HOUSE RESEARCH

Bill Summary

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Authors: Goodno

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Analyst: Randall Chun, 651-296-8639 (Articles 2 to 7)
Peg Hicks, 651-296-8079 (Articles 11 and 12)
Elisabeth Loehrke, 651-296-5043 (Articles 1 and 9)
Thomas Pender, 651-296-1885 (Article 8)
Amy Petschauer, 651-296-5808 (Articles 10 and 13)

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Article 1: Health Department

Overview

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

Sections 1 to 21 modify fees for the well program.

The following sections establish or modify other fees charged by the Health Department. Section

25 establishes fees for licensing of radioactive material and nuclear material, section 26 modifies licensing fees for various health care facilities, section 28 modifies the vital records surcharge, section 30 modifies environmental laboratory certification fees, and sections 53 and 55 modify fees charged to food, beverage, and lodging establishments.

Sections 32 to 37 prohibit an abortion from being performed without a woman's informed consent, and establishes informed consent requirements.

Sections 38 to 41 modify provisions governing distribution and use of maternal and child health block grant funds.

Sections 43 and 44 modify provisions governing eligibility criteria for, uses of, and a definition for family planning special projects grants.

Section 45 establishes a teen pregnancy prevention program, and section 47 establishes a program to eliminate health disparities.

Sections 48 to 52 sunset existing targeted and universally offered home visiting programs and establish a program to fund family home visiting programs.

1 **Fees for variances.** Amends § 103I.101, subd. 6. Increases from $120 to $150 the fee for processing requests for variances from rules related to the well program.

2 **Fee exemptions for state and local government.** Amends § 103I.112. Provides that the commissioner may not charge fees related to the well program to a federal agency.

3 **Well notification fee.** Amends § 103I.208, subd. 1. Increases well notification fees for new wells (from $120 to $150), well sealings (from $20 to $30), and construction of dewatering wells (from $120 to $150 for one well and from $600 to $750 for a dewatering project of five or more wells).

4 **Permit fee.** Amends § 103I.208, subd. 2. Increases permit fees for various classes of wells.

5 **Disclosure of wells to buyer.** Amends § 103I.235, subd. 1. Increases the fee charged by county recorders or registrars for receipt of a completed well disclosure certificate from $20 to $30, and also increases the amount of the fee that must be transmitted to the commissioner from $17.50 to $27.50.

6 **Application fee.** Amends § 103I.525, subd. 2. Increases the application fee for a well contractor's license from $50 to $75.

7 **License fee.** Amends § 103I.525, subd. 6. Increases the license fee for an individual well contractor's license from $50 to $75.

8 **Renewal.** Amends § 103I.525, subd. 8. Places in statute the renewal application fee of $250 for a well contractor's license.

9 **Incomplete or late renewal.** Amends § 103I.525, subd. 9. Places in statute the late fee of $75 for renewal of a well contractor's license.

10 **Application fee.** Amends § 103I.531, subd. 2. Increases the application fee for a limited well/boring contractor's license from $50 to $75.

11 **License fee.** Amends § 103I.531, subd. 6. Increases from $50 to $75 the fee for a limited well/boring contractor's license.

12 **Renewal.** Amends § 103I.531, subd. 8. Places in statute the renewal application fee of $75 for a limited well/boring contractor's license.

13 **Incomplete or late renewal.** Amends § 103I.531, subd. 9. Places in statute the late fee of $75 for renewal of a limited well/boring contractor's license.

14 **Application fee.** Amends § 103I.535, subd. 2. Increases from $50 to $75 the application fee for an elevator shaft contractor's license.

15 **License fee.** Amends § 103I.535, subd. 6. Increases from $50 to $75 the fee for an elevator shaft contractor's license.

16 **Renewal.** Amends § 103I.535, subd. 8. Places in statute the renewal application fee of $75 for an

elevator shaft contractor's license.

17 **Incomplete or late renewal.** Amends § 103I.535, subd. 9. Places in statute the late fee of $75 for renewal of an elevator shaft contractor's license.

18 **Application fee.** Amends § 103I.541, subd. 2b. Increases from $50 to $75 the application fee for a monitoring well contractor registration.

19 **Renewal.** Amends § 103I.541, subd. 4. Places in statute the renewal application fee of $75 for a monitoring well contractor registration.

20 **Incomplete or late renewal.** Amends § 103I.541, subd. 5. Places in statute the late fee of $75 for renewal of a monitoring well contractor registration.

21 **Registration of drilling machines required.** Amends § 103I.545. Increases from $50 to $75 the registration fee for drilling machines and pump hoists. This section is effective July 1, 2002.

22 **Suspension of immunization requirement; modification to schedule.** Amends § 121A.15, subd. 6. During parts of the year when the legislature is not in session, authorizes the commissioner of health to modify the immunization requirements that apply to children in child care facilities and schools. Requires any modification made to be part of the current immunization recommendations of the three listed organizations. Requires the commissioner to modify the immunization requirements using the expedited rulemaking process, and specifies that a rule so adopted is in effect until adjournment of the next regular legislative session held after the rule is adopted. Requires the commissioner to report to the legislature on any changes made to immunization requirements.

23 **Modifications to schedule.** Adds subd. 7 to § 135A.14. During parts of the year when the legislature is not in session, authorizes the commissioner of health to modify the immunization requirements that apply to students in post-secondary educational institutions. Requires any modification made to be part of the current immunization recommendations of the three listed organizations. Requires the commissioner to modify the immunization requirements using the expedited rulemaking process, and specifies that a rule so adopted is in effect until adjournment of the next regular legislative session held after the rule is adopted. Requires the commissioner to report to the legislature on any changes made to immunization requirements.

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

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

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

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

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

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

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

Subd. 6. Inspections. Requires the commissioner to make periodic safety inspections of the radioactive material and source and special nuclear material of a licensee, and allows the commissioner to determine the frequency of inspections.

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

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

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

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

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

27 **Program.** Amends § 144.148, subd. 2. Amends a subdivision governing the rural hospital capital improvement program operated by the commissioner of health, to allow certain rural hospitals that meet additional criteria to obtain up to $1,500,000 in grant funds for a capital improvement project. The additional criteria that must be met are being the only hospital in a county, having 25 or fewer beds and a specific net operating margin, being located in a medically underserved area or health professional shortage area, serving significant numbers of migrant workers, and having not received a rural hospital capital improvement grant before July 1, 1999. In current law, the grant cap for hospitals that do not meet the additional criteria is $300,000. Currently three hospitals-those in Warren, Wheaton, and Arlington-meet the additional criteria and would be eligible for grants of up to $1,500,000.

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

29 **Hospital charity care aid.** Adds § 144.585. Allows eligible hospitals to receive charity care aid to offset excessive charity care burdens borne by certain hospitals.

Subd. 1. Purpose. Specifies that the purpose of charity care aid is to help offset excess charity care burdens at Minnesota acute care, short-term hospital.

Subd. 2. Definitions. Defines terms: charity care and cost-to-charge ratio.

Subd. 3. Charity care reporting. Paragraph (a) requires a hospital to do the following to report amounts as charity care adjustments: generate and record a charge, have a policy on the provision of charity care, have made a reasonable effort to identify third party payers and encourage a patient to enroll in any relevant public programs, and ensure the patient meets the charity care criteria. Paragraph (b) lists criteria for the hospital to consider when determining whether to classify care as charity care. Paragraph (c) establishes income standards the hospital must use for determining charity care eligibility for reporting purposes.

Subd. 4. Application. To be eligible for charity care aid, requires a hospital to apply to the commissioner. Requires applications to meet criteria established by the commissioner and to contain

the dollar amount of charity care provided in the previous year, a list of the most common diagnoses for which charity care is provided, and descriptive statistics of the characteristics of patients who receive charity care.

Subd. 5. Allocation of funds. Specifies that a hospital's share of available charity care aid is that hospital's share of charity care relative to the total charity care provided by all applicant hospitals.

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

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

32 **Definitions.** Adds § 145.4241. Defines the following terms, for a series of sections establishing informed consent requirements for abortions: abortion, attempt to perform an abortion, medical emergency, physician, and probable gestational age of the unborn child.

33 **Informed consent.** Adds § 145.4242. Prohibits abortions from being performed unless the woman on whom the abortion is to be performed gives voluntary, informed consent. Specifies that the following requirements must be met for the woman's consent to be voluntary and informed:

at least 24 hours before the abortion, a physician who will perform the abortion or a referring physician must tell the woman the name of the physician who will perform the abortion, the particular medical risks associated with the procedure to be employed, the probable gestational age of the unborn child at the time the abortion is to be performed, and medical risks associated with carrying a child to term. This information may be conveyed by phone or in person, but not by tape recording. Also requires the physician to provide revised information if the information known to the physician changes;

at least 24 hours before the abortion, a physician who will perform the abortion, a referring physician, or a physician's agent must tell the woman that MA benefits may be available for prenatal and childbirth costs, that the father must help support the child, and that the woman has the right to review printed information describing agencies and services that are available and describing probable anatomical and physiological characteristics of the unborn child. This information may be provided by tape recording;

the female must certify in writing before the abortion that she has been furnished with the required information and has been given the opportunity to review additional information; and

before the abortion, the physician who will perform the abortion or the physician's agent must receive a copy of the female's certification.

34 **Printed information.** Adds § 145.4243. Requires the commissioner of health to publish the following information, in English and each language that is the primary language for 2 percent or more of the population in Minnesota:

a geographically indexed list of the public and private agencies available to help women through pregnancy, childbirth, and child-rearing; descriptions of the services they provide; and how to contact them. This information may also be provided through a toll-free phone line at the Health Department;

information on the probable anatomical and physiological characteristics of the unborn child, describing the child in two-week gestational increments. The materials are required to be objective, nonjudgmental, and conveying scientific information only; and

descriptions of the methods of abortion commonly used, medical risks associated with each procedure, detrimental psychological effects of abortions, and medical risks associated with carrying a child to term.

35 **Procedure in case of medical emergency.** Adds § 145.4244. In medical emergency situations when an abortion is required, requires the physician to inform the woman, before the abortion if possible, of the medical indications supporting the physician's judgment that an abortion is necessary to avert her death or that a 24-hour delay would cause a serious risk of substantial and irreversible impairment of a major bodily function.

36 **Remedies.** Adds § 145.4245. Establishes circumstances under which civil remedies may be sought, allows attorney's fees in certain situations, and directs the court to rule on whether the identity of the woman on whom the abortion was performed or attempted must be shielded from public disclosure.

Subd. 1. Civil remedies. Allows any person on whom an abortion has been performed or attempted without complying with the informed consent requirements, or the parents of any minor on whom an abortion has been performed without complying with the informed consent requirements, to bring suit against the person who performed the abortion for actual and punitive damages.

Subd. 2. Attorney fees. Awards attorney's fees to the plaintiff in cases in which the plaintiff prevails. Awards attorney's fees to the defendant in cases in which the defendant prevails and the court finds that the plaintiff's suit was frivolous and brought in bad faith.

Subd. 3. Protection of privacy in court proceedings. Requires the court to determine whether the identity of a woman on whom an abortion has been performed or attempted will be preserved from public disclosure, in civil suits brought under subdivision 1. If the woman's identity is to be shielded, requires the court to issue an order sealing the record and excluding people from the courtroom to preserve her identity. Requires the court to also make certain findings. Without written consent from the woman on whom the abortion was performed, requires anyone other than a public official who brings a suit under subdivision 1 to do so under a pseudonym.

37 **Severability.** Adds § 145.4246. Specifies that if any provision of the statutes requiring informed consent for abortions is found unconstitutional, the unconstitutional provision is severable and the rest of the provisions remain in effect.

38 **Duties.** Amends § 145.881, subd. 2. Adds to the duties of the maternal and child advisory task force, the duty of reviewing the measures used to define the variables of the funding distribution formula every two years and making recommendations for changes to the commissioner.

39 **Allocation to community health boards.** Adds subd. 4a to § 145.882. Establishes a new formula to allocate, to community health boards, maternal and child health block grant funds remaining after distributions made under another subdivision, (replacing the current formula). Requires community health boards to receive 95 percent of the funding they received for the 1998-1999 funding cycle, and requires funds for each board to be proportionally decreased if there are insufficient funds to provide the amounts provided in the 1998-1999 grant cycle. Requires funds remaining to be allocated to community health boards based on the following variables: 25 percent based on the maternal and child health population in the area served, 50 percent based on an average of the listed health risk factors of the maternal and child health population in the area served, and 25 percent based on the income of the maternal and child health population in the area served. Requires each variable to be expressed as a city or county score, and requires community health boards to be allocated funds equal to its score multiplied the amount of money available.

40 **Use of block grant money.** Amends § 145.882, subd. 7. Amends a subdivision establishing

allowable uses for block grant money, to allow the funds to be used to address the frequency and severity of child and adolescent health problems in high-risk target populations. Prohibits funds from being used for prepregnancy family planning services. Removes language that allowed money to be used to address childhood injuries and child and adolescent health problems only if the board's program also included components targeting high-risk populations, certain pregnant women, young children with chronic diseases or disabilities, and family planning and preventive medical services. Also strikes language allowing block grant funds to be used for other purposes in certain situations. Strikes language guaranteeing projects that received grants in 1981 at least the amount that they received in 1989 unless certain criteria are met.

41 **Additional requirements for community boards of health.** Amends § 145.885, subd. 2. Modifies a cross-reference to conform with section 38.

42 **AIDS prevention grants.** Amends § 145.924. A new subdivision 2 requires the commissioner, in consultation with interested agencies and organizations, to establish measurable outcomes to determine the effectiveness of grants provided under this section in three areas. A new subdivision 3 requires the commissioner to conduct a biennial evaluation of the activities funded under this section, specifies what information the evaluation must include, and requires the results of each evaluation to be reported to the relevant policy and finance committees in the house and senate.

43 **Eligible organizations; purpose.** Amends § 145.925, subd. 1. Makes nonprofit corporations ineligible to receive family planning special projects grants and makes tribal governments eligible for such grants. Requires the prepregnancy family planning services funded by family planning special projects grants to be targeted to low-income and minority populations. Makes local units of government who receive grants responsible for ensuring that the grant funds are used for services for these populations, and requires the local units of government to establish a goal for reducing specific pregnancy rates in the service area. Also requires the local units of government to consider the listed factors when determining populations to serve and services to provide. Allows a city, county, tribal government, or group of cities, counties, or tribal governments to contract for the provision of prepregnancy family planning services only if the contract is specifically authorized by the governing body of the local unit of government. Prohibits an organization or affiliate that provides, promotes, or directly refers for abortions from receiving funds under this subdivision.

44 **Family planning services; defined.** Amends § 145.925, subd. 1a. Amends the definition of family planning services for purposes of family planning special projects grants, to specify that family planning services do not include services that, directly or indirectly, encourage, counsel, refer, or provide abortions or abortion referrals.

45 **Teen pregnancy prevention.** Adds § 145.9257. Establishes a teen pregnancy prevention program administered by the commissioner of health.

Subd. 1. Goal. States that it is the goal of the state to reduce teen pregnancy rates by 24 percent by 2006, and directs the commissioner to establish a grant program to do so. Provides that if this goal is not met by December 31, 2006, this section expires June 30, 2007. Prohibits funds awarded under this section from being used for medical services, family planning services, or services that directly or indirectly encourage, counsel, refer, or provide abortions or abortion referrals. Also prohibits an organization or affiliate that provides, promotes, or directly refers for abortions from receiving funds under this section.

Subd. 2. State-community partnerships; plan. Directs the commissioner to consult with the listed groups and commissioners and develop and implement a comprehensive, coordinated plan to reduce the number of teen pregnancies.

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

Subd. 4. Statewide assessment. Requires the commissioner to use and enhance current statewide assessments of teen pregnancy risk behaviors and attitudes to establish a baseline for measuring the statewide effect of teen pregnancy prevention activities. Directs the commissioner to conduct the assessment so results can be compared with national data.

Subd. 5. Process. Directs the commissioner, in consultation with the partners listed in subdivision 2, to develop criteria and procedures to allocate grants under this section.

Subd. 6. Teen pregnancy prevention disparity grants. Directs the commissioner to award competitive grants for projects to reduce unintended teen pregnancy rates for American Indians and populations of color. Prohibits funds from being used for medical services, family planning services, or services that directly or indirectly encourage, counsel, refer, or provide abortions or abortion referrals. Also prohibits an organization or affiliate that provides, promotes, or directly refers for abortions from receiving funds under this subdivision. Lists who may be considered an eligible applicant and what strategies may be employed. Lists project criteria to which the commissioner will give priority when awarding grants.

Subd. 7. High-risk community teen pregnancy prevention grants. Directs the commissioner to award grants to communities with significant risk factors for teen pregnancies, have youth development programs, and want to expand existing teen pregnancy prevention efforts. Prohibits funds from being used for medical services, family planning services, or services that directly or indirectly encourage, counsel, refer, or provide abortions or abortion referrals. Also prohibits an organization or affiliate that provides, promotes, or directly refers for abortions from receiving funds under this subdivision. Specifies that tribal governments and community health boards are eligible for these grants, and lists what strategies may be employed. Lists project criteria to which the commissioner will give priority when awarding grants. Allows up to 15 grants to community health boards and three tribal governments, and requires grants to be awarded based on the listed risk factors.

Subd. 8. Adolescent parent grants. Requires the commissioner to transfer funds to the commissioner of children, families and learning to increase the number of adolescent parent grants currently provided.

Subd. 9. Coordination. Directs the commissioner to coordinate projects funded under this section with other efforts to avoid duplication.

Subd. 10. Evaluation. Directs the commissioner to conduct a biennial evaluation of the impact of each teen pregnancy prevention initiative in this section.

Subd. 11. Report. Requires biennial reports on the projects funded under this section and the results of the biennial evaluations.

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

Subd. 1. Definition. Defines eligible community clinic.

Subd. 2. Grants authorized. Directs the commissioner to award grants to eligible community clinics to ensure the ongoing viability of Minnesota's clinic-based safety net providers, support the capacity of clinics to serve low-income populations, reduce uncompensated care burdens, or provide for improved infrastructure.

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

Subd. 4. Evaluation. Requires the commissioner to evaluate the overall effectiveness of the grant program.

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

Subd. 1. Goal; establishment. States that it is the goal of the state to reduce by 50 percent by 2010, disparities in infant mortality rates and child and adult immunization rates for American Indians and populations of color as compared with rates for whites. Directs the commissioner to establish a grant program to address health disparities in infant mortality, breast and cervical cancer screening, HIV/AIDS and sexually transmitted infections, immunizations, cardiovascular disease, diabetes, and accidental injuries and violence. Provides that if this goal is not met by December 31, 2010, this section expires June 30, 2011.

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

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

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

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

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

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

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

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

Subd. 10. Coordination. Directs the commissioner to coordinate the projects funded under this section with other efforts to avoid duplication.

Subd. 11. Evaluation. Directs the commissioner to conduct a biennial evaluation of the community grant program under subdivision 7.

Subd. 12. Report. Requires biennial reports, beginning January 15, 2002, on the projects funded under this section and the results of the biennial evaluations. Specifies what the report must include.

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

49 **Expiration.** Adds subd. 5 to § 145A.15. Makes the section governing funding for the targeted home visiting programs expire June 30, 2003.

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

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

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

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

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

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

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

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

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

Subd. 7. Evaluation. Requires the commissioner to conduct ongoing evaluations of the programs funded under this section. Requires cooperation by community health boards and tribal governments.

As part of the evaluations, requires the commissioner to rate the impact of the programs on the outcomes listed in subdivision 6 and to determine whether home visiting programs are the best way to achieve qualitative goals for the program. If they are not the best way to achieve these goals, requires the commissioner to provide the legislature with alternatives.

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

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

53 **Establishment fees; definitions.** Amends § 157.16, subd. 3. Modifies license fees for food, beverage, and lodging establishments and resorts, with the new fees effective July 1, 2004. Specifies that the license fee for a new operator previously licensed under this chapter for the same calendar year is half the appropriate annual fee, plus any penalty. Also, the license fee for operators opening or after October 1 is half the appropriate annual fee, plus any penalty. Specifies that school food and beverage services are not exempt from these fees. Provides that the fees being increased shall be phased up, as provided in section 55, to the amounts established for July 1, 2004 and following years. For fiscal years 2002, 2003, and 2004, requires the commissioner to regulate these establishments within the limits of available appropriations.

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

55 **Establishment fees during transition period.** Phases up licensing fees for food and beverage service establishments, hotel, motels, lodging establishments, and resorts by equal amounts each year for fiscal years 2002, 2003, and 2004. The fees are being phased up from the fee amounts effective June 30, 2001 to the fee amounts effective July 1, 2004.

56 **Repealer.** Paragraph (a) repeals the current allocation formula for maternal and child block grant funds and a section establishing the bone marrow donor education program. Paragraph (b) repeals a subdivision sunsetting the rural hospital capital improvement grant program (repealing the sunset makes the program permanent). Paragraph (b) is effective the day following final enactment.

Article 2: Health Care

Overview

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

Raise the prescription drug program income limit for Medicare enrollees under age 65, to 120 percent of the federal poverty guidelines (section 2).

Excludes child support and other payments for basic needs as income, when determining MA eligibility for children under the TEFRA option or under a home and community-based waiver (section 10).

Modify premium calculations and MA asset requirements for employed persons with disabilities (sections 11 and 14).

Increase or modify reimbursement for hospitals located outside the metro area (section 7), certain prescription drugs (section 18), special transportation services (section 20), ambulance services (section 21), certain health clinics (section 23), non-metro PMAP counties (section 31), and certain dental services for children (section 34).

Eliminate automatic MA eligibility for MFIP-S participants, and make conforming changes (sections 9, 25, 26, 38, 39, and 40).

Increase the MA income limit for the elderly, blind, or disabled, and for families and children, to 100 percent of the federal poverty guidelines, and increase the medically needy standard to that level, subject to federal approval (sections 12 and 13)

Provide MA coverage for certain individuals with breast or cervical cancer (sections 15, 27, and 29), children with autism spectrum disorders (section 17), and oral language interpreter services (section 22).

Provide funding for uncompensated care in hospitals and enhanced hospital rates, through an intergovernmental transfer (section 28).

1 **Specific powers.** Amends § 256.01, subd. 2. Gives the commissioner of human services authority to collect the MA prescription drug rebate for drugs dispensed or administered in an outpatient setting.

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

3 **Purchasing alliance stop-loss fund.** Adds § 256.956.

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

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

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

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

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

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

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

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

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

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

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

6 **Operating payment rates.** Amends § 256.969, subd. 2b. Requires the commissioner to remain within the limits of available appropriations, when rebasing hospital payment rates.

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

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

9 **Families eligible under prior AFDC rules.** Amends § 256B.055, subd. 3a. Effective July 1, 2002, eliminates language that provides automatic MA eligibility for MFIP-S participants, to conform with federal law. Instead, ties MA eligibility to the AFDC standard in effect on July 16, 1996, increased by three percent. Similar changes are made elsewhere in the bill.

10 **Income and assets generally.** Amends § 256B.056, subd. 1a. Effective upon federal approval, excludes child support payments, social security payments, and other benefits for basic needs as income, for children eligible for MA under the TEFRA option or through a home and community-based waiver.

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

12 **Income.** Amends § 256B.056, subd. 4. Increases the MA income limit for persons who are aged, blind, or disabled to 100 percent of the federal poverty guidelines over a three-year period and provides that increases in Social Security benefits are not counted as income until the first day of the second full month following publication of the poverty guidelines. Also increases the MA income limit for families and children to 100 percent of the federal poverty guidelines effective July 1, 2002.

13 **Excess income.** Amends § 256B.056, subd. 5. States that the MA medically needy standard remains at 133 and 1/3 percent of the AFDC standard, plus three percent, if federal authorization to use a higher standard is not obtained.

14 **Employed persons with disabilities.** Amends § 256B.057, subd. 9. Modifies premium calculation under MA-EPD. Requires persons to pay a premium using a sliding fee scale, ranging from 1 percent of gross earned and unearned income at 100 percent of poverty to 7.5 percent for persons with incomes at or above 300 percent of poverty. Under current law, the premium is 10 percent of the person's earned and unearned income that exceeds 200 percent of poverty, up to the actual cost of coverage.

15 **Certain persons needing treatment for breast or cervical cancer.** Adds subd. 10 to § 256B.057. Allows medical assistance to be paid for a person who has been screened for breast or cervical cancer by the Minnesota breast and cervical cancer control program using program funds; needs treatment for breast or cervical cancer; meets the income eligibility guidelines for the Minnesota breast and cervical cancer control program; is under age 65; is not otherwise eligible for MA; and is not otherwise covered by health insurance. Specifies that MA covers only services provided during the time the person is being treated for cancer. Specifies that a person is eligible even if the person does

not meet specified MA income and asset eligibility criteria.

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

17 **Intensive early intervention behavior therapy services for children with autism spectrum disorders.** Amends § 256B.0625, by adding subd. 5a. Effective January 1, 2002, provides MA coverage for home-based intensive early intervention behavior therapy for children with autistic spectrum disorders. Specifies eligibility requirements, covered services, supervision and other requirements, and payment rates.

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

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

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

Allows MA to reimburse drugs that have had their wholesale prices reduced due to actions of the National Association of Medicaid Fraud Control Units at the average wholesale price (AWP), rather than AWP minus 9 percent.

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

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

20 **Transportation costs.** Amends § 256B.0625, subd. 17. Increases mileage reimbursement for special transportation services from $1.20 to $1.50 per mile. Also makes changes in terminology.

21 **Payment for ambulance services.** Amends § 256B.0625, subd. 17a. Requires the medical assistance program to pay for ambulance services provided on or after July 1, 2001, at the greater of: (1) the medical assistance rate in effect on June 30, 2000; or (2) the current Medicare reimbursement rate.

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

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

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

25 **Increased employment.** Amends § 256B.0635, subd. 1. Effective July 1, 2002, modifies provisions related to extended MA following an increase in earned income, to reflect the severing of the automatic link between MA and MFIP-S.

26 **Increased child or spousal support.** Amends § 256B.0635, subd. 2. Effective July 1, 2002, modifies provisions related to extended MA due to an increase in child support, to reflect the severing of the automatic link between MA and MFIP-S.

27 **Presumptive eligibility for certain persons needing treatment for breast or cervical cancer.** Adds § 256B.0637. Makes MA available during a presumptive eligibility period for persons needing

treatment for breast or cervical cancer eligible for MA under section 256B.057, subdivision 10. Specifies that presumptive eligibility begins on the date the local agency determines that the person meets the eligibility criteria based on preliminary information, and ends on the date a determination is made as to eligibility. If an application for MA is not submitted by the last day of the month following the month during which the determination is made, makes presumptive eligibility end on the last day of the month.

28 **Health care safety net preservation.** Adds § 256B.195. Requires Hennepin county, Ramsey county, and the University of Minnesota to pay an intergovernmental transfer that totals $2.833 million per month, effective July 1, 2001. Requires the proceeds to be used to increase payment rates for nonstate, government hospitals, and to fund hospital charity care aid under section 144.585.

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

30 **Prospective per capita payment.** Amends § 256B.69, subd. 5. Requires PMAP capitation rates established by the commissioner to be within the limits of available appropriations.

31 **Prospective reimbursement rates.** Amends § 256B.69, subd. 5b. Effective January 1, 2002, increases prepaid medical assistance program capitation rates for nonmetropolitan counties to 95 percent of the rate for metropolitan counties, excluding Hennepin county. (For CY 2001, the nonmetropolitan county rate for prepaid MA and prepaid GAMC combined is about 91 percent of the metropolitan rate; this percentage will decrease in CY 2002 when medical education payments are taken out of the nonmetropolitan rate one year after this was done for other county groups.) Requires the commissioner to adjust capitation rates paid to Hennepin county to make this increase budget neutral, and to require prepaid health plans to use all revenue received to increase reimbursement rates for providers.

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

33 **Hospital outpatient reimbursement.** Amends § 256B.75. Effective for services provided on or after July 1, 2002, requires rates based on the Medicare outpatient prospective payment system to be replaced by a budget neutral prospective payment system based on MA data. Requires DHS to present a proposal to the 2001 legislature to define and implement this provision.

34 **Physician and dental reimbursement.** Amends § 256B.76. Effective October 1, 2001, sets payment rates for diagnostic examinations and dental x-rays for children at the lower of the submitted charge or 85 percent of the median of 1999 charges. Allows the commissioner to designate dentists and dental clinics as critical access providers, and to increase reimbursement to these providers by 50 percent above what they would otherwise receive. Provide criteria for review and requires the commissioner to adjust prepaid health plan rates to reflect increased reimbursement to critical access providers. Also makes a technical change.

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

36 **General assistance medical care; eligibility.** Amends § 256D.03, subd. 3. Establishes the current GAMC income standard in statute, rather than through a cross-reference.

37 **General assistance medical care; services.** Amends § 256D.03, subd. 4. Requires GAMC capitation

rates established by the commissioner to be within the limits of available appropriations.

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

39 **Notification of program.** Amends § 256K.03, subd. 1. Effective July 1, 2002, eliminates the requirement that work first participants be notified of automatic MA eligibility.

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

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

42 **Rate setting.** Amends § 256L.12, subd. 9. Requires MinnesotaCare capitation rates established by the commissioner to be within the limits of available appropriations.

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

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

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

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

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

48 **Medication therapy management pilot program.** Requires the commissioner to establish a medication therapy management pilot program, in consultation with an advisory committee. Also requires the commissioner to evaluate the program and report to the legislature.

Subd. 1. Establishment. Requires the commissioner of human services, in consultation with an advisory committee, to implement a two-year medication therapy management pilot program for MA enrollees, beginning July 1, 2001. Requires medication management to be provided by teams of physicians and pharmacists working in collaborative practice. Allows the commissioner to enroll individual pharmacists as MA providers and requires the commissioner to seek to ensure geographic balance.

Subd. 2. Advisory committee. Requires the commissioner to establish a 10-member advisory committee. Specifies duties and membership.

Subd. 3. Evaluation. Requires the commissioner to evaluate the program, and report to the legislature by December 15, 2003.

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

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

50 **Repealer.** Effective January 1, 2002, repeals section 256B.037, subdivision 5 (relates to contracting on a prepaid basis with an organization for comprehensive health services, including dental services). Effective July 1, 2002, repeals section 256B.0635, subdivision 3 (extended MA for MFIP participants who discontinue cash assistance).

Article 3: Continuing Care and Home Care

Overview

This article contains provisions related to health care services for persons with developmental and other disabilities. Provisions in the article:

- Modify requirements for the provision of private duty nursing, personal care assistant, and other home care services (sections 15 to 17, 29 to 35, and 37 to 40).
- Provide MA coverage for relocation targeted case management and home care targeted case management (sections 19 to 27).
- Require the commissioner to implement a consumer-directed home care demonstration project for MA recipients receiving certain home care services (section 36).
- Clarify use of resources for the MR/RC waiver (section 42).
- Consolidate the authority for the commissioner to operate home and community-based waivers for persons under age 65 who need nursing home or hospital care, and require the commissioner to develop a common service menu for these waivers (sections 59 to 68).
- Establish a day training and habilitation payment structure pilot project (sections 73 to 77).

1	**Rate recommendation.** Amends § 245A.13, subd. 7. Upgrades a reference to the ICF/MR payment system, in a section dealing with review of rates for residential programs that are in receivership.
2	**Adjustment to the rate.** Amends § 245A.13, subd. 8. Clarifies and revises language related to rate adjustments for residential programs in receivership, and provides procedures for recovering amounts paid as rate adjustments, upon the sale, closure, or transfer of the residential program.
3	**Guaranteed floor.** Amends § 252.275, subd. 4b. Modifies the method of calculating county semi-independent living services grants, by eliminating the concept of the guaranteed floor minimum index and establishing a guaranteed floor of $1,000.
4	**Reserve account.** Amends § 254B.02, subd. 3. Provides that funds in the chemical dependency reserve account in excess of those needed to meet obligations for services cancel to the general fund, effective July 1, 2001.
5	**Local agency duties.** Amends § 254B.03, subd. 1. For calendar years 2002 and 2003, limits increases to chemical dependency vendors to two percent above the previous year's rate. For calendar years 2004 and 2005, prohibits rates from exceeding the rate in effect on January 1, 2003.
6	**Eligibility.** Amends § 254B.04, subd. 1. Specifies the income standards for persons eligible for, but not entitled to, chemical dependency fund services in terms of the 1997 federal poverty guidelines. Also provides that these groups of individuals shall be served within the limits of funds appropriated for each groups.
7	**Payments to improve services to American Indians.** Amends § 254B.09, by adding subd. 8. Allows the commissioner to set rates for tribal facilities providing chemical dependency services at

	the higher federally approved encounter rate, instead of the county-negotiated rate.
8	**Grants for case management services to persons with HIV or AIDS.** Amends § 256.01, by adding subd. 19. Allows the commissioner of human services to award grants for the development, implementation, and evaluation of case management services for persons with HIV. This provision is related to the transfer of funding for this activity from the department of health to DHS.
9	**Purpose and goals.** Amends § 256.476, subd. 1. Revises the statement of goals for the consumer support grant program. Eliminates a reference to the alternative care program, to conform to a change made elsewhere.
10	**Definitions.** Amends § 256.476, subd. 2. Clarifies terminology.
11	**Eligibility to apply for grants.** Amends § 256.476, subd. 3. Strikes language that allows persons eligible for alternative care services to apply for grants. (This reflects the availability of cash options under the alternative care program.) Strikes language limiting participation of nursing facility and ICF/MR residents.
12	**Support grants; criteria and limitations.** Amends § 256.476, subd. 4. Eliminates a reference to the alternative care program, to conform to a change made elsewhere.
13	**Reimbursement, allocations, and reporting.** Amends § 256.476, subd. 5. Clarifies language and makes conforming changes.
14	**Commissioner responsibilities.** Amends § 256.476, subd. 8. Strikes obsolete language.
15	**Private duty nursing.** Amends § 256B.0625, subd. 7. Expands the circumstances under which private duty nursing can be provided outside the home, and allows private duty nursing services to be reimbursed when provided by the spouse, parent, or legal guardian.
16	**Personal care assistant services.** Amends § 256B.0625, subd. 19a. Expands the circumstances under which personal care services can be provided outside the home and eliminates the July 1, 2001 sunset on language that allows noncorporate legal guardians or conservators to be reimbursed for personal care services.
17	**Personal care.** Amends § 256B.0625, subd. 19c. Makes conforming changes related to supervision of personal care assistants.
18	**Mental health case management.** Amends § 256B.0625, subd. 20. Allows mental health case management to be provided up to 180 days before discharge from a facility, and for up to six months in a calendar year. (Current limits are 30 days and two months.)
19	**Targeted case management.** Amends § 256B.0625, by adding subd. 43. Defines terms related to targeted case management under MA.
20	**Eligibility.** Amends § 256B.0625, by adding subd. 43a. Provides that MA eligible persons residing in institutions who chose to move to the community are eligible for relocation targeted case management services, and that MA eligible persons receiving home care services, who are not eligible for other MA reimbursable case management services, are eligible for home care targeted case management services beginning January 1, 2003.
21	**Relocation targeted case management provider qualifications.** Amends § 256B.0625, by adding subd. 43b. Specifies qualifications and certification standards for providers of relocation targeted case management.
22	**Home care targeted case management provider qualifications.** Amends § 256B.0625, by adding subd. 43c. Specifies qualifications and certification standards for providers of home care targeted case management.
23	**Eligible services.** Amends § 256B.0625, by adding subd. 43d. Lists the services eligible for MA

	reimbursement as targeted case management.
24	**Time lines.** Amends § 256B.0625, by adding subd. 43e. Requires case managers to visit a recipient eligible for relocation targeted case management within 20 working days of the request for a case manager. Allows recipients to obtain targeted relocation case management services from a home care targeted case management provider, if a county agency does not provide case management services as required. Requires recipients eligible for home care targeted case management to be assigned a case manager within 20 working days of requesting one.
25	**Evaluation.** Amends § 256B.0625, by adding subd. 43f. Requires the commissioner to evaluate the delivery of targeted case management.
26	**Contact documentation.** Amends § 256B.0625, by adding subd. 43g. Requires case managers to document each face-to-face and telephone contact with recipients and others involved in the individual service plan.
27	**Payment rates.** Amends § 256B.0625, by adding subd. 43h. Requires the commissioner to set payment rates for targeted case management, and specifies criteria for billing.
28	**Definition.** Amends § 256B.0627, subd. 1. Defines "activities of daily living", "complex and regular private duty nursing care", "instrumental activities of daily living", and "telehome care."
29	**Services covered.** Amends § 256B.0627, subd. 2. Makes conforming changes.
30	**Personal care assistant services.** Amends § 256B.0627, subd. 4. Clarifies and broadens the scope of personal care assistant services that are eligible for reimbursement. Allows the recipient or responsible party to supervise the personal care assistant, or have a qualified professional provide this supervision.
31	**Limitation on payments.** Amends § 256B.0627, subd. 5. Increases the number of skilled nurse visits allowed without prior authorization from five to nine, and increases from one to two the number of skilled nurse visits per day that can be authorized. Allows private duty nursing to be authorized for complex and regular care, beginning July 1, 2001. Makes conforming changes related to supervision. Corrects a cross-reference.
32	**Noncovered home care services.** Amends § 256B.0627, subd. 7. Allows home care services provided to persons receiving Medicare hospice benefits to be reimbursed. Makes a technical change.
33	**Shared personal care assistant services.** Amends § 256B.0627, subd. 8. Modifies the language governing provision of shared personal care assistant services, to conform to changes made earlier that allow recipients or responsible parties to supervise the care provided.
34	**Fiscal intermediary option available for personal care assistant services.** Amends § 256B.0627, subd. 10. Renames the fiscal agent option the fiscal intermediary option and revises language governing this option. Clarifies that the recipient or responsible party supervises and evaluates the personal care assistant, with assistance as needed from a physician or qualified professional.
35	**Shared private duty nursing option.** Amends § 256B.0627, subd. 11. Clarifies that the payment rate for shared private duty nursing care is based on the regular private duty nursing rate.
36	**Consumer-directed home care demonstration project.** Amends § 256B.0627, subd. 13.
	(a) Requires the commissioner, after receiving federal authority, to implement a consumer-directed home care demonstration project for MA recipients receiving certain home care services. Provides that the project will be administered locally.
	(b) Requires grants to persons receiving personal care, home health aide, or private duty nursing services for 12 consecutive months or more prior to enrollment to be determined on a case-by-case basis using historical expenditure data. Sets grant awards at 90 percent of the average monthly

	expenditure.
	(c) Requires grants to persons receiving the specified services for less than 12 consecutive months to be calculated on a case-by-case basis using the service authorization in place, adjusted by the average difference statewide between authorization and utilization. Sets grant awards at 90 percent of the estimated monthly expenditure.
	(d) Exempts the state, counties, and other entities from liability for damages, injuries, or liabilities sustained by participants in the consumer directed home care demonstration project.
37	**Telehomecare; skilled nurse visits.** Amends § 256B.0627, by adding subd. 14. Allows MA coverage for skilled nurse visits provided via telehomecare. Specifies requirements for coverage.
38	**Therapies through home health agencies.** Amends § 256B.0627, by adding subd. 15. Allows provision of physical therapy and occupational therapy services to individuals receiving home care services. Allows services provided by physical therapy assistants and occupational therapy assistants to be reimbursed when services are provided under the direction of a therapist who is not on premise.
39	**Hardship criteria; private duty nursing.** Amends § 256B.0627, by adding subd. 16. Allows payment for extraordinary services that require specialized nursing skills provided by parents of minor children, spouses, and legal guardians providing private duty nursing care, if specified hardship criteria are met.
40	**Quality assurance plan for personal care assistant services.** Amends § 256B.0627, by adding subd. 17. Requires the commissioner to establish a quality assurance plan for personal care services that includes performance-based provider agreements, consumer input, ongoing monitoring, and an ongoing public process for development, implementation, and review of the plan.
41	**Preadmission screening of individuals under 65 years of age.** Amends § 256B.0911, by adding subd. 4a. Sets requirements for preadmission screening of individuals under age 65, and individuals under age 21, in order to ensure that individuals with disabilities or chronic illness are served in the most appropriate setting and have information necessary to make choices about home and community-based service options. Allows the commissioner to pay counties directly for face-to-face assessments of certain individuals under age 65.
42	**Reduction of waiting list.** Amends § 256B.0916, subd. 1. Requires the commissioner of human services to use all resources budgeted during a biennium for the home and community-based waiver for persons with mental retardation and related conditions. Prohibits the commissioner of finance from reducing the spending forecast for a biennium for which appropriations have been made, when there is a waiting list for the waiver for persons who need services within the next 30 months. Requires the resulting funds to be used to serve persons through the waiver.
43	**Statewide availability of consumer-directed community support services.** Amends § 256B.0916, by adding subd. 6a. Requires the commissioner to submit a federal waiver amendment to the home and community-based waiver for persons with developmental disabilities, to make consumer directed support services available in every county by January 1, 2002. Requires the commissioner to contract for the provision of these services in counties that decline to meet program requirements. Exempts the state, counties, and other entities from liability for damages, injuries, or liabilities sustained by persons receiving consumer-directed community support services.
44	**Annual report by commissioner.** Amends § 256B.0916, subd. 7. Changes the reporting date from October 1 to November 1 of each year, for the commissioner's report on county and state use of resources for the home and community-based waiver for persons with mental retardation and related conditions.
45	**Legal representative participation exception.** Amends § 256B.0916, subd. 9. Provides that legal representatives providing support under the home and community-based waiver for persons with

	mental retardation shall not be considered to have a service provider interest (this has the effect of allowing a broader group of individuals beyond those providing services under consumer directed community support services to be reimbursed).
46	**Medical assistance for case management activities under the state plan medicaid option.** Amends § 256B.092, subd. 2a. Requires the commissioner to ensure that eligible persons are given a choice between county and private agency case management service providers. Prohibits case management providers from providing any other service to persons they serve.
47	**Federal waivers.** Amends § 256B.092, subd. 5. Requires the commissioner, in administering home and community-based waivers for persons with mental retardation and related conditions, to ensure that day services are not provided by a person's residential service provider, unless the person is offered a choice of providers and agrees to this in writing. In this situation, requires individual service plans to provide for contact with persons other than the residential service provider.
48	**Traumatic brain injury program duties.** Amends § 256B.093, subd. 3. Eliminates the requirement that the commissioner approve traumatic brain injury waiver eligibility and care plans.
49	**Quality assurance project established.** Amends § 256B.095. Extends the expiration date for the region 10 quality assurance project from June 30, 2001 to June 30, 2005 and removes references to a "pilot" project.
50	**Membership.** Amends § 256B.0951, subd. 1. Extends the expiration date for the region 10 quality assurance commission from June 30, 2001 to June 30, 2005.
51	**Commission duties.** Amends § 256B.0951, subd. 3. Requires the commissioner of human services, in consultation with the commission, to examine the feasibility of expanding the project and identify barriers to expansion. Requires a report to the legislature by December 15, 2004. Removes references to a pilot project.
52	**Commission's authority to recommend variances of licensing standards.** Amends § 256B.0951, subd. 4. Clarifies that the commission can recommend variances if the alternative licensing system does not "adversely" affect the health or safety of persons being served.
53	**Variance of certain standards prohibited.** Amends § 256B.0951, subd. 5. Clarifies that the commission can make recommendations related to alternatives or modifications of procedures, as well as rules. Removes a reference to a pilot project.
54	**Waiver of rules.** Amends § 256B.0951, subd. 7. Strikes an outdated reference to a waiver application.
55	**Federal waiver.** Amends § 256B.0951, by adding subd. 8. Requires the commissioner to seek federal authority to waive provisions of ICF/MR regulations to enable the demonstration and evaluation of the alternative quality assurance system for ICFs/MR under the project.
56	**Evaluation.** Amends § 256B.0951, by adding subd. 9. Requires the commission, in consultation with the commissioner, to conduct an evaluation of the alternative quality assurance system, and report to the commissioner by June 30, 2004.
57	**Notification.** Amends § 256B.0952, subd. 1. For each year of the project, requires region 10 counties that intend to join the project to give notice to the commissioners of human services and health by March 15, and to commit to participate until June 30, 2005. Requires counties already participating in the project to give notice of intent to continue by March 15, 2001, and to participate until June 30, 2005. Eliminates outdated language related to county participation.
58	**Appointment of quality assurance manager.** Amends § 256B.0952, subd. 4. Requires the quality assurance manager to provide reports from quality assurance teams to the commissioners of health and human services upon request. (Under current law, these reports are required to be provided to the

	commissioners.)
59	**Authority.** Amends § 256B.49, by adding subd. 11. Consolidates the authority for the commissioner to apply for home and community-based waivers to serve persons under the age of 65 who require nursing home or hospital care (the CADI, TBI, and CAC waivers).
60	**Informed choice.** Amends § 256B.49, by adding subd. 12. Requires the commissioner to provide persons requiring nursing facility or hospital care with information on home and community-based alternatives, and to be given a choice between institutional and community care.
61	**Case management.** Amends § 256B.49, by adding subd. 13. Requires recipients of home and community-based waivers to be provide case management services, and specifies requirements for these services.
62	**Assessment and reassessment.** Amends § 256B.49, by adding subd. 14. Sets requirements for assessment, reassessment, and screening of waiver clients, and allows waiver clients who become eligible before age 65 to remain eligible after age 65.
63	**Individualized service plan.** Amends § 256B.49, by adding subd. 15. Requires recipients of home and community-based waivered services to have a written plan of care and specifies requirements for this plan.
64	**Services and supports.** Amends § 256B.49, by adding subd. 16. Requires services and supports included in home and community-based waivers for persons with disabilities to meet federal requirements. Beginning January 1, 2003, requires the commissioner to establish a common service menu available to recipients regardless of age, disability type, or waiver program. Requires consumer directed community support services to be offered as an option to all persons eligible for the CADI, CAC, and TBI waivers, by January 1, 2002. Exempts the state, counties, and other entities from liability for damages, injuries, or liabilities sustained by persons receiving consumer directed community support services.
65	**Cost of services and supports.** Amends § 256B.49, by adding subd. 17.
	(a) Requires the commissioner to ensure that average waiver expenditures do not exceed institutional costs.
	(b) Requires the commissioner to implement on January 1, 2002, methods of allocating to local agencies the waiver resources available for recipients with disabilities needing nursing home or hospital care.
	(c) Until the allocation methods are implemented, sets the annual allowable waiver reimbursement at the greater of: (1) the statewide average payment amount assigned to the recipient under the current waiver system, modified by any provider rate increases; or (2) an amount approved by the commissioner based on the recipient's extraordinary needs that cannot be met under the current reimbursement level. Allows the additional reimbursement to be used for environmental modifications; assistive technology and equipment; and increased costs for supervision, training, and support services.
	(d) Beginning July 1, 2001, requires medically necessary private duty nursing to be authorized as complex and regular care.
66	**Payments.** Amends § 256B.49, by adding subd. 18. Requires the commissioner to reimburse vendors for waivered services using the invoice processing procedures of the Medicaid management information system.
67	**Health and welfare.** Amends § 256B.49, by adding subd. 19. Requires the commissioner to take necessary safeguards to protect the health and welfare of persons receiving waivered services.
68	**Traumatic brain injury and related conditions.** Amends § 256B.49, by adding subd. 20. Requires

	the commissioner to seek to amend the traumatic brain injury waiver to include, as eligible persons, individuals with an acquired or degenerative disease diagnosis where cognitive impairment is present, such as multiple sclerosis.
69	**Alternative integrated long-term care services; elderly and disabled persons.** Amends § 256B.69, subd.23. Allows enrollment in the integrated long-term care services demonstration projects for persons with disabilities to remain voluntary.
70	**Institution.** Amends § 256D.35, by adding subd. 11a. Defines institution for purposes of the MSA shelter needy payment.
71	**Shelter costs.** Amends § 256D.35, by adding subd. 18a. Defines shelter costs for purposes of the MSA shelter needy payment.
72	**Special needs.** Amends § 256D.44, subd. 5. Provides MSA recipients who are under the age of 65, relocating from an institution, and shelter needy (spend 40 percent or more of gross income on housing) with an additional payment equal to the maximum food stamp allotment for a single individual.
73	**Supplementary rate for certain facilities.** Amends § 256I.05, subd. 1e. Beginning July 1, 2001, increases the supplementary rate that a county agency must negotiate with a group residential housing provider that meets specific requirements from 25 to 125 percent of the supplementary service rate in subd. 1a. Also requires the rate increase to include any legislatively authorized inflationary adjustments and modifies the description of a group residential housing provider under this subdivision.
74	**Respite care pilot project for family adult foster care providers.** Adds section 256I.07. Requires the commissioner of human services to establish a pilot project to provide respite care payments to family adult foster care providers.
	Subd. 1. Program established. Requires the commissioner to establish a two-year respite care pilot project for family adult foster care providers in three counties.
	Subd. 2. Eligibility. States that a family adult foster care home provider who has been licensed for six months is eligible for 30 days of respite care per calendar year. Allows county social services agencies to waiver the six-month licensing requirement in cases of emergency. Requires providers to take time away from their residents in order to receive respite payment from group residential housing and alternative care.
	Subd. 3. Payment structure. (a) Requires the respite care payment rate for a resident eligible only for group residential housing to be based on the group residential housing base rate and the maximum difficulty of care rate.
	(b) Requires the respite care payment rate for a resident eligible for alternative care funds to be based on the alternative care foster care rate.
	(c) Requires the respite care payment rate for a resident eligible for MA home and community-based waiver funds to be based on the group residential housing base rate.
	(d) Provides that the total amount available to pay for respite care shall the based on the number of residents currently served and the source of funding for each resident. Requires respite care to be paid on a per diem basis and for a full day.
	Subd. 4. Private pay residents. Requires payment for respite care for private pay residents to be arranged between the provider and the resident or resident's family.
75	**Task force.** Amends Laws 1999, chapter 152, section 1. Adds a representative of the commissioner of human services to the day training and habilitation task force.

76	**Report.** Amends Laws 1999, chapter 152, section 4. Requires the day training and habilitation task force to make recommendations to the commissioner of human services on implementation of the pilot project for the individualized payment rate structure. Provides a December 30, 2003 expiration date for the task force.
77	**Day training and habilitation payment structure pilot project.** Requires the commissioner of human services to implement a pilot project and phase-in for an individualized day training and habilitation service payment structure.
	Subd. 1. Individualized payment rate structure. Requires the commissioner of human services to initiative a pilot project and phase-in for the individualized payment structure, to be completed by December 31, 2003. Allows the project to include all or some vendors in up to eight counties, with no more than two counties from the seven-county metro area.
	Subd. 2. Sunset. (a) States that the pilot project sunsets upon implementation of a new statewide rate structure to be recommended in accordance with the implementation plan developed by the day training and habilitation task force in its December 1, 2001, report to the legislature. Requires rates of pilot project vendors to be modified to be consistent with this rate structure.
	Subd. 3. Task force responsibilities. Requires the task force to evaluate the pilot project and by December 1, 2001, report to the relevant committee chairs on how and when the individualized payment rate structure will be implemented statewide. Specifies other requirements for the implementation plan.
	Subd. 4. Rate setting. (a) States that the rate structure is intended to allow a county to authorize an individual rate for each client in a vendor's program, based on the needs and expected outcomes of the individual client. Specifies other rate requirements.
	(b) Allows vendors, with county concurrence, to establish up to four levels of service, A through D, based on the intensity of services provided.
	(c) Requires county boards to establish for each vendor a dollar value for one hour of service at each of the service levels, based on the formula and guidelines developed by the day training and habilitation task force.
	(d) Allows vendors to maintain a single transportation rate or establish up to five specified types of transportation services. Sets rate requirements.
	(e) Requires county boards to translate a vendor's existing program and transportation rates to the rates and values in the pilot project using the conversion calculations contained in the day training and habilitation task force's recommendations to the legislature. Provides the methodology for conversion.
	Subd. 5. Individual rate authorization. Requires counties to authorize and document service and transportation packages, according to specified criteria.
	Subd. 6. Billing for services. Requires vendors to bill and be reimbursed for the service package rate and transportation package rate as authorized by the county.
	Subd. 7. Notification of change in client needs. Requires vendors to notify case managers within 30 days of changes in client need.
78	**County board responsibilities.** Requires county boards to document information submitted by day training vendors participating in the pilot project, and to establish a package period of one week, two weeks, or one month.
79	**Study of day training and habilitation vendor rates.** Requires the commissioner to identify vendors with the lowest rates or underfunded programs, and make recommendations to reconcile the discrepancies prior to implementation of the individualized payment rate structure.

80	**Federal approval.** Requires the commissioner of human services to seek any Medicaid plan amendments or federal waivers necessary to implement the day training pilot project.
81	**Semi-independent living services (SILS) study.** Requires the commissioner of human services to develop recommendations to revise the funding methodology for SILS, and report by January 15, 2002 to relevant committee chairs.
82	**Waiver request regarding spousal income.** Requires the commissioner of human services, by September 1, 2001, to seek federal approval to allow persons served under the CADI, CAC, and TBI waivers to choose either a waiver of deeming spousal income or the spousal impoverishment provisions, with the addition of the GRH rate to the personal needs allowance.
83	**Program options for certain persons with developmental disabilities.** Requires the commissioner of human services to ensure that services continue to be available to persons with developmental disabilities who were covered by social services supplemental grants prior to July 1, 2001. Requires services to be provided in the following priority order:
	(1) provision of targeted slots under the home and community-based waiver for persons with mental retardation and related conditions;
	(2) provision of group residential housing (GRH) funding; and
	(3) any remaining persons shall continue to receive services through community social services supplemental grants to affected counties.
84	**Federal approval.** Requires the commissioner of human services, by September 1, 2001, to request any federal approval and plan amendments needed to implement the choice of case manager provision.
85	**Federal waiver requests.** Requires the commissioner of human services to submit to the federal Health Care Financing Administration, by September 1, 2001, a request for a home and community-based services waiver for day services, including community inclusion, supported employment, and day training and habilitation services, for persons eligible for the home and community-based waiver for persons with mental retardation and related conditions.
86	**Repealer.** (a) Repeals sections 256B.0951, subd. 6 (waiver of rules for region 10 commission) and 256E.06, subd. 26.
	(b) Repeals sections 145.9245 (AIDS case management grants), 256.476, subd. 7 (consumer support grant program federal funding maximization), 256B.0912 (AC and waiver restructuring), 256B.0915, subds. 3a, 3b, and 3c (county-specific EW rates), and 256B.49, subd. 1-10 (home and community-based waiver for chronically ill children and disabled persons).
	(c) Repeals Laws 1995, chapter 178, article 2, section 48, subd. 6 (funding for county costs associated with minor caretaker evaluations).
	(d) Repeals specified rules related to the alternative care program and the CADI and CAC waivers.

Article 4: Consumer Information and Assistance and Community-Based Care

Overview

This article contains provisions related to services to the elderly. Provisions in the article:

Expand the scope of consumer information and assistance services provided to seniors through the board on aging's senior linkage line (section 3).
Establish a grant program for providers of older adult services (section 4).
Reorganize and revise law governing the preadmission screening program, and rename the

	program long-term care consultation services (sections 5 to 15). Equalize rates between the alternative care and elderly waiver programs (sections 28 and 30), and modify requirements for these programs, in part to reflect the shift to a new resident assessment system (sections throughout).
1	**Expansion of bed distribution study and creation of critical access sites.** Adds § 144A.35. Requires the commissioner of health to report on the distribution of older adult services, and with the commissioner of human services, to identify and designate critical access service sites.
	Subd. 1. Older adult services distribution study. Requires the commissioner of health to monitor and analyze the distribution of older adult services, and report annually to the legislature on the geographic distribution of services.
	Subd. 2. Critical access service site. Defines critical access service site as a nursing home, senior housing, housing with services, or a community-based service that is certified by the state as a necessary health care service to a geographic area. A necessary provider is one that is at least 20 miles from the next nearest long-term health care provider, the sole long-term health care provider in a county, or located in a medically under served area or health professional shortage area.
	Subd. 3. Identification of critical access service sites. Requires the commissioners of health and human services to identify and designate critical access service sites.
	Subd. 4. Critical access service sites. Requires the commissioner of health to implement waivers for sites and identify and make recommendations related to payment barriers for these sites.
2	**Grants for home-sharing programs.** Amends § 256.973, by adding subd. 6. Requires grants for home-sharing programs to be awarded through an RFP every two years, and prohibits the commissioner from giving priority to previous grantees. Allows the commissioner to evaluate programs and allocate funds based on the evaluation.
3	**Consumer information and assistance; senior linkage.** Amends § 256.975, by adding subd. 7. Requires the board on aging to operate a statewide information and assistance service (the senior linkage line) to help elder Minnesotans and their families make informed choices about long-term care options and health care benefits. Specifies requirements for the service.
4	**Community services development grants program.** Adds § 256.9754. Requires the commissioner of human services to establish and administer a grant program for providers of older adult services.
	Subd. 1. Definitions. Defines community, older adult services, and older adult.
	Subd. 2. Creation. Establishes the community services development grants program within DHS.
	Subd. 3. Purpose. Makes grants for capital costs, establishment of older adult services, training, renovation, transportation, home-sharing, and other specified purposes available to communities, providers of older adult services, and consortiums of providers.
	Subd. 4. Eligibility. Requires a local match of 50 percent of project costs.
	Subd. 5. Grant preference. Allows the commissioner to award grants of up to $750,000 to the extent grants funds are available and applications approved. States that denial in one year does not preclude application in a subsequent year.
5	**Purpose and goal.** Amends § 256B.0911, subd. 1. Renames the preadmission screening program "long-term care consultation services" and states the goal of the services as assisting persons with long-term or chronic care needs in making decisions and selecting options to meet their needs and reflect their preferences. Requires these services to be coordinated with the senior linkage services of the board on aging, the health care consumer assistance grant program, and services provided by other public and private agencies. Sections that follow make technical changes related to this name

	change and reorganize and revise the former preadmission screening statutes to reflect this broader emphasis.
6	**Definitions.** Amends § 256B.0911, by adding subd. 1a. (a) Defines "long-term care consultation services" as including: (1) the provision of information on the availability of services; (2) an intake process; (3) assessment of individual needs; (4) assistance in identifying services to maintain an individual in the least restrictive environment; (5) providing recommendations on cost-effective community services; (6) developing an individual's community support plan; (7) providing information on eligibility for Minnesota health care programs; (8) preadmission screening; (9) preliminary determination of Minnesota health care program eligibility for individuals who need nursing facility level care; (10) providing recommendations for nursing facility placement when no cost-effective community services are available; and (11) assistance to transition people back to the community after facility admission.
	(b) Defines "Minnesota health care programs" as MA, the alternative care program, and the prescription drug program.
7	**Long-term care consultation team.** Amends § 256B.0911, subd. 3. Allows county boards to designate public health or social services as the lead agency for long-term care consultation services. Requires long-term care consultation teams to provide long-term care consultation services to all persons in their county who request the services, regardless of eligibility for Minnesota health care programs. Strikes language that is reinstated elsewhere and makes technical changes.
8	**Assessment and support planning.** Amends § 256B.0911, by adding subd. 3a. Requires persons requesting assessment, services planning, or other assistance to be visited by a long-term care consultation team within ten working days after the date on which an assessment was requested or recommended. Requires the team to conduct the assessment in a face-to-face interview, and specifies other requirements. Requires the team to provide the person, or the person's legal representative, with written recommendations for facility or community-based services, a written community support plan if the person chooses community-based services, and other specified information.
9	**Transition assistance.** Amends § 256B.0911, by adding subd. 3b. Requires long-term care consultation teams to provide transition assistance to persons residing in nursing facilities, hospitals, regional treatment centers, and ICFs/MR, including assessment, community support plan development, referrals to Minnesota health care programs, and referrals to housing assistance. Requires the county to develop transition processes with institutional social workers and discharge planners.
10	**Preadmission screening activities related to nursing facility admissions.** Amends § 256B.0911, by adding subd. 4a. Reorganizes language governing preadmission screening for nursing facility admissions, and clarifies state and federal requirements.
	(a) Requires all applicants to MA certified nursing facilities to be screened, except as provided in subdivision 4b (exemptions and emergency admissions). States that the purpose of screening is to determine the need for nursing facility care under paragraph (d) and to complete activities required under federal law related to mental illness and mental retardation under paragraph (b).
	(b) Requires persons with mental illness or mental retardation to be screened before admission regardless of exemptions, unless admission prior to screening is authorized by the local mental health authority, local developmental disabilities case manager, or the county agency according to Public Law 100-508. Specifies criteria for preadmission screening.
	(c) Allows the local county mental health authority or the state mental retardation authority to prohibit admission if the individual does not need nursing facility level care or needs specialized services.

	(d) Requires the determination of need for nursing facility level care to be made according to criteria developed by the commissioner. Specifies requirements for inclusion or consultation with physicians or other personnel.
11	**Exemptions and emergency admissions.** Amends § 256B.0911, by adding subd. 4b. (a) Specifies persons who are exempt from federal screening requirements under subdivision 4a.
	(b) Specifies persons exempt from preadmission screening for purposes of determining the level of care.
	(c) Requires persons admitted to a nursing facility on an emergency basis, or from an acute care facility on a nonworking day, to be screened the first working day after admission.
	(d) Specifies when emergency admission to a nursing facility prior to screening is permitted.
12	**Screening requirements.** Amends § 256B.0911, by adding subd. 4c. (a) Allows persons to be screened for nursing facility admission by telephone or in a face-to-face consultation and lists categories of individual need.
	(b) Requires persons admitted on a nonemergency basis to a nursing facility to be screened prior to admission.
	(c) Requires the team to recommend case mix classifications when there is sufficient information. Authorizes the facility to conduct case mix assessments for persons for whom the county did not recommend a classification, or for persons admitted prior to a preadmission screening. States that the county retains responsibility for distributing case mix forms to the facility.
	(d) Requires county screening or intake activity to identify persons who may require transition assistance.
13	**Administrative activity.** Amends § 256B.0911, subd. 5. Makes conforming or technical changes.
14	**Payment for long-term care consultation services.** Amends § 256B.0911, subd. 6. Provides that payments for long-term care consultation services will be made to the two facilities nearest to the county seat, if a county has no nursing facility. Allows the county to bill specified activities as case management services. Prohibits an individual or family member from being charged for an initial assessment or initial support plan development. Makes conforming changes.
15	**Reimbursement for certified nursing facilities.** Amends § 256B.0911, subd. 7. Prohibits a facility from billing a private pay individual for resident days that preceded the date of completion of screening activities. Makes conforming changes.
16	**Purpose and goals.** Amends § 256B.0913, subd. 1. Removes references to "frail" elderly and makes other revisions in existing language.
17	**Eligibility for services.** Amends § 256B.0913, subd. 2. Strikes obsolete provisions and clarifies existing language.
18	**Eligibility for funding for services for nonmedical assistance recipients.** Amends § 256B.0913, subd. 4.
	Sets the payment limit for the alternative care program, until the first day of the state fiscal year in which the new resident assessment system is implemented, at 75 percent of the statewide weighted average monthly nursing facility rate for the case mix class to which the individual would be assigned under existing Minnesota rules, minus the individual's maintenance needs allowance.
	Once the new system is implemented, sets this limit at the alternative care monthly cap for the case mix class to which the client would be assigned under existing Minnesota rules, in effect on the last day of the previous fiscal year, and adjusted by any legislatively adopted

	increase in rates for home and community-based services or nursing facilities.
	Makes conforming changes related to long-term care consultation services.
	Clarifies and revises existing language, and strikes obsolete language.
19	**Services covered under alternative care.** Amends § 256B.0913, subd. 5.
	Allows alternative care funding to be used for environmental modifications, and includes provision of "discretionary funds" in the definition of other covered services.
	Modifies language setting maximum payment rates for foster care services, assisted living services, and residential care services to conform to the changes made in subdivision 4.
	Places in the subdivision language governing procedures for cash payments under the alternative care program that was incorporated by cross-reference to the consumer support grant program.
	Clarifies and revises existing language, and strikes obsolete language and language that is in the state's waiver plan.
20	**Alternative care program administration.** Amends § 256B.0913, subd. 6. Allows the commissioner to contract with federally recognized Indian tribes to serve as the lead agencies responsible for local administration of the alternative care program.
21	**Case management.** Amends § 256B.0913, subd. 7. Clarifies current law, by prohibiting case managers from approving alternative care funding for a client in a setting in which the case manager cannot reasonably ensure the client's health and safety, and from approving a care plan in which the cost of services exceeds the alternative care program payment limit.
22	**Requirements for individual care plan.** Amends § 256B.0913, subd. 8. Eliminates the requirement that the lead agency verify to the commissioner that an individual's alternative care is not available through any public assistance or service program. Makes a technical change.
23	**Contracting provisions for providers.** Amends § 256B.0913, subd. 9. Eliminates the requirement that the lead agency document to the commissioner certain information related to provider contracts.
24	**Allocation formula.** Amends § 256B.0913, subd. 10. Clarifies language governing alternative care program allocations to counties and strikes obsolete language.
25	**Targeted funding.** Amends § 256B.0913, subd. 11. Changes from June 1 to November 1 of each year the date by which counties need to submit applications for targeted alternative care funding. and strikes unnecessary language.
26	**Client premiums.** Amends § 256B.0913, subd. 12. Clarifies provisions related to payment of premiums by alternative care clients. Requires the commissioner of human services to bill and collect alternative care premiums from clients. (Under current law, this is a county responsibility.) Requires counties to record in the state's receivable system assessed premium amounts or the reason a premium has been waived.
27	**County biennial plan.** Amends § 256B.0913, subd. 13. Makes conforming changes related to long-term care consultation services and strikes certain county biennial plan requirements.
28	**Payment and rate adjustments.** Amends § 256B.0913, subd. 14. Equalizes rates between the alternative care program and elderly waiver, by setting the rate limit for each alternative care services at the greater of the alternative care statewide maximum rate or the elderly waiver statewide maximum rate. Allows counties to negotiate individual service rates with vendors up to the statewide maximum. Also clarifies and revises language related to payment rates. Strikes language assessing a financial penalty against counties for collecting less than 50 percent of client premiums due (a conforming change related to the amendment to subd. 12).

29	**Posteligibility treatment of income and resources for elderly waiver.** Amends § 256B.0915, subd. 1d. Strikes obsolete language.
30	**Limits of cases, rates, payments, and forecasting.** Amends § 256B.0915, subd. 3.
	Sets the monthly payment limit for the elderly waiver, until the first day of the state fiscal year in which the new resident assessment system is implemented, at the weighted average monthly nursing facility rate for the case mix class the individual would be assigned under existing Minnesota rules, minus the individual's maintenance needs allowance.
	Once the new system is implemented, sets this limit at the rate of the case mix class to which the client would be assigned under existing Minnesota rules, in effect on the last day of the previous fiscal year, and adjusted by any legislatively adopted increase in rates for home and community-based services or nursing facilities.
	Classifies environmental modifications as an allowable cost for elderly waiver clients.
	Modifies language setting maximum payment rates for assisted living and residential care services to conform to other changes made in this section.
	Equalizes rates between the elderly waiver and the alternative care program, by setting the rate limit for each elderly waiver service at the greater of the alternative care statewide maximum rate or the elderly waiver statewide maximum rate.
	Clarifies and revised existing language, and strikes obsolete language and language related to the waiver for persons with developmental disabilities.
31	**Reassessments for waiver clients.** Amends § 256B.0915, subd. 5. Strikes a reference to the waiver for persons with developmental disabilities.
32	**Contract.** Amends § 256B.0917, subd. 7. Provides that grants awarded under the living-at-home/block nurse program are to enable programs to continue or implement the living-at-home/block nurse program model. (Current law limits grants to programs currently operating.)
33	**Development and purpose of medical assistance pilot project on senior services.** Adds § 256B.0918. Requires the commissioner of human services to establish a voucher program for senior services.
	Subd. 1. Establishment and purpose. Requires the commissioner of human services to establish an MA pilot project on senior services to determine how converting the delivery of housing, supportive services, and health care into a voucher program will impact expenditures and provide consumer choice.
	Subd. 2. Federal waiver authority. Directs the commissioner to apply for any necessary federal waivers or approvals by April 15, 2002.
	Subd. 3. Report. Requires the commissioner to report to the legislature on waiver approval, and upon federal approval, seek legislative authorization to implement the pilot project. Once the project is implemented, requires the commissioner and participating communities to issue annual reports to appropriate legislative committee chairs.
	Subd. 4. Sunset. Provides a June 30, 2008 sunset.
34	**Service access study.** Requires the commissioner of human services to submit to the legislature, by February 15, 2002, recommendations for creating coordinated service access at the county agency level for long-term care services and housing options.
35	**Respite care.** Requires the Minnesota board on aging to report to the legislature by February 1, 2002, on the provision of respite care services on a sliding scale basis.
36	**Repealer.** Repeals provisions related to preadmission screening (§ 256B.0911, subd. 2, 2a, 4, 8, and

	9), the alternative care program (§ 256B.0913, subd. 3, 15a, 15b, 15c, and 16), and the elderly waiver (256B.0915, subd. 3a, 3b, and 3c). Also repeals rules for the preadmission screening and alternative care programs.

Article 5: Long-Term Care Reform and Reimbursement

Overview

This article contains provisions related to reimbursement and regulation of long-term care facilities. Provisions in the article:

Establish a new case mix assessment system for nursing facility residents, to be implemented between July 1, 2002 and January 1, 2003 (sections 1 and 32).
Increase the dollar threshold for moratorium exceptions, make other changes in moratorium exception process requirements, and provide statutory exceptions to the moratorium for certain facilities (sections 2 to 7).
Establish requirements to govern the relocation of nursing facility residents (section 8 to 16).
Require the commissioner of health to seek federal approval for an alternative nursing facility survey process (section 18).
Provide nursing facility rate increases, and additional rate adjustments for low rate facilities (sections 23 to 25).
Establish a process for the voluntary closure of nursing facilities (section 33).
Provide rate increases to ICFs/MR (section 34).
Require the commissioner to develop a new nursing facility reimbursement system and report to the legislature by January 15, 2003, and prohibit the commissioner from implementing a performance-based contracting system prior to July 1, 2003 (section 38).

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

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

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

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

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

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

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

assessments.

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

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

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

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

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

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

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

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

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

5 **Exceptions for replacement beds.** Amends § 144A.071, subd. 4a. Provides exceptions to the nursing home moratorium to allow:

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

licensure and certification of a total replacement project of up to 124 beds in Wilkin county that are in need of relocation from a nursing home substantially destroyed by flood;

licensure of 9 additional rule 80 beds in a 215-bed nursing home in Duluth;

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

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

Also makes a conforming change related to the increase in the dollar threshold for moratorium exceptions.

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

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

8 **Definitions.** Adds § 144A.185. Defines terms related to nursing facility closure and resident relocation.

9 **Initial notice.** Adds § 144A.1855. Requires the licensee, when there is an intent to close, curtail, reduce, or change operations, to notify the commissioners of health and human services, the local agency, the ombudsman for older Minnesotans, and the ombudsman for mental health and mental retardation. Specifies notice requirements.

10 **Planning process.** Amends § 144A.186. Requires the local agency to notify specified parties upon receiving notice from a licensee, and with the licensee convene a meeting to develop a relocation plan. Specifies requirements for the relocation plan.

11 **Requirements of licensee.** Adds § 144A.1865. Assigns duties to the licensee related to the relocation process. Requires the licensee to cooperate with other entities, establish an interdisciplinary team to coordinate and implement the relocation plan, and provide information to the local agency on residents to be relocated to the local agency.

12 **Resident and physician notice.** Adds § 144A.187. Requires the licensee to provide at least 60 days notice of closure or a change in operations to each resident, the resident's family member or designated representative, and the resident's physician. Also requires the licensee to request from a resident's attending physician medical information needed to update medical records and prepare transfer forms and discharge summaries.

13 **Relocation of residents.** Adds § 144A.1875. Requires the licensee to provide sufficient preparation to residents to ensure safe, orderly, and appropriate discharge or relocation. Assigns duties to the licensee related to relocation. Requires the licensee to assist residents in finding a placement, using the Senior LinkAge database. Requires the licensee to conduct meetings with residents and other individuals, and to account for personal property and funds. Requires the licensee to provide a final written notice of relocation to the resident seven days before relocation, that identifies the date of the anticipated relocation and the location to which the resident is being relocated. Requires the licensee to make arrangements or provide for transportation of residents, and upon request, to provide a staff person to accompany the resident.

14 **Relocation reports.** Adds § 144A.1885. Sets requirements for weekly status reports to be submitted by the licensee to the commissioners of health and human services or their designees and the local agency.

15 **Requirements of local agency.** Adds § 144A.1886. Assigns duties to the local agency related to the relocation process.

16 **Funding.** Adds § 144A.1887. Requires the commissioner to reimburse nursing homes for costs incurred during the closure process, within 60 days of cessation of operations. Specifies the method for reimbursing nursing homes.

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

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

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

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

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

18 **Alternative nursing home survey process.** Adds § 144A.37. Establishes an alternative process for nursing home surveys.

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

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

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

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

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

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

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

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

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

19 **Innovations in quality demonstration grants.** Adds § 144A.38. Requires the commissioner of health and the commissioner of human services to establish a long-term care grant program that demonstrates best practices and innovation for long-term care service delivery and housing. Sets criteria for the program and limits grants to $100,000 each.

20 **Long-term care quality profiles.** Adds § 144A.39. Establishes a long-term care quality profiles system.

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

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

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

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

21 **Special provisions for moratorium exceptions.** Amends § 256B.431, subd. 17. Eliminates the requirement that a project be authorized through the competitive moratorium exceptions process in

order to receive higher investment-per-bed limits.

22 **Payment during first 90 days.** Amends § 256B.431, by adding subd. 31. For rate years beginning on or after July 1, 2001, sets the total payment rate for a nursing facility under the cost-based or alternative payment systems, or any other payment system, at 120 percent of the facility's rate for each case mix class for the first 30 paid days, and at 110 percent of the facility's rate for each case mix class for the next 60 days. Beginning with day 91 after admission, sets the payment rate at the rate determined under the cost-based, alternative payment, or other relevant payment system. Provides that the subdivision applies to admissions occurring on or after July 1, 2001.

23 **Nursing facility rate increases beginning July 1, 2001, and July 1, 2002.** Amends § 256B.431, by adding subd. 32. For the next two rate years, requires the commissioner to provide three percent adjustments to the total operating payment rate of nursing facilities reimbursed under the cost-based and alternative payment systems.

24 **Additional increases for low rate metropolitan area facilities.** Amends § 256B.431, by adding subd. 33. Provides rate floors for each case mix category for nursing facilities located in the seven-county metropolitan area. Sets the floor for nursing homes with case mix class A rates below the region median at the set of case mix rates for the facility at the median for case mix A.

25 **Rate floor for facilities located outside the metropolitan area.** Amends § 256B.431, by adding subd. 34. For the rate year beginning July 1, 2001, requires the commissioner to adjust operating cost per diems for nursing facilities located outside the seven-county metropolitan area, by comparing current facility per diems for each case mix classification to per diems specified in the subdivision. Requires the commissioner to reimburse facilities using the specified per diems, if the facility would receive total reimbursement that is higher than the reimbursement the facility would otherwise receive using its facility specific per diems. If total reimbursement would be lower, the facility is to be reimbursed at its own per diems.

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

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

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

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

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

31 **Exemptions.** Amends § 256B.434, subd. 10. Eliminates language that exempts certain construction projects undertaken by facilities in the alternative payment system from the moratorium exception process, but which also prohibits contract rates from being increased to reflect these costs.

32 **Implementation of a case mix system for nursing facilities based on the minimum data set.** Adds § 256B.437. Establishes a new case mix reimbursement system for nursing facilities, based upon a 34

group, RUG-III model.

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

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

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

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

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

Subd. 6. Reconsideration of resident classification. Requires requests for reconsideration of resident classifications to follow procedures established by the commissioner of health.

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

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

Subd. 1. Definitions. Defines terms.

Subd. 2. Planning and development of community-based services. Requires the commissioner of human services to establish a process to adjust the capacity and distribution of long-term care services to fit with demand. Requires the process to support the expansion of alternative care and elderly waiver services, and requires integration with current county planning efforts. Specifies requirements for the plan.

Subd. 3. Request for applications for planned closure of nursing facilities. Requires the commissioner, by July 15, 2001, to implement and announce a program for nursing facility closure or partial closure. Requires the commissioner to approve planned closures of at least 5,140 beds by June 30, 2003, with no more than 2,070 approved for closure prior to July 1, 2002, less the number of beds in facilities that close without approved closure plans or have notified the commissioner of an intent to close. Allows facilities with an approved closure plan to assign a planned closure rate adjustment to another facility or facilities, or retain the adjustment in cases of partial closure. Allows facilities, including those without a closure plan or whose closure plan is not approved, to elect to have a planned closure rate adjustment or an equivalent amount, shared equally by the five lowest rate facilities in the state development region. Establishes application criteria.

Subd. 4. Criteria for review of application. Establishes criteria for reviewing applications.

Subd. 5. Review and approval of proposals. Establishes an application review and approval process, under which proposals are reviewed by the interagency long-term care planning committee and jointly approved or denied by the commissioners of human services and health.

Subd. 6. Planned closure rate adjustment. Provides a rate adjustment of $2,080 for each closed bed, which is applied to beds remaining in operation as identified in the closure plan.

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

Subd. 8. County costs. Requires the commissioner to allocate to counties up to $500 per bed that is closing, within the limits of appropriations, for costs related to their required role in the relocation process.

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

(b) Provides the methodology for calculating the rate adjustment.

(c) Provides that facilities with rates governed by closure agreements, receivership agreements, or under interim rates are not eligible for an adjustment.

35 **Physician and dental reimbursement.** Amends § 256B.76. Provides a 38 percent increase in reimbursement for mental health services for an entity that operates both a Medicare certified comprehensive outpatient rehabilitation facility and a Rule 80 facility, for which at least 33 percent of clients receiving rehabilitation services and mental health services are MA recipients.

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

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

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

39 **Report on standards for subacute care facility licensure.** Requires the commissioner of health to report to the legislature by January 15, 2003 on implementation of a licensure program for subacute care.

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

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

42 **Nursing assistant, home health aid curriculum.** Requires the commissioner of health, in consultation with specified parties, to report recommendations to legislative chairs on updating the nursing assistant and home health aide curriculum, by January 15, 2003.

43 **Evaluation of reporting requirements.** Requires the commissioners of human services and health,

in consultation with interested parties, to evaluate long-term care provider reporting requirements, eliminate unnecessary requirements, and seek any necessary law changes. Requires the commissioner to report to the relevant legislative committee chairs by February 1, 2002.

44 **Nursing facility multiple sclerosis pilot project.** Requires the commissioner of human services, for the period July 1, 2001 to June 30, 2003, to establish and implement a pilot project to contract with up to six nursing facilities that serve ten or more persons with multiple sclerosis. Sets the maximum payment rate for these individuals at 150 percent of the case mix rate. Requires the commissioner to determine if the additional payments enable facilities to adequately meet needs for individual care and specialized programming. Requires the commissioner to report to the legislature by January 15, 2003. Provides that the negotiated adjustment shall not affect private pay rates.

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

46 **Repealer.** Repeals § 144.0721, subd. 1 (assessment of the appropriateness and quality of care provided to private pay residents). Repeals § 256B.434, subd. 5. (This section allows facilities in the alternative payment system to elect to charge the Medicare rate to private pay residents who stay 100 days or less. If a private pay resident stays longer than 100 days, requires facilities to retroactively reduce the rate to the MA rate and reimburse the resident.)

Article 6: Work Force

Overview

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

Expand the summer health care intern program (section 1).
Provide grants for intergenerational programs to encourage students to work and volunteer in long-term care settings (section 2).
Require the commissioner to seek federal approval for the resident attendant worker category (section 3 to 6).
Allow registered nurses trained in other countries to receive temporary permits to practice (section 7).

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

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

3 **Assistance with eating and drinking.** Amends § 144A.62, subd. 1. Requires the commissioner of health to submit a new federal waiver request to establish the resident attendant worker category, by July 15, 2001.

4	**Definition.** Amends § 144A.62, subd. 2. Expands the definition of resident attendant to include persons who transport residents.
5	**Requirements.** Amends § 144A.62, subd. 3. Makes conforming changes related to resident attendants.
6	**Evaluation.** Amends § 144A.62, subd. 4. Makes conforming changes related to resident attendants.
7	**Temporary permit.** Amends § 148.212. Allows a temporary permit to practice as a registered nurse to be issued to an applicant who has been issued a commission on graduate of foreign nurse schools certificate and meets other criteria.

Article 7: Regulation of Supplemental Nursing Services Agencies

Overview

This article contains provisions related to the regulation of supplemental nursing services agencies (temporary nursing pools). Provisions in the article:

Require background studies to be conducted on employees and controlling persons of temporary nursing pools, and require temporary nursing pools to reimburse the commissioner of human services for the cost of background studies (sections 1 and 6).
Set maximums for temporary nursing pool charges (section 5).

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

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

3 **Registration requirements.** Adds § 144A.72. Establishes minimum requirements for registered temporary nursing pools, including a requirement that the pool document that temporary employees provided to health care facilities meet minimum licensing, training, and continuing education standards for their position.

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

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

6 **Background study of the applicant; definitions.** Amends § 245A.04, subd. 3. Requires temporary nursing pools to reimburse the commissioner of human services for background studies conducted on pool employees.

7 **Report on supplemental nursing services agency use.** Beginning July 1, 2001 through June 30, 2003, requires nursing facilities to report information on use of supplemental nursing services semiannually to the commissioner of human services.

Article 8: Long-Term Care Insurance

Overview

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

The change involves:

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

Instead the change focuses on premium rate stability by:

Requiring insurers to prove that their initial premium rate schedules can reasonably be expected to be stable over the lifetime of the policy form.
Requiring insurers to provide more information to prospective policyholders about possible future premium increases.
Requiring insurers to provide some benefits to policyholders who drop coverage in response to unexpected premium rate increases.

Sections 13 and 14 require state agencies to promote purchase of long-term care insurance.

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

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

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

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

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

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

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

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

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

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

11 **Premium rate schedule increases.** Adds § 62S.265. Specifies requirements that insurers must meet

to obtain permission to increase premium rate schedules on policies after they have been sold.

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

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

14 **Long-term care partnership.** Adds § 256B.0571. Requires the commissioner of human services and the commissioner of commerce to establish the Minnesota partnership for long-term care program to provide financing for long-term care by exempting from the MA asset limit assets equal to the value of long-term care insurance coverage. Requires the commissioner of human services to seek appropriate state plan amendments and federal waivers. Sets eligibility requirements and policy standards. This provision cannot go into effect unless the state can obtain from the federal government an administrative waiver or a change in federal law.

Article 9: Mental Health and Civil Commitment

Overview

This section amends definitions in the adult and children's mental health acts, provides Medical Assistance coverage for new mental health services, and makes other changes regarding mental health, and section 20 prohibits suicide statistics from being reported as crime statistics.

Section 1 establishes suicide prevention activities to be conducted by the commissioner of health.
Sections 7, 8, and 9 prohibit counties from requiring a child to demonstrate that mental health services were provided in a less restrictive setting and that the child did not make progress in that setting before the child may be served in a more restrictive setting.
Section 10 authorizes the commissioner of human services to use children's mental health grants to fund transition services for young adults ages 18 to 21.
Sections 12, 13, 21, and 22 establish a continuing care benefit program for persons with mental illness, require notice of the program to be provided, and require a study.
Sections 14, 15, and 18 establish Medical Assistance coverage for adult rehabilitative mental health services, adult mental health crisis response services, and mental health provider travel time.

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

Subd. 1. Public health goal; suicide prevention plan. Directs the commissioner to make suicide prevention an important public health goal and to refine, coordinate, and implement the state's suicide prevention plan.

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

Subd. 3. Workplace and professional education. Directs the commissioner, in collaboration with employer and professional associations, unions, and safety councils, to promote the use of employee

	assistance and workplace programs to support employees with psychiatric illnesses and substance abuse disorders and refer them to services. Also directs the commissioner to assist local public health and community-based professionals in implementing best practices for suicide prevention.
	Subd. 4. Collecting and reporting suicide data. Directs the commissioner to coordinate with other relevant agencies to collect, analyze, and annually report to the public on Minnesota-specific data on suicide and suicidal behaviors.
	Subd. 5. Periodic evaluations; biennial reports. Directs the commissioner to evaluate the outcomes of implementing the state's suicide prevention plan, and to make biennial reports of the results of those evaluations, beginning July 1, 2002, to the chairs of the House and Senate health and human services policy and finance committees.
2	**Day treatment services.** Amends § 245.462, subd. 8. Includes education and consultation provided to families and other individuals as part of the treatment process in the definition of day treatment under the adult mental health act.
3	**Mental health professional.** Amends § 245.462, subd. 18. Amends the definition of mental health professional in the adult mental health act to allow psychological practitioners, in addition to psychologists, to qualify as mental health professionals.
4	**Significant impairment in functioning.** Amends § 245.462, by adding subd. 25a. Defines significant impairment in functioning in the adult mental health act.
5	**Day treatment services.** Amends § 245.4871, subd. 10. Includes education and consultation provided to families and other individuals as part of the treatment process in the definition of day treatment under the children's mental health act.
6	**Mental health professional.** Amends § 245.4871, subd. 27. Amends the definition of mental health professional to allow psychological practitioners, in addition to psychologists, to qualify as mental health professionals.
7	**Criteria.** Amends § 245.4876, subd. 1. Adds a cross-reference to section 8, to require children to receive mental health services in the most appropriate, least restrictive settings.
8	**Appropriate setting to receive services.** Amends § 245.4876, by adding subd. 1a. Requires a child to be provided with mental health services in the least restrictive setting that is appropriate to meet the child's needs and current condition, and prohibits requiring the child to demonstrate that services were provided in a less restrictive setting and that the child failed to make progress in that setting before the child can access services in a more restrictive setting (like residential treatment or inpatient hospital treatment).
9	**Screening required.** Amends § 245.4885, subd. 1. Prohibits a county board from determining that inpatient treatment is not appropriate for a child solely because the child did not first receive services in a less restrictive setting and failed to make progress in that setting.
10	**Statewide program; establishment.** Amends § 245.4886, subd. 1. In a subdivision directing the commissioner of human services to establish a statewide program to help counties provide services with children with severe emotional disturbance, expands the scope of the program to include the provision of transition services to young adults between the ages of 18 and 21 and their families. Requires transition services to be designed to foster independent living in the community. This allows children's mental health grants to be used to fund transition services provided to young adults between ages 18 and 21 and their families.
11	**Administration of crisis housing assistance.** Amends § 245.99, subd. 4. Specifies that the crisis housing assistance program for adults with mental illness is not an entitlement program. Also authorizes the commissioner to transfer funds from mental health grants in the same appropriation or

	impose specified statewide restrictions on the type and amount of assistance available to recipients, if the commissioner projects that funds are not sufficient to meet demand in a given fiscal year.
12	**Payments.** Amends § 256.969, subd. 3a. Strikes language authorizing the commissioner of human services to establish contract beds, in which the commissioner contracts with hospitals for beds in which people with mental illness or chemical dependency may receive services for a length of stay longer than that allowed by the person's diagnostic category (portions of this language are being moved to section 256.9693). Adds a cross-reference to section 256.9693 to allow MA reimbursement for treatment of mental illness to not be based on diagnostic classification if services are provided in contract beds. This section is effective July 1, 2002.
13	**Continuing care program for persons with mental illness.** Adds § 256.9693. Directs the commissioner to establish a continuing care benefit program for persons with mental illness, to allow them to obtain acute care inpatient hospital treatment for mental illness for up to 45 days beyond that allowed by a diagnostic category. Allows MA-eligible persons to obtain treatment under this program in hospital beds for which the commissioner contracts. Allows the commissioner to contract with a utilization review organization to authorize access to the continuing care benefit, and directs the commissioner to establish admission criteria for accessing the benefit. Allows a person to be treated under this program as part of court-ordered inpatient treatment, but prohibits the commissioner from requiring a commitment or petition proceeding as a condition of accessing the program. Specifies that this benefit is not available for certain Medicare-eligible people. If a person is enrolled in a prepaid plan, specifies that this program is included in the plan's coverage. This section is effective July 1, 2002.
14	**Adult rehabilitative mental health services.** Adds § 256B.0623. Establishes medical assistance coverage for adult rehabilitative mental health services.
	Subd. 1. Scope. Specifies that MA covers adult rehabilitative mental health services, subject to federal approval, if provided to eligible recipients, provided by qualified provider entities and qualified individual providers, and determined to be medically necessary.
	Subd. 2. Definitions. Defines the following terms: adult rehabilitative mental health services, medication education services, and transition to community living services.
	Subd. 3. Eligibility. Specifies eligibility criteria for adult rehabilitative mental health services: recipients must be age 18 or older, diagnosed with a medical condition for which adult rehabilitative mental health services are needed, have a substantial disability and functional impairment in three or more areas, and have a recent diagnostic assessment documenting that such services are medically necessary.
	Subd. 4. Provider entity standards. Establishes 19 standards regarding provider capacity and skill, administrative ability, training, service delivery, flexibility in service delivery, quality assurance, and other areas that entities providing adult rehabilitative mental health services must meet. Requires a provider entity to be county-operated and certified by the state, or a private entity and certified by each county in which it provides services. Requires recertification at least every two years. Provides for decertification of provider entities. Requires the commissioner to develop statewide procedures for provider certification, including time lines for certification.
	Subd. 5. Qualifications of provider staff. Requires services to be provided by qualified staff of a certified provider entity. To be qualified, requires staff to be a mental health professional; a mental health practitioner working under the clinical supervision of a mental health professional; or a mental health rehabilitation worker working under the direction of a practitioner or professional and under the clinical supervision of a professional and meeting specified criteria relating to education, training, and life experience with mental illness or providing care to a person with mental illness.

	Subd. 6. Required training and supervision. Paragraph (a) requires mental health rehabilitation workers to receive at least 30 hours of continuing education every two years in relevant areas, and requires working under ongoing direction and clinical supervision. Paragraph (b) required mental health practitioners to receive continuing education as required by their professional license or at least 30 hours every two years in relevant areas, and requires working under ongoing clinical supervision. Paragraph (c) lists the tasks a mental health professional must perform when providing clinical supervision. Paragraph (d) requires a provider entity to have a treatment director who is a mental health practitioner or mental health professional, and specifies duties of the treatment director. Paragraph (e) requires a mental health practitioner who is serving as a treatment director to be supervised at least monthly by a mental health professional, and specifies duties of the supervising professional.
	Subd. 7. Personnel file. Requires a provider entity to maintain a personnel file on each staff person working for the provider entity. Lists what must be included in the personnel file.
	Subd. 8. Diagnostic assessment. Requires a service provider to complete a diagnostic assessment of a recipient of services within a specified time period, or to update a previous assessment, and specifies what must be included in the update.
	Subd. 9. Functional assessment. Requires a service provider to complete a functional assessment of a recipient of services within 30 days of intake, and requires the assessment to be reviewed and updated at least every six months thereafter. If there is a significant change in functioning, also requires the assessment to be updated. Allows one functional assessment to meet the case management and adult rehabilitative mental health services requirements, if the recipient agrees. Requires the recipient of services to have significant participation in the functional assessment's development, unless the recipient refuses.
	Subd. 10. Individual treatment plan. Requires providers to develop and implement individual treatment plans for each recipient. Defines individual treatment plan as a plan of intervention, treatment, and services for an individual recipient, based on diagnostic and functional assessments. Requires plans to be developed within 30 days of intake and updated every six months or whenever there is a change in situation, functioning, services, or service methods, or at the request of a recipient or legal guardian. Specifies what must be included in an individual treatment plan. Allows an individual community support plan developed under the adult mental health act to serve as the individual treatment plan if the recipient approves and if the mental health case manager is involved.
	Subd. 11. Recipient file. Requires providers to maintain a file for each recipient of services. Lists what must be included in each recipient's file.
	Subd. 12. Additional requirements. Requires providers to comply with the requirements relating to referrals for case management services in a section of the adult mental health act. Specifies where services may be provided and where they may not be provided. Allows services to be provided in group settings if appropriate for each recipient.
	Subd. 13. Excluded services. Lists services for which reimbursement is prohibited: recipient transportation services, services by providers not enrolled to provide adult rehabilitative mental health services, services by volunteers, provider performance of household tasks, time spent on call, activities that are primarily social or recreational, job-specific skills services, provider service time included in case management reimbursement, outreach services to potential clients, mental health services that are not medically necessary, and services provided by a hospital, board and lodging, or residential facility to patients or residents.
	Subd. 14. Billing when services are provide by qualified state staff. Includes state staff working under the adult mental health pilot projects as part of the local provider entity that is certified, and allows the entity to bill MA for services provided by these state staff. Payments for services by state

	staff shall only be made from federal funds.
15	**Adult mental health crisis response services.** Adds § 256B.0624. Establishes medical assistance coverage for adult mental health crisis response services.
	Subd. 1. Scope. Specifies that MA covers adult mental health crisis response services as defined in this section, subject to federal approval, if provided to an eligible recipient and provided by a qualified provider entity and by a qualified individual provider working within the provider's scope of practice, and if the services are medically necessary.
	Subd. 2. Definitions. Defines the following terms for this section: mental health crisis, mental health emergency, mental health crisis assessment, mental health mobile crisis intervention services, and mental health crisis stabilization services.
	Subd. 3. Eligibility. Specifies eligibility criteria for adult mental health crisis response services: recipients must be age 18 or older, screened as possibly experiencing a mental health crisis or emergency where a mental health crisis assessment is needed, and assessed as experiencing a mental health crisis or emergency and crisis intervention or stabilization services, or both, are determined to be medically necessary.
	Subd. 4. Provider entity standards. Requires a provider entity to be a county board-operated entity or a provider entity under contract with the county board in the county where the crisis or emergency is taking place. Establishes 18 standards regarding provider capacity and skill, administrative ability, training, service delivery and coordination of services, flexibility in service delivery, quality assurance, and other areas that entities providing adult mental health crisis response services must meet. Requires a provider entity to be an enrolled MA provider.
	Subd. 5. Mobile crisis intervention staff qualifications. Requires a mobile crisis intervention team to be comprised of at least two mental health professionals, or at least one mental health professional and one mental health practitioner with required mental health crisis training who is working under the clinical supervision of a mental health professional on the team. Specifies that the team must be composed of at least two people, with at least one member providing on-site crisis intervention services when needed. Lists skills team members must have. Requires the team to recommend and coordinate the team's services with appropriate local resources.
	Subd. 6. Initial screening, crisis assessment, and mobile intervention treatment planning. Requires a screening to occur before initiating mobile crisis intervention services, to gather information, determine whether a crisis situation exists, identify parties involved, and determine an appropriate response. If a crisis exists, requires a crisis assessment to be completed, and specifies what a crisis assessment must include. If an assessment determines that mobile crisis intervention services are needed, requires the services to be provided promptly. Requires at least one of the team members to be on-site providing services. Requires the team to develop a crisis treatment plan as soon as appropriate but no later than 24 hours after the initial face-to-face intervention. Specifies what the plan must include. Requires the team to document which short-term goals have been met. Requires the team to provide referrals to other necessary services and to coordinate planning for further services with the recipient's case manager, if the recipient has one.
	Subd. 7. Crisis stabilization services. Requires stabilization services to be provided by qualified staff of a provider entity. Requires a crisis stabilization treatment plan to be developed, requires staff providing services to satisfy the qualifications listed in another subdivision of this section, and requires services to be delivered according to the treatment plan and include face-to-face contact with the recipient. Specifies how services must be provided if they are provided in a supervised, licensed residential setting. Lists staffing requirements that apply to services provided in a setting that serves 4 residents or fewer and staffing requirements that apply to services provided in a setting that serves more than 4 residents.

	Subd. 8. Adult crisis stabilization staff qualifications. Requires mental health crisis stabilization services to be provided by qualified staff of a qualified provider entity. Specifies who are qualified staff: mental health professionals; mental health practitioners working under the qualified supervision of a mental health professional; and mental health rehabilitation workers who meet the education and training requirements in section 14, subdivision 5, clause (3), and who are working under the direction of a mental health practitioner of mental health professional and under the clinical supervision of a mental health professional. Requires mental health practitioners and mental health rehabilitation workers to have completed at least 30 hours of training in crisis intervention and stabilization in the past two years.
	Subd. 9. Supervision. Establishes clinical supervision requirements that mental health practitioners must meet to provide crisis assessment and mobile crisis intervention services. Requires the mental health provider entity to accept full responsibility for the services provided. Also requires the mental health professional providing clinical supervision to be available by phone or in person; to be consulted during the first three hours when on-site services are provided; to review, approve, and sign the crisis assessment and treatment plan; to contact the recipient face-to-face if mobile crisis intervention services continue into a second day; and to document and sign on-site observation.
	Subd. 10. Recipient file. Requires providers of mobile crisis intervention or crisis stabilization services to maintain a file for each recipient of services, and specifies what each recipient's file must contain.
	Subd. 11. Treatment plan. Lists what must be included in an individual crisis stabilization treatment plan.
	Subd. 12. Excluded services. Lists services for which reimbursement is prohibited: room and board services, services delivered to a recipient in a hospital, recipient transportation costs, services provided by a provider who is not an enrolled MA provider, services provided by volunteers, time spent on call, provider service time included in reimbursement for case management services, outreach services to potential recipients, and services that are not medically necessary.
16	**Mental health case management.** Amends § 256.0625, subd. 20. Amends a subdivision authorizing MA reimbursement for mental health case management services, to allow Indian tribal agencies to enroll with the state as MA providers and receive reimbursement for case management services. (Under current law, a tribal agency can receive MA reimbursement for these services only if the agency has a county contract.) Specifies that if services are provided by a tribal agency, the nonfederal share of any costs for mental health case management services must be provided by the recipient's tribe instead of by the recipient's county of responsibility.
17	**Appeal process.** Adds subd. 43 to § 256B.0625. Allows a provider, or a recipient acting on the provider's behalf, to appeal to the commissioner if a county declines to contract with or certify a provider for the provision of mental health services under MA. Specifies that if the commissioner finds that the provider meets applicable standards, the commissioner shall enroll the provider as an authorized provider. Directs the commissioner to develop procedures for appeals of county decisions to refuse to contract with or certify a provider. After the commissioner makes a decision regarding an appeal, allows a provider, recipient, or county to request reconsideration of the decision. Specifies that the commissioner's reconsideration decision is final and not subject to further appeal.
18	**Mental health provider travel time.** Adds subd. 44 to § 256B.0625. Provides MA coverage for provider travel time to provide MA-covered mental health services outside the provider's normal place of business, if the recipient's individual treatment plan so requires. Specifies that this does not include travel time included in other billable services.
19	**Reimbursement for mental health services.** Adds § 256B.761. Requires medication management, outpatient mental health, day treatment, home-based mental health, and family community support

	services to be reimbursed as follows:
	(1) for services rendered between July 1, 2001 and July 1, 2002, the lower of (i) submitted charges or (ii) the 73rd percentile of the 50th percentile of 1999 charges; and
	(2) for services rendered on or after July 1, 2002, the lower of (i) submitted charges or (ii) the 75th percentile of the 50th percentile of 1999 charges.
20	**Suicide statistics.** Adds § 299A.76. Prohibits the commissioner of public safety from labeling statistics on committing or attempting suicide as crime statistics. Allows the crimes of aiding suicide, aiding attempted suicide, and statistics directly related to the commission of a crime, to be labeled as crime statistics.
21	**Notice regarding establishment of continuing care benefit program.** Requires the commissioner of human services to provide notice to counties, health plan companies, providers, and enrollees of the existence of the continuing care benefit program. This section is effective July 1, 2002.
22	**Study; length of stay for Medicare-eligible persons.** Requires the commissioner of human services to study and make recommendations on how Medicare-eligible enrollees can access the continuing care benefit. Requires a report to the legislature by January 15, 2002.
23	**Development of payment system for adult residential services grants.** Requires DHS to review funding methods for adult residential services grants and develop a payment system that takes into account client difficulty of care. Requires a report to the legislature by January 15, 2002.

Article 10: Assistance Programs

Overview

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

Delay, for one year, the implementation date of when the Minnesota Food Assistance Program will be limited to noncitizens who are age 50 or older (section 2).
Put two-parent MFIP families into a separate state program that can only be paid for with state general fund dollars (section 3).
Relocate sections of current law to consolidate the MFIP application procedures that are currently located in various places within the MFIP statute (sections 4 to 8).
Provide for an annual adjustment to the MFIP earned income disregard so that most participants do not lose eligibility until the participant's income is 120 percent of the federal poverty guidelines (section 10).
Modify the sanction policy for MFIP applicants and participants who have been convicted of a drug-related offense (section 11).
Establish hardship extensions beyond the first 60 months on MFIP for certain categories of families (section 15).
Modify the sanction policy for noncompliant MFIP participants by providing for a 30 percent sanction with vendor payment for a second or third occurrence of noncompliance and disqualifying an assistance unit from MFIP for a fourth occurrence of noncompliance (section 17).
Delay, for one year, a provision that makes legal noncitizens ineligible for state-funded MFIP benefits.

1	**Immigration status verifications.** Amends § 256.01, subd. 18. Replaces a provision in current law with the current federal reporting requirement. Requires the commissioner to comply with reporting

	requirements under 42 U.S.C. § 611a and any federal regulation or guidance adopted under that law. This federal law requires certain entities to report to the INS, at least four times annually, any individual who, under the TANF or Welfare-to-Work programs, the entity "knows is not lawfully present in the United States." Federal guidance was issued on September 28, 2000, that clarifies the circumstances for which an entity "knows" that an individual is not lawfully present in the United States.
2	**Program established.** Amends § 256D.053, subd. 1. Delays the implementation date of when the Minnesota Food Assistance Program will be limited to noncitizens who are 50 or older by one year, until July 1, 2003.
3	**Separate state program for use of state money**. Creates new § 256J.021. Beginning October 1, 2001, requires the commissioner to treat all assistance paid to a two-parent family with a minor child as expenditures under a separate state program. (Note: This change means that federal TANF funds cannot be used to provide assistance to these families; only state monies may be used.)
4	**Where to apply**. Amends § 256J.09, subd. 1. Clarifies that to apply for assistance, a person must submit a signed application to the county agency where that person lives.
5	**County agency responsibility to provide information**. Amends § 256J.09, subd. 2. Clarifies that when a person inquires about assistance, a county agency must explain the eligibility requirements of, and how to apply for, diversionary assistance, emergency assistance, MFIP, or any other assistance for which the person may be eligible.
6	**Submitting the application form**. Amends § 256J.09, subd. 3. Paragraph (a), adds the following six items to the list of information that a county agency must disclose after the county agency provides application forms to a person who has inquired about assistance:
	the information the county agency will verify at application;
	the county's average application processing time and how the application will be processed;
	how to contact the county agency if the person's application information changes and how to withdraw the application;
	the next step in the application process and what a person must do if the application is approved;
	the child care and transportation services that are available to help caregivers attend the initial screening and orientation; and
	identify any language barriers and arrange for translation assistance during appointments, including but not limited to the screening, orientation, and initial assessment.
	New paragraph (c), relocates a provision in current law that requires the county agency, upon the participant's request, to arrange for transportation and child care or reimburse the participant for transportation and child care expenses necessary to enable participants to attend the screening and orientation.
7	**Screening**. Adds new subd. 3a to § 256J.09. Relocates a provision in current law that requires the county agency or, at county option, the county's employment and training service provider, to screen each applicant to determine immediate needs and to determine whether the applicant may be eligible for another program not funded by TANF, diversionary assistance, or emergency assistance.
8	**Interview to determine referrals and services**. Adds new subd.3b to § 256J.09. Provides that a county agency must do the following if an applicant is not diverted from applying for MFIP, and the applicant meets the MFIP eligibility requirements:
	(1) identify applicants who are under age 20 and explain the assessment procedures and

	employment plan requirements for minor parents (relocates a provision in current law that is being repealed in this article);
	(2) explain the criteria for an exemption for victims of family violence and explain what a participant should do to develop an alternative employment plan;
	(3) determine if an applicant qualifies for an exemption from employment and training services requirements, explain how to report status changes, and explain that a person who is exempt may volunteer to participate in employment and training services;
	(4) for applicants who are not exempt from the orientation requirement, arrange for an orientation and initial assessment;
	(5) inform an applicant who is not exempt from the orientation requirement that failure to attend the orientation is considered an occurrence of noncompliance and will result in a sanction; and
	(6) explain how to contact the county agency for questions about compliance with program requirements.
9	**Eligibility after disqualification due to noncompliance**. Adds subd. 3 to § 256J.15. Paragraph (a), specifies that an applicant for MFIP who was disqualified from the program because of noncompliance with the program's requirements, and who reapplies for MFIP within six months of the disqualification, is considered to be a new MFIP applicant. This means that the $2,000 asset limit and the initial income test apply, and that if the applicant is determined to be eligible, a county agency has the option of providing MFIP assistance in vendor payment form for up to six months.
	Paragraph (b), reduces the assistance unit's grant by 10 percent of the applicable MFIP standard of need for the first six months that the assistance unit returns to MFIP under this subdivision.
	Paragraph (c), provides that participants who have been disqualified from the program two or more times and who are eligible for MFIP under this subdivision are considered to have a third occurrence of noncompliance and must be sanctioned at the 30 percent level for the first six months on MFIP.
10	**MFIP exit level**. Amends § 256J.24, subd. 10. Authorizes the commissioner to annually adjust the MFIP earned income disregard to ensure that most participants do not lose eligibility for MFIP until their income is greater than or equal to 120 percent of the federal poverty guidelines. (Current law authorizes the commissioner to make such adjustments in state fiscal years 2000 and 2001 only.)
11	**Person convicted of drug offenses**. Amends § 256J.26, subd. 1. Paragraph (a), clause (2), specifies the sanction for an MFIP participant who has been convicted of a drug-related offense and who fails a random drug test. Item (i), requires that for failing a random drug test the first time, the assistance unit's grant, after making vendor payments for rent and utilities, be reduced by 30 percent of the applicable MFIP standard of need. Requires a job counselor to attempt to meet with the person face-to-face and specifies that, during the face-to-face meeting, the job counselor must inform the participant of the consequences of a subsequent drug test failure and of the right to appeal. If a face-to-face meeting is not possible, requires the county to send a notice of adverse action, which must include the information required in the face-to-face meeting.
	Item (ii), permanently disqualifies a participant from MFIP if the participant has been convicted of a drug-related offense and fails a drug test two times. Reduces the assistance unit's grant by the amount that would have otherwise been made available to the disqualified participant. Clarifies that disqualification under this item does not make a participant ineligible for food stamps. Before the disqualification is imposed, requires the job counselor to attempt to meet with the participant face-to-face. During the face-to-face meeting, requires the job counselor to identify other resources that may be available to meet the needs of the family and inform the participant of the right to appeal. If a face-to-face meeting is not possible, requires the county to send a notice of adverse action, which

	must include the information required during the face-to-face meeting.
	Paragraph (a), clause (3), specifies that if a participant who fails a drug test the first time and is under sanction for failing to comply with other MFIP requirements, the participant is considered to have more than one occurrence of noncompliance and is subject to the applicable level of sanction.
	Paragraph (b) makes applicants or participants who request or receive only food stamps and who have been convicted of a drug-related offense and who have failed a random drug test one or more times, subject to the same sanctions under paragraph (a) for applicants requesting or receiving both the cash and food portion of the MFIP grant. Also provides for the same face-to-face meeting requirements under paragraph (a).
12	**Participant's right to notice**. Amends § 256J.31, subd. 4. Provides that a notice of adverse action must be understandable at a seventh grade reading level. Requires a notice written in English, and including the Department of Human Services language block, to be sent to every applicable participant.
13	**Requirement to report to immigration and naturalization service**. Amends § 256J.32, subd. 7a. Replaces a provision in current law with the current federal reporting requirement. Requires the commissioner to comply with reporting requirements under 42 U.S.C. § 611a and any federal regulation or guidance adopted under that law. This federal law requires certain entities to report to the INS, at least four times annually, any individual who, under the TANF or Welfare-to-Work programs, the entity "knows is not lawfully present in the United States." Federal guidance was issued on September 28, 2000, that clarifies the circumstances for which an entity "knows" that an individual is not lawfully present in the United States.
14	**Case review**. Adds new subd. 6 to § 256J.42. Paragraph (a), requires a job counselor to review a participant's case within 180 days before the end of the participant's 60th month on MFIP to determine if the employment services plan is still appropriate, or if the participant is exempt under § 256J.56 from the employment and training services component, and to attempt to meet with the person face-to-face.
	Paragraph (b), specifies information that the job counselor must explain to the participant during the face-to-face meeting, as follows:
	(1) how many months of counted assistance the participant has accrued and when the participant is expected to reach the 60^{th} month;
	(2) the hardship extension criteria and what the participant should do if the participant thinks an extension applies;
	(3) other resources that may be available to meet the needs of the family; and
	(4) the right to appeal.
	Paragraph (c), requires the county to send a notice of adverse action if a face-to-face meeting is not possible.
	Paragraph (d), requires the county to ensure the following before a participant's case is closed under this section: that the case has been reviewed by the job counselor's supervisor or the review team to determine if the criteria for a hardship extension were applied appropriately and that the job counselor attempted to meet with the person face-to-face.
15	**Hardship extensions**. Creates new § 256J.425. Establishes hardship extensions for certain participants.
	Subd. 1. Eligibility. Provides that a participant (or, if there is more than one participant in the household, each participant) must be in compliance in order to be eligible for assistance beyond the first 60 months of assistance. Defines compliance, for the purposes of determining eligibility for a

	hardship extension, as any month in which a participant has not been sanctioned.
	Subd. 2. Ill or incapacitated participants; dependent household member. Paragraph (a) provides that an assistance unit may be eligible to receive a hardship extension if the participant belongs to any of the following groups:
	(1) participants who are suffering from a certified illness, injury or incapacity, which is expected to continue for more than 30 days, and prevents the person from finding or keeping a job, and who are following the treatment recommendations of the health care provider certifying the illness, injury or incapacity;
	(2) participants who are needed in the home to care for a household member who is certified to be ill or incapacitated, and the illness or incapacity is expected to continue for more than 30 days; or
	(3) caregivers who are needed in the home to care for a household member who meets certain disability or medical criteria, or certain criteria for severe emotional disturbance, or serious and persistent mental illness.
	Paragraph (b) allows an assistance unit receiving assistance under a hardship extension under this subdivision to continue to receive assistance as long as the participant continues to belong to the groups under paragraph (a). Requires a quarterly case review of assistance units receiving assistance under this subdivision to determine if the participant still falls under one of the groups under paragraph (a).
	Subd. 3. Certain hard-to-employ participants. Paragraph (a) provides that an assistance unit may be eligible to receive a hardship extension if the participant belongs to any of the following groups:
	(1) a person who is diagnosed as mentally retarded or mentally ill, and that condition prevents the person from obtaining or retaining employment;
	(2) a person who has been assessed by a vocational specialist, job counselor, or the county agency, to be unemployable. Requires a participant's eligibility under this category to be reassessed at least annually; or
	(3) a person who is determined by the county agency to have a learning disability, provided that if a rehabilitation plan is developed or approved, the person is following the plan. Specifies that a rehabilitation plan does not replace the requirement to develop an comply with an employment plan.
	Paragraph (b) allows an assistance unit receiving assistance under a hardship extension under this subdivision to continue to receive assistance as long as the participant continues to meet the criteria in paragraph (a), clause (1), (2), or (3), and all participants in the assistance unit remain in compliance with, or are exempt from, the employment and training service requirements.
	Subd. 4. Victims of family violence. Establishes a hardship extension for participants who received assistance that counted toward the federal 60-month time limit, while at the same time, the participant complied with a safety plan, or after October 2, 2001, an alternative employment plan. Extends assistance for a period of time equal to the number of months that were counted toward the federal 60-month time limit while the participant complied with a safety plan or, after October 1, 2001, an alternative employment plan.
	Subd. 5. Accrual of certain exempt months. Paragraph (a) establishes a hardship extension for a caregiver who is no longer eligible for a hardship extension under subdivision 2, paragraph (a), clause (3) (extension for participants caring for a disabled household member) and the person received assistance that counted toward the federal 60-month limit while, at the same time, the

	person was or would have been exempt from employment and training requirements because the participant was needed in the home to care for a disabled household member. Extends assistance for a period of time equal to the number of months that were counted toward the federal 60-month time limit while the participant was or would have been exempt from the employment and training requirements because the participant was needed in the home to care for a disabled household member.
	Paragraph (b) establishes a hardship extension for caregivers who received TANF assistance that counted toward the federal 60-month limit while, at the same time, met the state's exemption criteria under § 256J.42, subd. 5 (minor caregivers, caregivers over age 60, months in which an assistance unit received emergency or diversionary assistance). Extends assistance for a period of time equal to the number of months that were counted toward the federal time limit while the caregiver met the state time limit exemption criteria.
	(Currently, months in which a caregiver meets the criteria for a *state* exemption from the time limit, are paid for with state-only funds. This has the effect of stopping the federal time limit. Before the final TANF regulation was released in April 1999, the state was uncertain how to handle state exemptions to the time limit and, in some cases, used federal, or a combination of state and federal money to provide assistance to exempt assistance units. Under this paragraph, an extension would be granted to give back those months of eligibility that the assistance unit would have had if the assistance would have been paid for using state-only money.)
16	**County agency to provide orientation**. Amends § 256J.45, subd. 1. Clarifies that a county agency must provide a face-to-face orientation to each MFIP caregiver. Also makes a technical change, revising the provision concerning who must receive an orientation to directly specify, rather than specifying by internal cross-reference, the caregivers who are exempt because they are working enough hours.
17	**Participants not complying with program requirements**. Amends § 256J.46, subd. 1. Paragraph (a), clarifies that before a sanction may be imposed, a county must send a notice of intent to sanction and, when applicable, a notice of adverse action.
	New paragraph (b), requires an alternative employment plan to be reviewed to determine if the plan's activities are still appropriate before a sanction can be imposed on a victim of family violence who fails to comply with the plan. If the activities are not appropriate, requires that the plan be revised with a person trained in domestic violence and approved by a job counselor. Requires the participant to comply with regular employment services activities if the participant fails to comply with an alternative employment plan that is still appropriate and does not need to be revised.
	Paragraph (c), corrects a cross-reference.
	Paragraph (d), clauses (1) and (2), update terminology to refer to an "assistance unit" rather than a "household." Clause (2), specifies that the 30 percent sanction with vendor payment applies to a second or third occurrence of noncompliance and provides that a participant's case must be reviewed as required under paragraph (e) if an assistance unit is sanctioned under this clause.
	New clause (3) of paragraph (b), disqualifies an assistance unit from receiving MFIP assistance when there is a fourth occurrence of noncompliance. Requires the disqualification to be in effect for at least one month. Clarifies that disqualification under this clause does not make a participant ineligible for food stamps. Before an assistance unit is disqualified under this clause, the county must ensure that the case has been reviewed by the job counselor's supervisor or the review team to determine if the review required under paragraph (e) has occurred and that the job counselor attempted to meet with the person face-to-face.

	Paragraph (e), when a 30 percent sanction is in effect, requires the county agency or job counselor to determine if the employment services plan is still appropriate and to attempt to meet with the participant face-to-face. If a face-to-face meeting is not possible, requires the county to send a notice of adverse action.
	New clause (1) of paragraph (b) lists the topics that a job counselor must cover with the participant during the face-to-face meeting.
	Clause (2), adds qualification of for a family violence waiver to the situations in which the grant must be restored retroactively to the first day of the month that the participant was found to qualify.
	Makes the family violence provisions in paragraph (e) effective October 1, 2001, if the alternative employment plan and family violence provisions in § 256J.52, subd. 6 are enacted during the 2001 session.
18	**Dual sanctions.** Amends § 256J.46, subd. 2a. Paragraph (b) provides that a participant who was subject to sanction for noncompliance with program requirements before being subject to sanction for noncooperation with support requirements (or vice versa) is considered to have more than one occurrence of noncompliance and faces the applicable level of sanction.
	Paragraph (c) clarifies that, for a participant who first becomes subject to sanction for both noncompliance with program requirements and for noncooperation with support requirements at the same time, in the second and subsequent months of noncompliance and noncooperation, the participant is considered to have more than one occurrence of noncompliance and is subject to the applicable level of sanction. Corrects cross-references throughout the subdivision.
19	**Sanction status after disqualification**. Adds new subd. 3 to § 256J.46. Provides that if an MFIP applicant who was disqualified from the program because of noncompliance returns to MFIP within six months of the disqualification, the applicant is considered to have a first occurrence of noncompliance. Provides that if an MFIP applicant who was disqualified from the program a second or subsequent time returns to MFIP within six months of the disqualification, the applicant is considered to have a third occurrence of noncompliance. Requires the applicant to stay in compliance with program requirements for six months in order for a subsequent occurrence of noncompliance to be considered a first occurrence.
20	**Employment and training services component of MFIP**. Amends § 256J.50, subd. 1. Requires counties to provide employment and training services within 30 days of receipt of a request from a caregiver who is no longer eligible for MFIP due to reaching the 60-month time limit, and whose income is below 120 percent of the federal poverty guidelines. Requires a caregiver to request employment and training services within 12 months after the caregiver's case was closed.
21	**Local service unit plan**. Amends § 256J.50, subd. 7. Adds a requirement that a local service unit's plan must address how it will use local intervention grants for self sufficiency (LIGSS) to target and provide outreach to caregivers who, within the last 12 months, are no longer eligible for MFIP due to reaching the 60-month time limit, and whose income is below 120 percent of the federal poverty guidelines.
22	**Employment and training services component; exemptions**. Amends § 256J.56. Updates terminology to refer to a "participant" rather than "caregiver" or "individual." Specifies that a participant is exempt from employment and training services requirements if the participant is needed in the home to care for an ill or incapacitated household member, when the illness or incapacity is expected to continue for more than 30 days. Strikes provisions in current law that exempt the following two groups from the employment and training services requirements: single parents, or one parent in a two-parent family, that are employed at least 35 hours per week; and second parents in two-parent families employed for 20 or more hours per week when the first parent

	is working at least 35 hours per week.
23	**Notice of intent to sanction**. Amends § 256J.57, subd. 2. When a job counselor or the county sends a notice of intent to sanction, provides that a notice written in English, including the Department of Human Services language block, must be sent to every applicable participant.
24	**Continuation of certain services.** Amends § 256J.62, subd. 9. Authorizes the continuation of case management, counseling, or other supportive services for participants who are no longer eligible for MFIP because they have reached the 60-month limit. Permits counties to provide these services for up to 12 months after the participant is no longer eligible for or on MFIP.
	Also removes a limitation from current law that prevents a county from spending funds for the duration of an employment and training service if the funds have not been obligated before the participant loses MFIP eligibility.
25	**Establishment; guaranteed minimum allocation**. Amends § 256J.625, subd. 1. Allows counties or tribes to use the guaranteed minimum allocation of local intervention grants for self-sufficiency (LIGSS) money to serve participants who, within the last 12 months, have been determined to be ineligible for MFIP because they have reached the 60-month limit, and whose income is below 120 percent of the federal poverty guidelines.
26	**Set-aside funds**. Amends § 256J.625, subd. 2. Allows counties or tribes that are awarded additional LIGSS funds to use those additional funds to serve participants who are no longer eligible for MFIP because they have reached the 60-month limit, and whose income is below 120 percent of the federal poverty guidelines.
27	**Use of funds**. Amends § 256J.625, subd. 4. Prohibits the use of LIGSS funds for benefits defined under federal law as "assistance" for assistance units that are no longer eligible for MFIP due to reaching the 60-month time limit.
28	**County performance management**. Amends § 256J.751. Modifies the county performance management section to include a quarterly report to each county on that particular county's performance on certain measures; a quarterly report to all counties on each county's performance on certain measures; and an annual report to all counties and the legislature.
	Subd. 1. **Quarterly county caseload report**. Directs the commissioner to report quarterly to each county on that particular county's performance on the following 11 measures:
	(1) number of MFIP cases receiving only the food portion;
	(2) number of child-only cases;
	(3) number of minor caregivers;
	(4) number of cases that are exempt from the 60-month time limit, by exemption category;
	(5) number of participants who are exempt from employment and training services requirements, by exemption category;
	(6) number of assistance units receiving assistance under a hardship extension;
	(7) number of participants and number of months spent in each level of sanction;
	(8) number of MFIP cases that have left assistance;
	(9) federal participation requirements as specified in Title I of the federal welfare reform law;
	(10) median placement wage rate;
	(11) of each county's total MFIP caseload, less the number of cases in clause (1) to (6), the number of one-parent cases; number of two-parent cases; percent of one-parent cases that are working more than 20 hours per week; percent of two-parent cases that are working more

	than 20 hours per week; and percent of cases that have received more than 36 months of assistance.
	Subd. 2. Quarterly comparison report. Directs the commissioner to report quarterly to all counties on each county's performance on the following measures:
	(1) percent of MFIP caseload working in paid employment;
	(2) percent of MFIP caseload receiving only the food portion of assistance;
	(3) number of MFIP cases that have left assistance;
	(4) federal participation requirements as specified in Title I of Public Law Number 104-193;
	(5) median placement wage rate; and
	(6) caseload by months of TANF assistance;
	Subd. 3. Annual report. Directs the commissioner to report to all counties and to the legislature, beginning January 1, 2002 and each January 1 thereafter, on each county's annual performance on the measures required under subd. 1 by race and ethnic group. Specifies that the report must also include each county's performance on the number of out-of-wedlock births and births to teen mothers; and MFIP cases by racial and ethnic group.
	Subd. 4. Development of performance measures. Adds a specific date (January 1, 2002) by which the commissioner, in consultation with counties, must develop measures for county performance and adds the appropriateness of services provided to minority groups to the list of items that the commissioner must consider when developing these measures.
	Subd. 5. Failure to meet federal performance standards. Makes technical changes to conform with this section.
29	**Establishment and purpose.** Amends § 256K.25, subd. 1. Strikes a provision in current law that specifies that the supportive housing and managed care pilot projects must be located in two counties, one within the metro area and one outside the metro area.
30	**County eligibility.** Amends § 256K.25, subd. 3. Paragraph (a), adds the following item to the list of requirements that a county must comply with before it requests funding: the county must address, within its pilot design, the prevalence of mental illness, history of substance abuse, or HIV in the homeless population served.
	New paragraph (b), allows preference to be given to counties that cooperate with other counties that are participating in the pilot project for purposes of evaluation and to counties that provide additional funding.
31	**Participant eligibility.** Amends § 256K.25, subd. 4. (a) Strikes mental illness, a history of substance abuse, and HIV from the list of required eligibility criteria for the pilot project.
	New paragraph (d), permits counties participating in the project to initiate disenrollment criteria, subject to the commissioner's approval.
32	**Funding.** Amends § 256K.25, subd. 5. Strikes a reference to "TANF eligible" project participants, allowing the county to request general funds for any project participant. (The 2000 Legislature funded the project with TANF funds, which limited the use of those dollars to TANF eligible participants.) Also permits the commissioner to redirect funds to the pilot project.
33	**Report.** Amends § 256K.25, subd. 6. Provides that an assessment of the feasibility of financing the supportive housing and managed care pilot project through other health and human services programs must be included in the annual report.
34	**Specific powers.** Amends § 268.0122, subd. 2. Directs the commissioner of economic security to

	require all general employment and training programs that receive state funds to make available information about opportunities for women in nontraditional careers in the trades and technical occupations.
35	**Ineligibility for state funded programs.** Amends Laws 1997, chapter 203, article 9, section 21, as amended by Laws 1998, chapter 407, article 6, section 111, and Laws 2000, chapter 488, article 10, section 28. Delays for one year, until July 1, 2002, a provision that makes legal noncitizens ineligible for state-funded MFIP benefits.
36	**Report on assessment of county performance.** Requires the commissioner, in consultation with counties, to report on a proposal for assessing county performance using a methodology that controls for demographic, economic, and other variables that may impact county achievement of MFIP performance outcomes. Provides that the proposal must recommend how state and federal funds may be allocated to counties to encourage and reward high performance.
37	**Repealer**. Repeals the following:
	§ 256J.42, subdivision 4, which exempts victims of family violence from the 60-month time limit (in section 16 of this article, victims of family violence are eligible for a hardship extension);
	§ 256J.44, relating to the initial screening of MFIP applicants. The provisions of this section are relocated in section 7 and 8 of this article; and
	§ 256J.46, subdivision 1a, obsolete transitional sanction language.

Article 11: DHS Licensing

Overview

This article makes various policy and technical changes to human services licensing, data practices, maltreatment of minors, and vulnerable adults statutes. Provisions in this article:

- Modify and clarify requirements relating to disqualifications, maltreatment determinations, licensing actions based on those determinations, and appeal rights associated with those determinations (sections 2, 4, 6, 7, 9 to 17, 21 and 23).
- Permit the commissioner of human services and county agencies to share certain information regarding substantiated maltreatment with licensed programs and other agency and licensing boards (section 1).
- Authorize health-related licensing boards to take disciplinary action against individuals the boards regulate based on a report of substantiated maltreatment or background study (sections 3, 5 and 8).
- Require the department of human services to assess and investigate reports of maltreatment in a juvenile correctional facility (sections 18 to 20).
- Modify the definition of neglect and related reporting provisions under the Vulnerable Adults Act (sections 22 to 24).
- Require background studies to be conducted on employees and controlling persons of temporary nursing pools (section 2).

1	**Licensing data.** Amends § 13.46, subd. 4. (b) Permits the commissioner of human services, local social services agency, or county welfare agency to inform a license holder of the identity of a substantiated perpetrator and victim of maltreatment when both the perpetrator and victim are affiliated with the licensed program.
	(h) Permits the department of health to have access to not public data relating to a report of

	substantiated maltreatment for the purposes of completing background studies.
	(i) Permits the department of human services to share data on individuals relating to licensing activities or maltreatment investigations with the departments of human rights, health, and corrections, ombudsman for mental health and retardation, and professional regulatory boards when there is reason to believe that the laws or standards of those agencies may have been violated.
	(j) Requires the commissioner or local social services agency to notify the head of a facility that an individual is a substantiated perpetrator of child maltreatment based on sexual abuse, when the commissioner or agency knows that the individual is responsible for a child's care in that facility. Requires that the notice include information regarding the individual's appeal rights and status of any appeal. Also requires that a copy of the notice be given to the individual.
	Effective date. Makes this section effective July 1, 2001.
2	**Background studies on licensees and supplemental nursing services agency personnel.** Amends § 144.057. Requires background studies to be conducted on employees and controlling persons of temporary nursing pools (called supplemental nursing services agencies in this legislation). Adds a cross reference. Clarifies that the commissioner's decision regarding a reconsideration of a disqualification is not the final administrative agency action in cases where the disqualification is: (1) based on a preponderance of evidence that the individual committed a disqualifying act; (2) based on a determination that the individual committed serious or recurring maltreatment; or (3) the individual is an employee of a public employer.
	Effective date. Makes this section effective January 1, 2002.
3	**Health-related licensing boards; determinations regarding maltreatment.** Amends § 214.104. (a) Provides that a health-related licensing board must determine whether a regulated person under the board's jurisdiction should be the subject of disciplinary or corrective action because of a report of substantiated maltreatment or a background study that shows substantiated maltreatment. Strikes language from current law requiring the board to disqualify licensed individuals from direct contact with persons receiving services because of substantiated maltreatment.
	(b) Requires the board to notify the commissioner of human services of a report of substantiated maltreatment and whether the board has jurisdiction in the matter. If the board does not have jurisdiction, requires the commissioner of human services to make an appropriate disqualification decision. Also requires the board to immediately notify the commissioners of health and human services if the board knows that a facility or program is allowing a regulated person to provide direct contact services in violation of requirements placed on the person.
	(c) Permits the board to temporarily suspend the license, deny a credential, or require continuous supervision of a regulated person if the board finds there is probable cause to believe the person poses an immediate risk of harm to vulnerable persons. Provides that a board must consider certain information as part of its licensing action. Establishes procedures for providing notice to the regulated person, the commissioners of health and human services, and all known employment and practice settings of the regulated person of the licensing action and disciplinary hearing regarding the action.
4	**Exception.** Amends § 245A.03, subd. 2b. Makes terminology change.
	Effective date. Makes this section effective January 1, 2002.
5	**Notification to subject and license holder of study results; determination of risk of harm.** Amends § 245A.04, subd. 3a. (a) Provides that the commissioner may notify an agency initiating a background study of the basis for an individual's disqualification, when the individual is disqualified for failing to cooperate with the background study or for substantiated maltreatment of a minor or vulnerable adult.

	(b) Adds cross reference. Clarifies that, in cases where the subject of the background study is regulated by a health-related licensing board, the board, and not the commissioner of human services, will determine whether to impose disciplinary or corrective action if the subject of the background study is determined to be responsible for substantiated maltreatment of a minor or vulnerable adult.
	Also adds references to registered temporary nursing pools.
6	**Reconsideration of disqualification.** Amends § 245A.04, subd. 3b. (a) Provides that an individual who is disqualified based on serious or recurring maltreatment of a minor or vulnerable adult may request reconsideration of both the maltreatment and disqualification determinations. The individual must request reconsideration within 30 days of receipt of the notice of disqualification. Also provides that a maltreatment determination is deemed conclusive if an individual does not request reconsideration.
	(b) Requires the commissioner to rescind a disqualification if the commissioner finds that the information relied upon to disqualify the individual is incorrect.
	(d) Requires the commissioner to respond to a request for reconsideration within 45 working days after receiving the request if the request is based on both risk of harm and the accuracy and completeness of the information.
	(e) Strikes provision from current law making the commissioner's decision to disqualify, or set aside a disqualification of, an individual a final agency action not subject to further review or appeal. Provides that a disqualified person may request a fair hearing to review the disqualification if the person is disqualified based on a preponderance of the evidence that the person committed a disqualifying act or a failure to make a mandated report required by the Maltreatment of Minors Act or Vulnerable Adults Act. Provides that the commissioner's final order following a fair hearing is conclusive on the issue of disqualification and is the only administrative appeal of the final agency determination regarding the disqualification.
	(f) Provides that a reconsideration of a maltreatment determination and disqualification based on the maltreatment determination must be consolidated into one reconsideration. Requires the county agency to conduct the consolidated reconsideration if the county agency made the maltreatment and disqualification determination. Also provides that, if a person is disqualified on the basis of serious or recurring maltreatment and requests a fair hearing on the maltreatment determination, the scope of the hearing must include the maltreatment determination and disqualification. Provides that the commissioner's final order following a fair hearing is the only administrative appeal of the maltreatment determination and disqualification.
	Also adds references to registered temporary nursing pools.
	Effective date. Makes this section effective January 1, 2002.
7	**Contested case.** Amends § 245A.04, subd. 3c. (a) Provides that, when an employee of a public employer is disqualified based on a maltreatment determination, the scope of the contested case hearing must include the maltreatment determination and disqualification.
	(b) Provides that, when a disqualification is the basis for a denial of a license or a licensing sanction, the license holder has the right to a contested case hearing. Specifies the procedures for, and scope of, the hearing.
	(c) Provides that, when the disqualified person is not the license holder and the disqualification is the basis for a licensing sanction, there may be one consolidated contested case hearing with the consent of the parties and administrative law judge.
	(d) Provides that the commissioner's final order is conclusive and that the contested case hearing is

	the only administrative appeal of the final agency determination regarding the maltreatment and disqualification.
	Effective date. Makes this section effective January 1, 2002.
8	**Disqualification.** Amends § 245A.04, subd. 3d. (a) Clarifies language. Provides that persons over the age 13 and persons ages 10 to 12 living in the household where a licensed program will be provided, and persons who may have unsupervised access to children in the licensed program, must be disqualified from access to persons receiving services from the license holder if a background study shows that the person has been convicted of certain crimes or has admitted to or committed a disqualifying act. Defines "access" for purposes of this section.
	(b) Provides that a health-related licensing board must determine whether to impose disciplinary or corrective action when a person regulated by the board is determined to be responsible for substantiated maltreatment of a child or vulnerable adult. Requires the commissioner to notify the board upon completion of a background study of the maltreatment finding and indicate whether the person would be disqualified under the human services licensing act. Also requires the commissioner to concurrently send a copy of the notice to the person. Provides that the commissioner must make an appropriate disqualifying decision if the health-related licensing board informs the commissioner that it does not have jurisdiction. Permits the commissioner to monitor a facility's compliance with the requirements that a health-related licensing board places on the regulated person, to order immediate removal of a person who poses a risk of harm to persons served by the program, and notify the board of noncompliance with the requirements the board places on a facility or person. Provides that a facility that does not comply with the requirements imposed by the board is subject to a negative licensing action.
	Also adds references to registered temporary nursing pools.
9	**Denial of application.** Amends § 245A.05. Relocates provisions stricken from section 11. Permits the commissioner to deny a license if an applicant fails to comply with laws or rules or knowingly withholds or gives false or misleading information to the commissioner. Adds cross reference to the rules that will govern a hearing regarding the denial of an application.
	Effective date. Makes this section effective January 1, 2002.
10	**Correction order and conditional license.** Amends § 245A.06.
	Subd. 1. **Contents of correction orders and conditional licenses.** Provides that the commissioner may order a conditional license, instead of imposing a fine, when an applicant or license holder fails to comply with an applicable rule or law that does not imminently endanger the persons served by the program. Specifies factors the commissioner must consider when issuing a conditional license and information that must be included in the conditional license. Strikes language in current law regarding imposing fines.
	Subd. 3. Failure to comply. Permits the commissioner to impose a fine and order other licensing sanctions when an applicant or license holder has not corrected the violations specified in the conditional license. Strikes language in current law regarding imposing fines and taking other licensing actions for failure to correct a violation.
	Subd. 4. Notice of conditional license; reconsideration of conditional license. Relocates provisions stricken from section 11. Specifies requirements for notifying a license holder that a license is conditional. Also specifies procedures for a license holder to request reconsideration of the order of conditional license. Strikes provisions from current law relating to fines.
	Effective date. Makes this section effective January 1, 2002.
11	**Sanctions.** Amends § 245A.07.

	Subd. 1. Sanctions available. Clarifies language regarding sanctions that the commissioner may order.
	Subd. 2. Temporary immediate suspension. (a) Provides that the commissioner may temporarily suspend a license when the license holder's actions or failure to comply with applicable law or rule poses an imminent risk of harm to persons served by the program. Provides for an expedited hearing instead of a contested case hearing.
	(b) Provides that the commissioner is liable to a license holder for actual damages for days of lost service in an amount not more than $50,000 if the commissioner immediately suspends a license and the administrative law judge recommends, after a review of the facts in the expedited hearing process, that reasonable cause did not exist at the time the commissioner issued the immediate suspension.
	(c) Provides that the commissioner is not liable to a license holder if the administrative law judge recommends that reasonable cause exists for the immediate suspension.
	Subd. 2a. Immediate suspension expedited hearing. Specifies procedures and time lines for an expedited hearing of an immediate suspension of a license.
	Subd. 3. License suspension, revocation, or fine. Clarifies provisions regarding the commissioner's authority to suspend or revoke a license or impose a fine. Strikes provisions in current law regarding conditional licenses that are relocated in sections 9 and 10. Specifies procedures for providing notice, appeal, and payment of fines. Also specifies the amount of fines for certain violations of law or rule.
	Effective date. Makes this section effective January 1, 2002.
12	**Hearings.** Amends § 245A.08.
	Subd. 1. Receipt of appeal; conduct of hearing. Adds cross references.
	Subd. 2. Conduct of hearings. Adds cross references.
	Subd. 2a. Consolidated contested case hearings for sanctions based on maltreatment determinations and disqualifications. Specifies the scope of contested case hearings under certain circumstances; provides that the county attorney must defend sanctions issued in family child care, child foster care, and adult foster care homes; provides that the commissioner's final order following the contested case hearing is the final agency action and is not subject to further review; and provides for consolidation of hearings in certain circumstances.
	Subd. 3. Burden of proof. Clarifies provisions regarding the burden of proof at a hearing on a licensing sanction. Corrects cross reference.
	Subd. 5. Notice of the commissioner's final order. Adds cross references.
	Effective date. Makes this section effective January 1, 2002.
13	**Delegation of authority to agencies.** Amends § 245A.16, subd. 1. Makes conforming language changes.
	Effective date. Makes this section effective January 1, 2002.
14	**Sanctions available.** Amends § 245B.08, subd. 3. Makes conforming language changes.
	Effective date. Makes this section effective January 1, 2002.
15	**State agency hearings.** Amends § 256.045, subd. 3. (a) Provides for a state agency hearing for persons disqualified for serious or recurring maltreatment; persons disqualified on the basis that a preponderance of the evidence indicates they committed a disqualifying act; and persons who fail to make reports required by the Maltreatment of Minors Act or Vulnerable Adults Act. Specifies procedures for consolidation and scope of review of the hearings. Adds cross reference.

	Effective date. Makes this section effective January 1, 2002.
16	**Standard of evidence for maltreatment and disqualification hearings.** Amends § 256.045, subd. 3b. Specifies the evidentiary standard that a referee must find to affirm a proposed disqualification determination at a hearing regarding a disqualification. Adds cross reference.
	Effective date. Makes this section effective January 1, 2002.
17	**Conduct of hearings.** Amends § 256.045, subd. 4. Adds cross references.
	Effective date. Makes this section effective January 1, 2002.
18	**Persons mandated to report.** Amends § 626.556, subd. 3, of the Maltreatment of Minors Act. (c) Clarifies provisions requiring a person mandated to report child abuse or neglect occurring in a licensed facility. Specifies the agency to which a person must report the child abuse or neglect.
19	**Agency responsible for assessing or investigating reports of maltreatment.** Amends § 626.556, subd. 3c, of the Maltreatment of Minors Act. Specifies that the department of human services has responsibility for assessing and investigating reports of alleged child maltreatment in juvenile correctional facilities licensed by the department of corrections. Currently, the local county welfare agency where the institution is located has this authority.
20	**Duties of commissioner; neglect or abuse in facility.** Amends § 626.556, subd. 10b, of the Maltreatment of Minors Act. (c) Provides that an agency responsible for assessing or investigating a report of alleged child maltreatment occurring in a facility must be given access to information relevant to the assessment or investigation, and access to the facility. Provides that a facility that denies the investigating agency access to information must be subject to a negative licensing action. Also permits the investigating and licensing agencies to share not public data as necessary to complete an investigation or determine an appropriate licensing action.
21	**Administrative reconsideration of final determination of maltreatment and disqualification based on serious or recurring maltreatment.** Amends § 626.556, subd. 10i, of the Maltreatment of Minors Act. (a) Provides that an individual determined to have maltreated a child or who was disqualified on the basis of serious or recurring maltreatment may request reconsideration of the maltreatment determination and disqualification. Specifies that an individual must request reconsideration within 30 days of receiving notice of the disqualification.
	(b) Adds cross reference.
	(d) Adds cross reference.
	(e) Provides that a request for reconsideration of a maltreatment determination, and a request for reconsideration of a disqualification based on the maltreatment determination, must be consolidated into one reconsideration or fair hearing. Specifies that the scope of the hearing must include the maltreatment determination and disqualification.
	(f) Provides that, if a licensing sanction is based on a maltreatment determination or disqualification based on a maltreatment determination, the license holder has the right to a contested case hearing. Specifies the scope of the hearing and provides for consolidation of the hearings.
	Effective date. Makes this section effective January 1, 2002.
22	**Timing of report.** Amends § 626.557, subd. 3, of the Vulnerable Adults Act. (e) Requires a mandated reporter to report an error in the provision of care or services to a vulnerable adult that results in injury or harm to the vulnerable adult, which reasonably requires the care of a physician. Requires the reporter to provide information explaining how the reported error is not neglect, if the reporter believes that to be the case. Requires the investigating agency to consider this information when assessing the case.

	Effective date. Makes this section effective the day following final enactment.
23	**Administrative reconsideration of final disposition of maltreatment and disqualification based on serious or recurring maltreatment; review panel.** Amends § 626.557, subd. 9d, of the Vulnerable Adults Act. (a) Provides that an individual determined to have maltreated a vulnerable adult or who was disqualified on the basis of serious or recurring maltreatment may request reconsideration of the maltreatment determination and disqualification. Specifies that an individual must request reconsideration within 30 days of receiving notice of the disqualification.
	Effective date. Makes this paragraph effective January 1, 2002.
	(b) Adds cross reference.
	Effective date. Makes this paragraph effective January 1, 2002.
	(e) Provides that a request for reconsideration of a maltreatment determination, and a request for reconsideration of a disqualification based on the maltreatment determination, must be consolidated into one reconsideration or fair hearing. Specifies that the scope of the hearing must include the maltreatment determination and disqualification.
	Effective date. Makes this paragraph effective January 1, 2002.
	(f) Provides that, if a licensing sanction is based on a maltreatment determination or disqualification based on a maltreatment determination, the license holder has the right to a contested case hearing. Specifies the scope of the hearing and provides for consolidation of the hearings.
	Effective date. Makes this paragraph effective January 1, 2002.
	(g) Provides that, until August 1, 2002, an individual or facility determined to be responsible for neglect that occurred after October 1, 1995, and before August 1, 2001, may request reconsideration of the neglect determination if they believe that the finding does not meet the amended definition of neglect (in section 24). Requires the commissioners of human services and health to mail a notice to the last know address of persons eligible to seek reconsideration under this paragraph. Provides that the commissioner must review and make a determination on the reconsideration request within 15 calendar days and that the commissioner's decision is the final agency action. Specifies procedures for destructing data and rescinding disqualification determinations when a determination of substantiated maltreatment has been changed.
	Effective date. Makes this paragraph effective the day following final enactment.
24	**Neglect.** Amends § 626.5572, subd. 17. (c) Modifies definition of "neglect" in the Vulnerable Adults Act. Provides that a vulnerable adult is not neglected when an individual makes an error in providing therapeutic contact that results in injury or harm to the vulnerable adult, which reasonably requires the care of a physician if: the necessary care is timely provided; the injury or harm does not result in chronic injury or illness, or permanent disability above and beyond the vulnerable adult's preexisting condition; the error is not part of a pattern of errors; and, if the error occurs in a facility, the error is immediately reported, corrective action is taken, and the report and corrective action are sufficiently documented.
	(e) Provides that a facility is subject to a correction order for not immediately reporting, correcting, or documenting its compliance if it is determined that the facility's failure to take these actions is the sole reason for the maltreatment determination.
	Effective date. Makes this section effective the day following final enactment.
25	**Federal law change request or waiver.** Requires the commissioner of health or human services to pursue federal law changes necessary to allow greater discretion on disciplinary activities of unlicensed health care workers. Also requires the commissioner of health or human services to apply for necessary federal waivers or approval that would permit a disqualification set aside process for

	nurse aides in nursing homes by July 1, 2002.
26	**Waiver from federal rules and regulations.** Requires the commissioner of health, by January 2002, to examine federal rules and regulations prohibiting neglect, abuse, and financial exploitation of residents in nursing facilities. Also requires the commissioner to apply for federal waivers to allow the use of Minnesota law in the identification and prevention of maltreatment of residents in nursing facilities and in the disqualification or discipline of persons providing services in nursing facilities.

Article 12: Miscellaneous

Overview

This article makes changes to a variety of health and human services-related statutes. Provisions in this article:

Establish licensing requirements for family day care and group family day care providers to allow children in care to use swimming pools located at the day care homes (sections 1 and 4).
Modify requirements relating to public guardianship and require the commissioner of human services to provide county agencies with funds for public guardianship alternatives based upon county proposals to establish private alternatives (sections 6 to 12, 14 and 16).
Require that $6,000,000 each biennium be transferred from the shared services account to the general fund (section 5).
Delay until June 30, 2005, the sunset date for the council on disability (section 13).

1	**Pools at family day care or group family day care homes.** Amends § 144.1222, by adding subd. 2a. Provides that a swimming pool located at licensed family day care or group family day care home is not a public pool and is exempt from the regulatory requirements for public pools. Requires that a provider meet the licensing requirements in section 245A.14, subdivision 10 (section 2 of the bill), if the provider chooses to allow children cared for at the family day care or group family day care home to use the pool located at the home.
2	**Background checks.** Amends § 148B.21, subd. 6a. Directs the Board of Social Work to deposit all fees collected to conduct background checks on applicants for social work licensure into the miscellaneous special revenue fund, and to reimburse the Bureau of Criminal Apprehension for the cost of the background checks.
3	**Background checks.** Amends § 148B.22, subd. 3. Directs the Board of Social Work to deposit all fees collected to conduct background checks on social work licensees into the miscellaneous special revenue fund, and to reimburse the Bureau of Criminal Apprehension for the cost of the background checks (the background check requirement in this subdivision applies to social work licensees applying for license renewal who did not undergo a background check as part of the application for initial licensure).
4	**Swimming pools; family day care and group family day care providers.** Amends § 245A.14, by adding subd. 10. (a) Provides that a family day care or group family day care provider is eligible to allow a child in care to use a swimming pool located at the day care home if the provider has not had a licensing sanction or correction order or fine relating to the supervision or health and safety of children substantiated during the prior 24 months and the provider satisfies the following requirements:
	obtains annual written consent from a child's parents or legal guardian allowing the child to use the pool. The written consent must include materials from the department of health regarding the risk of disease and other health risks associated with swimming pools and a statement that the department of health and county will not monitor or inspect the provider's

	swimming pool to ensure compliance with the licensing requirements in this section;
	enters an annual written contract with a child's parents or legal guardian that specifies that the provider agrees to perform all requirements in this section;
	attends and successfully completes a pool operator training course once every five years. Specifies acceptable pool training courses;
	requires a caregiver trained in first aid and child cardiopulmonary resuscitation to supervise and be present at the pool with children using the pool; and
	meets several other requirements relating to maintaining the health and safety of children using the swimming pool.
	Provides that the requirements under this subdivision do not apply to portable wading pools or whirlpools located at family day care or group family day care homes.
	(b) Provides that a violation of the licensing requirements in this section is grounds for a sanction or correction order or fine. Prohibits a provider from continuing to allow children in care to use the pool located at the day care home if the provider receives a licensing sanction or correction order or fine relating to the supervision or health and safety of children in care.
5	**Shared services account.** Amends § 246.57, by adding subd. 7. Provides that, beginning July 1, 2001, $6,000,000 each biennium is transferred from the shared services account to the general fund. (The shared services account is the account into which receipts for shared services received by regional treatment centers or state-operated nursing homes under section 246.57, subdivision 1, are deposited.) Also provides that this subdivision expires June 30, 2005.
6	**Guardianship service providers.** Amends § 252A.02, by adding subd. 3a. Defines guardianship service providers. A guardianship service provider means an individual or agency that meets the ethical conduct and best practices standards of the National Guardianship Association, meets criminal background check requirements, and does not provide any other services to the individual for whom guardianship services are provided.
7	**Comprehensive evaluation.** Amends § 252A.02, subd. 12. Clarifies the definition of comprehensive evaluation. Provides that a case manager's report must include the most current individual service plan under section 256B.092, subdivision 1b. (Section 256B.092, subdivision 1b, identifies nine required components of an individual service plan for a person with mental retardation or a related condition.)
8	**Case manager.** Amends § 252A.02, subd. 13. Clarifies the definition of case manager. Provides that a case manager is the person designated under section 256B.092. (Section 256B.092 requires a county of financial responsibility to provide case management services to a person diagnosed as having mental retardation or a related condition.) Strikes language from current law providing that a case manager means the person designated by the county board to provide case management services.
9	**Special duties.** Amends § 252A.111, subd. 6. Adds requirement that the commissioner, in exercising the powers and duties of a public guardian or conservator, must protect and exercise the legal rights of the ward. Strikes obsolete provision from current law requiring the commissioner to prohibit filming of a ward.
10	**Review required.** Amends § 252A.16, subd. 1. Clarifies that the commissioner must require an annual review of the physical, mental, and social adjustment and progress of every ward and conservatee. Also clarifies that the review must contain the information required under Minnesota Rules, part 9525.3065, subp. 1.
11	**Petition.** Amends § 252A.19, subd. 2. Provides that procedures in current law for the appointment of

	a new guardian or conservator do not apply to a petition to remove a public guardian. (Section 525.61, subdivision 3, provides that a court, upon a motion to remove a guardian or conservator, shall appoint a new guardian or conservator if the court finds: (1) the existing guardian or conservator failed to perform duties or provide for the best interests of the ward or conservatee; and (2) the ward's or conservatee's best interests would be served by the appointment of a new guardian or conservator.)
12	**Witness and attorney fees.** Amends § 252A.20, subd. 1. Strikes language from current law prohibiting reimbursement for the services and travel of physicians, psychologists, or social workers who assist in the preparation of the comprehensive evaluation and who are employed by an area mental health retardation board.
13	**Sunset.** Amends § 256.482, subd. 8. Provides that the council on disability shall not sunset until June 30, 2005. (Under current law, the council on disability shall sunset June 30, 2001.)
14	**Public guardianship alternatives.** Requires the commissioner of human services to provide county agencies with funds up to the amount appropriated for public guardianship alternatives based upon the counties' proposals to establish private alternatives.
15	**Automatic defibrillator study.** Requires the emergency medical services regulatory board, in consultation with the department of public safety, to study and report to the legislature by December 15, 2002, regarding making automatic defibrillators available outside of the seven-county metropolitan area.
16	**Repealer.** Repeals section 252A.111, subd. 3 (requirements relating to a ward receiving outpatient services or temporary care from a regional treatment center).

Article 13: Appropriations

Overview

Article 13 contains the appropriations and riders for the Omnibus Health and Human Services Appropriations bill. This summary briefly summarizes the riders and related statutory section that is included at the end of the article. Note: This article does not include the detailed line-item appropriations and base amounts 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 the health and human services, and is a separate document.

1	**Health and human services appropriations.** Specifies that the total appropriations, for all state funds and TANF funds, made in the article are $3.653 billion in FY 2002 and $3.976 billion in FY 2003.
2	**Commissioner of human services.**
	Subd. 1. Total Appropriation. Specifies that the total human services appropriations, for all state funds and TANF funds, made in this article are appropriations of $3.468 billion in FY 2002 and $3.793 billion in FY 2003. Contains the following riders:
	Appropriation for court-ordered mental health treatment. Specifies an amount for the cost of implementing H.F. 560, if enacted.
	Appropriations for civil commitment. Specifies an amount for the cost of implementing H.F. 281 (relating to civil commitment), if enacted. Also specifies an amount to be transferred to the Minnesota Supreme Court for costs associated with petitions filed for judicial commitment.
	Appropriations for child support. Specifies amounts for the cost of implementing H.F.

		1807 and H.F. 1446, if enacted.
		Appropriation for patient protections. Specifies an amount from the general fund for the cost of implementing H.F. 560 (relating to patient protections), if enacted. Also specifies an amount from the health care access fund for the costs of implementing H.F. 560.
		Receipts for systems projects. Requires the state appropriations and federal receipts for the department's major computer systems to be deposited in the department's state systems account. Permits money appropriated for computer projects to be transferred between projects, and from development to operations, as needed. Permits unexpended funds to be available for ongoing development and operations.
		Gifts. Permits the commissioner to accept nonstate funds to finance the cost of assistance program grants, or to finance administrative costs.
		Systems continuity. Permits the commissioner, in the event that the department's technical systems or computer operations are disrupted, to use available grant appropriations to ensure that payments for maintaining the health, safety, and well-being of the people served by the programs continue uninterrupted.
		Special revenue fund information. Requires the commissioner to provide detailed fund balance information for each special revenue fund account to the chairs of the house health and human services finance committee and the senate health, human services, and corrections budget division.
		Federal administrative reimbursement. Appropriates certain federal administrative reimbursement to the commissioner. Requires any balance remaining at the end of the biennium to be transferred to the general fund.
		Nonfederal share transfers. Allows the nonfederal share of activities for which federal administrative reimbursement is appropriated to the commissioner to be transferred to the special revenue fund. Requires any balance remaining at the end of the biennium to be transferred to the general fund.
		Major systems transfer. Specifies an amount from the state systems account to be transferred to the general fund for the biennium ending June 30, 2003 and an amount from the state systems account to be transferred to the general fund for the biennium ending June 30, 2005.
		TANF funds appropriated to other entities. Requires expenditures from the TANF block grant to be expended according to the federal welfare reform law, and any applicable federal regulation. Requires the commissioner to ensure that the funds are expended in compliance with federal law and that federal reporting requirements are met. Specifies that an entity receiving TANF funds must implement a memorandum of understanding that assures compliance prior to the expenditure of funds. Requires the commissioner to receipt TANF funds appropriated to other state agencies and to coordinate all related interagency accounting transactions necessary to implement these appropriations. Specifies that unexpended TANF funds cancel at the end of the state fiscal year unless appropriating language permits otherwise.
		TANF funds transferred to other federal grants. Delineates requirements that the commissioner must follow when transferring TANF funds to other federal grants.
		TANF maintenance of effort. Specifies which non-federal expenditures the commissioner is permitted to report as TANF MOE. When the legislature is not in session, provides for interim review by the Legislative Commission on Planning and Fiscal Policy of TANF MOE expenditures, if the expenditures in paragraph (a) are not sufficient to meet the state's MOE

	requirements.
	Subd. 2. Agency management.
	(a) Financial operations.
	(b) Legal and regulation operations. Contains the following riders:
	Core licensing activities. Specifies an amount to support 14 new licensor positions and an amount to cover maintenance and operational costs for a new computer system. Lists outcomes that the commissioner must meet by January 1, 2003, in order to receive continued appropriations for these purposes.
	Expedited maltreatment investigations. Specifies an amount for various staff positions to achieve the goals for expedited maltreatment investigations. Provides that, by January 1, 2003, the commissioner must reduce the average length of time to complete maltreatment investigations to 60 days in order to receive continued appropriations for this purpose.
	Public guardianship incentives. Specifies an amount to provide fiscal incentives to encourage counties to establish private alternatives.
	(c) Management operations.
	Subd. 3. Administrative reimbursement/pass through.
	Subd. 4. Children's services grants. Contains the following riders:
	Adoption assistance incentive grants. Specifies an amount for adoption incentive grants.
	TANF transfer to social services. Requires the commissioner to authorize a transfer of funds from the TANF block grant to the state's social services block grant.
	Social services block grant funds for concurrent permanency planning. Specifies an amount from the social services block grant that are to be distributed to counties for concurrent permanency planning.
	Subd. 5. Children's services management.
	Subd. 6. Basic health care grants.
	(a) MinnesotaCare grants. Contains the following riders:
	MinnesotaCare federal receipts. Requires that any receipts received as a result of federal participation pertaining to administrative costs of the Minnesota health care reform waiver must be deposited as nondedicated revenue into the health care access fund. Specifies how the funds must be used.
	MinnesotaCare funding. Allows the commissioner to expend money appropriated from the health care access fund for MinnesotaCare in either year of the biennium.
	(b) MA basic health care grants - families and children.
	(c) MA basic health care grants - elderly and disabled. Contains the following rider:
	Medically needy standard and federal authorization. Specifies how funds must be used in the event that federal authorization to use the medical assistance income standard in § 256B.056, as the medically needy standard is not obtained.
	(d) General assistance medical care.
	(e) Health care grants - other assistance. Contains the following rider:
	Purchasing alliance stop-loss funding. Specifies an amount for the cost of establishing the purchasing alliance stop-loss fund under Minn. Stat. § 256.956.

	Subd. 7. Basic health care management.
	(a) Health care policy administration.
	(b) Health care operations. Contains the following rider:
	Prepaid medical programs. Specifies that the nonfederal share of the prepaid medical assistance program fund must be disbursed as grants using either a reimbursement or block grant mechanism.
	Subd. 8. State-operated services. Contains the following riders:
	Mitigation related to state-operated services restructuring. Allows money for mitigation expenses related to restructuring state operated services programs and administrative services to be transferred between fiscal years within the biennium.
	State-operated services chemical dependency programs. Relates to cash-flow transfers between the state operated services CD fund and the general fund when the operation of state-operated services chemical dependency fund is affected by cash deficiencies because receivables have been delayed.
	State-operated services restructuring. Relates to the options for state operated services employees whose positions are being eliminated under the restructuring.
	Repairs and betterments. Authorizes the commissioner to spend unencumbered appropriations balances for state residential facilities repairs and betterments and special equipment in either year of the biennium.
	Subd. 9. Continuing care grants.
	(a) Community social services block grants. Contains the following rider:
	CSSA traditional appropriation. Requires the principal portion of the CSSA appropriation to be allocated to counties in proportion to the amount of aid received by a county in CY 2000.
	(b) Aging adult service grants. Contains the following rider:
	County planning and service development. Specifies an amount for distribution to county boards for planning and development of community services for the elderly. Specifies how funds must be distributed to each county.
	(c) Deaf and hard-of-hearing services grants. Contains the following rider:
	Services to deaf persons with mental illness. Specifies an amount for a grant to a nonprofit agency that currently serves deaf and heard of hearing adults with mental illness through residential programs and supportive housing outreach activities.
	(d) Mental health grants.
	(e) Community support grants.
	(f) Medical assistance long-term care waivers and home care. Contains the following rider:
	Provider rate increases. Requires the commissioner to increase reimbursement rates by 3 percent in each year of the biennium for certain providers listed in paragraph (2) of the rider. Specifies that increases are effective for services rendered on or after July 1 of each year.
	(g) Medical assistance long-term care facilities. Contains the following riders:
	Moratorium exceptions. Relates to the approval of certain moratorium exception projects.
	Nursing facility operated by the Red Lake band of Chippewa Indians. Specifies how the

	MA payment rates for the 47-bed nursing facility operated by the band must be calculated and requires the commissioner to provide certain rate adjustments in each year.
	ICF/MR disallowance. Specifies an amount to reimburse a four-bed ICF/MR in Ramsey county for field audit disallowances.
	Community services development grants program. Specifies a one-time appropriation community services development grants. Allows unexpended appropriations in FY 2002 to be available for these purposes in FY 2003.
	Long-term care consultation services. Requires long-term care consultation services payments to all counties to continue at the payment amount in effect for readmission screening in FY 2001.
	(h) Alternative care grants. Contains the following riders:
	Alternative care transfer. Provides that unspent funds allocated for the alternative care program do not cancel, but are transferred to the MA account.
	Alternative care appropriation. Permits the commissioner to expend the money appropriated for the alternative care program in either year of the biennium.
	(i) Group residential housing.
	(j) Chemical dependency entitlement grants.
	(k) Chemical dependency non-entitlement grants. Contains the following rider:
	Consolidated chemical dependency treatment fund one-time transfer. Specifies an amount of the consolidated chemical dependency treatment fund (CCDTF) general reserve account to be transferred to the general fund.
Subd. 10. Continuing care management. Contains the following riders:	
	County involvement costs. Specifies an amount that must be allocated to counties for resident relocation costs resulting from planned closures and resident relocations. Provides that unexpended funds in the first year do not cancel, but are available in the second year.
	Region 10 quality assurance commission. Specifies an amount to be allocated to the region 10 quality assurance commission for certain projects and evaluations.
Subd. 11. Economic support grants.	
	(a) Assistance to families grants .
	(b) Work grants. Contains the following riders:
	Nontraditional career assistance. Specifies a one-time appropriation from the TANF block grant for grants for nontraditional career assistance training programs.
	Supportive housing and managed care pilot project. Specifies an amount for the supportive housing and managed care pilot project and allows the appropriation to be transferred between fiscal years within the biennium.
	Intensive intervention transitional employment training project. Specifies a one-time appropriation from the TANF block grant for the Southeast Asian collaborative in Hennepin county. Specifies how the funds must be used within the program.
	Local intervention grants for self-sufficiency carryforward. Provides that unexpended LIGSS funds in FY 2002 do not cancel, but are available in FY 2003.
	(c) Economic support grants - other assistance. Contains the following riders:
	TANF transfer to child care and development block grant. Specifies an amount to be

	transferred from the TANF block grant to the child care and development block grant (CCDBG).
	Working family tax credits. Specifies that the following specified portion of the expenditures under the state's Working Family tax credit program will be made with TANF funds, rather than the state general fund dollars: in FY 2002, $25 million, in FY 2003, $16 million.
	(d) Child support enforcement. Contains the following riders:
	Child support payment center. Requires that payments for services performed by the child support payment center must be deposited into the state systems account and are appropriated to the commissioner for the operation of the child support payment center or system.
	(e) General assistance. Contains the following rider:
	General assistance standard. Sets the monthly GA standard of assistance for a single adult at $203.
	(f) Minnesota supplemental aid.
	(g) Refugee services.
	Subd. 12. Economic support management.
	(a) Economic support policy administration. Contains the following riders:
	Food stamp administrative reimbursement. Requires the commissioner to reduce quarterly food stamp administrative reimbursement to counties in FY 2002 and FY 2003 by a specified amount. Specifies how the reductions must be allocated to each county and how adjustments to MA administrative reimbursement are to be distributed.
	Employment services tracking system. Specifies a one-time appropriation for the development of an employment tracking system. Provides that unexpended funds in FY 2002 do not cancel, but are available in FY 2003.
	(b) Economic support operations. Contains the following riders:
	Spending authority for food stamp enhanced funding. Provides that if the state qualifies for food stamp enhanced funding, the commissioner shall retain 25 percent for the Minnesota food assistance program, and must distribute the remaining 75 percent to counties, based on each county's impact on the statewide food stamp error rate.
	Financial institution data match and payment of fees. Specifies an amount from the PRISM special revenue account for payments to financial institutions in exchange for performing data matches between account information held by financial institutions and the public authority's database of child support obligors.
3	**Commissioner of health.**
	Subd. 1. Total appropriation. Specifies that the total health department appropriations, for all state funds and TANF funds, made in this article are appropriations of $138.591 million in FY 2002 and $138.716 million in FY 2003.
	Subd. 2. Family and community health. Contains the following riders:
	Eliminating health disparities. Specifies an amount for reducing health disparities and how the appropriations must be used.
	Teen pregnancy prevention. Specifies an amount from the TANF block grant for a teen pregnancy prevention program and how the appropriations must be used.
	Poison information system. Specifies a one-time appropriation for poison control system

	grants.
	Suicide prevention. Specifies an amount for suicide prevention activities and how the appropriation must be used.
	TANF home visiting program. Specifies an amount from the TANF block grant for the family home visiting programs. Clarifies that the appropriation includes the amounts that were appropriated to the commissioner of human services for transfer to the commissioner of health authorized by the 2000 Legislature.
	TANF home visiting carryforward. Provides that any unexpended balance of the TANF funds appropriated for the family home visiting program in the first year does not cancel, but is available in the second year.
	Teen pregnancy prevention carryforward. Provides that any unexpended balance of the TANF funds appropriated for the teen pregnancy program in the first year does not cancel, but is available in the second year.
	WIC transfers. Permits the appropriation for the WIC program to be transferred between fiscal years, in order to maximize federal funds or to minimize fluctuations in the number of participants.
	Minnesota children with special health needs carryforward. Provides that general fund appropriations for treatment services in the services for Minnesota children with special health needs program are available for either year of the biennium.
	One-time reduction for family planning special project grants. Reduces the base-level funding for the family planning special project grants for FY03.
	Subd. 3. Access and quality improvement. Contains the following riders:
	Health care safety net. Specifies an amount for a grant program to aid safety net community clinics and an amount for a grant program to provide rural hospital capital improvement grants.
	Subd. 4. Health protection. Contains the following rider:
	Emerging health threats. Specifies amounts to increase the state capacity to identify and respond to emerging health threats; to expand state laboratory capacity; and to train, consult, and assist local officials responding to clandestine drug laboratories and minimizing health risks to responders and the public.
	Subd. 5. Management and support services.
4	**Veterans nursing homes board.** Specifies that the total veterans nursing homes board appropriations, for all state funds, made in this article are appropriations of $30.336 million in FY 2002 and $28.784 million in FY 2003. Contains the following riders:
	Veterans homes special revenue account. Transfers the general funds that are appropriated to the board to the veterans homes special revenue account, and appropriates the monies from that account to the board, for the board's facilities and programs.
	Setting cost of care. Sets the cost of care for the domiciliary residents at the Minneapolis veterans home at 100 percent occupancy at each facility.
	Deficiency funding. Specifies an amount, with the approval of the commissioner of finance. Provides that approval is contingent upon review of a report from the board.
5	**Health-related boards.**
	Subd. 1. Total appropriations. Specifies that the total health-related boards appropriations, for all

	state funds, made in this article are appropriations of $10.8 million in FY 2002 and $10.892 million in FY 2003. Contains the following riders:
	State government special revenue fund. Specifies that all appropriations to the health-related boards are from the state government special revenue fund.
	No spending in excess of revenues. Prohibits the commissioner of finance from permitting a board to spend money appropriated in this section that is in excess of its anticipated biennial revenues or accumulated surplus revenues from fee collections.
	Subd. 2. Board of chiropractic examiners.
	Subd. 3. Board of dentistry.
	Subd. 4. Board of dietetic and nutrition practice.
	Subd. 5. Board of marriage and family therapy.
	Subd. 6. Board of medical practice.
	Subd. 7. Board of nursing. Contains the following rider:
	Health professional services activity. Specifies an amount for the health professional services activity.
	Subd. 8. Board of nursing home administrators.
	Subd. 9. Board of optometry.
	Subd. 10. Board of pharmacy. Contains the following rider:
	Administrative services unit. Specifies the portion of this appropriation that is for the health board's administrative services unit.
	Subd. 11. Board of physical therapy.
	Subd. 12. Board of podiatry.
	Subd. 13. Board of psychology.
	Subd. 14. Board of social work.
	Subd. 15. Board of veterinary medicine.
6	**Emergency medical services board.** Specifies that the total emergency medical services board appropriations, for all state funds, made in this article are appropriations of $3.033 million in FY 2002 and $3.037 million in FY 2003. Contains the following rider:
	Comprehensive advanced life support (CALS). Specifies an amount for the comprehensive advanced life support educational program.
7	**Council on disability.** Specifies that the total council on disability appropriations, for all state funds, made in this article are appropriations of $692,000 in FY 2002 and $714,000 in FY 2003.
8	**Ombudsman for mental health and mental retardation.** Specifies that the total ombudsman for mental health and mental retardation appropriations, for all state funds, made in this article are appropriations of $1.378 million in FY 2002 and $1.378 million in FY 2003.
9	**Ombudsman for families.** Specifies that the total ombudsman for families appropriations, for all state funds, made in this article are appropriations of $171,000 in FY 2002 and $171,000 in FY 2003.
10	**Transfers.**
	Subd. 1. Grants. Authorizes the commissioner, with the approval of the commissioner of finance, and after notifying the chairs of the senate health and family security budget division and the house health and human services finance committee, to transfer unencumbered appropriations balances

	within fiscal years between the following programs: MFIP; GA; GAMC; MA; MSA; GRH; and the entitlement portion of the consolidated chemical dependency treatment fund (CCDTF).
	Subd. 2. Administration. Permits the commissioners of health and human services, and the veterans nursing homes board, to transfer positions, salary money, and nonsalary administrative money within the departments, and within the board's programs, with the advance approval of the commissioner of finance. Requires quarterly reports to the chairs of the appropriate legislative committees about transfers made under this subdivision.
11	**Indirect costs not to fund programs.** Prohibits the commissioners of health and of human services from using indirect cost allocations to pay for the operational costs of any program for which they are responsible.
12	**Carryover limitation.** Prohibits any of the funding in this article that is allowed to be carried forward from the first to the second year from becoming part of an activity's base level funding, unless specifically directed.
13	**Sunset of uncodified language.** Provides that all uncodified language in this article expires June 30, 2001, unless there is a different expiration date explicit in the language of an uncoded provision.
14	**Project labor.** Codifies a rider relating to project laborers.