **See section 55.**

64 **See section 55.**

65 **See section 55.**

66 **See section 55.**

67 **Tobacco use prohibited.** Adds § 246.0141. Prohibits the possession or use of tobacco or a tobacco-related device (cigarette papers or pipes for smoking) by a patient, staff, guest, or visitor on the grounds or in a state regional treatment center, the Minnesota security hospital, the Minnesota sex offender program or the Minnesota extended treatment options program. This prohibition does not apply to the possession or use of tobacco or a tobacco-related

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device by an adult as part of a traditional Indian spiritual or cultural ceremony.

68 **Estimated tax; hospitals; surgical centers.** Amends § 295.55, subd. 2. Strikes the provision exempting hospitals that have received grants under the rural hospital financial assistance grant program from making estimated payments of the provider tax. (This grant program is being repealed.)

69 **Petroleum products.** Amends § 296A.01. Update references to technical ASTM definitions of various petroleum products for the purposes of state taxation of these motor fuels.

70 **See section 69.**

71 **See section 69.**

72 **See section 69.**

73 **See section 69.**

74 **See section 69.**

75 **See section 69.**

76 **See section 69.**

77 **See section 69.**

78 **See section 69.**

79 **See section 69.**

80 **See section 69.**

81 **Nonethanol oxygenate.** Amends § 296A.01, by adding subd.38a. Defines nonethanol oxygenate.

82 **Applications, fees.** Amends § 326.42. Establishes in law fees for approval of plumbing system plans and specifications.

83 **Agreement.** Amends § 471.59, subd.1. Adds nonprofit hospitals to the definition to the term "governmental unit" for the purpose of entering into agreements with other governmental units to jointly or cooperatively exercise any power common to the contracting parties or any similar powers.

84 **Technical corrections.** Make technical corrections to Laws 2003, chapter 99 (Minnesota Adverse Health Care Events reporting Act of 2003). Section 85 also adds the lack of restraints as a reportable event. Section 86 also strikes language requiring the reporting system to be operated with state appropriations effective July 1, 2005.

85 **See section 84.**

86 **See section 84.**

87 **Authority to collect certain fees suspended.** Suspends the collection of hearing instrument dispenser certification fees for dispensers renewing their certification during FY 2004. It also suspends the collection of occupational therapy licensing fees during FY 2004 and 2005.

88 **Revisor's instruction.** Instructs the revisor to amend and delete references where appropriate and to correct punctuation, grammar, and structure.

89 **Repealer.** Repeals the following sections of law and rule:

- Sections 62J.15 and 62J.152: Health Technology Advisory Committee.

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- Sections 62J.451 and 62J.452: Health Data Institute.
- Section 144.126: Inborn metabolism error testing without charge to recipient.
- Section 144.1484: Rural hospital finance assistance grant program.
- Section 144.1494: Rural physician loan forgiveness program.
- Section 144.1495: Mid level practitioner loan forgiveness program.
- Section 144.1496: Nurses in nursing homes or ICFs/MR loan forgiveness program.
- Section 144.1497: Rural clinical sites for nurse practitioner education grant program.
- Section 144A.36: Nursing facility transition planning grants.
- Section 144A.38: Long term care innovations in quality demonstration grants.
- Section 148.5194, subdivision 3a: Licensing surcharge fee (subdivision expires June 30, 2003, under current law).
- Section 148.6445, subdivision 9: Licensing surcharge fees (language expired in 2001).
- Rules, parts 4763.0100 to 4763.0170: Rural and urban primary care physician loan forgiveness program.
- Rules, parts 4763.0180 to 4763.0250: Mid-level practitioner education account.
- Rules, parts 4763.0260 to 2763.0300: Nursing home or intermediate care facility nurses' education account.

Article 8: Local Public Health Grants

Overview

Amends statutes relative to community health service subsidy and maternal and child health special projects to create a single local public health grant program for distribution to community health boards using a single formula. Eliminates references to deleted sections of statutes and amends references to amended sections.

1 **Review criteria.** Amends § 144E.11, subd. 6. Eliminates reference to a repealed section in criteria for reviewing ambulance service applications.

2 **Purpose.** Amends § 145.88. Deletes legislative finding with respect to state-wide planning and coordination of maternal and child health services and support of such services through a grants process.

3 **Duties.** Amends § 145.881, subd. 2. Amends duties of the task force to eliminate recommendations with regard to grant awards, recommendations on administration of maternal and child health block grant funds, and recommendations with respect to the funding distribution formula for maternal and child health block grant funds. Additional duty to establish statewide outcomes to improve the health status of mothers and children.

4 **Funding.** Amends § 145.882, subd. 1. Eliminates review of proportional expenditure of maternal and child health block grants by the maternal and child health advisory task force.

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5 **Allocation to the commissioner of health.** Amends § 145.882, subd. 2. One-third of federal block grant money has been available for administrative and technical services, projects of regional or statewide significance or direct services to handicapped children. This section allows that one-third to be used to prepare the 5-year needs assessment and the block grant application, health status data collection and evaluation, technical assistance to community health boards, program evaluation, and services to children under 16 receiving benefits under Title XVI of the Social Security Act.

6 **Allocation to community health.** Amends § 145.882, subd. 3. Block grants to be allocated to community health boards on the basis of a new formula (found in section 28) rather than to community health services areas. Eliminates minimum allocations and requirement for proportional decreases among grant recipients. Clarifies local match requirements.

7 **Nonparticipating community health boards.** Amends § 145.882, by adding a subdivision. Commissioner made responsible for directing maternal and child health block grant activities in geographic areas of boards that either elect not to participate or are not funded by the commissioner.

8 **Use of block grant money.** Amends § 145.882, subd. 7. Eliminates reference to community health services areas as potential recipients of maternal and child health block grant money. Includes adolescent health issues, child abuse prevention, and nutritional issues for women, infants and children in allowable uses for grant money. Eliminates exception from permitted uses list for projects funded before the creation of the block grant program.

9 **Accountability.** Adds new § 145.8821. Community health boards receiving block grant money must select two statewide maternal and child health outcomes by February 1, 2005. Provides for monitoring and evaluation of progress towards outcomes selected. From January 1, 2004, until December 31, 2005, all community health boards must work toward goal of reducing the state's percentage of low birth weight babies.

10 **Scope.** Amends § 145.883, subd. 1. References to repealed section eliminated.

11 **Community health board.** Amends § 145.883, subd. 9. The definition of community health services area is replaced with a definition for community health board.

12 **Community health board.** Amends § 145A.02, subd. 5. Replaces reference to 145A.13 (which expires under this bill on January 1, 2004) with reference to new section 145A.131.

13 **Community health services.** Amends § 145A.02, subd. 6. Eliminates list of program categories of community health services.

14 **Community health service area.** Amends § 145A.02, subd. 7. Replaces reference to 145A.13 (which expires under this bill on January 1, 2004) with reference to new section 145A.131.

15 **Generally.** Amends § 145A.06, subd. 1. Amends reference to include newly added subdivision.

16 **Community health board; eligibility.** Amends § 145A.09, subd. 2. Replaces reference to 145A.13 (which expires under this bill on January 1, 2004) with reference to new section 145A.131.

17 **Cities.** Amends § 145A.09, subd. 4. Replaces reference to 145A.13 (which expires under this bill on January 1, 2004) with reference to new section 145A.131.

18 **Withdrawal.** Amends § 145A.09, subd. 7. Replaces reference to 145A.13 (which expires under this bill on January 1, 2004) with reference to new section 145A.131. Replaces reference to old community health subsidy formula with reference to new community health grant formula in context of payment reduction upon withdrawal of a county from a multi-

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county community health board.

19 **Preemption.** Amends § 145A.10, subd. 2. Replaces references to present public health subsidy with proposed public health grant.

20 **Duties.** Amends § 145A.10, by adding a subdivision. Additional duty of community health boards to establish local priorities and determine mechanisms to address them and to achieve statewide outcomes. Lists factors to be considered by community health boards in making these determinations. Requires written notice by boards to commissioner of statewide outcomes selected. Requires annual report from boards to commissioner documenting progress towards achievement of selected outcomes, as well as identification of any additional local priorities.

21 **State and local advisory committees.** Amends § 145A.10, subd. 10. Eliminates per diem for members of public health advisory committees. Eliminates mandate for appointment of community health advisory committee. Eliminates minimum number of members and minimum number of meetings per year. Provides that committee will advise on new duties of community health board provided in section 20.

22 **Consideration of local public health priorities and statewide outcomes.** Amends § 145A.11, subd. 2. Provides that local health priorities and statewide outcomes established under new law will be considered by cities and counties when levying certain taxes. Current law requires consideration of objectives of the community health plan for this purpose.

23 **Ordinances relating to community health services.** Amends § 145A.11, subd. 4. Deletes cross-reference to deleted section.

24 **Administrative and program support.** Amends § 145A.12, subd. 1. Assistance to community health boards by commissioner to include standards developed by the state community health advisory committee. Deletes reference to a plan approval that was required by a deleted section.

25 **Personnel standards.** Amends § 145A.12, subd. 2. For purposes of commissioner's standards for community health personnel, eliminates reference to competence in program areas where the definitions of the program areas are repealed by the bill.

26 **Statewide outcomes.** Amends § 145A.12, by adding a subdivision. Requires the commissioner to establish statewide outcomes for local public health grants, to include at least one outcome in each of six service areas, for the period from January 1, 2004, to December 31, 2005. By December 31, 2005, and every five years thereafter, the commissioner is to develop statewide outcomes for local public health grants based upon additional consultation and updated criteria.

27 **Expiration.** Amends § 145A.13, by adding a subdivision. Provides that the community health services subsidy program expires on January 1, 2004 (replaced by local public health grant – see section 28).

28 **Local public health grant.** Adds new § 145A.131. New program to replace variety of dedicated grant programs. The state community health advisory committee may recommend a formula for distribution of funds by July 1, 2004 for use beginning January 1, 2006. Base funding to community public health boards shall be determined by the board's fiscal year 2003 allocations (prior to unallotment) for the community health services subsidy, state and federal maternal and child health special projects grants, family home visiting grants, TANF MN ENABL grants, TANF youth risk behavior grants, and available women, infants and children grant funds in fiscal year 2003 (prior to unallotment) distributed based on the proportion of WIC participants served in fiscal year 2003 within the CHS service area. Base funding to be adjusted by the percentage difference between the base and available funding. Multi-county health boards receive up to $15,000 per year for each county included in the

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board. Seventy-five percent local match from specified sources required.

Commissioner is responsible for activities to meet statewide outcomes in geographic areas where the board does not participate in the grant program. Boards must demonstrate progress toward outcomes to remain eligible for grants. Establishes criteria and procedures for commissioner's determination not to distribute funds for failure to make progress.

29 **Indian health grants.** Amends § 145A.14, subd. 2. Amends Indian health grant provisions to eliminate the requirement that such grants be to community health boards pursuant to a community health plan. Provides $1.5 million annually for tribal governments.

30 Amends § 256B.0596. Requires counties to contract with eligible providers to provide mental health case management services if the provider is willing to provide the case management services and has a minimum of at least one contact with the client per week.

31 **Revisor's instruction.** Instructs the revisor to replace internal references to section 145A.13 (scheduled to expire under this bill on January 1, 2004) with a reference to new section 145A.131. Directs revisor to delete internal cross-references and make changes necessary to correct punctuation, grammar and structure.

32 **Repealer.**

Statutes repealed. Repeals § 144.401 (community prevention grant program), § 145.882, subd. 4, 5, 6 and 8 (formula for distribution of maternal and child health block grants), § 145.883, subd. 4 and 7 (definitions of "essential services" and "special project" for purposes of the maternal and child health block grant), § 145.884 (rulemaking authority for grants under maternal and child block grant), § 145.885 (application procedures for maternal and child health care grants), § 145.886 (grant review process), § 145.888 (grant limitations), § 145.889 (rulemaking authority), § 145.890 (health coverage purchase for children with special health care needs), § 145A.02, subd. 9, 10, 11, 12, 13 and 14 (certain definitions from the Local Public Health Act), § 145A.09, subd. 6 (boundaries of community health service areas), § 145A.10, subd. 5, 6, and 8 (certain planning and reporting obligations of community health boards), § 145A.11, subd. 3 (certain approval obligations of cities and counties), § 145A.12, subd. 3, 4 and 5 (certain planning and reporting assistance obligations of the commissioner), § 145A.14, subd. 3 and 4 (certain grants to prevent tobacco use and to establish health promotion teams), and § 145A.17, subd. 2 (allocation of funds to family home visiting programs.)

Rules repealed. Repeals Minnesota Rules, parts 4736.0010, 4736.0020, 4736.0030, 4736.0040, 4736.0050, 4736.0060, 4736.0070, 4736.0080, 4736.0090, 4736.0120, and 4736.0130 (all local public health services rules except those relating to Indian Health Grants and personnel standards for community health services administrators) effective January 1, 2004.

Repeals Minnesota Rules, parts 4705.0100 to 4705.1600 (rules regarding services for children with handicaps) effective June 30, 2004.

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Article 9: Child Care and Miscellaneous Provision

Overview

This article makes modifications to the child care assistance programs in order to prevent fraud, reduce eligibility, adjust local market rates paid to providers, and adjust the copayment schedule.

1 **Child care.** Amends § 119B.011, subd. 5. Amends the definition of "child care."

2 **Child care fund.** Amends § 119B.011, subd. 6. Removes references to the at-home infant care program in the definition of "child care fund."

3 **Income.** Amends § 119B.011, subd. 15. Removes references to the at-home infant care program in the definition of "income." Includes "assistance specifically excluded from income by law" in the list of items excluded from income.

4 **Provider.** Amends § 119B.011, subd. 19. Amends the definition of "provider" to include individuals or child care centers or facilities holding a valid child care license issued by another state or a tribe and providing child care services in the licensing state or in the area under the licensing tribe's jurisdiction.

5 **Registration.** Amends § 119B.011, proposing a new subd. Defines "registration" as the process used by a county to determine whether a provider meets the requirements necessary for payment of child care assistance for care provided by that provider.

6 **Transition year families.** Amends § 119B.011, subd. 20. Defines "transition year extension year families" as families who have completed their transition year of child care assistance and who are eligible for, but on a waiting list for, basic sliding fee child care. Prohibits these families from being considered transition year families. Allows transition year extension child care to be used to support employment or a job search.

7 **Recoupment of overpayments.** Amends § 119B.011, subd. 21. Amends the definition of "recoupment of overpayments" to allow for recoupment from child care providers as well as families.

8 **Child care services.** Amends § 119B.02, subd. 1. Removes obsolete language.

9 **Duties of counties.** Proposes coding for new law § 119B.025.

Subd. 1. Factors which must be verified. Requires counties to verify certain information at all initial child care applications using the universal application. Requires families who have not completed the universal application to complete it at their next recertification. Requires the commissioner to develop a recertification form to redetermine eligibility that minimizes paperwork for the county and the participant.

Subd. 2. Social security numbers. Requires counties to request social security numbers from all applicants for child care assistance. Prohibits counties from denying child care assistance solely on the basis of failure of an applicant to report a social security number.

10 **Funding priority.** Amends § 119B.03, subd. 4. Requires transition year families to be added to the basic sliding fee waiting list on the date they begin transition year child care and to be moved into basic sliding fee child care as soon as possible after they complete their transition year.

11 **Portability pool.** Amends § 119B.03, subd. 9. Requires families who have moved from one county to another to notify the new county of residence within 60 days (instead of 30 days)

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of moving and to submit information to the new county to verify eligibility for the basic sliding fee program.

12 **Eligible participants.** Amends § 119B.05, subd. 1. Requires transition year families to meet certain employment and training criteria in order to be eligible for MFIP child care assistance. Includes transition year child care in the MFIP child care forecast.

13 **Child care fund plan.** Amends § 119B.08, subd. 3. Modifies child care fund plans, requiring counties to submit plans biennially instead of annually, and modifies the list of items the plan must include.

14 **General eligibility requirements for all applicants for child care assistance.** Amends § 119B.09, subd. 1. Modifies income eligibility establishing eligibility at less than or equal to 175 percent of the federal poverty guidelines at program entry and 250 percent or less of the federal poverty guidelines at program exit. Currently, income eligibility is 75 percent or less of the state median income.

15 **Sliding fee.** Amends § 119B.09, subd. 2. Removes references to state median income.

16 **Date of eligibility for assistance.** Amends § 119B.09, subd. 7. Removes references to the at-home infant care program.

17 **Licensed and legal nonlicensed family child care providers; assistance.** Amends § 119B.09, by adding subd. 9. Prohibits licensed and legal nonlicensed family child care providers from receiving child care assistance subsidies for their own children or children in their custody.

18 **Payment of funds.** Amends § 119B.09 by adding a subd. Requires all federal, state, and local child care funds to be paid directly to the child care provider on behalf of the eligible family, except in cases where a provider cares for children in the children's own home. Under current law, counties have the option of paying the provider or the family.

19 **Recovery of overpayments.** Amends § 119B.11, subd. 2a. Allows overpayments to be recovered even when the overpayment is caused by agency error or circumstances outside of the control of the family or provider. Requires overpayments to be recouped from the family if the overpayment benefited the family by causing the family to pay less for child care expenses than the family would have been required to pay under program requirements. Requires overpayments to be recovered from the provider if the overpayment benefited the provider by causing the provider to receive more child care assistance than otherwise would have been paid on the family's behalf under program requirements. Makes both the family and the provider jointly liable for overpayments if they acted together to intentionally cause overpayment.

20 **Parent fee.** Amends § 119B.12, subd. 2. Changes references to state median income to federal poverty guidelines and removes obsolete language. Removes the requirement that parent fees be established in rule.

21 **Provider requirements.** Proposes coding for new law § 119B.125.

Subd. 1. Authorization. Requires counties to authorize providers to receive child care assistance payments before the county makes payments to the provider. Requires the commissioner to establish the requirements necessary for authorization of a provider.

Subd. 2. Persons who cannot be authorized. Lists 13 conditions that prohibit people from becoming authorized as a legal nonlicensed family child care provider.

Subd. 3. Authorization exception. Allows counties to authorize a person as a provider after the county has initially denied a person authorization as a legal

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nonlicensed family child care provider if three conditions are met.

Subd. 4. Unsafe care. Allows counties to deny authorization as a child care provider to any applicant or rescind authorization of any provider when the county knows or has reason to believe that the provider is unsafe or that the circumstances of the chosen child care arrangement are unsafe.

Subd. 5. Provisional payment. Allows the county to provide a provisional payment after receiving a completed application from the provider, while the county is determining final authorization

Subd. 6. Record keeping requirement. Requires all providers to keep daily attendance records for children receiving child care assistance and make those records available immediately to the county upon request. Requires providers to keep daily attendance records for six years after the date of service. Allows counties to deny authorization as a child care provider or rescind authorization of any provider when the county knows or has reason to believe that the provider has not complied with the record keeping requirement.

22 **Subsidy restrictions.** Amends § 119B.13, subd. 1. Requires the commissioner to determine the maximum rate for each type of care on an hourly, full-day, and weekly basis.

23 **Legal nonlicensed family child care provider rates.** Amends § 119B.13. Requires that legal nonlicensed child care providers receiving child care assistance reimbursements be paid in hourly blocks of time. Limits the maximum rate paid to legal nonlicensed family child care providers to 80 percent of the county maximum hourly rate for licensed family child care providers. Allows a rate which includes a provider bonus or a special needs rate to be in excess of the maximum rate allowed under this subdivision. Prohibits legal nonlicensed family child care providers from receiving reimbursement for registration fees for families receiving assistance.

24 **Provider payments.** Amends § 119B.13, subd. 6. Makes technical and conforming changes. Requires providers to submit all bills within 60 days of the last date of service on the bill. Allows counties to pay bills submitted more than 60 days after the last date of service if the provider can show good cause as to why the bill was submitted late. Requires counties to define good cause in their child care fund plan. Prohibits counties from paying bills submitted more than one year after the last date of service on the bill. Allows counties to stop payment issued or to refuse to pay a bill under certain circumstances.

25 **Fair hearing allowed for providers.** Amends § 119B.16, by adding a subd. Allows providers who have been assigned responsibility for an overpayment to request a fair hearing to challenge the assignment of responsibility for the overpayment and the amount of the overpayment.

26 **Joint fair hearings.** Amends § 119B.16, by adding a subd. Requires the county to make the family in whose case the overpayment was made a party to the fair hearing if a fair hearing is requested by the provider. Requires the county to make the provider a party to a fair hearing if a fair hearing is requested by the family. Requires all other issues raised by the family to be resolved in the same proceeding. Allows referees assigned to fair hearings to join a family or a provider as a party to the fair hearing.

27 **Informal conference.** Amends § 119B.16, subd. 2. Requires county agencies to offer an informal conference to providers to whom the county agency has assigned responsibility for an overpayment in an attempt to resolve the dispute. Allows the county agency or the provider to ask the family in whose case the overpayment arose to participate in the informal

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conference, but the family may refuse to do so.

28 **Child care resource and referral programs.** Amends § 119B.19, subd. 7. Adds an item to the list of items child care resource and referral programs must perform.

29 **Statewide advisory task force.** Amends § 119B.21, subd. 11. Adds school-based early childhood programs and special education programs to the list of groups that must be represented on the statewide advisory task force on child care.

30 **Biennial plan.** Amends § 119B.23, subd. 3. Removes references to the community social services plan to be consistent with the repeal of the community social services act.

31 **Hearing authority.** Amends § 256.046, subd. 1. Requires local agencies to initiate administrative fraud disqualification hearings for individuals, including child care providers caring for children receiving child care assistance, accused of wrongfully obtaining assistance or intentional program violations, in lieu of a criminal action when it has not been pursued.

32 **Qualifying overpayment.** Amends § 256.0471, subd. 1. Makes it easier and less expensive for counties to collect overpayments from former recipients.

33 **Disqualification from program.** Amends § 256.98, subd. 8. Establishes a disqualification period for providers convicted of wrongfully obtaining public assistance. The disqualification must be for a period of one year for the first offense and two years for the second offense.

34 **Direction to commissioner; provider rates.** Requires the provider rates for fiscal year 2003 implemented on July 1, 2002, to be continued in effect through June 30, 2005. Directs the commissioner to evaluate the costs of child care, examine the differences in the cost of child care in rural and metropolitan areas, and make recommendations to the legislature for containing future cost increases by January 15, 2005. Requires the commissioner to take into consideration the impact any recommendations might have on work incentives for low and middle-income families and possible changes to MFIP child care, basic sliding fee child care, and the dependent care tax credit. Requires the commissioner to examine the basic sliding fee allocation formula and make recommendations to the legislature in order to create a more equitable formula. Also requires the commissioner to study the relationship between child care assistance subsidies and tax credits or incentives related to child care expenses and include this information in the January 15, 2005, report to the legislature.

35 **Child care waiting list.** Allows the commissioner to manage the child care assistance waiting list on a regional or statewide basis in order to ensure that families listed under higher priority categories are served before families listed under lower priority categories.

36 **Child care assistance parent fee schedule.** Establishes a new parent fee schedule.

37 **Eligibility for families with household income greater than 250 percent of the federal poverty guidelines.** Allows families with incomes greater than 250 percent of the federal poverty guidelines receiving child care assistance on July 1, 2003, to be eligible to continue receiving child care assistance until the family's next eligibility redetermination.

38 **Repealer.** Repeals the at-home infant child care program, provider rate bonus for accreditation, MFIP social services child care sunset and report, and an obsolete child care report.

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Article 10: Child Support Federal Compliance

Overview

This article requires applicants for driver's licenses and noncommercial game and fish licenses to provide their social security numbers on license applications. Federal law requires states to collect social security numbers on driver's and recreational license applications for purposes of child support enforcement. This article also makes various changes to current laws relating to occupational and driver's license suspensions and modifies the state administration of federal funding for access and visitation programs.

1 **Classifications.** Amends § 13.69, subd. 1. Requires the department of public safety to provide social security numbers in driver's license and motor vehicle registration records to the department of natural resources for purposes of license application administration. Provides that the department may release a social security number only as provided under this section. Prohibits the department from selling or otherwise providing social security numbers for any other purpose.

2 **License applications; collection of social security numbers.** Adds § 97A.482. Requires an applicant for an individual noncommercial game and fish license to provide the applicant's social security number on the license application. Also requires that, if the applicant does not have a social security number, the applicant must certify that they do not have a social security number. Also provides that the social security numbers collected are private data and must be provided to the commissioner of human services for child support enforcement purposes, as required by federal law.

3 **Contents of application; other information.** Amends § 171.06, subd. 3. Requires that an application to the department of public safety for an identification card, instruction permit, provisional license, or driver's license include the applicant's social security number. Also requires that, if an applicant does not have a social security number, the applicant must certify that they do not have a social security number. Strikes language from current law making the provision of social security numbers on driver's license applications optional.

4 **Use of social security number.** Amends § 171.07, by adding subd. 14. Provides that an applicant's social security number must not be displayed on the driver's license or included on the magnetic strip or bar code used to store data on the license. Also provides that the social security number must not be used as a Minnesota driver's license or identification number.

5 **Occupational license suspension.** Amends § 518.551, subd. 12. Amends the child support statute dealing with an occupational license suspension, by streamlining the procedure for suspending the license. Prior to the suspension of an occupational license for noncompliance with an approved child support written payment agreement, the public authority must notify the obligor that it intends to suspend the license and that the obligor must request a hearing within 30 days of the date of the notice to contest the suspension. If the obligor does not timely request a hearing, the public authority must direct the licensing board or agency to suspend the obligor's license. If the obligor is a licensed attorney, the public authority must report the matter to the lawyers professional responsibility board. If the obligor requests a hearing within 30 days, this section also specifies other requirements related to the hearing.

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6 **Driver's license suspension.** Amends § 518.551, subd. 13. Amends the child support statute dealing with driver's license suspension by streamlining the procedure for suspending the license. Prior to the suspension of a driver's license for noncompliance with an approved child support written payment agreement, the public authority must notify the obligor that it intends to suspend the license and that the obligor must request a hearing within 30 days of the date of the notice to contest the suspension. If the obligor does not timely request a hearing, the public authority must direct the department of public safety to suspend the obligor's license. If the obligor requests a hearing within 30 days, this section also specifies other requirements related to the hearing.

7 **Federal funds for visitation and access.** Amends Laws 1997, chapter 245, article 2, section 11. Requires the commissioner of human services to administer the federal funding for access and visitation programs. Strikes language from current law requiring the commissioner to transfer the funds to the state court administrator for the children pilot project and parent education program. Permits the commissioner to distribute the funds on a competitive basis and monitor, evaluate, and report on access and visitation programs.

8 **Effective date.** Sections 1 to 4 are effective August 1, 2003.

Article 11: Community Services Act

Overview

This article consolidates various state and federal social services grants to counties into a single consolidated grant that counties must use to address the needs of children, adolescents, and adults. Provisions in this article specify how children and community services grants will be allocated to the counties, and the various duties of the Commissioner of Human Services and the counties with regard to the administration of the consolidated grant. This article also eliminates several state programs and certain program requirements to give counties greater flexibility in administering the children and community services grants.

1 **Citation.** Adds § 256M.01. Provides that the sections in this article may be cited as the "Children and Community Services Act." Also provides that the act establishes a fund to address the needs of children, adolescents, and adults in each county in accordance with a county's service plan. Requires that the service plan specify outcomes, strategies, and state and county roles. Also requires the service plan to be reviewed and updated every two years, or sooner if necessary.

2 **Definitions.** Adds § 256M.10. Defines the following terms for purposes of this article: children and community services; commissioner; county board; former children's services and community service grants; and human services board.

3 **Duties of commissioner of human services.** Adds § 256M.20.

Subd. 1. General supervision. Requires the commissioner to allocate funds to each county under the grant allocation process in section 5 of this article and service plans in section 4 of this article. Requires counties to use the funds to address the needs of children, adolescents, and adults. Also requires the commissioner, in consultation with counties, to provide technical assistance and evaluate county

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performance in achieving outcomes.

Subd. 2. Additional duties. Specifies the commissioner's additional duties in supervising the administration of this act.

Subd. 3. Sanctions. Requires the commissioner to establish and maintain a monitoring program to reduce noncompliance with federal laws and regulations that may result in federal fiscal sanctions. Gives the commissioner the authority to withhold a portion of a county's share of state and federal funds if the county is not complying with federal law and regulations and the noncompliance may result in federal fiscal sanctions. Specifies requirements for the amount the commissioner may withhold, the duration of the withholding, and possible reallocation of the withheld funds.

Subd. 4. Corrective action procedure. Specifies the procedures the commissioner must comply with when reducing a county's funds. The procedures include the commissioner providing notice to the county of noncompliance, a 30-day opportunity for the county to demonstrate compliance, and an opportunity for the county to develop and implement a corrective action plan.

4 Service plan. Adds § 265M.30.

Subd. 1. Service plan submitted to commissioner. Effective January 1, 2004, in order to receive funds under this act, requires each county to have a biennial service plan submitted to the commissioner. Permits counties to submit multicounty or regional service plans.

Subd. 2. Contents. Requires counties to complete a service plan in a form prescribed by the commissioner. Specifies the contents of the plan, including a statement of needs and community strengths and resources; strategies to achieve performance targets; a description of the county's process to solicit public input; and budget.

Subd. 3. Continuity of services. In developing a service plan, requires the county to endeavor, within the limits of funds available, to consider the continuing need for services and programs for children and persons with disabilities that were funded by the former children's services and community service grants.

Subd. 4. Information. Requires the commissioner to provide each county with certain information and technical assistance needed to complete the service plan.

Subd. 5. Timelines. Requires each county to submit the preliminary service plan to the commissioner by October 15, 2003, and by October 15 every two years thereafter.

Subd. 6. Public comment. Requires the county to solicit public participation and comments in the development and contents of the service plan.

Subd. 7. Commissioner's responsibilities. Requires the commissioner, within 60 days of receiving each county service plan, to inform the county if the service plan has been approved. If the plan is not approved, the commissioner must inform the county of any revisions needed for approval.

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5 **State children and community services grant allocation.** Adds § 256M.40.

Subd. 1. Formula. Species how the commissioner will allocate to counties the state funds appropriated for children and community services grants.

(a) For July 1, 2003, through December 31, 2003, the county allocation is equal to the county's allocation for the former children's services and community service grants for calendar year 2003, less payments made on or before June 30, 2003.

(b) For calendar years 2004 and 2005, the commissioner shall allocate available funds to each county in proportion to the county's share of the calendar year 2003 allocations for the former children's services and community service grants.

(c) For calendar year 2006 and following, the commissioner shall allocate available funds in proportion to the county's share in the preceding calendar year.

Subd. 2. Project of regional significance; study. Requires the commissioner to study whether and how to dedicate a portion of the allocated funds for projects of regional significance and report to the legislature by January 15, 2005, on the study. Requires the commissioner of finance, in preparing the proposed biennial budget for fiscal years 2006 and 2007, to include $25,000,000 each year in funding for projects of regional significance.

Subd. 3. Payments. Requires the commissioner to make calendar year allocations of state funds appropriated for children and community services grants to counties on or before July 10 each year.

6 **Federal children and community services grant allocation.** Adds § 256M.50. Beginning in federal fiscal year 2004, requires that federal Title XX social services funding be allocated to each county according to section 256M.40 (section 5 of this article), except for funds allocated for administrative purposes and migrant day care.

7 **Duties of county boards.** Adds § 256M.60.

Subd. 1. Responsibilities. Requires the county board of each county to be responsible for administration and funding of children and community services. Also requires the county board to coordinate and facilitate the effective use of formal and informal helping systems to best support and nurture children, adolescents, and adults who experience dependency, abuse, neglect, poverty, disability, chronic health conditions, or other factors that may result in poor outcomes or disparities, as well as services for family members.

Subd. 2. Day training and habilitation services; alternative habilitation services. To the extent provided in the county service plan, requires each county board to be responsible for providing day training and habilitation services or alternative habilitation services during the day for persons with developmental disabilities to the extent required by the person's individualized service plan.

Subd. 3. Reports. Requires the county board to provide necessary reports and data to the commissioner.

Subd. 4. Contracts for services. Permits a county board to contract with certain boards, political subdivisions, collaboratives, or private organizations to discharge its duties.

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Subd. 5. Exemption from liability. Provides that the state, county boards, or agencies acting on behalf of county boards in implementing and administering children and community services are not liable for damages, injuries, or liabilities sustained through an individual's, a family's, or authorized representative's purchase of services under this section.

Subd. 6. Fees for services. Permits the county to establish a schedule of fees based upon clients' ability to pay to be charged to recipients of children and community services.

8 Fiscal limitations. Adds § 256M.70.

Subd. 1. Demonstration of reasonable effort. Requires the county to make reasonable efforts to comply with all children and community services requirements, within the limits of available funding, including efforts to identify and apply for commonly available state and federal funding.

Subd. 2. Identification of services to be provided. Specifies criteria that a county must consider in limiting services when the county has made reasonable efforts to provide services under its service plan, but funds appropriated under this chapter are insufficient.

Subd. 3. Denial, reduction, or termination of services due to fiscal limitations. Specifies the county requirements when denying, reducing, or terminating services to an individual due to fiscal limitations.

9 Program evaluation. Adds § 256M.80.

Subd. 1. County evaluation. Requires each county to submit outcome data to the commissioner from the past calendar year no later than March 1 of each year, beginning March 1, 2005. Also requires the commissioner to prescribe the standard methods counties will use to provide the data.

Subd. 2. Statewide evaluation. Requires the commissioner to prepare a report on counties' progress in improving children's, adolescents', and adults' outcomes relating to safety, permanency, and well-being six months after the end of the first full calendar year and annually thereafter. Also requires the commissioner to disseminate the report throughout the state.

10 Grants and purchase of service contracts. Adds § 256M.90.

Subd. 1. Authority. Authorizes a local agency to purchase community social services by grant or purchase of service contract.

Subd. 2. Duties of local agency. Specifies the duties of the local agency regarding grants or purchase of service contracts.

Subd. 3. Local agency criteria. Requires the local agency to establish written criteria for vendor approval if it purchases community social services from a vendor that is not subject to state licensing laws or department rules.

Subd. 4. Case records and reporting requirements. Provides that case records and data reporting requirements for grants and purchased services are the same as requirements for direct services.

Subd. 5. Files. Requires the local agency to keep an administrative file for each

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grant and contract.

Subd. 6. Contracting within and across county lines; lead county contracts. Specifies requirements related to contracting within and across county lines and lead county contracts.

Subd. 7. Contracts with community mental health boards. Permits a local agency within a geographic area served by a community mental health board to contract directly with the community mental health board.

Subd. 8. Placement agreements. Requires that a placement agreement be used for residential services. Specifies other requirements related to the placement agreement.

11 **Revisor's instruction.** Requires the revisor to delete internal cross-references and make necessary changes to correct punctuation, grammar, or structure in sections or rules affected by the repealed sections in this article.

12 **Repealer. (a)** Repeals sections 245.478 (adult component of community social services plan); 245.4886 (children's community-based mental health fund); 245.4888 (children's component of community social services plan); 245.496 (start-up funds for local children's mental health collaboratives); 254A.17 (prevention and treatment initiatives); 256E.01 to 256E.115 and 256E.13 to 256E.15 (Community Social Services Act, except for grants for community support services programs for persons with serious and persistent mental illness); 256F.01 to 256F.08 (the Minnesota Family Preservation Act, except for child welfare targeted case management); 256F.11 (grant program for crisis nurseries); 256F.12 (grant program for respite care); 256F.14 (family group decision-making); 257.075 (grants for support services for minority children in out-of-home placements); 257.81 (training for interviewers of maltreated children; commissioner of human services duties); 260.152 (mental health screening of children); and 626.562 (child abuse professional consultation telephone line).

(b) Repeals Minnesota Rules, parts 9550.0010 to 9550.0093 (administration of community social services).

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Article 12: Health Care

Overview

This article contains a variety of provisions related to state health care program eligibility, covered services, reimbursement rates, funding, and policy. Provisions in the article:

- give the commissioner of human services additional authority to recover from or take action against enrollees of health care programs for assistance that is wrongfully obtained (sections 3, 12 to 14, and 94);
- establish a prescription drug discount program effective July 1, 2005 (section 4) and a prescription drug assistance program (section 11), and modify MA coverage and reimbursement for prescription drugs (section 35);
- reduce or modify state health care program reimbursement rates for inpatient hospital services (sections 8 and 9), prescription drugs (section 35), special transportation services (section 36), outpatient hospital services (sections 55 and 66), GAMC services (section 69), and managed care plans (sections 61 and 82);
- limit MA eligibility, by reducing the asset limit for families (section 18), reducing program income limits for pregnant women (section 19) and children (20), and making other changes;
- modify premiums and make other changes for the MA employed persons with disabilities eligibility category (section 22);
- modify MA asset transfer and asset recovery provisions (sections 24 to 29, 40 to 52, and 90);
- limit MA and MinnesotaCare coverage of adult dental services (sections 34 and 71) and delay implementation of MA coverage of intensive early intervention behavior therapy for children with autism (section 33);
- establish copayments for MA (section 37) and GAMC (section 69);
- require elderly waiver services to be provided to elderly individuals through the prepaid medical assistance program and expand coverage of nursing home services through that program (sections 58, 59, 62, 63, and 65);
- modify GAMC eligibility, by creating a new eligibility category of persons with incomes between 75 and 175 percent of FPG who apply during hospitalization and are eligible for coverage of inpatient hospital and related physician services, eliminating the GAMC spend-down and one-month retroactive coverage, eliminating GAMC emergency coverage, and making other changes (sections 68 and 69);
- modify MinnesotaCare eligibility and covered services, by creating a limited benefit set for enrollees who are single adults and households without children with incomes between 75 and 175 percent of FPG (section 72), prohibiting parents from remaining enrolled if their incomes exceed $50,000 (section 73), eliminating the increase in the income limit at which children quality for reduced premiums (section 85), lowering the MinnesotaCare asset limit (section 86), and

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making other changes; and

- increase MinnesotaCare sliding scale premiums (section 84).

1 **Federal financial participation.** Amends § 62J.692, subd. 8. Requires the commissioner of human services to use physician clinic rates where possible when seeking to maximize federal financial participation in payments for medical education and research costs.

2 **Specific powers.** Amends § 256.01, subd. 2. Requires rebates for the prescription drug program to be equal to the rebate as defined under the federal Medicaid rebate program. (Current law requires the rebate to be equal to the "basic" rebate of that program.)

3 **Hearing authority.** Amends § 256.046, subd. 1. Adds GAMC, MinnesotaCare for adults without children and, upon federal approval, all categories of MA and the remaining categories of MinnesotaCare except children through age 18, to a list of programs for which a local agency must initiate administrative fraud disqualification hearings.

4 **Prescription drug discount program.** Adds § 256.954. Establishes a prescription drug discount program within the department of human services.

Subd. 1. Establishment; administration. Requires the commissioner of human services to establish and administer the prescription drug discount program, effective July 1, 2005.

Subd. 2. Commissioner's authority. Directs the commissioner to administer a rebate program for drugs purchased through the prescription drug discount program, using the terms and conditions of the federal Medicaid rebate program.

Subd. 3. Definitions. Defines terms.

Subd. 4. Eligible persons. In order to be eligible, requires an applicant to:

- be a permanent resident of Minnesota;
- not be enrolled in a state health care program or the prescription drug program;
- not be enrolled in and have available prescription drug coverage through a health plan or a pharmacy benefit program offered by a pharmaceutical manufacturer;
- not be enrolled in and have available prescription drug coverage through a Medicare supplement plan; and
- have a gross household income that does not exceed 250 percent of the federal poverty guidelines.

Subd. 5. Application procedure. Requires applications to be available at specified sites. Requires individuals to submit applications to the commissioner, and requires the commissioner to determine eligibility within 30 days. Specifies that eligibility begins the month after approval. Requires the commissioner to develop an application form that does not exceed one page in length.

Subd. 6. Participating pharmacy. Requires participating pharmacies to sell prescription drugs to enrolled individuals at the pharmacy's usual and customary retail price, minus the rebate amount and plus any administrative fee and switch fee. Also requires pharmacies to provide the commissioner with information necessary to administer the program.

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Subd. 7. Notification of rebate amount. Requires the commissioner to notify each drug manufacturer, each calendar quarter or according to a schedule established by the commissioner, of the amount of rebate owed on prescription drugs sold to enrolled individuals.

Subd. 8. Provision of rebate. Requires manufacturers to provide a rebate equal to the MA rebate, for any prescription drug purchased by an enrolled individual at a participating pharmacy. Requires full payment within 30 days of the state invoice, or according to a schedule established by the commissioner, and also requires manufacturers to provide the commissioner with information to verify the rebate determined per drug. Requires the commissioner to deposit rebates into the Minnesota prescription drug dedicated fund.

Subd. 9. Payment to pharmacies. Requires the commissioner to distribute to pharmacies, on a biweekly basis, the rebate amount obtained for prescription drugs sold by the pharmacy, minus the administrative fee.

Subd. 10. Administrative fee; switch fee. Requires the commissioner to establish an administrative fee that covers expenses for enrollment, claims processing, and distributing rebates. Requires the commissioner to establish a switch fee to cover expenses incurred by pharmacies in formatting claims for electronic submission.

Subd. 11. Dedicated fund; creation; use of fund. Establishes the Minnesota prescription drug dedicated fund in the state treasury. Requires the commissioner of finance to credit to the fund all rebates paid, any federal funds received, and any designated appropriations or allocations. Specifies that money in the fund is appropriated to the commissioner of human services to reimburse participating pharmacies, pay expenses related to administration of the prescription drug program, and repay the appropriation provided. Requires the commissioner to administer the program so that costs do not exceed the funds appropriated plus drug rebate proceeds.

Subd. 12. Expiration. States that the section expires upon the effective date of an expanded prescription drug benefit under Medicare.

5 **Eligibility.** Amends § 256.955, subd. 2a. Strikes language that would have expanded the prescription drug program income limit for the elderly to 135 percent of FPG effective July 1, 2003 (this maintains the current law income limit of 120 percent of FPG).

6 **Prescription drug coverage.** Amends § 256.955, subd. 3. Eliminates prescription drug program coverage, for specific enrollees who are not on a spenddown, of drugs that are available under an assistance program offered by a pharmaceutical manufacturer. Provides that the section is effective 90 days after the board on aging implements a prescription drug assistance program.

7 **Referrals to prescription drug assistance program.** Amends § 256.955, by adding subd. 4a. Requires county social services agencies, in coordination with the commissioner and the board on aging, to refer applicants and enrollees to the prescription drug assistance program for all drugs that are covered under an assistance program offered by a pharmaceutical manufacturer. Establishes a 90-day phase-in period and exempts individuals on a spenddown from the subdivision. Provides that the section is effective 90 days after the board on aging implements a prescription drug assistance program.

8 **Operating payment rates.** Amends § 256.969, subd. 2b. Eliminates the rebasing of MA and GAMC inpatient hospital rates scheduled to take effect January 1, 2005.

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9 **Payments.** Amends § 256.969, subd. 3a. Reduces MA and GAMC inpatient hospital fee-for-service payment rates by 5 percent, for admissions occurring on or after July 1, 2003. Excludes certain mental health services and Indian health service facilities from this reduction.

10 **Admissions for persons who apply during hospitalization.** Amends § 256.969, by adding subd. 8b. Requires inpatient hospital payment rates for GAMC enrollees who are eligible for the program on the basis of income and not through receipt of other assistance to be established on a per day basis for days they are eligible, if they are admitted before the date of eligibility. Provides an October 1, 2003, effective date.

11 **Prescription drug assistance.** Amends § 256.975, by adding subd. 9. (a) Requires the Minnesota board on aging to establish and administer a program to assist individuals in accessing programs by pharmaceutical manufacturers that provide free or discounted prescription drugs, or provide coverage for prescription drugs. Requires the board to use computer software programs to list program eligibility requirements, list drugs that are included, and link individuals to appropriate programs. Also requires the board to make information on the program available and to coordinate the program with the Senior LinkAge line.

(b) Requires the board to work with the commissioner and county social services agencies to coordinate the enrollment of individuals referred from the prescription drug program.

12 **Amount of assistance incorrectly paid.** Amends § 256.98, subd. 3. In a section allowing recovery or sentencing for wrongfully obtaining assistance, specifies that the amount of assistance incorrectly paid is equal to all payments for health care services, including capitation payments, under MinnesotaCare, MA, or GAMC, for which the person was not entitled due to concealment or misrepresentation of facts.

13 **Recovery of assistance.** Amends § 256.98, subd. 4. In a section allowing recovery of assistance incorrectly paid, allows MinnesotaCare participants who have wrongfully obtained assistance but otherwise remain eligible for the program to have their premiums increased by 10 percent or $10/month, whichever is greater, until the debt is satisfied.

14 **Disqualification from program.** Amends § 256.98, subd. 8. Requires disqualification of persons found to be guilty of wrongfully obtaining GAMC, MinnesotaCare for adults without children, and upon federal approval, all categories of MA and the remaining categories of MinnesotaCare except children through age 18. Sets the period of disqualification at one year after the first offense, two years after the second offense, and permanently after the third or subsequent offense. Specifies other requirements for disqualification.

15 **Residents of institutions for mental diseases.** Amends § 256B.055, by adding subd. 13. Beginning October 1, 2003, provides that persons who would be eligible for MA except for residence in an institution for mental diseases (IMD) are eligible for MA without federal financial participation, except for payment for a nursing facility determined to be an IMD.

16 **Income and assets generally.** Amends § 256B.056, subd. 1a. Makes a conforming change related to the modification of the earned income disregards and deductions for families and children.

17 **Families with children income methodology.** Amends § 256B.056, subd. 1c. Effective July 1, 2003, sunsets the current earned income disregard for children one to five of 21 percent of earned income for four months. Effective October 1, 2003, applies a $90 work expense deduction to income for children age one through 18 and effective July 1, 2003, clarifies that deductions for dependent care and child support paid under a court order

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continue. For parents in MA families, children 19 to 21, and children and families on a spend-down, effective July 1, 2003 retains the 17 percent earned income disregard of four months and clarifies that deductions for dependent care and child support paid under court order continue.

18 **Asset limitations for families and children.** Amends § 256B.056, subd. 3c. Reduces the MA asset limit for families from $30,000 to $20,000 for a household of two or more, and from $15,000 to $10,000 for a household of one.

19 **Pregnant women and infants.** Amends § 256B.057, subd. 1. Reduces the MA income limit for pregnant women from 275 percent of FPG to 200 percent of FPG, effective February 1, 2004 or upon federal approval. (Implementation of this change will be delayed until July 1, 2004, in order to maximize receipt of federal funds in accordance with the rider in article 13C, section 2, subdivision 1.) Provides a July 1, 2003, expiration date for the special work expense deduction for pregnant women, and requires dependent care and child support paid to be deducted from countable income, effective February 1, 2004, or upon federal approval.

20 **Children.** Amends § 256B.057, subd. 2. Effective October 1, 2003, reduces the MA income limit for children one through 18 from 170 percent of FPG to 150 percent of FPG. (Implementation of this change will be delayed until July 1, 2004, in order to maximize receipt of federal funds in accordance with the rider in article 13C, section 2, subdivision 1.)

21 **Qualifying individuals.** Amends § 256B.057, subd. 3b. Makes MA funding for Medicare beneficiaries who are qualifying individuals contingent upon federal funding (current law provides funding to the extent of the federal allocation, which is time-limited).

22 **Employed persons with disabilities.** Amends § 256B.057, subd. 9. Makes a number of changes related to the MA employed persons with disabilities eligibility category.

The amendment to (a) allows individuals who lose employment for reasons not attributable to the enrollee to retain eligibility for up to four consecutive months after the month of job loss, effective January 1, 2004, and makes conforming changes.

A new (c), effective January 1, 2004, provides an earned income disregard of $65 and requires applicants to have earned income above this disregard level. Also requires Medicare, social security, and applicable state and federal income taxes to be paid or withheld to be considered earned income. (Implementation of these changes will be delayed until July 1, 2004, in order to maximize receipt of federal funds in accordance with the rider in article 13C, section 2, subdivision 1.)

The amendment to (d) requires all enrollees, effective January 1, 2004, to pay a premium that is the greater of $35 or a premium based on a sliding scale that starts at one percent of gross earned and unearned income for persons with incomes equal to or greater than 100 percent of FPG and increases to 7.5 percent of income for persons with incomes at or above 300 percent of FPG. Also requires enrollees with unearned income to pay one-half of one percent of unearned income in addition to the premium, effective November 1, 2003. Effective November 1, 2003, limits reimbursement for cost-effective Medicare Part B premiums to enrollees with incomes that do not exceed 200 percent of FPG.

The amendment to (f), effective July 1, 2003, requires premiums to be redetermined at six-month income reviews, rather than annually at certification. Requires enrollees to report changes in income or household size within ten days and specifies when premium changes

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take effect.

The amendment to (h), effective July 1, 2003, clarifies that individuals disenrolled for nonpayment of premiums must pay any past due premiums as well as current premiums, prior to being reenrolled, except when an installment agreement is accepted by the commissioner.

23 **Certain persons needing treatment for breast or cervical cancer.** Amends § 256B.057, subd. 10. Corrects a citation to the definition of creditable coverage in federal law.

24 **Prohibited transfers.** Amends § 256B.0595, subd. 1. Clarifies that the current prohibition on asset transfers at less than fair market value applies to all transfers, including those made by a community spouse after the month in which the institutionalized spouse is determined eligible for MA. Provides a July 1, 2003, effective date.

25 **Prohibited transfers.** Amends § 256B.0595, by adding subd. 1b. Extends the lookback period for asset transfers to 72 months and applies this to transfers made on or after July 1, 2003. Also extends asset transfer prohibitions to transfers made by a community spouse after the month in which the institutionalized spouse is determined to be MA eligible (this clarifies current policy). Gives the commissioner authority to determine valid trust purposes and provides that assets placed in a trust that is not for a valid purpose remain available for purposes of MA eligibility. Specifies the applicability of the asset transfer requirements and provides that transfers shall affect eligibility for all MA services or for long-term care services, whichever receives federal approval. Provides a July 1, 2003, effective date, to the extent permitted by federal law. Requires the commissioner to apply for necessary waivers and federal authority, if any provision in the section is not effective as of July 1, 2003, because of prohibitions in federal law.

26 **Period of ineligibility.** Amends § 256B.0595, subd. 2. Provides that periods of ineligibility due to uncompensated transfers begin the first day of the month after the month in which the transfer occurred. (Under current law, the period of ineligibility begins with the month the transfer occurred.) Provides a July 1, 2003, effective date.

27 **Period of ineligibility.** Amends § 256B.0595, by adding subd. 2b. Modifies the methodology used to calculate penalty periods. Also modifies the starting date for periods of ineligibility due to improper transfers. For applicants, provides that the period of ineligibility begins with the month in which the person applied for MA or the first month the local agency became aware of a transfer, if later. For recipients, provides that the period of ineligibility begins the first month the local agency becomes aware of the transfer, or the month following an existing period of ineligibility. Establishes a cause of action for services received because of a failure to report transfers at any time and makes other changes. Provides a July 1, 2003, effective date, to the extent permitted by federal law. Requires the commissioner to apply for necessary waivers and federal authority, if any provision in the section is not effective as of July 1, 2003, because of prohibitions in federal law.

28 **Homestead exception to transfer prohibition.** Amends § 256B.0595, by adding subd. 3b. Effective for transfers made on or after July 1, 2003, does not permit the transfer of the homestead to certain individuals but allows a transfer at less than fair market value if the individual demonstrates an intent to dispose of the homestead for fair market value or other valuable consideration, or the local agency grants a waiver because denial of eligibility would cause undue hardship and there is a threat to the individual's health and well-being. Provides a July 1, 2003, effective date, to the extent permitted by federal law. Requires the commissioner to apply for necessary waivers and federal authority, if any provision in the section is not effective as of July 1, 2003, because of prohibitions in federal law.

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29 **Other exceptions to transfer prohibition.** Amends § 256B.0595, by adding subd. 4b. Prohibits further transfers between spouses, once eligibility has been established and assets divided, and also prohibits assets transferred to a spouse from being transferred to another person at less than fair market value. Provides that assets or income transferred to a trust established for a disabled child revert to the state upon the child's death, to the extent MA has paid for services. Specifies other exceptions to the transfer prohibition. Provides a July 1, 2003, effective date, to the extent permitted by federal law. Requires the commissioner to apply for necessary waivers and federal authority, if any provision in the section is not effective as of July 1, 2003, because of prohibitions in federal law.

30 **Mental health case management.** Adds § 256B.0596. Requires counties to contract with eligible providers to provide mental health case management services, and specifies additional requirements for these providers.

31 **Citizenship requirements.** Amends § 256B.06, subd. 4. Beginning October 1, 2003, makes persons receiving services from the center for victims of torture who are otherwise ineligible for MA or GAMC eligible for MA without federal financial participation, for the period they are receiving services from the center. Exempts these individuals from participation in PMAP.

Strikes obsolete provisions and makes conforming changes.

32 **Eligibility; retroactive effect; restrictions.** Amends § 256B.061. Strikes a delayed verification provision that allows MA applicants meeting specified criteria (gross income and assets less than 90 percent of program limits; do not reside in a long-term care facility; meet all other eligibility requirements) to be determined eligible in the month of application, subject to providing all required verifications within 30 days. Provides an effective date of July 1, 2003, or upon federal approval.

33 **Intensive early intervention behavior therapy services.** Amends § 256B.0625, subd. 5a. Delays implementation of MA coverage of intensive early intervention behavior therapy for children with autism spectrum disorders until July 1, 2007, and makes a conforming change in the submittal date for a study on the effectiveness of the services.

34 **Dental services.** Amends § 256B.0625, subd. 9. Limits MA coverage of dental services for adults over age 21 who are not pregnant to diagnostic and preventative services, basic restorative services, and emergency services. Establishes a $500 annual benefit limit but excludes from this limit emergency services, dentures, and extractions related to dentures.

35 **Drugs.** Amends § 256B.0625, subd. 13. A new (b) limits the quantity of dispensed drugs to a 34-day supply, unless authorized by the commissioner.

A new (c) provides MA coverage for specified over-the-counter drugs, when prescribed by a licensed practitioner or by a licensed pharmacist who meets standards established by the commissioner, in consultation with the board of pharmacy. Requires licensed pharmacists, when prescribing over-the-counter drugs, to consult with the recipient to determine necessity, provide drug counseling, review drug therapy for potential adverse interactions, and make referrals as needed.

Subd. 13c. Formulary. Modifies the membership of the formulary committee and assigns additional duties to the committee.

Subd. 13d. Drug formulary. Prohibits the MA formulary from covering drugs used for weight loss but allows coverage of medically necessary lipase inhibitors for

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recipients with diabetes (current law prohibits inclusion of anorectics). Also makes various conforming changes.

Subd. 13e. Payment rates. Requires the commissioner to estimate the acquisition cost used in setting pharmacy reimbursement rates at AWP-11.5 percent (the formula in current law is AWP-9 percent).

Allows the commissioner to set maximum allowable costs for multisource drugs that are on the federal upper limit list (this is done by striking language that limits the commissioner to setting maximum allowable costs for drugs not on the federal upper payment list). Modifies the payment method for drugs with generic equivalents, by setting payment at the level of actual acquisition cost or the maximum allowable cost. Reinstates payment rate language stricken elsewhere in the section.

Subd. 13f. Prior authorization. The amendments to (a) and (b) require the formulary committee to establish general criteria to be used for prior authorization of brand-name drugs. Also strikes and reinstates in expanded and more detailed form procedures for prior authorization.

A new (c) exempts atypical antipsychotic drugs from prior authorization if there is no generically equivalent drug available; and the drug was initially prescribed for the recipient before July 1, 2003; or the drug is part of the recipient=s current course of treatment.

The amendment to (d) specifies that prior authorization for any antihemophilic factor drug where there is no generically equivalent drug available may only be imposed by the commissioner in conjunction with any supplemental drug rebate program or multistate preferred drug list established and administered by the commissioner. Extends the expiration date for this paragraph for two years until July 1, 2005.

A new (e) allows the commissioner to require prior authorization for brand name drugs whenever a generic product is available, even if the prescriber indicates "dispense as written – brand medically necessary."

Subd. 13g. Preferred drug list. Requires the commissioner to adopt and implement a preferred drug list by January 1, 2004. Allows the commissioner to contract with a vendor or one or more states. Establishes procedures for administration and modification of the preferred drug list. Requires the preferred drug list to be administered as part of the supplemental drug rebate program. Requires the commissioner to seek any necessary federal waivers or approvals.

36 **Transportation costs.** Amends § 256B.0625, subd. 17. Modifies reimbursement rates, procedures, and terminology for MA special transportation services. Specifies the following maximum reimbursement rates:

(1) $18 for the base rate and $1.40 per mile for services to persons who need a wheelchair-accessible van;

(2) $12 for the base rate and $1.35 per mile for services to persons who do not need a wheelchair-accessible van; and

(3) for all trips, a base rate of $36 and $1.40 per mile, and an attendant rate of $9 per trip, for persons who need a stretcher-accessible vehicle.

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Makes the requirement that a physician's order be provided to obtain special transportation services permissive. Requires providers to obtain written documentation of the time a recipient arrived at a health care provider for services. Prohibits providers from billing separate base rates for the continuation of trips beyond the original destination. Requires providers to use the most direct route.

37 **Medical assistance copayments.** Adds § 256B.0631. Establishes copayments for certain MA services.

Subd. 1. Co-payments. Establishes the following copayments, effective for services provided on or after October 1, 2003:

- $3 per nonpreventive visit
- $3 for eyeglasses
- $6 for nonemergency visits to a hospital-based emergency room
- $3 per brand-name prescription and $1 per generic prescription, subject to a $20 per month maximum. Prohibits copayments for antipsychotic drugs.

Subd. 2. Exceptions. Exempts the following individuals or services from copayments: children under age 21, pregnant women for services that relate to pregnancy or any other condition that may complicate a pregnancy, recipients expected to reside for 30 days in an institution, recipients receiving hospice care, 100 percent federally funded services provided by an Indian health service, emergency services, family planning, services paid for by Medicare for which MA pays the coinsurance and deductible, and copayments that exceed one per day per provider for nonpreventive visits, eyeglasses, and nonemergency visits to a hospital-based emergency room.

Subd. 3. Collection. Reduces MA reimbursement to providers by the amount of the copayment except when an individual has reached the $20 per month maximum for prescription drug copayments. States that providers collect copayments from recipients, and prohibits providers from denying services to individuals who are unable to pay the copayment, except as provided in subdivision 4.

Subd. 4. Uncollected debt. Allows providers to refuse services to individuals with uncollected copayments, if it is the routine business practice of the provider to refuse service to persons with uncollected debt.

38 **Increased employment.** Amends § 256B.0635, subd. 1. Makes the provision of extended MA to persons who lose eligibility due to an increase in hours of employment or employment income, or the loss of an earned income disregard, contingent upon federal funding.

39 **Increased child or spousal support.** Amends § 256B.0635, subd. 2. Makes the provision of extended MA to persons who lose eligibility due to the collection of child or spousal support contingent upon federal funding.

40 **Policy, applicability, purpose, and construction; definition.** Amends § 256B.15, subd. 1. Provides a statement of policy and applicability related to sections that follow dealing with estate recovery. The overall policy is that MA recipients and their spouses should use their own assets to pay their share of MA costs. This section also states that the modifications to recovery statutes are based on federal law on that topic but do not give rise to liens in favor of any parties not named in the statute. This section further provides that it modifies

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common law principles by continuing a recipient=s life estate or joint tenancy interest in real property after the recipient=s death. This section requires MA recovery laws and rules to be liberally construed to accomplish their intended purposes. This section also defines alternative care program payments as medical payments subject to an estate claim. This section, and sections 42 to 52, are effective August 1, 2003, and apply to estates of decedents who die on or after that date.

41 **Estates subject to claims.** Amends § 256B.15, subd. 1a. Makes a conforming change to refer to additional grounds for claims against estates. Also makes counties eligible for ten percent of collections for alternative care claims directly based on county effort.

42 **Notice of potential claim.** Amends § 256B.15, by adding subd. 1c. Allows a state agency to file a notice of potential claim anytime before or within one year after an MA recipient dies. Specifies procedures for filing a notice.

43 **Effect of notice.** Amends § 256B.15, by adding subd. 1d. Provides that once it takes effect, a notice shall be a notice that life estates and joint tenancy interests continue to exist, and are subject to liens and claims, and may be included in the recipient's estate.

44 **Full or partial release of notice.** Amends § 256B.15, by adding subd. 1e. Allows the claimant to fully or partially release a notice, and also modify or amend the recorded notice and related lien.

45 **Agency lien.** Amends § 256B.15, by adding subd. 1f. Provides that the notice constitutes a lien in favor of the department for a period of 20 years from the date of filing or the recipient's death, whichever is later. Provides that a recipient's life estate and joint tenancy interests shall not end upon the recipient's death. Specifies procedures for releasing liens, requesting hearings, and filing claims in cases of probate.

46 **Estate property.** Amends § 256B.15, by adding subd. 1g. Provides that if a claim is presented, interests or the proceeds of interests in real property a decedent owned as a life or joint tenant shall become part of the estate.

47 **Estates of specific persons receiving medical assistance.** Amends § 256B.15, by adding subd. 1h. Defines the estate and specifies other procedures for recipients who died single, or are the surviving spouse of a couple, and who are not survived by individuals from whom estate recovery is limited. Provides that the person's life estate or joint tenancy interest does not end at death but continues.

48 **Estates of persons receiving medical assistance and survived by others.** Amends § 256B.15, by adding subd. 1i. Defines the estate and specifies lien and claim procedures for recipients who are survived by a spouse, minor child, or child who is blind or disabled. Includes in the estate the recipient's life estate or joint tenancy interests in real property. Allows a claim to be filed against the estate and a lien to be placed. Provides that the lien is not enforceable until the surviving spouse has died or the decedent has no surviving child as described above.

49 **Claims in estates of decedents survived by other survivors.** Amends § 256B.15, by adding subd. 1j. Defines the estate and specifies lien and claim procedures for recipients who are survived by a child or grandchild who lived in the homestead and proved care to the recipient, or a sibling who lived in the homestead prior to the recipient's institutionalization and continuously since the date of institutionalization. Includes in the estate the recipient's life estate or join tenancy interests in real property. Allows a lien to be placed on the homestead if the estate does not have sufficient assets to pay the claim in full. Provides that the lien is not enforceable until the child, grandchild, or sibling no longer lives in the homestead or the homestead is sold or transferred.

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50 **Filing.** Amends § 256B.15, by adding subd. 1k. Specifies filing procedures for notices, liens, releases, and other documents.

51 **Surviving spouse, minor, blind, or disabled children.** Amends § 256B.15, subd. 3. Removes the ban on estate claims when the survivors include a child who is under age 21, or blind, or permanently disabled. This section allows claims in those situations under the new provisions established in the preceding sections.

52 **Other survivors.** Amends § 256B.15, subd. 4. Specifies procedures for delivering liens to the county agency against homestead property, if there is an unpaid balance to a claim and a claim is limited to nonhomestead property due to a decedent being survived by certain individuals.

53 **Payments to certain safety net providers.** Amends § 256B.195, subd. 3. Allocates any extra money received through hospital intergovernmental transfers as a result of the 5 percent reduction in inpatient hospital payment rates. If Fairview University Medical Center is included in the IGT, the money is allocated to the largest 10 percent of hospitals measured by 2001 state health care program payments in the nonstate government hospital category, in proportion to each hospital's share of those payments. If Fairview University Medical Center is not included in the IGT, the money is allocated to the largest 10 percent of hospitals measured by 2001 state health care program payments in the nonstate government and nongovernment hospital categories, in proportion to each hospital's share of those payments.

54 **Inclusion of Fairview University Medical Center.** Amends § 256B.195, subd. 5. Modifies the allocation of any money received from inclusion of Fairview University Medical Center in an intergovernmental transfer. Requires 29 percent of the transfer plus federal matching funds to be paid to the largest 10 percent of hospitals in the nongovernment hospital category, based on each hospital's share of state health care program payments in 2001.

55 **Facility fee payment.** Amends § 256B.32, subd. 1. Reduces MA and GAMC fee-for-service facility fee payments to hospitals for outpatient hospital facility services by 5 percent, effective for services provided on or after July 1, 2003. Exempts services provided by Indian health service facilities from this reduction.

56 **Definitions.** Amends § 256B.69, subd.2. Strikes a provision that allows MA enrollees who fail to submit income reports or recertification forms in a timely manner to continue to receive MA services from a prepaid health plan through the last day of the month in which the enrollee became ineligible.

57 **Limitation of choice.** Amends § 256B.69, subd. 4. Requires the commissioner to exempt from PMAP persons with access to cost-effective employer-sponsored insurance or persons enrolled in an individual health plan determined to be cost-effective. Permits the commissioner to enroll into PMAP seniors who are age 65 or over and who are eligible for MA by spending down excess income.

58 **Prospective per capita payments.** Amends § 256B.69, subd. 5. Permits the commissioner beginning July 1, 2004, to include payments for elderly waiver services and 180 days of nursing home care in the capitation rates for PMAP for seniors. Requires payments for elderly waiver services to be made no earlier than the month following the month in which the services were received.

59 **Managed care contracts.** Amends § 256B.69, subd. 5a. Authorizes the commissioner to issue separate contracts with requirements specific to services to MA recipients age 65 and older. Sets criteria for managed care plan performance targets. Allows county-based purchasing plans to include as admitted assets withhold amounts expected to be returned.

60 **Medical education and research fund.** Amends § 256B.69, subd. 5c. Effective July 1, 2003, requires that portion of GAMC capitation payments that would otherwise be

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transferred to the medical education and research fund to be transferred to the general fund. This section also reduces the amount carved out of the PMAP capitation rates and transferred to the commissioner of health for the medical education and research fund (this reduction is due to the reduction of the appropriation from the health care access fund to the university for physician training).

61 **Payment reduction.** Amends § 256B.69, by adding subd. 5h. Reduces MA payments to managed care plans by 1.0 percent for services provided on or after October 1, 2003, and an additional 1.0 percent for services provided on or after January 1, 2004. Excludes payments for nursing home services, home and community-based waivers, and payments to demonstration projects for persons with disabilities.

62 **Nursing home services.** Amend § 256B.69, subd. 6a. Requires up to 180 days of nursing facility services to be covered under PMAP for individuals who are not residing in a nursing facility at the time of PMAP enrollment. (Current law requires up to 90 days.) Permits the commissioner to develop a schedule to phase in implementation of this provision.

63 **Home and community-based waiver services.** Amends § 256B.69, subd. 6b. Requires elderly waiver services to be covered under PMAP for all individuals who are eligible according to section 256B.0915. Permits the commissioner to develop a schedule to phase in implementation of these waiver services.

64 **Prescription drugs.** Amends § 256B.69, by adding subd. 6d. Permits the commissioner, effective January 1, 2004, to exclude or modify coverage for prescription drugs from the prepaid managed care contracts. States that this subdivision is contingent on federal approval and the collection of additional prescription drug rebates.

65 **Preadmission screening waiver.** Amends § 256B.69, subd. 8. Waives preadmission screening for senior recipients enrolled in PMAP.

66 **Hospital outpatient reimbursement.** Amends § 256B.75. Reduces MA and GAMC fee-for-service facility fee payments to hospitals for outpatient hospital facility services by 5 percent, effective for services provided on or after July 1, 2003. Exempts services provided by Indian health service facilities from this reduction.

67 **Physician and dental reimbursement.** Amends § 256B.76. Requires the commissioner, for services provided on or after January 1, 2007, to make payments for physician and professional services based on Medicare relative value units. Requires the change to be budget neutral and that the cost of implementing relative value units be incorporated in the conversion factor.

68 **General assistance medical care; eligibility.** Amends § 256D.03, subd. 3. Modifies eligibility for GAMC.

The amendment to (a) limits GAMC eligibility, effective October 1, 2003, to: (1) persons receiving general assistance or group residential housing payments; (2) Minnesota residents with gross incomes that do not exceed 75 percent of FPG, and assets that do not exceed $1,000 per assistance unit; and (3) Minnesota residents with gross incomes greater than 75 percent but not exceeding 175 percent of FPG, with assets not exceeding the MA asset limit for families, who apply during an inpatient hospitalization. Effective October 1, 2003, eliminates GAMC eligibility for individuals who spend-down to the GAMC level, reside in institutions for mental diseases, or are served by the center for victims of torture.

The amendment to (b) makes a conforming change related to paragraph (a).

The amendment to (c) provides that for applications received on or after October 1, 2003,

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eligibility may begin no earlier than the date of application (one-month retroactive coverage is eliminated). Requires individuals who apply during an inpatient hospitalization to reapply if there is a subsequent period of hospitalization.

The amendment to (d) eliminates delayed verification, by striking language allowing eligibility to be granted to certain individuals, subject to the provision of all required verifications within 30 days. Also clarifies the procedure by which a health care provider can act on an applicant's behalf to establish the date of an initial application. These provisions are effective July 1, 2003.

The amendment to (g) eliminates a reference to emergency GAMC, effective July 1, 2003.

The amendment to (h) adds a conforming cross-reference.

The amendment to (j) eliminates GAMC coverage for undocumented noncitizens and nonimmigrants, effective July 1, 2003, except that individuals receiving services from the center for victims of torture remain eligible through September 30, 2003.

The amendment to (k) eliminates the definition of emergency services, effective July 1, 2003.

A new (l) eliminates GAMC emergency services, effective July 1, 2003.

69 **General assistance medical care; services.** Amends § 256D.03, subd. 4. The amendment to (a) modifies GAMC benefits for enrollees with incomes not exceeding 75 percent of FPG, by limiting coverage of dental services and dentures to the level of coverage provided under MA, and specifying that coverage of medical transportation excludes special transportation. Effective October 1, 2003, provides that GAMC benefits for enrollees with incomes greater than 75 percent but not exceeding 175 percent of FPG, who apply during an inpatient hospitalization, are limited to inpatient hospital services, including physician services provided during an inpatient hospital stay. Requires a $1,000 deductible for each inpatient hospitalization.

The amendment to (b) strikes language as a conforming change related to the modification of GAMC benefits for persons enrolling during an inpatient hospitalization.

The amendment to (c) eliminates a provision that allows GAMC enrollees who fail to submit income reports or certification forms in a timely manner to continue to receive GAMC services from a prepaid health plan through the last day of the month in which the enrollee became ineligible. Also removes the restriction on requiring GAMC enrollees to pay copayments.

A new (d) establishes the following copayments, effective for services provided on or after October 1, 2003 to GAMC enrollees with incomes not exceeding 75 percent of FPG:

- $3 per nonpreventive visit
- $25 for eyeglasses
- $25 for nonemergency visits to a hospital-based emergency room

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- $3 per brand-name prescription and $1 per generic prescription, subject to a $20 per month maximum. Prohibits copayments for antipsychotic drugs
- 50 percent coinsurance on basic restorative dental services.

A new (e) reduces GAMC reimbursement to providers by the amount of the copayment, except when a recipient has reached the $20 per month maximum for prescription drug copayments. States that providers collect copayments from recipients, and prohibits providers from denying services to individuals who are unable to pay the copayment, except as provided in paragraph (f).

A new (f) allows providers to refuse services to individuals with uncollected copayments, if it is the routine business practice of the provider to refuse service to persons with uncollected debt.

A new (k) reduces GAMC inpatient and outpatient payments by 5 percent, effective July 1, 2003, and specifies that this is in addition to an existing 5 percent reduction also effective on that date.

A new (l) reduces GAMC payments for all health care services (except inpatient, outpatient, and pharmacy) by 5 percent, effective July 1, 2003.

A new (m) reduces GAMC payments to managed care plans by 5 percent, effective for services provided on or after October 1, 2003.

A new (n) allows hospitals receiving reduced payments to apply the unpaid balance toward satisfaction of the hospital's bad debts.

70 **Non-Minnesota residents.** Amends § 256G.05, subd. 2. Makes a conforming change related to the elimination of emergency GAMC.

71 **Covered health services.** Amends § 256L.03, subd. 1. Modifies MinnesotaCare coverage of dental services for adults, by setting coverage at the level provided under MA for adults. Makes conforming changes related to limited benefits coverage for single adults and households without children with incomes above 75 percent but not exceeding 175 percent of FPG.

72 **Limited benefits coverage for certain single adults and households without children.** Adds § 256L.035. (a) Defines covered health services for MinnesotaCare enrollees who are single adults or households without children, with incomes greater than 75 percent but not exceeding 175 percent of FPG, as:

(1) inpatient hospital benefits with a 10 percent copayment up to $10,000 and subject to an annual limit of $10,000;

(2) physician services provided during an inpatient stay;

(3) physician services not provided during an inpatient stay, outpatient hospital services, chiropractic services, lab and diagnostic services, and prescription drugs, subject to an aggregate cap of $2,000 per calendar year and copayments of $50 per emergency room visit, $3 per prescription drug, and $5 per nonpreventive physician visit. (The aggregate cap has been increased to $5,000 as a result of the receipt of federal funds; see the rider in article 13C, section 2, subdivision 1.)

(b) Requires the November 2006 MinnesotaCare forecast for the biennium beginning July 1, 2007 to assume an adjustment on the $2,000 cap on specified services, in $1,000 increments

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up to a maximum of $10,000 but not less than $2,000, to the extent that the balance in the health care access fund is sufficient in each year of the biennium to pay for this benefit level. Requires the aggregate cap to be adjusted according to the forecast.

(c) Reduces MinnesotaCare reimbursement to providers by the amount of the copayment, except when an enrollee has reached the $20 per month maximum for prescription drug copayments. States that providers collect copayments from recipients, and prohibits providers from denying services to individuals who are unable to pay the copayment, except as provided in (d).

(d) Allows providers to refuse services to individuals with uncollected copayments, if it is the routine business practice of the provider to refuse service to persons with uncollected debt.

73 **Families with children.** Amends § 256L.04, subd. 1. Effective October 1, 2003, eliminates dependent siblings as a MinnesotaCare eligibility category. Allows these individuals to apply as a separate household, rather than being counted in the parental household. Effective July 1, 2003, or upon federal approval, whichever is later, prohibits parents from remaining enrolled in MinnesotaCare if their gross household income exceeds $50,000.

74 **Citizenship requirements.** Amends § 256L.04, by adding subd. 10. Limits MinnesotaCare eligibility to citizens, qualified noncitizens, and other persons lawfully residing in the U.S., and states that undocumented noncitizens and nonimmigrants are not eligible.

75 **Renewal of eligibility.** Amends § 256L.05, subd. 3a. Beginning October 1, 2004, requires enrollee eligibility to be renewed every six months and specifies procedures for renewals. (Under current law, eligibility is reviewed every 12 months.)

76 **Application processing.** Amends § 256L.05, subd. 4. Eliminates a delayed verification provision that allows individuals who appear to meet eligibility requirements to enroll in MinnesotaCare subject to timely payment of premiums, and to remain enrolled if all required verifications are provided within 30 days. Provides an effective date of July 1, 2003, or upon federal approval, whichever is later.

77 **Commissioner's duties and payment.** Amends § 256L.06, subd. 3. Eliminates the option for enrollees to pay MinnesotaCare premiums on an annual basis, but adds the option of paying premiums on a semiannual basis.

78 **General requirements.** Amends § 256L.07, subd. 1. Eliminates the July 1, 2003 increase, from 150 percent to 175 percent of FPG, in the maximum income limit at which children are exempt from the requirement that they not have access to employer-subsidized insurance. Also provides an exemption from the four-month uninsured requirement for this group. Effective October 1, 2003, limits the MCHA exemption for persons whose income increases above program income limits to families. Effective February 1, 2004, limits the exemption to children, and reduces the notice period from 18 to 12 months.

79 **Other health coverage.** Amends § 256L.07, subd. 3. Eliminates the July 1, 2003 increase, from 150 percent to 175 percent of FPG, in the income limit at which children can remain or become eligible for MinnesotaCare while having other health insurance lacking certain types of coverage. Effective October 1, 2003, exempts individuals with cost-effective coverage paid for by MA from the four-month uninsured requirement.

80 **Copayments and benefit limits.** Amends § 256L.12, subd. 6. Corrects a cross-reference.

81 **Rate setting; performance withholds.** Amends § 256L.12, subd. 9. For services provided on or after January 1, 2004, requires the commissioner to withhold five percent of managed

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care plan payments, pending completion of performance targets. Sets criteria for performance targets. Allows managed care and county-based purchasing plans to include as admitted assets withhold amounts expected to be returned.

82 **Rate setting; ratable reduction.** Amends § 256L.12, by adding subd. 9a. Reduces total MinnesotaCare payments to managed care plans by 1.0 percent, for services provided on or after October 1, 2003.

83 **Premium determination.** Amends § 256L.15, subd. 1. Makes a conforming change in a cross-reference.

84 **Sliding fee scale to determine percentage of gross individual or family income.** Amends § 256L.15, subd. 2. Effective October 1, 2003, requires the commissioner to increase each percentage in the sliding scale by 0.5 percentage points for enrollees with incomes greater than 100 percent but not exceeding 200 percent of the federal poverty guidelines, and to increase each percentage by 1.0 percentage points for families and children with incomes greater than 200 percent of the federal poverty guidelines. Effective February 1, 2004, requires children in families with gross incomes above 275 percent of FPG to pay the maximum premium.

85 **Exceptions to sliding scale.** Amends § 256L.15, subd. 3. Eliminates the July 1, 2003 increase, from 150 percent to 175 percent of FPG, in the income limit for children paying $48 annual premiums.

86 **Limit on total assets.** Amends § 256L.17, subd. 2. Effective July 1, 2003, reduces the MinnesotaCare asset limit to $20,000 for a household of two or more persons and $10,000 for a household of one (under current law, these asset limits are $30,000 and $15,000).

87 **Exemptions.** Amends § 295.53, subd. 1. Removes the exemption for payments received by providers under MA, GAMC, and Minnesota Care for purposes of taxable revenue under the provider tax.

88 **Government payments.** Amends § 297I.15, subd. 1. Eliminates the exemption from premium taxes for MA, GAMC, and MinnesotaCare.

89 **Premiums paid to health carriers by the state.** Amends § 297I.15, subd. 4. Specifies that premiums paid by the MA, GAMC, and MinnesotaCare programs to health carriers are not exempt from premium taxes.

90 **Time limits; claim limits; liens on life estates and joint tenancies.** Amends § 514.981, subd. 6. Expands the MA lien law by creating a lien on life estates and joint tenant interests. This section provides that an MA recipient=s life estate or interest in real property as a joint tenant does not end when the recipient dies if the interest is subject to an MA lien. A formula is provided for determining the value of these life estates and joint tenancies. Liens on these interests are exempt from certain provisions regarding lien release and lien time limits that apply to other liens. This section notes that it modifies common law principles under which these interests terminate upon death.

91 **Medical aid.** Amends § 641.15, subd. 2. Prohibits the Anoka county board from paying providers, for medical services provided to prisoners, at levels higher than the maximum allowed MA rate for a service.

92 **Pharmacy plus waiver.** Directs the commissioner of human services to seek a pharmacy plus waiver that uses the accumulated savings from the pharmacy and asset transfer provisions of the act, and previously adopted pharmacy savings strategies, as the factor to prove fiscal neutrality. If the waiver is approved and federal funds are received, requires the commissioner to expand prescription drug program eligibility by first increasing the income limit for the elderly to 135 percent of FPG and then increasing the income limit for disabled persons to 135 percent of FPG. Requires the commissioner to publish the new eligibility

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levels in the *State Register* and inform relevant organizations.

93 **Review of special transportation eligibility criteria and potential cost savings.** Requires the commissioner of human services, in consultation with the commissioner of transportation and special transportation service providers, to review eligibility criteria for MA special transportation services and methods for reducing the cost of special transportation services. Requires the commissioner to present recommendations to specified legislative chairs by January 15, 2004. Prohibits the commissioner from using a broker or coordinator to manage special transportation services until July 1, 2005, except to check eligibility, authorize the level of service, and monitor provider compliance. Exempts the purchase or management of common carrier transportation from this prohibition.

94 **Federal approval.** Requires the commissioner of human services to seek federal authority and waivers necessary for implementation, if the amendments to sections 256.046, subdivision 1 (fraud disqualification hearings for health care program enrollees) and 256.98, subdivision 8 (authority to disqualify health care program enrollees for wrongfully obtaining benefits) are not effective because of prohibitions in federal law.

95 **Withhold exemption.** Permits the commissioner of human services to exempt certain managed care plans from the five percent withhold required under section 256B.69, subdivision 5a, and the 1.0 percent withhold required under section 256L.12, subdivision 9

96 **Drug purchasing program.** Requires the commissioner of human services, in consultation with other state agencies, to evaluate whether participation in a multistate or multiagency drug purchasing program can reduce costs or improve the operations of drug benefit programs administered by the state. Recommendations must be submitted to the legislature by January 15, 2004.

97 **Mail order dispensing of prescription drugs.** Requires the commissioner of human services to assess the cost savings that could be generated by the mail order dispensing of prescription drugs to recipients of MA, GMAC, and the prescription drug program. The commissioner must report to the Legislature by January 7, 2004.

98 **Nonprofit foundation grants.** Permits the commissioner of human services to accept grants or donations from a nonprofit charitable foundation for purposes of increasing dental access in the MA program. Allows the commissioner to increase critical access dental payments.

99 **Pharmaceutical care demonstration project.** Requires the commissioner of human services to seek federal approval for a demonstration project to provide culturally specific pharmaceutical care to American Indian medical assistance recipients who are age 55 or older. Defines pharmaceutical care. Upon receipt of federal approval, requires the commissioner to seek legislative approval for implementation.

100 **Health care program reductions.** Allows the commissioner of human services to implement changes to state health care programs to reduce state expenditures during the period July 1, 2004 through June 30, 2005. Allows the commissioner to: (1) require providers to use practice guidelines; (2) implement clinical care coordination programs; and (3) volume purchase services. Requires the commissioner to notify the chairs of the house and senate health and human services finance committees of any changes implemented.

101 **Repealer.** (a) Repeals sections 256.955, subd. 8 (annual report on the prescription drug program); and 256B.057, subd. 1b (MA eligibility for two years for auto-newborns), effective July 1, 2003.

(b) Repeals section 256B.055, subd. 10a (MA eligibility for two years for auto-newborns), effective July 1, 2003, or upon federal approval, whichever is later.

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Articles 13A, 13B and 13C: Appropriations

Overview

These articles reflect forecast adjustments for the remainder of fiscal year 2003 and appropriate money for the Department of Human Services, Department of Health, the health-related boards, and other councils and boards for fiscal years 2004 and 2005.

Article 13A: Health and Human Services Forecast Adjustments

1 **Health and human services appropriations.** Adjusts fiscal year 2003 appropriations from the general fund, the health care access fund, and the federal TANF fund.

2 **Commissioner of human services.** Adjusts fiscal year 2003 appropriations to the commissioner of human services from the general fund, the health care access fund, and the federal TANF fund.

3 **Commissioner of health.** Adjusts fiscal year 2003 appropriations to the commissioner of health from the general fund.

4 **Effective date.** Effective the day following final enactment.

Article 13B: Department of Children, Families, and Learning Forecast Adjustments

1 **Adjustment.** Adjusts fiscal year 2003 appropriations from the general fund.

2 **Appropriations; early childhood and family education.** Adjusts fiscal year 2003 appropriations to the commissioner of children, families and learning for MFIP child care.

Article 13C: Appropriations

1 **Health and Human Services Appropriations.** Appropriates general revenue, state government special revenue, health care access, federal TANF, and lottery prize funds to the agencies and for the purposes specified for fiscal years 2004 and 2005.

2 **Commissioner of Human Services.**

Subd. 1. Total appropriation. Appropriates general revenue, state government special revenue, health care access, federal TANF, and lottery cash flow funds to the commissioner in fiscal years 2004 and 2005.

- Appropriates additional federal Medicaid funds to the commissioner for use in the state's medical assistance and MinnesotaCare programs. Describes how the funds must be used.
- Requires appropriations and federal receipts for information systems for MAXIS, PRISM, MMIS, and SSIS to be deposited in the state system account. Allows money appropriated for computer projects to be transferred from one project to another and from development to operations as the commissioner considers necessary. Makes any unexpended balance in these appropriations

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available for ongoing development and operations.

- Allows the commissioner to accept gifts on behalf of the state for the purpose of financing the cost of assistance program grants or nongrant administration.
- Allows the commissioner to use available grant appropriations under certain circumstances to insure continuity of payments to clients served by human services programs.
- Allows the nonfederal share of activities for which federal administrative reimbursement is appropriated to be transferred to the special revenue fund.
- Requires any expenditures from the TANF block grant to be expended in accordance with the requirements and limitations of any applicable federal laws or requirements. Cancels any unexpended TANF funds appropriated to any state, local, or nonprofit entity at the end of the fiscal year, unless appropriating language permits otherwise.
- Requires the commissioner to authorize transfers from TANF to other federal block grants. Requires the commissioner to preserve the future potential transfer capacity from TANF to other block grants.
- Limits the allowable activities that may be reported as fulfilling the nonfederal TANF maintenance of effort (MOE). Lists the allowable activities. Requires the commissioner to ensure that sufficient qualified nonfederal expenditures are made each year to meet the state's TANF MOE requirements. Makes this clause expire June 30, 2007.
- Allows state agencies and constitutional offices to carry forward unexpended and unencumbered nongrant operating balances from FY 2003 general fund appropriations into FY 2004 to affect general budget reductions.
- Allows the commissioner to transfer unencumbered appropriation balances for the biennium ending June 30, 2003, between certain programs and between fiscal years of the biennium.
- Prohibits TANF funds appropriated to the department of trade and economic development and to the job skills partnership board from being available until expended. As of June 30, 2003, any un-obligated TANF funds will cancel to the TANF fund.
- Requires the commissioner to make up to 100 percent of the calendar year 2005 payments to counties for developmental disabilities semi-independent living services grants, developmental disabilities family support grants, and adult mental health grants from fiscal year 2006 appropriations. Clarifies that this is a one-time shift. Makes this clause expire June 30, 2006.
- Requires that fiscal year 2004 and 2005 health care access fund appropriations to the University of Minnesota be used to increase MA capitation payments.

Subd. 2. Agency management. Appropriates general revenue, state government special revenue, health care access, and federal TANF, for agency management in fiscal years 2004 and 2005.

- Requires the commissioner to transfer $1.4 million of uncommitted special revenue fund balances to the general fund.

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Subd. 3. Revenue and pass-through.

- Transfers federal TANF funds to the Social Services Block Grant in fiscal year 2005 to provide services for families with children whose incomes are at or below 200 percent of the federal poverty guidelines.
- Makes available to the commissioner federal TANF funds in fiscal years 2006 and 2007 to replace general funds.
- Reduces transfers to the child care development fund in fiscal year 2004 and increases transfers in 2005 for the purposes of MFIP child care.

Subd. 4. Children's services grants. Appropriates general funds and federal TANF funds in fiscal years 2004 and 2005 for children's services grants.

- Appropriates federal funds available during fiscal years 2004 and 2005 for adoption incentive grants.
- Permits commissioner to transfer unencumbered balances for adoption assistance and relative custody assistance between fiscal years and programs.
- Prohibits counties from reducing children and community service grants for services to adults with disabilities by more than the overall percentage of the reduction in the county's allocation of these funds when compared to the previous allocation.
- Requires Minnesota youth who need out-of-home placement through a corrections order to be placed in a Minnesota program or facility, unless a program in a border state is closer to the youth's home or there is no vacancy in an appropriate in-state program or facility.

Subd. 5. Children's services management. Appropriates general funds in fiscal years 2004 and 2005 for children's services management.

Subd. 6. Basic health care grants. Appropriates general funds and health care access funds in fiscal years 2004 and 2005 for MinnesotaCare grants, MA basic health care grants, GAMC grants, other health care grants, and for the prescription drug program.

- Makes annual updates to the federal poverty guidelines effective each July 1.
- Requires receipts received as a result of federal participation pertaining to administrative costs of the Minnesota health care reform waiver to be deposited as nondedicated revenue in the health care access fund. Requires receipts received as a result of federal participation pertaining to grants to be deposited in the federal fund and used to offset health care access funds for payments to providers.
- Allows the commissioner to expend money from the health care access fund for MinnesotaCare in either fiscal year of the biennium.
- Requires the commissioner to use available federal funds for the SCHIP program for medical assistance services for pregnant women who are not otherwise eligible for federal financial participation.
- Requires the commissioner to increase the total payments to managed care plans by an amount equal to the cost increases due to several factors.

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- Delays the last payment to providers for medical assistance and general assistance medical care services in fiscal year 2005. Requires this payment to be included in the first payment in fiscal year 2006.
- Requires the commissioner to transfer funds to the deaf and hard-of-hearing grants if the service provider is not able to earn a certain amount through participation in medical assistance intensive rehabilitation services.
- Appropriates general funds for the prescription drug dedicated funds.
- Prohibits unspent 2002 and 2003 dental access grant funds from canceling and allows the funds to be carried forward.
- Limits the use of appropriations to the stop-loss fund account.
- Appropriates $1.589 million for the prescription drug assistance program.
- Appropriates rebate revenues from drug manufacturers to the commissioner to augment funding of the prescription drug program.

Subd. 7. Health care management. Appropriates general funds and health care access funds in fiscal years 2004 and 2005 for health care policy administration and health care options.

- Earmarks funds for a study to determine the appropriateness of eliminating reimbursement for certain payment codes under certain programs. Requires the commissioner to examine covered services under the health care programs and make recommendations on possible modifications of the services covered. Requires the commissioner to report to the legislature by January 15, 2005.
- Requires excess annual funds in the health care access fund to be transferred to the general fund on June 30 of FY 2005, 2006, and 2007. Lists estimated transfer amounts.
- Appropriates federal administrative reimbursements.
- Eliminates state funding for the nonfederal share of prepaid medical assistance program administration costs for county managed care advocacy and enrollment operations for counties in which this program has been operation for 12 or more months.

Subd. 8. State-operated-services. Appropriates general funds for fiscal years 2004 and 2005 for state-operated-services.

- Allows money appropriated to finance mitigation expenses related to restructuring state-operated services to be transferred between fiscal years.
- Allows the commissioner to transfer unencumbered appropriation balances between fiscal years for the state residential facilities repairs and betterment account and special equipment.
- Makes a one-time transfer of funds from state-operated services to the general fund.

Subd. 9. Continuing care grants. Appropriates general funds and lottery prize funds for community social services, aging and adult service grants, deaf and hard-of-hearing service grants, mental health grants, community support grants, MA long-term care waivers and home care grants, MA long-term care facilities grants, alternative

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care grants, group residential housing grants, and chemical dependency entitlement and nonentitlement grants.

- Allows the commissioner to use funds appropriated for a long-term care report for that purpose in 2005.
- Reduces funding by 15 percent for the SAIL project grants, senior nutrition programs, foster grandparents program, retired senior volunteer program, and the senior companion program.
- Allows the commissioner to make budget neutral transfers to effectively implement the restructuring of adult mental health services.
- Earmarks funds for compulsive gambling programs.
- Effective July 1, 2003, requires the commissioner to reduce payment rates for services and individual or service limits by 1 percent for home- and community-based waivered services for the elderly, DT&H services for adults with MR/RC, the group residential housing supplementary service rate, chemical dependency service rates, consumer support grants, and home- and community-based services for alternative care services. Requires the commissioner to reduce allocations made to county agencies to assure a 1 percent reduction in state spending for MR/RC, CADI, CAC, and TBI services.
- Requires the commissioner, in consultation with others, to study the financing of centers for independent living. Lists required study components.
- Requires the commissioner to reduce the growth in the MR/RC waiver by not allocating the 300 additional diversion allocations that are included in the February 2003 forecast for fiscal years 2004 and 2005.
- Requires the commissioner to allocate money for the TBI waiver so that the caseload growth for this program assures a reduction in state spending that is equivalent to limiting the caseload growth to 150 in each year of the biennium. Sets priorities for the allocation of funds.
- Delays targeted case management benefits for home care recipients until July 1, 2005.
- Delays implementation of the common service menu option within the home and community-based waivers until July 1, 2005.
- Requires the commissioner to limit allocations made available in the CADI wavier program in order not to exceed average caseload growth of 95 per month from June 2003 program levels, plus any additional legislatively authorized program growth. Requires the commissioner to allocate available resources to achieve certain outcomes.
- Transfers any money that is not spent in the alternative care program to the medical assistance account. Gives the commissioner carry forward authority for the funds appropriated for the alternative care program. Changes premiums and eligibility for alternative care.
- Increases the home and community-based service rates and county allocations provided to group residential housing effective July 1, 2004.

Subd. 10. Continuing care management. Appropriates general funds, state

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government special revenue funds, and lottery prize funds for fiscal years 2004 and 2005 for continuing care management.

Subd. 11. Economic support grants. Appropriates general funds and federal TANF funds for fiscal years 2004 and 2005 for the MFIP program, work grants, other economic support grants, child support enforcement grants, general assistance grants, and Minnesota supplemental aid grants.

- Sets the monthly standard of assistance for general assistance units at $203. Allows the commissioner to reduce this amount.
- Creates an allocation formula for FY 2004-2005 for the consolidated MFIP support services grant.
- Earmarks general funds for the supportive housing and managed care pilot project. Prohibits this appropriation from becoming part of base level funding for the biennium beginning July 1, 2007.
- Limits the amount appropriated for emergency general assistance and emergency Minnesota supplemental aid.

Subd. 12. Economic support management. Appropriates general funds, health care access funds, and federal TANF funds for fiscal years 2004 and 2005 for economic support policy administration and economic support operations.

- Appropriates federal Food Stamp program enhanced funding to the commissioner. Creates an allocation formula for the funds.
- Requires the commissioner to deposit payments received for services performed by the child support payment center in the state systems account. Appropriates these payments for the operation of the child support payment center.
- Requires the commissioner to transfer $247,000 of child support cost recovery fees collected in FY 2005 to the PRISM special revenue account.
- Authorizes the commissioner to allocate up to $310,000 in each fiscal year 2004-2005 from the PRISM special revenue account to financial institutions for performing data matches.
- Allows for the transfer of accounts from other sate agencies to DHS.

3 Commissioner of health.

Subd. 1. Total appropriation. Appropriates general funds, state government special revenue funds, health care access funds, and federal TANF funds for fiscal years 2004 and 2005 to the commissioner of health.

Subd. 2. Health improvement. Appropriates general funds, state government special revenue funds, health care access funds, and federal TANF funds for fiscal years 2004 and 2005 for health improvement.

- Transfers funds from the tobacco use prevention and local public health endowment expendable trust fund to the general fund and the special revenue fund.
- Makes TANF funds available for home visiting and nutritional activities and eliminating health disparities. Authorizes carry forward of unexpended TANF

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funds from one year of the biennium to the next.

- Allows carry forward of funds appropriated for children with special health needs.
- On July 1, 2003, transfers the tobacco use prevention and local public health endowment fund and the medical education endowment fund to the general fund.

Subd. 3. Health quality and access. Appropriates general funds, state government special revenue funds, and health care access funds for fiscal years 2004 and 2005.

- Transfers $4 million from the special revenue fund to the general fund on July 1, 2003.
- Authorizes the commissioner to expend up to $230,000 from the FY 2003 special revenue appropriation for nursing home regulation for certain costs and under certain conditions.
- Requires review of current licensure provisions and report to the legislature by November 1, 2004.
- Appropriates funds in the medical education expendable trust fund to the commissioner.

Subd. 4. Health protection. Appropriates general funds and state government special revenue funds for fiscal years 2004 and 2005 for health protection.

Subd. 5. Management and support services. Appropriates general funds for fiscal years 2004 and 2005 for management and support services.

4 **Veteran's nursing homes board.** Appropriates general funds for fiscal years 2004 and 2005 for the veteran's home board. Allows the general fund appropriations to be transferred to a veterans homes special revenue account.

5 **Health related boards.**

Subd. 1. Total appropriations. Appropriates funds in fiscal years 2004 and 2005 for the health related boards.

- Clarifies that these appropriations are from the special revenue fund, except where noted.
- Prohibits the commissioner from permitting expenditures in excess of anticipated biennial revenues or accumulated surpluses.
- Transfers funds from the special revenue fund to the general fund on July 1, 2003.

Subd. 2. Board of chiropractic examiners. Appropriates funds in fiscal years 2004 and 2005.

- Transfers funds to pay for contested case activity.

Subd. 3. Board of dentistry. Appropriates special revenue funds and health care access funds in fiscal years 2004 and 2005.

Subd. 4. Board of dietetic and nutrition practice. Appropriates funds in fiscal years 2004 and 2005.

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Subd. 5. Board of marriage and family therapy. Appropriates funds in fiscal years 2004 and 2005.

Subd. 6. Board of medical practice. Appropriates funds in fiscal years 2004 and 2005.

Subd. 7. Board of nursing. Appropriates funds in fiscal years 2004 and 2005.

Subd. 8. Board of nursing home administrators. Appropriates funds in fiscal years 2004 and 2005.

Subd. 9. Board of optometry. Appropriates funds in fiscal years 2004 and 2005.

Subd. 10. Board of pharmacy. Appropriates funds in fiscal years 2004 and 2005.

- Earmarks funds for the health boards administrative services unit.

Subd. 11. Board of physical therapy. Appropriates funds in fiscal years 2004 and 2005.

Subd. 12. Board of podiatry. Appropriates funds in fiscal years 2004 and 2005.

Subd. 13. Board of psychology. Appropriates funds in fiscal years 2004 and 2005.

Subd. 14. Board of social work. Appropriates funds in fiscal years 2004 and 2005.

Subd. 15. Board of veterinary medicine. Appropriates funds in fiscal years 2004 and 2005.

Subd. 16. Board of behavioral health and therapy. Appropriates funds in fiscal years 2004 and 2005.

- Clarifies that this amount is from the special revenue fund and is in addition to other appropriations.

6 Emergency medical services board.

Subd. 1. Total appropriations. Appropriates general funds and state government special revenue funds for fiscal years 2004 and 2005 for the emergency medical services board.

- Earmarks funds for the health professional services activity.
- Limits the amount of money that may be used for administrative costs for the comprehensive advanced life support program.
- Appropriates royalty payments from the sale of the Internet-based ambulance reporting program to the board.
- Earmarks funds for emergency medical services regional grants.
- Prohibits ambulance training grant funds from canceling and requires they carry forward.

7 Council on disability. Appropriates general funds for fiscal years 2004 and 2005 for the Council on Disability.

8 Ombudsman for mental health and mental retardation. Appropriates general funds for

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fiscal years 2004 and 2005 for the ombudsman for mental health and mental retardation.

9 **Ombudsman for families.** Appropriates general funds for fiscal years 2004 and 2005 for the ombudsman for families.

10 **Department of children, families, and learning.**

Subd. 1. Total appropriation. Appropriates general funds, federal TANF funds, and special revenue funds in fiscal years 2004 and 2005.

Subd. 2. Child care. Appropriates general funds in fiscal years 2004 and 2005 for basic sliding fee child care, MFIP child care, child care program integrity, and child care development.

Subd. 3. Child care assistance special revenue account. Appropriates special revenue account funds in fiscal years 2004 and 2005 for child care assistance. Makes a one-time transfer of $1.8 million from the special revenue fund to the general fund on July 1, 2003.

Subd. 4. Child care assistance TANF funds. Appropriates federal TANF funds in fiscal years 2004 and 2005 for basic sliding fee child care, MFIP and transition year child care, and child care development grants.

Subd. 5. Self-sufficiency programs. Appropriates general funds in fiscal years 2004 and 2005 for Minnesota economic opportunity grants and food shelf programs.

Subd. 6. Family assets for independence. Appropriates general funds in fiscal year 2004 for the family assets for independence program.

11 **Transfers.**

Subd. 1. Grants. Allows the commissioner of human services to transfer unencumbered appropriation balances for the fiscal year 2004-2005 biennium within fiscal years among the MFIP, general assistance, general assistance medical care, medical assistance, MFIP child care assistance, Minnesota supplemental aid, and group residential housing programs, and the entitlement portion of the chemical dependency consolidated treatment fund, and between fiscal years of the biennium.

Subd. 2. Administration. Allows positions, salary money, and nonsalary administrative money to be transferred within the departments of human services and health and within the programs operated by the veteran's nursing home board as the commissioners and the board consider necessary. Requires quarterly legislative notice about transfers made under this provision.

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 veteran's nursing home board without approval of the legislature.

12 **Indirect costs not to fund programs.** Prohibits the commissioners of health and human services from using indirect cost allocations to pay for the operational costs of any program for which they are responsible.

13 **Carryover limitation.** Prohibits allowed carryovers from fiscal year 2004 to 2005 from becoming part of the base level funding for the 2006-2007 biennial budget, unless specifically directed by the legislature.

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14 **Sunset of uncodified language.** Requires all uncodified language in this article to expire on June 30, 2005, unless a different expiration date is explicit.

15 **Repealer.** Repeals Laws 2002, chapter 374, article 9, section 8 (fiscal 2003 TANF MOE).

16 **Effective date.** Makes the provisions of this article effective July 1, 2003, unless a different effective date is specified.