House Research Act Summary

CHAPTER: 245 **SESSION:** 1999 Regular Session

TOPIC: Omnibus Health and Human Services Appropriations

Date: June 2, 1999
Analyst: Randall Chun, 651-296-8639
Joe Cox, 651-296-5044
Elisabeth M. Loehrke, 651-296-5043
Jayne Sprinthall Rankin, 651-296-8079

Overview

Article 1 contains the appropriations and riders for the Omnibus Health and Human Services Appropriations bill. This summary outlines the total amount appropriated to each state agency under the Health and Human Services Finance Committee's jurisdiction, summarizes the riders, and also summarizes related statutory sections that are included at the end of the article. Riders in this article:

Provide rate increases of 4 percent in FY 2000 and 3 percent in FY 2001 for a variety of home and community-based health care services. Eighty percent of this increased revenue must be used to increase the compensation of staff, other than administrator and central offices staff (rider in section 2, subdivision 8).

Increase the base level funding for the SILS (semi-independent living services) program for persons with developmental disabilities. Also increase the base level funding for the family support grant program (riders in section 2, subdivision 8).

Increase the funding for the DD waiver (the MA home and community-based waiver program for persons with developmental disabilities) to allow 100 more persons into this program in each year (rider in section 2, subdivision 8).

Provide $600,000 in one-time funding for start-up grants to establish community dental clinics in areas where enrollees in the public health care programs have limited access to dental care (rider in section 2, subdivision 5).

Substitute federal TANF block grant funds for state general funds in the CSSA block grant to counties; transfer TANF funds to provide funds to counties to continue the concurrent permanency planning project that was begun last year; use TANF funds to reduce the size of the

job counselor caseloads in MFIP; and transfer TANF funds to increase funding to counties through the CSSA block grant (rider in section 2, subdivision 10).

Note: This article does not include the detailed line-item appropriations and base reductions that are contained in the fiscal tracking sheet adopted by the Health and Human Services Finance Committee. The tracking sheet is created and maintained by the Fiscal Analysis Department analyst assigned to health and human services, and is a separate document.

	FY0 0	FY01
		(Dollars in thousands)
1 Health and Human Services appropriations. Total, all state funds:	$2,836,486	$2,988,751
2 Commissioner of human services.		
Subd. 1. Total appropriations. All state funds:	2,694,991	2,847,745
Indirect costs not to fund programs. Prohibits the commissioner from using indirect cost allocations to fund the operational costs of any Department of Human Services (DHS) program.		
Fund and account reporting required. Requires the commissioner to report on December 1, 1999 and December 1, 2000, to the chairs of the legislative committees with jurisdiction over the agency's budget, with detailed fund balance statements for: each fund or account used in the agency's ongoing operations; each of the agency's major state-operated computer system; and the social services information system.		
Subd. 2. Agency management. By fund:		
General fund	28,311	28,345
State government special revenue fund	371	392
Health care access fund	3,268	3,321
Receipts for systems projects. Requires state appropriations and federal receipts for the department's major computer systems to be deposited in the department's state systems account. Permits money appropriated for computer projects to be transferred between projects, and from development to operations, as needed. Permits unexpended funds to be available for ongoing development and operations.		
Reimbursement of county costs. Provides $10,000 to reimburse counties for the legal and related costs of contesting decisions on DHS-administered or financed programs that affect state spending on the programs. Expenses occurring on or after January 1, 1998 are eligible for reimbursement.		
Subd. 3. Children's grants. General fund:	52,845	54,931
Adoption assistance. Appropriates federal funds that are available during the biennium for adoption incentive grants, adoption and foster care recruitment and other adoption services, to the commissioner for those purposes.		
Subd. 4. Children's services management. General fund:	3,900	3,740
Subd. 5. Basic health care grants. By fund:		

General fund:	867,174	916,234
Health care access fund:	116,490	145,469

Hospital inpatient copayments. Authorizes the commissioner to require hospitals to refund hospital inpatient copayments paid by MinnesotaCare enrollees between March - December, 1999. Specifies that if the commissioner requires hospitals to refund these copayments, the hospitals must collect the copayment directly from the commissioner.

MinnesotaCare outreach federal matching funds. Requires that any federal matching funds received as a result of MinnesotaCare outreach activities be deposited in the health care access fund, and be dedicated for those outreach purposes.

Federal receipts for administration. Requires that any federal funds received for the administrative costs of the state's health care reform waiver be deposited as non-dedicated revenue in the health care access fund. Requires that any federal financial participation received for grants be used to offset health care access funds for provider payments.

Health care access fund. Permits MinnesotaCare appropriations from the health care access fund to be spent in either year of the biennium.

Community dental clinics. Provides $600,000 in FY 2000 in one-time funding for start-up grants to establish community dental clinics to provide dental care to people enrolled in the state's health care programs. Grant recipients must provide a 1:1 match with nonstate funds.

Surcharge compliance. Specifies actions the commissioner must take in the event that the state's MA surcharges and intergovernmental transfers are restricted by the federal government.

Blood products litigation. Waives specified state statutes as necessary to resolve the state's claims in connection with litigation concerning blood products.

Dental access grant. Provides $75,000 in one-time funding for a grant to a nonprofit dental clinic in Clay county, to increase access to dental services for persons in the state's health care programs in the northwest area of the state. Specifies that this appropriation is available immediately.

Subd. 6. Basic health care management. By fund:

General fund:	23,268	23,227
Health care access fund:	15,208	14,853

Telemedicine report. Requires the commissioner to report, by January 15, 2001, on whether the inclusion of telemedicine services in the MA and GAMC package of covered services has resulted in cost savings or other benefits, and whether this inclusion should continue beyond June 30, 2001.

MinnesotaCare staff. Provides $1.060 million in FY 2000 and

$733,000 in FY 2001 from the health care access fund to improve MinnesotaCare processing and caseload management. Adds $483,000 of the appropriation to the base.

Work incentives for disabled. Provides $28,000 each year as the required 5 percent state match for $550,000 in annual federal funding for the Social Security Administration's work incentives demonstration project. Transfers this appropriation to the commissioner of economic security. Establishes base level funding for this activity at $28,000.

Systems continuity. Permits the commissioner, in the event that the department's technical systems or computer operations are disrupted, to use available grant appropriations to ensure that payments for maintaining the health, safety and well-being of the people served by the programs continue uninterrupted.

Prepaid medical programs. Permits the nonfederal share of PMAP monies that is appropriated to fund county operating costs for managed care advocacy and enrollment to be distributed either on a reimbursement or a block grant basis. Also permits these monies to be transferred between grants and nongrant administrative costs with the commissioner of finance's approval.

Subd. 7. State-operated services. General fund: 206,929 212,002

Day training services. Exempts the regional treatment centers (RTCs), the METO program at the Cambridge RTC, and state-operated community services for persons with developmental disabilities (DD) from the requirement that the provider of day treatment and habilitation services to a developmentally disabled person have no financial interest in the entity that provides residential services to the person. Specifies that this exemption does not expire.

Mitigation related to developmental disabilities downsizing. Permits appropriations made for mitigation expenses that are related to the downsizing of the RTC programs for persons with DD to be spent in either year of the biennium.

Regional treatment center chemical dependency programs. When the RTC chemical dependency (CD) fund is affected by cash deficiencies because receivables have been delayed, and when the deficiencies would be corrected within the budgeting period, permits the commissioner of finance to transfer general fund cash reserves into the RTC CD fund as needed to meet cash demands. Requires that the cash flow transfers be returned to the general fund in the same fiscal year the transfer was made. Specifies that interest earned on the transferred general fund monies accrues to the general fund.

Leave liabilities. Permits the accrued leave liabilities of state employees who are transferred from RTCs to state-operated community service programs to be paid from the appropriations made under this subdivision for state-operated services.

Regional treatment center restructuring. Requires that an RTC or state nursing home employee whose position is being eliminated

under restructuring be afforded the options provided in the applicable collective bargaining agreements. Requires all salary and mitigation allocations to be carried forward from the first to the second fiscal year. Absent a conflict with a collective bargaining agreement, specifies that position reductions are to occur through means other than layoff.

Regional treatment center population. If the population of residents at the state's RTCs is higher than was forecast, transfers from the appropriations for the MA program to the appropriations for the RTCs an amount equal to the cost of MA services that would have been provided in community-based settings as an alternative to RTC services.

Repairs and betterments. Authorizes the commissioner to spend unencumbered appropriations balances for RTC repairs and betterments and special equipment in either year of the biennium.

Project labor. Authorizes the commissioner to pay wages for project labor out of repairs and betterments monies, if the project is short-term and nonrecurring. Requires compensation to be based on prevailing wage rates. Specifies that project laborers are not eligible for state-paid insurance and benefits.

Year 2000 costs at RTCs. Specifies that $44,000 of the appropriation for the RTCs is for costs associated with potential Year 2000 problems. Makes $19,000 of this amount available immediately.

Subd. 8. Continuing care and community support grants. By fund:

General fund:	1,174,195	1,259,767
Lottery prize fund:	1,158	1,158

CSSA traditional appropriation. Requires the principal portion of the CSSA appropriation to be allocated to counties in proportion to the amount of aid received by a county in CY 1998. Requires a report and recommendations for the revision of the CSSA formula by January, 15, 2000.

Living-at-home/block nurse program. Provides $120,000 each year to expand the living-at-home/block nurse program to six new sites.

Minnesota senior service corps. Provides $160,000 for the biennium: (a) to increase the hourly stipend by 10 cents per hour in the foster grandparent, retired and senior volunteer (RSVP) and senior companion programs; and (b) for a grant to the Tri-Valley Opportunity Council to expand services in ten counties in northwestern Minnesota.

Health insurance counseling. Provides $100,000 each year in one-time funding for the state board on aging to award health insurance counseling grants to the area agencies on aging that provide state-funded health insurance counseling services.

Services to deaf persons with mental illness. Provides $100,000 each year in one-time funding for a grant to a nonprofit agency, to

operate a community support program for mentally ill persons that is communicatively accessible for deaf and hard-of-hearing persons.

Deaf-blind orientation and mobility services. Provides $120,000 in one-time funding for a grant to DeafBlind Services Minnesota to hire an orientation and mobility specialist to work with deaf-blind Minnesotans.

Crisis housing. Provides $126,000 in FY 2000 and $150,000 in FY 2001 in one-time funding for the adult mental illness crisis housing assistance program under Minnesota Statutes, section 245.99 (created in Article 4, section 8).

Adolescent compulsive gambling grant. Appropriates $150,000 each year from the lottery prize fund for a grant to a compulsive gambling council in St. Louis county to help finance a statewide compulsive gambling prevention and education project for adolescents.

Crisis intervention project. Provides $40,000 in FY 2000 for the action, support and prevention project of southeastern Minnesota.

SILS funding. Provides $1 million each year for the semi-independent living services (SILS) program for persons with developmental disabilities. Adds this appropriation to the program's base level funding. Permits unexpended funds from the first year to be carried forward to the second year.

Family support grants. Provides $1 million in FY 2000 and $2.5 million in FY 2001 to expand the family support grant program for families with developmentally-disabled dependents. Adds this appropriation to the program's base level funding. Permits unexpended funds from the first year to be carried forward to the second year.

Provider rate increases. (a) Provides annual adjustments of 4 percent in FY 2000 and 3 percent in FY 2001 to the MA rates paid for community-based health care services. The rider:

(b) Increases reimbursement rates for the following community-based health care services by 4 percent in FY 2000, and by an additional 3 percent in FY 2001:

home and community-based waivered services for developmentally disabled persons

home and community-based waivered services for elderly persons

waivered services for chronically ill children and disabled persons (CADI and CAC programs)

traumatic brain injury waivered services

nursing services and home health services

personal care services and nursing supervision of personal care services

private-duty nursing services

day training and habilitation services for developmentally disabled adults

alternative care services

adult residential mental health grants

community support grants for mentally ill adults; and family community support grants for mentally ill children

semi-independent living services (SILS); including SILS funding under county social services grants

community support services for mentally ill deaf and hard-of-hearing adults who use, or would like to use, sign language as their primary means of communication.

(c) Increases reimbursement rates by 2 percent in FY 2000 for the group residential housing (GRH) supplementary service rate.

(Note: See article 4, section 78, for rate adjustments for physician and professional services; and article 3, section 20, for COLA adjustments for nursing facilities.)

(d) Requires providers receiving a rate increase to use at least 80 percent of the additional revenue to increase the compensation of employees other than administrator and central office staff.

(e) Requires a copy of the provider's plan for complying with paragraph (d) to be made available to all employees. Permits an employee who does not receive the salary adjustment to contact a union representative or the commissioner.

(f) Technical, specifying that the rate increases do not sunset, but will be added to the base level funding for these services.

Developmental disabilities waiver slots. Provides $1.746 million in FY 2000 and $4.683 million in FY 2001 to increase the number of available slots in the MA home and community-based waiver program for persons with developmental disabilities (the DD waiver program).

Moratorium exceptions. Provides $250,000 each year for the MA costs of approved nursing facility moratorium exception projects. Permits unexpended funds from the first year to be carried forward to the second year.

Nursing facility operated by the Red Lake Band of Chippewa. In clause (1), requires the MA payment rates for the 47-bed nursing facility operated by the band to be calculated according to the MA allowable reimbursement cost provisions, and are subject to the facility-specific Medicare upper limits.

In clause (2), requires the commissioner to provide operating payment rate adjustments in FY 2000 and FY 2001 that are equal to the nursing facility rate adjustments specified in Article 3, section 20.

ICF/MR disallowances. Provides $65,000 in one-time funding in FY 2000 to reimburse a four-bed ICF/MR in Ramsey county for field audit disallowances. ***This appropriation was vetoed.***

Costs related to facility certification. Provides $168,000 to fund half of the state share of MA costs for residential and day

habilitation services provided to the residents of an ICF/MR in Northfield. Makes this appropriation available immediately.

Alternative care transfer. Provides that unspent funds allocated for the alternative care program do not cancel, but are transferred to the MA account.

Preadmission screening amount. Sets the payment for preadmission screening at the level in effect for fiscal year 1999.

Alternative care appropriation. Allows appropriations for the alternative care program to be used in either year of the biennium.

Group residential facility for women in Ramsey county. Authorizes a new 23-bed GRH facility for women in Ramsey county to negotiate, with county approval, a supplementary service rate in addition to the applicable board and lodging rate. Caps the allowed monthly supplementary service rate at $564 per person, and the allowed monthly total rate at $1,177 per person. Provides $19,000 in FY 2000 and $38,000 in FY 2001 for the costs associated with this rate setting provision.

Chemical dependency services. Provides $450,000 in FY 2000 for chemical dependency services to persons who are eligible for services under Tier II of the Consolidated Chemical Dependency Treatment Fund.

Repeat DWI offender program. Provides $100,000 each year in one-time funding for the cost of chemical dependency treatment for repeat DWI offenders at the Brainerd regional human services center. Specifies that payment may only be authorized from this appropriation after all potential public and private third-party payers have been billed, but the costs are not reimbursable. ***This appropriation was vetoed.***

Subd. 9. Continuing care and community support management. By fund:

General fund:	17,318	17,616
Lottery prize fund:	142	142
State government special revenue fund:	114	115

Minnesota senior health options project. Permits up to $200,000 to be transferred to the Minnesota senior health options project special revenue account, to be used as matching funds.

Persons with brain injuries. Requires the commissioner to study and report, by January 15, 2000, on the status of persons with brain injuries residing in public and private institutions. Specifies the kinds of information the report must contain. Also requires the commissioner to apply to the federal HCFA for a grant for a demo project to transition disabled persons out of nursing facilities. Specifies six requirements for this demo project. Makes this provision immediately effective.

Camp. Earmarks $15,000 each year from the mental health special projects account for a camping program for adults and children with mental illness.

Demo project external advocacy funding cap. Limits the amount of the appropriation for the demonstration project for persons with developmental disabilities (DD) that may be paid for external advocacy to a maximum of $79,000 per year.

Region 10 quality assurance commission. Provides $210,000 each year in one-time funding for a grant to the region 10 quality assurance commission, for the continuation of the alternative quality assurance licensing system pilot project for persons with DD. Permits unexpended FY 2000 funds to be carried forward to FY 2001.

Subd. 10. Economic support grants. General fund: 142,037 124,758

Gifts. Permits the commissioner to accept nonstate funds to finance the cost of assistance program grants, or to finance administrative costs.

Child support payment center recoupment account. Authorizes the payment center to create a recoupment account to cover checks issued in error, or when there are insufficient funds to cover a check sent by an obligor. Funds in the recoupment account are appropriated to the commissioner for the account, and any unexpended balance in the account does not cancel, but is available until expended.

Federal TANF funds. (1) Appropriates $256,265,000 in FY 2000 and $249,682,000 in FY 2001 from the state's federal TANF block grant awards to the commissioner. (Note: The state's TANF block grant amount is $268 million per fiscal year.) Also permits the commissioner to make other TANF appropriations or transfers that are enacted into state law.

(2) Uses $15 million of the TANF appropriations in clause (1) in each year to replace an equivalent amount of general fund monies that would otherwise be appropriated for the state's community social services (CSSA) block grant to counties. (Note: This substitution of federal TANF funds for state general funds is possible because the federal law permits TANF funds to be transferred to the federal Title XX social services block grant, which the state combines with the state CSSA general fund block grant.)

(3) Transfers $10.990 million each year of the TANF appropriations in clause (1) to the state's federal Title XX social services block grant. Out of this total: $140,000 each year is for grants to the Indian Child Welfare Defense Corporation; $4.650 million each year is for grants to counties to continue the concurrent permanency planning project for children in out-of-home placement that was begun last year; and $6.2 million each year is for the commissioner to distribute as additional funding to counties through the CSSA block grant. Also specifies that in FY 2002 and FY 2003, $140,000 each year is for grants to the Indian Child Welfare Defense Corporation.

(4) Specifies that $13,360,000 each year of the TANF appropriations in clause (1) is for increased employment and training efforts. Of this amount: $140,000 each year is for a grant to the new chance

program, to provide comprehensive services to young parents in Hennepin county who have dropped out of school and are on public assistance; $260,000 each year is for the parents fair share program, to assist unemployed noncustodial parents with job search and parenting skills; and $12,960,000 each year is to increase employment and training services grants to counties. Of this last allocation, $750,000 each year is to be transferred to the job skills partnership board for the health care and human services worker training and retention program (created in Article 10, sections 2 to 8). Specifies that $10.4 million of these appropriations must be added to the base level funding for the 2002-2003 biennium.

(5) Transfers $1.094 million in FY 2000 and $1.676 million in FY 2001 of the TANF appropriations in clause (1) to the state's child care and development fund block grant, and appropriates this money to the commissioner of children, families and learning for the MFIP child care costs that are associated with increasing the MFIP exit level in Article 6, section 28.

(6) Specifies that $1 million for the biennium of the TANF appropriations in clause (1) is to create and expand adult-supervised supportive living arrangement services for minor MFIP parents. Requires that minor parents who are MFIP participants be given priority for this housing, and permits excess living arrangements to be used by minor parents who are not MFIP participants.

(7) Permits the commissioner, in order to maximize the transfers under clauses (2), (3) and (5), to make these transfers in the first year of the biennium, to the extent allowed under federal law and to the extent that program funding requirements can be met in the second year of the biennium.

(8) Requires the commissioner to ensure that the state has sufficient qualified expenditures each year to meet the federal TANF basic maintenance of effort requirements. Authorizes the commissioner to apply any allowable source of state expenditures toward these federal requirements.

Worker training and retention eligibility procedures. Requires the commissioner to develop eligibility procedures to permit TANF funds to be expended for the new health care and human services training and retention program that is created in Article 10, sections 2 to 8.

Employment services carryover. Permits FY 2000 general funds and federal TANF block grant funds for employment services that are still unspent after the new reallocation process for distributing these grants to counties (created in article 6, sections 72 and 73) to be carried forward into FY 2001.

Child support payment center. Requires payments for services performed by the child support payment center to be deposited into the department's state systems account. Makes an open and standing appropriation of these payments to the commissioner for the operation of the child support payment center or system.

Child support expedited process. Transfers $2.340 million for the biennium to the state court administrator to fund the child support expedited process. Places specified conditions on this transfer, and establishes the program's base to $1.170 million for the 2002-2003 biennium. Requires federal funds earned under the state court's cost reimbursement claims to be disbursed to the state court administrator.

Transfers from state TANF reserve. Transfers $4.666 million in FY 2000 of state funds out of the state's TANF reserve and into the general fund. (Section 20 repeals the state TANF reserve account on July 2, 1999.)

General assistance standard. Sets the monthly GA standard of assistance for a single adult at $203.

Subd. 11. Economic support management. By fund:

General fund:	40,950	40,357
Health care acces fund:	1,313	1,318

Food stamp administrative reimbursement. Requires the commissioner to reduce quarterly food stamp administrative reimbursement to counties in FY 1999, FY 2000 and FY 2001 by a specified amount. Specifies that the reductions must be allocated to each county in proportion to each county's contribution to the amount of the adjustment. Provides that adjustments to MA administrative reimbursement are to be distributed to counties in the same manner. Makes this provision immediately effective.

Spending authority for food stamp enhanced funding. Provides that if the state qualifies for food stamp enhanced funding, the commissioner shall retain 25% of the enhanced funding, and must distribute the remaining 75% of this funding to counties, based on each county's impact on the statewide food stamp error rate.

Eligibility determination funding. Appropriates to the commissioner any increased federal funds for the costs of eligibility determinations and other permitted activities that are available to the state as the result of the federal welfare reform act requirement that all states determine MA eligibility for certain groups based on the state's former AFDC program.

MAXIS base reduction. Reduces the base level funding for the MAXIS computer system by $2.5 million for each year of the 2002-2003 biennium.

Fraud prevention and control funding. Permits unexpended funds from FY 2000 program integrity activities to also be used for fraud prevention and control initiatives, and to be carried forward into FY 2001. Permits unexpended funds to be transferred between the fraud prevention investigation program and the fraud control program.

Transfers to Title XX for CSSA. Requires the base level funding for the CSSA block grant for FY 2002-2003 to include $11 million each year in funds that are transferred from the TANF block grant to the Title XX block grant.

3 Commissioner of health.

Subd. 1. Total appropriation. All state funds:	$100,424	$98,641
Indirect costs not to fund programs. Prohibits the commissioner from using indirect cost allocations to fund the operational costs of any health department program.		
General fund grant reductions. Prohibits the commissioner from reducing general fund appropriations for grants, unless she has specific legislative authority to do so.		
Subd. 2. Health systems and special populations. Total, all state funds:	66,999	66,269
Subtotal; General fund:	46,593	46,299
Subtotal; State government special revenue fund:	10,557	10,012
Subtotal; Health care access fund:	9,849	9,958
WIC transfers. Permits the appropriation for the WIC program to be transferred between fiscal years, in order to maximize federal funds or to minimize fluctuations in the number of participants.		
Minnesota children with special health needs carryover. Permits the general fund appropriations for this program to be used in either year of the biennium.		
Suicide prevention study. Provides $100,000 in FY 2000 for the commissioner to study suicide issues and develop a suicide prevention plan by January 15, 2000.		
Family practice residency program. Provides $300,000 in FY 2000 for a grant to Duluth for a family practice residency program for northeastern Minnesota.		
Uncompensated care. Requires the commissioner to study and report to the legislature by January 15, 2000 on the amount and types of uncompensated health care provided in the state, and to make recommendations for reducing the level of uncompensated care.		
Rural hospital capital improvement grant program. Paragraph (a) provides $2.8 million each year in one-time funding from the health care access fund for rural hospital capital improvement grants.		
Paragraph (b) specifies that the commissioner may provide up to $300,000 of the amount in paragraph (a) for hospital and clinic improvements at the Westbrook Care Center. A match of at least 1:1 in nonstate funds is required if these funds are allocated to Westbrook.		
Access to summary minimum data set (MDS). Requires the commissioner to work to obtain access to the minimum data set (MDS) data that is collected from nursing facilities for the federal government, in order that the MDS may be used by industry trade associations for quality improvement efforts and comparative analyses.		
Nursing home moratorium report. Requires the commissioners of health and human services to include an analysis of the adequacy of the supply of nursing home beds by measuring prompt hospital discharges to nursing homes, as well as an analysis of the impact of		

assisted living facilities on the MA utilization of nursing homes, in the upcoming version of the biennial nursing home moratorium report.

Health care purchasing alliances. Provides $100,000 each year in one-time funding from the health care access fund for grants to develop health care purchasing alliances in the northwest and southwest areas of the state.

General fund tobacco base reduction. Effective with the 2002-2003 biennium, reduces the general base level funding for tobacco prevention and control programs and activities by $1.1 million each year. (Funding for these activities is shifted to the tobacco use prevention and local public health endowment fund in Article 11, section 4.)

Standards for special case autopsies. Provides $20,000 in one-time funding for a grant to conduct case studies, and develop and disseminate guidelines, for autopsy practice in special cases.

Subd. 3. Health protection. Total, all state funds:	27,046	27,240
Subtotal; General fund:	12,221	12,417
Subtotal; State government special revenue fund:	14,825	14,823

Portable wading pools. Defines portable wading pools that are used in licensed or legal nonlicensed family day care settings as private residential pools, rather than public pools, for the purpose of the health department's regulation of swimming pools. In order for a child at a licensed or legal nonlicensed family day care setting to use a portable wading pool, the child's parent or legal guardian must provide written consent. Makes this provision effective immediately.

Subd. 4. Management and support services. Total, all state funds:	6,379	5,132
Subtotal; General fund:	6,102	4,849
Subtotal; State government special revenue fund:	181	185
Subtotal; Health care access fund:	96	98

Health needs of special populations. Provides $400,000 from the general fund for FY 2000, for grants to local health agencies to conduct a health needs assessment the is specific to populations of color. Permits unexpended funds from the first year to be carried forward to the second year.

Year 2000 survey of facilities and water systems. Specifies that $157,000 of the general fund appropriation is for the costs of the commissioner surveying facilities and water supply systems for Year 2000 problems by July 1, 1999. Makes $54,000 of this appropriation available immediately.

Single point of entry. Requires the commissioner to develop a plan for: creating a single point of entry of health care consumer assistance and advocacy services; integrating state offices of health care consumer assistance; and coordinating and collaborating with other agencies and nongovernmental agencies. The commissioner must consult with the commissioners of commerce and human

services, the ombudsman for mental health and mental retardation, and the board on aging in developing the plan. The plan is due January 15, 2000.

4 Veterans nursing homes board. This is a general fund appropriation. 26,121 27,103

Allowance for food. Permits the board to adjust its allowance for food to reflect changes in the producer price index. Provides that adjustments for FY 200 and FY 2001 are based on the June 1998 and June 1999 producer price index respectively.

Improvements using donated money. Permits the board to make specified improvements at the board's facilities using money donated for those purposes.

Asset preservation; facility repair. Provides $1.190 million each year for asset preservation and facility repair. Makes the appropriations available in either year of the biennium, and permits them to be use for abatement and repair at the Luverne home.

Veterans homes special revenue account. Transfers the general funds that are appropriated to the board to the veterans homes special revenue account, and appropriates the monies from that account to the board, for the board's facilities and programs.

Setting the cost of care. Permits the board to set the FY 2000 cost of care at the Fergus Falls home based on the cost of average skilled nursing care at the Minneapolis home for the same year. Requires the FY 2000 and FY 2001 cost of care for the domiciliary residence at the Minneapolis veterans home and the skilled nursing care residence at the Luverne home to be calculated based on a full census at each facility.

Licensed bed capacity for Minneapolis veterans home. Prohibits the commissioner of health from reducing the licensed capacity of the Minneapolis veterans home before the project originally authorized in 1990 is completed.

Luverne environmental quality. Provides $591,000 in FY 2000 to ensure adequate staffing during repairs at the Luverne veterans home. Makes $229,000 of this appropriation available immediately.

5 Health related boards.

Subd. 1. Total appropriation. This is from the state government special revenue fund: 10,376 10,576

State government special revenue fund. Specifies that the appropriations to the health-related boards are from the state government special revenue fund.

No spending in excess of revenues. Prohibits the commissioner of finance from permitting a board to spend money appropriated in this section that is in excess of its anticipated biennial revenues or accumulated surplus revenues from fee collections.

Subd. 2. Board of chiropractic examiners. 350 361

Subd. 3. Board of dentistry. 783 806

Subd. 4. Board of dietetic and nutrition practice. 92 95

Subd. 5. Board of marriage and family therapy.	107	111
Subd. 6. Board of medical practice.	3,469	3,593
Subd. 7. Board of nursing.	2,202	2,245
Subd. 8. Board of nursing home administrators.	548	566
Health professional services unit. Specifies the portion of this appropriation that is for the health professional services activity.		
Subd. 9. Board of optometry.	87	90
Subd. 10. Board of pharmacy.	1,125	1,137
Administrative services unit. Specifies the portion of this appropriation that is for the health boards' administrative services unit.		
Subd. 11. Board of physical therapy.	227	185
Subd. 12. Board of podiatry.	41	42
Subd. 13. Board of psychology.	556	534
Part-time positions funding. Provides that $34,000 of the FY 2000 appropriation is to fund two part-time positions that had been funded through the Legislative Advisory Commission (LAC), and for a budget shortage.		
Subd. 14. Board of social work.	641	658
Subd. 15. Board of veterinary medicine.	148	153
6 Emergency medical services board. Total, all state funds:	2,420	2,467
Subtotal; General fund:	694	694
Subtotal; Trunk highway fund:	1,726	1,773
Comprehensive advanced life support (CALS). Provides $108,000 each year in general fund monies for the board to establish the CALS educational program.		
Emergency medical services grants. Provides $18,000 in FY 2000 and $36,000 in FY 2001 from the trunk highway fund for grants to regional EMS programs.		
7 Council on disability. This is a general fund appropriation.	650	670
8 Ombudsman for mental health and mental retardation. This is a general fund appropriation.	1,338	1,378
9 Ombudsman for families. This is a general fund appropriation.	166	171

10 Transfers of funds.

Subd. 1. Grant programs. Authorizes the commissioner of human services, with the approval of the commissioner of finance, and after notifying the chairs of the legislative committees with jurisdiction over the agency's budget, to transfer unencumbered appropriations balances within fiscal years between the following programs: MFIP; GA; GAMC; MA; MSA; GRH; and the entitlement portion of the consolidated chemical dependency treatment fund (CCDTF).

Subd. 2. Approval required. Permits the commissioners of health and human services, and the veterans nursing homes board, to transfer positions, salary money and nonsalary administrative money within the departments, and within the board's programs, with the advance approval of the commissioner of finance. Requires quarterly reports to the chairs of the appropriate legislative committees about transfers made under this subdivision.

11 Provisions. Paragraph (a) permits money that is provided for the purchase of provisions at the RTCs but that is not used because of population decreases to be transferred, and used for purchasing drugs and medical and hospital supplies, with the approval of the commissioner of finance after notifying the chairs of the appropriate legislative committees.

Paragraph (b) provides an inflation adjustment for the allowance for food, so that it reflects changes in the producer price index over the specified period.

12 Carryover limitation. Prohibits any of the funding in this act that is allowed to be carried forward from the first to the second year from becoming part of an activity's base level funding, unless specifically directed.

13 Sunset of uncodified language. Provides that all uncodified language in this article expires June 30, 2001, unless there is a different expiration date explicit in the language of an uncoded provision.

14 Appropriation transfers to be reported. (Adds subd. 3 to § 144.05) Requires the commissioner of health, whenever operational money is transferred between programs, to provide the chairs of the legislative committees with jurisdiction over the agency's budget with information on what account the money was originally appropriated to, and to what account the money is being transferred.

15 Appropriation transfers to be reported. (Adds subd. 5 to § 198.003) Requires the veterans nursing homes board, whenever operational money is transferred between programs, to provide the chairs of the legislative committees with jurisdiction over the agency's budget with information on what account the money was originally appropriated to, and to what account the money is being transferred.

16 Specific powers. (Amends § 256.01, subd. 2.) Amends clause (8) of the commissioner of human services' powers to clarify that funds encumbered for an adoption assistance agreement remain available until the agreement is fulfilled or terminated. Also adds clauses (22), (23) and (24) to the list of the commissioner's specific powers:

Clause (22) requires the commissioner to operate a communication systems account as a revolving fund to manage shared communication costs (the interactive voice and visual communications systems located at regional treatment center sites and at the central DHS office) that are necessary for the department's programs. Authorizes nonprofit agencies and state, county and local government agencies involved in human services programs to use the interactive communications systems and share in their operating costs.

Clause (23) requires the commissioner to receive any federal MA money that is available for the consumer satisfaction survey, and appropriates any federal money for the consumer satisfaction survey to the commissioner for the survey.

Clause (24) requires the commissioner to incorporate cost reimbursement claims from First Call Minnesota into the department's federal cost reimbursement claiming process, and requires any reimbursement that is received to be disbursed to First Call Minnesota.

17 Appropriation transfers to be reported. (Adds subd. 18 to § 256.01) Requires the commissioner of human services, whenever operational money is transferred between programs, to provide the chairs of the legislative committees with jurisdiction over the agency's budget with information on what account the money was originally appropriated to, and to what account the money is being transferred.

18 Issuance operations center. (Adds subd. 4 to § 256.014) Makes an open and standing appropriation of payments for services or reports provided by the issuance operations center to the commissioner, for the operations of the issuance operations center.

19 Payment policy. (Amends § 256J.39, subd. 1) Authorizes the commissioner of human services, with the advance approval of the commissioner of finance, to issue cash assistance grant payments up to three days before the first day of each month, including before the start of a fiscal year. Makes up to

three percent of the annual state appropriation for these cash grants available to the commissioner in the previous fiscal year to this purpose. (This provision is immediately effective.)

20 Repealer. Repeals § 256J.03, which created the TANF reserve account in the state treasury, effective July 2, 1999. (A rider in section 2, subdivision 12, transfers the current balance in this account to the general fund on July 1, 1999.)

21 Effective date. Specifies that section 19 is effective immediately.

Article 2: Health Department

Overview

This article contains provisions related to rural health, public health, and Health Department programs and functions. The article:

Repeals the regional coordinating boards effective July 1, 1999, and removes all references to regional coordinating boards from statutes (sections 2 to 7, 13, and 23).

Modifies provisions governing state funding of medical education activities, and directs the commissioner of health to make recommendations to the legislature for an application process for state grants for medical research (sections 9 to 11, 38, and 45, paragraph (b)).

Establishes in statute the state's authority to enter into agreements with the U.S. Nuclear Regulatory Commission to assume regulatory authority over certain types of nuclear materials (sections 16 to 19, 28, 29, and 45, paragraph (c)).

Amends the Clean Indoor Air Act and requires rules to be adopted to restrict smoking in factories and workhouses (sections 24 to 26).

Modifies the MN ENABL program by adding an additional program goal and moving responsibility for the media and public relations campaigns from the attorney general's office to the commissioner of health (sections 32 and 33).

Raises registration fees for speech-language pathologists and audiologists (sections 34 to 37).

Raises the bond requirement for any person contracting to do plumbing work in the state, from $2,000 to $25,000 (sections 39 to 41).

Repeals the Office of Health Care Consumer Assistance, Advocacy, and Information (section 45, paragraph (a)).

1 Later expiration. Amends § 15.059, subd. 5a. Strikes an expiration date of June 30, 1999 for the public programs risk adjustment work group convened by the commissioners of health and human services (this extends the work group to June 30, 2001).

2 Cost containment duties. Amends § 62J.04, subd. 3. Strikes references to the Minnesota Health Care Commission and the regional coordinating boards (the commission has been repealed, and the section establishing the regional coordinating boards is being repealed effective July 1, 1999).

3 Immunity from liability. Amends § 62J.06. Strikes a reference to the regional coordinating boards, which are being repealed.

4 Legislative oversight. Amends § 62J.07, subd. 1. Strikes a reference to the regional coordinating boards, which are being repealed.

5 Reports to the commission. Amends § 62J.07, subd. 3. Strikes a reference to the regional coordinating boards, which are being repealed.

6 Repealer. Amends § 62J.09, subd. 8. In a subdivision establishing a repealer date for the regional coordinating boards, moves up the date on which they are repealed from July 1, 2000 to July 1, 1999.

7 Consumer information. Amends § 62J.2930, subd. 3. Strikes a reference to the regional coordinating boards, which are being repealed.

8 Uniform billing requirements. Adds § 62J.535. Requires the commissioner of health, after consultation with the commissioner of commerce, to adopt uniform billing standards that comply with the federal Health Insurance Portability and Accountability Act (HIPAA). Specifies that these standards apply to all paper and electronic claims, and to all Minnesota payers, including government programs. Also requires all health care providers to conform to the uniform billing standards developed under this section, and makes the requirements for the uniform remittance advice report effective 12 months after the date of required compliance for standards for the electronic remittance advice transaction under HIPAA.

9 Purpose. Adds § 62J.691. Establishes a legislative purpose for state medical education and medical research activities of helping offset lost patient care revenue for certain teaching institutions and helping ensure the continued excellence of health care research in Minnesota.

10 Medical education. Adds § 62J.692. Directs the commissioner of health to distribute funds to clinical medical education programs to pay for a portion of the costs of medical education. Defines terms, establishes an advisory committee, describes the application and distribution processes for funds, requires reports, requires the commissioner of human services to seek to maximize federal financial participation, and permits reviews of eligible providers. (This section rewrites the existing MERC statute, making technical and organizational changes as well as substantive changes.)

Subd. 1. Definitions. Defines the following terms: accredited clinical training, commissioner, clinical medical education program, sponsoring institution, teaching institution, trainee, and eligible trainee FTEs.

Subd. 2. Medical education and research advisory committee. Directs the commissioner of health to appoint an advisory committee to provide advice and oversight on the distribution of medical education funds. Lists factors the commissioner must consider in appointing members to the committee, and lists the groups from which members of the committee must be drawn. Makes the committee expire June 30, 2001. (The advisory committee exists in current law but was to expire June 30, 1999.)

Subd. 3. Application process. Lists criteria a clinical medical education program must meet to be eligible for funds. Requires applications for funds to be submitted by September 30 of each year, and lists information that an application must contain. Disqualifies an applicant from receiving funds if the applicant does not provide information requested by the commissioner.

Subd. 4. Distribution of funds. Lists the criteria the commissioner must use to annually distribute medical education funds to qualifying applicants. Prohibits funds from being used to displace current funding appropriations. Requires funds to be distributed to sponsoring institutions, which then distribute the funds to clinical education programs. The education programs then distribute the funds to training sites as specified in the commissioner's approval letter. Allows accredited sponsoring institutions to contract directly with training sites for clinical training. Provides for redistribution of funds that a recipient fails to distribute in accordance with the commissioner's approval letter.

Subd. 5. Report. Requires sponsoring institutions receiving funds to submit medical education grant verification reports verifying that the correct grant amounts were forwarded to training sites. An institution that fails to submit a report by the deadline must return its funds received to the commissioner within 30 days of receiving notice from the commissioner. Lists information that the reports must include. By February 15 of each year, requires the commissioner to provide a summary report to the legislature on implementing the medical education section.

Subd. 6. Other available funds. Authorizes the commissioner to distribute funds from other sources for medical education, including allocations for the commissioner of human services for medical education and research.

Subd. 7. Transfers from the commissioner of human services. Directs the commissioner to distribute funds carved out of the county MA and GAMC capitation rates to qualified, clinical

medical education programs, based on an education factor weighted at 50 percent and a public program volume factor weighted at 50 percent. Specifies that public program revenue, for purposes of determining the public program volume factor, includes revenue from MA, prepaid MA, GAMC, and prepaid GAMC. States that training sites receiving no public program revenue are ineligible for funds under this subdivision.

Subd. 8. Federal financial participation. Directs the commissioner of human services to maximize federal financial participation (FFP) in payments for medical education and research costs. If the commissioner of human services determines that FFP is available, requires the commissioner of health to transfer to the commissioner of human services the amount of state funds needed to maximize federal funds. Requires the state funds plus the federal funds obtained from FFP to be distributed to MA providers according to the distribution methodology in subdivision 4.

Subd. 9. Review of eligible providers. Allows the commissioner and the advisory committee to review provider groups whose clinical medical education programs may receive funds, to ensure that the distribution of funds is consistent with the purposes of this section. Requires results of such reviews to be reported to the legislative commission on health care access.

11 Medical research. Adds § 62J.693. Directs the commissioner of health to make recommendations for a process by which entities may apply for state grants for medical research. (This section is new.)

Subd. 1. Definitions. Defines health care research for this section.

Subd. 2. Grant application process. Requires the commissioner of health to make recommendations to the legislature, by January 15, 2000, for a process by which entities may apply for state grants for medical research. Requires the process to give priority to certain types of applications, and requires grant recipients to comply with federal regulations on human subjects research. Allows grants to be awarded to the University of Minnesota, the Mayo Clinic, or any other public or private medical research organization in the state. Allows the commissioner to either consult with the medical education and research advisory committee or appoint a research advisory committee for advice on the grant application process.

12 Public programs. Amends § 62Q.03, subd. 5a. Makes the public programs risk adjustment work group expire June 30, 2001, rather than June 30, 1999. A new paragraph (e) requires the commissioner of human services, before including risk adjustment in a contract for PMAP, PGAMC, or MinnesotaCare, to provide the contractor with an analysis of how implementing risk adjustment will impact the contractor. Provides that the analysis may be limited by available data and resources and is not binding on future contracts. Exempts the commissioner from this requirement if the contractor does not give the commissioner the information necessary to do the analysis. A new paragraph (f) requires the commissioner to report to the risk adjustment work group on the methodology to be used for risk adjustment, and specifies how the commissioner is to phase in the risk adjustment over the first two contract years.

13 Local public accountability and collaboration plan. Amends § 62Q.075. Strikes references to the regional coordinating boards, which are being repealed.

14 Provider contracts. Amends § 62R.06, subd. 1. In a section governing contracts by health provider cooperatives, modifies the requirements for contracts between provider cooperatives and purchasers to allow them to provide for payment to the cooperative on a capitated basis, by fee-for-service arrangements, or by other financial arrangements authorized by state law (current law requires payment arrangements to be on a substantially capitated basis).

15 Prevention and treatment of sexually transmitted infections. Amends § 144.065. In a section directing the commissioner of health to help local agencies detect and treat venereal diseases, replaces the term "venereal disease" with "sexually transmitted infection." Adds research and screening to the list of services to be provided. Specifies that the commissioner shall determine a method of funding to detect and treat STI's for state agencies, state councils, and nonprofit

corporations, and boards of health (current law requires the commissioner to determine the method of funding for local health agencies only). Allows planning and implementation of services and technical assistance to be conducted in collaboration with boards of health, state agencies, state councils, nonprofit organizations, and representatives of affected populations.

16 Definitions. Adds § 144.1201. For a series of sections specifying the authority of the commissioner of health to regulate by-product, source, and special nuclear materials, defines the following terms: by-product nuclear material, radiation, radioactive material, source nuclear material, and special nuclear material.

17 United States Nuclear Regulatory Commission agreement. Adds § 144.1202. Authorizes the governor to enter into agreements with the U.S. Nuclear Regulatory Commission to have the state assume regulatory authority over by-product, source, and special nuclear materials. Designates the health department as the lead agency to accomplish this. Provides for the transition of licenses when regulatory authority moves from the federal government to the state, and specifies the conditions under which an agreement can be implemented. (The substance of this section was enacted in session law in 1998, and that section of session law is being repealed.)

Subd. 1. Agreement authorized. Authorizes the governor to enter into agreements with the United States Nuclear Regulatory Commission in which the Nuclear Regulatory Commission will discontinue its regulation over by-product, source, and special nuclear materials, and the state will assume regulatory authority over these materials.

Subd. 2. Health department designated lead. Designates the health department as the lead agency to pursue an agreement on behalf of the governor, and to assume licensing and regulatory authority according to the terms of an agreement with the NRC, including the authority to set and collect fees. Requires the commissioner of health to establish an advisory group to help prepare the state to meet the requirements for reaching an agreement. Allows the commissioner to adopt rules to allow the state to assume regulatory authority.

Subd. 3. Transition. States that a person who had an NRC license that is subject to the agreement between the NRC and the state on the effective date of the agreement is deemed to possess a similar license issued by the health department. Makes a health department license obtained under this subdivision expire on the expiration date of the federal license.

Subd. 4. Agreement; conditions of implementation. Requires an agreement entered into before August 2, 2002 to remain in effect until terminated under federal law. Prohibits the governor from entering into an initial agreement after August 1, 2002. If no agreement is entered into, repeals any rules adopted under this section. Requires an agreement entered into to be approved in law before being implemented.

18 Training; rulemaking. Adds § 144.1203. Requires the commissioner to adopt rules to require that individuals handling or using radioactive materials under the terms of a license issued by the commissioner have proper training and qualifications. Requires these rules to contain requirements at least as stringent as federal regulations on proper training and qualifications, and allows these rules to incorporate federal regulations by reference.

19 Surety requirements. Adds § 144.1204. Establishes requirements for financial assurances and trust agreements, and allows the commissioner to establish additional criteria in rule.

Subd. 1. Financial assurance required. Allows the commissioner to require applicants for licensure or current licensees to post a financial assurance to ensure that all requirements established by the commissioner for decontamination, closure, decommissioning, and reclamation will be completed. Requires the financial assurance posed to be sufficient to pay the costs of surveillance and care when radioactive materials remain at the site after the licensed activities end. Allows the commissioner to establish financial assurance criteria by rule, and lists factors the commissioner may consider in establishing such criteria.

Subd. 2. Acceptable financial assurances. Permits the commissioner to establish the types of financial assurances that meet the requirements of this section.

Subd. 3. Trust agreements. Requires the financial assurances to be established together with trust agreements, and requires the form and substance of the financial assurances and trust agreements to meet requirements established by the commissioner.

Subd. 4. Exemptions. Allows the commissioner to exempt any licensee from the financial assurance requirements of this section if the commissioner determines that an exemption would not result in a significant risk to the public health, public safety, or environment and does not pose a financial risk to the state.

Subd. 5. Other remedies unaffected. Specifies that this section does not relieve a licencee of any civil liability or of obligations to prevent or mitigate the consequences of improper handling or abandonment of radioactive materials.

20 Exemption from examination requirements; operators of certain bone densitometers. Adds subd. 8 to § 144.121. Exempts individuals who operate certain types of bone densitometers to estimate bone mineral density, and the facilities in which they are operated, from the requirement that all operators of x-ray equipment pass an examination approved by the commissioner. Defines the bone densitometers covered by this exemption.

21 Rural hospital capital improvement grant program. Amends § 144.148. Makes changes to the rural hospital capital improvement grant program, modifying the program from a grant and loan program to a grant program. Sunsets the program on June 30, 2001.

Subd. 1. Definition. Amends the definition of "eligible rural hospital" to make it identical to the definition of "eligible rural hospital" that exists for the rural hospital planning and transition grant program.

Subd. 2. Program. Modifies the maximum amount of a grant, from $1,500,000 (grant or loan) per hospital to $300,000 (grant) per hospital. Requires hospitals to certify that at least 25 percent of the amount, which may include in-kind services, is available from non-state sources. Strikes language allowing hospitals to apply the funds retroactively to improvements made in the two previous fiscal years.

Subds. 3 and 4. Strikes references to "a loan."

Subd. 5. Program oversight. Permits the commissioner to collect, from hospitals receiving grants, any information needed to evaluate the program. Strikes language requiring the commissioner to review a hospital's audited financial information to assess the hospital's eligibility.

Subds. 6 and 7. Strikes subdivisions 6 and 7, relating to loan payments and accounting for grants and loans.

Subd. 8. Expiration. Makes the program expire June 30, 2001, rather than June 30, 1999.

22 Rural health initiatives. Amends § 144.1483. In a section generally establishing the duties of the commissioner of health related to rural health initiatives, amends the definition of "critical access hospital" for purposes of a Medicare rural hospital flexibility program. Adds to the definition, hospitals in designated medical underserved areas or health professional shortage areas, and allows these hospitals to continue to be recognized as critical access hospitals even when the medical underserved area or health professional shortage area designation is withdrawn.

23 Eligible applicants and criteria for awarding of grants to rural communities. Amends § 144.1492, subd. 3. Strikes a reference to the regional coordinating boards, which are being repealed.

24 Public place. Amends § 144.413, subd. 2. In the definition of "public place" in the Clean Indoor Air Act, corrects a cross-reference to the current definition of public school.

25 Public places. Amends § 144.414, subd. 1. Requires the commissioner of health to adopt rules to

restrict or prohibit smoking in factories and warehouses (under current law, the prohibition on smoking in public places except in designated smoking areas does not apply to factories or warehouses).

26 Tobacco products prohibited in public schools. Amends § 144.4165. In a section prohibiting tobacco products from being used in public schools, corrects a cross-reference to the current definition of public school.

27 Boarding care homes. Amends § 144.56, subd. 2b. Prohibits the commissioner of health from adopting or enforcing any rule that limits a noncertified boarding care home registered as a housing with services establishment from providing home care services in accordance with the home's registration.

28 Remedies available. Amends § 144.99, subd. 1. Allows the commissioner of health to use the commissioner's enforcement powers under the Health Enforcement Consolidation Act to enforce sections 144.1201 to 144.1204 (sections authorizing the commissioner to regulate certain types of radioactive material according to an agreement with the Nuclear Regulatory Commission).

29 Securing radioactive materials. Adds subd. 12 to § 144.99. Paragraph (a) creates an additional enforcement power for the commissioner of health in the Health Enforcement Consolidation Act. In the event of an emergency that poses a danger to the public health, gives the commissioner authority to impound the radioactive materials and associated shielding of any person who fails to follow the law. If impounding is impractical, allows the commissioner to lock or otherwise secure the parts of a facility that contain radioactive materials and shielding that pose a danger to the public health. Makes such actions effective for 72 hours, and requires the commissioner to seek an injunction or take other administrative action to secure radioactive materials after the initial 72-hour period.

Paragraph (b) allows the commissioner to release impounded radioactive materials and associated shielding in certain circumstances, or to bring an action in court for an order directing the disposal of the impounded materials or other disposition as necessary to protect the public health and safety and the environment. Requires the owner, licensee, or any other person using the radioactive materials and shielding to pay the costs of disposal.

30 Assisted living home care license established. Amends § 144A.4605, subd. 2. Allows client records kept by assisted living home care providers to include daily records of home care services provided. (Current law refers to a weekly summary.) Also strikes a reference to client status.

31 AIDS prevention grants. Amends § 145.924. In a section authorizing the commissioner of health to award grants for counseling and evaluation to populations at risk for being infected with HIV, a new paragraph (c) requires all state grants awarded under this section for programs targeted to adolescents to include the promotion of abstinence from sexual activity and drug use.

32 Establishment. Amends § 145.9255, subd. 1. In a subdivision establishing the Minnesota Education Now and Babies Later program (MN ENABL), adds an additional goal for the program of promoting abstinence until marriage.

33 Program components. Amends § 145.9255, subd. 4. In a subdivision listing the components of the MN ENABL program, requires the media and public relations campaign to reinforce the additional message of promoting abstinence from sexual activity until marriage. Allows the commissioner to continue to target populations with a high incidence of adolescent pregnancy with culturally appropriate messages. Also moves responsibility for developing and implementing the MN ENABL media and public relations campaign from the attorney general's office to the commissioner of health. Allows the commissioner to continue to use any campaign or media materials developed before July 1, 1999.

34 Biennial registration fee. Amends § 148.5194, subd. 2. Raises the fee for initial registration, biennial registration, temporary registration, and renewal for speech-language pathologists and

audiologists from $160 to $200.

35 Biennial registration fee for dual registration as a speech-language pathologist and audiologist. Amends § 148.5194, subd. 3. Raises the registration fee for persons dually registered as speech-language pathologists and audiologists, from $160 to $200.

36 Surcharge fee. Adds subd. 3a to § 148.5194. Establishes a surcharge fee of $25 for each registration or registration renewal, to be effective for four years. Sunsets this subdivision June 30, 2003.

37 Penalty fee for late renewals. Amends § 148.5194, subd. 4. Raises the penalty fee for late renewals of speech-language pathologist and audiologist registrations from $15 to $45.

38 Medical education and research fund. Amends § 256B.69, subd. 5c. In a subdivision carving out funds from capitation rates for MA and GAMC for transfer to the medical education and research fund, changes a cross-reference from a section being repealed to a new medical education section created in this article and makes other conforming changes.

39 Bond; insurance. Amends § 326.40, subd. 2. Requires any person contracting to do plumbing work to file a bond with the state in the amount of $25,000, for all work entered into within the state. Strikes language setting the bond amount at $2,000.

40 Alternative compliance. Amends § 326.40, subd. 4. Specifies that local bond requirements are deemed to satisfy the bond and insurance requirements for plumbers if the local ordinance requires at least a $25,000 bond.

41 Fee. Amends § 326.40, subd. 5. Authorizes the commissioner to charge an annual bond filing fee to administer the bond and insurance requirements for people engaging in plumbing work.

42 Study regarding the expansion of plumber licensure and plumbing inspection requirements. Directs the commissioner of health to consult with representatives of the plumbing industry and make recommendations to the legislature, by January 15, 2000, on (1) whether licensure requirements for plumbers should be expanded; (2) whether any modifications are necessary to the education requirements for plumber licensure; (3) whether the commissioner may charge fees the fund the hiring of inspectors and plan reviewers; and (4) whether the commissioner's inspection authority should be expanded to require inspections of all new plumbing installations for new construction and additions.

43 Case studies to develop standards for autopsy practice in special cases. Allows a professional association representing coroners and medical examiners in Minnesota to conduct case studies on controversial autopsy cases, develop guidelines and procedures, and report to the legislature.

Subd. 1. Case studies. States that of a professional association of coroners and medical examiners accepts the grant from the commissioner of health for this purpose, it must comply with this section. Allows the professional association to conduct 12 or more case studies to examine cases in which performing autopsies is controversial. Using these case studies, permits the association to develop guidelines for coroners and medical examiners regarding when to perform autopsies in controversial situations, and special methods for performing these autopsies. When these guidelines and procedures are developed, allows the association to disseminate them to all coroners and medical examiners in Minnesota.

Subd. 2. Report to legislature. Permits the association to report to the legislature by January 15, 2000 on the results of the case studies, the guidelines and procedures developed, and how this information has been or will be disseminated.

Subd. 3. Data privacy. Requires the association to keep confidential all data held by the association, and prohibits the guidelines and procedures for autopsies from containing individually identifiable information.

44 Amendment to rules. Requires the commissioner of health to amend rules governing sources of ionizing radiation, exempting operators of certain types of bone densitometers and the facilities in

which they are operated from the examination requirements for operators of x-ray equipment. Allows these rules to be adopted using an expedited process.

45 Repealer. Paragraph (a) repeals sections 13.99, subdivision 19m; 62J.77; 62J.78; and 62J.79 (office of health care consumer assistance, advocacy, and information).

Paragraph (b) repeals section 62J.69 (medical education and research); 144.9507, subdivision 4 (grants for lead cleanup equipment and materials); 144.9511 (lead-safe property certification); and 145.46 (dental health education program).

Paragraph (c) repeals Laws 1998, chapter 407, article 2, section 104 (authorizing the governor to enter into an agreement with the U.S. Nuclear Regulatory Commission to allow the state to assume regulation over certain types of nuclear materials).

46 Effective date. Establishes effective dates for this article.

Article 3: Long-term Care

Overview

This article contains provisions related to nursing facilities, ICFs/MR, group residential housing (GRH), and other long-term care services. This article:

Establishes a local system needs planning process for ICFs/MR and establishes requirements for the new ICF/MR payment system that is to be implemented October 1, 2000 (sections 10 and 33).

Provides rate increases for nursing facilities (section 20).

Delays implementation of the new nursing facility reimbursement system until July 1, 2001, and requires the commissioner to present recommendations on specific issues (section 25).

Establishes a modified system for GRH rates, based on county average rates (section 40).

Contains other provisions and changes related to long-term care services.

1 Replacement restrictions. Amends § 144A.073, subd. 5. Modifies the provisions of an existing nursing facility moratorium exception.

2 Training and education for nursing facility providers. Amends § 144A.10, by adding subd. 1a. Requires the commissioner of health to establish and implement a process and program for providing training and education to providers licensed by the department of health, prior to using any new regulatory guideline or other materials used in surveyor training. Requires the process to: (1) facilitate the implementation of immediate revisions to any course curriculum; (2) conduct training of long-term care providers and health department survey staff; and (3) within available resources, require the commissioner to cooperate in the development of clinical standards, work with vendors regarding hazards, and identify research of interest.

3 Data on follow-up surveys. Amends § 144A.10, by adding subd. 11. Requires the commissioner to make available to the nursing home associations and public, upon request, copies of statements of deficiencies and related letters pertaining to federal certification surveys, if this is not prohibited by federal law. Also requires the commissioner to make available on a quarterly basis aggregate data on federal certification follow-up or resurvey statements.

4 Nurse aide training waivers. Amends § 144A.10, by adding subd. 12. Requires the commissioner to grant waivers for the continuation of nurse aide training programs or competency evaluation programs conducted by or on the site of nursing facilities that would otherwise lose approval for the program or programs. Requires the commissioner to consider specified criteria.

5 Immediate jeopardy. Amends § 144A.10, by adding subd. 13. Prohibits the commissioner from issuing a finding for immediate jeopardy unless the violation poses an imminent risk of life-

threatening or serious injury to a resident. Prohibits the commissioner from issuing findings of immediate jeopardy after the conclusion of a survey, unless the survey team identified the violation prior to the close of the exit conference.

6 Informal dispute resolution. Amends § 144A.10, by adding subd. 14. Requires the commissioner to respond in writing to a request from a nursing facility for informal dispute resolution, within 30 days of the exit date of the facility's survey. Specifies requirements for this response.

7 Use of civil money penalties; waiver from state and federal rules and regulations. Adds § 144A.102. Requires the commissioner of health to apply for federal waivers and identify necessary changes in state law to: (1) allow the use of civil money penalties to abate any deficiencies identified in a nursing facility's plan of correction; and (2) stop accrual of any fine when a follow-up survey is not conducted by the department within the regulatory deadline.

8 Housing with services establishment or establishment. Amends § 144D.01, subd. 4. Specifies that a housing with services establishment does not include a certified boarding care home (current law excludes noncertified as well as certified boarding care homes).

9 Determinations; redeterminations. Amends § 252.28, subd. 1. Exempts residential services for persons with developmental disabilities from the determination of need process. Also exempts changes of ownership from this process.

10 ICF/MR local system needs planning. Adds § 252.282. Establishes a local system needs planning process for ICFs/MR.

Subd. 1. Host county responsibility. Requires counties, in collaboration with the commissioner and ICF/MR providers, to complete a local system needs planning process for each ICF/MR facility by May 15, 2000, and by July 1 every two years thereafter. The process must determine the need for ICF/MR services by program type, location, demographics, and size. Requires more frequent planning if the needs or preferences of consumers change. Requires the local system needs plan to be amended whenever recommendations for modifications are made to the host county.

Subd. 2. Consumers needs and preferences. Establishes requirements for counties to follow when conducting the local system needs planning process.

Subd. 3. Recommendations. Requires the host county to make recommendations by May 15, 2000, and by July 1 every two years thereafter beginning in 2001. Requires recommendations involving rate increases and adjustments to be submitted to the statewide advisory committee, and recommendations on other matters to be submitted to the commissioner.

Subd. 4. The statewide advisory committee. Requires the commissioner to appoint a five-member statewide advisory committee to review and recommend requests for facility rate adjustments. Specifies requirements for the committee.

Subd. 5. Responsibilities of the commissioner. Requires the commissioner to: (1) ensure that services recognize the preferences and needs of persons with developmental disabilities; (2) publish notices announcing the opportunity to submit requests for rate adjustments; (3) designate system funding parameters; and (4) contract with ICF/MR providers.

11 Exception for Lake Owasso project. Amends § 252.291, by adding subd. 2a. Requires DHS to license a new ICF/MR at Lake Owasso in Ramsey County, effective January 1, 2000, and establishes an MA rate methodology for the facility.

12 Payment for preadmission screening. Amends § 256B.0911, subd. 6. Requires the commissioner to include payments made by nursing facilities for preadmission screening as operating costs under the cost-based and new performance-based contracting systems.

13 Services covered under alternative care. Amends § 256B.0913, subd. 5. Allows alternative care funding to be used for other services, including direct cash payments to clients. Limits payments for other services to the greater of 10 percent of a county's annual alternative care base allocation or

$5,000. Allows for-profit organizations to provide companion services. Specifies requirements for using alternative care program allocations for other services. These include the requirement that a cash payment to a client not exceed 80 percent of the monthly payment limit for that client and that payments be used for expenses that meet the guidelines of the consumer support grant program.

14 Allocation formula. Amends § 256B.0913, subd. 10. Provides the methods for allocating alternative care funding to county agencies for the biennium ending June 30, 2001. Requires the commissioner to distribute funding based on each county's proportion of current allocations, if the appropriation for alternative care is inadequate to fund the combined county allocations.

15 Client premiums. Amends § 256B.0913, subd. 12. Raises the asset limit above which alternative care clients must pay premiums, from $6,000 to $10,000.

16 Conversion of enrollment. Amends § 256B.0913, subd. 16. Modifies the requirement that current AC clients be transferred to the elderly waiver (EW) program, when eligibility for the waiver program is expanded. Allows existing AC recipients and new applicants to be eligible for AC if their income is above the EW maintenance needs amount but below the EW income cap.

17 Operating costs after July 1, 1998. Amends § 256B.431, subd. 2i. Deletes outdated nursing facility reimbursement language.

18 Special provisions for moratorium exceptions. Amends § 256B.431, subd. 17. Paragraph (h) increases the replacement-costs-new per bed limits for moratorium projects that involve total replacement, to $74,280 per bed in multiple-bed rooms and $111,420 per bed in single rooms. Creates a semi-private bed limit of $92,850. Requires these amounts to be adjusted annually.

Paragraph (i) provides modified replacement-costs-new per bed limits for a previously approved project in Carlton county.

19 Changes to nursing facility reimbursement beginning July 1, 1997. Amends § 256B.431, subd. 26. Modifies a reimbursement provision for a previously approved nursing facility moratorium exception project.

20 Nursing facility rate increases beginning July 1, 1999, and July 1, 2000. Amends § 256B.431, by adding subd. 28. Modifies nursing facility reimbursement in a variety of ways for the upcoming biennium, including:

For the rate year beginning July 1, 1999, requires the commissioner to make available rate increases of 4.843 percent for compensation related costs and 3.446 percent for all other operating costs.

For the rate year beginning July 1, 2000, requires the commissioner to make available rate increases of 3.632 percent for compensation related costs and 2.585 percent for all other operating costs.

Facilities must develop a plan to distribute these compensation increases and must make a copy of the plan available to employees.

For the rate year beginning July 1, 1999, specified facilities in Carver, Faribault, and Houston counties receive an increase equal to 67 percent of the increase they would receive if the spendup limits did not apply.

For the rate year beginning July 1, 1999, specified facilities in Chisago and Murray counties receive an increase equal to 67 percent of the increase they would receive if the spendup and high cost limits did not apply.

For the rate year beginning July 1, 1999, a specified facility in Hennepin County receives an increase in its care-related and other operating cost per diems and receives an increase equal to 67 percent of the increase it would receive if the spendup and high cost limits did not apply.

21 Duration and termination of contracts. Amends § 256B.434, subd. 3. Extends the notice period for termination of contracts under the alternative payment demonstration system from 30 to 90 days. Removes the four-year limit on the number of times a contract can be renewed for one-year terms.

22 Alternate rates for nursing facilities. Amends § 256B.434, subd. 4. States that the annual inflation adjustment under this subdivision for nursing facilities reimbursed under the alternative contract payment system applies only to the property related payment rate, for the rate years beginning on July 1, 1999, and July 1, 2000.

23 Facility rate increases. Amends § 256B.434, by adding subd. 4a. Provides rate increases effective July 1, 1999, for a number of specific facilities as follows:

a Becker County facility receives a rate increase at each case mix level, ranging from $1.30 at level A to $1.59 at level K;

a Chisago County facility receives a $3.67 increase at each case mix level;

a facility in Canby receives a property-related per diem increase of $1.21;

a facility in Golden Valley receives a rate increase of $14.83; and

a county-owned facility in Park Rapids receives a rate increase of $1.02 for costs related to comparable worth requirements.

24 Payment system reform advisory committee. Amends § 256B.434, subd. 13. Removes the June 30, 1997 sunset date for the payment system reform advisory committee and strikes obsolete language related to a permanent managed care payment system.

25 Nursing facility reimbursement system effective July 1, 2001. Amends § 256B.435. The amendment to **subdivision 1** requires the commissioner to implement a performance-based contracting system for nursing facilities on July 1, 2001 (current law requires implementation July 1, 2000). States that the laws and rules for the cost-based system will be used to establish operating cost payment rates for new facilities. Requires funding for incentive-based payments to be included as a budget change request in each biennial budget.

Requires the commissioner to present recommendations to the legislature by February 15, 2000 in the following areas:

(a) development of an interim default payment mechanism for: facilities that do not respond to the state's RFP but wish to continue in MA, facilities that the state does not select in the RFP process; and facilities whose contract has been canceled;

(b) development of criteria for facilities to earn performance-based incentive payments;

(c) development of criteria and a process under which facilities can request rate adjustments for low base rates, geographic disparities, or other reasons;

(d) development of a dispute resolution mechanism for nursing facilities;

(e) development of a property payment system that will be funded with additional appropriations;

(f) establishment of a transitional plan to move from dual assessment instruments to the federally mandated resident assessment system;

(g) identification of net cost implications for facilities and DHS of preparing for and implementing performance-based contracting or any proposed alternative system;

(h) identification of facility financial and statistical reporting requirements; and

(i) identification of exemptions from current regulations and laws applicable under performance-based contracting.

A new **subdivision 1a** requires the commissioner to issue, before July 1, 2001, a request for proposals for facilities operating under the cost-based system to provide nursing facility services under the new performance-based contract system. Sets requirements for the RFP process and criteria

for the commissioner to use in developing contract terms. Directs the commissioner to renegotiate contracts for facilities reimbursed under the alternative payment system on January 1, 2001, without requiring an RFP.

The amendment to **subdivision 2** requires performance-based contracts to require facilities to specify the method for resolving disputes, and allows the commissioner to negotiate different contract terms for different facilities. Strikes language requiring contracts to establish additional penalties for facilities not meeting contract standards.

A new **subdivision 2a** establishes criteria related to the duration and termination of contracts.

The amendments to **subdivision 3** provide additional criteria for payment rates. The amendments:

require the inflation factor to be based on the change in the employment cost index for private industry workers - total compensation, for rate years beginning on or after July 1, 2001;

specify that the payment rate to be inflated is the total payment rate in effect on June 30, 2001, minus the property rate and the per diem for preadmission screening costs;

require a per diem for preadmission screening to be added to the contract rate;

allow the commissioner to implement a new method of payment for property-related costs, for rate years beginning on or after July 1, 2001.

A new **subdivision 4** allows an interim rate to calculated, if cost-based rates used to calculate the rate under the performance-based system are under appeal, and requires a retroactive adjustment once the appeal is resolved.

A new **subdivision 5** provides standards for residence grievance procedures and requires facilities to make available to residents and families a copy of the performance-based contract and the outcomes to be achieved.

A new **subdivision 6** specifies that participation of nursing facilities in MA is voluntary and that the terms and procedures governing performance-based contracts are determined under this section and through negotiation between the commissioner and the nursing facility.

A new **subdivision 7** requires the commissioner to implement the new system subject to any required federal waivers or approval and in a manner consistent with federal requirements. Provides that federal law supersedes any inconsistent state provisions. Directs the commissioner to seek federal approval and request waivers as necessary to implement the new system.

26 Prohibited practices. Amends § 256B.48, subd. 1. As a condition of participation in MA, prohibits facilities from requiring a third-party guarantee of payment as a condition of admission, expedited admission, or continued stay. Also clarifies existing prohibitions related to the admission of applicants. Strikes language that exempts a specific facility from these prohibitions.

27 Termination. Amends § 256B.48, subd. 1a. Strikes unnecessary language.

28 Exception. Amends § 256B.48, subd. 1b. Strikes obsolete language.

29 Medicare certification. Amends § 256B.48, subd. 6. Strikes obsolete language.

30 Attorney's fees and costs. Amends § 256B.50, subd. 1e. Requires fees and costs awarded to providers as a result of appeals to be reimbursed within 120 days of the final decision on the award of attorney fees and costs. Strikes references to inclusion of these fees and costs in cost reports.

31 In general. Amends § 256B.5011, subd. 1. Effective October 1, 2000, requires the commissioner to index each facility's operating payment rate under the new ICF/MR contracting system, rather than the total rate. Strikes a reference to "performance based" contracting.

32 Contract provisions. Amends § 256B.5011, subd. 2. Removes the requirement that contracts under the new system include provisions for monitoring service quality and replaces the requirement for reporting statistical information on staffing with a more general requirement to report statistical information. Requires the commissioner to recommend to the legislature by January 15, 2000

whether contracts should include service quality monitoring.

33 ICF/MR payment system implementation. Adds § 256B.5012. Establishes requirements for a new ICF/MR payment system.

Subd. 1. Total payment rate. Specifies the components of the total payment rate and states that the initial rate year is to run from October 1, 2000 through December 31, 2001, with subsequent rate years coinciding with the calendar year.

Subd. 2. Operating payment rate. Specifies that the operating payment rate is the facility's total payment rate in effect on September 30, 2000, minus the property rate. Within the limits of appropriations, requires the rate to be adjusted annually for inflation, using a new inflation index, and to be adjusted effective October 1, 2000 to reflect an occupancy rate of 100 percent of capacity days.

Subd. 3. Property payment rate. Specifies that the property payment rate effective October 1, 2000 is based on the modified rate in effect on September 30, 2000. Effective October 1, 2000, sets a minimum rate of $8.13. Within the limits of appropriations, provides annual inflation adjustments, effective January 1, 2002. Provides increases of 0, 1, or 2 percent, based on the modified property rate in effect on September 30, 2000.

34 Payment rate adjustments. Adds § 256B.5013. Specifies the conditions for ICF/MR payment rate adjustments.

Subd. 1. Variable rate adjustments. Establishes the procedures for counties to approve enhanced rates for individuals. Also requires the commissioner to recommend to the legislature by January 15, 2000 a methodology to use profile groups based on the functional characteristics of residents to determine variable rates.

Subd. 2. Other payment rate adjustments. Allows facilities to submit requests for adjustments in total payment rates to the statewide advisory committee and allows counties, with authorization from the committee, to adjust rates.

Subd. 3. Relocation. Establishes procedures for determining rates for relocated facilities.

Subd. 4. Temporary rate adjustments to address occupancy and access. Requires the commissioner to adjust the total payment rate if a facility is operating at less than 100 percent of occupancy or if a resident is discharged, but prohibits the use of this mechanism to pay for hospital or therapeutic leave days beyond the maximums. Requires adjustments exceeding 90 days to be submitted to the statewide advisory committee.

35 Financial reporting. Adds § 256B.5014. Requires facilities to maintain financial records and provide annual income and expense reports to the commissioner. Specifies contents of the reports.

36 Pass-through of training and habilitation services costs. Adds § 256B.5015. Requires training and habilitation costs to be paid for on a pass-through basis.

37 Nursing home services. Amends § 256B.69, subd. 6a. Requires up to 90 days of nursing facility services to be covered under the prepaid medical assistance program.

38 Home and community-based waiver services. Amends § 256B.69, subd. 6b. Eliminates language requiring elderly waiver services to be covered under the prepaid medical assistance program. Specifies that waiver services for Minnesota Senior Health Options (MSHO) enrollees under age 65 with physical disabilities shall be covered according to the terms and conditions of the federal agreement governing MSHO.

39 Moratorium on the development of group residential housing beds. Amends § 256I.04, subd. 3. Provides an exemption from the moratorium on new GRH beds with rates higher than the MSA equivalent rate for settings used by recipients receiving home and community-based waiver services who resided in a nursing facility for the six months immediately prior to entry into a GRH setting. Specifies rate limits.

40 Maximum rates. Amends § 256I.05, subd. 1. Allows counties to approve GRH supplementary room and board rates. Limits the average supplementary room and board rate in a county for a calendar year to the average supplementary room and board rate for that county in effect on January 1, 2000. Allows counties with no facilities with supplementary room and board rates, or counties with supplemental rates under $100 per person, to submit requests for these rates to the commissioner.

41 Supplementary service rates. Amends § 256I.05, subd. 1a. Provides that the supplementary service rate plus the supplementary room and board rate cannot exceed $426.37, unless otherwise provided in law.

42 Supplementary rate for certain facilities. Amends § 256I.05, by adding subd. 1e. Requires a county agency to negotiate a supplementary GRH rate for a provider located in Hennepin county that serves a chemically dependent clientele and meets other criteria.

43 Facility certification. Amends Laws 1995, chapter 207, article 3, section 21. After January 1, 1999, makes the MA program responsible for one-half the state share for the cost of services provided to residents of an ICF/MR located in Northfield (these costs are currently a county responsibility).

44 Deadline extension. Requires the commissioner of health to extend approval to May 31, 2000, for a total replacement of a 96-bed nursing home located in Carlton county previously approved under the competitive moratorium exception process.

45 State licensure conflicts with federal regulations. Requires incontinent residents to be checked according to a specific time interval written in the care plan. Requires physician approval for intervals over two hours.

46 Group residential housing study. Requires the commissioner of human services to submit to the legislature by February 15, 2000, a study of the cost of GRH payments and an analysis of these costs to market rate costs.

47 ICF/MR service reconfiguration project. (a) Allows the commissioner of human services to authorize a project to reconfigure two existing ICFs/MR in Carver county, totaling a 60 beds in one 46-bed facility and one 14-bed facility. Allows up to six beds to be relocated to a six-bed ICF/MR, with the remaining ICFs/MR consisting of one 34-bed and one ten-bed facility.

(b) Requires the project to include the development of alternative home and community-based services for individuals relocated, and requires two beds in the 34-bed facility to be reserved for temporary care services. Allows that facility to modify its need determinations.

(c) Requires the project to be approved by the commissioner, include criteria on how individuals will be selected for alternative services, and use an RFP process for choosing vendors. Authorizes the commissioner to develop two additional beds and to set aside waivered services slots as needed.

(d) Specifies reimbursement conditions for the facilities involved in the reconfiguration project.

48 ICF/MR reimbursement effective October 1, 1999. Extends the modified spend-up limit and exemption from the high-cost limit found in session laws to the rate year beginning October 1, 1999, and also exempts certain facilities from the spend-up limit. (Without this provision, the spend-up and high-cost limits in section 256B.501, subd. 5b would take effect October 1, 1999.)

49 Section is a duplicate of section 44.

50 Section is a duplicate of section 46.

51 Repealer. (a) Repeals § § 144.0723 (client reimbursement classifications) and 256B.5011, subd. 3 (ICF/MR rate setting effective October 1, 2000).

(b) Repeals § 256B.434, subd. 17 (outdated reference to a report).

(c) Repeals § 256B.501, subd. 3g (assessment of clients) effective October 1, 2000.

(d) Repeals Laws 1999, chapter 203, article 4, section 55 (PMAP exemption for certain elderly waiver clients).

(e) Repeals section 45 (checking incontinent residents) effective July 1, 2001.

52 Effective date. States that sections 3 to 7 and 45 are effective the day following final enactment.

Article 4: Health Care Programs

Overview

This article contains provisions related to health care programs administered by the Department of Human Services (DHS). This article:

Modifies procedures for the provision and reimbursement of special education services covered under MA (sections 4 to 7, 45, 72, and 107).

Contains initiatives to reduce the waiting list for the home and community-based waiver for persons with mental retardation and related conditions (section 61).

Allows the implementation of county-based purchasing to be delayed until six months after federal waiver approval and authority has been granted (sections 70, 71, 76, and others).

Modifies requirements for the senior drug program (sections 19 to 23 and 104).

Expands and clarifies MA coverage of health care services (sections throughout).

Makes changes related to the provision of services for persons with developmental disabilities, including allowing greater flexibility in the use of personal care assistant hours and allowing the use of fiscal agents (sections throughout).

Expands MA eligibility for employed persons with disabilities (section 34).

Provides rate increases for physicians, dentists, and other providers (sections 25, 74, 77, and 78).

Contains other initiatives and changes related to DHS health care programs.

1 Payments on behalf of enrollees in government programs. Amends § 62A.045. Modifies DHS subrogation rights to collect from third parties for health care provided through DHS programs. Subrogation rights may be asserted within three years after the service is provided. The definition of "state agency" for purposes of this section is clarified.

2 License and rules. Amends § 122A.09, subd. 4. Requires the board of teaching, when adopting rules to license teachers who provide health-related services to disabled children, to adopt rules consistent with the license or registration requirements of the health-related boards who license personnel who perform similar services outside of the school.

3 School district obligations. Amends § 125A.08. Requires the individual education plan team to consider, and allows the team to authorize, services covered by MA under § 256B.0625, subd. 26. Requires compliance with this and related requirements to the extent required by federal law as of July 1, 2000 (current law requires compliance as of July 1, 1999).

4 Implementation. Amends § 125A.744, subd. 3. Requires school districts to be reimbursed by the commissioner of human services for the federal share of services for special education services covered under MA, minus up to 5 percent retained by the commissioner for administrative costs, not to exceed $350,000 per fiscal year. Strikes language related to MA services and prepaid health plans.

5 Special education base revenue. Amends § 125A.76, subd. 2. Includes, as part of the special education base revenue for FY 2001 and later, costs related to district expenditures for the nonfederal share of MA services according to section 256B.0625, subd. 26.

6 Monitor medical assistance services for disabled students. Adds § 127A.11. Requires the commissioner of children, families, and learning, in cooperation with the commissioner of human services, to monitor the costs of health-related, special education services provided by public schools.

7 **Coordination with board of teaching.** Adds § 214.045. Requires the commissioner of health and the health-related licensing boards to coordinate with the board of teaching when modifying licensure requirements for regulated persons, in order to have consistent requirements for personnel who perform services in schools.

8 **Adult mental illness crisis housing assistance program.** Adds § 245.99. Establishes an adult mental illness crisis housing assistance program in the department of human services. The program can pay for up to 90 days of housing assistance (to be extended on a case-by-case basis) for people with serious and persistent mental illnesses who need inpatient care to be stabilized. Specifies that only people of low or moderate income, as determined by the commissioner of human services, are eligible for this housing assistance. Allows the commissioner to contract with another agency or organization to operate the program.

9 **Notification to subject and license holder of study results; determination of risk of harm.** Amends § 245A.04, subd. 3a. Modifies the requirement that the subject of a background study must be notified of the results by eliminating this requirement for certain individuals involved in day care or foster care services unless the study leads to disqualification. This section also authorizes counties to develop alternative systems, subject to DHS approval, for determining whether the subject of a background study poses an immediate risk of harm to program clients.

10 **Notice of the commissioner's final order.** Amends § 245A.08, subd. 5. Prohibits an applicant who is denied a DHS license from being licensed for the next two years, unless the applicant produces new information indicating a substantial change in the conditions that caused the denial.

11 **Reporting incidents and emergencies.** Amends § 245B.05, subd. 7. Requires persons holding a license to provide services to persons with developmental disabilities to report deaths or serious injuries of consumers to the DHS licensing division (current law requires

a report to the commissioner).

12 **Staff orientation.** Amends § 245B.07, subd. 5. Allows staff providing services to persons with developmental disabilities to administer medications only after they demonstrate the ability to do so, as defined in the license holder's medication administration policy and procedures.

13 **Policies and procedures.** Amends § 245B.07, subd. 8. Requires policies for safe medication administration to incorporate an observed skill assessment. Requires license holders to provide consumers with at least 60 days notice of a temporary service suspension (current law requires notice "as soon as possible").

14 **Consumer funds.** Amends § 245B.07, subd. 10. Requires license holders who assist consumers with funds or other property to have written authorization, and to provide statements of receipts and disbursement in the manner preferred by the consumer, consumer's legal representative, and case manager. Makes changes in terminology.

15 **Reports and allocations.** Amends § 252.32, subd. 3a. Requires any remaining funds for the family support grant program, after allocation to counties based on their guaranteed floors, to be allocated to county agencies to support children in their family homes. Strikes outdated language.

16 **State agency has lien.** Amends § 256.015, subd. 1. Expands the definition of "state agency" for purposes of establishing DHS lien rights against third parties in efforts to recover for the cost of medical or cash benefits provided to recipients.

17 **Prosecutor.** Amends § 256.015, subd. 3. Provides a list of parties who may retain legal representation to enforce liens.

18 **Tax rebates.** Adds § 256.028. Excludes federal and state tax rebates from being counted as income or assets for purposes of public assistance programs.

19 **Prescription drug coverage.** Amends § 256.955, subd. 3. Limits coverage under the senior drug

program to drugs covered under MA that are provided by manufacturers that have signed separate senior drug rebate agreements with the commissioner. (Under current law, manufacturers are to sign one rebate agreement that applies both to MA and the senior drug program.) Strikes language that allows coverage for certain drugs cleared by the FDA.

20 **Application procedures and coordination with medical assistance.** Amends § 256.955, subd. 4. Specifies that eligibility for the senior drug program begins the month after approval.

21 **Cost sharing.** Amends § 256.955, subd. 7. Modifies cost sharing requirements for the senior drug program, by eliminating the $120 annual premium, increasing the annual deductible to $420 (paid in $35 monthly increments), and eliminating the option to pay the annual deductible biannually.

22 **Report.** Amends § 256.955, subd. 8. Deletes a reference to the $120 annual premium, which is being eliminated.

23 **Program limitation.** Amends § 256.955, by adding subd. 9. Requires the commissioner to administer the senior drug program so that costs do not exceed appropriations plus drug rebate proceeds. Appropriates senior drug program rebate revenues to the commissioner. Requires new enrollment to cease if the commissioner determines that program costs will exceed appropriations and rebate proceeds.

24 **Administrative reconsideration.** Amends § 256.9685, subd. 1a. Codifies a rule provision that allows physicians and hospitals to request reconsideration of decisions that inpatient hospital services are not medically necessary, by submitting a written request to the commissioner within 30 days of receiving notice of the decision.

25 **Hospital cost index.** Amends § 256.969, subd. 1. Extends, from CY 1999 to CY 2001, the exemption for MA from the prohibition on inflation adjustments for hospital payment rates. Requires the index for CY 2000 for MA hospital payment rates to be reduced by 2.5 percentage points to recover earlier overprojections.

26 **Personal care services.** Amends § 256B.04, subd. 16. Makes conforming changes related to the amendments to sections 256B.0625, subd. 19c and 256B.0627, subd. 10.

27 **Performance data reporting unit.** Amends § 256B.04, by adding subd. 19. Requires the commissioner to establish a performance data reporting unit to provide performance data reports to individual counties, share expertise, and participate in joint planning to link county data sources.

28 **Lien for cost of care.** Amends § 256B.042, subd. 1. Expands the definition of "state agency" for purposes of enforcing DHS liens to recover for the cost of medical care provided to recipients.

29 **Lien enforcement.** Amends § 256B.042, subd. 2. Deletes a definition of "state agency" from DHS lien enforcement language.

30 Amends § 256B.042, subd. 3. Provides a list of parties that may retain legal representation to enforce medical liens.

31 **MFIP-S families; families eligible under prior AFDC rules.** Amends § 256B.055, subd. 3a. Strikes language that requires public assistance clients to meet deprivation requirements, in order to receive MA. (This has the effect of eliminating the requirement that the primary wage earner in two-parent families work less than 100 hours per month to retain MA eligibility.)

32 **Income.** Amends § 256B.056, subd. 4. Effective July 1, 2000, requires the base AFDC standard in effect for MA to be increased by 3 percent. Strikes language directing the commissioner, for rate years beginning on or after July 1, 1999, to consider increasing the base AFDC standard by the change in the CPI-U. Effective January 1, 2000, and each successive January, allows SSI recipients to have an income up to the SSI income standard to qualify for MA.

33 **Qualified medicare beneficiaries.** Amends § 256B.057, subd. 3. Simplifies language that raised the income standard for Qualified Medicare Beneficiaries (QMB's) to 100 percent of federal poverty

guidelines, effective in 1991.

34 **Employed persons with disabilities.** Amends § 256B.057, by adding subd. 9. Allows MA to be paid for employed persons who: (1) are disabled under SSI standards; (2) have countable assets no greater than $20,000 excluding certain assets; and (3) pay a premium, if required, under this section. Spousal income and assets are disregarded when determining eligibility and premium determinations. The premium is equal to 10 percent of gross income above 200 percent of federal poverty guidelines.

35 **Availability of income for institutionalized persons.** Amends § 256B.0575. Adds, to the list of amounts that can be deducted from an institutionalized person's income, all exclusions mandated by federal law.

36 **Eligibility; retroactive effect; restrictions.** Amends § 256B.061. States that an applicant who meets certain criteria shall be determined eligible for MA beginning in the month of application.

37 **Telemedicine consultations.** Amends § 256B.0625, by adding subd.3b. Provides MA coverage for telemedicine consultations. Provides a July 1, 2001 expiration date.

38 **Home health services.** Amends § 256B.0625, subd. 6a. Allows MA coverage of home health services for residents of health care facilities licensed by the commissioner of health that are not hospitals, nursing facilities, or intermediate care facilities.

39 **Physical therapy.** Amends § 256B.0625, subd. 8. Clarifies that MA coverage of physical therapy and related services includes specialized maintenance therapy.

40 **Occupational therapy.** Amends § 256B.0625, subd. 8a. Clarifies that MA coverage of occupational therapy and related services includes specialized maintenance therapy.

41 **Speech language pathology services.** Amends § 256B.0625, by adding subd. 8b. Clarifies that MA covers speech language pathology and related services, including specialized maintenance therapy.

42 **Care management; rehabilitation services.** Amends § 256B.0625, by adding subd. 8c. Establishes one-time thresholds to replace annual thresholds for therapy services at the level included in the DHS 1997 provider manual and states that the thresholds shall include sensory skills and cognitive training skills. This section also requires that a care management approach for authorization of services beyond the threshold be instituted and requires the commissioner to implement an expedited five-day turnaround time to review authorization requests for emergency rehabilitation services when the threshold limit has been exhausted.

43 **Drugs.** Amends § 256B.0625, subd. 13. Deletes the ban on MA coverage of drugs from manufacturers who have not signed a drug rebate agreement with the Senior Citizen Drug Program. This section also requires DHS to set the maximum allowable cost for drugs that are available from multiple sources but are not on the federal upper limit list and defines "multisource drugs." It also provides coverage for anorectics under limited circumstances.

44 **Personal care.** Amends § 256B.0625, subd. 19c. Allows personal care services to be supervised by the recipient under the fiscal agent option or by a qualified professional. Defines "qualified professional" to mean a mental health professional or a registered nurse. (Under current law, supervision must be done by a registered nurse.)

45 **Special education services.** Amends § 256B.0625, subd. 26. Makes the following changes related to MA coverage of special education services:

Specifies covered services.

Requires mental health services eligible for MA reimbursement to be provided or coordinated through a children's mental health collaborative, where one exists, if the child is included in the collaborative's target population.

States that the nonfederal share of costs is the responsibility of the local school district.

Provides that approval of health-related services for inclusion in the individual education plan satisfies MA prior authorization requirements.

Requires the commissioner to develop and implement package rates, bundled rates, and per diem rates for special education services, and to seek necessary federal waivers.

Requires the commissioner to develop a cost-based payment structure for these services.

States that MA services provided under an individual education plan or an individual family service plan shall not count against MA authorization thresholds, effective July 1, 2000.

46 **Certified nurse practitioner services.** Amends § 256B.0625, subd. 28. Adds certified neonatal nurse practitioner services to the list of nurse practitioner services covered by medical assistance. Requires nurse practitioner services provided on an inpatient basis to be excluded from the payment rate for inpatient services.

47 **Other clinic services.** Amends § 256B.0625, subd. 30. Effective July 1, 1999, eliminates the requirement that federally qualified health centers and rural health clinics become essential community providers in order to receive cost-based reimbursement. Effective January 1, 2000, limits payments to the cost phase-out schedule of the Balanced Budget Act of 1997.

48 **Nutritional products.** Amends § 256B.0625, subd. 32. Strikes obsolete language related to the nutritional supplementation products advisory committee.

49 **Family community support services.** Amends § 256B.0625, subd. 35. To the extent authorized by rules, adds the following services as family community support services: services identified in an individual treatment plan when provided by a trained mental health behavioral aide under supervision, mental health crisis intervention and crisis stabilization services provided outside of hospital inpatient settings, and the therapeutic components of preschool and therapeutic camp programs.

50 **Definition.** Amends § 256B.0627, subd. 1. Clarifies assessment procedures for personal care services. Allows service updates to substitute for face-to-face assessments when there is not a significant change in recipient condition or care needs. Adds conforming changes related to sections 256B.0625, subd. 19c and 256B.0627, subd. 10.

51 **Services covered.** Amends § 256B.0627, subd. 2. Adds, to the list of covered home care services, consulting professionals for personal care assistant (PCA) services under the fiscal agent option and service updates and review by county public health nurses of temporary increases for personal care assistant services. Adds references to qualified professionals and face-to-face assessments.

52 **Personal care services.** Amends § 256B.0627, subd. 4. Allows parents of adult recipients, adult children, or siblings to obtain a hardship waiver to provide personal care services, when the relative, because of special language needs, is needed to provide an adequate number of PCAs. Applies the waiver requirement to all siblings (not just adult siblings).

53 **Limitation on payments.** Amends § 256B.0627, subd. 5. Allows recipients to receive up to two face-to-face assessments and one service update without prior authorization. Strikes language allowing the service update to substitute for the annual reassessment and adds language requiring the commissioner to review service updates and requests for temporary services. Makes changes related to qualified professionals.

54 **Shared personal care assistant services.** Amends § 256B.0627, subd. 8. Makes changes in terminology and phrasing in a subdivision dealing with shared PCA services.

55 **Flexible use of personal care assistant hours.** Amends § 256B.0627, by adding subd. 9. Allows the scheduled use of authorized PCA services to vary within the service authorization period in order to more effectively meet the needs and schedule of the recipient or responsible party. Sets requirements for this more flexible use of hours and allows the commissioner to deny, revoke, or suspend this authorization if the requirements are not met.

56 **Fiscal agent option available for personal care assistant services.** Amends § 256B.0627, by adding subd. 10. Gives the commissioner authority to allow recipients of PCA services to use fiscal agents to assist in paying and accounting for these services. Specifies requirements for recipients or responsible parties, fiscal agents, and consulting professionals. Requires the fiscal agent and recipient to enter into a written agreement before services are provided. Sets the payment rate for PCA services provided under this subdivision at the MA rate. Except for an administrative fee paid to the fiscal agent, requires the remainder of the payment rate to be used to pay for salary and benefits for the PCA or those providing professional consultation. Specifies the conditions under which the commissioner can

deny, revoke, or suspend the use of the fiscal agent option, and allows appeals.

57 **Shared private duty nursing option.** Amends § 256B.0627, by adding subd. 11. Allows two recipients in the same setting to share private duty nursing care. Limits reimbursement to 1.5 times the nonwaivered private duty nursing rate for serving a single individual who is

not ventilator dependent. Sets documentation and other requirements for the provision of shared services.

58 **Public health nurse assessment rate.** Amends § 256B.0627, by adding subd. 12. Specifies reimbursement rates for public health nurse visits that relate to the provision of personal care services. Requires the rates to be adjusted to reflect any future rate increases for personal care assistant services.

59 **Medical assistance for MFIP-S participants who opt to discontinue monthly cash assistance.** Amends § 256B.0635, subd. 3. Allows persons who opt to discontinue receiving MFIP-S cash assistance to receive MA, as long as they meet MFIP-S eligibility requirements.

60 **Conflicts of interest related to Medicaid expenditures.** Adds § 256B.0914. Adopts federal requirements for restricting conflicts of interests in MA procurement and contracting. Defines terms and applicability. Places restrictions on disclosing procurement information, employment negotiations, acceptance of compensation, and representation and communication. Allows waivers and provides exceptions. Establishes criminal and civil penalties and allows administrative corrective action.

61 **Expansion of home and community-based services; management and allocation responsibilities.** Amends 256B.0916. Requires the commissioner of human services and counties to take steps to increase the availability of services under the MR/RC waiver. Strikes paragraphs (a) through (d) of section 256B.0916 and adds the seven new subdivisions summarized below. Paragraphs (a) through (c) contain obsolete language related to the transfer of semi-independent living services to home and community based services. Paragraph (d) is replaced by subdivision 7.

Subd. 1. Reduction of waiting list. (a) Provides findings related to the waiting list for the MR/RC waiver.

(b) Requires the waiting list for the program to be reduced or eliminated by June 30, 2003, and requires funding to be increased to add 100 additional persons each year to the MR/RC waiver.

(c) Requires the commissioner to use all resources according to specified priorities, and then to serve other persons on the waiting list. Requires unexpended resources allocated to serve persons affected by closures to be used to serve other persons on the waiting list.

(d) For fiscal year 2001, requires at least one-half of the increase in funding for the waiver to be used to serve persons not affected by the closures.

Subd. 2. Distribution of funds; partnerships. (a) Requires the commissioner, beginning in FY

2000, to distribute all funding for the MR/RC waiver to individual counties or groups of counties that form partnerships, and to encourage counties to form partnerships with a sufficient number of recipients and funding to adequately manage risk and maximize use of available resources.

(b) Requires counties to submit a request for funds and a plan for administering the program. Specifies plan requirements.

(c) In allocating resources, requires priority to be given to groups of counties that form partnerships and to counties determined by the commissioner to have sufficient waiver capacity to maximize resource use.

(d) Requires the commissioner to provide a written response to county funding requests and plans, within 30 days of receipt.

(e) States that counties determined to have sufficient capacity, and groups of counties in partnership, are eligible to receive MA reimbursement for administrative costs.

Subd. 3. Failure to develop partnerships or submit a plan. (a) Requires the commissioner to notify the county board if a county determined by the commissioner to have insufficient capacity fails to develop a partnership or submit a plan, and to provide technical assistance to the county or group of counties that fails to form a partnership or submit a plan. If a county has not joined a partnership or submitted a plan within 30 days of this notice, directs the commissioner to require and assist the county to develop a plan or contract with a county or group of counties to plan and administer the waiver services program in that county.

(b) Allows counties to request technical and other assistance from the commissioner at any time, and requires the commissioner to respond to requests within 30 days.

Subd. 4. Allowed reserve. Allows counties or groups of counties that have submitted a plan to develop an allowed reserve amount to meet crises and other unmet needs of waiver recipients. Specifies reserve requirements.

Subd. 5. Priorities for reassignment of resources and approval of increased capacity. Requires the commissioner, in order to maximize the number of persons served with waiver funds, to monitor county utilization of allocated resources, reassign resources not utilized, and approve increased capacity within county allocations. Specifies priorities for reassignment of resources and increased capacity.

Subd. 6. Waiver request. (a) Requires the commissioner to request a federal waiver to include an option that would allow waiver recipients to directly receive 95 percent of the funds that would be allocated to individuals.

(b) Requires the commissioner, in cooperation with other parties, to develop criteria related to this waiver request.

(c) If the waiver is approved and implemented, requires unspent money to be used to meet the needs of other eligible persons waiting for services.

(d) Requires the commissioner, in consultation with other parties, to evaluate the effectiveness of this option within two years of implementation.

Subd. 7. Annual report by commissioner. Requires the commissioner to issue an annual report each October 1 on county and state use of resources for the MR/RC waiver, and specifies report contents.

Subd. 8. Financial information by county. This subdivision contains the language currently in paragraph (e) of section 256B.0916.

Subd. 9. Legal representative participation exception. Requires the commissioner to develop criteria to allow legal representatives to be reimbursed for support services, and to submit amendments for federal approval by October 1, 1999.

62 **Living-at-home/block nurse program.** Amends § 256B.0917, subd. 8. Expands the number of LAH/BN programs from 27 to 33.

63 **Membership.** Amends § 256B.0951, subd. 1. Adds the commissioner of human services or the commissioner's designee to the membership of the region 10 quality assurance commission.

64 **Commission duties.** Amends § 256B.0951, subd. 3. Assigns duties to the commission that under current law are the responsibility of the commissioner of human services.

A new paragraph (c) requires the commission and commissioner to establish an ongoing review process for the alternative quality assurance licensing system.

A new paragraph (d) requires the commission to contract with an independent entity to conduct a financial review of the alternative quality assurance project. Sets requirements for the review and requires the review to be completed by December 15, 2000.

A new paragraph (e) requires the commission to submit a report to the legislature by January 15, 2001 on the results of the review process, a summary of the results of the independent financial review, and recommendations on whether the pilot project should be extended beyond June 30, 2001.

65 **Duties of the commissioner of human services.** Amends § 256B.0955. Strikes duties of the commissioner that have been transferred to the commission.

66 **Civil action for recovery.** Amends § 256B.37, subd. 2. Provides a list of parties that may retain legal representation to enforce DHS subrogation rights.

67 **Prohibited practices.** Amends § 256B.48, subd. 1. Allows nursing facilities to require residents to use pharmacies that utilize unit dose packing systems, and to use pharmacies that are able to meet federal regulations for safe and timely administration of medications. Prohibits a facility from restricting a resident's choice of pharmacy because the pharmacy utilizes a specific system of unit dose packing.

68 Section is a duplicate of section 66.

69 **Payment for persons with special needs for crisis intervention services.** Amends § 256B.501, subd. 8a. Makes changes related to delivery of and payment for crisis intervention services. Allows crisis intervention services to be provided by private sector ICFs/MR, as well as state operated community services. Allows residential crisis services to be provided at sites other than foster care settings. Specifies that payment rates are to be consistent with county negotiated crisis intervention services and sets other requirements related to payment.

70 **County authority.** Amends § 256B.69, subd. 3a. Allows the commissioner of human services to grant a delay in the implementation of county-based purchasing until federal waiver authority and approval has been granted. (Current law allows a 9-month delay until October 1, 1999.) Prohibits the commissioner from requiring implementation, until six months after federal waiver approval. Allows submittal of additional information. Allows counties 60 days to amend their final plan, if this is necessary due to the terms and conditions of waiver approval. Requires implementation six months after submittal of the revised plan.

71 **Provision of data to county boards.** Amends § 256B.69, by adding subd.3b. Requires the commissioner to identify information and data necessary for county boards to make recommendations to the commissioner related to the prepaid medical assistance program and to effectively administer county-based purchasing. States that this information includes, but is not limited to, county-specific, individual-level fee-for-service and prepaid health plan claims information.

72 **Individualized education plan and individualized family service plan services.** Amends § 256B.69, by adding subd. 4b. Requires the commissioner to amend the federal waiver allowing the state to separate out individual education plan and individualized family service plan services.

Effective July 1, 1999, or upon federal approval, provides that MA coverage of these services shall not be included in PMAP or MinnesotaCare. Upon federal approval, requires school districts to bill the commissioner for these services, and requires claims to be paid on a fee-for-service basis.

73 **Managed care contracts.** Amends § 256B.69, subd. 5a. Specifies that requirements for prepaid health plans serving MA, GAMC, and MinnesotaCare enrollees established after the effective date of a contract with DHS take effect when the contract is next issued or renewed.

74 **Prospective reimbursement rates.** Amends § 256B.69, subd. 5b. Effective January 1, 2001, increases prepaid MA contract rates for nonmetropolitan counties, on a weighted average, to 89 percent of the capitation rates for metropolitan counties, excluding Hennepin county.

75 **Medical education and research payments.** Amends § 256B.69, by adding subd. 5e. Provides that hospitals that participate in funding the federal share of the MERC trust fund are not liable for amounts attributable to this payment that are above the MA charge limit. Requires the commissioner to assume liability for any corresponding federal share of payments above the limit.

76 **Duties of the commissioner of health.** Amends § 256B.692, subd. 2. Specifies that the county board is the governing body of a county-based purchasing program, and the joint powers board the governing body in a multi-county arrangement. Clarifies that counties must satisfy the commissioner of health that they will meet the consumer protection and fiscal solvency requirements applicable to HMOs or community integrated service networks. Requires the commissioner to adopt administrative and financial reporting requirements for county-based purchasing related to specified sections of statute that are specific to county administrative, accounting, and reporting systems, and consistent with other statutory requirements of counties.

77 **Hospital outpatient reimbursement.** Amends § 256B.75. Effective January 1, 2000, provides an 8 percent increase for nonsurgical outpatient hospital facility fees and emergency room facility fees, except for those services for which there is a federal maximum allowable payment. Requires MA reimbursement to be based on a cost-based payment system for outpatient, emergency, and ambulatory surgery hospital facility fee services for critical access hospitals.

78 **Physician and dental reimbursement.** Amends § 256B.76. Effective January 1, 2000, provides a 3 percent increase for physician and professional services, except for home health agency and family planning agency services. Provides that these increases are effective January 1, 2000 for managed care. Also strikes obsolete language related to reimbursement rates.

Adds the following clauses related to changes in dental reimbursement and dental services:

(3) increases reimbursement for dental services by 3 percent, effective January 1, 2000;

(4) directs the commissioner to award grants to community clinics, other nonprofit community organizations, and other entities, for specified initiatives to improve access to dental care;

(5) beginning October 1, 1999, increases payment for tooth sealants and fluoride treatments to the lower of the submitted charge or 80 percent of the 1997 median.

(6) Specifies that the increases in clauses (3) and (5) are to be implemented January 1, 2000 for managed care.

79 **Provider rate increases.** Adds § 256B.765. Establishes a methodology for granting inflation adjustments to a variety of community-based and waiver service providers, effective July 1, 2001.

80 **Eligible individuals.** Amends § 256B.77, subd. 7a. Strikes language allowing individuals residing on an Indian reservation to be excluded from the demonstration project for persons with disabilities. Also corrects a cross-reference.

81 **American Indian recipients.** Amends § 256B.77, by adding subd. 7b. Paragraph (a) provides a purchasing model for American Indian MA recipients who are required to enroll in the demonstration project for persons with disabilities. The model would provide reimbursement on a

fee-for-service basis to American Indian health services facilities and facilities operated by a tribe or tribal organization. Makes implementation subject to federal approval. Paragraph (b) requires the commissioner to develop a plan for tribes to assist in the enrollment process under the demonstration project and to be included in coordinating care. Paragraph (c) provides a definition of American Indian.

82 **Responsibilities of the county administrative entity.** Amends § 256B.77, subd. 8. Specifies that enrollees in the demonstration project for persons with disabilities who choose not to develop a personal support plan are subject to the network and prior authorization requirements of the county administrative entity or service delivery organization 60 days after enrollment.

83 **Capitation payment.** Amends § 256B.77, subd. 10. A new paragraph (c) provides the risk-sharing formula to be used when the aggregate fee-for-service cost of covered services provided by a county administrative entity under the demonstration project for persons with disabilities exceeds the aggregate sum of capitation payments. A new paragraph (d) allows the commissioner to increase payments by up to 0.25 percent of the projected per person costs that would otherwise have been paid under MA fee-for-service, in order to: (1) offset rate increases for RTC services; and (2) implement incentives to encourage appropriate, high quality, efficient services.

84 **External advocacy.** Amends § 256B.77, subd. 14. States that funding for external advocacy shall be provided through general fund appropriations. Removes the requirement that external advocacy contractors have the expertise to advocate on behalf of "all categories" of eligible individuals.

85 **Service coordination transition.** Amends § 256B.77, by adding subd. 27. Allows demonstration sites, with the permission of an eligible individual, to implement the service coordination requirement beginning 60 days prior to an individual's enrollment.

86 **General assistance medical care; eligibility.** Amends § 256D.03, subd. 3. States that an applicant who meets certain criteria shall be determined eligible for General Assistance Medical Care (GAMC) beginning in the month of application.

87 **General assistance medical care; services.** Amends § 256D.03, subd. 4. Provides for GAMC coverage of telemedicine consultants, to the extent they are covered under MA. Adds certified neonatal nurse practitioner services to the list of nurse practitioner services covered by GAMC. Requires nurse practitioner services provided on an inpatient basis to be excluded from the payment rate for inpatient services.

88 **Private insurance policies.** Amends § 256D.03, subd. 8. Expands the definition of "state agency" for purposes of DHS subrogation rights in the GAMC program and expands the list of parties that may seek recoveries based on those subrogation rights.

89 **Copayments and coinsurance.** Amends § 256L.03, subd. 5. Eliminates MinnesotaCare copayments for: (1) parents and relative caretakers of children under age 21 in households with income at or below 175 percent of federal poverty guidelines; (2) pregnant women; and (3) children under age 21. States that the section shall be implemented only if required to obtain federal MA funding. Provides a July 1, 2000 expiration date for the section.

90 **Lien.** Amends § 256L.03, subd. 6. Expands the definition of "state agency" for purposes of DHS lien rights under the MinnesotaCare program.

91 **Cooperation in establishing third-party liability, paternity, and other medical support.** Amends § 256L.04, subd. 2. Adds relative caretakers to the list of persons who must cooperate with DHS in establishing paternity of enrolled children and obtaining medical care support and payments for the children.

92 **Applicants potentially eligible for medical assistance.** Amends § 256L.04, subd. 8. Allows MinnesotaCare applicants who are potentially eligible for MA, and who do not receive a disability-based pension, to enroll in either MinnesotaCare or MA.

93 MinnesotaCare outreach. Amends § 256L.04, subd. 11. Authorizes the commissioner to terminate an outreach grant if the outreach effort does not increase enrollment in MA, GAMC, or the MinnesotaCare program.

94 Families with relative caretakers, foster parents, or legal guardians. Amends § 256L.04, subd. 13. Strikes language that allows families with a grandparent to apply as a family or separately for the children. (Grandparents can still apply if they meet the definition of relative caretaker.) For caretakers that can apply separately for the children, eliminates the requirement that all children must apply.

95 Retroactive coverage. Amends § 256L.05, by adding subd. 3. States that coverage shall begin the first day of the month following termination from MA or GAMC for families and individuals who are eligible for MinnesotaCare and who have requested in writing MinnesotaCare eligibility within 30 days of notification of termination from MA or GAMC.

96 Application processing. Amends § 256L.05, subd. 4. Allows presumptive eligibility once annually at application or reenrollment, and requires timely payment of premiums. Requires enrollees to provide verifications within 30 days of notification of eligibility determination (current law refers to enrollment).

97 Administration and commissioner's duties. Amends § 256L.06, subd. 3. Expands the definition of failure to pay a premium, and specifies guaranteed forms of payment. Allows persons disenrolled for nonpayment to be reenrolled retrospectively to the first day of disenrollment, if they pay all premiums due within 20 days of disenrollment.

98 Eligibility for MinnesotaCare. Amends § 256L.07. Makes a number of modifications in MinnesotaCare eligibility policy, including:

clarifies that a family or individual must not have had access to employer-subsidized coverage through a current employer for 18 months prior to application or re-application.

changes terminology to clarify that these policies apply to MinnesotaCare clients who pay 100 percent of their premium as well as to clients who receive a premium subsidy;

deletes an outdated reference to examining income over a four-month period to determine whether income exceeds program limits;

clarifies conditions under which certain families with existing health insurance coverage may qualify for MinnesotaCare;

requires persons who were on MA or on GAMC within one month of their application for MinnesotaCare to meet the MinnesotaCare insurance barriers related to no employer-subsidized or private insurance coverage.

This section also allows counties to pay the premiums for families with children when a parent has been determined to be in need of chemical dependency treatment for one year. After one year, upon renewal, the family is responsible for any premiums owed. The counties are required to assist a family in applying for MinnesotaCare if the family is not already enrolled.

99 Premium determination. Amends § 256L.15, subd. 1. Makes a technical change.

100 Payments nonrefundable. Amends § 256L.15, subd. 1b. Specifies that MinnesotaCare premiums paid for future months of coverage for which a health plan capitation fee has not been paid may be refunded.

101 Sliding fee scale to determine percentage of gross individual or family income. Amends § 256L.15, subd. 2. The amendment to paragraph (a) clarifies procedures for premium determination based on a sliding scale. The amendment to paragraph (b) requires enrolled individuals and families whose gross annual income increases above 275 percent of poverty to pay the maximum premium. Provides the method of calculating this maximum premium.

102 Administrative reconsideration of final determination of maltreatment. Amends § 626.556, subd. 10i. Establishes timelines for certain administrative hearings and decisions.

103 Additional waiver request for employed disabled persons. Amends Laws 1995, chapter 178, article 2, section 46, subdivision 10. Clarifies language passed in 1995 that requires DHS to seek a federal waiver to implement a work incentive for disabled persons.

104 Senior drug program. Amends Laws 1997, chapter 225, article 4, section 4. Eliminates the requirement that the commissioner of human services administer the senior drug program so that state costs do not exceed $4 million plus rebate amounts.

105 Charity care data collection. Requires the commissioner of health to determine definitions for charity care and bad debt and to collect data using these definitions on uncompensated care in hospitals, surgical centers and clinics located in Minnesota.

106 MinnesotaCare application simplification. Requires the commissioner of human services to develop a one-page pre-application form for MinnesotaCare and authorizes the commissioner to develop a pilot project to use this form to determine the feasibility of using a one-page form for the application process.

107 Expansion of special education services. Requires the commissioner of human services to examine opportunities to expand the scope of providers eligible for reimbursement of MA services listed in a child's individual education plan, to complete these activities by December 15, 1999, and to seek necessary federal approval.

108 Home-based mental health services. Requires the commissioner of human services, by January 1, 2000, to amend Minnesota Rules under the expedited process, to: (1) permit a county board to contract with any agency qualified to provide home-based mental health services; and (2) permit children's mental health collaboratives approved by the children's cabinet to contract with any agency qualified to provide home-based mental health services.

109 Medicare supplemental coverage for low-income seniors. Requires the commissioner of health to study various aspects of Medicare supplemental health care coverage.

110 Programs for senior citizens. Requires the commissioner of human services to study the extent to which programs for senior citizens can be combined, simplified, or coordinated to reduce administrative costs and improve access. Also requires the commissioner to study potential barriers to enrollment related to depletion of resources. Requires a report to the legislature by June 30, 2001.

111 Amending medical assistance rules. Requires the commissioner of human services, by January 1, 2000, to amend specified rules to implement the changes related to family community support services.

112 Request for waiver. Requires the commissioner of human services or the commissioner of health to request a federal waiver by October 1, 1999, to implement section 256B.0951, subd. 7 (exemption of residents of ICFs/MR who participate in the quality assurance project from supervised living facility rules).

113 Dental access study. Requires the commissioner of human services, in consultation with other parties, to review the dental access problem, evaluate the effects of dental access initiatives, and make recommendations on dental access. Requires a progress report to be presented to the legislature by January 15, 2000 and a final report by January 15, 2001.

114 Report on rate setting and risk adjustment. Requires the commissioner of human services to report to the legislature by January 15, 2000, on the rate setting process for state prepaid programs, rate setting and risk adjustment methods in other states, and the results of the application of risk adjustment on a trial basis in Minnesota. Specifies other requirements for the report.

115 Report on prepaid medical assistance program. Requires the commissioner of human services to present recommendations to the legislature by December 15, 1999, on specified issues related to

counties and state health care programs.

116 Physician and professional services payment methodology conversion. Requires the commissioner to submit a proposal to the legislature detailing MA physician and professional payment methodology conversion to resource-based relative value scale.

117 Recommendation for definition of specialized maintenance therapy. Requires the commissioner of human services to present recommended definitions of specialized maintenance therapy to the chairs of the house health and human services finance committee and the senate health and family security budget division, by November 15, 1999.

118 Dental hygienist demonstration project. Allows the commissioner of human services to develop demonstration projects that use dental hygienists outside a traditional dental office to provide dental hygiene services to limited access patients. Requires the commissioner to report to the legislature on the demonstration project by January 15, 2001.

119 Reports on alternative resource allocation methods and parents of minors. Requires the commissioner of human services, in consultation with specified parties, to consider and evaluate administrative methods other than the current resource allocation system for the MR/RC waiver, and to report to the chairs of the house health and human services finance committee and the senate health and family security budget division by January 15, 2000. Requires the commissioner to report to the legislature by January 15, 2000, on the conditions under which parents of minors may be reimbursed for services.

120 Repealer. Repeals sections 256B.74, subdivisions 2 and 5 (obsolete subdivisions on physician and dental reimbursement); and 462A.208 (mental illness crisis housing assistance account).

121 Effective date. States that sections 3, 5, 45, and 97 are effective July 1, 2000. Provides that section 56 is effective upon federal approval.

Article 5: State Operated Services; Chemical Dependency; Mental Health; Land Conveyances

Overview

This article makes changes to human services statutes related to state-operated services, chemical dependency, mental health, and conveyances of state RTC lands. Provisions in this article:

Modify the requirements for practice for case management service providers and mental health practitioners in the Adult Mental Health Act and Children's Mental Health Act, and make case management services eligible for reimbursement under the Medical Assistance program (sections 2 to 4 and 6 to 8).

Direct the commissioner to study and make recommendations to the legislature on establishing enterprise activities within state-operated services and allow the commissioner to establish accounts for cash flow purposes (sections 9, 10 and 28).

Amend provisions of the Civil Commitment Act and provide for health plan company coverage of services to an enrollee that are court-ordered (sections 12 to 15).

Amend provisions related to chemical dependent treatment, and provide for payment of room and board costs from the consolidated CD treatment fund for clients receiving CD treatment (sections 16 to 18).

1 Specific purchases. Amends § 16C.10, subd. 5. In a subdivision listing the items that are exempt from the solicitation process the state must use to procure goods and services, expands the exemption from the solicitation process to the purchase of goods and services used at any community-based facility operated by the commissioner of human services (in current law this exemption applies to community-based residential facilities).

2 Case management service provider. Amends § 245.462, subd. 4. Paragraph (a) amends the

definition of case manager in the Adult Mental Health Act to define a "case management service provider" as either a case manager (already defined in this law) or a case manager associate, a new provider classification created in paragraph (f) of this section. Also clarifies that a case manager holding a bachelor's degree in social work, psychology, or nursing meets the current law requirement for a bachelor's degree. Strikes other requirements related to supervised experience and training, because these provisions are relocated and further modified in paragraphs (b) to (e).

Paragraph (b) specifies the supervision requirements that apply to a case manager, both for the first year of service and after the first year.

Paragraph (c) specifies the continuing education and training requirements for a case manager who has a bachelor's degree, but who is not credentialed by a health-related licensing board.

Paragraph (d) requires a case manager with a bachelor's degree who lacks the required hours of supervised experience to obtain 40 hours of approved training; this provision is relocated from paragraph (a).

Paragraph (e) requires a case manager who does not hold a bachelors degree to meet one of three specified types of qualifications.

Paragraph (f) creates the new "case manager associate" classification. A case manager associate must work under the direction of a case manager or case management supervisor; be at least 21 years of age; have a high school diploma or equivalent; and either meet one of four specified criteria relating to education and life work experience, or be a mental health practitioner. This paragraph also specifies how a case manager associate can qualify as a case manager, and specifies other requirements for preservice training, continuing education, and mentoring that a case manager associate must meet.

Paragraph (g) requires a case management supervisor to meet the criteria for mental health professionals that is defined in another provision of the Adult Mental Health Act.

Paragraph (h) removes a sunset date on language allowing an immigrant who does not meet any other qualifications for case management service providers to provide case management services to adult immigrants of the same ethnic group, if the immigrant meets the requirements of the paragraph. (Striking the sunset language has the effect of making this provision permanent.)

This section also strikes provisions relating to waivers for case managers who lack a bachelor's degree but have supervised work experience, because this provision has been replaced by the "case manager associate" classification created in paragraph (f).

3 Mental health practitioner. Amends § 245.462, subd. 17. Adds another way in which a person may qualify as a mental health practitioner under the Adult Mental Health Act, by permitting a person who is fluent in the non-English language of the ethnic group to which over 50 percent of the person's clients belong, and who meets the specified training and supervision requirements and has a bachelor's degree, to qualify as a mental health practitioner.

4 Availability of case management services. Amends § 245.4711, subd. 1. Amends the Adult Mental Health Act to make case management services eligible for MA reimbursement. Permits costs associated with mentoring, supervision, and continuing education to be included in the MA reimbursement rate methodology used for these services.

5 Day treatment services provided. Amends § 245.4712, subd. 2. A new paragraph (b) allows an adult day treatment program to choose from among the following methods to comply with MA requirements for clinical supervision:

complying with the definition of clinical supervision for mental health services in DHS rule;

using a mental health practitioner who maintains a consulting relationship with a mental health professional who accepts full professional responsibility and meets requirements for on-site observation of the mental health practitioner; or

meeting the minimum quality assurance standards for mental health centers or mental health clinics by having and implementing policies and procedures related to peer review, internal utilization review, staff supervision, continuing education for staff, procedures for discipline, and data protections.

Specifies how day treatment programs can demonstrate compliance with clinical supervision requirements.

6 Case management service provider. Amends § 245.4871, subd. 4. Amends the definition of case manager in the Children's Mental Health Act, making similar changes to the ones that were made to the Adult Mental Health Act in section 2. Modifies the definition of case manager, and the supervision, education, and experience requirements that apply, and also creates the new provider classification of case manager associate.

7 Mental health practitioner. Amends § 245.4871, subd. 26. Makes similar changes to the ones made in section 3. Adds another way in which a person may qualify as a mental health practitioner under the Children's Mental Health Act, permitting a person who is fluent in the non-English language of the ethnic group to which over 50 percent of the person's clients belong and who meets the specified training and supervision requirements and has a bachelor's degree, to qualify as a mental health practitioner.

8 Availability of case management services. Amends § 245.4881, subd. 1. Makes similar changes to the ones made in section 4. Amends the Children's Mental Health Act to make case management services eligible for MA reimbursement. Permits costs associated with mentoring, supervision, and continuing education to be included in the MA reimbursement rate methodology used for these services.

9 Planning for transition of regional treatment centers and other state-operated services to enterprise activities. Adds § 246.0136. Requires the commissioner of human services to study and make recommendations on establishing enterprise activities within state-operated services. Allows the commissioner to implement enterprise activities for adolescent services, and to establish a public group practice, without legislative authorization. Lists the required components of any proposal to establish an enterprise activity.

Subd. 1. Planning for enterprise activities. Directs the commissioner to study and make recommendations on establishing enterprise activities within state-operated services. Requires statutory authorization to implement an enterprise activity, except for adolescent services. Defines enterprise activities, and specifies that they will care for vulnerable people for whom no other services are available or for whom state-operated services may be provider selected by the payer.

Subd. 2. Required components of any proposal; considerations. Lists the components that any proposal for an enterprise activity submitted to the legislature by the commissioner must obtain. Also lists the criteria the commissioner must consider when studying the feasibility of establishing an enterprise activity.

10 Collections dedicated. Amends § 246.18, subd. 6. Directs services or programs operated as enterprise activities to keep the revenues earned in interest-bearing accounts. When the commissioner decides to transition a program from direct appropriations to enterprise activities for which the commissioner has authority, transfers, to the general fund, funds up to the amount of the appropriation from the interest-bearing account (all funds in the account over the appropriation amount can be used for cash flow). This transfer occurs at the end of the fiscal year before the transition to enterprise activity.

11 Variances. Amends § 252.46, subd. 6. Modifies the conditions under which the commissioner of human services can provide a rate variance for day training and habilitation services. As amended, the section would allow variances to be provided when: (1) a determination of need is approved for a significant program change necessary to provide services to existing and new clients who meet

specified criteria; (2) a licensing determination requires a program change that the vendor cannot comply with due to funding constraints; (3) a determination of need is approved for a decrease in licensed capacity, and the vendor demonstrates the need to retain staffing levels to serve the remaining clients; or (4) cases where clauses (1) to (3) do not apply but a determination of need is approved for an unusual circumstance that significantly impacts the type or amount of services delivered and there is concurrence by the commissioner. Allows county boards to assign persons discharged from Minnesota extended treatment options a payment rate of 200 percent of the current statewide average rates, and also eliminates a reference to "self injurious or assaultive" behaviors in a description of clients eligible for this higher rate.

12 Health plan company; definition. Adds subd. 5 to § 253B.045. Defines "health plan company" for a section on payment for services provided to people who are subject to temporary confinement under the Civil Commitment Act.

13 Coverage. Adds subd. 6 to § 253B.045. Requires a health plan company to cover, according to the terms of the policy, all services provided to an enrollee that are medically necessary and that are ordered by a court under the Civil Commitment Act.

14 Prepetition screening. Amends § 253B.07, subd. 1. In a subdivision that requires a preliminary investigation to occur before a petition for commitment can be filed, requires the screening team that conducts the preliminary investigation to seek input from the proposed patient's health plan company to give the court information about what services the proposed patient needs and about the least restrictive alternatives appropriate for the proposed patient.

15 Aftercare and case management. Adds subd. 5 to § 253B.185. In a section specifying procedures for committing people with sexual psychopathic personalities and sexually dangerous persons, specifies that the state, in collaboration with counties, is responsible for arranging and paying for aftercare and case management for people discharged after July 1, 1999.

16 Room and board rate. Adds subd. 7 to § 254B.01. Defines "room and board rate" for the chapter on chemical dependency treatment.

17 Chemical dependency fund payment. Amends § 254B.03, subd. 2. Requires payments from the consolidated chemical dependency treatment fund to all community hospitals licensed by the commissioner of health, and other certified vendors, for room and board costs for clients who meet the criteria for placement in a residential CD treatment program and who are receiving CD treatment services from a licensed program that is reimbursed by the fund.

18 Licensure required. Amends § 254B.05, subd. 1. Lists requirements that vendors of room and board services must meet to obtain reimbursement for room and board services from the CD fund, effective January 1, 2000.

19 Advisory task forces. Amends § 256.01, subd. 6. Allows the commissioner to pay a $35 per diem to consumers and family members who participate in legislatively-authorized human services task forces and who are not serving as paid representatives of any agency or organization.

20 Mental health case management. Amends § 256B.0625, subd. 20. In paragraph (c), allows a provider to receive payment under MA or MinnesotaCare for case management services if the provider documents at least a phone contact with the eligible adult or the adult's legal representative and documents face-to care contact with the adult or the adult's legal representative within the preceding two months. In paragraphs (s) and (t), specifies the mechanism by which a county's share of state-funded mental health grants is adjusted for changes in the number of persons who receive case management services.

21 Pilot projects to provide alternatives to delivery of adult mental health services. Codifies a section of session law in statute as § 245.4661. (This section of session law authorizes pilot projects to provide alternatives or enhance delivery of adult mental services.)

22 Transition for the compulsive gambling treatment program. Amends Laws 1997, ch. 203, art. 9, sec. 19. Delays the transition to the fee-for-service model for the last one-third of individuals receiving compulsive gambling treatment by one year, from July 1, 1999, to July 1, 2000.

23 Land description. Amends Laws 1998, ch. 407, art. 7, sec. 2, subd. 3. Technical, correcting a description of land located in Crow Wing county.

24 Establishment and purpose of the supportive housing and managed care pilot project. Allows the commissioner to create a supportive housing and managed care pilot project for homeless hard-to-serve individuals, if funding is available. Specifies the purpose of the pilot, eligibility criteria and report requirements. Sunsets the pilot project on June 30, 2005.

25 Conveyance of state lands to county of Isanti. Allows the commissioner of human services, through the commissioner of administration, to transfer state lands no longer used by the Cambridge Regional Human Services Center to Isanti county for no consideration. Allows the commissioner of human services and the county to attach any conditions to the transfer that they find appropriate, and requires the deed conveying the property to provide that the property reverts to the state if no longer used for a public purpose. Requires the conveyance to be in a form approved by the attorney general. Describes the land to be transferred. Allows Isanti county to use the land for economic development, specifies that economic development is a public purpose, and provides that property will not revert to the state if it is conveyed or otherwise encumbered by the county as part of the county economic development activity.

26 Conveyance of state land to city of Cambridge. Allows the commissioner of human services, through the commissioner of administration, to transfer state lands no longer used by the Cambridge Regional Human Services Center to the city of Cambridge for no consideration. Allows the commissioner of human services and the city to attach any conditions to the transfer that they find appropriate, and requires the deed conveying the property to provide that the property reverts to the state if no longer used for a public purpose. Requires the conveyance to be in a form approved by the attorney general. Describes the land to be transferred. Allows Cambridge to use the land for economic development, specifies that economic development is a public purpose, and provides that property will not revert to the state if it is conveyed or otherwise encumbered by the city as part of the city economic development activity.

27 Conveyance of city land to state of Minnesota. Allows the commissioner of administration to accept all or any part of land transferred from the city of Cambridge, after the city council declares the property is surplus. Requires the conveyance to be in a form approved by the attorney general. Specifies that the land is subject to a scenic easement on the part of the land included in the wild and scenic river system. Describes the land to be transferred to the state.

28 Report to legislature on establishing enterprise activities within state-operated services. Requires the commissioner of human services to report to the legislature by December 15, 1999 on establishing enterprise activities within state-operated services and their status.

29 Repealer. Repeals § 254A.145, an inhalant abuse demonstration project administered by the commissioner of human services.

Article 6: Assistance Programs

Overview

This article makes changes to Minnesota's welfare reform program, the Minnesota Family Investment Program (MFIP), as well as to several other related programs. Many sections revise and clarify program policies. Other sections implement initiatives included in the governor's budget recommendations for these programs. Changes made by the article include:

Sections 1 and 2 eliminate the current cap of $400 per participant in the Food Stamp

Employment and Training (FSET) program, and instead limit counties to average expenditures of $400 per participant.

Section 4 requires the commissioner to review GA cases where the applicant has been denied other benefits, and permits the commissioner to require that such an applicant appeal the denial, if appropriate.

Section 5 specifies additional activities for which federal TANF block grant funds may be used.

Sections 3 and 14 makes permanent the provision of state-funded food assistance to legal noncitizens who are not eligible for federal food stamps. Section 3 removes the sunset on the Minnesota Food Assistance program, and limits eligibility effective July 1, 2001, to legal noncitizens who are age 50 or older. Section 14 makes permanent the state-funded MFIP food portion for noncitizen families on MFIP who are not eligible for federal food stamps.

Section 26 exempts new MFIP assistance units from the requirement to vendor pay assistance for the first six months when the caregiver is not the parent and is not included in the MFIP grant.

Section 46 clarifies the deeming provisions that apply to a noncitizen's sponsor if the noncitizen applies for or receives MFIP assistance.

Section 47 permanently exempts four groups from the requirement to count $100 of housing assistance as unearned income under MFIP: caregivers over age 60; caregivers who are certified as disabled; caregivers who are needed at home to care for a disabled household member; and households where the parental caregiver receives SSI. This section also delays the effective date of the $100 housing subsidy requirement for all other recipients for 18 months, until January 1, 2001.

Section 53 exempts MFIP caregivers who are already working the required number of hours from the requirement to attend an MFIP orientation. **Section 54** exempts certain pregnant and parenting minors from the MFIP orientation. **Sections 64 and 66** permit a participant to limit job search to jobs that are consistent with the person's employment goal, if the job counselor agrees. **Section 65** authorizes a job counselor to require, as part of a secondary assessment, that a participant complete a chemical use or psychological assessment. (Section 87, requiring protocols to implement these special assessments, is related to this section.) **Section 67** requires that participants with low reading and math skills be allowed to include basic education activities in their plan. **Section 69** requires both parents in a two-parent family to use the same employment and training provider, unless special needs exist.

Sections 72 and 73 establish a new formula for allocating employment and training block grant funds to counties and eligible tribal providers.

Section 80 requires the commissioner to provide counties with performance management reports that show each county its relative performance on selected MFIP measures. The section also specifies that any federal sanctions for failing to meet work participation rates will be borne 88 percent by the state and 12 percent by the counties.

Sections 81 to 83 establish a new formula for allocating administrative funding to counties.

Section 84 requires the commissioner to submit recommendations to the legislature next session regarding MFIP families where the caregiver has reached the 60-month lifetime limit on federally-funded assistance.

Section 86 requires the commissioner to submit a proposal to the legislature next session to create an incentive bonus program for high-performing counties.

This article also makes technical changes throughout, to change the name of the program by dropping the "-Statewide" at the end of the name, and to correspondingly change the acronym from MFIP-S to

MFIP.

1 **Duties of commissioner.** (Amends § 256D.051, subd. 2a) Technical, inserting a reference to the next section.

2 **Program funding.** (Adds new subd. 6c to § 256D.051) Within the limits of available appropriations, requires the commissioner to reimburse counties and employment and training service providers for their actual FSET (food stamp employment and training) costs, including costs for participant support services, direct program services and program administration. Prohibits a county's cost for FSET services from exceeding an average of $400 per participant. Imposes a 15 percent cap on administrative costs. Permits a county to spend in excess of the limits in this section, but no state reimbursement is available for the

excess spending. Specifies an allocation method to distribute these state funds for the counties' FSET activities. (Under current law a county is limited to $400 per FSET recipient, unless the recipient meets the definition of a "hard-to-employ individual." Section 89 repeals both this $400 limit and the provision allowing a variance for a hard-to-employ individual.)

3 **Program established.** (Amends § 256D.053, subd. 1) Removes the sunset on the Minnesota food assistance program, so that the program continues past June 30 of this year. Also updates the reference to the federal laws that authorize the state option to purchase federal food stamp benefits, and on which the Minnesota food assistance program is based. Effective July 1, 2000, limits the eligibility for this program to otherwise eligible noncitizens who are age 50 or older.

4 (Amends § 256D.06, subd. 5) Requires the commissioner to review cases where a GA applicant has applied for and been denied other maintenance benefits. Permits the commissioner to require a GA applicant who has been denied these other benefits to appeal the denial, if appropriate.

5 **Use of money.** (Amends § 256J.02, subd. 2) Adds the following programs to the list of allowable uses of MFIP funds: health care and human services worker training and retention program (created in Article 10); family assets for independence accounts; pathways program under § 116L.04, subd. 1a; welfare to work extended employment services; family homeless prevention and assistance; rental assistance for family stabilization.

6 **Caregiver.** (Amends § 256J.08, subd. 11) Adds adult half-siblings to the list of persons who could be an MFIP caregiver.

7 **Disregard.** (Amends § 256J.08, subd. 24) Adds a cross-reference to section 28 of the article, because that is where the earned income disregard percentage will be calculated.

8 **Encumbrance.** (Adds subd. 28a to § 256J.08) Defines "encumbrance" as a legal claim against property that is payable when the property is sold.

9 **MFIP standard of need.** (Adds new subd. 55a to § 256J.08) Adds to the definition section of the MFIP chapter a definition of the "MFIP standard of need," which is used to determine MFIP benefit payments. The MFIP standard of need may be:

the transitional standard (used when the caregiver has no earned income);

the shared household standard (used when an unrelated individual lives with the assistance unit); or

the interstate payment standard (which Minnesota has been enjoined from implementing).

The term "MFIP standard of need" is used throughout the bill, in place of the current law references to one or more of these specific standards.

10 **Participant.** (Amends § 256J.08, subd. 65) Excludes from the definition of "participant" someone who requests closure before the first of the month, and repays cash and food assistance within that month. Clarifies that someone who receives only food assistance is still a participant under this definition. Also clarifies that someone who is not getting cash and food assistance because the

person has been suspended from the program is still a participant under this definition.

11 **Sanction.** (Amends § 256J.08, subd. 82.) Modifies this definition to reflect the new definition of "MFIP standard of need" that is added in section 9.

12 **Significant change.** (Amends § 256J.08, subd. 83) Technical, replacing the absolute disregard percentage of 36 percent under current law with a reference to the definition section of the MFIP law, and specifically to the provision (in section 7 of the article) where "disregard" is defined.

13 **Unrelated member.** (Amends § 256J.08, subd. 86a) Strikes a provision that excludes from the definition of "unrelated individual" a person who provides child care to a child in the assistance unit. (This same provision is recodified in a new location in a later section.)

14 **Noncitizens; food portion.** (Amends § 256J.11, subd. 2) Strikes obsolete language. Notwithstanding a provision in session law that sunsets noncitizen eligibility for state-funded assistance, makes noncitizens who are on MFIP but who are not eligible for federally-funded food stamp benefits permanently eligible for the food portion of an MFIP grant, funded with state dollars.

15 **Benefits funded with state money.** (Amends § 256J.11, subd. 3) Clarifies that the citizenship application requirements that apply to an adult noncitizen who has lived in the U.S. for at least four years refer to a noncitizen who has been a lawful permanent resident.

16 **30-day residency requirement.** (Amends § 256J.12, subd. 1a) Clarifies that the 30-day residency requirement is met when a child or caregiver has lived in the state for 30 consecutive days.

17 **Exceptions.** (Amends § 256J.12, subd. 2) Clarifies how the 30-day residency requirement is met when a minor child or minor caregiver moves to Minnesota to live with a relative and applies for MFIP.

18 **Eligibility for parenting or pregnant minors.** (Amends § 256J.14) Adds requirement that the county inform minor applicants about applicable information from the MFIP orientation. Also requires that a minor caregiver's grant be paid as a protective payment when possible, regardless of the minor's living situation.

19 **Other property limitations.** (Amends § 256J.20, subd. 3) Modifies the vehicle exclusion provisions to exclude the value of a vehicle for a physically disabled unit member. Also clarifies the treatment of vehicles that are used for employment.

20 **Income exclusions.** (Amends § 256J.21, subd. 2) Excludes carpooling reimbursement as income. Strikes language excluding 1997 property tax rebates as income. Also excludes the income of minor children and minor caregivers who are cooperating with any applicable school attendance requirements. Clarifies the exclusions that apply to the income of a minor parent's parent or stepparent.

21-22 **Initial income test. Monthly income test and determination of assistance payment.** (Amends § 256J.21, subds. 3 and 4) Replaces the absolute disregard percentage of 36 percent under current law with a reference to the definition of "disregard" in section 7 of the article. Makes other technical changes.

23 **Mandatory assistance unit composition.** (Amends § 256J.24, subd. 2) Clarifies that children who must be included in an assistance unit are only the minor children.

24 **Individuals who must be excluded from an assistance unit.** (Amends § 256J.24, subd. 3) Strikes provision that excludes a person living at home while doing court-imposed community service work from the MFIP assistance unit.

25 **Family wage level standard.** (Amends § 256J.24, subd. 7) Modifies this definition to reflect the new definition of "MFIP standard of need" that was added in section 9.

26 **Assistance paid to eligible assistance units.** (Amends § 256J.24, subd. 8) Exempts new assistance

units from the six-month vendor pay requirement, if the caregiver is not the parent of the minor children in the assistance unit and the caregiver is not included in the grant.

27 **Shared household standard; MFIP.** (Amends § 256J.24, subd. 9) Adds an exception to the shared household standard for cases where the unrelated individual provides child care to a child in the assistance unit. (This provision was relocated from the definition of "unrelated member" in an earlier section.)

28 **MFIP exit level.** (Adds subd. 10 to § 256J.24) In **paragraph (a)**, for state fiscal years 2000 and 2001, requires the commissioner to adjust the size of the earned income disregard so that most MFIP participants do not reach the MFIP exit level until their income is greater than or equal to 120 percent of the federal poverty guidelines that are in effect in October of each of these fiscal years. Requires the earned income disregard percentage to be calculated so that a household of three attains this exit level, and specifies that the resulting disregard percentage must be applied to all household sizes. Requires the commissioner to implement these adjustments at the same time the annual adjustment of the MFIP food portion occurs.

In **paragraph (b)**, specifies that in FY 2000 and future years, the earned income disregard percentage will be the same as the percentage calculated for FY 2001.

29 **Person convicted of drug offenses.** (Amends § 256J.26, subd. 1) Technical, modifying the references to the MFIP standard to reflect the new definition of "MFIP standard of need" that was added in section 5. Also clarifies that for a participant who is under an MFIP sanction and who then fails an initial drug test, the failure is treated as a second sanction. Also clarifies that the policies in this section for convicted drug offenders apply to offenses, not convictions, that occurred after July 1, 1997.

30 **Requirement to apply for other benefits.** (Amends § 256J.30, subd. 2) Clarifies that MFIP applicants must accept other available benefits if they are eligible for them.

31 **Due date of MFIP household report form.** (Amends § 256J.30, subd. 7) Deletes a requirement that the county agency send a notice of termination because of a late or incomplete MFIP household report form.

32 **Late MFIP household report forms.** (Amends § 256J.30, subd. 8) Modifies the timing of when notices are sent out after an assistance unit submits an incomplete or late household report form.

33 **Changes that must be reported.** (Amends § 256J.30, subd. 9) Strikes a provision requiring a caregiver to report changes within ten days of when the caregiver learns of the change. (Other current law requirements of when changes must be reported are not stricken or amended.) Inserts a cross-reference to a provision that specifies how overpayments for late reports are calculated. Requires the caregiver to report any change that may relate to whether or not the unit is exempt from using the shared household standard. Requires the caregiver to report a change in household composition.

34 **Mailing of notice.** (Amends § 256J.31, subd. 5) In **paragraphs (a) and (b)**, modifies the requirements of when notices of adverse action are mailed. Provides for two categories of notices, a ten-day notice and a "four working days" notice. Specifies six situations when the four working days' notice provisions apply.

In **paragraph (c)**, adds a notice requirement for situations where the caregiver requests closure of the MFIP case.

In **paragraph (d)**, specifies when a notice of adverse action that is the result of some change the caregiver has reported on the required household report form must be mailed.

35 **Right to discontinue cash assistance.** (Amends § 256J.31, subd. 12) Clarifies that an assistance unit whose benefits are being vendor paid cannot opt out of the cash portion of MFIP assistance. Adds a provision specifying how a participant who opts out of the cash portion retains eligibility for

MFIP child care assistance and medical assistance (MA).

36 **Factors to be verified.** (Amends § 256J.32, subd. 4) No longer requires the expected high school graduation date of an 18 year old to be verified. Requires that a claim of an exception to the shared household standard be verified.

37 **Recertification.** (Amends § 256J.32, subd. 6) Requires that a claim of an exception to the shared household standard be verified at the time of recertification.

38 **Prospective and retrospective determination of MFIP eligibility.** (Amends § 256J.33) Technical, modifying a reference to the MFIP standard to reflect the new definition of "MFIP standard of need" that was added in section 9.

39 **Prospective budgeting.** (Amends § 256J.34, subd. 1) Requires a county to use prospective budgeting for the first two months for a person who wants to be added to an assistance unit.

40 **Additional use of retrospective budgeting.** (Amends § 256J.34, subd. 3) Technical, modifying a reference to the MFIP standard to reflect the new definition of "MFIP standard of need" that was added in section 9.

41 **Significant change in gross income.** (Amends § 256J.34, subd. 4) Specifies four situations when there could be a significant change in a participant's income, but when a supplemental assistance payment is not available to offset the change: receipt of a lump sum; receipt of an extra paycheck; business fluctuation in self-employment income; and participation in a strike or other labor action.

42 **Amount of assistance payment.** (Amends § 256J.35) Technical, modifying a reference to the MFIP standard to reflect the new definition of "MFIP standard of need" that was added in section 9. Also strikes paragraph (d); this provision is relocated to a later section in this article.

43 **Allocation for unmet need of other household members.** (Amends § 256J.36) Technical, modifying a reference to the MFIP standard to reflect the new definition of "MFIP standard of need" that was added in section 9.

44 **Deemed income from ineligible household members.** (Amends § 256J.37, subd. 1) Technical, modifying a reference to the MFIP transitional standard to reflect the new definition of "MFIP standard of need" that was added in section 9.

45 **Deemed income from disqualified members.** (Amends § 256J.37, subd. 1a) Technical, modifying a reference to the MFIP transitional standard to reflect the new definition of "MFIP standard of need" that was added in section 9.

46 **Deemed income and assets of sponsor of noncitizens.** (Amends § 256J.37, subd. 2) In **paragraph (a)**, specifies that, in determining MFIP eligibility, the income and resources of a legal noncitizen are deemed to include the income and assets of the noncitizen's sponsor and the sponsor's spouse under paragraphs (b) and (c).

In **paragraph (b)**, specifies that the sponsor's income and assets must be attributed to the noncitizen pursuant to the standards in the 1996 federal welfare reform law if the sponsor signed an affidavit of support.

In **paragraph (c)**, specifies that if paragraph (b) does not apply, the sponsor's income and assets must be attributed to the noncitizen pursuant to the federal Balanced Budget Act of 1997. The relevant portion of that act is essentially a grandfather clause specifying that the rules relating to income attribution that were in effect before the 1996 federal welfare reform law are applicable to noncitizens who were legally in the U.S. on or before August 22, 1996 (when the welfare reform law was enacted).

47 **Unearned income.** (Amends § 256J.37, subd. 9) In **paragraph (a)**, makes a technical change, modifying a reference to the transitional standard to reflect the new definition of "MFIP standard of need" that was added in section 9.

In **paragraph (b)**, delays the effective date of the requirement to count $100 of the value of federal HUD public and assisted rental subsidies by 18 months to January 1, 2001.

In **paragraph (c)**, specifies three types of MFIP recipients to whom the requirement to count $100 of the value of federal HUD rental assistance as unearned income effective January 1, 2001, does not apply:

(i) persons exempt from MFIP employment and training requirements because they are age 60 or older;

(ii) persons exempt from MFIP employment and training requirements because they have a certified disability or illness that prevents them from obtaining or retaining employment; and

(iii) persons exempt from MFIP employment and training requirements because they are needed to care for another member of their household who has a certified disability or illness.

In **paragraph (d)**, specifies that the requirement to count $100 of the value of federal HUD rental assistance as unearned income effective January 1, 2001, also does not apply to an MFIP assistance unit where the parental caregiver receives supplemental security income.

48 **Treatment of lump sums.** (Amends § 256J.37, subd. 10) Technical, modifying a reference to the transitional standard to reflect the new definition of "MFIP standard of need" that was added in section 9.

49 **Recouping overpayments from participants.** (Amends § 256J.38, subd. 4) Technical, modifying a reference to the transitional standard to reflect the new definition of "MFIP standard of need" that was added in section 9.

50 **Time limit.** (Amends § 256J.42, subd. 1) In **paragraph (a)**, strikes an unnecessary reference to the food portion for noncitizens. Specifies that time when a participant receives assistance under a tribal TANF program counts towards the participant's 60-month lifetime limit on federally-funded assistance.

Also rewords **paragraph (b)** to clarify that months when the recipient was participating in the Minnesota investment plan field trials are not counted toward the 60-month limit.

51 **Exemption for certain families.** (Amends § 256J.42, subd. 5) Technical, inserting a more complete cross-reference to clarify that persons who are age 60 or older are exempt from the 60-month time limit on assistance.

52 **Interstate transitional standards.** (Amends § 256J.43) Makes technical changes throughout this section to update references to the applicable MFIP standard of need.

53 **County agency to provide orientation.** (Amends § 256J.45, subd. 1) Exempts caregivers who are working at least 35 hours per week, and second parents who are working at least 20 hours per week, from the requirement to attend an MFIP orientation. Makes other conforming changes.

54 **Pregnant and parenting minors.** (Adds subd. 1a to § 256J.45) Exempts pregnant minors and minor parents who are complying with program requirements from the requirement to attend the MFIP orientation. Requires instead that the county agency provide information from the orientation that is applicable to a minor caregiver.

55 **Sanctions for participants not complying with program requirements.** (Amends § 256J.46, subd. 1) Technical, replacing references to the different standards to reflect the new definition of "MFIP standard of need" that was added in section 9. Also clarifies that references to the "residual" refer to the residual grant after a sanction has been applied.

56 **Sanctions for refusal to cooperate with support requirements.** (Amends § 256J.46, subd. 2) Technical, modifying a reference to the transitional standard to reflect the new definition of "MFIP standard of need" that was added in section 9.

57 **Dual sanctions.** (Amends § 256J.46, subd. 2a) Technical, modifying a reference to the MFIP transitional standard.

58 **Ineligibility for MFIP; emergency assistance; and emergency general assistance.** (Amends § 256J.47, subd. 4) Technical, modifying a reference to the MFIP standard to reflect the new definition of "MFIP standard of need" that is added in section 9.

59 **Eligibility.** (Amends § 256J.48, subd. 2) Provides that emergency assistance (EA) is not available if the reason for the family's emergency needs is that the assistance unit is under a sanction or the caregiver is disqualified from receiving MFIP.

60 **Emergency needs.** (Amends § 256J.48, subd. 3) In **paragraph (c)**, makes a technical change, modifying a reference to the MFIP transitional standard to reflect the new definition of "MFIP standard of need" that is added in section 9.

In **paragraph (g)**, adds refuse removal service to the list of utility costs for which an emergency assistance grant may be paid.

61 **Employment and training services component of MFIP.** (Amends § 256J.50, subd. 1) Strikes a provision that allows counties to provide employment and training services to caregivers who are exempt but who volunteer for the services. Requires counties to provide employment and training services within 30 days after an MFIP recipient is required to participate in the services.

62 **Overview of employment and training services.** (Amends § 256J.515) Clarifies that attending the employment and training services orientation is mandatory, and that failing to attend without good cause will result in a sanction.

63 **Application limited to certain participants.** (Amends § 256J.52, subd. 1) Technical, striking a cross-reference to the provision about exempt caregivers volunteering for employment and training, because that provision was stricken in section 61.

64 **Job search; job search support plan.** (Amends § 256J.52, subd. 3) Permits an MFIP participant's job search to be limited to jobs that are consistent with the participant's employment goal, if the job counselor and participant agree to this limitation. Also permits a participant to fulfill a specified portion of the 30-hour weekly job search requirement by attending adult basic education (ABE) or English as a second language (ESL) classes, if this is specified in the job search support plan.

65 **Secondary assessment.** (Amends § 256J.52, subd. 4) In **paragraph (b)**, provides that the failure to complete a secondary assessment will result in a sanction.

Adds **paragraph (c)**, which authorizes a job counselor to require that a participant complete a professional chemical use assessment or a professional psychological assessment, when the job counselor has a reasonable belief that the participant's ability to get and keep a job is impaired by a medical condition. Permits the job counselor to ensure that appropriate services, like child care and transportation, are available to meet needs identified by an assessment under this paragraph. Specifies how data gathered in an assessment under this paragraph is treated under the state Data Practices Act.

In **paragraph (d)**, specifies the minimum information on additional employment and training resources that an employment and training services provider must make available to each MFIP participant; this includes information on: activities operated under the Minnesota job skills partnership; community and technical colleges; adult basic education (ABE) programs; and services offered by vocational rehabilitation programs.

66 **Employment plan; contents.** (Amends § 256J.52, subd. 5) When job search is an activity in an MFIP participant's employment plan, permits the job search to be limited to jobs that are consistent with the participant's employment goal, if the job counselor and participant agree to this limitation.

67 **Basic education activities in plan.** (Adds subd. 5a to §256J.52) Requires, for a participant who is proficient in reading or math only at or below an eighth-grade level, that the participant be allowed

to include basic education activities in the participant's job search support plan or employment plan.

68 **Responsibility for assessment and employment plan.** (Amends § 256J.54, subd. 2) Permits, at county option, an 18- or 19-year old caregiver who does not have a high school diploma, to have a social services agency conduct the required MFIP assessment and complete the employment plan. Also permits an 18- or 19-year old caregiver who has been receiving services from a social services agency, and who does not have a high school diploma, to choose whether to continue receiving services from the social services agency, or to instead use an employment and training services provider.

69 **Choice of provider.** (Amends § 256J.55, subd. 4) Requires, for two-parent families, both parents to choose the same employment and training services provider, unless an identified special need (e.g. bilingual services) is not available through one service provider.

70 **Employment and training services component; exemptions.** (Amends § 256J.56) Technical changes only, revising the MFIP acronym.

71 **Good cause for failure to comply.** (Amends § 256J.57, subd. 1) Adds a good cause exemption for individuals whose mandatory MFIP meeting conflicts with a judicial proceeding or a meeting related to a juvenile court matter, or a participant's work schedule. Also requires the job counselor to work with the participant to reschedule a mandatory MFIP meeting, if the participant falls into one of the specified categories.

72 **Allocation.** (Amends § 256J.62, subd. 1) Requires eligible tribal providers to also receive an allocation from the appropriation for employment and training services grants, under the formula specified in the next section.

73 **Caseload-based funds allocation.** (Adds subd. 2a to § 256J.62) Creates a new formula to allocate employment and training funding to counties and eligible tribal providers, for fiscal years 2000 and thereafter. Each county or eligible tribe will receive money based on its average number of MFIP cases as a proportion of the statewide total number of cases.

In **clause (1)**, provides that the average number of cases is calculated from the previous year's quarterly counts, but excludes child-only cases and cases where all caregivers are age 60 or over (and thus are exempt from employment and training requirements). Provides that two-parent cases are multiplied by a factor of 2 in this calculation.

In **clause (2)**, provides that the case count for each eligible tribal provider is based on the number of active MFIP cases that include a member who is enrolled in, or eligible for enrollment, in the tribe. Requires that the cases that are included in the count must be ones where the member resides within the tribal program's service delivery area.

In **clause (3)**, requires the MFIP cases counted as part of a tribal provider's allocation to be excluded from the case counts of the respective counties where the members reside, in order to prevent duplicate counts.

In **clause (4)**, requires the commissioner to first set aside $1 million before allocating funds under this section. Allows the commissioner to use these set-aside monies to provide additional funding to counties or to tribal providers who experience an unforeseen influx of MFIP participants, or other situations beyond their control.

In **clause (5)**, requires that some of the $1 million set-aside be used to offset reductions in the allocations to counties caused by the new allocations to tribal providers. Requires that funds under this clause that remain unspent by March 31 of each year be reallocated to county and tribal providers under the same formula.

74 **Bilingual employment and training services to refugees.** (Amends § 256J.62, subd. 6) Technical, revising the MFIP acronym.

75 **Work literacy language programs.** (Amends § 256J.62, subd. 7) Technical, revising the MFIP

acronym.

76 **Reallocation.** (Amends § 256J.62, subd. 8) Technical, revising the MFIP acronym.

77 **Continuation of certain services.** (Amends § 256J.62, subd. 9) Extends the availability of optional case management and related services for an additional six months, so that a county may continue to provide the services for up to 12 months after a participant leaves MFIP, rather than up to six months. Also makes technical changes to revise the MFIP acronym.

78 **Employment plan.** (Amends § 256J.67, subd. 4) Technical, modifying a reference to the transitional standard to reflect the new definition of "MFIP standard of need" that is added in section 9.

79 **Concurrent eligibility, limitations.** (Amends § 256J.74, subd. 2) In **paragraph (a)**, recodifies a provision relating to a caregiver's concurrent eligibility when they have moved from another state where they were receiving assistance. (This provision is being relocated from an earlier section.)

In **paragraph (b)**, clarifies the treatment of an individual who is a member of more than one assistance unit in this state in a given month. Also clarifies that the provisions relating to the treatment of foster care payments apply to all types of foster care payments, not just federal Title IV-E payments.

80 **County performance management.** (Adds new § 256J.751)

In **paragraph (a)**, requires the commissioner to provide each county with a quarterly report showing the county's relative performance on five measures: the percent of the MFIP caseload working in paid employment; the percent of the caseload receiving only the MFIP food portion; the number of MFIP cases that have left the program; the county's performance with respect to the federal work participation requirements; and the median placement wage.

In **paragraph (b)**, requires the commissioner to develop additional county performance standards. Requires the commissioner to consult with counties to develop these measures. Also requires that the commissioner consider: a measure for cases that leave MFIP due to employment; job retention after participants leave MFIP; and participant earnings at some point after leaving MFIP.

In **paragraph (c)**, specifies that if the federal government imposes sanctions on the state because of failures to meet the federal work participation requirements, the state must pay 88 percent of the sanction. Requires counties to pay the remaining 12 percent of the sanction, each county in proportion to its percentage of the average monthly MFIP caseload during the period for which the sanction is imposed.

In **paragraph (d)**, if a county fails to meet the federal performance standards in any year, requires the commissioner to work with counties to organize a joint state-county technical assistance team to assist the particular county. Requires the commissioner to coordinate the technical assistance with other state agencies as necessary.

81 **Administrative functions.** (Amends § 256J.76, subd. 1) Permits a county to request, before July 15 of this year, that the commissioner review the FY 1996 data that was used to set the county's base for its MFIP administrative allocation, if it believes the data was inaccurate or incomplete. Requires the commissioner to adjust the base if necessary, by August 15, 1999. Requires the commissioner to adjust the county's 1999 allocation amount to reflect the base change.

82 **Allocation of county funds.** (Amends § 256J.76, subd. 2) In **paragraph (b)**, creates a new formula to allocate administrative funds to counties. Administrative funds will be allocated on a calendar year basis, beginning January 1, 2000, under this formula. The formula provides each county with a base allocation of up to $2,000, and further specifies the calculation of a guaranteed floor for each county's allocation.

83 **Reporting requirement and reimbursement.** (Amends § 256J.76, subd. 4) Requires the commissioner to regularly review each county's administrative expenditures as compared to the

county's allocation under the previous section. Permits the commissioner to reallocate funds from counties that will not have expended their allocations to counties that have expenditures that are greater than their allocation.

84 **Recommendations to 60-month limit.** By January 15, 2000, requires the commissioner to submit recommendations to the legislature regarding MFIP families that include a caregiver who has reached the 60-month time limit for receiving federally-funded assistance.

85 **Review of Minnesota supplemental aid special diet allowance; report.** Requires the commissioner to review the Minnesota supplemental aid special diet allowance and provide a report to the appropriate Senate and House committee chairs that contains updated special diet allowance rates.

86 **Proposal required.** By January 15, 2000, requires the commissioner to submit a proposal to the legislature for creating an MFIP incentive bonus program for high-performing counties. Requires the proposal to include recommendations on how to implement a system that would provide an incentive bonus to a county that demonstrates high performance with respect to the county's MFIP participants.

87 **Assessment protocols.** Requires the commissioner to consult with county agencies, employment and training service providers, the commissioners of human rights, economic security, and children, families and learning, and advocates to develop protocols for implementing the new provision in the secondary assessment section of the MFIP statute that permits a job counselor to require an MFIP participant to have a chemical use or psychological assessment (in section 65 of this article).

88 **FATHER project; time-limited waiver of existing statutory provisions.** Requires the commissioner to waive enforcement of the specified statutory provisions, and the related administrative rules and standards, for the limited purpose of allowing the entire amount of current child support payments to be disbursed for the children of noncustodial parents who are participating in the FATHER demonstration project, and so that these child support payments are excluded as income when the custodial parent is an MFIP participant. Sunsets the waiver authority granted by this section on July 1, 2002.

89 **Repealer.** Repeals the following provisions:

§ 256D.051, subdivisions 6 and 19, on FSET spending limits. These provisions are replaced by sections 1 and 2 of the article.

§ 256D.053, subdivision 4, requiring the commissioner to submit a plan to the USDA for the Minnesota food assistance program. This subdivision is now obsolete.

§ 256J.30, subdivision 6, requiring an MFIP assistance unit that does not have to file a monthly household report form to file one every six months.

§ 256J.62, subdivisions 2, 3 and 5, specifying the allocation of employment and training services block grant to counties. These subdivisions are replaced by sections 72 and 73 of the article.

Laws 1997, chapter 85, article 1, section 63, on county performance standards and requiring a plan to allocate federal fiscal sanctions. This section is replaced by section 80 of the article.

Article 7: Child Support

Overview

This article makes various policy and technical changes to the child support system. These include provisions relating to: data practices, paternity establishment, social security numbers, suspension or denial of recreational licenses, satisfaction of support obligation, collections, and entry and docketing of judgments. Items described as federal mandates carry the possibility of loss of funds for child support and TANF (MFIP) if not enacted.

1 **Data practices.** (Amends § 13.46, subd. 2) Allows the department of human services to share data with other state agencies to evaluate child support program performance and to identify and prevent fraud in the child support program.

2 **Social security numbers.** (Amends § 256.87, subd. 1a) Requires that the social security numbers of a mother, father, and child appear on all support orders. This is a federally mandated, technical change consistent with changes made elsewhere in 1997.

3 **Locating parties.** (Amends § 256.978, subd. 1) Technical clarifications. Clarifies that the "locate" statute can be used to obtain information needed to establish paternity *in addition to* physically locating the obligor. Clarifies that the locate provisions can also be used to locate a custodial parent to disburse support to that parent. Adds "credit grantors" to the list of entities required to provide locate information.

4 **Temporary child support.** (Amends § 257.62, subd. 5) Provides that temporary support payments may be held in escrow by the public authority instead of the court if the public authority is a party and is providing services. Under current paternity law, a court may order an alleged father to pay child support pending resolution of the action. The support is then held in escrow by the court.

5 **Judgement; order.** (Amends § 257.66, subd. 3) allows the court to order the obligor to reimburse the mother's wages that were lost due to medical necessity.

6 **Revocation of a recognition of paternity.** (Amends § 257.75, subd. 2) Changes the time period for revocation of a voluntary paternity acknowledgment from 30 to 60 days. This is a federally mandated change.

7 **Social security numbers.** (Amends § 518.10) Similar to section 4, requires the social security numbers of a mother, father, and child to be on a support order, as federally mandated.

8 **Recreational license suspension.** (Adds subd. 15 to § 518.551) **Paragraph (a).** Allows an obligee or the public authority to bring a motion to suspend or bar receipt of recreational licenses for a child support obligor if:

the obligor is in arrears for support, maintenance, or both, at least equal to six times the monthly obligation and is not in compliance with a written payment agreement addressing the arrearages and current support; or

the obligor failed to comply with a subpoena relating to a paternity or child support proceeding.

Before using this subdivision the court must find that other substantial enforcement mechanisms have been attempted but have proven unsuccessful.

Paragraph (b). Provides that the following hunting and fishing licenses and stamps may be suspended or denied under this subdivision: deer, bear, moose, elk, small game, pheasant, turkey, migratory waterfowl, fish, and trout and salmon. (Note that equipment-related licenses, such as for boats or ATVs, are not included.)

Paragraph (c). Allows obligors affected by this subdivision to provide proof to the court of compliance with a written payment agreement addressing the arrearages and current support. Within 15 days of receiving the proof, the court must notify the DNR that licenses can be issued or reinstated.

The authority to suspend recreational licenses is mandated by federal law.

9 **Creditor collections.** (Adds subd. 6 to § 518.5851) Clarifies that the child support payment center is not a third party for garnishment or levy purposes.

10 **Collections unit recoupment account.** (Adds subd. 11 to § 518.5853) Allows the commissioner of human services to establish a revolving account to cover funds issued in error due to insufficient funds or other reasons. This section is a codification of a current budget rider.

11 **Modification.** (Amends § 518.64, subd. 2) Clarifies that support modifications allowed under this section include interest that may have accrued.

12-21 **Entry and docketing of judgments.** (Amends §§ 548.09 and 548.091) Provides that child support judgements have the same legal effect and are subject to the same procedures and defenses as other judgments. Provides that a court may order interest on a child support debt to stop accruing if an obligor is: (1) unable to pay because of a significant physical or mental disability, or (2) a recipient of certain assistance. Strikes language relating to "automatic" increases to a child support judgment, but provides that a child support judgment may be renewed or increased multiple times as appropriate. Makes other technical corrections relating to entry and docketing of child support judgments.

22 **Child support assurance program.** (Amends Laws 1995, chap. 257, art. 1, sec. 35, subd. 1) Requires the commissioner of human services to continue planning a demonstration project of child support assurance by administering a federal grant already awarded for that purpose.

23 **Child support arrearage forgiveness report.** Requires the Commissioner of Human Services to examine the feasibility of forgiving child support arrears in a fair and consistent manner, and develop child support arrearage forgiveness policies to be used throughout the state. The commissioner shall also explore the possibility of forwarding a portion, or the entire amount, of the child support award to the custodial parent under circumstances where that currently is not happening. The report is due December 1, 1999.

24 **Repealer.** Repeals § 548.091, subds. 3, 5, and 6 (relating to the changes to the entry and docketing of child support judgments).

Article 8: Child Protection and Related Federal Maximization of Funds

Overview

This article makes various policy and technical changes to child protection and welfare laws. These include provisions relating to: the public/private adoption initiative, child welfare case management, child placement plans, relative searches, relative custody assistance, adoption assistance, children in need of protection or services, guardian ad litems, and termination of parental rights, alternative responses to child maltreatment, abuse definitions, substance abuse assessments, maximization of federal funding.

1 **Birth certificate request.** (Amends § 144.1761, subd.1) Requires the state registrar to provide a copy of an adopted person's original birth certificate to a representative from an American Indian tribe in order to determine the adopted person's eligibility for enrollment or membership in a tribe.

2 **Licensing prohibition for certain juvenile facilities.** (Amends § 245A.30) Changes provisions in the law to allow the state to claim a federal match for certain medical expenses associated with "Rule 5" facilities, which are facilities for children with severe emotional disturbance.

3 **Chemical dependency/child protection.** (Amends § 254A.175) Requires the Commissioner of Human Services to explore and experiment with different chemical dependency treatment models for parents with children who are found to be in need of treatment pursuant to an assessment done under the child abuse reporting act or a child protection case plan.

4 **Eligibility.** (Amends § 254B.04, subd. 1) Amends the eligibility for the chemical dependency treatment fund "tier 1" services by requiring the local agency to assist persons with dependent children who are determined to be in need of treatment pursuant to an assessment under the Child Abuse Reporting Act or a child protection case plan in accessing needed treatment services. This section also amends "tier 2" services by requiring that the county give preferential treatment to persons who are not eligible under tier 1, but are found to be in need of treatment pursuant to an assessment under the Child Abuse Reporting Act or a child protection case plan, if the county is

notified by the state agency of limited funds.

5 **Residential services for children with severe emotional disturbance.** (Amends § 256B.0625, subd. 41) Expands MA to cover certain residential services for children with severe emotional disturbance, effective July 1, 2000.

6 **Child welfare case management.** (Amends chapters 256B and 256F) Expands the authority to claim child welfare case management funds to include contracted staff of a local social services agency and Indian tribes.

7 **Child welfare case management.** (Amends chapters 256B and 256F) Expands the authority to claim child welfare case management funds to include contracted staff of a local social services agency and Indian tribes.

8 **Child welfare case management.** (Amends chapters 256B and 256F) Expands the authority to claim child welfare case management funds to include contracted staff of a local social services agency and Indian tribes.

9 **Provider qualifications.** (Amends § 256B.0945) Establishes MA requirements for coverage of certain residential services for children with severe emotional disturbance, effective July 1, 2000. This section specifies provider qualifications, covered services, centralized disbursement of medical assistance payments, payment rates, quality measures, use of federal earnings, maintenance of effort requirements, related reports, sanctions and commissioner recommendations. The new federal funding that is earned as a result of the changes in this section and sections 2 and 6 is to be used, in part, to increase prevention and early intervention and supportive services, which include alternative responses to child maltreatment, children's mental health services, and family preservation services.

10-18 **Child welfare case management.** (Amends chapters 256B and 256F) Expands the authority to claim child welfare case management funds to include contracted staff of a local social services agency and Indian tribes.

19 **Placement plan.** (Amends § 257.071, subd. 1) Requires local social service agencies to make diligent efforts to locate absent parents and offer services to both parents. Provides that a noncustodial or nonadjudicated parent may provide day-to-day care for a child by agreement or court order. Requires a nonadjudicated parent to cooperate with paternity establishment. If neither parent is fit to care for a child, the case plan must address the conditions each parent needs to mitigate. If a child cannot be returned to the legal custodian after services have been provided, the agency may seek to establish legal custody with the noncustodial parent. The local social services agency may be relieved of the duty to locate and offer services to one or both parents for good cause.

Clarifies that a case plan must indicate the date the child is expected to return home and be safe there, or, alternatively, placed for adoption or otherwise permanently removed.

Requires that, in concurrent permanency planning cases, the social services agency must notify the parents of: placement and reunification time limits, the nature of available services, the consequences of failing to use provided services or correct the negative conditions, relative placement alternatives, and the benefits of returning the child home or terminating parental rights in a timely fashion.

Requires that the case plan set forth a permanency hearing or termination of parental rights hearing.

Requires the case plan to document the steps taken to finalize the adoption or legal guardianship of a child when parental rights are terminated.

Requires that a copy of the case plan be provided to foster parents.

20 **Placement decisions based on best interest of the child.** (Amends § 257.071, subd. 1a) Clarifies that siblings should be placed together for foster care and adoption at the earliest possible time unless it is not possible after appropriate efforts by the responsible social services agency.

21 **Notice before voluntary placement.** (Amends § 257.071, subd. 1c) Amends the section of law dealing with parents who are considering voluntary placement of their children by requiring the local social services agency to provide information regarding permanent placement.

22 **Relative search.** (Amends § 257.071, subd. 1d) Clarifies that a relative search must begin as soon as possible. Requires parents to cooperate in giving information about relatives unless it is not in the best interests of the child. Provides that notice of an intent to permanently place a child or terminate parental rights need not be given to a child's relatives if the child is in a foster home that has committed to be a permanent placement for the child.

23 **Change in placement.** (Amends § 257.071, subd. 1e) Requires that the court hold a hearing within ten days after the child is "removed from the permanent placement" instead of within ten days after the child is "taken into custody."

24 **Review of voluntary placements.** (Amends § 257.071, subd. 3) Amends the section of law dealing with the review of voluntary placements by listing what a petition may include, and by also amending what a specific plan for permanency may include.

25 **Review of developmentally disabled and emotionally handicapped child placements.** (Amends § 257.071, subd. 4) Provides that no permanency hearing is required for a placement due solely to a child's handicapping condition when custody of the child is not transferred to the responsible social services agency.

26-33 **Relative custody assistance.** (Amends § 257.85) Makes changes to the relative custody assistance program. Incorporates important friends with whom the child has resided or had significant contact into the program. Incorporates relatives who live outside Minnesota into the program.

Defines "relative custodian" as a person who has permanent legal and physical custody of a child. Clarifies that non-resident relative custodians must seek public assistance for which the child is eligible in their state. (Minnesota residents are currently required to do so.)

Provides that a relative custodian may appeal an assistance rate modification based on a failure to provide documentation relating to a change, or lack thereof, in the child's physical, mental, emotional, or behavioral needs or based on a change in the gross income of the relative custodian's family. Other grounds for appeal currently exist as well.

Provides that relative custody assistance payments shall not be used in determining income under MFIP.

Makes other technical and conforming changes.

34 **Adoption assistance appeals.** (Amends § 259.67, subd. 6) Provides that an adoption assistance agreement may be entered into after an adoption is final if the child is and was eligible but an agreement was not entered into due to extenuating circumstances. Usually, an adoption assistance agreement must be entered into prior to adoption.

35 **Reimbursement for adoption services.** (Amends § 259.67, subd. 7) Provides that the commissioner may enter into contracts for the placement of children under state guardianship with licensed out-of-state child placing agencies.

36 **Reimbursement of nonrecurring adoption expenses.** (Amends § 259.73) Provides that nonrecurring adoption expenses must be reasonable to be reimbursable.

37-39 **Post adoption service grants.** (Amends § 259.85) Expands eligibility for post adoption service grants beyond age 18 to age 22 if the child remains dependent on the adoptive parents and is enrolled in full-time secondary education. Requires that certification statements relating to eligibility for the grant individually address all criteria.

40 **Birth certificate provided to Indian tribe.** (Adds subd. 6 to § 259.89) Requires the state registrar to provide a copy of an adopted person's birth certificate to an Indian tribe to determine eligibility

for enrollment or membership. (This is related to the amendments that authorize tribes to claim child welfare case management funds.)

41 **Policy.** (Amends § 260.011, subd. 2) Adds language required by federal law related to reasonable efforts, and adds transferring permanent legal and physical custody of a child to a relative as a permanency option when a child cannot return home.

42 **Reasonable efforts.** (Amends § 260.012) Expands circumstances when reasonable efforts to reunify are not required to include abandoned infants and when a prima facie case that services are futile under § 260.191, subd. 3b, is presented. Clarifies that the social services agency has the burden to prove that reasonable efforts were made or not required under the circumstances. Requires the social service agency to disclose when it is pursuing concurrent permanency planning. Makes other technical and conforming changes.

43 **Child in need of protection or services.** (Amends § 260.015, subd. 2a) Amends the definition of the term "child in need of protection or services" by including language regarding a child in voluntary placement under certain circumstances, and by striking language regarding a child whose custodial parent's parental rights to another child have been involuntarily terminated within the past five years.

44 **"Relative."** (Amends § 260.015, subd. 13) Modifies the definition of "relative" for CHIPS, TPRs, and permanency proceedings to mean a person related to the child by blood, marriage, or adoption, or an individual who is an important friend with whom the child has resided or had significant contact.

45 **"Egregious harm."** (Amends § 260.015, subd. 29) Expands the definition of "egregious harm" to include conduct toward a child that constitutes criminal sexual conduct under sections 609.342 to 609.345.

46 **Review of foster care status.** (Amends § 260.131, subd. 1a) **Paragraph (a)** requires that a petition be filed within 90 days of a voluntary placement made under § 257.071, subd. 3. Requires the petition to state the reason for the placement, the progress on the case plan, and the statutory basis for the petition. Upon agreement of all parties, and if the court finds it is in the best interests of the child, the court may find that: the child's needs are being met, the placement is in the best interests of the child, and the child will be returned home within the next six months. In that case, the matter will be continued for six months. If the case is not resolved and dismissed at that time, it will return to the court for further proceedings under the statute.

Paragraph (b) requires that a petition be filed within six months of a voluntary placement of a handicapped child. The petition must state the start date, the nature of the child's condition, the plan, the parent's participation, and the statutory basis. Provides that if all parties agree, the court may approve the voluntary arrangement and dismiss the matter from further jurisdiction. Provides that the matter must be returned to the court for further review if the child remains in placement after 12 months. Provides for contested proceedings when the parties disagree.

47 **Petition.** (Amends § 260.133, subd. 1) Provides that a court has jurisdiction over a domestic child abuse matter even if there is a parent in the child's household willing to enforce the court's order and accept services on behalf of the family.

48 **Temporary order.** (Amends § 260.133, subd. 2) Simplify procedures for a petition and temporary order relating to domestic child abuse.

49 **Notice.** (Adds subd. 1a to § 260.135) Requires the following people to be notified a CHIPS proceeding is pending, unless they voluntarily appear or are summoned: an adjudicated or presumed father, an alleged father, a noncustodial mother, and a grandparent with a right to participate under § 260.155, subd. 1a.

50 **Guardian ad litem.** (Amends § 260.155, subd. 4) Clarifies that a guardian ad litem must be

appointed in child abuse and neglect cases.

51 **Waiver.** (Amends § 260.155, subd. 8) Removes the ability of a guardian ad litem to waive or object to legal issues on behalf of a child who does not have a lawyer.

52 **Hearing and release requirements.** (Amends § 260.172, subd. 1) **Paragraph (d)**, prior to an adjudicatory hearing and upon request of a county attorney, requires the court to determine:

whether the petition makes a prima facie case for TPR on specified grounds (and provides that in this case a trial must be scheduled within 90 days of the petition filing);

whether the county attorney has determined not to proceed with a TPR petition under § 260.221, subd. 1b; or

whether a TPR petition under § 260.191, subd. 3b makes out a prima facie case that provision of services or further services is futile (and provides that in this case a permanency hearing must be scheduled within 30 days).

Paragraph (e) provides that the court may order the parent of a child placed out of home to provide information about the child's father or relatives.

53 **Case plan.** (Adds subd. 5 to § 260.172) Requires a case plan to be filed with the court within 30 days of a CHIPS petition under § 260.131. Allows the court and parent to agree with the case plan. Provides that the case plan may be modified upon motion. If the parent does not agree to the case plan, the court may not order compliance until making a disposition under § 260.191, subd. 1.

54 **Dispositions.** (Amends § 260.191, subd. 1) Expands or clarifies the options a court has in placing a child in need of protection or services to include: placing the child in the home of the other parent, placing the child with a nonadjudicated father (provided he cooperates with establishing paternity), and placing the child in the home of a noncustodial parent. Makes other technical changes.

55 **Written findings.** (Amends § 260.191, subd. 1a) Amends the written findings related to the disposition made by the court in the previous section.

56 **Domestic child abuse.** (Amends § 260.191, subd. 1b) Amends the statute dealing with the domestic abuse of a child by allowing the agency to be dismissed as a party, and allowing the order to be renewed as necessary for the continued protection of the child for a period not to exceed one year.

57 **Review of placements; permanent placement determination.** (Amends § 260.191, subd. 3b) Provides that permanency hearing requirements do not apply to children in placement due solely to their handicapping condition. Eliminates the requirement for multiple petitions in order to cumulate out-of-home placement time. Requires the court to have "compelling reasons," in addition to being in the best interests of the child, to extend an out-of-home placement beyond 12 months up to 18 months before making a permanency determination.

58 **Dispositions; voluntary foster care placements.** (Amends § 260.192) Makes conforming changes by deleting language that would be redundant considering changes made in an earlier section (the section that amends § 260.131, subd. 1a).

59 **Voluntary and involuntary TPRs.** (Amends § 260.221, subd. 1) Language specifying that reunification efforts are not necessary if futile and unreasonable is relocated from § 260.221, subd. 5 to subd. 1.

Makes changes relating to when a previous involuntary termination of parental rights may be used as a presumption to terminate rights to a sibling. Eliminates references to terminations that occurred under specific statutory sections and instead references all instances of previous involuntary termination.

Modifies a presumption of when reasonable efforts to reunify a family have failed by changing standards relating to the cumulative time period a child has been placed out of home. Provides for a different standard for children under age eight. Requires court approval of a case plan before

terminating rights under this paragraph. Eliminates a requirement that the court make predictions about a family's future circumstances and instead requires the court to consider present circumstances.

Makes other technical and conforming changes.

60 **Evidence of abandonment.** (Amends § 260.221, subd. 1a) Amends the section of law relating to abandonment of a child by eliminating the requirement that an adoption proceeding be pending before certain presumptions regarding abandonment apply to the case.

61 **Required TPRs.** (Amends § 260.221, subd. 1b) Provides that a TPR petition is triggered when a social services agency determines that a child has been subjected to egregious harm. Under current law the trigger is when the child has been placed out of home.

Provides that a TPR petition normally required by this subdivision is not required if: (1) a petition is filed to give permanent custody to a relative; or (2) a CHIPs petition and case plan are filed documenting "compelling reasons" why TPR is not in the child's best interests.

62 **Current foster care children.** (Amends § 260.221, subd. 1c) Provides that mandatory permanency actions do not apply to children in placement due solely to a handicapping condition. Also makes changes relating to when TPR petitions that are normally required need not be filed. (These changes are similar to changes made in other sections.)

63 **When prior finding required.** (Amends § 260.221, subd. 3) Technical change deleting obsolete references.

64 **Findings regarding reasonable efforts.** (Amends § 260.221, subd. 5) Stricken language is relocated to § 260.221, subd. 1.

65 **Alternative response programs for child protection assessments or investigations.** (Amends § 626.5551)

Subd. 1. Authorizes counties to establish programs that use alternative responses to child abuse reports. Types of responses that might be used are listed, such as a family assessment and services approach, but other responses identified in the county's plan may also be used.

Subd. 2. Is the general framework for determining how to respond to a report. It includes the circumstances under which an investigation must be conducted, based on the allegations in the report, and the procedure for terminating an investigation and initiating an alternative response. Law enforcement always must be notified and may conduct its own investigation.

Subd. 3. Contains documentation requirements regarding the outcome of cases in which an alternative response is used. The documentation must be retained for at least four years.

Subd. 4. Provides that in order to use the alternative response program, the county must include the program in its community social service plan and program evaluation under chapter 256E. The plan must address the alternative responses and services that will be used and protocols for determining the appropriate response to reports.

66 **Definitions.** (Amends § 626.556, subd. 2) Amends the definitions of sexual abuse, neglect, medical neglect, physical abuse, facility, mental injury, and threatened injury.

67 **Persons mandated to report.** (Amends § 626.556, subd. 3) adds the term "agency responsible for licensing or supervising the facility" where appropriate.

68 **Agency responsible.** (Amends § 626.556, subd. 3b) Adds a new subdivision listing the agencies that are responsible for assessing or investigating reports of alleged child maltreatment in facilities.

69 **Immunity from liability.** (Amends § 626.556, subd. 4) Amends the provision dealing with who is immune from civil or criminal liability.

70 **Report.** (Amends § 626.556, subd. 7) Requires the local welfare agency to inform the person who reports maltreatment or abuse within 10 days after the report is made if the report was accepted for

assessment or investigation, if the reporter requests to be notified of that information.

71 **Duties.** (Amends § 626.556, subd. 10) Amends the duties of the local welfare agency upon receipt of a report by requiring the agency to conduct an assessment of substance abuse, and if the assessment indicates a potential for abuse of drugs or alcohol, then the local agency is required to take further steps and report the determination, recommendation, and any referrals to the state authority on alcohol and drug abuse.

72 **Duties; abuse in facility.** (Amends § 626.556, subd. 10b) Adds the term "agency responsible for licensing or supervising the facility" where appropriate.

73 **Notification of neglect or abuse in facility.** (Amends § 626.556, subd. 10d) Amends the notification requirements of neglect or abuse in a facility by referencing each applicable facility, and clarifies that the reference to commissioner is the commissioner "of the agency responsible for licensing or supervising the facility."

74 **Determinations.** (Amends § 626.556, subd. 10e) Amends the provision dealing with local welfare agency determinations by striking language referencing the maltreatment of minors advisory committee established in the 1997 legislative session.

75 **Notice of determinations.** (Amends § 626.556. subd. 10f) Adds the term "agency responsible for licensing or supervising the facility" where appropriate.

76 **Release of data to mandated reporters.** (Amends § 626.556, subd. 10j) Amends the provisions dealing with the release of data to mandated reporters by specifying who is considered to be a mandated reporter.

77 **Records.** (Amends § 626.556, subd. 11) Adds the term "agency responsible for licensing or supervising the facility" where appropriate.

78 **Data received from law enforcement.** (Amends § 626.556, subd. 11b) Adds the term "agency responsible for licensing or supervising the facility" where appropriate.

79 **Records.** (Amends § 626.556, subd. 11c) Adds the term "agency responsible for licensing or supervising the facility" where appropriate.

80 **Establishment of the team.** (Amends § 626.558, subd. 1) Amends the county established multi-disciplinary child protection team by requiring that a member of the team be designated as the lead person responsible for coordinating its activities with battered women's programs and services.

81 **Amend chemical dependency assessment criteria.** Requires the Commissioner of Human Services to amend chemical dependency assessment criteria to include criteria that addresses issues related to parents who have open child protection cases. In amending the rule, the commissioner is required to use the expedited rule making procedures under Chapter 14, and assure that notification provisions are in accordance with federal law. The commissioner is also required to amend the chemical dependency rules to address pregnancy as a risk factor in the need for chemical dependency treatment.

82 **Rehabilitation services.** Requires the Commissioner of Human Services, in consultation with the Association of Minnesota Counties and other stakeholders, to design a proposal to add rehabilitation services to the state MA plan for adults with mental illness or other debilitating conditions, which may include chemical dependency.

83 **Targeted case management for vulnerable adults.** Requires the Commissioner of Human Services, in consultation with the Association of Minnesota Counties and other stakeholders, to design a proposal to provide MA coverage for targeted case management service activities for certain adults receiving services through a county or state agency.

84 **Recommendations to the legislature.** Requires the commissioner to submit to the Legislature the design and implementation recommendations for the proposals required in Sections 81 and 82, by

January 15, 2000 for implementation by July 1, 2000.

85 **Instruction to revisor.** Is an instruction to the Revisor to delete certain statute references.

86 **Repealer.** Repeals obsolete language regarding rule making authority.

87 **Effective date.** Makes sections 2, 6, and 10 effective July 1, 2000.

Article 9: Health Occupations

Overview

Article 9 makes changes to statutes governing the Emergency Medical Services Regulatory Board and physical therapists. Sections 1, 2, 4 to 47, 65, and 66 add requirements for ambulance services, emergency medical technicians, EMT instructors, and the EMS Regulatory Board. Sections 3 and 48 to 64 move the regulation of physical therapists from the Board of Medical Practice to a new Board of Physical Therapy, and make physical therapists licensed rather than registered.

1 **Ambulance service data.** Amends § 13.99, subd. 38a. Changes a cross-reference in the Data Practices Act from a section that is being repealed to a new section being created.

2 **EMT, EMT-I, EMT-P, or first responder misconduct.** Adds subd. 39b to § 13.99. Amends the Data Practices Act by adding a cross-reference to the data classification of reports of emergency medical technician and first responder misconduct.

3 **Exemptions.** Amends § 144A.46, subd. 2. In a subdivision exempting people from the requirements of obtaining a home care license, changes a reference from registration to licensure for physical therapists.

4-22 Define the following terms in chapter 144E governing the emergency medical services regulatory board: advanced airway management, advanced life support, ambulance service personnel, basic airway management, basic life support, clinical training site, defibrillator, emergency medical technician or EMT, emergency medical technician-intermediate or EMT-I, emergency medical technician-paramedic or EMT-P, medical control, part-time advanced life support, physician, physician assistant, prehospital care data, program medical director, registered nurse, standing order, and training program coordinator.

23 **License required.** Amends § 144E.10, subd. 1. Strikes language giving the EMS regulatory board authority to set licensure fees and to prescribe rules governing license expiration and renewal.

24 **Ambulance service requirements.** Adds § 144E.101. Establishes requirements for the operation of ambulance services, including requirements for personnel, patient care, continual service and denial of service, types of services, various forms of life support, drivers, mutual aid agreements, and service outside primary service areas.

Subd. 1. Personnel. Prohibits ambulance services from operating unless their personnel are appropriately certified or meet the staffing criteria for the type of ambulance service. Requires all ambulance services to have a medical director.

Subd. 2. Patient care. Establishes staffing requirements in the patient compartment for when a patient is being transported.

Subd. 3. Continual service. Requires an ambulance service to offer service 24 hours a day every day of the year, unless otherwise authorized by the board.

Subd. 4. Denial of service prohibited. Prohibits an ambulance service from denying prehospital care, because of an inability to pay or the source of payment, to any person who needs ambulance service. Allows transport to be limited to the nearest appropriate emergency medical facility.

Subd. 5. Types of service. Lists the types of ambulance services the EMS regulatory board must regulate: basic life support, advanced life support, part-time advanced life support, and specialized

life support.

Subd. 6. Basic life support. Requires a basic life support ambulance to be staffed by at least two personnel (at least one of whom must be an EMT). Specifies the level of care that must be provided by basic life support ambulances, including basic airway management and, by January 1, 2001, automatic defibrillation. Allows medical directors to authorize the use of medical anti-shock trousers and the performance of intravenous infusion.

Subd. 7. Advanced life support. Establishes staffing requirements for advanced life support ambulances. Requires such ambulances to provide basic life support, advanced airway management, manual defibrillation, and administration of intravenous fluids and pharmaceuticals. Requires these ambulance services to have a written agreement with their medical directors to ensure medical control for patient care, and lists information the agreement must include. Also allows advanced life support services to staff additional ambulances to provide basic life support.

Subd. 8. Part-time advanced life support. Establishes staffing and equipment requirements for part-time advanced life support services, and allows them to provide service for less than 24 hours every day. Also requires these services to have a written agreement with their medical directors to ensure medical control for patient care.

Subd. 9. Specialized life support. Allows specialized life support services to provide basic or advanced life support, in a form restricted by the board.

Subd. 10. Driver. Requires ambulance drivers to have a current driver's license and to have attended an emergency vehicle driving course that included actual driving experience.

Subd. 11. Personnel roster and files. Lists the roster information and documentation in files that an ambulance service must maintain regarding its ambulance service personnel and medical director.

Subd. 12. Mutual aid agreement. Requires ambulance services to have a written agreement with a neighboring ambulance service for coverage of the service's primary service area when its own ambulances are not available.

Subd. 13. Service outside primary service area. Allows an ambulance service to provide service outside its primary service area only if requested by a transferring physician or an ambulance service licensed to provide services in that area.

25 **Equipment.** Adds § 144E.103. Establishes requirements for the equipment that ambulances must carry. Lists equipment that all ambulances must carry and that advanced life support ambulances must carry. Requires equipment in ambulances to be securely stored, and requires ambulances to be equipped with safety straps and seat belts in the patient compartment.

26 **Renewal requirements.** Adds subd. 9 to § 144E.11. Makes ambulance service licenses valid for two years from the date of licensure, and establishes requirements for license renewal.

27 **Air ambulance service requirements.** Adds § 144E.121. Requires air ambulance services to comply with state and federal regulations for aircraft, and requires air ambulances to carry equipment appropriate to the level of service being provided. Requires air ambulance service personnel to be appropriately certified or licensed and to be trained in the use of equipment on air ambulances. Lists training that EMS personnel must receive, and requires the service's medical director to certify that each person has successfully completed this training.

28 **Prehospital care data.** Adds § 144E.123. Requires ambulance services to collect and provide prehospital care data to the board. If a patient is transported to a hospital, requires the ambulance service to give the hospital a copy of the ambulance report. Allows prehospital care data to be reviewed by the board, and classifies the data as private data. Makes failing to report all information required by the board a ground for license revocation.

29 **Operational procedures.** Adds § 144E.125. Requires ambulance services to have written

procedures for responding to complaints, maintaining ambulances and equipment, handling drugs, and controlling infections.

30 **Interhospital transfer.** Adds § 144E.127. Allows a physician, registered nurse, or physician assistant to take the place of one of the required ambulance personnel when a patient is transferred from one hospital to another.

31 **Types of services to be regulated.** Amends § 144E.16, subd. 4. Strikes language listing the types of ambulance services to which board rules are to apply (basic, intermediate, advanced, specialized, and air ambulance services). Also strikes language stating that until rules are adopted, the current rules continue to operate.

32 **Inspections.** Amends § 144E.18. Specifies that board inspections of ambulance services are to determine whether the services are in compliance with requirements in statute and rule, and allows the board to review documentation required to be on file with ambulance services.

33 **Disciplinary action.** Adds § 144E.19. Establishes disciplinary powers for the board and the rights of ambulance services against which disciplinary action is proposed.

Subd. 1. Suspension; revocation; nonrenewal. Allows the board to suspend, revoke, refuse to renew, or condition the license of an ambulance service upon a finding that statute or rule has been violated or the service has stopped providing services.

Subd. 2. Notice; contested case. Requires the board to give notice to the ambulance service of the right to a contested case hearing before taking any disciplinary action. If a service requests a hearing withing 30 days, requires the board to initiate a hearing. Establishes timelines under which contested case reports and orders must be issued.

Subd. 3. Temporary suspension. Allows the board to temporarily suspend an ambulance service's license if the board determines that the continued provision of service would create an imminent risk to public health or harm to others. Requires temporary suspension orders to include notice of the right to a preliminary hearing, and requires the board to schedule a hearing on whether to continue or lift the temporary suspension. Establishes timelines under which orders must be issued after temporary suspension hearings and timelines for contested case hearings.

34 **Medical director.** Adds § 144E.265. Requires an ambulance service medical director to be a Minnesota-licensed physician, be experienced in emergency care, and be familiar with emergency medical service systems. Lists responsibilities for medical directors. Also requires the medical director or a designee to annually assess the practical skills of all personnel on the ambulance service roster, and verify each person's proficiency.

35 **Denial, suspension, revocation.** Adds subd. 5 to § 144E.27. Paragraph (a) lists grounds for disciplinary action against first responders registered with the board. Paragraph (b) requires the board to give notice of first responders against whom discipline is proposed of the right to a contested care hearing, and requires a contested case hearing to be initiated if the individual requests one within 30 days after receiving notice. Paragraph (c) establishes timelines under which contested case reports and orders must be issued. Paragraph (d) allows first responders who were disciplined to apply to the board for reinstatement six months after the board's disciplinary action.

36 **Temporary suspension.** Adds subd. 6 to § 144E.27. Allows the board to temporarily suspend a first responder's registration if the board determines that the continued provision of service by the individual would create an imminent risk to public health or harm to others. Requires temporary suspension orders to include notice of the right to a preliminary hearing, and requires the board to schedule a hearing on whether to continue or lift the temporary suspension. Establishes timelines under which orders must be issued after temporary suspension hearings and timelines for contested case hearings.

37 **Certification of EMT, EMT-I, and EMT-P.** Adds § 144E.28. Establishes certification

requirements for EMTs, intermediate EMTs, and paramedic EMTs.

Subd. 1. Requirements. To be eligible for certification, requires EMTs, EMT-Is, and EMT-Ps to successfully complete a U.S. Department of Transportation course and pass written and practical examination requirements approved by the board.

Subd. 2. Expiration dates. Establishes dates on which certifications expire.

Subd. 3. Reciprocity. Allows the board to certify individuals who have current National Registry of Emergency Medical Technicians registrations from other jurisdictions.

Subd. 4. Forms of disciplinary action. Lists forms of disciplinary action that the board may take against emergency medical technicians.

Subd. 5. Denial, suspension, revocation. Lists grounds upon which emergency medical technicians may be disciplined by the board, and requires the board to give notice to the individual before taking disciplinary action. Establishes timelines under which reports and orders must be issued. Allows a disciplined person to apply to the board for reinstatement six months after the board's disciplinary action.

Subd. 6. Temporary suspension. Allows the board to temporarily suspend an EMT's certification if the board determines that the continued provision of service by the individual would create an imminent risk to public health or harm to others. Requires temporary suspension orders to include notice of the right to a preliminary hearing, and requires the board to schedule a hearing on whether to continue or lift the temporary suspension. Establishes timelines under which orders must be issued after temporary suspension hearings and timelines for contested case hearings.

Subd. 7. Renewal. Lists requirements for certification renewal as an EMT, EMT-I, or EMT-P. Requires certifications to be renewed every two years, and that an individual's certification expires if the applicant does not meet renewal requirements.

Subd. 8. Reinstatement. Allows the board to reinstate a person's certification upon submission of evidence of completion of continuing education requirements, if the submission is within four years of the certification's expiration. If more than four years have passed, requires applicants to complete the initial certification process.

38 **EMT instructor qualifications.** Adds § 144E.283. To be an EMT instructor, requires a person to be currently certified as an EMT, physician, physician assistant, or registered nurse; have two years of active emergency medical practical experience; be recommended by a medical director; and successfully complete the U.S. Department of Transportation EMS instructor training program or its equivalent.

39 **Training programs.** Adds § 144E.285. Requires EMT training programs to be approved by the board, and lists qualifications that programs must meet for approval. Establishes additional training program requirements for EMT paramedic programs. Makes training program approvals expire two years after the date of approval, and requires training programs to apply for re-approval at least three months before the expiration of the approval. Allows the board to suspend, revoke, condition, or refuse to renew a program's approval if the program violates a statute or rule or misrepresents or falsifies application information. Permits the board to temporarily suspend a training program's approval if the board finds that the continued provision of service by the training program would create an imminent risk to public health or harm to others. Allows the board to audit training programs, including investigating complaints, course inspections, classroom observation, review of instructor qualifications, and student interviews.

40 **Examiner qualifications for emergency medical technician testing.** Adds § 144E.286. Establishes qualifications for examiners testing the qualifications of emergency medical technicians.

41 **Fees.** Adds § 144E.29. Establishes fees for ambulance service licenses, the operations of each

ambulance, training program approval, and duplicates of original licenses, certifications, and approvals. Specifies that fees are for a two-year period and are nonrefundable. Directs fees collected to be deposited in the trunk highway fund.

42 **Reporting misconduct.** Adds § 144E.305. Establishes voluntary and mandatory reporting requirements regarding grounds for disciplinary action, and immunity from civil liability or criminal prosecution for reporters and other actors.

Subd. 1. Voluntary reporting. Permits any person who knows of any conduct by a first responder, EMT, intermediate EMT, or paramedic EMT that is a ground for disciplinary action to report that conduct to the board.

Subd. 2. Mandatory reporting. Requires ambulance services to report any conduct by a first responder, EMT, EMT-I, or EMT-P that is a ground for disciplinary action, any dismissal of one of these employees, and any resignation by one of these employees while disciplinary proceedings are ongoing or about to be commenced.

Subd. 3. Immunity. Provides immunity from civil liability and criminal prosecution to any person or entity that submits a report of conduct that may be a ground for disciplinary action, and to board personnel involved in investigating violations and preparing and managing charges. Classifies reports as confidential data on individuals or protected nonpublic data, while an investigation is active. Closes all disciplinary hearings to the public.

43 **Correction order and fines.** Adds § 144E.31. Authorizes the board to issue correction orders and fines for ambulance services and training programs that violate statutes or rules if the violation does not imminently endanger public health or safety.

Subd. 1. Correction order. Allows the board to issue a correction order if an ambulance service or training program violates a statute or rule and if the violation does not imminently endanger public health or safety. Lists information the correction order must include.

Subd. 2. Reconsideration. Allows an ambulance service or training program to ask the board to reconsider a correction order if the service or program believes the correction order is in error.

Subd. 3. Fine. Allows the board to order a fine at the same time as a correction order, or after the ambulance service or training program has not corrected a violation within a specified time. Allows the ambulance service or training program to appeal the fine order. Lists fine amounts, and requires fines collected to be deposited in the trunk highway fund.

Subd. 4. Additional penalties. Specifies that the board is also allowed to take other disciplinary action, in addition to ordering a fine.

44 **Penalty.** Adds § 144E.33. Makes a person who violates any provision of sections 144E.001 to 144E.33 guilty of a misdemeanor.

45 **Comprehensive advanced life support.** Adds § 144E.37. Requires the board to establish a comprehensive advanced life support (CALS) educational program to train all medical personnel practicing in rural areas to recognize and treat life-threatening emergencies.

46 **Audits.** Adds subd. 6 to § 144E.50. Requires each regional EMS board to be audited biennially by an independent auditor, covering all funds received by the board. Requires the audit to be performed within 60 days of the end of the biennium, and requires copies of the audits to be filed with specified state entities. If an audit is not conducted or if copies of audits are not filed with the appropriate entities, requires the EMS regulatory board to reduce funding to the relevant regional board.

47 **Emergency medical care.** Amends § 145A.02, subd. 10. Corrects a cross-reference to a description of life-support transportation in the chapter regulating the activities of community health boards.

48 **State board of physical therapy, duties.** Amends § 148.66. For purposes of authority to regulate

physical therapists, strikes references to the board of medical practice. Establishes a board of physical therapy and authorizes it to regulate physical therapists.

49 **State board of physical therapy; membership appointments, vacancies, removals.** Amends § 148.67. Eliminates the physical therapy council, which had advised the board of medical practice on the regulation of physical therapists. Specifies membership on the board of physical therapy of nine members, and states that membership terms, compensation, removal of members, filling of vacancies, reporting requirements, and other issues are governed by chapter 214. Directs the American Physical Therapy Association to recommend to the governor qualified members to serve on the board.

50 **Officers; executive director.** Adds § 148.691. Directs the board to elect officers and employ an executive secretary and other persons needed to carry out its work. Allows officers to serve for one year or until a successor is elected. Classifies all communications or information received by or disclosed to the board as confidential and privileged, and classifies certain disciplinary actions, settlement agreements, and votes on disciplinary matters as public data. Requires the board to exchange information with other Minnesota licensing boards, agencies, or departments. Also requires the board, upon request, to give a complainant a description of the activities and actions the board took relating to the complaint, a summary of the results, and the reasons for the actions taken.

51 **Applicants, qualifications.** Amends § 148.70. Specifies that the board of physical therapy, rather than the board of medical practice, will establish and administer program requirements. Modifies terms to indicate that physical therapists are licensed, not registered. As a condition of licensure, requires applicants to complete an accredited physical therapy education program.

52-58 Modifies terms to indicate that physical therapists are licensed, not registered. Makes other technical changes.

59 **Malpractice history.** Adds § 148.745. Requires any person who wants to be licensed to practice physical therapy in Minnesota and who has previously practiced in another state to file information on the person's professional liability insurer in the other state and any malpractice settlements or awards made relating to the quality of services provided. Directs the board to consider this information.

60 **Licenses; denial, suspension, revocation.** Amends § 148.75. Specifies that physical therapists are licensed, not registered. Replaces references to the board of medical practice with references to the board of physical therapy.

61 **Prohibited conduct.** Amends § 148.76. In addition to existing conduct that is prohibited relating to physical therapy, also prohibits any person from practicing physical therapy unless licensed, and changes references from registration to licensure.

62 **Prosecution, allegations.** Amends § 148.78. Changes a reference from registration to licensure.

63 **Health-related licensing board.** Amends § 214.01, subd. 2. Amends the definition of health-related licensing board in chapter 214 to include the board of physical therapy, which is being created in this article.

64 **Initial appointments to board.** Allows the first physical therapist members appointed to the board of physical therapy to be registered, rather than licensed, physical therapists.

65 **Revisor's instruction.** Instructs the revisor to delete the listed statutory references and replace them with other listed references.

66 **Repealer.** Repeals statutes and rules governing the EMS regulatory board that are no longer needed.

Article 10: Other Provisions

Overview

This article makes changes to a variety of other human services-related statutes. Provisions in this article:

Require the commissioners of health and commerce to ensure that any appropriations to reduce annual MCHA assessments are reflected in the premium rates for small employers and individual health plans (section 1).

Create a health care and human services worker training and retention program (sections 2 to 8).

Sunset the grant program for child welfare services to minor refugees on June 30, 2001 (section 9).

Repeal the homesharing grant program on June 30, 2001; and continue a prohibition against MA and GAMC paying for an MCHA recipient's premiums (sections 10 and 11).

1 **State funding; effect on premium rates of members.** Adds subd. 13 to § 62E.11. requires the commissioners of health and commerce, in approving premium rates for small employer and individual health plans, to ensure that any appropriation to reduce the annual Minnesota Comprehensive Health Insurance Act (MCHA) assessments is reflected in these premium rates.

2 **Job skills partnership program.** Amends § 116L.02. In a new paragraph (b), directs the Job Skills Partnership Program to administer the health care and human services worker training and retention program, which is created in sections 3 to 8.

3 **Program established.** Adds § 116L.10. Creates a health care and human services worker training retention program to alleviate critical worker shortages in these fields, and to increase opportunities for current and potential direct care employees to qualify for advanced employment in these fields.

4 **Definitions.** Adds 116L.11. Defines the following terms for the new program: "eligible employer"; "potential employee target groups"; and "qualifying consortium."

5 **Funding mechanism.** Adds § 116L.12.

Subd. 1. Applications. Requires a qualifying consortium to apply as directed by the job skills partnership board.

Subd. 2. Fiscal requirements. Requires an application to specify how the qualifying consortium will make maximum use of available funding, to minimize the need for training and retention grants. Requires a consortium to designate a lead agency as the fiscal agent.

Subd. 3. Program targets. Requires an application to describe targeted employers or types of employers, and the specific critical workforce shortage the program is designed to alleviate.

Subd. 4. Grants. Requires the job skills partnership board to make grants to qualifying consortia, within the limits of available appropriations, to operate local, regional or statewide training and retention programs. Requires each grant award to establish specific, measurable outcomes and timelines for achieving the outcomes.

Subd. 5. Local match requirements. Requires a consortium to provide a local match of at least 50 percent. Specifies other conditions that apply to this local match requirement.

Subd. 6. Ineligible worker categories. Prohibits grants from being made to alleviate shortages of physicians, physician assistants, or advanced practice nurses.

Subd. 7. Evaluation. Requires the job skills partnership board to evaluate the success of consortia receiving grants in achieving expected outcomes, and to report annually to the legislature.

6 **Program requirements.** Adds § 116L.13.

Subd. 1. Marketing and recruitment. Requires a qualifying consortium to implement a marketing and outreach strategy to recruit potential employees.

Subd. 2. Recruitment and retention incentives. Requires employer members of a qualifying consortium to provide incentives to train and retain employees. Lists examples of possible incentives.

Subd. 3. Work hour limits. Prohibits participants who are high school students from working more than 20 hours per week when school is in session.

Subd. 4. Collective bargaining agreements. Requires this section to be implemented in a manner that is consistent with existing collective bargaining agreements covering health care and human services employees.

7 **Career enhancement requirements.** Adds § 116L.14. Requires consortium members to work cooperatively to establish and maintain a career ladder program that provides direct care staff with opportunities for advancing along a career development path.

8 **Small employer protection.** Adds § 116L.15. Requires grantees to guarantee that small employers be allowed to participate in consortium programs. Requires a small employer's financial contribution to be adjusted to reflect the employer's financial circumstances.

9 **Child welfare services to minor refugees.** Adds subd. 6 to § 256.485. Sunsets this grant program, which provides specialized child welfare services to Asian and Amerasian refugees under age 18, on June 30, 2001.

10 **Repealer.** In **paragraph (a)**, repeals the homesharing grant program, which matches low and moderate income elderly, developmentally disabled and single parent homeowners with prospective tenants, on June 30, 2001.

In **paragraph (b)**, repeals a provision in the 1997 MinnesotaCare Act amendments that would have sunset the provisions preventing MA or GAMC from covering premiums for recipients who are covered under an MCHA plan. This repealer has the effect of continuing the prohibition against the MA and GAMC programs paying for an MCHA recipient's premiums.

11 **Effective date.** Makes the repealer in section 10, paragraph (b), immediately effective.

Article 11: Tobacco Settlement Payments

Overview

Two endowment funds are created in article 11 for the one-time tobacco settlement payments received by the state in 1998, 1999, 2000, and 2001. The medical education endowment fund is to receive 39 percent of the settlement payments, and earnings from the fund are to be used for medical education activities and for the instructional costs of health professional programs. The tobacco use prevention and local public health endowment fund is to receive 61 percent of the settlement payments, and earnings from the fund are to be used for statewide and local tobacco use prevention activities for youth and for local public health promotion and protection activities for youth.

1 **Tobacco settlement fund.** Adds § 16A.86. Creates the tobacco settlement fund as a clearing account in the state treasury. Directs the commissioner of finance to deposit into the account the one-time tobacco settlement payments received by the state in 1998, 1999, 2000, and 2001. Of the amounts credited to the fund, appropriates 61 percent for transfer to the tobacco use prevention and local public health endowment fund and 39 percent for transfer to the medical education endowment fund. Sunsets the tobacco settlement fund June 30, 2015.

2 **Medical education endowment fund.** Adds § 62J.694. Creates a medical education endowment fund, and delineates how expenditures from the fund are to be made.

Subd. 1. Creation. Creates the medical education endowment fund in the state treasury, and directs the state board of investment to invest the fund. Requires all earnings of the fund to be credited to the fund, and requires the principal of the fund to stay inviolate.

Subd. 2. Expenditures. Appropriates, on a quarterly basis, up to 5 percent of the fair market value of

the fund for medical education activities in Minnesota. Prohibits actual appropriations from exceeding actual earnings. Makes the appropriations as follows:

For FY 2000, 70 percent of the appropriation is for transfer to the board of regents for instructional costs of health professional programs at the academic health center and affiliated teaching institutions, and 30 percent is for transfer to the commissioner of health for distribution for medical education.

For FY 2001, 49 percent of the appropriation is for transfer to the board of regents for instructional costs of health professional programs, and 51 percent is for transfer to the commissioner of health for distribution for medical education.

For FY 2002 and subsequent fiscal years, 42 percent of the appropriation may be appropriated by another law for instructional costs of health professional programs, and 58 percent is for transfer to the commissioner of health for distribution for medical education. Up to $150,000 of each annual appropriation to the commissioner of health may be used by the commissioner for administrative expenses associated with distributing medical education funds.

Subd. 3. Audits required. Requires the legislative auditor to audit endowment fund expenditures to ensure that the money is spent for allowable purposes.

Subd. 4. Sunset. Sunsets the medical education endowment fund on June 30, 2015, and upon expiration directs the commissioner of finance to transfer the principal and any remaining interest to the general fund.

3 Health professional education budget plan. Adds § 137.44. Requests that the board of regents adopt a biennial budget plan for making expenditures from the medical education endowment fund for instructional costs of health professional programs. Allows these plans to be submitted as part of the University of Minnesota's biennial budget request.

4 Tobacco use prevention and local public health endowment fund. Adds § 144.395. Establishes the tobacco use prevention and local public health endowment fund, and delineates how expenditures from the fund are to be made.

Subd. 1. Creation. Creates the tobacco use prevention and local public health endowment fund in the state treasury, and directs the state board of investment to invest the fund. Requires all earnings of the fund to be credited to the fund, and requires the principal of the fund to stay inviolate.

Subd. 2. Expenditures. Appropriates up to 5 percent of the fair market value of the fund on the preceding July 1 to reduce the human and economic consequences of tobacco use among youth and for other public health initiatives. Makes the appropriations as follows:

On January 1, 2000, up to 5 percent of the fair market value of the fund on that date is appropriated to the commissioner of health, with (1) 67 percent of the appropriation as grants to fund statewide tobacco use prevention initiatives for youth; and (2) 16.5 percent of the appropriation as grants to fund local public health initiatives for youth for tobacco use prevention in coordination with other health-related efforts. The commissioner may use up to $200,000 of this appropriation to conduct statewide assessments of tobacco behaviors and attitudes among youth. The commissioner may also use up to $150,000 of this appropriation for administrative expenses.

Beginning July 1, 2000 and on July 1 of each subsequent year, appropriates (1) 67 percent of the amount available for expenditure as grants to fund statewide tobacco use prevention initiatives for youth; (2) 16.5 percent of the amount for expenditure as grants to fund local public health initiatives for youth for tobacco use prevention in coordination with other health-related efforts; and (3) 16.5 percent of the amount to distribute to community health boards for local health promotion and protection activities not related to tobacco use prevention. The commissioner may use up to $150,000 of each annual appropriation for administrative

expenses. Also, beginning July 1, 2001, $1,100,000 of each annual appropriation that is to be spent for statewide tobacco use prevention initiatives may be used for base level funding for the commissioner's tobacco prevention and control programs.

5 Tobacco use prevention. Adds § 144.396. Details the activities to be funded using earnings from the tobacco use prevention and local public health endowment fund. Directs the commissioner of health to establish measurable outcomes for grant programs, conduct evaluations of programs receiving grants, develop criteria and procedures for awarding grants, and do a statewide assessment of tobacco behaviors and attitudes among youth. Also directs the commissioner to award grants for statewide tobacco prevention and local tobacco prevention, and to distribute funds to community health boards for local health promotion and protection activities not related to tobacco.

Subd. 1. Purpose. States that the legislature finds that it is important to reduce the prevalence of tobacco use among youth, and makes it the goal of the state to reduce tobacco use among youth by 30 percent by the year 2005 and to promote statewide and local tobacco use prevention activities to achieve this goal.

Subd. 2. Measurable outcomes. Directs the commissioner to consult with tobacco use prevention organizations and establish measurable outcomes to be used to determine the effectiveness of programs receiving grants under this section.

Subd. 3. Statewide assessment. Requires the commissioner to conduct a statewide assessment of tobacco behaviors and attitudes among youth to establish a baseline for measuring the statewide effect of tobacco use prevention activities.

Subd. 4. Process. Requires the commissioner to develop criteria and procedures for allocating grants under this section, and requires the criteria to include an administrative cost limit for grant recipients. Directs the commissioner to inform grant recipients of the outcomes that are established, and requires grant recipients to coordinate tobacco use prevention activities with other entities engaging in tobacco use prevention activities in the recipient's service area.

Subd. 5. Statewide tobacco prevention grants. Requires the commissioner to award competitive grants for tobacco use prevention projects, including statewide public education and information campaigns and coordinated special projects. Lists some of the entities eligible for grants, and requires applicants to submit proposals to the commissioner that specify the strategies to be implemented and that take into account the need for a coordinated, statewide tobacco prevention effort. Directs the commissioner to give priority to funding projects that include specified criteria.

Subd. 6. Local tobacco prevention grants. Directs the commissioner to award grants for local and regional projects that coordinate tobacco use prevention and the reduction of other high-risk behaviors in youth. Lists project areas that may be included for grants, and lists some of the entities eligible for grants. Requires applicants to submit proposals to the commissioner that specify the strategies to be implemented and that are targeted to achieve outcomes established by the commissioner. Directs the commissioner to give priority to funding projects that include specified criteria. Specifies that the commissioner must divide the state into geographic regions, allocate a percentage of the funds to programs in each region, and if necessary, provide technical assistance to ensure adequate proposals are developed for each region.

Subd. 7. Local public health promotion and protection. Directs the commissioner to distribute funds to community health boards for local health promotion and protection activities aimed at high risk health behaviors among youth other than tobacco use. Requires these funds to be distributed based on demographics and other health-related, need-based factors.

Subd. 8. Coordination. Directs the commissioner to coordinate projects funded under this section with tobacco use prevention activities of the Minnesota Partnership for Action Against Tobacco (MPAAT), community health boards, other organizations, and national tobacco prevention efforts.

Subd. 9. Evaluation. Using the outcome measures developed, directs the commissioner to conduct a biennial evaluation of the statewide and local tobacco use prevention projects and community health board activities. Lists elements the evaluation must include, and requires grant recipients and community health boards to cooperate with the commissioner in the evaluations. Beginning January 15, 2003, requires the results of each evaluation to be submitted to the chairs and members of the house health and human services finance committee and senate health and family security budget division. Allows up to $150,000 of the annual appropriation made on July 1, 2000 and each subsequent odd-numbered year to be used by the commissioner for a tobacco use monitoring system and to conduct evaluations.

Subd. 10. Report. Requires the commissioner of health to submit annual reports to the chairs and members of the house health and human services finance committee and senate health and family security budget division on the projects and activities funded under this section. Lists information the reports must include, and requires the reports to be issued by January 15 of each year beginning in 2001.

Subd. 11. Audits required. Requires the legislative auditor to audit endowment fund expenditures to ensure that the money is being spent for allowable purposes.

Subd. 12. Endowment fund not to supplant existing funding. Prohibits endowment funds from being used as a substitute for traditional funding sources for tobacco use prevention or public health activities. Requires any local unit of government receiving money under this section to ensure that existing local financial efforts remain in place.

Subd. 13. Sunset. Sunsets this endowment fund June 30, 2015. Upon expiration, directs the commissioner of finance to transfer the principal and remaining interest to the general fund.

Effective date. Makes sections 1 to 3 and 5 effective the day following final enactment.

Irreconcilable provisions. Provides that if a tobacco settlement fund is created in the Omnibus Tax Bill, that provision is superseded by section 1 of this article, which also creates a tobacco settlement fund.